Newcastle Safeguarding Adults Board

Safeguarding Adults and Medication Incidents

Deciding whether to refer a medication incident to the Safeguarding Adults Procedures

Launched: December 2011
Review date: December 2012
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A working group was established in March 2010 in response to the Newcastle Safeguarding Adult Board’s request to write a protocol/guidance to assist staff in deciding when a medication error is a safeguarding issue.

The remit was to define what is meant by a medication error with the aim of establishing a standard approach to consider when an incident/error involving medication should be referred to safeguarding services. The document should be able to be utilised by the wide diversity of services that may be involved in the initial identification of an incident such both in primary and secondary care settings such as:

- Intermediate care settings such as resource centres
- Nursing and Residential Care Homes
- Community based services such as domiciliary care services, district nurses
- GP practices
- Hospital wards and departments (including Acute Health services and Mental Health services)
- NHS direct
- Care Quality Commission
- Others

Representatives from a wide variety of health and social care settings were approached to contribute to the working group. Initially, these people were from Newcastle and North Tyneside based services, but later there were requests from representatives in Northumberland services to be included in the discussions. A list of these people is available in Appendix 1 at the back of this document.

Clare Abley  
Chair of the Improving Practice Committee
Deciding whether to refer a medication incident to the Safeguarding Adults Procedures

Aim of Protocol
This protocol provides guidance for staff in all sectors who are concerned that a medication incident (or drug errors) may have arisen as a result of poor practice, neglect or intention to cause harm and therefore have to decide whether to make a referral to the Newcastle Safeguarding Adults interagency procedures.

Introduction
Neglect is the deliberate withholding OR unintentional failure to provide appropriate and adequate care and support, where this has resulted in, or is highly likely to result in the person experiencing severe ill health or adverse effects.

All cases of actual or suspected neglect should be referred through the safeguarding procedures. Although not all poor practice is neglect, some may be. Poor practice may also need to be reported through the safeguarding procedures, to ensure areas of concern are appropriately addressed.

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, and poor communication (See section on definition of medication errors).

If necessary an alert must then be made to Social Care Direct or the allocated social worker or the Hospital Social Work team. The safeguarding alert should be made clearly documenting the incident, actions and outcomes in relevant case notes, by contacting one of the following:

• The relevant Adult Services Team Manager – when patient/service user is known to Adult Services and has an allocated social worker/care manager.
• The Hospital Social Work Team Manager – when patient/service user is in hospital.
• Social Care Direct – when the alleged abuse has taken place in a care home or if you are unsure who else to contact.
• The Out of Hours Service (formerly Emergency Duty Team – EDT) for alerts being made out of working hours.
• Any other local organisational reporting system.
Staff should also refer to:

- Their own organisation’s policies and procedures on medication management.
- Other relevant local and national guidelines, protocols and policies e.g. NICE Guidance, NMC, incident reporting policies.

The decision as to whether there should be a safeguarding investigation is made at the Safeguarding Adults Strategy meeting/discussion. These Strategy meetings are convened in response to individual cases.

\[1\] If the alleged abuse has occurred in a care home, hospital or other registered services, the Care Quality Commission should also be notified.

The term “staff” is used to refer to employees from all sectors.

The term “patient” is used throughout this document. However, this term also refers to residents/service users in care homes and those living in their own homes.
Definitions of a Medication Error

“A medication error is 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.”

The following list gives examples of scenarios where medication errors can occur. Near misses in any of the sections below should also be considered. The definitions have been divided into sections according to the National Patient Safety Agency (NPSA) Safety in doses: medication safety incidences in the NHS (2007).

Based on information gathered from:

- **CHUMS report:**
  [http://qualitysafety.bmj.com/content/18/5/341.full.pdf](http://qualitysafety.bmj.com/content/18/5/341.full.pdf)

- **CQC**

- **NPSA alerts:**
  [http://www.nrls.npsa.hns.uk/alerts](http://www.nrls.npsa.hns.uk/alerts)

This is not a definitive list and as such clinicians, managers and clinical governance managers must exercise professional judgment prior to progressing the issue.

1. Prescribing Errors

- Patient prescribed the wrong medication/dose/route/rate.
- Incomplete information e.g. no strength or route specified.
- Medication omitted from prescription.
- Medication prescribed to the wrong patient.
- Transcription errors.
- Prescribing without taking into account the patients clinical condition.
- Prescribing without taking into account patients clinical parameters e.g. weight.
- Prescription not signed.

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2. Dispensing Errors
• Patient dispensed the wrong medication/dose/route.
• Medication dispensed to the wrong patient.
• Patient dispensed an out of date medicine.
• Medication is labelled incorrectly.

