Medicines Management
Care Homes Support

NHS
Coventry and
Warwickshire

Medication incidents in care homes: errors and near misses

What is a medication error?

Any preventable event that may cause or lead to inappropriate medication use or harm to a person. Errors can occur at different stages of the medication use process. A medicines error is any 'patient safety incident', where there has been an error while:

- prescribing
- preparing
- dispensing
- administering
- monitoring
- providing advice on medicines.

Medicines errors are not the same as adverse drug reactions. Medicine errors occur when weak medication systems or human factors affect processes. Medicine errors can result in severe harm, disability, and death.

Human factors to consider:

- fatigue
- environmental conditions
- staffing levels.

Examples of medication errors include the following (also Appendix 1). The list is not exhaustive:

- Wrong dose administered – too much or too little
- Omissions – any prescribed dose not given or delayed
- Wrong medicine prescribed, supplied, or administered to a person
- Extra dose given
- Administration of a medication to which the resident has a known allergy
- Administration of a medication past its expiry date

What is a near miss?

NHS England defines a near miss as a 'prevented patient safety incident'. A 'near miss is an event not causing harm but has the potential to cause injury or ill health. Reviewing near misses can provide useful learning and areas for improvement.

What if a person is unwell because of the medication error?

- **Medical assistance should be sought straight away. This may mean calling 111 in Out of Hours or 999 in a life-threatening emergency situation.**
- All care comes should have a medication policy which includes guidance on dealing with medication errors and near misses. There should be a clear reporting system, including the requirement for a written report describing the incident, what was done to rectify the immediate situation and actions taken to prevent it happening again.
- Regular meetings should be held with all staff involved with medicines to review the outcomes and investigations of errors and near misses to share learning and prevent recurrence of similar errors or near misses.
- The care home staff should use an open and supportive culture. Staff who discover an error should feel confident in reporting it.
- Care home staff should report and feedback any incidents that occur because of errors made as part of the prescribing or dispensing process. For example, by a prescriber and community pharmacists.

What incidents need to be reported locally?

Both Coventry and Warwickshire Quality and Contract Monitoring Teams require the reporting of Significant Incidents from Nursing & Residential Care Homes. In particular, the following types of Significant Incident must be reported to the local Contract Monitoring Team "without delay":

- Falls resulting in fractures
- Pressure ulcer grades 3 and 4
- Medication errors
- Unexpected deaths

What are the safeguarding requirements around reporting medication errors?

Care home staff must be aware of local arrangements for safeguarding incidents. There may be different arrangements for notifying suspected or confirmed medicine-related incidents. Providers should record this in their care home medicines policy.

NICE Guidance SC1 states that when social care providers are responsible for medicines support, they must have robust processes for medicines-related safeguarding incidents. It also indicates that a safeguarding issue in relation to managing medicines could include:

- deliberate withholding of a medicine without a valid reason
- incorrect use of a medicine for reasons other than the benefit of a resident
- deliberate attempt to harm through use of a medicine
- accidental harm caused by incorrect administration or a medication error.

Nurses must follow the Nursing and Midwifery Council professional standards of practice and behaviour.

What are the statutory requirements around reporting medication errors?

CQC must be told about certain safety incidents (see Regulation 18). The registered person must record the action taken on the relevant notification form.

Care staff must tell CQC about:

- the death of a person who uses the service
- deaths and unauthorised absences of people who are detained or liable to be detained under the Mental Health Act 1983
- serious injuries to a person who uses the service
- other safety incidents.

There is no requirement to notify CQC about medicines errors, but staff must tell them if a medicines error has caused:

- a death
- an injury
- abuse, or an allegation of abuse
- an incident reported to or investigated by the police.

Where relevant, staff should make it clear that a medicine error was a known or possible cause or effect of these incidents or events being notified.

References & resources (all accessed 13.6.22)

Reporting medicine related incidents | CQC Public Website

Issue 9: Medicines management | CQC Public Website

Regulation 18: Notification of other incidents | CQC Public Website

Regulation 20: Duty of candour | CQC Public Website

Medicines in health and adult social care (cqc.org.uk)

Safeguarding adults – Coventry City Council

Safeguarding Adults (safeguardingwarwickshire.co.uk)

NHS England » National patient safety incident reports

RIDDOR in health and social care (hse.gov.uk)

Appendix 1: -

Examples of errors which may be considered appropriate for referring into safeguarding:

- Any medication error that leads to harm or death.
- Any medication error requiring medical intervention e.g. GP consultation, attendance at A&E attendance.
- The medication error was a deliberate act.
- Medication is administered covertly (disguised) without appropriate practice process.
- The medication error is part of a pattern or culture. The pattern could be same drug, same carer, or same vulnerable person. The duration and frequency must be considered.
- The medication error involved the administration of warfarin, lithium, insulin or clozapine.
- The medication error involved the administration of a Controlled Drug (CD).
- The medication error involves more than one adult.
- The medication error involves medication often associated with misuse/abuse, for example:
    - 'Z' drugs – e.g. zopiclone, zolpidem and zaleplon
    - Benzodiazepines – e.g. diazepam, nitrazepam, lorazepam, temazepam
    - Opiate based pain killers – e.g. dihydrocodeine, codeine, morphine, tramadol

Examples of errors that are classed as NEVER medication events that should be reported.

- Wrongly prepared high-risk injectable medication e.g. insulin
- Maladministration of potassium-containing solutions
- Maladministration of insulin
- Overdose of midazolam during conscious sedation
- Opioid overdose of an opioid-naïve person
- Inappropriate administration of daily oral methotrexate

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Suggested pathway for reporting medication errors in care homes

What are the immediate or potential risks to the person from the error?

For example:

- Wrong dose administered – too much or too little
- Omissions – any prescribed dose not given or delayed
- Wrong medicine prescribed, supplied or administered to the person

Does the person require urgent medical attention?

Immediately contact:
111 or if an emergency 999

If urgent review not required, contact person's GP or Community Pharmacy Team to ask further advice.

Immediately inform:
care home manager, senior nurse, senior carer
(as per care home policy)

Has the person and/or family/representative(s) been informed of the medication error?

If appropriate, **have the medication error and outcomes been reported** to the care home's allocated Council and Healthcare Quality and Contract Monitoring Teams, Local Safeguarding Team and a CQC notification submitted?
If a person with an NHS contract in a Care Home with Nursing is involved, report as a serious incident to the Patient Safety Team as per contractual requirement.

Does the medication error need to be risk assessed and a clinical incident report completed in line with the care home medicines policy?

Has a member of staff completed all the relevant documents?

- Person's care records
- Medicine incident reporting form (internal)
- Medicine incident reporting form(s) (external as described above)

Have any training needs to support the care home staff and processes been identified?

Providers should use this guidance in conjunction with Medicine Patient Information Leaflets, NICE Guidance 'Managing Medicines in Care Homes' SC1 and should check the CQC website for recent updates. Prepared by Care Home Support, Medicines Optimisation Team, NHS Coventry & Warwickshire updated July 2022.