4LSAB Multi-Agency Protocol for Medication Errors and Adult Safeguarding

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Protocol for medication errors and adult safeguarding

1. Introduction

This guidance is designed to help managers and professionals know when to consider and report an incident of misuse or maladministration of medications, including errors in prescribing, dispensing, preparing, and monitoring, or concerns around the provision or accuracy of advice, as a safeguarding concern.

237 million medication errors occur at some point in the medication process in England annually[1]Most errors occur in the administration (54%), prescribing (21%) dispensing (16%) and monitoring (7%) of medication [1].

For the purpose of this protocol a medication error is defined as an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicine advice, regardless of whether any harm occurred.

For those adults that need to take medication, it is essential to ensure that the adult has access to the correct and appropriate medication.

[1] Elliott RA, Camacho E, Jankovic D, et al Economic analysis of the prevalence and clinical and economic burden of medication error in England BMJ Quality & Safety 2021;30:96-105.

Wherever possible the adult should be encouraged to discuss, with appropriate support, any medication issues they are experiencing with their prescriber, pharmacist or other relevant healthcare professional.

In the event of a medication error advice should always be sought from the prescriber or pharmacist.

It is also important that medication is not given without consent and where the adult lacks capacity to consent to medication prescription and administration then medication needs to be administered in accordance with the Mental Capacity Act (2005) and/or Mental Health Act (1983), and this must be reflected in the care plan which should be followed and regularly reviewed.

When a medication error occurs involving an adult who has, or may have, care and support needs, and they are at risk of or experiencing abuse or neglect consideration needs to be given around the proportionality of when these should be referred as a safeguarding concern to the Local Authority. Nationally around 72% of medication errors have little/no potential for harm[1].

2. Scope

This policy applies to all medications, whether prescribed or purchased by or for the individual, and covers misuse or maladministration of medication including errors in prescribing, dispensing, administering, monitoring, or the provision or accuracy of medication advice, including cases where individuals self-administer their medication.

This policy covers all types of provider and community settings including:

- Residential Care Homes
- Nursing Homes
- Home Care (domiciliary care)
- Supported Living Schemes
- Extra care
- Shared Lives
- Day Services
- GP
- Community pharmacies
- Private Hospitals
- Hospices
- Hospitals
- Education and training settings

3. Responsibilities for regulated and non-regulated providers

Regulated providers and non-regulated care settings who are commissioned to provide any medication administration services are responsible for ensuring that medicines are administered in a safe way and at the times required in accordance with the individuals care plans.

- Regulated and non-regulated providers have a responsibility to ensure safe practice of the administration of medications process. Certain provider settings will have a “Registered Person” who has overall responsibility for this.

- All staff involved in the administration of medication process must have received appropriate training in line with their organisational policies, including competency assessments and refresher training in line with the organisations own policies and procedures.

- In some service areas, individuals are encouraged to manage and administer their own medication as part of their care plan. Clear policies, procedures and risk assessments 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 relating to arrangements for monitoring and auditing their medication administration processes as well as reporting any errors, adverse drug reactions, incidents and near misses relating to medicines.

- NHS providers such as Hospitals and Community NHS Trusts will follow the Patient Safety Incident Reporting Framework (PSIRF) but will need to consider mediation errors individually to determine whether or not there is a safeguarding concern that requires reporting into the Local Authority.

- Providers should have clear escalation protocol around when to refer back to the prescriber (e.g. escalation that medication reviews are not being undertaken appropriately etc).

- These arrangements should encourage local and where applicable, national reporting and learning and promote an honest, open and fair culture of safety.

4. Types of medication errors and contributary factors

Some common types of medication errors are:

- Giving the wrong medication or the incorrect formulation
- Giving the wrong dosage of medication
- Not adhering to the prescribed time for administration
- Giving medication to the wrong person
- Incorrect route of administration
- Failure to check if a person has medication allergies
- Failure to follow prescribing and administration directions
- Administering medication without the person's consent
- Improper use of medication
- Missing a dose of medication
- Administering expired medication
- Ignoring or overlooking a person's medical histories
- Missing or incorrect monitoring of the person
- Incorrect documentation
- Incorrect prescribing of medication
- Mistakes in the dispensing of medication

Contributary factors in medication errors include:

- Decision-making mistakes.
- System failures, such as inadequate opportunities for training, work overload, inadequate staffing levels, and suboptimal work environment.