3. Preparation and Administration Errors
• Patient administered the wrong medication/dose/route.
• Patient administered an out of date medicine.
• Medication administered to the wrong patient.
• Medication omitted without a clinical rationale.
• Medication incorrectly prepared.
• Unauthorised administration i.e. disguised in food. ³
• Incorrect infusion rate.
• Medication administered late/early. ⁴
• Medication deliberately not administered without good reason.
• Administration of medication recorded incorrectly or not recorded.

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

5. Other errors may include:
• Poor or inadequate communication.
• Poor, inadequate or incorrect recording/documentation.
• Inappropriate or inadequate disposal of medicines.
• Inappropriate administration of medication to chemically manage a patient’s behaviour that has not been prescribed or giving additional doses to sedate patient.
• Deviation from local policy and guidelines relating to Medicines Management.

³ There may be occasions when covert drug administration is acceptable. Nurses should follow Nursing and Midwifery Council (NMC) advice. Action must adhere to the Mental Capacity Act (2005).

⁴ It is recognised that this is a complex issue and the full context of late/early administration should be taken into account. Where late / early medication administration would have a significantly detrimental effect on patient care, this constitutes an error.
When a medication incident or potential incident occurs, staff should follow the standard policy, procedure and reporting systems for their organisation. The flow chart below demonstrates the process for reaching the decision to refer to Newcastle Safeguarding Adults procedures.

1. Medicine incident occurred (or potentially occurred) with relevant documentation complete
2. Patient has suffered/potentially suffered harm
3. Review by line manager and complete assessment using decision making tool regarding medicine incidents
4. Decide whether to refer through Safeguarding Adults Procedures based on responses to key questions), if unsure as to whether to make a referral – contact Newcastle Safeguarding Adults Unit for advice

- Refer to Safeguarding by contacting the appropriate person by telephone and by completing Safeguarding Adults Multiagency Alert Form (SAMA1)
- Do not refer to Safeguarding
  Action any other recommendations identified in the report form
**Decision making tool to determine if medicine incident (or potential incident) should lead to a referral through the Newcastle Safeguarding Adults interagency procedures**

This form is to be completed by the line manager receiving the medicine incident report. It should be signed on completion.

Please attach this form when progressing to completion of the relevant safeguarding alert form. This form is for reference only.

The content of this form is restricted on completion and should only be shared as part of the procedures, in the best interests of the vulnerable adult.

<table>
<thead>
<tr>
<th>Name of patient/resident/service user</th>
<th></th>
</tr>
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<tbody>
<tr>
<td>Normal address of patient/resident/service user</td>
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</tr>
<tr>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>NHS number</td>
<td></td>
</tr>
<tr>
<td>Place of current care</td>
<td></td>
</tr>
<tr>
<td>Previous place of care (if appropriate)</td>
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<tr>
<td>GP or Consultant</td>
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<tr>
<th>Name of person completing form (print)</th>
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<tbody>
<tr>
<td>Signature</td>
<td></td>
</tr>
<tr>
<td>Designation</td>
<td></td>
</tr>
<tr>
<td>Date &amp; time</td>
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**Date and time of medication incident:**

**Description of medication incident that has occurred or potentially occurred, where a person has suffered or potentially suffered harm.**

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<td>Medication incident decision making tool</td>
<td>Final November 2011</td>
<td>Restricted on completion</td>
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</table>
Describe as objectively as possible (include detail of medicines involved)

1. Have there been recent changes to the person’s circumstances e.g. recent admission to hospital, change of medication, person’s condition has deteriorated, staff changes?
   - Yes
   - No
   If so, have a reassessment and additional measures been implemented?
   - Yes
   - No
   Give details:

2. Has professional advice been taken regarding the incident e.g. Doctor, NHS Direct, Care Quality Commission (CQC)?
   - Yes
   - No
   go to 2a
   - No
   go to 2b

2a. If yes, please give details:
   - Who gave advice?
   - Taken by:  
   - Date:
   - Detail of the advice:
   - Subsequent action taken:

2b. If no, why not? (give explanation):

3. Has next of kin or family been informed?
   - Yes
   - No

3a. If yes, who has been informed:

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### 3b If no, give reason:

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### 4a Does the individual staff member’s employing organisation have a medicine policy and procedures for staff to follow?

- [ ] Yes
- [ ] No

Comments:

### 4b Have medicine policy and procedures been followed by the individual staff member(s) involved in the incident (e.g. completion of relevant training, evidence of competency assessment)?

- [ ] Yes
- [ ] No

Comments:

### 5 Have the staff member(s) involved or the service involved in the incident been involved in previous medication concerns?

