

A black and white photograph of a woman with her hair in a bun, wearing a dark polo shirt with 'Sue Care' on it, smiling broadly. She is sitting outdoors and talking to an older man whose profile is visible on the left. The background shows a fence and trees.

# Contributory factors framework for medicines errors in adult social care settings

An interactive guide



# Introduction

**This framework can be used by those investigating medicines errors in adult social care, e.g. managers of adult social care services and safeguarding teams, to:**

- highlight factors to consider in relation to the medicines error to support a [root cause analysis \(RCA\)](#) approach
- prompt wider thinking around the causes of the medicines error
- support those reviewing the error with their review process
- promote a consistent, constructive and fair evaluation of the actions of staff involved
- encourage the incident reviewer to work with the staff involved to apply the framework (this gives a rounded perspective of the event as the staff member is given an opportunity to say **why** a factor contributed to the error)
- enable staff to be involved in the review of an error to give them the opportunity to say **why** factors contributed to an error and gives them a voice (involving staff in identifying what can be done to prevent a recurrence can help them feel part of the solution rather than being blamed)
- help identify **how** it can be prevented from happening again
- encourage working together as a team and sharing the learning across the sector to make care services safer for the people being supported.

It is estimated that over [92 million medicine errors](#) happen in care homes throughout the UK every year. Most of these do not cause any harm to the person being supported but some can lead to severe harm or even death.

### **The care homes use of medicine study 2009 (CHUMS) found:**

“on any given day seven out of ten residents were subject to at least one form of medication error”.

‘Low’ reporting from an organisation should not be taken as a ‘safe’ organisation. This may represent under-reporting. A ‘high’ reporting rate should not be taken as an ‘unsafe’ organisation. In fact, this may represent a culture of greater openness.

The CQC report [Medicines in health and adult social care Learning from risks and sharing good practice for better outcomes](#) identified the six most common areas of risk with medicines across health and care:

- prescribing, monitoring and reviewing
- administration
- transfer of care
- reporting and learning from incidents
- supply, storage and disposal
- staff competence and workforce capacity.

**Medicines errors occur when weak medicines systems or human factors affect processes. Human factors to consider include fatigue, environmental conditions and staffing levels.**

**Medicines errors can result in severe harm, disability and death. They can occur at different stages of the medicines process, for example:**

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

**This interactive document highlights factors to consider in medicines errors. It should help to support a [root cause analysis](#) approach.**

**Medicines errors are not the same as adverse drug reactions.** An [adverse drug reaction](#) (ADR) is an unwanted or harmful reaction which occurs after administration of a drug or drugs. They can occur when a medicine is used within or outside its approved use. Report ADRs through the [yellow card scheme](#).

When things go wrong in the workplace, it can cause significant distress for staff members who can become [‘second victims’](#). Having a robust process to review incidents that focuses on safety systems and improvement helps to support staff and to highlight themes that require action.

Safety incidents are usually signs of underlying issues that require wider action. Singling out an individual is rarely appropriate.

Supporting staff to be open about mistakes allows valuable lessons to be learnt and prevents errors from being repeated.

Treating staff fairly can foster a culture of openness, equity and learning where staff feel confident to speak up when things go wrong.

In rare circumstances concerns about an individual’s conduct or fitness to practise may be raised. In these specific circumstances NHS England’s [‘Being fair’ tool](#) can help decide what next steps to take. Please note: the tool should only be used when concerns about an individual’s conduct or fitness to practise are raised. It is not for routine use.



# How to use this guide

**This interactive document has features to help you quickly and easily navigate through and find the information you need.**

Use the links below to go to the start of different sections. If you'd like to return to this navigation page, choose the 'Return to navigation page' option at the start of each section. Alternatively, you can scroll through the document.

There are hyperlinks to resources and websites for additional information throughout. Hyperlinks are underlined and highlighted in a different colour. Just click on them to access further information.