- Poor communication – illegible handwriting, language barriers, misunderstandings.
- Human factors such as distraction, fatigue, stress, pressure, lack of time, lack of resources, lack of knowledge.
- Improper labelling of original packaging or differences between prescription or labelling.
- Transcription error when transferring prescription to medication administration record Poor stock management- overstocking, understocking lack or robust auditing of expiry dates.

To support avoiding medication errors consideration should be given to the 'rights' of medication administration, see Appendix One.

5. Organisational response to medication errors

As soon as the error is discovered organisations should have clear policies and procedures in place to ensure that the adult receives the appropriate response including, when required, access to emergency and primary care services to ensure the immediate safety of the individual.

Every organisation is responsible for monitoring themes and trends related to medication errors through robust governance mechanisms and for reporting any systems weaknesses.

Organisations should:

- Review each incident to decide whether further action and /or investigation is required and/or if an adult safeguarding referral needs to be made.
- Ensure the safety and ongoing support needs of the adult. What was the actual effect on the individual? What actions were taken at the time.
- Discuss with the adult the concerns, explain what has happened/needs to happen and when, ascertain the views, wishes and outcomes of the adult and/or where appropriate the family or advocate.
- Consider issues of mental capacity and consent.
- Consider what the contributary factors were.
- Consider what went well and what could have been done better.
- Consider the risk issues identified including for near miss events.
- Generate other appropriate responses, i.e. undertake Duty of Candour, incident reporting, CQC notification.
- Consider lessons learned and what actions need to be taken to minimise any reoccurrence.

Any identified issues within practice requires management oversight and response to ensure safety, prevent medication errors and mitigate the risk of negative impact on people and workforce standards.
Taking action in response to all medication errors mitigates against the risk of reoccurrence and improves practice.
Any actions taken should include a whole systems approach and be in line with a no blame 'just' culture.

6. When to report medication errors as a safeguarding concern

It is not reasonable or proportionate to report every medication error to the Local Authority. The information in this guidance should help you decide if a particular medication error needs reporting as a safeguarding concern.

You may need to raise a safeguarding concern to the Local Authority for incidents where the adult Section 42 (1) a) has, or may have, care and support needs, and b) they are experiencing or at risk of abuse or neglect (for further guidance see 4LSAB Policy and thresholds guidance).

Examples are:

1) The medication error involves administration of a time critical or essential medication by a provider or informal carer,
    - Time critical medicines are those for which an omission or unacceptable delay, could cause serious harm or death, this will vary depending on the adult and the reason for them having that medication prescribed. Such medicines are those for which a delay or omission of a single dose is significant (Please see examples of time critical medication in Appendix Two).
    - There may also be examples of medications that are not considered “acutely essential” for the population as a whole, but which are essential for a particular adult (e.g. laxatives for an adult on clozapine, or loperamide for an adult with a high output stoma, paracetamol for an adult with osteoarthritis etc).
    - These medicines should be identified by the prescriber or pharmacist, by endorsing as “critical” on the drug chart or adding a note to this effect to the e-prescribing system.
    - If you are in doubt around if a medication is time critical or essential for an individual, please discuss this with the prescriber or a pharmacist.

2) The medication error (time critical medication or any other) has caused harm or had an adverse effect on the adults physical or mental health, some examples are, (please note that this is not an exhaustive list)
    - a medication not given in the correct time window (i.e. delayed Parkinson’s medication).
    - medications given that interacts with each other.
    - too much or the wrong medication is given.

3) Any medication error requiring urgent or significant medical intervention (paramedic attendance, attendance at A&E, or escalation to relevant medical staff).

