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Medication Safety, Governance and Safeguarding

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Session Plan

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1. Introduction & Housekeeping
2. Medication Safety
3. Medication Governance
4. Medicines Safeguarding
5. Case Studies and Quiz
6. Questions

Housekeeping

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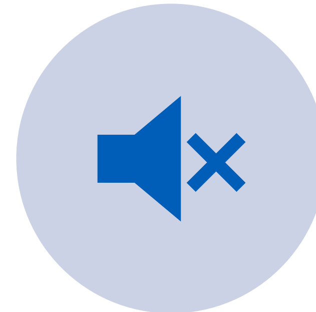
Please write your name and the care home/provider you are from in the chat



Please remain on mute when not speaking

Q&A section at the end – please use the "raise hand" function or "chat" function

This session does not equate to competency in the subject area – individual providers are responsible for assessing competency.

Meet the Team - NHS BLMK ICB Care Home Medicines Optimisation Pharmacists & Pharmacy Technicians

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Please send details of your query/referral to the relevant area's team email address (no proforma required). Individual contacts can be used if needed.
Emails are monitored Monday—Friday, 9am—5pm (excluding Bank Holidays) and will be triaged to the most appropriate member of the team.
Patient identifiable details should ONLY be sent from and to secure email addresses (e.g. NHS.net to NHS.net).
More information, guidance documents & newsletters can be found on the BLMK ICB Care Home Medicines Optimisation (MO) team website.

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Our Role

- Supportive – the ICB is not a care home regulatory body.
- The team provides support to a number of key stakeholders including:
  - Care homes / Learning Disability Homes
  - Primary Care Networks (PCNs) / Practices
  - The ICB Quality Team
  - Local Authorities
  - Other community services
  - Secondary care

BLMK ICB Medication Training Offer – Tiered System

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1
- Medication eLearning – PrescQIPP

2
- Online Medication Training Sessions – BLMK ICB

3
- Medication Champions Scheme

BLMK ICB Care home Medicines Optimisation team – Training offer

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Tier 1 – Medication eLearning:

- Hosted by PrescQIPP (Skills for Care and NICE endorsed)
- Care Home staff- ‘Medicines use in care homes: courses 1, 2 & 3’ (access code needed) - **Course 1 updated with new code, Course 2 recently reviewed – new code available**
- Community-based Care staff –'Managing medicines for adults receiving social care in the community: courses 1 & 2’ (no access code required)
- Fully funded by BLMK ICB / Health Education England - free of charge
- Provides foundation knowledge in medicines management within social care and supports the implementation of recommendations in the NICE SC1 (Managing medicines in care homes) and NICE NG67 (Managing medicines for adults receiving social care in the community)
- PrescQIPP annual update- You should have completed the full PrescQIPP course before taking the annual update

BLMK ICB Care home Medicines Optimisation team – Training offer…continued

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Tier 2 – Online Medication Training Sessions

- Provided by the BLMK ICB Care Home Medicines Optimisation team, free of charge
- On the selected topics below and will focus on local guidance and procedures:
  - Homely Remedies and Self Care - delivered
  - When Required (PRN) Medication - delivered
  - Covert Administration of Medication - delivered
  - Medicines Reconciliation & Transfers of Care - delivered
  - Controlled Drugs & Controlled Drug Regulations in Care Homes – delivered
  - Medication Safety, Governance & Safeguarding – today's session
- These sessions will be repeated 2024 – 25 – dates to be confirmed

Tier 3 – Medication Champions Scheme – COMING APRIL 2024

Medication Safety

CHUMS Study
(Care homes use of medicines)

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- CHUMS study published 2009
- Surveyed 256 residents (mean age 85yrs) from 55 different care homes
- Revealed unacceptable levels of medication errors
- Errors at different stages – Prescribing, Administration, Dispensing, Monitoring
- Medication safety in care homes is a systems issue – not down to one group

Report concluded:

“That two thirds of residents were exposed to one or more medication errors of concern. The will to improve exists, but there is lack of overall responsibility. Action is required from all concerned”

Medicine-related incidents and errors

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A medicine error is any patient safety incident, where there has been an error while:

- **Prescribing** – e.g., GP or other HCP could prescribe the wrong strength or the directions could be wrong
- **Preparing** – e.g., liquid antibiotic may not have been made up properly by the pharmacy or at the home
- **Dispensing** – picking error at dispensing e.g. clobazam instead of clonazepam
- **Administration** – e.g., missed dose
- **Monitoring** – inappropriate or absence of monitoring, certain medicines such as digoxin, lithium, antipsychotics require regular blood tests
- **Providing advice on medicines** – e.g., not enough advice and guidance on inhaler technique or eye drops administration

Why do errors happen?

Poor medication processes or systems

- Inappropriate staff training and knowledge
- Lack of guidance e.g. policy, protocols

Human factors

- Fatigue and tiredness
- Environmental conditions – e.g. interruptions
- Staffing levels

Medicine errors can result in severe harm, disability and death.

Near miss

NHS England defines a 'near miss' as a 'prevented patient safety incident'

With a 'near miss', significant harm could have happened but was prevented.