# Terms used

- **Action plan**  
A document that lists the action steps needed to achieve goals and objectives. An action plan may be paper based or electronic. Care services may use alternative terms such as improvement plan, etc.
- **Care plan**  
An assessment of the person's needs which identifies the support required, when it should be provided and who is responsible for providing it. Care plans may be paper based or electronic.
- **Care provider/care service**  
Any setting which provides health and/or social care to adults such as residential care home, nursing care home, supported living, day care, respite, domiciliary care (this list is not exhaustive).
- **Care Quality Commission (CQC)**  
The independent regulator of health and social care in England.
- **Being fair**  
An approach to foster a culture of openness, equity and learning where staff feel confident to speak up when things go wrong.
- **Medicines administration record (MAR)**  
The formal record of administration of medicines within the care setting. The MAR may be paper based or electronic.
- **Medicines error**  
Any patient safety incident or event relating to medicines.
- **Near miss**  
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.
- **Person/person supported**  
The individual person receiving support with their medicines although care services may use alternative terms such as resident, service user, patient, customer, etc.
- **Root cause analysis (RCA)**  
A process of discovering the root causes of problems in order to identify appropriate solutions. RCA assumes it is more effective to prevent and solve underlying issues rather than treating ad-hoc symptoms and putting out fires.
- **Second victim**  
Staff members who have experienced a significant personal or professional impact as a result of a safety incident can be referred to as a second victim.
- **Staff**  
People employed to provide care and support to people, such as registered nurses, non-clinical carers, agency staff, bank staff (this list is not exhaustive). Care services may use alternative terms such as colleague, etc.

# Guidance

## National Institute for Health and Care Excellence (NICE):

**NICE guidance on [managing medicines in care homes \(SC1\)](#) states that:**

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Commissioners and providers of health or social care services should ensure that a robust process is in place for identifying, reporting, reviewing and learning from medicines errors.

**NICE guidance for [adults receiving social care in the community \(NG67\)](#) states:**

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When social care providers have responsibilities for medicines support, they should have robust processes for identifying, reporting, reviewing and learning from medicines-related problems.

## Care Quality Commission (CQC):

The CQC guide [Reporting medicine related incidents](#) says providers should:

- maintain an open 'fair blame' policy
- encourage staff to report medicines errors without delay
- have a robust process for sharing learning from incidents across the organisation
- have mechanisms in place to make changes in practice to improve safety
- record accurate details of medicines-related safeguarding incidents. Record them as soon as possible after the incident. This information must be available for any investigation and reporting.

In all cases, the safety of the person should be the primary concern. Where necessary, contact the prescriber or emergency services, the family or carer. Agree a process for care staff to follow. This should be agreed between health professional(s) and commissioners. It should set out who to contact in normal office hours and out of hours.

**The CQC guide [Reporting medicine related incidents](#) says:**

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Care providers should have a policy which includes a process for recording all medicines related incidents. This also includes all 'near misses' and incidents that do not cause any harm. The policy should cover:

- whether to notify CQC
- which medicines related safety incidents to report under local safeguarding processes
- how to report the incident to the person, their family or carers
- how to handle referrals to regulators and other agencies, such as Nursing and Midwifery Council (NMC).

Report incidents related to controlled drugs (including loss or theft) to your local NHS [Controlled Drugs Accountable Officer](#) (CDAO) at NHS England\*. You should also report incidents to the police (if necessary). You must tell CQC if the incident meets the criteria of a [statutory notification](#).

All care providers have an overarching [duty of candour](#) to be open and transparent with people using their services. The duty of candour applies at all times and in all cases. So care providers must let the person know what has happened.

When a care provider has a safety incident, they should also check [Regulation 20](#) to see if it is a 'notifiable safety incident'. If it is, the regulation also tells you how you must support the relevant people.

Give people, their family or carers information about reporting medicines related safety incidents. This should include information about how they can report their concerns about medicines. It should include:

- your complaints process
- any local authority (or local safeguarding) processes
- any relevant regulatory processes.

**\*Please note: incidents related to controlled drugs are to be reported via the reporting portal [www.cdreporting.co.uk](http://www.cdreporting.co.uk)**

You must tell CQC about certain [safety incidents](#) via the relevant [notification form](#).

