Partners in improving local health

Teeswide Safeguarding Adults Board

Practice Guidance for Reporting Medication incidents Into Safeguarding

Version 2.2

Contents

Date	Revision Number	Date Approved by the Board	Links to Other Policies	Review Date:
Mar 2020	2	N/A annual review; Near Miss Form amended	All other Teeswide Safeguarding Adults Policies	March 2022
Mar 2022	2.1	N/A – Minor review	All other Teeswide Safeguarding Adults Policies	March 2025
Oct 2025	2.2	N/A Annual Review – minor amends (TSAB Dec 2025 – Info Only)	All other Teeswide Safeguarding Adults Policies	October 2027

1.0 Purpose

The Teeswide Safeguarding Adults Board (TSAB) has developed this medication error practice guidance to assist with the appropriate reporting of medication issues as a safeguarding concern. This practice guidance is applicable to all settings where medication is included as part of their service delivery and should be applied in conjunction with the services' policies and procedures. The TSAB recognises that maintaining high quality services is essential to identify, respond to and minimise medication errors. It is also recognised that for safeguarding to be relevant and effective it also needs to be proportionate to the incident and the level of risk.

This guidance will support staff in all sectors who are concerned that a medication related incident may have arisen as a result of poor practice, neglect or intention to cause harm and therefore have to decide whether to raise a safeguarding concern under multi-agency safeguarding policy and procedures.

2.0 Definition of medication error

The National Patient Safety Agency (NPSA) 2009[1] defines a medication error as 'an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicine advice, regardless of whether any harm occurred'. Errors may result in an incident or an adverse event or where averted they can be classified as a 'near miss'.

3.0 Examples of medication errors

3.1 Prescribing

- Duplicate medicine; a drug prescribed by the both brand and generic names or two medicines that have the same action
- Wrong dosage, strength or formulation
- Issuing of a discontinued medicine
- Medication requested from surgery but no prescription supplied without reason
- A service user is prescribed a medicine that they are known to be allergic to
- A service user is prescribed a medicine that is contraindicated
- A service user is prescribed a medicine that is unnecessary for them
- A service user is prescribed a medicine that has an unwanted interaction with another medication that they are taking without the rationale for the risk having been documented.

3.2 Monitoring

- Monitoring not requested
- Monitoring requested but not carried out
- Monitoring performed but results not available
- Results not acted upon.

[1] Safety in Doses: Improving the use of medicines in the NHS Learning from national reporting 2007. National Reporting and Learning Service. National Patient Safety Agency

Examples of drugs requiring monitoring include: anticoagulants; cardiac glycosides; diuretics; antiarrhythmic; thyroid hormone; anti-manic agents; insulin and some anti-rheumatic drugs.

3.3 Dispensing

- Supply of duplicate medication
- Supply of the wrong dose to that prescribed
- Supply of the wrong strength to that prescribed
- Supply of a wrong formulation to that prescribed
- Supply of a wrong drug to that prescribed
- Supply of an out of date medication
- Omission in the supply of a prescribed medication
- Labelling error.

3.4 Administration

- Omission of a prescribed medication for a non-clinically indicated reason
- Administration of another person's medication which is not prescribed for them
- Administration of an extra dose(s)
- Administration of a wrong dose(s)
- Administration of a medication when a person has a known allergy to it.
- Administration of the wrong medicine
- Administration of the wrong formulation
- Administration of an out of date medication
- Administration of a medication at the wrong time
- Administration of a medication via the wrong route.

3.5 Ordering and record keeping

- Stock not ordered
- Stock not booked in correctly
- Stock not carried forward correctly
- Booking in of discontinued /not prescribed medication
- Stock not stored in the appropriate location
- Controlled Drug (CD) records not completed correctly
- Medication Administration Record (MAR) form not signed
- MAR form signed inappropriately (e.g. as if medication was administered, when stock count/ Multiple Dose Systems (MDS) packs show the contrary
- Deliberate alteration or amendment of MAR chart.

4.0 How to manage medication errors and near misses

4.1 In the event of a medication error:

If there is any doubt about the person's wellbeing, a 999 call for an ambulance must be made immediately. If the medication error results in serious harm[2] or death report to the police and to the Care Quality Commission (CQC) if the incident has occurred in a regulated service.