It is just as important that 'near misses' are reported along with those incidents where actual harm occurred

Reviewing near misses can provide useful learning and areas for improvement

This can reduce the potential for similar events to recur in the future.

Responsibilities of care home providers and staff

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- Must ensure that staff responsible for handling medicines have the necessary qualifications, competence and skills to provide safe care and treatment
- Must have a robust process in place for identifying, reporting, reviewing and learning from medicines errors involving residents
- Must have a clear process for reporting medicines-related safeguarding incidents under local safeguarding processes, including providing residents and/or family and carers with information on how to report a medicine-related incident or any medicine-related concerns they may have.
- Must ensure that incidents are analysed to identify trends and minimise re-occurrence. Evidence to show that appropriate action has been taken must be documented
- Should encourage an open and supportive 'no blame' culture in order to increase reporting of medicine-related incidents and 'near misses'
- Discuss any training needed by staff to find out the root cause of medicines related incidents.

Process for medicine-related incidents and errors

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The safety of the resident should be the primary concern

- Report all suspected and confirmed medicines-related incidents or ‘near misses’ to the care home manager (or other relevant senior staff members) without delay
- If necessary, contact a healthcare professional for advice to:
  - Ensure immediate health concerns are addressed
  - Confirm if the person must be monitored, how to monitor and for how long
- Follow your care home policy for medicines related incidents. This will include:
  - How to report the incident to the person, family or carers
  - Which incidents to report to safeguarding as per local safeguarding guidance and processes
  - Whether to notify CQC - [Reporting medicine related incidents - CQC]

Process for medicine-related incidents and errors…continued

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- The whole process including action(s) taken and any advice received and/or given should be documented in an incident recording folder and the person's care plan.
- If the person (e.g., service user, resident) requires monitoring after the event, this should also be documented
- Any Controlled drug errors and incidents must be reported to the NHS England CD Accountable Officer using the online CD Reporting Tool: https://www.cdreporting.co.uk/tool/reporting/
- If criminality is suspected relating to a controlled drug error or incident, the Police Controlled Drug Liaison Officer must be contacted: local police CD liaison officer

Duty of candour

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You have an overarching duty of candour so be open and honest – let the person/resident know what has happened

For a ‘notifiable safety incident’ under Regulation 20, providers must:

- Act in an open and transparent way with relevant persons about the care and treatment provided
- Tell them in person (or person acting on their behalf) as soon as possible after finding out about incident, support them
- Provide an accurate account of what happened – all facts, to the best of your knowledge
- Tell them in person what further enquiries you will need to make
- Offer an apology in person
- Follow this by giving the same information in writing. Give an update on any enquiries
- Keep a written record of all communication with the relevant person

LFPSE – Reporting and learning from errors

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- The National Reporting and Learning System (NRLS) is being replaced by the new ‘Learn from patient safety events service’ (LFPSE)
- All healthcare staff in England are encouraged to use the LFPSE system: Learn from patient safety events (learn-from-patient-safety-events.nhs.uk)

Should social care providers be using the LFPSE service?

The LFPSE service can be used by social care providers to record information (e.g. medication errors) about NHS funded healthcare patients

Adverse Drug Reactions (ADRs) and Yellow Card Scheme

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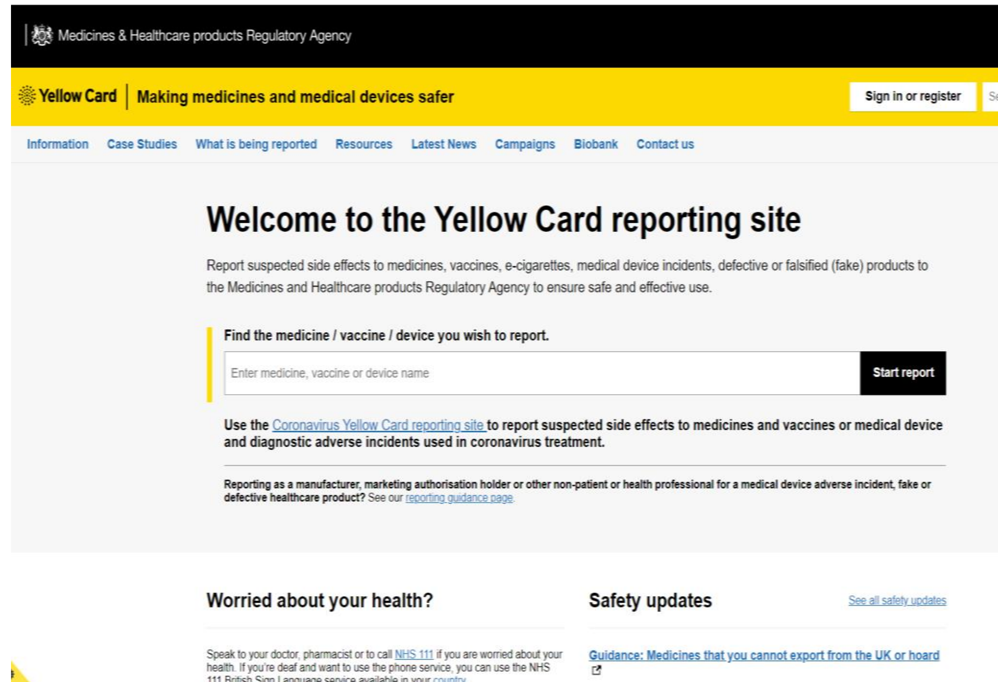

If you suspect one of your residents is having an adverse reaction that may be related to a medication, vaccine or complementary remedy then this can be reported via https://yellowcard.mhra.gov.uk .

