Norfolk County Council

Norfolk Safeguarding Adults Board

Quality Assurance, Norfolk County Council
& Norfolk Safeguarding Adults Board

Medication error and Safeguarding: Guidance for Providers

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Medication Error and Safeguarding - Guidance for Providers

1. Introduction

1.1 This guidance has been jointly produced by the Integrated Quality Service of Norfolk County Council and the Norfolk Safeguarding Adults Board (NSAB). For those adults that need to take medication to maintain their health and wellbeing, it is *essential* to ensure that the adult has the right level of medication and has access to medication when necessary.

1.2 It is also important that medication is not given without consent. If the adult is unable to consent, then the evidence of this and a clear best interest decision must be in place. These must be reflected in the care plan and the care plan should be followed.

1.3 Norfolk County Council receives many thousands of notifications from providers concerning medication errors. This guidance has been produced to:

- Assist providers to determine the threshold for raising a safeguarding concern to the Council; and,
- Align the threshold for raising a safeguarding concern with the threshold for statutory notifications set out by the Care Quality Commission (in respect of providers registered under the Health and Social Care Act 2008); and,
- Align the threshold for raising a safeguarding concern with requirements set out in the terms and conditions of various legal contracts between providers and the Council; and,
- Identify examples of the actions to be taken in respect of non-notifiable medication incidents, and how these actions will be assessed by the Council.

2. Scope

2.1 This guidance is relevant to accredited providers commissioned by Norfolk County Council under a Framework Agreement, Spot or other contract in respect of the following adult health and social care services:

- Residential Care Homes
- Nursing Homes
- Home Care (domiciliary care)
- Supported Living Schemes
- Day Services

3. What is the threshold for raising a Safeguarding concern?

3.1. A Safeguarding concern will *always* need to be raised where the medication error triggers a notification to CQC.

3.2. A CQC notification is required where the cause or effect of a medication error results in:

- Death
- Injury
- Abuse or an allegation of abuse
- An incident reported to or investigated by the police

3.3 **In addition**, the Council expects a safeguarding concern to be raised where the person or persons in question came to harm or potential harm. Harm, is defined as an impairment to health which results in a permanent increase to a person's care and support needs.

3.4 **If any of the following occur, a Safeguarding concern MUST also be raised**:

- Medication is given as a form of unlawful restraint (e.g. a non-prescribed sedative is administered, or a prescribed medicine is administered at a higher dose or more frequently than prescribed).
- A deliberate act to administer/neglect to administer medication contrary to the directions of the prescriber (e.g. deliberately increasing the dose of a medication or failing to administer it).
- A medication is administered covertly where no specific approved covert medication protocol is in place (e.g. administering a tablet in yoghurt where a client with or without capacity has refused).
- Consecutive/multiple medication incidents involving the same client (e.g. prescribed medication is not administered over more than one round because it has not been ordered or collected).
- Single medication incident involving multiple clients (e.g. a whole medication round missed or delayed).

- Multiple/repeat incidents within the same service, or by the same perpetrator (eg medication is administered incorrectly by a specific member of staff on more than one occasion).

4. What action is required if a medication error does NOT trigger raising a Safeguarding concern?

4.1 Whether or not a medication error triggers raising a Safeguarding concern, *any* identified poor practice in administration of medication requires a management response.

4.2 This is because poor practice at any level which is not addressed can lead to medication errors which have a negative impact on clients. Taking action in response to all medication errors mitigates against the risk of reoccurrence and improves practice. Actions include:

Audit – Conducting a robust, regular audit of medication systems will assist in ensuring that errors and trends are quickly identified. Look out especially for medications which sometimes have variable doses (e.g. Warfarin) those which are non-routine (e.g. antibiotics) and those stored other than in the medication cabinet (e.g. eyedrops and some topical creams) as errors often occur with these.

A good audit will check that stock is ordered in good time, that medication from the pharmacy is confirmed correct on receipt, that recording of administration, refusal and disposal is accurate, expiry dates are reviewed and that recording of administration is consistent with stock held. The frequency of audit should be increased where new staff are deployed to administer medication, and in response to errors identified.

Investigate – It is important to investigate the cause of any medication error to determine whether written procedures need to be reviewed, individuals or teams of staff require additional training, or whether the risk of accidental error can be mitigated by implementing changes to practice.

A thorough investigation report will capture detail which might include: statements of involved staff, anonymised copies of MAR sheets, care delivery records, communication with relevant parties (e.g. GP, Safeguarding, CQC), a written factual account of the investigation conducted, conclusion and action taken.

Record – Both as an audit tool and to evidence the action you've taken it is necessary to maintain a record of medication errors, their investigation and the action taken to address the incident. There is no requirement to establish a specific recording process if medication errors trigger an existing incident reporting procedure. Whichever

recording procedure is adopted, it should be possible to periodically audit medication errors to determine error trends which in turn may identify a specific training need or the requirement for a Safeguarding notification. The Integrated Quality Service or Care Quality Commission may request information relating to medication errors to ensure that management processes are robust.

Share learning – Even if the medication error is relatively minor in nature it is good practice to share learning. Effectively communicating learning from investigation of medication errors is critical to creating a culture where it is acknowledged that errors can and do happen. Learning shared in a manner which promotes improved practice rather than encourages staff to hide or disguise genuine errors for fear of punishment, is likely to result in more transparent disclosure of errors where they occur.

5. Examples of poor practice which do *NOT* trigger a safeguarding notification:

A gap in recording (eg a signature is missed on the MAR chart, but your investigation concludes that the medicine was correctly administered, no harm has occurred, you have taken appropriate action with the member of staff concerned and recorded this).

Medication is not given on one occasion (eg the adult does not receive prescribed medication (missed/wrong dose) on one occasion and no harm occurs. You have taken appropriate action with the member of staff concerned and recorded this).

Medication is not given on more than one occasion and no harm occurs (eg recurring missed medication or administration errors identified through observation or audit. You take swift action once identified through training/supervision. You monitor the situation closely until poor practice has been corrected. You have recorded the incident and action taken/advice given.

Medication was given late (eg an unforeseen event meant that some people received their medication later than scheduled, you have checked to ensure that no medication was time-sensitive and confirmed this with the GP who has advised that no harm has occurred, you have recorded the incident and action taken/advice given).

A member of staff signs the MAR chart in red ink (eg you have reminded the staff member of your policy and ensured a supply of black pens is available/removed the red pens).

The pharmacy now delivers medication in patient packs instead of blister packs (eg you have checked that your medication procedure reflects the change in packaging, have familiarised staff with the procedure and have introduced a more

frequent random 'spot-check' audit until you are content that the new system is working effectively). You have recorded your actions

A member of staff has changed initials and the sample signature sheet reflects their previous name (e.g. the member of staff signs the sample signature sheet again with their new initials and the date on which they started to sign MAR sheets with their new initials, the original entry remains on the sample signature sheet so that previous MAR entries can be traced to this person).

While the above examples do not trigger a safeguarding notification, they MUST trigger a management response through training, supervision or auditing. Remember to record what action/s you have taken.

6. Examples which MAY trigger raising a safeguarding concern and where advice should be sought:

- One off medication error for more than one person with no harm caused
- Previous concerns identified and corrective action is not maintained
- Insufficient prevention measures in place such as training, supervision and auditing

7. Raising a safeguarding adult concern

To raise a safeguarding adult concern ring 0344 800 8020. Before raising the concern refer to the Raising a Safeguarding Adults Concern: Checklist (June 2019) to ensure you provide as much information as possible.

END.

Quick Reference Medication Error Decision Maker