Medication Errors Reporting Process in Care Homes

1. Introduction

Medication errors in all of Warrington Borough Councils commissioned providers are usually reported as safeguarding alerts. All safeguarding alerts are risk assessed, irrespective of the circumstances, in order to determine what actions need to be taken.

Warrington Safeguarding Adults Board’s recognises maintaining high quality services, including those provided by internally and externally commissioned providers, is essential to identify, respond to and minimise medication errors.

However it is also recognised that for safeguarding to be relevant and effective it also needs to be proportionate and have the capacity to respond to the more serious incidents where significant harm has occurred, or is likely to occur.

This document outlines a change in approach to the reporting and responding to medication errors within nursing and residential care homes.

2. Medication Errors and Safeguarding

A review of available literature and research identifies that there is a high frequency of medication errors, but a low impact in terms of their seriousness.

The British Medical Journals ‘Care homes use of medicines’ study’ (2009) found that nearly 70% of residents within the study had experienced one or more errors, but with the average potential harm being low.

The General Medical Councils study ‘Investigating the prevalence and causes of prescribing errors in general practice’ (2012) identified prescribing or monitoring errors for one in eight individuals, with the vast majority of errors of a mild to moderate severity, with only 1 in 550 errors described as severe.

The Department of Health report ‘Building a safer NHS for patients’ (2004) identified a number of factors prevalent in medication errors. It identified that there may be a tendency not to report ‘near misses’ even though identifying near misses can promote learning as much as from actual errors. The report identifies that the more serious the error, the more likely it was to be reported and the number of incidents reported is likely to be only a small proportion of the total number of low level, or ‘near miss’ events.

Individual error is rarely the root cause of a medication error. Usually errors are caused by the systems and processes surrounding the prescription and administration of medication. The overall consensus of available research suggests that the vast majority of medication errors, despite being high frequency, are low impact.

The Care Quality Commission’s Market Report (2012) identified medication management as the greatest problem area of non-compliance within the social care sector, 20% of nursing homes and 16% of residential homes did not meet the standard on medicine
management. The report acknowledged that social care services were facing increasing challenges because of the significant growth in service users presenting with multiple health problems and requiring complex drug treatment.

In considering the local picture of medication errors reported as safeguarding alerts to Warrington Borough Council, there are broadly two groupings:

2.1. Significant Harm or the Likelihood of Significant Harm

Medication errors that result in actual harm to the service user should always follow the safeguarding route as part of the ‘significant harm’ criteria contained within ‘No Secrets’ and other associated guidance.

Dependant on the seriousness and the circumstances of the incident, other professionals or agencies could be involved in this process, including Police and health organisations as appropriate. Within some settings, such as hospitals, it may be appropriate for their own ‘significant incident’ investigation to take place alongside any safeguarding process.

The likelihood of significant harm includes incidents that are ‘near misses’, where significant harm could have happened, but was prevented. There should have been a real likelihood in such situations, rather than a vague, fanciful risk of significant harm.

Also, incidents that do not result in harm to the service user, but may indicate a pattern or trend within a provider service which could form part of wider concerns that they are failing to meet minimum safe standards. For example, multiple errors by one or more members of staff, failures to audit correctly, delays in ordering repeat medications, or the provider being placed in default can indicate the absence of adequate training, procedures, quality assurance systems or management oversight.

These incidents are of low frequency, but high impact when they occur.

2.2. Low Level Medication Errors

Medication errors which do not result in harm to the service user, and do appear to indicate a wider trend or pattern of incidents. This circumstance is by far the most common and accounts for a high percentage of all safeguarding alerts, and can happen in any setting, even where the quality of care more than meets minimum standards.

Such incidents are of high frequency but low impact, and the way in which these incidents in care homes are reported in future will change as outlined in section 4 below.
3. **Process**

From 2014 the way in which medication errors in care homes are reported will change. This change in process has been agreed by Warrington Borough Council, Bridgewater Community Healthcare NHS Trust and the Warrington Clinical Commissioning Group (CCG).

This change in process is to:

- Enable immediate advice to be given to the care home by a clinician as to appropriate treatment or actions in response to a medication error
- Determine whether the incident should be referred as a safeguarding alert to the Access to Social Care Team
- To have all intelligence on medication errors collated and held within one database to develop a more accurate picture of frequency and trends to better inform services and improvement
- Focus the safeguarding process on those incidents where significant harm, or likelihood of significant harm is present

Instead of a care provider reporting medication errors to the Access to Social Care Team (ASC) as a safeguarding alert, the provider will contact Bridgewater Community Healthcare NHS Trusts Single Point of Access Service (SPA) instead.

All medication errors will be reported by care homes to the SPA. On discussion with the SPA Service, a safeguarding alert could still need to be made by the care home to ASC, but this not likely to be a low level medication error as described in section 2.2 above. However, the individual circumstances of each incident should be considered, and it remains the responsibility of the care home to determine whether a safeguarding alert should be made to ASC.

The SPA Service is designed to support the organisation of unscheduled care for patients. The service does not provide patients with a direct service, assessment or diagnosis, but confirms and arranges appropriate care pathways for patients with other community services.

The SPA Service will make available to WBC Quality Monitoring Officers information on individual care homes prior to a monitoring visit to enable all medication errors to be considered, including those referred to ASC as a safeguarding alert, and those deemed as dealt with only by SPA.

