** Safeguarding Adults**

**Guidance on Raising Concerns about Abuse and Neglect**

**Appendix 2: Supplementary guidance on when to consider raising a safeguarding concern regarding medication errors**

This supplementary guidance should be read in conjunction with:

* [Guidance on Raising Concerns about Abuse and Neglect](https://www.eastsussexsab.org.uk/documents/guidance-on-raising-concerns-about-abuse-and-neglect/)
* [Sussex Safeguarding Adults Policy and Procedures](http://sussexsafeguardingadults.procedures.org.uk/).

**What is a medication error?**

The National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP) defines a medication error as “any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer”.

Incidents involving medication errors have a number of causal factors including lack of knowledge, failure to adhere to appropriate protocols, interruptions, staff competency, poor instruction or communication, lack of training or basic human error.

**Medication errors and safeguarding**

***Agencies must use their own internal incident policy and processes and ensure that all medication errors are reported using the appropriate procedures. Not all medication errors will require a safeguarding concern to be raised. What is important is that each incident needs to be considered according to the individual circumstances of the situation and a professional judgement reached.***

Note: the same principles outlined within this guidance apply to family carers as well as provider services.

**Responsibilities of care providers**

* Care providers who are commissioned to provide any medication administration service are responsible for ensuring that people who require this service have their medicines at the times they need them and in a safe way.
* Care providers must have clear procedures in place 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 appropriate national reporting and learning, and promote an open honest culture of safety.

**Statutory requirements of care providers around reporting medication errors**

* The registered person must protect adults in their service against the risks of 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 purpose of the regulated activity.
* All medication errors should be reported in line with the care providers management of incidents policy as soon as possible after the incident.

**Good practice in the management 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 Controlled Drug Accountable Officer (CDAO).
* 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 adults using the service who are 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 since a series of similar incidents may meet the criteria for a safeguarding concern to be raised.

***The Care Quality Commission (CQC), as part of their inspection process, will require written evidence to confirm that internal reviews, including subsequent actions, have taken place.***

**Raising a safeguarding concern for a medication error**

Under the Care Act 2014 agencies have a legal responsibility to raise a safeguarding concern with the local authority where there is a suspicion that abuse of an adult with care and support needs has taken place as a result of neglect or omission of care.

**Situations in which a safeguarding concern should be raised:**

* Where a medication error leads to actual harm or death. Possible examples include:
	+ People left without pain relief resulting in a prolonged period of pain.
	+ Significant deterioration in physical or mental wellbeing due to missed medication.
	+ Significant emotional distress.
	+ Elongation of an illness due to prescribed medication not being given.
	+ Adverse effects causing significant harm due to wrong mediation being administered.
* Any medication error requiring urgent medical attention as significant harm may have been caused. Possible examples include:
	+ Attendance at A&E.
	+ Need for an urgent review by a health professional such as a district nurse, GP or paramedic.
* Any medication error which was a deliberate act. Possible examples include:
	+ Malicious intent to cause harm.
	+ Inappropriate use of PRN medication.
	+ Use of medication to control behaviour or restrict an individual.
* Where a medication error is part of a pattern or culture. Possible examples include:
	+ The same medication being omitted repeatedly.
	+ The same member of staff repeatedly failing to administer medication appropriately.
	+ The same adult(s) within a service being repeatedly being affected by the medication error regardless of level of harm.

**Systemic failings**

Where there are systemic failings in a providers’ medication management process which leads to repeated medication errors, consideration should be given as to whether a safeguarding enquiry into organisational abuse is warranted. There is an obligation on all services involve to identify such failings and ensure that safeguarding concerns are raised where necessary, and that issues are addressed.

**Covert medication**

A safeguarding concern should always be raised when medication has been administered covertly without appropriate due consideration to issues of consent, and in situations where the person lacks capacity adherence to the Mental Capacity Act 2005 and the Best Interests Decision Making process.

***If there is any doubt as to whether to raise a safeguarding concern you should contact Health and Social Care Connect for further consultation on 0345 60 80 191.***