4) If there has been repeated medication errors in the same service such as
    - The same prescribed medication being repeatedly omitted.
    - The same staff member/carer/informal carer or the individual repeatedly failing to administer medication in line with the prescription or directions for use (e.g. 3 errors in 3 months).
    - The same individual being affected by the medication errors, regardless of the level of harm.
    - A single medication incident involving multiple individuals (e.g., a whole medication round missed or delayed without appropriate explanation).
    - Where there are systemic failings in a care providers medicine management process which leads to repeated medication errors.

    Given the range and size of provider services covered by this protocol, it is the expectation of the 4LSAB’s that originations operationalise the guidance and consider within their local policy what ‘repeated’ may look like for their service. If a service is unsure what this may mean for them then advice may be sought from relevant partners.

5) The medication error was a deliberate act (i.e. intended to cause harm, given to control behaviour or restrict an individual without there being an agreed care plan in place, administered or neglected to administer medication contrary to the directions of the prescriber or inappropriate use of as required 'PRN' medication).

6) Where there is a concern that the controlled mediation management processes have not been followed.

7) Medication is administered covertly where there is no medically approved best interest decision recorded or specific approved covert medication protocol in place.

8) If you identify that the medication error originated outside of your organisation (e.g. delay in prescribing or where stock has not been or could not be delivered, when you are informed about an error occurring within a third-party organisation).

9) Ongoing failure to provide appropriate medication reviews.

10) Where the adult is continually or significantly mismanaging their medication, regardless of their capacity, some examples may include intentional overdose, not taking prescribed medication, not taking medication in line with prescription or recommended dose.

11) A Safeguarding adult concern referral will always need to be raised where the medication error triggers a notification to CQC and/or a report to the Police.

Where the error has taken place in an NHS provider, if following NHS internal processes there remains doubt as to whether a safeguarding referral should be made, then guidance must always be sought from the safeguarding lead within the Trust.

Ensure all medication errors are looked at individually to decide if there has been any harm caused/impact on the adult and if a safeguarding concern needs reporting.

This should include considering the view and wishes of the adult.

Within a provider service there needs to be consideration around the safety of others.

If there is a suspected crime this should be referred to the police as well as a safeguarding referral being made.

7. Safeguarding referrals for medication errors

Within adult safeguarding medication errors can be seen as different types of abuse including physical abuse, neglect and acts of omission, organisational, self-neglect and domestic abuse (i.e. neglect or control by someone 'personally connected' to the adult).

In your safeguarding referral to the Local Authority you will need to include:

- The impact of the incident on the adult
- The adults' views and wishes
- Immediate actions taken (e.g. emergency medical review etc)
- Analysis of the circumstances as to why the error may have happened and what type of abuse or neglect has occurred
- Lessons learned and actions you have taken to prevent it from happening again
- Any onward referrals made (e.g. health, GP, CQC and Police etc)

By providing full details around the error and the actions taken the Local Authority may be able to close the contact without further information from you.

8. When to report medication errors to CQC

All notifiable incidents should be reported to the Care Quality Commission (CQC) in line with Regulation 18: Notification of other incidents.

Generally, the CQC should be notified if any of the following are involved:

- death,
- injury,
- abuse, or allegation of abuse,
- incident reported to or investigated by the police

A Safeguarding adult concern referral will always need to be raised where the medication error triggers a notification to CQC and/or a report to the Police.

Appendix One – The 10 Rights of Medication Administration

1. Right patient

- Check the name on the prescription and wristband
- Ideally, use 2 or more identifiers and ask the patient to identify themselves

2. Right medication

- Check the name of the medication, brand names should be avoided

- Check the expiry date
- Check the prescription
- Make sure medications, especially antibiotics, are reviewed regularly

3. Right dose
- Check the prescription.
- Confirm the appropriateness of the dose using the BNF or local guidelines
- If necessary, calculate the dose and have another nurse calculate the dose as well

4. Right route
- Again, check the order and appropriateness of the route prescribed
- Confirm that the patient can take or receive the medication by the ordered route

5. Right time
- Check the frequency of the prescribed medication
- Double-check that you are giving the prescribed at the correct time
- Confirm when the last dose was given