4.2 Staff member's responsibilities

- Contact the resident's GP, on-call service or pharmacist for advice
- Monitor the resident in accordance with the instruction from the GP, on-call service or pharmacist
- Inform the Registered Manager
- Inform the resident and/or relative as appropriate
- Record full details of the incident, including time, medication given, action taken and full signature in the resident's care plan
- Complete Incident report form (in adherence to service policy)
- Generate a safeguarding concern form if meeting Care Act (2014) criteria (Appendix A).

4.3 Managers responsibilities

- Review each incident to decide whether further action or investigation is required
- Generate a safeguarding concern form if meeting Care Act (2014) criteria (Appendix A) if this has not already been generated
- Inform the Care Quality Commissioner (CQC) as per regulatory requirement.
- Share learning with entire team
- Ensure staff are supported following incident
- Encourage and open reporting culture
- A full report needs to be placed on the person's file along with a copy of the incident form.

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[2] Patient Safety Incident Response Framework (PSIRF)
Serious harm may include:
Permanent physical harm resulting in long-term disability or loss of function
Psychological harm that significantly impairs a person's ability to function in daily life for a sustained period (e.g. 28 days or more)
Death resulting from the incident

Organisations should refer to their Patient Safety Incident Response Plan (PSIRP) to determine the appropriate response pathway and ensure that the incident is recorded in the Learn from Patient Safety Events (LFPSE) system.

5.0 Controlled Drugs

In the event of a discrepancy in the quantity of a controlled drug the Registered Manager must be contacted immediately. The Registered Manager, with the person who has discovered the discrepancy should:

- Check the date of receipt of the controlled drug and the amount of tablets / liquid entered into the controlled drug book
- Check this amount against the subsequent entries for administration of this drug
- If it is still calculated that there is a shortfall, the Registered Manager must investigate fully.

If there are facts that lead to a suspicion of theft, the police and the CQC and the Accountable Officer must be informed.

The Accountable Officer for this service is: …… (Manager to complete).

6.0 When a medication error should be reported as a safeguarding concern

Appendix A identifies the criteria in a flow chart format for whether a medication incident meets safeguarding reporting criteria. Appendix B provides some fictitious scenarios to provide examples of when a medication error would meet safeguarding criteria. In the event of a medication error if the adult has care and support needs and they came to harm or there had been potential for significant harm this meets the criteria for a safeguarding concern to be submitted into the relevant Local Authority.

For the purposes of this practice guidance significant harm is defined as: death or impairment to health which results in a permanent increase to a person's care and support needs.

If the criteria are not met at this stage the agency is required to complete an internal investigation.

The Medication Incident Log (Appendix C) should be completed within care home settings and sent to the Local Authority at the identified frequency within commissioning contractual arrangements.

During the internal investigation the medication error will meet the safeguarding criteria if one of the following is identified:

- The medication was given as a form of unlawful restraint
- The error was a result from an intentional act
- The medication had been administered covertly without due legal process
- There had been consecutive, multiple (more than two) medication errors involving the same adult
- The medication incident involved multiple adults
- Multiple repeat incidents within the same service area (e.g. Ward, Unit, Staff) or involving the same perpetrator