This site also allows you to report medical devices that may be defective, or if you believe the medication to be defective or not genuine i.e. a counterfeit product.

Any adverse drug reaction should also be reported to an appropriate healthcare professional at the surgery so this can be documented in their records.

Further Medicine Safety Learning Points

Remember the 6 Rights

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Right resident
Right medication
Right time
Right dose
Right route
Right to refuse

Other ‘Rights’ to consider

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Do carers have the…

- Right knowledge and understanding of the medication?
- Right questions to challenge – are you confident to challenge, query or question the medication if you felt it was inappropriate?
- Right response or outcomes awareness – is your resident responding in the right way? For example, if they are on furosemide, is their leg swelling improving?

High risk medication

Medicines administration that may carry a higher risk of an error occurring

- Anti-epileptics (e.g. sodium valproate)
- Anticoagulants (e.g. warfarin)
- Anti-diabetic medication – especially insulins
- Controlled drugs
- Diuretics (e.g. furosemide)
- Medicines administered covertly
- Medicines administered via feeding tubes
- Medicines for Parkinson’s disease
- Nonsteroidal anti-inflammatory drugs (e.g. ibuprofen, naproxen)
- Specialist mental health medicines (e.g. clozapine, lithium)
- Specialist emergency medicines (e.g. buccal midazolam).

Time sensitive medication

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Some medicines need to be given at a certain time to make sure they work effectively and safely. Some examples of time sensitive medications include:

- Medicines **containing Paracetamol –** pay attention to dose intervals
- Medicines to be given **with or after food**
- **Bisphosphonates** include alendronic acid and risedronate. The tablets need to be swallowed whole with a full glass of water whilst sitting or standing; on an empty stomach at least 30 minutes before breakfast or another oral medication
- **Residents with Parkinson's disease** need medication administered on time for symptom control and management of the condition (symptoms include slow movements, rigidity and shaking). Stopping or delaying administration of these medications reduces the effectiveness of the medication resulting in poor symptom control.

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Critical Medication

No doses of medicines should be missed, however this is a list of common critical medicines that should NEVER be intentionally omitted or delayed unless there is a valid clinical or safety reason that the medicine cannot be given. Reasons for omission and any appropriate escalation should always be documented.

- Antimicrobials
- Anticoagulants
- Parkinson’s medication
- Anti-epileptic
- Anti-psychotics and all medication prescribed for long term mental health conditions
- Insulin
- Immunosuppressant
- Corticosteroid
- Analgesia
- Substance Misuse maintenance treatment

Risk of falls associated with medicines

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Around a third of people aged 65 and over, and around half of people aged 80 and over, fall at least once a year

Emergency admissions for falls in people aged 65 have increased over the last 10 years, from 185,000 in 2010/11 to 223,000 in 2020/21 (England)

Falls and fall related injuries are a common and a serious problem for older people

Some medicines may cause dizziness or drowsiness which may contribute to the risk of falls – Fall-Risk-Increasing-Drugs (FRIDs)

A full medication review should be undertaken for people with a history of falls

Medication and falls risk

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Medication and the Risk of Falls in Older People

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Falls and fall-related injuries are a common and a serious problem for older people. Whilst there can be many contributing factors, the use of certain medications is recognised as a major and modifiable risk factor for falls. Therefore, **a full medication review** should form part of the assessment for people with a history of falls.
A medication review should include modification or withdrawal of **Fall-Risk-Increasing Drugs (FRIDs)**, where possible. One of the prominent risk factors is the use of FRIDs.

To support clinicians in the management of FRIDs when performing a medication review, and to facilitate the deprescribing process, the **STOPPFall (Screening Tool of Older Persons Prescriptions in older adults with high fall risk)** and a **deprescribing tool** have been developed by a European expert group (see table below).

For any medication, withdrawal should always be considered where there is no indication for prescribing or if a safer alternative is available. In addition, the deprescribing guidance for the STOPPFall medication classes outlines in which cases to consider withdrawal, whether stepwise withdrawal is needed and whether monitoring is advised after deprescribing. Withdrawal of medication should ALWAYS be done under the supervision of a suitable clinician.

The table below includes the STOPPFall medication classes and deprescribing guidance.