**You 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.

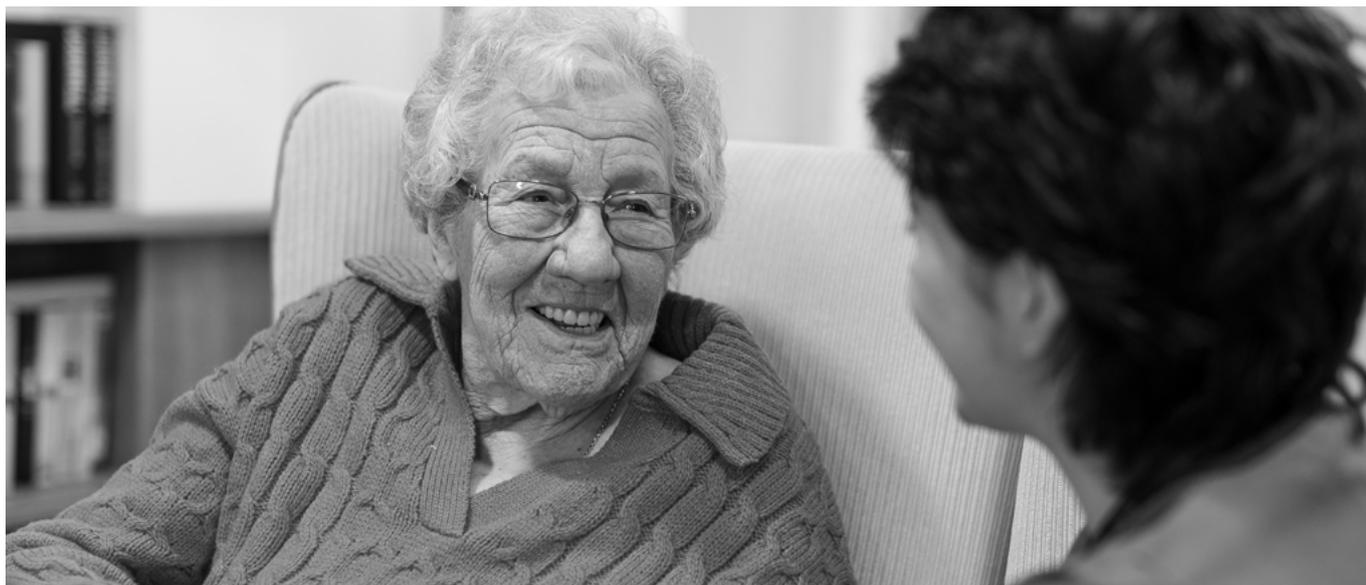
Although there is no requirement to notify CQC about all medicines errors, you must tell CQC if a medicines error has caused:

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

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

Be aware of local arrangements for safeguarding incidents. There may be different arrangements for notifying suspected or confirmed medicine-related incidents. Providers should describe this in their medicines policy.





# What medicines related issues need to be reported to safeguarding?

The NHS webpage [‘Abuse and neglect of vulnerable adults’](#) says there are many forms of abuse and neglect.

- Physical abuse - includes the misuse of medicines.
- Neglect - includes not making sure people have the right medicines.

## Examples of medicines related safeguarding 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 medicines error.

**Remember:** you must tell CQC if a medicines error has caused a death or an injury, if there was abuse, or an allegation of abuse or if the incident was reported to or investigated by the police.

Be aware of local arrangements for safeguarding incidents.

# How could the framework be used in practice?

**This error framework can be used by those investigating medicines errors in adult social care services and is intended to complement existing review/investigation processes.**

It takes the reviewer through contributing factors, offering supporting links on how each factor might be considered in relation to the error.

The reviewer should work with the staff member(s) involved in the error to establish which factors they feel contributed to the error. This gives a rounded perspective of the event as the staff member(s) is given an opportunity to say why a factor contributed to the error.

When reviewing a medicine-related error, the reviewer could use the 'Contributory factors framework for medicines errors form' to prompt wider thinking around the causes of the error and to document their findings.

This may take time, but it's important to involve key individuals, including those external to the care service, such as pharmacists, GP's and hospitals. This covers all factors and allows learning in other parts of the system if required.

Once the review has been completed, the reviewer should collate the contributing factors using the summary section of the 'Contributory Factors Framework for Medicines Errors Form' and identify why they played a part in the incident.

An action plan should then be generated to identify actions that need to be taken to prevent future occurrences of this incident or similar incidents. Each action should be allocated to a responsible individual to oversee its delivery, any additional resources required, and a realistic completion date. More importantly, the reviewer is asked how they will be sharing the learning from the incident.

What happens in one care service can happen elsewhere. By working together as a team and sharing the learning across the sector we can make care services safer.

The framework has been designed so that the factors can be reviewed in a generic way to generate themes and trends within both the individual care service and the local authority.

**Please note:** The action plan section is optional and may not be required if the care provider already has a robust action planning tool available.

The '**Contributory factors framework for medicines errors within adult social care**' is not intended to replace any existing reporting procedures within the care service or how you collate your evidence, such as written accounts.

You will need to check with your local commissioning team what your external reporting requirements are and follow local policies in relation to these.

# Completing the summary and planning form

The reviewer should complete the 'Details of the medicines error' section then check each domain or factor and decide whether it contributed to the error.

For audit purposes, try to include medicine details (if known) and details of any health care professionals who provide advice.

