Multi-Agency Protocol for Medicines Incidents and adult safeguarding

VERSION 2

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Multi-agency protocol to support medication error related adult safeguarding decision making in relation to safeguarding concerns and Section 42.

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1. Medication Error Guidance

1.1 This guidance is designed to help managers and professionals know when to report an incident of misuse or maladministration of medications in accordance with the IOW Safeguarding Adults Board's Adult Safeguarding Policy and Procedures.

Good medical care also includes the proper use of non-oral medication, equipment and appliances including catheter care, use of oxygen, etc. There are isolated cases of medication being mismanaged recklessly or intentionally, such as the misappropriation and misuse of drugs by staff. These should always be reported.

Mistakes are made by people across the process from the GP to the pharmacist and care staff. Incidents occur where a person is accidentally given the wrong medication, given too much or too little of their own medication or given it at the wrong time. Most errors do not result in significant harm, but mistakes can lead to serious and, in some cases, fatal consequences.

Incidents meeting the lower level criteria should, wherever possible, be addressed at a local level with the individuals and professionals concerned with the aim of promoting positive relationships and an open culture which addresses the underlying issues.

1.2 Definition of a Medication Error

The National Patient Safety Agency (NPSA) 2001 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’.

1.3 Examples of medication errors (this is not a definitive list)

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

- 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.

1.4 Managers responsibilities

- Review each incident to decide whether further action and /or investigation is required
- Ensure the safety and ongoing support needs of the adult Discuss with the adult the concerns, explain what has happened/needs to happen and when, ascertain the views, wishes and outcomes of the adult
- Consider issues of capacity and consent
- Generate other appropriate responses, i.e. Duty of Candour, incident report
- Generate a safeguarding concern referral form if meeting Care Act (2014) criteria
- Inform the Care Quality Commissioner (CQC) as per regulatory requirement
- 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.

When a medication error should be reported as a safeguarding concern

Decision support tool:

Guidance: This tool does not replace professional judgement or aim to set a rigid threshold for intervention. It helps you consider the type and seriousness of abuse and the circumstances in which a referral to adult social care may be required.

Types of abuse and seriousness	**Levels of harm and related indicators/examples**				
	Would not normally be reported to safeguarding. Incidents meeting the lower level criteria should, wherever possible, be addressed at a local level with the individuals concerned with particular attention to preventing reoccurrences.		↔ Would normally need to be reported to safeguarding regardless of whether harm has occurred or not.		**Serious criminal matter – immediate discussion with police required.** **Must be reported to safeguarding in all cases.**
Medication errors	• Isolated incident where the person is accidentally given the wrong medication, given too much or too little medication or given it at the wrong time but no harm occurs.	• Isolated incident causing no harm that is not reported by staff member. • Isolated prescribing or dispensing error by GP, pharmacist or other medical professional resulting in no harm.	• Recurring missed medication or errors that affect more than one adult and result in actual or potential harm to one or more adults. • Recurring prescribing or dispensing errors by GP, pharmacist or other medical professional that affect more than one adult and/or result in harm to one or more adults.	• Covert administration without the person's consent or having a best interest decision recorded in the care plan. • Misuse of/ over-reliance on sedatives to control challenging behaviour.	**Deliberate maladministration of medications or failure to follow proper procedures, e.g. controlled medication**. • **Pattern of recurring errors or an incident of deliberate maladministration that results in ill-health or death.** • **Deliberate falsification of records or coercive/ intimidating behaviour to prevent reporting.**

Medication Incident Decision Pathway