- [ ] Yes
- [ ] No
- [ ] Don’t know

Comments:

### 6 Is there evidence of poor practice or neglect relating to this incident?

- [ ] Yes
- [ ] No

If NO: DO NOT refer but record decision in section 6c

If YES: ACTION: Refer or seek advice through safeguarding procedures.

If yes:

Give details of evidence of poor practice

And/ or give details of evidence of neglect

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<td>Adults Board</td>
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</table>
7 **Outcome**

Having completed the assessment, complete the relevant section below describing the decision made regarding the action taken

a) **Safeguarding Adults Multiagency Alert form (SAMA1)**
   - Completed by:
   - Date:
   - Forwarded to:

b) **Advice**
   - Detail of advice given:
     - Advice given by:
     - Date:
     - Action taken (give detail):

c) **No referral to safeguarding**
   - Decision made by:
   - Detail any action to be taken internally as identified as part of the assessment

| Assessment completed by (print name): |  |
| Signature: |  |
| Designation: |  |
| Place of Work |  |
| Qualifications: |  |
| Date: |  |

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The core working group for the production of this document consisted of:

Sue White (Chair)  Prescribing Adviser, Medicines Management (Provider) Team
Patricia Amis  Safeguarding Lead, NHS Newcastle and North Tyneside Community Health
Mary Burns  Safeguarding Lead, The Newcastle upon Tyne NHS Foundation Trust (previously representing NHS Newcastle and North Tyneside Community Health)
Sheona Duffy  Safeguarding Adults Team Manager, Newcastle City Council
Dave Cutler  NHS Direct, Mental Health Lead
Jackie Moon  Quality and Safety Lead, NHS Newcastle and North Tyneside Community Health
Andrea Marshall  Acting Manager, Resource Centres, Adult and Culture Services, Newcastle City Council
Lorna Clark  Pharmacist for Elderly Care, Assistant Director of Pharmacy (Clinical Services), The Newcastle upon Tyne Hospitals NHS Foundation Trust (on behalf of Julia Blagburn)
Heather Carmichael  Lead for Safeguarding Adults, Northumbria Healthcare NHS Foundation Trust

Additional input and support from:

Janet Kelly  Clinical Manager, NHS Newcastle and North Tyneside Community Health
Mike Earnshaw  Pharmacist Inspector, Care Quality Commission
Dennis Davison  (for Michelle Hall) Lead Nurse, Learning Disabilities Directorate
Northumberland Tyne & Wear NHS Foundation Trust
Liz Harris  Head of Nursing, The Newcastle upon Tyne Hospitals NHS Foundation Trust (on behalf of Helen Lamont)
Sue Hook  (for Eleanor Binks) Senior Manager, Community Support Adult Social Care, North Tyneside Council
Stephen Blair  General Practitioner, NHS North of Tyne
David Campbell  Chief Pharmacist, Northumbria Health Care Trust
Julie Gillson  Chief Matron, Emergency Surgery & Elective Care, Northumbria Healthcare Trust
Safeguarding Adults Multi-agency Alert Form
Reference: SAMA1

This form is to be used to notify Adult and Culture Services Directorate/ Adult Social Care Direct Team of any suspected or actual instances of abuse. Phone 0191 278 8377 (8.45am – 5.00pm) or 0191 232 8520 before 8.45am or after 5.00pm.

Person completing the form:

Organisation Name:

Service / Ward Name:

Phone contact details:

Date of Notification to Adult Social Care Direct:

Details of incident/suspected or actual abuse
To be completed by the manager or lead officer within the organisation responsible for safeguarding adults

Date of alleged incident/harm:

Area where incident/harm took place:

Who reported the alert:

Date:

Who was involved:

Details of Alleged Victim
Name:

Address:

Date of Birth:

Phone :

Name and address of GP:

Ethnic Origin:

Nature of alleged victims’ vulnerability:

Any other details (e.g. communication needs):

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<table>
<thead>
<tr>
<th>Details of Alleged Perpetrator</th>
<th>Ethnic Origin:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Relationship to victim:</td>
</tr>
<tr>
<td>Address:</td>
<td>Are they a vulnerable adult? Yes/No</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>Alleged perpetrators vulnerability (if applicable):</td>
</tr>
<tr>
<td>Phone Contact:</td>
<td>Any other details:</td>
</tr>
<tr>
<td>If the alleged perpetrator is a staff member, please provide staff details (e.g. job role, employer, address of place of work)</td>
<td></td>
</tr>
</tbody>
</table>

| Have you made the victim aware that details of the incident are being recorded and will be investigated: Yes/No |
| If not, why not? |

