Safeguarding and Medicines Management: Guidance for Providers

1. Introduction

1.1 This guidance has been produced by the Somerset Safeguarding Adults Board Policy and Procedures Subgroup, and is based on similar guidance first produced by the Norfolk Safeguarding Adults Board.

1.2 This guidance is produced on the best available understanding of the issues; however, providers should also refer to the latest CQC guidance, and if necessary their own legal advice, in more complex matters.

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

1.4 If the adult is unable to consent, then medication needs to be administered in accordance with the principles of the Mental Capacity Act. These must be reflected in the care plan and the care plan should be followed **and regularly reviewed**.

1.5 In the event of a medication error advice should always be sought for the prescriber or dispensing pharmacist. This document explains that this is important because some medicines can cause more harm than others when omitted or delayed.

1.6 All guidance provided with the medication should be read before it is administered.

1.7 Advice should be sought from the dispensing pharmacist or NHS Somerset CCG 'Specials Guidance' **before** a medication that does not include an instruction to take with food is mixed with food.

1.8 Somerset County Council's Adult Safeguarding Service receives a large number of notifications from providers concerning medication errors. This guidance has been produced to:

- Assist providers to determine when they should raise a safeguarding concern with the Council's Adult Safeguarding Service; and,
- Ensure that providers are aware of when a safeguarding concern should be raised with the Council's Adult Safeguarding Service as well as the requirements for statutory notifications to the Care Quality Commission (CQC) for NHS and non-NHS Providers (in respect of providers registered under the Health and Social Care Act 2008); and,
- Identify examples of the actions to be taken in respect of medication incidents that do not require a statutory notification to CQC, and how these actions will be assessed by the Council.

2. Scope

2.1 This guidance is relevant to all providers of health and social care services to adults in Somerset to enable organisations to understand when a safeguarding referral to Somerset County Council's Safeguarding Service is required (see 2.3 and 3.1 to 3.4). This guidance is in addition to, and does not preclude all organisations from adherence to, their own specific policies and guidance relating to medicines

management and incident management, along with any other relevant legislation, policy and guidance.

2.2 For the avoidance of doubt, organisations commissioned or contracted by the NHS (e.g. care homes providing care to people funded by Continuing Heath Care) fall within the scope of this guidance.

2.3 Where the error has taken place in a hospital, if following NHS internal processes there remains doubt as to whether a safeguarding referral should be made, then guidance **must always** be sought from Somerset County Council's Safeguarding Service.

2.4 Medication needs to be administered in accordance with the Mental Capacity Act (2005) and Mental Health Act (1983)

2.5 Where controlled medicines are involved this should be referred to the police if there is a concern that a crime has been committed.

3. What is the decision-making process for raising a Safeguarding concern?

3.1 Where a medication error triggers a notification to CQC and/or a report to the police a Safeguarding concern will always need to be raised with Somerset County Council's Safeguarding Service. There are three ways to do this:

- Telephone: Adult Social Care on 0300 123 2224 (Monday to Friday 8.30am to 5.30pm, Saturday and Sunday closed)
- E-mail: adults@somerset.gov.uk
- By completing a secure electronic safeguarding referral form

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, a safeguarding referral must be raised where the person or persons in question came to harm and/or required a hospital admission.

In this context 'harm' is defined as any physical or mental change experienced by an individual that is caused by, or consider likely to have been caused by, the error, which results in a permanent increase to a person's care and support needs and/or a high level of distress.

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 (see Appendix 2 for more information about covert administration) where no specific approved covert medication protocol is in place (e.g. administering a tablet in yoghurt where a person with or without capacity has refused) **and** the person experiences harm.
- Consecutive/multiple medication incidents involving the same person (e.g. prescribed medication is not administered over more than one round because it has not been ordered or collected) **and** the person experiences harm.
- Single medication incident involving multiple people (e.g. a whole medication round missed or delayed) **and** there is a significant risk of a person or persons experiencing harm.
- Multiple/repeat incidents within the same service, or by the same person (e.g. medication is administered incorrectly by a specific member of staff on more than one occasion) where harm occurs.
- Where a controlled medicine is involved and there has been harm and/or a crime.
- Where a referral is required to a professional body

3.4 The Somerset Safeguarding Adults Board Adult Safeguarding Decision Making Tool should be used to support decision making

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

4.1 If you have confirmed and documented that none of the circumstances in 3.1– 3.3 apply then, whether or not a medication error triggers raising a Safeguarding concern, ***any*** **identified poor practice in the administration of medication requires a management response by the service provider.**

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 the people that the service provides care and support to. 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 each person's medication is administered in line with each person's needs, 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 the remaining amounts of each person's

medications that are held. The frequency of audit should be increased where new staff are deployed to administer medication, and in response to errors identified.

