Diogelu Gwent
Gwent Safeguarding

Medication Errors Protocol



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Protocols and Procedures
Sub-Group

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1. Introduction

This **Medication Errors Protocol** is a multi-agency safeguarding procedure devised to support in the response to cases where there has been a medication error and is applicable to both children and adults.

All medication errors must be recorded and reported using the appropriate procedures, but not all errors will be safeguarding concerns. The purpose of this protocol is to provide guidance on the handling of medication errors and determining when a safeguarding concern is raised.

This protocol applies to all healthcare settings where medication is prescribed, supplied, administered, or monitored. This includes acute and community healthcare services, primary care, mental health services, care homes, domiciliary care providers, and any other commissioned or regulated care environments. The document should be read in accordance with individual agency policy and the Wales Safeguarding Procedures which can be found here: Safeguarding Wales.

Throughout the document the term 'practitioner,' will be used as a generic term and will encompass any individual with responsibility for prescribing, supplying, administering or monitoring medication. The term 'individual,' will be used to refer to the person receiving the medication.

Purpose

NICE Guidance (2014) indicates that providers 'should ensure that a robust process is in place for identifying, reporting, reviewing and learning from medicines errors involving residents' (https://www.nice.org.uk/guidance/sc1)

There is also a Duty of Candour which seeks to ensure that individuals and public safety is protected. This necessitates transparency and immediacy when responding to incidents of actual or potential harm, as well as timely, consistent and objective responses.

This protocol seeks to support these principles by outlining the procedures which should be followed when a medication error takes place in order to ensure consistency. If there are occasions where a safeguarding response is not required, this protocol outlines responsibilities in terms of recording and monitoring to ensure that any patterns or ongoing concerns can be identified.

Practitioners must be mindful that upon discovering any concerns regarding a medication error, the initial priority is to ensure the safety and well-being of the individual by ensuring an appropriate medical response. This should be followed by prompt safeguarding action where necessary, such as the submission of a Duty to Report by telephone to the appropriate local authority, followed up in writing within 24 hours.

It is important to distinguish between the statutory requirement to notify Care Inspectorate Wales (CIW) of certain incidents and the process of making a referral to CIW or submitting a Duty to Report regarding concerns about an individual practitioner or provider. In accordance with Welsh regulatory requirements, regulated care services must submit notifications to CIW for reportable incidents, which may include medication errors where the incident meets the relevant reporting thresholds. These notifications form part of the provider's duty to ensure transparency, regulatory oversight and continuous improvement in the safety and quality of care. The submission of a notification should not be interpreted as a referral for enforcement or regulatory action, but rather as a routine requirement to enable appropriate monitoring and scrutiny of incidents within regulated services

Please note that ABUHB hospital settings will be managed by their own organisational policies and procedures in relation to medications errors.

2. Definition - What is a Medication Error?

The World Health Organisation (2022) 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.'

For more information please see here: MEDICATION ERROR

Errors may result in an incident or harm to an individual , or an adverse impact may be averted. When averted this may be classed as a 'near miss,' however, recording of these is still important to allow for any patterns of concern to be identified.

Medication incidents have a number of causes, such as lack of knowledge, failure to adhere to system and protocols, interruptions, staff competency, poor handwriting and instruction, poor communication, lack of training or basic human error. It is important that staff are supported when they have been involved in a medication error.

The Importance of MAR Charts

It is now the expectation that Electronic Medication Administration Records (eMAR) are used. Robust processes must be in place to ensure that medication information is transferred accurately and promptly from prescriptions, dispensing labels, hospital discharge information, or paper MAR charts. Staff must verify that all medication details, including dosage, frequency, route, and any changes to treatment, are correctly entered and updated within the electronic system before administration takes place.