Details of Medicine Error	
Name of care service: Click or tap here to enter text.	
Form completed by (give name and job title): Click or tap here to enter text.	
Incident date: Click or tap to enter a date.	Harm: Choose an item.
Date of completion: Click or tap to enter a date.	
Brief description of medicine error: Click or tap here to enter text.	
What information and support has the staff member, the person and their family or representative involved been given? Click or tap here to enter text.	

# Establishing factors and completing the summary section

The reviewer should work with the staff member(s) involved in the error to establish which factors they feel contributed to the error.

Where a factor did not contribute, this can be left blank.

**Remember:** if the reviewer or the staff member(s) are unsure about what a ‘domain’ or ‘contributing factor’ means, they should use this document for further explanation.

Use the ‘summary’ section to describe how/why the factors identified contributed to the error.

Domain 1: Situational Factors	Summary
<b>A) Team Factors</b> Were there any failure of team function? <i>For example:</i>	If applicable: Describe here how/why these factors contributed to the error.
1. Conflicting team goals <input type="checkbox"/> 2. Lack of respect for colleagues <input type="checkbox"/> 3. Poor delegation <input type="checkbox"/> 4. Absence of feedback <input type="checkbox"/> 5. Other: <input type="checkbox"/> Click or tap here to enter text.	
<b>B) Individual Staff Factors</b> Were there any reasons why this was more likely to occur with the team member involved? <i>For example:</i>	If applicable: Describe here how/why these factors contributed to the error.
1. Fatigue <input type="checkbox"/> 2. Stress <input type="checkbox"/> 3. Rushed <input type="checkbox"/> 4. Distraction <input type="checkbox"/> 5. Inexperience <input type="checkbox"/> 6. Lack of confidence <input type="checkbox"/> 7. Illness <input type="checkbox"/> 8. Hunger <input type="checkbox"/> 9. Language barriers <input type="checkbox"/> 10. Other related medicines errors <input type="checkbox"/> 11. Personal equipment <input type="checkbox"/> 12. Other: <input type="checkbox"/> Click or tap here to enter text.	
<b>C) Task Characteristics</b> Did the task features make the incident more likely? <i>For example:</i>	If applicable: Describe here how/why these factors contributed to the error.
1. Unfamiliar task <input type="checkbox"/> 2. Difficult task <input type="checkbox"/> 3. Boring task <input type="checkbox"/> 4. Care plan not clear <input type="checkbox"/> 5. Other: <input type="checkbox"/> Click or tap here to enter text.	
<b>D) Person Supported Factors</b> Were there any reasons why this incident was more likely to occur to this person? <i>For example:</i>	If applicable: Describe here how/why these factors contributed to the error.
1. Language barrier <input type="checkbox"/> 2. Person is self-administering <input type="checkbox"/> 3. Medicines declined <input type="checkbox"/> 4. Complex medical needs/medical history <input type="checkbox"/> 5. Person asleep <input type="checkbox"/> 6. Person intoxicated <input type="checkbox"/> 7. Unusual presentation of the person supported <input type="checkbox"/> 8. Other: <input type="checkbox"/> Click or tap here to enter text.	

# Completing the action plan section

The action plan is where the reviewer can describe how to tie the learning and the sharing together and help prevent similar errors from happening again. This form allows for actions to be monitored and can help demonstrate to stakeholders e.g. CQC, safeguarding teams, what steps are being taken to prevent any further recurrence of the error.

## Action to be taken:

This section covers a brief outline of what action you intend to take to prevent this happening again. This should include any required resources.

Most, if not all tasks, will need some sort of resource to complete them. This may be time or other resources (new equipment, a new policy etc).

## Things to consider:

- Time
- Telephone numbers / email addresses / contact details
- Training documents
- Policies / procedures / guidelines
- Care plans / MAR Charts

ACTION PLAN - What needs to be done to prevent a reoccurrence of the error?				
Action to be taken	Responsible person	Completion Date	Evidence of improvement	How will learning be shared?
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.	Click or tap here to enter text.	Click or tap here to enter text.
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Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.	Click or tap here to enter text.	Click or tap here to enter text.

### Responsible person:

Each action needs to have a central point for managing the task. This creates accountability and gives other people a point of contact.

It does not mean that this individual is going to complete the task single handed if this is not appropriate. The tasks can be shared but someone needs to retain an overall responsibility

### Completion date:

This needs to be realistic and manageable. The urgency of the task will be dictated by the scale of the task, the seriousness of the incident and the likelihood it may occur again.

### Evidence of improvement:

For a change to be successful it needs to have an achievable measure attached to it that can be evidenced. This can be:

- a change in your internal policies and processes
- new documentation templates
- new equipment with associated training and maintenance plans
- an audit demonstrating a change in practice.