6. Right patient education
- Check if the patient understands what the medication is for.
- Make them aware they should contact a healthcare professional if they experience side-effects or reactions

7. Right documentation
- Ensure you have signed for the medication AFTER it has been administered
- Ensure the medication is prescribed correctly with a start and end date if appropriate

8. Right to refuse
- Ensure you have the patient consent to administer medications
- Be aware that patients do have a right to refuse medication if they have the capacity to do so

9. Right assessment
- Check your patient actually needs the medication
- Check for contraindications
- Baseline observations if required

10. Right evaluation
- Ensure the medication is working the way it should
- Ensure medications are reviewed regularly
- Ongoing observations if required

https://nursingnotes.co.uk/resources/10-rights-of-medication-administration/

Appendix Two – Time Critical Medication

Please remember that time critical medical will be dependent on the individual and reason it has been prescribed.

Medicines which must not be omitted or delayed (time critical medicines)

Time critical medications	Relevant indication	Examples

Movement disorders	Parkinson's / myasthenia medication	• Levodopa
		  ○ Co-beneldopa
		  ○ Co-careldopa
		• COMT inhibitors
		  ○ Entacapone
		  ○ Tolcapone
		  ○ Opicapone
		• Dopamine agonists
		  ○ Pramipexole
		  ○ Ropinirole
		  ○ Rotigotine
		• MAO-B inhibitors
		  ○ Rasagiline
		  ○ Selegiline
		  ○ Safinamide
		• Produodopa (Foslevodopa-foscarbidopa)
		• Acetylcholine inhibitors
		  ○ Pyridostigmine/mestinon
		  ○ Neostigmine)

Immunomodulators (including HIV medications)	Organ Transplant
	
	Rheumatic diseases (Rheumatoid arthritis, juvenile idiopathic arthritis)
	
	Gastrointestinal Disease (Severe Crohn's disease, ulcerative colitis)
	
	HIV
		• Antiproliferative Immunosuppressants
		  ○ Azathioprine,
		  ○ Mycophenolate mofetil
		• Calcineurin Inhibitors
		  ○ Ciclosporin
		  ○ Tacrolimus
		• Cytokine Modulators (DMARDs)
		  ○ Methotrexate
		  ○ Sulfasalazine
		  ○ Leflunomide
		• TNF-alpha Inhibitors/Biologicals
		  ○ Adalimumab
		  ○ Etanercept
		  ○ Infliximab
		Sirolimus
		Pomalidomide

Sugar	Diabetes	• Metformin (Biguanides)
		• SGLT2 Inhibitors
		  ○ Dapagliflozin,
		  ○ Canagliflozin
		• DPP-4 Inhibitors
		  ○ Sitagliptin
		• Sulfonylureas
		  ○ Glipizide
		  ○ Glyburide
		• GLP-1 Agonists
		  ○ Semaglutide,
		  ○ Liraglutide
		• Thiazolidinediones (TZDs)

		○ Pioglitazone • Insulin
Steroids	Addison's & adrenal insufficiency	• Hydrocortisone (Cortef) • Prednisolone • Fludrocortisone (Florinef) • Dexamethasone
Epilepsy	Anticonvulsants	• Levetiracetam (Keppra) • Lamotrigine (Lamictal) • Sodium Valproate (Epilim) • Carbamazepine (Tegretol) • Topiramate (Topamax) • Lacosamide (Vimpat) • Gabapentin (Neurontin) / Pregabalin (Lyrica) • Benzodiazepines ○ Clobazam ○ Clonazepam
Direct oral anti-coagulants (DOACs) & warfarin	Atrial Fibrillation (AF), Deep vein thrombosis (DVT), Pulmonary embolus (PE)	• Direct Factor Xa Inhibitors ○ Apixaban (Eliquis) ○ Rivaroxaban (Xarelto) ○ Edoxaban (Lixiana). ○ Betrixaban (Bevyxxa) • Direct Thrombin Inhibitor ○ Dabigatran (Pradaxa) • Warfarin (Marevan)

Appendix Three - Multi-Agency tools to support decision makers in raising a safeguarding concern to the Local Authority – Medication Errors

MEDICATION ERRORS

The relationship between medicines errors and the safeguarding adults' agenda has been challenging and there has been a lack of consensus on what constitutes a safeguarding adults concern. The level of harm has been a common pointer for making a safeguarding adult's referral previously, but this results in an inconsistent approach as harm is interpreted differently. This information in the decision tool and the supporting medication protocol should help you decide if this medication error needs reporting as a safeguarding concern.