As paper-based recording is now the exception in most commissioned care settings, particularly care homes and domiciliary care services, organisations must ensure that staff are appropriately trained and competent in the use of electronic medication systems. Any discrepancies identified between source documentation and electronic records must be reported immediately, investigated, and resolved in line with local medication error reporting procedures to minimise the risk of harm and support safe medicines management

Examples

Below are some generic examples of when medication errors may occur across all settings. This list is not exhaustive and should be considered in conjunction with professional judgement.

Prescribing
• Duplicate medicine: a drug prescribed by 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 • An individual is prescribed a medicine that they are known to be allergic to • An individual is prescribed a medicine that is contraindicated • An individual is prescribed a medicine that is unnecessary for them • An individual 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 (Examples of drugs requiring monitoring include anticoagulants; cardiac glycosides; diuretics; antiarrhythmic; thyroid hormone; anti-manic agents; insulin and some anti-rheumatic drugs.)
• Monitoring not requested • Monitoring requested but not carried out • Monitoring performed but results not available • Results not acted upon
Dispensing
• 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
Administration
• 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) or 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. • Medication being given covertly or without clear prescriber direction for manipulation.
Ordering and Record Keeping
• Stock not ordered, not booked in correctly, or not carried forward correctly • Lack of recording as to reasons why medication has not been ordered/is not available • Review/appropriate steps not taken to source medication when not initially available • 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 • Deliberate alteration or amendment of MAR chart • MAR chart not being completed/updated correctly • MAR chart not being used

3. Threshold for Raising a Safeguarding Concern

Not all medication errors will require the submission of a Duty to Report. However, there are some circumstances where a medication error will also require the submission of a Duty to Report, for example where the person or persons in question came to harm or potential harm. Harm is defined as an impairment to health which results in an increase to a person's care and support needs.

There will also be additional processes and duties within organisations, such as local and national reporting arrangements, and the application of the Duty of Candour within the Health & Social Care (Quality & Engagement Act) (Wales) 2020. Organisational policy should always be followed.

Details on the Gwent process for submission of a Duty to Report can be found here:

Report an adult at risk - Gwent Safeguarding

Report a child at risk - Gwent Safeguarding

There are some circumstances where a medication error must always result in the submission of a Duty to Report.

Examples where a Duty to Report MUST be submitted (this is not an exhaustive list):

- The medication error results in death, injury, worsening of an individual's condition (for example admission to hospital);
- There is abuse or neglect, or a suspicion of abuse or neglect;
- An incident is reported to, or investigated by, the Police.
- 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 where no specific approved covert medication protocol is in place (e.g. administering a tablet in yoghurt where a client with or without capacity has refused).
- Consecutive/multiple medication incidents involving the same client (e.g. prescribed medication is not administered over more than one round because it has not been ordered or collected).
- Single medication incident involving multiple clients (e.g. a whole medication round missed or delayed).
- Multiple/repeat incidents within the same service, or by the same practitioner (e.g., medication is administered incorrectly by a specific member of staff on more than one occasion).
- Excess medication being found which suggests that medication is not being administered appropriately.

Where a practitioner has concerns regarding a potential medication error, advice and guidance should immediately be sought from their Designated Safeguarding person and/or the local authority.

Examples where a Duty to Report MAY be submitted and where advice should be sought:

- One off medication error for more than one person with no harm caused
- Previous concerns identified and corrective action is not maintained
- Insufficient prevention measures in place such as training, supervision and auditing.

Contact details for all Gwent local authorities Children's and Adult Services departments can be found here:
Report an adult at risk - Gwent Safeguarding

Report a child at risk - Gwent Safeguarding

There may be occasions where poor practice is identified leading to a medication error but a Duty to Report is not necessary. However, any identified poor practice in administration of medication requires a documented management response, regardless of whether a DTR is submitted or not. This is because poor practice at any level which is not addressed can lead to medication errors which have a negative impact on clients. Taking action in response to all medication errors mitigates against the risk of reoccurrence and improves practice. (for further detail, please see below).