ACTION PLAN - What needs to be done to prevent a reoccurrence of the error?				
Action to be taken	Responsible person	Completion Date	Evidence of improvement	How will learning be shared?
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.	Click or tap here to enter text.	Click or tap here to enter text.
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Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap to enter a date.	Click or tap here to enter text.	Click or tap here to enter text.

## How will learning be shared?

The learning from incidents should be shared to create a safer environment within your organisation and externally. There is a chance that the error that has happened may happen in another care service. Sharing your anonymised learning may prevent another person from coming to severe harm.

This can also be used on your [CQC Provider Information Return](#) form.

### Internally you may consider:

- one-to-one meetings with staff or team meetings
- posters
- newsletters
- new training sessions.

### Externally you may consider:

- discussions at your local care provider forums/registered managers meetings
- presentations to stakeholders or local conferences
- if you need to update your commissioning and safeguarding teams
- do you need to inform/update the CQC?
- do any external reports need to be made such as to the [Medicines and Healthcare products Regulatory Agency \(MHRA\)](#)?

## Reports and/or referrals:

If the medicines error has been reported to an external body, such as CQC, your local safeguarding team, the Controlled Drug Accountable Officer (CDAO), etc., you can capture it here:

Reports and/or Referrals	
<b>CQC:</b> Choose an item.	<b>Date:</b> Click or tap to enter a date.
<b>Safeguarding:</b> Choose an item.	<b>Date:</b> Click or tap to enter a date.
<b>CDAO (for Controlled Drugs):</b> Choose an item.	<b>Date:</b> Click or tap to enter a date.
<b>Police:</b> Choose an item.	<b>Date:</b> Click or tap to enter a date.
<b>Professional body e.g. NMC:</b> Click or tap here to enter text.	<b>Date:</b> Click or tap to enter a date.
<b>Commissioning Team:</b> Choose an item.	<b>Date:</b> Click or tap to enter a date.
<b>Other:</b> Click or tap here to enter text.	<b>Date:</b> Click or tap to enter a date.



## Domain 1 - Situational factors

**Situational factors are the factors that can have an impact on the individual rather than within the individual themselves.**



## A. Team factors

Effective teams in health and social care environments have been shown to reduce errors and improve safety. They can lead to better staff outcomes due to reduced stress and improved job satisfaction.

**Was there any failure of team function? For example:**

1. Conflicting team goals
2. Lack of respect for colleagues
3. Poor delegation
4. Absence of feedback
5. Other

## 1. Conflicting team goals

- Did the [team work well together](#)? If the team are working in isolation/in silos or not collaborating effectively this can cause problems.
- Does everyone understand the plan for the shift?

Ensuring all staff understand what every team member is doing is referred to as a [shared mental model](#). This improves '[situational awareness](#)' and improves the team members awareness of what is happening around them.

## 2. Lack of respect for colleagues

- Are working relationships respectful and effective?
- Is there a negative atmosphere in the team?
- Is everyone treated equally and fairly?

[Issues in the workplace leads to errors.](#)

## 3. Poor delegation

- Have tasks been delegated unfairly?
- Is a staff member being asked to do more than others despite being equally skilled and competent?
- Is someone being asked to work outside their [scope of practice](#)?

## 4. Absence of feedback

Are staff members receiving feedback (good and constructive) on their work? A staff member may be unaware of a competence issue that has led to the error. Feedback does not necessarily need to come from a manager or team leader it can be from a peer. Staff members should also be encouraged to feedback to the management of the care service especially around how to make improvements.

## 5. Other

This is for any other team related factors that may have contributed to the error. Please be clear in the 'what' it is and 'why' it is thought to have contributed.



## B. Individual staff factors

Although these are related to the individual, they include external factors impacting on them. This section covers some of the most common factors that can contribute to an individual.

**Were there any reasons why this was more likely to occur with the team member involved? For example:**

1. Fatigue
2. Stress
3. Rushed
4. Distraction
5. Inexperience
6. Lack of confidence
7. Illness
8. Hunger
9. Language barriers
10. Other related medicines errors
11. Personal equipment
12. Other

## 1. Fatigue

All staff members can at times feel [fatigued](#). Identifying the source of the fatigue can help to identify if the staff member may need additional support. For example:

Was the staff member fatigued due to significant caring responsibilities?

Do they work more than one job?

Are they up late studying?

Have they been actively socialising regularly?