<table>
<thead>
<tr>
<th>Type of Abuse (Please tick all that apply) ✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual</td>
</tr>
<tr>
<td>Psychological/ Emotional</td>
</tr>
<tr>
<td>Financial/Material</td>
</tr>
<tr>
<td>Institutional</td>
</tr>
<tr>
<td>Radicalisation/ Concerns of Extremism (PREVENT)</td>
</tr>
</tbody>
</table>

| Description of alleged incident / alleged harm, detailing all people involved including witnesses. On this page please give a detailed description of the incident (please include times) and any other comments you feel are relevant. If necessary attach further pages. |

| What action did you take immediately after the incident/allegation of harm? (e.g. administered first aid, asked perpetrator to leave, took victim to secure area) |

<table>
<thead>
<tr>
<th>Were the Police called: Yes / No</th>
<th>Were any other emergency services called: Yes / No</th>
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<tbody>
<tr>
<td>If yes, which service(s)?</td>
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<tr>
<th>Names and badge numbers of Police:</th>
<th>Outcome: (Response time, taken to hospital etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there any other Agencies involved? Yes/No</td>
<td>Please provide details of agencies:</td>
</tr>
<tr>
<td>Are there any mental capacity issues? Yes/No</td>
<td>Please provide details:</td>
</tr>
<tr>
<td>Has the victim made any previous referrals/alerts? Yes/No</td>
<td>Please provide details (e.g. dates, type of abuse):</td>
</tr>
<tr>
<td>Is the victim in immediate danger of further abuse? Yes/No</td>
<td>Have any immediate actions been identified to reduce the potential for further abuse? Yes/No</td>
</tr>
<tr>
<td>Has an initial assessment been made to determine further potential risk to the victim? Yes/No</td>
<td>What actions have been taken to reduce the potential for further abuse?</td>
</tr>
<tr>
<td>Are there any risks to others? Yes/No (Vulnerable adults, children)</td>
<td>Please provide details (include who this information has been shared with – e.g. Children’s Social Care, Police):</td>
</tr>
</tbody>
</table>

Signed:  
Date:  
Time:  

You must telephone Adult Social Care Direct team / or allocated social worker/ Out of Hours Service within 24 hours of the suspected or actual abuse, or as soon as possible after being made aware. Information on how and who to send this form to is available at the end of this form.

This is a **restricted** document when completed and should be stored securely according to your own organisation’s procedures. It is your responsibility to ensure that this is done.

**Decision by Safeguarding Manager (Adult and Culture Services Directorate only)**  
Safeguarding Alert: Yes / No  
If No – please give reasons for decision:

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**Information about how this document should be sent safely and securely**

Once completed, this document contains personal and sensitive information and is classified as “restricted”.

**Sending the information to Adult and Culture Services**

- The SAMA1 should not be sent to Adult and Culture Services without first telephoning and speaking to Adult Social Care Direct/allocated Social Worker/Out of Hours Service.

- Following the telephone conversation there should be agreement on how and who the SAMA1 form is going to be sent to Adult Social Care Direct/allocated Social Worker/Out of Hours Service. Under no circumstances should the SAMA1 be sent without first confirming these details.

**Options for sending the SAMA1**

- **Email.** The completed SAMA1 should only be sent by email if secure email addresses are used by both sender and receiver (.pnn.police.uk, .cjsm.gov.uk, .gsi.gov.uk, .nhs.net, .gcsx.gov.uk) or the email is encrypted (contact your IT support about email encryption). The subject field of the email address should clearly be marked RESTRICTED as well as reference made in the body of the email. Internal email systems are not usually secure. Where there are no secure email addresses or encryption this document should not be sent electronically.

- **Fax.** The procedure for sending restricted information by fax is as follows:

1. The sender needs to check the fax number they are sending the SAMA1 to.
2. Ensure the recipient is waiting at the fax machine for the fax.
3. Fax covering note should be used and needs to be marked “restricted”.
4. Send the fax
5. The recipient then needs to confirm receipt with the sender.

- **Post.** The documents should be sent via recorded delivery in external post. Documents should be double enveloped. On the outer envelope it should clearly state “To be opened by named addressee only”. There should be a return address on the outer envelope. The inner envelope should be marked “restricted”. Do not use internal post.

- **Delivery in person.** Do not use internal post. SAMA1 should be hand-delivered. You should obtain a signature from the intended recipient to confirm delivery.

**Telephone concern:**

- Adult Social Care Direct
- Allocated Social Worker
- Out of Hours Service

Agree how and who SAMA1 is going to be sent to: email, fax, post, in person

Follow procedures for the safe transfer of information for email or fax or post or delivery in person (as above)

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