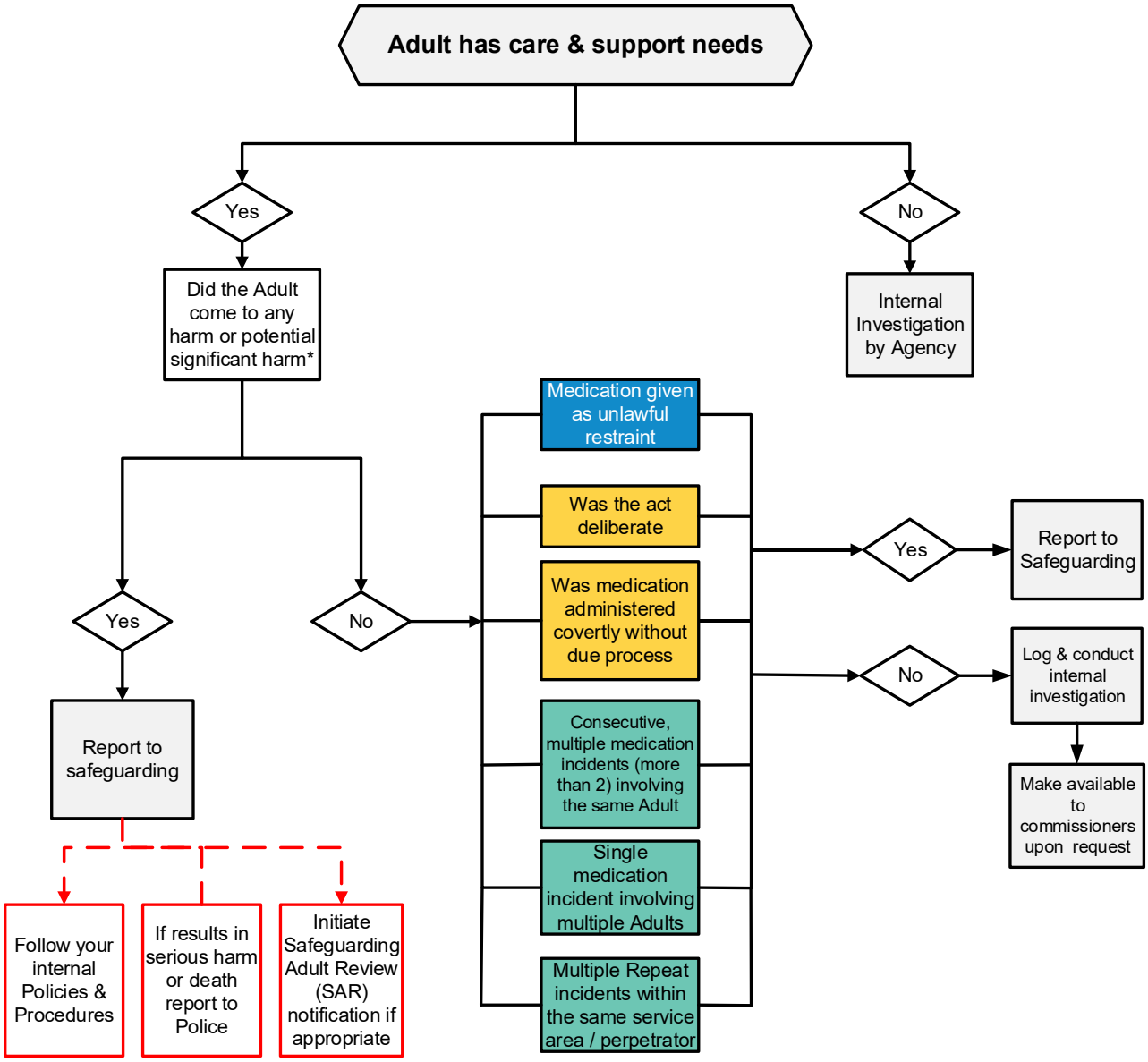
7.0 Near misses

If the error is made by an external agency contact the relevant service and advise them of the incident e.g.:

- Agency staff error
- Pharmacy errors report to pharmacy
- GP errors report to GP
- Hospital discharge errors report to discharging ward.

If the error is recognised and rectified by the service and there has been no harm caused to an individual, complete the Near Miss Report Form (Appendix D) and fax to the appropriate area for the responsible organisation to report and investigate internally, learn and share lessons. Each organisation will follow their internal governance structures for this process and monitor for any multiple occurrences which would require reporting into safeguarding procedures as outlined in the Medication Incident Decision Pathway.

Appendix A – Medication Incident Decision Pathway



Key - Types of abuse

- Physical
- Neglect & Acts of Omissions
- Organisational

*** Significant Harm:** Is defined as: Death or impairment to health which results in a permanent increase to a person's care and support needs.

Appendix B: Fictitious examples

During a medication review, the GP decided to change the resident's blood pressure medication. A letter was sent to the care home informing them of this and requesting a blood test in three weeks' time to monitor effects of the new medication. The new medication is added to the repeat prescription by the GP and the previous one discontinued. The care home has already ordered the next month's medication so send the new request to start with the next monthly order.

The next medicine cycle starts and the resident has a supply of both the discontinued medicine and the new medicine prescribed on the MAR sheet.

The carer administers the morning medication according to the MAR sheet, but on signing it she identifies the problem. The GP is contacted immediately and advises that the individual is monitored regularly. All observations remain within normal parameters and the patient reports no ill effects.