Have they been asked to work additional shifts or changed shift pattern without sufficient rest?

Use of the [IMSAFE](#) checklist can help staff members assess if they are well enough to perform the medicines round or medicines related task. Staff need to speak up and ask for support if they use the IMSAFE checklist and deem themselves to be unsafe.

## 2. Stress

[Stress](#) is the body's reaction to feeling under pressure from a situation or life event. It can cause emotional, behavioural, and physical changes. For example:

Does the staff member have issues going on at home such as family related problems, relationship issues or financial worries?

Has there been a change in circumstances in the work environment that has caused an impact on the staff member?

Use of the [IMSAFE](#) checklist can help staff members assess if they are well enough to perform the medicines round or medicines related task. Staff need to speak up and ask for support if they use the IMSAFE checklist and deem themselves to be unsafe.



### 3. Rushed

Is the staff member expected to do a high number of tasks in a short period of time? If so, they may feel [under pressure](#) and rush which can lead to poor performance. Carrying out [multiple tasks](#) at the same time introduces risk – when we alternate between tasks it can lead to error and can take us longer to complete the tasks as we must continually refocus on each task. It is also true that undertaking two demanding tasks in succession can affect how well we complete them.

### 4. Distraction

A [distraction](#) is anything that causes a break in concentration. Whilst it is not possible to remove every distraction within the care service, measures need to be taken to reduce them where possible. Was the staff member distracted when they were managing medicines or carrying out medicines administration? Things to consider:

- You may have processes in place (e.g. expect staff to wear a red tabard) - were these processes followed?
  - If they were and the staff member was still distracted – by who and why?
  - Was it a person being supported, another staff member, a visitor such as a relative or health care professional?
  - Why did the individual (identified as above) distract the staff member?
  - Was it avoidable/could a different staff member have helped/intervened?
- Were they distracted by something else i.e. an emergency, their personal mobile phone, the work phone?

### 5. Inexperience

Being inexperienced in performing a task can lead to errors. This does not necessarily mean that the staff member is incompetent. Inexperienced staff members can overestimate their abilities. This is known as the '[Dunning-Kruger effect](#)'.

- Has the staff member been through a period of mentorship?
- Is there a system in place for them to ask for additional help and support if they feel that they need it?
- Do staff have appropriate supervision?
- Is the staff member working in an unfamiliar care setting? e.g. agency staff, bank staff.
- Was the layout of the care service unfamiliar to the staff member?
- Did staff have time to read the persons care plan before starting their shift?

## 6. Lack of confidence

Staff may lack confidence in their ability to perform a specific task or in themselves generally. If the staff member has a lack of confidence, they are more likely to [overcompensate](#) which can lead to errors<sup>1</sup>. A robust training package with a period of mentorship can help to address this.

## 7. Illness

If a staff member is not feeling well, they are more likely to be distracted and not fully focusing on their medicines related task. Use of the [IMSAFE](#) checklist can help staff members assess if they are well enough to perform the medicines round or medicines related task. Staff need to speak up and ask for support if they use the IMSAFE checklist and deem themselves to be unsafe.

## 8. Hunger

Evidence show that when a staff member is hungry or dehydrated their mental performance is impaired. Things to consider:

- Did the staff member have a break or opportunity to eat and/or drink?
- Are they eating properly?

Again use of [IMSAFE](#) can help staff members assess if they are well enough to undertake the medicines round or medicines related task. Staff need to speak up and ask for support if they use the IMSAFE checklist and deem themselves to be unsafe.



<sup>1</sup> Peak Performance Under Pressure. Dr Stephen Hearn (2019)



## 9. Language barriers

Most care plans and MAR charts are written in English. However, English may not be the first language of the staff member administering the medicines.

## 10. Other related medicines errors

- Has the staff member been involved in other medicines related errors?
- Are you noticing any patterns with this staff member?
- If so, what are they?
- Was this staff member involved in any previous investigation to identify what happened or were they just told the outcome?

If a staff member has been involved in a previous incident and feels the outcome was not sufficient this can have an impact on their future performance.

## 11. Personal equipment

Do staff have assessments for personal reasonable adjustments e.g. on induction? If reasonable adjustments were required for this staff member, were these in use?

Does the staff member require any equipment, such as reading glasses? Was the staff member using the required equipment when the error occurred?

## 12. Other

This is for any other factor related to the staff member that may have contributed to the error. Please be clear in 'what' it is and 'why' it is thought to have contributed.



## C. Task characteristics

Tasks are made up of several steps. If there is a problem with one feature this can lead to error. The [design of the task](#) and how [staff members interact](#) with it can cause issues.