Training and guidance should be sought on best practice, and this should be regularly reviewed and updated. Consideration should also be given to arranging for an external organisation to support auditing processes.

- **Investigate** – **It is important to investigate the root 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**.

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

- **Record** – **You should maintain a record of relevant medication errors for investigation, auditing and quality improvement process and to evidence the action you've taken to address the incident**. Organisations are required to put in place their own documentation 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 Somerset County Council Quality Assurance Team and any other relevant commissioners or the CQC may request information relating to medication errors to ensure that management processes are robust. Also refer to NICE guidance for best practice.

- **Share learning** – **Even if the medication error is relatively minor in nature it is good practice to share learning across the organisation**. 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 across the organisation 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

While the examples below may not trigger a safeguarding notification, they **MUST** trigger a management response through training, supervision or auditing and may still be notifiable. Remember to always record what action/s you have taken.

- **A gap in recording**. A single signature is missed on the MAR chart, but your investigation concludes that the medicine was correctly administered, **and** 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.** The person the adult does not receive prescribed medication (missed/wrong dose) on one occasion, advice has been sought from the prescriber, **and** no harm occurred. You have clearly recorded the incident, advice from the prescriber and action taken with the member of staff concerned.
- **Medication is not given on more than one occasion,** advice has been sought from the prescriber, and no harm has occurred (e.g. recurring missed medication or administration errors identified through observation or audit). You take swift action once identify through training, supervision. You monitor the situation closely until poor practice has been corrected. You have clearly recorded the incident, advice from the prescriber and action taken.
- **Medication was given late.** 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 where appropriate this has been confirmed this with the prescriber who has advised that no harm has occurred. You have clearly recorded the incident, advice from the prescriber and action taken.
- **A member of staff signs the MAR chart in incorrect coloured ink.** You have reminded the staff member of your policy and ensured a supply of black or blue pens is available and removed the incorrectly coloured pens.
- **The pharmacy has made a change and now delivers medication in patient packs instead of blister packs** 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**. You have ensured that the member of staff has signed 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. You have recorded your actions.

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

While, following consideration by Somerset County Council's Adult Safeguarding Service, the examples below may not result in an enquiry under section 42 of the Care Act (2014), they **MUST** trigger a management response through corrective action, the implementation of protective measures, training, supervision or auditing and may still be notifiable. Remember to always record what action/s you have taken.

- A one-off medication error involving more than one person with no harm caused **and** there is a significant risk of a person or persons experiencing harm
- Where previous concerns identified, and corrective action is not maintained
- Where insufficient prevention measures in place such as training, supervision and auditing