Examples where a medication error may not require a Duty to Report, but will need a documented management response:

- A gap in recording (e.g. a signature is missed on the MAR chart, but your investigation concludes that the medicine was correctly administered, 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 (e.g. the adult does not receive prescribed medication (missed/wrong dose) on one occasion and relevant health care professional* confirms no harm occurred. You have taken appropriate action with the member of staff concerned and recorded this).
- Medication is not given on more than one occasion and relevant health care professional confirms no harm occurred (e.g. recurring missed medication or administration errors identified through observation or audit. You take swift action once identified through training/supervision. You monitor the situation closely until poor practice has been corrected. You have recorded the incident and action taken/advice given.
- Medication was given late (e.g. 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 confirmed this with the relevant health care professional who has advised that no harm has occurred, you have recorded the incident and action taken/advice given).
- A member of staff signs the paper MAR chart in red ink (e.g. you have reminded the staff member of your policy and ensured a supply of black pens is available/removed the red pens
- An error in recording/transcription during the booking in process or transcription of MAR charts that has not impacted on the administration of medication, however posed a risk of medication errors occurring as a result if not picked up (near miss) for example, a PRN medication has been recorded as regular dose due to transcription error or amount received / carried forward had not been recorded upon receipt.
- A member of staff has changed initials and the sample signature sheet reflects their previous name (e.g. the member of staff signs 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).

These examples are not exhaustive lists, and it is important that practitioners consider each medication error on a case-by-case basis using professional judgement. If there is any doubt as to whether a Duty to Report is required, advice should always be sought from Children's or Adult Services.

Controlled Drug Errors

Not all controlled drug errors will require the submission of a Duty to Report form. A Duty to Report should be submitted when a controlled drug error involves harm or potential harm where there is concern of abuse, neglect, or unsafe practice.

However, all controlled drug errors, including those reported to safeguarding, should be reported to the Health Board Controlled Drug Accountable Officer (CDAO) using the dedicated CDAO form which is sent to Care Homes when applicable (Please see Appendix 1).

4. Documented Management Response to Medication Errors

All medication errors will require a documented response by the setting with the responsibility to administer the medication, whether the threshold for safeguarding is met or not. This allows for any patterns of poor practice, which may be indicative of wider concerns regarding abuse or neglect, to be identified and addressed appropriately.

All settings have a responsibility to ensure that all records and documentation of medication administration, either paper or electronic, are made available to all relevant health and social care practitioners.

Each agency, organisation, and care provider will have its own internal framework, policies, and procedures for managing and responding to medication errors. These local arrangements may vary according to regulatory requirements, staffing structures, and operational models. The steps outlined below offer a suggestion for a documented response but this should be read in conjunction with each agencies own safeguarding expectations and organisational pathways.

Some actions may 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

It is important to investigate the root cause of any medication error to determine whether written procedures need to be reviewed, whether individuals or teams of staff require additional training, refresher training, competency reassessment, or supervision, and whether the risk of accidental error can be mitigated through changes to practice. Providers should ensure that practitioners involved in the administration and monitoring of medication receive appropriate training on induction and at regular intervals thereafter, in line with organisational policy and assessed competence.

For more widespread concerns a thorough investigation report will include detail which might include statements of involved staff, anonymised copies of MAR sheets/digital records, care delivery records, communication with relevant parties (e.g. prescriber, Safeguarding, CIW), 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 Local Authority Quality Assurance Team/Local Authority and Health board Commissioning Teams, and any other relevant commissioners or the CIW may request information relating to medication errors to ensure that management processes are robust. Also refer to NICE guidance and RISCA for best practice.

Products - Medicines management | Topic | NICE

Regulation and Inspection of Social Care (Wales) Act 2016

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

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 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.
Support staff - It is vitally important to support staff when they have been involved in a medication error/near miss as it can cause distress and concern for practitioners, particularly when there is a direct impact.
Support should be provided on an individualised basis and may include Referral to the Staff Well-Being service / Referral to Occupational Health service / Facilitation of Trade Union support. Professional development needs will also be identified and facilitated in order to minimise the risk of such errors recurring. This may include reflection, supervision, further training and competency assessment. The ABUHB Policy for managing and supporting staff following a medication error_BESS.pdf can be found here.