**Did the task features make the error more likely? For example:**

- |                        |
|------------------------|
| 1. Unfamiliar task     |
| 2. Difficult task      |
| 3. Boring task         |
| 4. Care plan not clear |
| 5. Other               |

## 1. Unfamiliar task

Tasks that are new to a staff member are prone to error.

- Have they had the correct training and mentorship to become familiar with the task that they are being asked to perform?
- If the task is a delegated healthcare activity have the [Guiding principles from Skills for Care](#) been applied?

## 2. Difficult task

- Is the task difficult for the staff member to complete?
- Is there an alternative way that it can be performed?

Sometimes staff will find their own ways of completing the task which can include shortcuts, and this can have a negative impact. This is referred to as '[work as done versus work as imagined](#)'. Did this happen?

## 3. Boring task

Tasks that are boring make it hard for staff to maintain their concentration and they can become [complacent](#).

- Is there an alternative way that it can be performed?
- Is there an opportunity to create breaks or share the task between staff?

## 4. Care plan not clear

A medicines care plan should detail how staff will support a person with their individual medicines.

- Has the prescriber made it clear in how and when the person should receive their medicines?
- Has this been written correctly in the care plan/medicines administration record?
- If the care plan/medicines administration record is handwritten is it clear?

## 5. Other

This is for any other factor related to the task that it is thought to have contributed to the error. Please be clear 'what' it is and 'why' it is thought to have contributed.

## D. Person supported factors

The *right dose* of the *right medicine* needs to be administered to the *right person* at the *right time* by the *right route*.

People supported, like staff members, are unique and play an important part in the medicines administration process. We also need to be aware that people being supported have a *right to decline* and the impact that this can have on their health. Every adult has the right to make their own decisions.

A person must be assumed to have capacity unless it is established that they lack capacity. If the person supported does not have mental capacity to understand then we need to follow the Mental Capacity Act 2005, which is the legal framework for acting and making decisions on behalf of individuals who may lack capacity for certain decisions. It applies to all people aged over 16. The principals of the Mental Capacity Act 2005 are to be followed when considering covert administration of medicines.

### Were there any reasons why this incident was more likely to occur to this person we support? For example:

1. Language barrier
2. Person is self-administering
3. Medicines declined
4. Complex medical needs/history
5. Person asleep
6. Person intoxicated
7. Unusual presentation of the person supported
8. Other



### 1. Language barrier

Language barriers can contribute to medicines errors. Is the first language of the person supported different to that of the staff member administering the medicines?

- If so, did this contribute to the error?
- How can this be prevented in the future?

### 2. Person is self-administering

It is important that people being supported [maintain independence](#) where appropriate.

- Does the person self-administer all or some of their medicines?
- How is this process supported/observed?
- Where required is there a system in place to ensure that the person supported has taken their medicines as prescribed?
- Has the persons support requirements with their medicines changed?

### 3. Medicines declined

People supported have the right to decline to take their medicines. Missing a dose of a medicine may have an impact of their ongoing health. The care plan should have an agreed plan of what to do if the person declines their medicines.

Things to consider:

- Would waiting a short while before offering it again have helped?
- Were the persons reasons for declining explored?
- If a reason for declining has been given, has it been documented?
- Where appropriate, has the prescriber been informed?
- Do alternatives need to be explored?
- Does the person have capacity to decline?

#### 4. Complex medical needs/history

The person supported may have a complex medical history. They may have several co-morbidities that require multiple medicines ([polypharmacy](#)) at certain times during the day. Keeping on top of their administration schedule can be difficult. Did this contribute to the error?

- Have the person's medicines been reviewed recently?
- Is there an opportunity to reduce or streamline their medicines?

#### 5. Person asleep

Care providers should have robust processes for staff who are supporting people to take their medicines, including what to do when the person supported is asleep when their medicines are due to be taken. Some policies state that people cannot be woken from sleep to take medicines, but this may not be appropriate for all.

- Is the person prescribed '[time critical](#)' medicines, such as Parkinson's medicines or other medicines\* that should not be missed?
- Does this happen regularly with this person?
- Can the medicines be reviewed and prescribed for another time of day?



\*Examples of common medicines that must not be delayed or omitted within the PrescQIPP guide: [Care homes - Refused and missed doses](#)

## 6. Person intoxicated

Some people that we support choose to consume alcohol. Sometimes this can have [a negative impact](#) on medicines. For instance,

- a person may consume more than usual and may not want to take their medicines
- some medicines cannot be taken with alcohol.