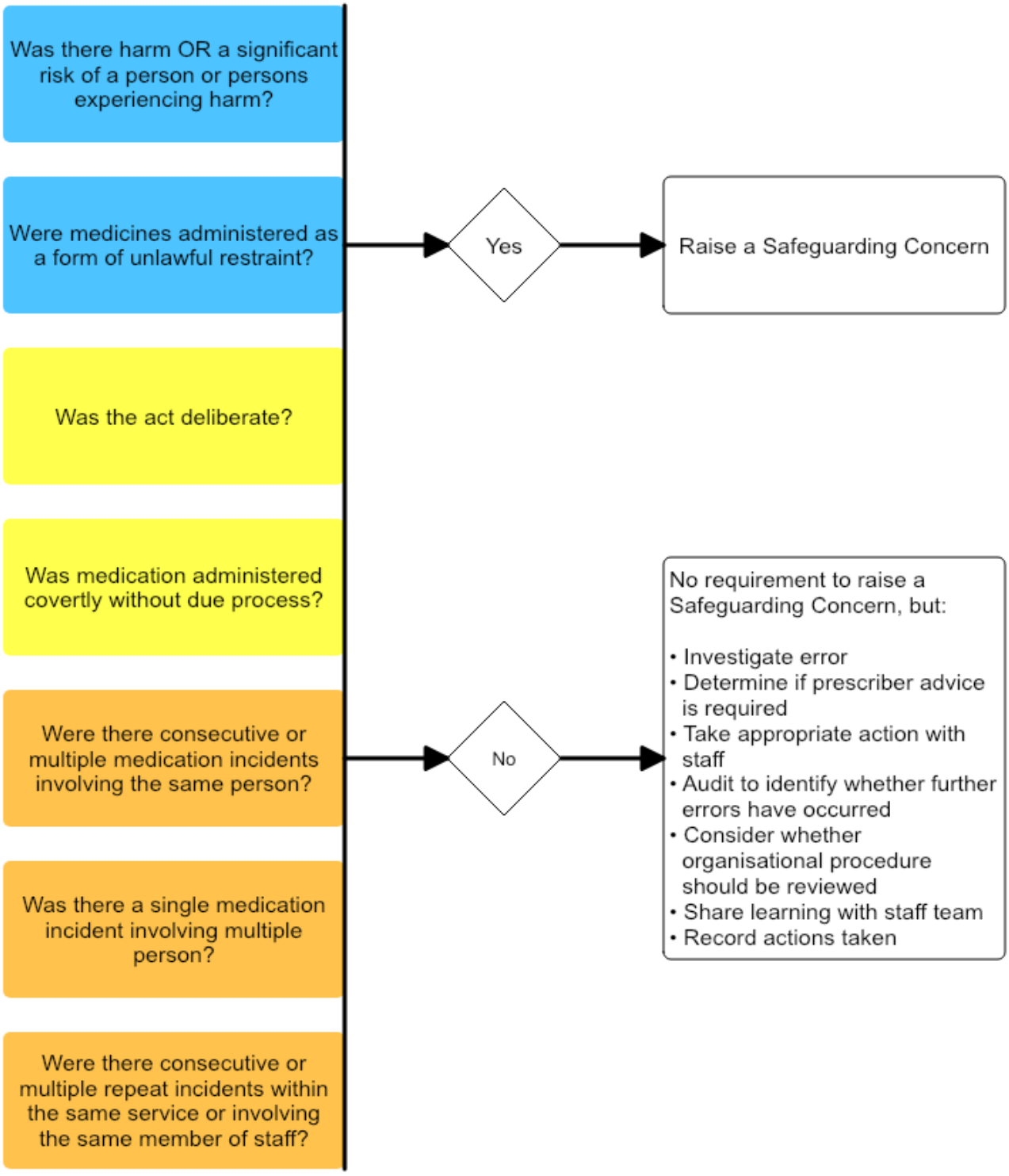
7. Raising a safeguarding adult concern

In the first instance the organisation's safeguarding lead should be consulted, who should refer to the Somerset Safeguarding Adults Board Adult Safeguarding Decision Making Tool and Information Gathering Checklist. Should it be determined that a referral is required then this should be made to Somerset County Council's Adult Safeguarding Service:

- Telephone: 0300 123 2224 (Monday to Friday 8.30am to 5.30pm, Saturday and Sunday closed)
- E-mail: adults@somerset.gov.uk

Or, if you are a professional, complete a secure electronic safeguarding referral form

Appendix 1: Quick Reference Medication Error Decision Maker



Appendix 2: Covert Administration of Medication

Covert administration is when medicines are administered in a disguised format. The medicines could be hidden in food, drink or through a feeding tube without the knowledge or consent of the person receiving them. As a result, the person is unknowingly taking a medicine. Every person has the right to refuse their medicine, even if that refusal appears ill-judged to staff who are caring for them. Covert administration is only likely to be necessary or appropriate where:

- a person actively refuses their medicine
- that person is judged not to have the capacity to understand the consequences of their refusal. Such capacity is determined by the Mental Capacity Act 2005
- the medicine is deemed essential to the person's health and wellbeing

Covert administration of medicines should be a last resort. You must make reasonable efforts to give medicines in the normal manner. You should also consider alternative methods of administration. This could include, for example, liquid rather than solid dose forms

In circumstances where the medication is put into food to make it more palatable and the person is aware **and** has agreed then it is not being administered covertly. In these circumstances their agreement should be documented.

Always remember that administering medicines in food or drink can alter their therapeutic properties and effects. They could become unsuitable or ineffective. Always take advice from a healthcare professional to make sure medicines are safe and effective.

Further guidance on the covert administration of medicines is available from CQC: https://www.cqc.org.uk/guidance-providers/adult-social-care/covert-administration-medicines