Medication class	Commonly used medications within the class	Consider withdrawal if any of the following occur	Stepwise withdrawal needed?	Monitoring after deprescribing?
Benzodiazepines and benzodiazepine-related drugs*	Chlordiazepoxide, clonazepam, diazepam, flurazepam, lorazepam, lormetazepam, nitrazepam, oxazepam, temazepam, zolpidem, zopiclone	Daytime sedation, cognitive impairment, or psychomotor impairments. If given for both indications: sleep and anxiety disorder.	In general, stepwise withdrawal needed.	Monitor: anxiety, insomnia, agitation. Consider monitoring: delirium, seizures, confusion.
Antipsychotics*	Amisulpiride, aripiprazole, chlorpromazine, fluphenazine, haloperidol, olanzapine, quetiapine, risperidone, sulpiride, trifluoperazine	Extrapyramidal or cardiac side effects, sedation, signs of sedation, dizziness, or blurred vision. If given for behavioural and psychosocial symptoms of dementia (BPSD) or sleep disorder, possibly if given for bipolar disorder.	In general, stepwise / gradual withdrawal needed.	Monitor: recurrence of symptoms (e.g. psychosis, aggression, agitation, delusion, hallucination) Consider monitoring: insomnia
Opioids	Buprenorphine, codeine (including co-codamol, co-dydramol), dihydrocodeine), fentanyl, methadone, morphine, oxycodone, tramadol	Slow reactions, impaired balance, or sedative symptoms If given for chronic pain, and possibly if given for acute pain	In general, stepwise / gradual withdrawal needed.	Monitor: recurrence of pain Consider monitoring: musculoskeletal symptoms, restlessness, gastrointestinal symptoms, anxiety, insomnia, diaphoresis, anger, chills
Antidepressants*	Amitriptyline, citalopram,	Hyponatremia, orthostatic	In general,	Monitor: recurrence of

BLMK ICB Falls documents:

Falls-Poster-Final.pdf (icb.nhs.uk)

Falls-Patient-Leaflet-Final.pdf (icb.nhs.uk)

Structured Medication Reviews (SMR)

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An SMR is a critical examination of a person's medicines with the objectives:

1. Reaching an agreement with the person about treatment
2. Optimising the impact of medicines
3. Minimising number of medication-related problems
4. Reducing waste.

- The resident should be involved in the review if possible
- A minimum of an annual review should be expected, but more often if clinically appropriate.
- Review inappropriate Polypharmacy (when prescribed or taking too many medicines)
- Opportunity to Deprescribe (process for safe and effective withdrawal of inappropriate medicines)

Antipsychotic prescribing for BPSD

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Behavioural and psychological symptoms (BPSD) are often experienced by people living with dementia e.g., agitation, aggression, hallucinations, delusions

First psychological and environmental interventions (non-drug methods) are recommended to reduce distress e.g., check for pain, infection, delirium

Antipsychotic medication should only be used if the person is either:

* At risk of harming themselves or others
* Experiencing agitation, hallucinations or delusions that are causing severe distress

Risperidone and Haloperidol are the only antipsychotics licensed in the UK for treating non-cognitive symptoms of dementia – regular reviews recommended. Risperidone generally used as first-line choice

Other antipsychotics (e.g., Quetiapine, Olanzapine, Aripiprazole etc) may be used – this is unlicensed prescribing

Informed consent from the person (or those that have authority to consent on their behalf) should be provided and documented before prescribing

Antipsychotics and the risks

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In 2008 the government commissioned the Banerjee report (published 2009)

This report highlighted a clear increased risk of stroke (approx. 3x increased risk) and a small increased risk of death (1-2%) when antipsychotics are used in elderly people with dementia

Regular reviews are important – In BPSD some may benefit, but for others the risks may outweigh any benefits

Antipsychotics may be prescribed for other mental health conditions (e.g., schizophrenia, bipolar disorder, personality disorder, severe depression etc.) – generally prescribed for longer-term use, but still require regular reviews and monitoring

STOMP Initiative

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STOMP = Stopping overmedication of people with a learning disability and autistic people is a national project to reduce overprescribing of psychotropic medicines

Psychotropic medicines include – antipsychotics, antidepressants, mood stabilisers, anxiolytics (benzodiazepines), sedatives, antiepileptics

Psychotropic medicines can cause problems if people take them for too long, or take too high a dose, or take them for the wrong problems

Psychotropics must not be used excessively or inappropriately to control a person's behaviours.

Psychotropics should only be considered if:

- Psychological or other interventions have not helped – remember have robust person-centred PRN protocols in place for medicines used to manage behaviours: “When Required” (PRN Medication) – Guidance for Care Homes – BLMKICB Medicines Management
- The risk of harm to the person or others is very severe

Medication Governance

Good governance of medicines

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All providers need to have effective governance systems to ensure safe and effective care and treatment.

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 states that providers must have effective governance that includes assurance and auditing systems or processes.

These must assess, monitor, and drive improvement in:

- the quality and safety of the services provided
- the quality of the experience for people using the service
- any risk relating to the health, safety and welfare of people using services and others.

Providers must continually evaluate and improve their governance and auditing practice. This includes securely maintaining accurate, complete, and detailed records for:

- each person using the service
- the employment of staff
- the overall management of the regulated activity.

