When to consider raising a safeguarding concern following a Medication Error

Note: The same principles apply when considering errors by family carers.

1) Medication errors and safeguarding

- **All medication errors must be recorded and reported using the appropriate procedures but not all errors will be safeguarding concerns.** The purpose of this section is to provide guidance on the handling of medication errors and determining when a safeguarding concern is raised.

What is a medication error?

- The National Patient Safety Agency (NPSA) defined 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. For the purposes of making a decision about the need for a safeguarding concern then, if a medication error as defined above has occurred and in addition there is evidence of significant impact upon or significant harm to the individual subject of the error then a safeguarding concern should be raised. Otherwise the error should be reported and recorded in accordance with medication and management of incidents policies and procedures.
- Medication incidents have a number of causes, such as lack of knowledge, failure to adhere to system and protocols, interruptions, staff competency, poor handwriting and instruction, poor communication, lack of training or basic human error.

2) Responsibilities of regulated care providers

- Regulated care providers who are commissioned to provide any medication administration service within a care plan are responsible for ensuring that people who require this service have their medicines at the times they need them and in a safe way.
- In some service areas, individuals are encouraged to self-medicate as part of their care plan. Clear policies and procedures must be in place, and be followed, to support an individual safely and reduce the risk of harm arising from self-medication errors.
- Care providers must have clear procedures which include arrangements for reporting adverse events, adverse drug reactions, incidents, errors and near misses relating to medicines.
- These arrangements should encourage local and where applicable, national reporting and learning and promote an honest, open and fair culture of safety.

3) Statutory requirements for reporting medication errors

- The registered person must protect individuals against the risks associated with the unsafe use and management of medicines, by means of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity. Refer to NICE Guidance.
- All medication errors should be reported in line with the regulated care providers, management of incidents policy as soon as possible after the incident.

4) Best practice for the handling of medication errors

- The organisation must have clear procedures for staff detailing how a medication error should be recorded, including specific processes for controlled drugs and reporting mechanisms to the CDAO (Controlled Drug Accountable Officer).
- All medication errors including near misses must be recorded. This record must detail the impact of the error, any immediate action taken and record the date, time and names of staff and individual/s involved.
- The error should be reviewed and an action plan put in place to ensure lessons are learnt and the risk of the error being repeated is reduced. It is also important to review the error in the context of previously recorded errors as a series of similar incidents may meet the criteria for a safeguarding concern.

The CQC, as part of the inspection process, will require evidence to confirm that internal reviews, including subsequent actions, have taken place.

Raising a Safeguarding Concern following a medication error

Under the Care Act 2014*, agencies have a legal responsibility to raise safeguarding concerns where there is a suspicion that abuse of a vulnerable adult has occurred. This is supplementary to the requirements set out above around the management of medication errors.

**'Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action'.*

1) Raising a safeguarding concern following a medication error

1. Some examples of errors which **must** be considered for raising a safeguarding concern:-a medication error that leads to actual harm or death

Some possible examples (not exhaustive)

a. People left without pain relief resulting in a prolonged period of pain
b. Significant deterioration in physical or mental wellbeing due to missed medication
c. Significant emotional distress
d. Elongation of an illness due to medication not being given
e. Adverse effects causing significant harm due to wrong medication being administered

2. any medication error requiring medical intervention

Some possible examples (not exhaustive)

a. Attendance at A&E
b. The need for an urgent review by health profession such as district nurse, GP or Tele-med consultation as a result of the error causing harm

3. the medication error was a deliberate act

Some possible examples (not exhaustive)

a. Malicious intent to cause harm
b. Inappropriate use of PRN medication (also known as 'as required' medication)
c. Use of medication to control behaviour or restrict an individual

4. The medication error is part of a pattern or culture. The pattern could be same drug, same carer or same vulnerable person.

Some possible examples (not exhaustive)

a. Same drug being omitted repeatedly
b. Same carer repeatedly failing to administer medication appropriately
c. Same individual being affected by the medication error regardless level of harm

Systemic failings

- Where there are systemic failings in a care providers medicine management process which leads to repeated medication errors, a safeguarding concern should be raised under organisational abuse.Where an error is due to external factors or services e.g. pharmacy error, mismanagement by family, hospital discharge, GP prescribing etc. there is an obligation on all services to identify the failing and ensure the issue is addressed.

This can be done through contacting the appropriate services to support a resolution. This could include local medicine management team, GP's, Social Workers or Care Co-ordinators, family members, or discussing with commissioners of local services. Where any of the above four criteria for a safeguarding concern apply, services must also raise a safeguarding concern.

Covert Medication

A safeguarding concern should always be raised when medication has been administered covertly without appropriate due consideration to the Mental Capacity Act 2005, Best Interest Decision process and consent. Refer to Cover Medication Guidance on LSAB Website.

This document is intended as a guidance tool, and should be used in conjunction with professional judgement. When there is any doubt as to whether to raise a safeguarding concern, staff should always speak to the safeguarding lead in their organisation, and if further advice is required to the local authority safeguarding team via the Customer Access Service safeguarding line: 0300 123 6721.

Links to Medication Guidance Information:
NICE Guidance **https://www.nice.org.uk/guidance/ng5**
NHS Controlled Drug Reporting **www.cdreporting.co.uk**
Covert Medication Guidance **http://www.lancashiresafeguarding.org.uk/lancashire-safeguarding-adults/resources/mca-dols.aspx**