5. Resources

Recommendations | Medicines optimisation: the safe and effective use of medicines to enable the bes…

Discussing-and-planning-medicines-support-quick-guide-1.pdf

Professional guidance on the administration of medicines in healthcare settings - Royal College of Pharmacy

All-Wales-guidance-to-support-integrated-medicines-management-in-community-settings

Policy for managing and supporting staff following a medication error_BESS.pdf

Regulation and Inspection of Social Care (Wales) Act 2016

Appendix One: Aneurin Bevan Controlled Drug Accountable Officer Form

When completing this report, please provide as much information as possible. Incidents, concerns and discrepancies MUST be reported to the CDAO as soon as possible, ideally within 48 hours.

Please note patient details should not routinely be sent with this form. Take care to forward this form to the CDAO through a secure route.

Reference number: (office use)	**Date:**
Premises name and address:	
Post code:	**Contractor or Practice code** (if applicable)**:**

Responsible person in location:	**Job title:**
Telephone no:	**Email address:**

Person reporting incident:	**Job title:**
Telephone no:	**Email address:**

Locations involved in the incident *(Check all applicable boxes)*							
GP Practice	☐	GP OOH Provider	☐	Dental Practice	☐	Substance Misuse Service	☐
Hospital Ward	☐	Hospital Theatre	☐	Hospital Pharmacy	☐	Hospital Other	☐
Care Home	☐	Community Outpatient	☐	Community Nursing	☐	Community Pharmacy	☐
Midwifery	☐	Welsh Network	☐	Police Custody Suite	☐	Other:	

Description of issue/concern (Provide a clear account of what happened or what the concern is):	
Date of incident:	**Time of incident**:

Personnel involved (continue on separate sheet if necessary):				
Name	**Job Title**	**Registration No**	**Contact Details**	**Role**

Incident	**Check all boxes that apply**	**Detail**
Prescribing incident:	☐	Details of prescriber:
Dispensing/supply incident:	☐	Details of dispenser/supplier:
CD register discrepancy against actual stock:	☐	Details of discrepancy:
Administration incident:	☐	Details of person administering:
Missing CDs:	☐	Details:

Record keeping:	☐	Details of record keeping:
Security:	☐	Details of security:
Suspected/Actual criminality or fraud:	☐	Details of criminality or fraud:
Other (specify)**:**		

Details of the actions taken to resolve the issue, including immediate steps to prevent or reduce harm to patients and any investigations undertaken (provide details of actions taken up until the point of reporting to the CDAO. If an investigation is still underway, please state this within your report to allow the CDAO to follow up at a later date):

Person investigating:	**Job title:**
Person investigating:	**Job title:**
Person investigating:	**Job title:**

Details of action taken to prevent a recurrence of this type of incident (include details of actions that are still to be completed that either relate to the incident itself or to be taken to prevent a similar incident/concern occurring in the future. This may involve staff briefings, training, personal reflections, significant event form etc.):	
Issue reported on Datix? Y/N	**Datix Number:**

Action taken by CDAO (office use):

Signature of Responsible Person from CD Governance Team:

Date:

When an incident or near miss involving controlled drugs occurs this form should be completed electronically and returned to: **ABB.CDAO@wales.nhs.uk**

Jonathan Simms
Controlled Drug Accountable Officer
Aneurin Bevan University Health Board
Llanarth House
Newbridge
NP11 5GH
Telephone 01495 241290
Email: **ABB.CDAO@wales.nhs.uk**

Appendix Two: Flowchart

IF THE INDIVIDUAL REQUIRES MEDICAL ATTENTION ENSURE THIS IS SOUGHT IMMEDIATELY