Examples of good governance

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Improving outcomes for people

- Gathering people's views e.g., residents, relatives, other healthcare professionals
- Finding out how they are getting on with their medication, are they happy with their medication, encourage self-care etc

Sharing outcomes to promote improvements for people

Having robust medicines policies with clear expectations for staff

Regular training and refresher training. Promoting opportunities to share learning both internally and externally

Regular reviews of medicines processes and record any actions required

Ensure systems in place to follow up and complete any required actions

Explore the use of electronic systems that may support quality improvement e.g. electronic MARs, SystmOne Proxy ordering of medicines

National Support and resources

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The National Institute for Health and Care Excellence (NICE) provide a range of tools and resources to support good governance of medication:

Managing medicines in care homes – Social Care guideline (SC1)

Managing medicines for adults receiving social care in the community (NG67)

Medicines management in care homes Quality Standard (QS85) – quality standards describe high-quality care in priority areas. There is a list of quality statements covering the following areas:

- Record keeping
- Sharing information
- Self-administration
- Prescribing medicines
- Medication review
- Covert administration

Medicines policy

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All care home providers **must** have a medicines policy.

The policy should ensure that processes are in place for safe and effective use of medicines in the care home.

The medicines policy must accurately represent the day-to-day activities in the care home and needs to be signed and followed by all members of staff. It needs to be updated accordingly and be reviewed regularly to ensure it stays relevant.

Care home staff may wish to use the NICE policy checklist as a tool to develop or review their medicines policy - NICE checklist for health and social care staff developing and updating a care home policy

BLMK ICB Medicines Policy Guide

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How to produce a Medicines Policy for care homes

Care home providers should have a medicines policy in place to ensure the safe and effective use of medicines. This is a recommendation made by the National Institute for Health and Care Excellence (NICE) in its guideline on 'Managing medicines in care homes', Social Care Guideline [SC1] which can be accessed here. The medicines policy should be regularly reviewed to make sure it is up to date and based on current legislation and the best available evidence.

The medicines policy should reflect the day-to-day activities in the care home and should be followed by every member of staff undertaking these activities. This guide is to assist care homes in gathering information required to write or update their policy.

The policy should be current and specific to the home and should include:

- The name of the home
- The name of the person (or organisation details) who wrote the policy
- The name and signature of the responsible person in the home who implements the policy
- The date the policy was written and review date
- An index sheet and numbered pages (optional)
- Staff signing sheet or auditable electronic method to ensure each staff member has read, understood, and will work to the medicines policy

A medicines policy should include written processes for the areas suggested in the box below. This list is based on the NICE 'Checklist for health and social care staff developing and updating a care home medicines policy'. The checklist supports with implementing the NICE guideline on managing medicines in care homes.

Areas to be covered in a care home medicines policy (click links below)

- Supporting residents to make informed decisions and recording these decisions
- Sharing information about a resident's medicines e.g., transfer between care settings
- Ensuring that records are accurate and up to date
- Identifying, reporting and reviewing medicines-related problems
- Keeping residents safe (safeguarding)
- Accurately listing a resident's medicines (medicines reconciliation)
- Reviewing medicines (medication review)
- Ordering medicines
- Receiving, storing and disposing of medicines
- Helping residents to look after and take their medicines themselves (self-administration)
- Care home staff administering medicines to residents, including staff training and

How to Produce a Care Home Medicines Policy – BLMKICB Medicines Management

National Patient Safety Alerts (NPSA)

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- Patient safety alerts are produced by NHS England to rapidly alert the healthcare system to risks and provide guidance on preventing potential incidents that may lead to harm or death.
- As care providers you can sign up to the NHS England's national system that cascades alerts and other safety notices via the Central Alerting System (CAS alerts)
- The alerts give instructions on what providers need to do to reduce the risk
- CQC states: "Providers must comply with relevant Patient Safety Alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS)"
- **What to consider** – act on relevant alerts, demonstrate how you receive and share relevant information with staff, document any action taken, demonstrate your systems to ensure you act quickly, and where appropriate, refer back to a prescriber (e.g., GP) for a review or to get further support

Local Support

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Training and education support to care providers or help with medicines reviews, queries or audits can come via local support routes:

- Community Pharmacies - e.g., medicines audits
- Local Authority teams – quality assessments e.g. PAMMs assessment
- Primary Care Networks (PCNs) and GP Practices
- Other healthcare professionals from wider MDT
- BLMK ICB Care Home Medicines Optimisation team

BLMK ICB Care home team – Medication Quality audit

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The pharmacy technicians in your area will aim to visit your home on an annual basis, but can visit more often if needed for support, guidance or training needs (e.g. if under serious concerns or heightened monitoring).

We carry out a medication quality audit which is designed to help and support the homes with their medicines management processes and procedures.

We offer guidance on areas that may need improvement, with links to resources

A copy of our report, with written advice and guidance, including a summary of recommendations, will be provided to the care home for their follow up and action.

A follow up visit may be conducted to ensure any actions are being implemented or if further support or training is needed.