Wider intelligence and trends will also be shared by Bridgewater Community Healthcare NHS Trust at the monthly Safeguarding and Quality Intelligence Meeting, chaired by the Warrington Borough Councils Assistant Director for Quality Assurance.
4. **Pathway**

See section 5 for process flowchart.

In the event of a medication incident in a care home SPA is available Monday to Friday 08.00 - 19.00 hrs via fax number **01925 867953** or if a more urgent response is required (i.e. within 20 minutes) via telephone number **01925 867905**.

Outside of these hours the 111 Service and Warrington’s GP Out of Hours Service is available via Tel No: **111**.

The contact details of Access to Social Care Team is telephone number **01925 444239**, if urgent contact Out of Hours Service on **01925 444400**.

4.1. **Urgent/Emergency Treatment Required**

1. Call 999

2. Transfer service user/patient with records and information of incident to A+E
   - Where appropriate inform next of kin of transfer to hospital and incident
   - Document service user/patients records appropriately
   - Action appropriate incident reporting procedures for care home

3. Fax information of incident to Single Point of Access (SPA) **01925 867953**
   - SPA will return a call to provide onward support and advice as appropriate to need and best practice, where available pathways and guidelines are used to enhance support, i.e. NICE, Map of Medicine
   - SPA will collate statistical information of medication errors for vulnerable adults in Warrington
   - Promoting and developing best practice guidelines and benchmarking to support and prevent incidents
   - The service users GP’s is advised of the medication incident in a timely manner dependent on priority (Information transferred no later than 08.00 hrs the next working day)
   - Where harm has occurred SPA will advise the care home follows safeguarding procedures and contacts CQC as per their registration requirements. Where appropriate, SPA will report the incident of harm to safeguarding

4.2. **Non Urgent Medication Incident**

Less urgent priority including incidents of possible harm or incidents with no harm (e.g. missed medication, medication audit issues where medications have not been signed for).
No emergency transfer to Hospital is required and care or advice can be given in the community.

4.2.1. In Hours Pathway (08:00 – 19:00 hrs, Mon – Fri)

1. Fax or Telephone SPA as to care priority

2. SPA nurse will contact care home to provide best practice advice and support including triage guidance based on the following information:
   
   - Service users current presenting complaint, including incident, current signs and symptoms, recorded vital signs observations TPR, BP, Oxygen saturation percentage
   - Service users medical history, inclusive of medications and allergies

3. Document service users records appropriately and action incident reporting procedures

4. Where appropriate inform the service user and where relevant advise their family

6. SPA nurses will further utilise guidelines from BNF/Mims/Patient Information Leaflets and where necessary via the additional support of a Pharmacist, GP or The National Poison Safety Centre to ensure the correct care treatment and support is offered

7. Patients may require onward referral to hospital, GP assessment or other community services

8. SPA will collate statistical information of medication errors for vulnerable adults in Warrington to promote and develop best practice to support and prevent incidents

9. The patients GP’s is advised of the medication incident in a timely manner dependent on priority (Information will be transferred by 08.00 hrs next working day)

10. Where harm has occurred SPA will advise the care home follows safeguarding procedures and contacts CQC as per their registration requirements. Where appropriate, SPA will report the incident of harm to safeguarding

4.2.2. Out of Hours Pathway

1. Telephone 111

2. The Out of Hours Service will provide best practice advice and support including triage guidance based on the following information:
- Service users current presenting complaint, including incident, current signs and symptoms, recorded vital signs observations TPR, BP, Oxygen saturation percentage
- Service users medical history, inclusive of medications and allergies

SPA nurses will further utilise guidelines from BNF/Mims/Patient Information Leaflets and where necessary via the additional support of a Pharmacist, GP or The National Poison Safety Centre to ensure the correct care treatment and support is offered. The service user may require onward referral to hospital, GP assessment or other community services.

3. Fax SPA to advise of the incident

4. Document service users records appropriately and action incident reporting procedures

5. Where appropriate inform the service user and where relevant advise their family

6. The next working day the SPA nurse will return a call to the care home to coordinate any outstanding care issues

7. The service users GP’s will be advised of the medication incident in a timely manner dependent on priority (Information will be transferred by 08.00 hrs next working day).

SPA will collate statistical information of medication errors for vulnerable adults in Warrington to promote and develop best practice to support and prevent incidents.

8. Where harm has occurred SPA will advise the care home follows safeguarding procedures and contacts CQC as per their registration requirements. Where appropriate, SPA will report the incident of harm to safeguarding.

A process flowchart is included in section 5 below and if you require any further advice or information please contact Paul Dalby at pdalby@warrington.gov.uk or Tel No. 01925 444283.

5. **Process Flowchart**

(See page 7 below)
Medication Incident Reporting Process Flowchart

Medication Incident

Has it resulted in significant harm or was there a likelihood of significant harm

Yes

Is the incident ‘in hours’?

No

Contact 111 and follow pathway (see section 4.2.2)

Is any treatment of health advice required?

Yes

No

Is the incident ‘in hours’?

No further action

Contact SPA and follow pathway (see section 4.2.1.)

Is urgent/emergency treatment required?

Yes

Contact SPA and follow pathway (see section 4.2.1.)

No

Contact 111 and follow pathway (see section 4.2.2)

Make a safeguarding alert to Warrington Borough Council.

Contact Numbers:
SPA: 01925 867953
WBC: 01925 444239
01925 444400
(Out of hours)