

## Care homes - Safeguarding and medicines

### What is considered a safeguarding incident in relation to medicines?

The National Institute for Clinical Excellence (NICE) in their guidance on Managing Medicines in Care Homes<sup>1</sup> outlined that a safeguarding issue in relation to managing medicines could include:

- The deliberate withholding of a medicine(s) without a valid reason,
- The incorrect use of medicine(s) for reasons other than the benefit of a resident,
- Deliberate attempt to harm through use of a medicine(s), or
- Accidental harm caused by incorrect administration or a medication error.

### What is meant by a 'near miss'?

Where significant harm could have happened, but was prevented, it is referred to as a 'near miss'. These are important because incidents that do not result in harm to the resident may indicate a pattern or trend which could form part of wider concerns that the care home is failing to meet minimum safety standards. For example, multiple errors by one or more members of staff, delays in ordering repeat medications. These incidents can be of low frequency, but have a high impact when they occur.

### Recommendations

- The culture of the organisation should be open and supportive to encourage reporting of any medicines-related incidents and near misses.
- Commissioners, health and social care practitioners and care home staff should comply with the recommendations outlined in the NICE guidance on managing medicines in care homes (see national guidance section).
- Care home staff should have suitable access to immediate advice from a suitable healthcare professional regarding appropriate treatment or action to take following a medication error.
- Local processes for notifying suspected or confirmed medicines related safeguarding incidents should be clearly documented and communicated with all relevant people - including care home staff, healthcare professionals, commissioners and providers.
- All information on medication errors and near misses should be collated for periodic review to help with service improvement. Having all of the information on medication errors and near misses collated in one database helps to develop a more accurate picture of frequency and trends.
- Where covert administration of medication is necessary, ensure the correct steps have been taken to assess capacity and any decisions taken in the resident's best interest involve interventions which are the least restrictive and are documented and reviewed periodically.
- For the safeguarding process, priority should be given to those incidents where there is a likelihood or incidence of significant harm (see section on potential areas of high risk).
- Care homes should be registered to receive patient safety alerts, public health messages and other critical safety information as it emerges, which are issued via the Central Alerting System (CAS), web-based cascading system. Contact the CAS helpdesk via telephone on 020 3080 6747 or email [safetyalerts@dh.gsi.gov.uk](mailto:safetyalerts@dh.gsi.gov.uk) to register.

## National guidance

NICE guidance on Managing medicines in care homes has outlined a series of recommendations for commissioners, health and social care providers and care home staff around medicines safeguarding issues.<sup>1</sup>

### Recommendations for commissioners and providers

- Commissioners and providers of health or social care services should ensure that a robust process is in place for identifying, reporting, reviewing and learning from medicines errors involving residents (Recommendation 1.5.1).
- Commissioners and providers of health or social care services should all be aware of local arrangements for notifying suspected or confirmed medicines-related safeguarding incidents (Recommendation 1.6.1).

### Recommendations for health and social care practitioners

- Health and social care practitioners should consider working with all relevant stakeholders to develop a locally agreed action plan, in line with other local and national strategies and governance arrangements, for improving the safety of residents and reducing medication errors in care homes (Recommendation 1.5.2).