BLMK ICB Medication Quality audit

Bedfordshire, Luton and Milton Keynes Integrated Care Board

BLMK ICB Medication Quality Audit checklist - *All guidance/links are correct at the time of publication*

All information in this report has been collated by the BLMK ICB Medicines Optimisation Care Home Team and is intended for the named care home only. In some instances the pharmacy professional may recommend sharing the audit with other parties, however any authorities wishing to quote information in this document must seek written permission from the named pharmacy professional carrying out this audit

NICE: Managing medicines in care homes, Social care guideline Published: 14 March 2014 www.nice.org.uk/guidance/sc1
CQC: Regulations for service providers and managers https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulations-service-providers-managers

Home Details:		Visit Details	
Care home name:		Name of pharmacy professional visiting:	
Type of service:		Contact details:	
Care Home Manager:		Date and time of visit: (time entering and leaving)	
Email address/telephone:		Visit completed with:	
Number of beds/number of residents		Unit (if applicable):	
Aligned GP Practice/PCN		Any other notes to add:	
Named GP:			
Weekly check-in/MDTs by surgery:			
Nominated Pharmacy:			
Last CQC inspection date and rating:		Suggested Follow-Up Period (if needed):	

Summary of action points

BLMK ICB Medication Quality audit

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BLMK ICB Medication Quality Audit checklist - *All guidance/links are correct at the time of publication*

Overall policies/ competencies *NICE guidance 1.1* **CQC Reg 12/17**	**Yes**	**No**	**Comments**	**Guidance (if applicable)**
Does the home have an overall policy for safe and effective use of medicines?				How to Produce a Care Home Medicines Policy – BLMKICB Medicines Management Care home providers should have a care home medicines policy, which they review to make sure it is up to date and is based on current legislation and the best available evidence. checklist-for-care-home-medicines-policy-pdf-13716829 (nice.org.uk) For further information on implementing NICE guidance relevant to medicines optimisation in care homes, please see the PrescQIPP bulletin below: Bulletin 305: Implementing NICE and SIGN guidelines in care homes | PrescQIPP C.I.C

Staff training *NICE guidance 1.17* **CQC Reg 12**	**Yes**	**No**	**Comments**	**Guidance (if applicable)**
Is there a policy or inclusion in over-arching medicines policy for staff training and competence requirements?				Training and competence for medicines optimisation in adult social care - Care Quality Commission (cqc.org.uk) Care home providers must ensure that designated staff administer medicines only when they have had the necessary training and are assessed as competent.
Is there evidence that all staff who administer medicines have attended a relevant training course and undertaken assessments?				
Are staff administering medicines continually assessed?				
Are staff/management aware of how to access specialist training, if applicable (e.g. end of life medication)?				

BLMK ICB Care home team – Observation of medication round

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We also observe medication rounds in a supportive manner, this is in conjunction with the audit checklist

Observation of a medication round is not intended to be used to shadow a specific member of staff or to assess for competency

For routine quality visits, medication rounds will be observed by the team for a minimum of 45 minutes, but a full medication round can be observed when required or when requested

Where a home is under serious concerns or requiring heightened monitoring (in relation to medication), the team would carry out observation of a full medication round

Following the observation of a full medication round, a copy of our report, with written advice and guidance, including a summary of recommendations, will be provided to the care home for their follow up and action.

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Medicines Safeguarding

Safeguarding

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The CQC's Essential standards of quality and safety (2010) define safeguarding adults as: 'Ensuring that people live free from harm, abuse and neglect and, in doing so, protecting their health, wellbeing and human rights'.

The 'Three Step Test' (Care Act 2014)

Safeguarding duties apply to an adult who:

1. Has need for care and support (whether or not the local authority is meeting any of those needs); AND
2. Is experiencing, or at risk of, abuse or neglect; AND
3. As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

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What could be considered a medicine related safeguarding incident?

NICE Guidance (SC1) indicates that a safeguarding issue in relation to managing medicines could include:

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

Some examples

Medicines-related safeguarding incidents could include errors relating to the preparation or administration of medicines, missed doses, monitoring, communication, documentation, disposal or not following local policy

Below is a list of examples (not exhaustive):

- Medicines being given covertly without following the correct procedure
- Missed doses of medicines not recorded with a valid reason
- Medicines not being reviewed, resulting in medicines being continued unnecessarily with risk of adverse effects
- Side effects of medicines not being identified or reported
- Removing responsibility from residents who could manage their own medicines with support.
- Medicines given at the wrong time
- Wrong medication, dose or route administered to the resident
- Out of date medicine administered to the resident
- Medication administered to the wrong resident
- Medication incorrectly prepared or administered

Key recommendations on how to manage medicines safeguarding incidents – PrescQIPP

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Open and supportive culture to encourage reporting

Be aware of local arrangements and contacts for notifying suspected or confirmed medicines-related safeguarding incidents

Process should be recorded in the care home medicines policy

Contact a healthcare professional to ensure action is taken to safeguard any resident involved in a medicines related safeguarding incident

Record all medicines-related safety incidents, including ‘near misses’ as a resident safety incident. If notifiable safeguarding concerns – report to CQC

Local safeguarding processes should include the investigation of each report and monitoring of trends

Key recommendations ….continued

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Find out the root cause of medicines related incidents

Training needed by staff to find out the root cause of medicines-related incidents is specified

Residents and/or their family members/carers should be given appropriate information on reporting medicines-related safety incidents or concerns

Providers should ensure that all residents can use advocacy and independent complaints services when they have concerns about medicines

What should be reported to CQC?