Does a Safeguarding concern need to be generated? Follow the Medication Incident Decision Pathway (Appendix A)

Does the resident have care and support needs? Yes

Did the patient come to harm? No

Report to Safeguarding? No

The care home manager makes a log of the incident and investigates internally.
The findings are

- The medicine change wasn't communicated at hand over nor the care plan updated.
- The care home didn't inform the pharmacy so that they could update patient records.
- The pharmacist should have intervened and not dispensed the discontinued medication.
- In the care home, as part of the ordering process, the person responsible for ordering the prescriptions should have made an intervention when the prescription/EPS token arrived for checking against what was ordered.
- The pharmacist, as part of a clinical check on the prescription, could have made an intervention when two drugs from the same class were prescribed.
- The care home, as part of the booking in process, should have made an intervention when checking the previous MAR.
- The care assistant administering the medication should know from the care plan that the medication had been changed

The care home puts an action plan for improvement about communicating dose changes internally as well as to community pharmacy and tightens up the ordering and booking in procedures. The community pharmacy is informed so they can investigate and learn from the incident.

Alternative Scenarios: The following scenarios are based on the above example, but can also be applied to other settings, such as hospital wards and prisons.

Scenario 1

The carer/ registered nurse administers all the medication as listed on the MAR/ drug chart. It is only when the resident/patient falls and cuts his head, that the community matron realises a medication error has occurred.

Does a Safeguarding concern need to be generated? Follow the Medication Incident Decision Pathway (Appendix A)

Does the resident/patient have care and support needs? Yes

Did the resident/patient come to harm? Yes

Report to Safeguarding? Yes

Scenario 2

The error is not noticed until a weekly audit identified the incident.

Does a Safeguarding concern need to be generated? Follow the Medication Incident Decision Pathway (Appendix A)

Does the resident/patient have care and support needs? Yes

Did the resident/patient come to harm? No

Has multiple incidents occurred? Yes

Report to Safeguarding? Yes

Scenario 3

The medication is correctly changed, but the resident/patient has dementia and refuses to take it, accusing the carer/registered nurse of poisoning her. The carer/registered nurse has a busy medication round so puts the capsule in some chocolate mousse and gives it to the resident/patient. She records this on the back of the MAR/ drug chart.

Does a Safeguarding concern need to be generated? Follow the Medication Incident Decision Pathway (Appendix A)

Does the resident/patient have care and support needs? Yes

Did the resident/patient come to harm? No

Has the medicine been administered covertly without due process? Yes

Report to Safeguarding? Yes

Scenario 4

The medication is correctly changed. The nurse subsequently ticks the diary entry to say the blood sample has been taken but does not perform the procedure. When the GP surgery/hospital ward phones to chase the results the omission becomes apparent.

Does a Safeguarding concern need to be generated? Follow the Medication Incident Decision Pathway (Appendix A)

Does the resident/patient have care and support needs? Yes

Did the resident/ patient come to harm? No

Was the act deliberate? Yes

Report to Safeguarding? Yes

Scenario 5

The carer/registered nurse administer all the medication as listed on the MAR/ drug chart. The resident/patient is found dead in his bedroom/hospital ward a few days later. The GP/doctor attends and reviews his notes whilst certifying death and detects the error.

Does a Safeguarding concern need to be generated? Follow the Medication Incident Decision Pathway (Appendix A)

Does the resident/patient have care and support needs? Yes

Did the resident/patient come to harm? Yes
Report to Safeguarding? Yes

Report to police if serious harm or death? Yes

Initiate Safeguarding Adult Review? Yes

Appendix C - Medication Incident Log

Teeswide Safeguarding Adults Board

Name of service: **Month/Year:**

Date	Location and staff members involved	Name of person affected	Brief Summary of Incident	Type of Abuse Neglect (N) Physical (P) Organisational (O)	Has the Adult been subject to a medication error in the last 12-months?		Summary of Actions Taken Following the Incident	Managers Analysis and actions
					Yes	No		
					Yes	No		
					Yes	No		

Name: …….. Designation: …… Signed: …… Date: ……

Medication error near miss report form		
Date Incident Reported		
Date Incident Occurred		
Resident(s)/ Patients involved		
Resident(s)/ Patients DOB		
Name of Service		
Location of incident (include ward or unit details)		
Other services involved in providing care/ support		
Indicate at which stage of the process the incident occurred;		
Prescribing	**Ordering**	**Pharmacy Dispensing**
Receipt	**Administration**	**Missed Monitoring**
Recording	**Other:**	
Person/team who made the error (if known)		
Details of medication incident		
Who was contacted?		
What advice was given/action taken?		
How was the advice followed?		

Name of person completing form and faxing to relevant agency
Date
Please email this form to your commissioner, e.g. ICB or Local Authority and follow your internal reporting procedures.