### Recommendations for care home staff and providers

- Care home staff (registered nurses and social care practitioners working in care homes) should report all suspected adverse effects from medicines to the health professional who prescribed the medicine or another health professional as soon as possible; this would usually be the GP or out-of-hours service. Staff should record the details in the resident's care plan and tell the supplying pharmacy (if the resident agrees that this information can be shared) (Recommendation 1.5.3).
- Care home providers should have a clear process for reporting medicines-related safeguarding incidents under local safeguarding processes and to the Care Quality Commission (CQC) (or other appropriate regulator) (Recommendation 1.6.2). The process should be recorded in the care home medicines policy and should clearly state:
  - » When the CQC (or other appropriate regulator) should be notified.
  - » Which medicines-related safeguarding incidents should be reported under local safeguarding processes and when.
  - » That accurate details of any medicines-related safeguarding incidents are recorded as soon as possible so that the information is available for any investigation and reporting.
- Care home staff should contact a health professional to ensure that action is taken to safeguard any resident involved in a medicines-related safeguarding incident. They should follow a process agreed between health professional(s) and commissioners, which sets out who to contact in normal office hours and out-of-hours (Recommendation 1.6.4)
- Care home providers should record all medicines-related safety incidents, including all 'near misses' and incidents that do not cause any harm, as a resident safety incident. Where there are notifiable safeguarding concerns these should be reported to the CQC (or other appropriate regulator) (Recommendation 1.6.5)
- Care home staff should find out the root cause of medicines-related incidents (Recommendation 1.6.8)
- Care home providers should make sure that any training needed by staff to find out the root cause of medicines-related incidents is specified in contracts with commissioners (Recommendation 1.6.9).
- Care home staff should give residents and/or their family members or carers information on how to report a medicines-related safety incident or their concerns about medicines, using the care home provider's complaints process, local authority (or local safeguarding) processes and/or a regulator's process (Recommendation 1.6.10).

- Care home providers should ensure that all residents can use advocacy and independent complaints services when they have concerns about medicines (Recommendation 1.6.11).

NICE has produced a diagram which outlines the medicines-related incidents and safeguarding pathway in care homes<sup>2</sup> it can be accessed using the following link <http://pathways.nice.org.uk/pathways/managing-medicines-in-care-homes#path=view%3A/pathways/managing-medicines-in-care-homes/medicines-related-incidents-and-safeguarding-in-care-homes.xml&content=view-index>

## What do the regulations say?

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 outlined that:<sup>3</sup>

- In order to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm, providers must assess the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe. Providers must make sure that the premises and any equipment used is safe and where applicable, available in sufficient quantities. Medicines must be supplied in sufficient quantities, managed safely and administered appropriately to make sure people are safe (Regulation 12).
- Providers must safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005. For these purposes, 'restraint' includes the use or threat of force, and physical, chemical or mechanical methods of restricting liberty to overcome a person's resistance to the treatment in question (Regulation 13). Please refer to appendix 1 (page 6).

## Safeguarding incidents

Examples of scenarios which could be raised as safeguarding incidents:

### Preparation and administration errors

- » Medicines being given covertly without following correct procedure, i.e. assessing capacity, holding a best interest meeting and documenting the joint decision, see appendix 1 (page 6).<sup>4</sup>
- » Essential medicines not being given and no valid reason recorded.
- » Medicines not being reviewed resulting in medicine being continued unnecessarily with risk of adverse effects.
- » Side effects of medicines not being identified or reported.
- » Removing responsibility from people who could manage their own medicines with support.
- » Medicines given at wrong time, e.g. paracetamol less than four hours apart, Parkinson drugs not given at specified times.
- » Resident administered the wrong medication, dose, route.
- » Resident administered an out of date medicine.
- » Medication administered to the wrong patient.
- » Medication incorrectly prepared.
- » Incorrect infusion rate.
- » Administration of medication recorded incorrectly or not recorded.

### Monitoring errors

- » Patient known to be allergic to medication but the medication was prescribed and/or dispensed and/or administered.
- » Failure to provide the patient with correct information regarding their medication, e.g. when to take, what it is for, side effects.
- » Failure to monitor therapeutic levels.
- » Failure to monitor resident who is undertaking self-medication.
- » Failure to react appropriately to signs of ill health, pain or requests for help due to being unwell associated with medication administration.

### Other errors may include:<sup>5</sup>

- » Poor or inadequate communication.
- » Poor, inadequate or incorrect recording/documentation.
- » Inappropriate or inadequate disposal of medicines.
- » Inappropriate administration of medication to chemically manage a resident's behaviour that has not been prescribed or giving additional doses to sedate resident.
- » Deviation from local policy and guidelines relating to medicines management.

See appendix 2 (page 7) for ways of preventing maladministration of medication.

See appendix 3 (page 8) for an example of how to assign levels of risk.