Care home providers are not required to notify CQC about all medicine errors

CQC must be notified if the medicine error resulted in the following circumstances

- A death
- An injury
- Abuse or an allegation of abuse
- An incident reported to or investigated by the police.

Safeguarding medicines – our input and support

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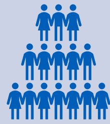

As a team, we work closely with the Local authority and the ICB Quality & Safeguarding teams – they may refer into us for help and support

Where necessary, we may also raise safeguarding incidents related to medication following discussions with the ICB Quality & Safeguarding team

Our team have an internal process that we follow to support care homes where safeguarding or medication concerns have been raised, a stepwise approach is used:

- Immediate/Initial action (if applicable) e.g., ensure resident is safe, manager has been made aware of incident
- Care Home/Provider Support e.g., visit the home, check policy covers processes on safeguarding, accurate records kept, root cause analysis done, training needs etc
- Onward Reporting – e.g., involve surgery, safeguarding referral, report to CQC if notifiable incident, report on LFPSE, accountable officer if CD etc
- Feedback and documentation e.g., provide written feedback with recommendations

Contact details – Local Authority Adult Safeguarding teams in BLMK

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Bedford Borough Safeguarding Adults team
adult.protection@bedford.gov.uk
Tel: 01234 276222

Central Bedfordshire Safeguarding Adults team
adult.protection@centralbedfordshire.gov.uk
Tel: 0300 300 8122 (Monday to Friday, 8:45am to 5:20pm)
Tel: 0300 300 8123 (outside of these hours)

Luton Safeguarding Adults team
adultsafeguarding@luton.gov.uk
Tel: 01582 547730

Milton Keynes Safeguarding Adults team
safeguardingadults@milton-keynes.gov.uk
Tel: 01908 252835

Case Studies – Interactive Section

Case Study 1

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You notice on your morning medication round that someone has already signed for Edith's morning dose of Apixaban, but her other morning medication has not been signed for:

- What type of medicine is Apixaban?
- What is the potential risk of giving too much?
- What is the potential risk of giving too little?
- Would you administer her Apixaban?
- What would you do next?

Case Study 1…. suggestions

- Apixaban is an anticoagulant medication (prevents blood clots), it is a critical medication which can have significant consequences if there is an administration error. Side effects include bleeding – minor or serious
- You do not administer the Apixaban until you have more information
- Edith does not have capacity to inform you if she has had her morning dose of Apixaban
- You contact the staff member on the last shift who informs you that the morning dose of Apixaban was not administered and this was a recording error on the MAR chart
- You also check the remaining stock which indicates the Apixaban has not been given this morning
- The Apixaban dose can therefore be safely administered

Case Study 1…. Suggestions continued

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Administration of the dose will need to be recorded on the MAR chart, this may need to be recorded on the reverse of the MAR chart to explain the recording error or as an additional note on eMAR systems. It would be good practice to make a note in the care plan also.

You document all actions taken and outcomes in the care plan

As a medicines-related incident and ‘near miss’ this recording error could have resulted in an administration error. Therefore, it should be reported to the care home manager (or other relevant senior staff members)

Reviewing this incident and ‘near miss’ could provide useful learning and reduce the risk of similar events occurring in the future.

Case Study 2

You are a carer working in the community at a supported living facility, you receive a delivery of medication for one of your service users, this includes the following medicine:

Memantine 10mg/ml oral solution sugar free x 50ml

Dose on pharmacy label reads as:

‘Take 10mg (10ml) every night’

Any thoughts?

Case Study 2…continued

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Memantine 10mg/ml oral solution sugar free x 50ml

Dose on pharmacy label reads as:

‘Take 10mg (10ml) every night’

Type of error:

- *Prescribing error – dose not accurate and may cause confusion, could be given as 10ml which is equivalent to 100mg, not 10mg*
- *Dispensing error – dose not picked up at dispensing stage in pharmacy so incorrect label*

What would you do next?

Case Study 2…suggestions

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Contact a prescriber or appropriate healthcare professional at the surgery – a new prescription with the correct dose will be needed

Surgery may provide interim verbal advice/direction before new supply can be issued, in this case:

Ensure a second staff member is present to listen to the conversation

Clearly document any advice (e.g. dose amendment) on MAR chart (with a counter-signature) and in care plan as appropriate

Care home staff are advised not to alter the pharmacy dispensing label

The surgery will need to discuss and record this as a 'significant event' as per their own procedures and learn from the event to prevent it happening again

Case Study 2…suggestions continued

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Contact the dispensing pharmacy to inform them of the error (surgery may have also spoken to the pharmacy) – the pharmacy will also need to conduct their own investigation and record as a ‘significant event’

The dispensing pharmacy will need to provide the new supply with a new pharmacy label that has correct instructions for safe administration

Dispose of the supply with the incorrect dosage instructions (as per medicines policy) when new supply received

Document all actions taken, advice given and share information with all seniors (e.g. during handover)

Share learning from the incident

Quiz

1. A medication error could include a dispensing error?

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True

False

1. A medication error could include a dispensing error?

2. A ‘near miss’ is when significant harm has occurred?

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True

False

2. A ‘near miss’ is when significant harm has occurred?

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3. Which of the following is a ‘critical medication’?