Please see below the 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'.

The nature of the medication error will depend what category of abuse it falls under i.e. neglect, physical or organisational

Type of abuse	Non-reportable	Requires consultation	Reportable
MEDICATION ERRORS **Mismanagement /misadministration /misuse of drugs.** **Links to Policy and Guidance:**	Lower-level concern where it would be unlikely to meet the definition of a safeguarding concern. Internal policies and procedures should be followed and an internal written record of what happened and what action was taken should be kept. **Where there are several low-level concerns, consideration should be given as to whether the criteria may be met for a safeguarding concern due to increased risk and therefore should be reported as the local authority have the statutory duty to make this decision.**	All appropriate action should be taken to reduce risk and internal policies and procedures followed. Consultation should be undertaken internally, refer to your local 4LSAB Safeguarding Adults Policy and Procedures and consider if consultation is needed with the local authority. Incidents at all levels should be recorded. **Following consultation, consideration should be given as to whether the criteria may be met for a safeguarding concern and therefore a referral into the local**	Incidents at this level should be raised as a safeguarding concern with the local authority. **Consideration should also be given as to whether the police or other emergency services need to be contacted. Ensure whole family approach if children or other adults may be impacted.**

		authority or whether other referral pathways need to be considered.	
	Examples: • Isolated incident of errors in prescribing, dispensing or administering medication (non-time critical medications – see medication protocol) but no harm occurs. (i.e. too much, too little, given at the wrong time) • Isolated incident causing no harm that is not reported by staff member	**Examples:** • Reoccurring prescribing, dispensing or administration errors (non-time critical medications – see medication protocol) that cause no harm (possible neglect or organisational) • Isolated incident of errors in prescribing, dispensing or • administering medication (time critical medications – see medication protocol) (i.e. too much, too little, given at the wrong time) but appropriate action is taken • (possible neglect) • Failing to report or document a medicines administration error according to agency policy and procedure (possible neglect or organisational) • Isolated incident of failing to monitor or seek appropriate medical advice and support following a medication error • (possible neglect) • Failure to follow proper procedures for the administration	**Examples:** Recurring or administration errors (time critical medications – see medication protocol) that affect more than one adult and/or result in harm to one or more adults. (organisational) Deliberate maladministration of medications (physical) Failure to follow proper procedures for the administration of time critical medication (see medication protocol) (neglect) Over medication used as inappropriate form of restraint/ way to manage behaviour without a care plan (physical) Covert administration without the person's consent or having a best interest decision recorded in the care plan. (could be neglect or organisational) Failing to monitor or seek appropriate medical advice and support following medication errors, where harm occurred (could be neglect or organisational)

		of non-time critical medication (see medication protocol) (possible neglect or organisational)	Deliberate falsification of records or coercive/ intimidating behaviour to prevent reporting. (organisational)
Alternative actions to consider at every stage	• Review of relevant policies and procedures. • Internal relevant training provided. Review of existing care plans or creation of new care plans/risk assessments. • Internal complaints or disciplinary processes.	• Share information with the ICB Quality Team and/or the CQC. • DATIX, serious incident or alternative review or investigative process. • Discussion with the GP/Pharmacy.	**RAISE SAFEGUARDING CONCERN** If there is an indication a criminal act has occurred, the police **MUST** be informed. Immediate safety plans must be implemented.

https://hampshiresab.org.uk/wp-content/uploads/2025/07/Safeguarding-Concerns-Multi-Agency-Tools-July-2025-FINAL.pdf