### Potential areas of high risk

- Processes which involve the use of appliances which require special administration techniques such as catheters, oxygen and enteral feeding tubes.
- Administration of controlled drug preparations, in particular combinations of immediate release and slow release, e.g. different preparations of morphine Sevredol® and MST Continus®.
- Handling of medicines with similar names e.g. risperidone and ropinirole, amiloride and amlodipine, hydroxyzine and hydralazine, Maxidex® and Maxitrol®, promethazine and promazine.
- Anticoagulant dosing
- Insulin dosing

### Sources of further information

PrescQIPP bulletin 101. Covert administration of medication. September 2015. Available at <https://www.prescqipp.info/carehomes#b101-covert-administration>

PrescQIPP bulletin 143. Supporting self-administration of medication in the care home. November 2016. Available at <https://www.prescqipp.info/carehomes#b143-supporting-self-administration-of-medication-in-the-care-home>

PrescQIPP bulletin 151. Care homes – how to use multidisciplinary teams effectively. October 2016. Available at <https://www.prescqipp.info/carehomes#b151-how-to-use-multidisciplinary-teams-effectively>

Social Care Institute for Excellence – Mental Capacity Act (MCA) free e-learning training. Available at <http://www.scie.org.uk/mca/e-learning/>

Root Cause Analysis (RCA) Investigation Resource. Available at <http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/>

Social Care Institute for Excellence – Mental Capacity Act (MCA) free e-learning training module 8 Deprivation of Liberty Standards (DoLS) Available at <http://www.scie.org.uk/assets/elearning/dols/Web/module8/main.html>

### References

1. Managing medicines in care homes. NICE (SC1). March 2014. <https://www.nice.org.uk/guidance/sc1> Accessed 03/07/16
2. NICE Pathway: Medicines related incidents and safeguarding in care homes pathway. <http://pathways.nice.org.uk/pathways/managing-medicines-in-care-homes#path=view%3A/pathways/managing-medicines-in-care-homes/medicines-related-incident-and-safeguarding-in-care-homes.xml&content=view-index> Accessed 10/07/16.
3. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. <http://www.cqc.org.uk/content/regulations-service-providers-and-managers> Accessed 10/07/16

4. The Mental Capacity Act 2005 available at <http://www.legislation.gov.uk/ukpga/2005/9/introduction>
5. Social Care Institute for Excellence. Commissioning care homes: common safeguarding challenges. February 2012 available at <http://www.scie.org.uk/publications/guides/guide46/commonissues/maladministration.asp> accessed 30/05/17

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The use and application of this guidance does not override the individual responsibility of health and social care professionals to make decisions appropriate to local need and the circumstances of individual patients (in consultation with the patient and/or guardian or carer). [Terms and conditions](#)

## Additional PrescQIPP resources



Implementation tools

Available here:

## Appendix 1 – Assessing mental capacity under the Mental Capacity Act 2005 and deprivation of liberty safeguards

### The Mental Capacity Act (MCA), 2005 and safeguarding medicines

Using the guiding principles of the MCA, chemical restraint or restriction can be used if it is in the resident's best interests.

The five principles of the Act are:

1. Always presume that someone has capacity unless the evidence tells you otherwise.
2. Do all you can to help someone understand and make decisions about their care and treatment.
3. People are allowed to make unwise decisions. An unwise decision does not necessarily mean that they lack capacity.
4. Any decisions you make on behalf of someone who lacks capacity must be made in their best interests.
5. Always look for the least restrictive option to meet their needs.

### The two-stage test for assessing mental capacity

<b>Stage 1</b>	Does the person have an impairment of, or a disturbance in the functioning of the mind or brain?
	Does the impairment or disturbance mean the person is unable to make a decision when they need to?
	A person is unable to make a decision at this time if the answer to any of the questions below is NO.
	Re-assess capacity if there are any changes in the resident's medical condition.

<b>Stage 2</b>	Can the resident understand the information to make a decision at this time?
	Can the resident retain the information?
	Can the resident weigh or use that information as part of the decision-making process?
	Can the resident communicate their decision (by talking, sign language or by any other means)?