a. Parkinsons medication

b. Anticoagulant

c. Insulin

d. Anti-epileptic

3. Which of the following is a ‘critical medication’?

All of the below

a. Parkinsons medication

b. Anticoagulant

c. Insulin

d. Anti-epileptic

4. An example of good medicines governance may include having a robust medicines policy in place?

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True

False

4. A example of good medicines governance may include having a robust medicines policy in place?

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5. Which of the following is an example of a medicines-related safeguarding incident?

a. Medicines being given covertly without following the correct legal process

b. Medicines given at the wrong time

c. Missed dose with no valid reason recorded

d. Out of date medication administered

5. Which of the following is an example of a medicines-related safeguarding incident?

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All of the below

a. Medicines being given covertly without following the correct legal process.

b. Medicines given at the wrong time

c. Missed dose with no valid reason recorded

d. Out of date medication administered

Useful resources:

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- Medicines information for adult social care services - Care Quality Commission (cqc.org.uk)
- Time sensitive medicines - Care Quality Commission (cqc.org.uk)
- Good governance of medicines - Care Quality Commission (cqc.org.uk)
- Reporting medicine related incidents - Care Quality Commission (cqc.org.uk)
- National Patient Safety Alerts in adult social care - Care Quality Commission (cqc.org.uk)

Care Home Resources and Training

Resources

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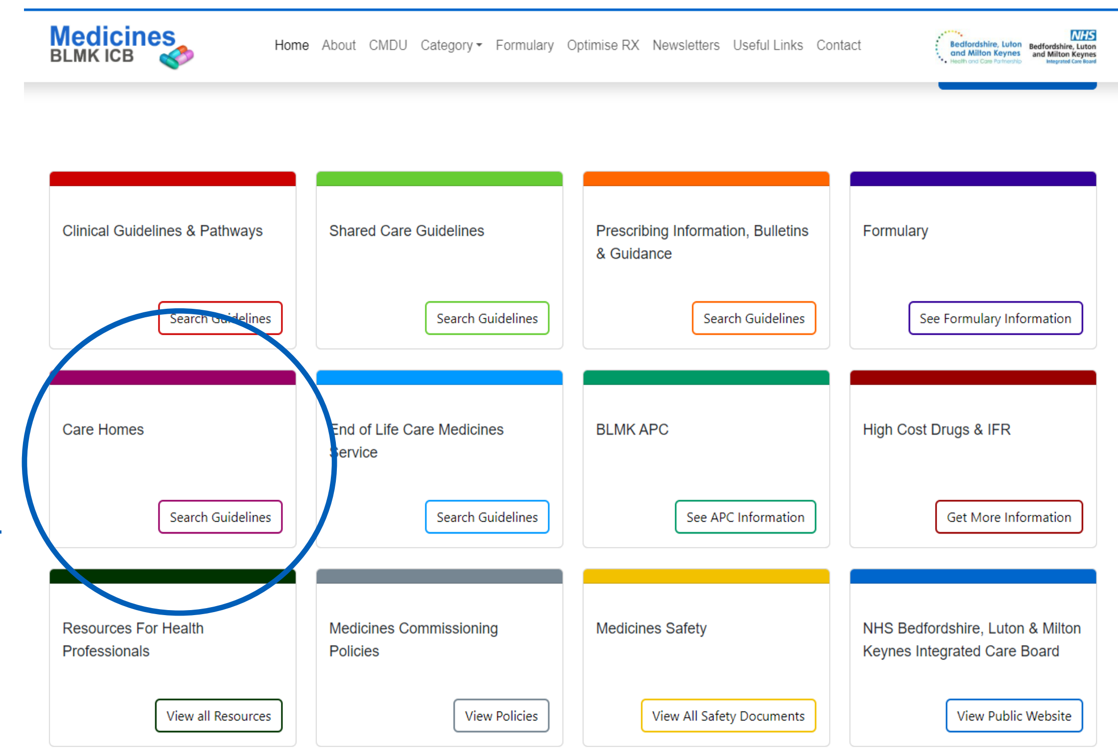
BLMK ICB Medicines website - BLMKICB Medicines Management

Care Homes page (purple box):
Care Homes – BLMKICB Medicines Management

Key Documents:

- Care Home team Service Referral Pathway
- Homely remedies toolkit and First Dressing scheme
- Self Care Tool Kit for Care homes
- Covert Administration Guidance (Adults)
- When Required (PRN Medication) – Guidance for Care Homes
- Expiry dates for medication - Guidance for Care homes
- Meds room and refrigerator temperature guide
- Falls Documents – leaflet and poster
- Care home newsletters



Other resources

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- British National Formulary (BNF)
  - Paper copy - ensure using an up-to-date copy.
  - Online: https://www.medicinescomplete.com
- Electronic Medicines Compendium (EMC)
  - https://www.medicines.org.uk/emc
- National Institute for Health & Care Excellence
  - https://www.nice.org.uk
  - checklist-for-care-home-medicines-policy-pdf-13716829 (nice.org.uk)
- CQC Website
  - https://www.cqc.org.uk

Questions

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