### Deprivation of liberty safeguards and medication

If the restrictions and restraint used deprives a person of their liberty, extra safeguards are needed.

When deciding whether a resident will be deprived of their liberty consider whether:

- The resident is subject to continuous supervision and control, and
- Are they free to leave? The focus should not be upon whether a person seems to want to leave, but on how those who support them would react if they did want to leave.
- If medication is used to sedate or control the behaviour of a resident, an application for deprivation of liberty should be made to the local authority.

## Appendix 2: Maladministration prevention checklist

Adapted from Social Care Institute for Excellence (SCIE) Maladministration Prevention checklist <http://www.scie.org.uk/publications/guides/guide46/commonissues/maladministration.asp>

- All residents should be supported to manage their own medicines unless they are assessed as lacking mental capacity to do so.
- Medication should be stored in the resident's room in a locked cupboard. An assessment should be made of the risk to each resident and to others as a result of them having unsupervised access to the cupboard.
- Robust systems for medication administration and record-keeping are clearly set out in the home's procedures.
- There is evidence that the manager checks adherence on a regular basis.
- All staff responsible for administration of medication receive regular training and can demonstrate that they are competent in this area of practice.
- Training includes administration procedures, knowledge of the medicines and expected effects of taking them, including side-effects and knowledge of the conditions or illnesses being treated.
- Staff are aware that they should report concerns about over-medication through safeguarding procedures.
- The home has an open and supportive culture. Staff discovering an error feel confident in reporting it and are not tempted to cover it up.
- Staffing levels are always adequate to enable staff to adhere properly to agreed practice and protocols on the administration of medication.
- The GP carries out regular reviews of all patients receiving medication and there is a focus on the reduction of medication where possible.
- The home works with the GP and pharmacist to examine mistakes with a view to improvement.
- Staff receive support from community health professionals in the management of health conditions.
- The home has a multi-agency and person-centred approach to the management of challenging behaviour.
- Where the decision to use, or not use, medication could be considered as serious, staff should adhere to the Mental Capacity Act. If a person lacks capacity, and there are no relatives or friends to act in their best interests, staff should refer to an Independent Mental Capacity Advocate (IMCA).

## Appendix 3: Assigning levels of risk

Adapted from the document **Supporting Medicines Management through feedback produced by Lambeth and Southwark PCT**

Note the level of risk has been considered in relation to the resident; however there are also risks to other residents, care home staff and care home that also need to be recognised. This is not a definitive list but rather some examples of common issues that can occur in the care home setting.

### High risk to the resident

- Medicine given to the wrong resident.
- Wrong dose administered.
- Hospital discharge changes not acted upon.
- Discontinued medicines still being administered.
- Medicines not being in stock (level of risk will depend on the medicine – refer to pharmacist or doctor to determine level of risk).
- Medicines routinely signed for as administered that could not have been given, e.g. if not in stock or if medicine has not been removed from packaging.
- Controlled drugs procedures not followed.
- Covert administration undertaken without proper procedure having been followed or documented.
- Medication without label or that is kept despite no longer being in use for that resident.
- Recognised drug error not acted on appropriately.
- No recorded allergy status.

### Medium risk to resident

- Medicines signed for routinely after medication round.
- Gaps in administration records for internal preparations.
- No individual guidelines for use of 'when required' psychotropic drugs.
- Keys to drug cupboard/clinical room not safely kept on responsible person.
- Medicines left out for residents to take later (but can pose a high risk).
- Staff do not follow best practice when administering drugs via a PEG feed.
- Lack of regular medication review.
- Medicines not stored under correct conditions, e.g. clinical room over 25°C, or fridge not kept between 2°C and 8°C or minimum/maximum temperature not recorded daily.
- 'As directed' instructions.
- Medicines incorrectly recorded on receipt.
- No accurate records of administration on MAR chart for prescribed food supplements.

### Low risk to patient

- Variable dose not recorded (may be medium risk depending on medicine concerned).
- Administration of external preparations not recorded properly on administration.
- Carers administering externals who have not been adequately trained.
- Homely remedies not accounted for.