## 7. Unusual presentation of the person supported

The person supported may become unwell or present with a condition that is not normal for them. They may be suffering from an acute medical event which prevents their medicines from being administered. They may develop a rash which prevents a patch or cream being applied as directed. They may have had a fall and are unable to get up and are in an unsuitable position to swallow oral medicines.

- Does your policy offer guidance on what action to take in these situations?

## 8. Other

This is for any other factor related to the person supported that it is thought to have contributed to the error. Please be clear 'what' it is and 'why' it is thought to have contributed.





## Domain 2 - Working conditions within the care service

**Working conditions within the care service need to be considered as they are an integral part of the system. Understanding how individuals integrate within the environment is vital to preventing future errors.**



## A. Workload and staffing

Achieving safe management and administration of medicines needs input from staff. They are one of the human elements of the system, so we need to look at each factor carefully.

**Was there a mismatch between workload and available staff around the time of the incident? For example:**

1. Required 'vs' actual number of staff on duty
2. Staff sickness
3. Staff late for duty
4. High workload
5. Medicines trained and competent staff available
6. Recruitment/retention issues
7. Other

## 1. Required vs actual number of staff on duty

- What are your safe staffing levels? How many staff are [required](#) to be on duty at any given time?
- How many staff were on duty at the time of the medicines task?
- If the number was less than required did this lead to the staff member being interrupted or distracted during the medicines round or medicines related task?
- How can this be prevented in the future?

## 2. Staff sickness

Has there been a wave of sickness through the team? Has this led to a sudden shortage of available staff to work on a shift?

If so, did all staff members present with the same symptoms? If this is the case it may mean that there has been an 'outbreak' of an illness.

- Think about your [infection control measures](#).
- Do you need to [report](#) this to any other bodies i.e. Public Health?
- Is there a contingency plan to cover staff sickness? Was this followed?

## 3. Staff late for duty

Sometimes staff can be late due to circumstances beyond their control, but it can have an impact on others.

- Did the staff member running late mean that another staff member had to do some of their tasks on top of their own?
- Did it mean that tasks were delayed until the staff member arrived? In the case of medicines this can lead to late or missed doses.
- Is this a regular occurrence for this staff member?





#### 4. High workload

Busy shifts are expected in health and social care environments, but some are busier than others. It may be despite having the required number of staff on duty, the number of tasks they need to do outstrips demand. There may be new admissions, people returning from hospital, or a higher number than normal of unwell people being supported.

#### 5. Medicines trained and competent staff available

- Were the correct number of staff (who are training and competent to administer medicines) available?
- Are staff rotas planned to ensure there is the correct number of medicines trained and competent staff available on each shift?
- Are medicines trained and competent staff available on all required shifts, e.g. night shifts to administer PRN medicines?

#### 6. Recruitment/retention issues

- Are there recruitment/retention issues? How can this be improved? Are there local initiatives etc?
- Is there a high use of agency or bank staff due to the recruitment/retention issues?

#### 7. Other

This is for any other factor related to *workload* and *staffing* that it is thought to have contributed to the error. Please be clear 'what' it is and 'why' it is thought to have contributed.



## B. Leadership, supervision and roles

Achieving safe management and safe administration of medicines requires good leadership. The leadership team within the care service should support each staff member to reach their own potential. They should empower staff members through delegation to deliver safe care including medicines management and administration. This means that each staff member needs to be clear about their responsibilities.

### Was there any failure in team function? For example?

1. Inappropriate delegation of tasks
2. Unclear responsibilities
3. Supervision
4. Lack of supervision/support
5. Other

## 1. Inappropriate delegation of tasks

Medicines should only be managed and administered by appropriately trained and competent staff members. If a staff member who was not [appropriately trained](#) and/or not deemed to be competent was asked to manage or administer medicines what were the circumstances around the request? How can this be prevented in the future?

## 2. Unclear responsibilities

- Do you have more than one staff member who is trained and competent to manage and administer medicines?
- Are staff aware when they are responsible for managing and/or administering medicines on a shift?
- Is it clear to other staff members and people being supported who is responsible for managing and/or administering medicines?

## 3. Supervision

- Is the staff member responsible for managing and/or administering medicines under [supervision](#)?
- What does that supervision look like?
- Was that supervision there?
- Is everyone clear on the supervision model?
- Was appropriate supervision/support available at the time of the incident?

## 4. Lack of supervision/support

Although staff members may not need direct [supervision](#) to manage or administer medicines if staff are suitably trained and assessed as competent, there still needs to be a way that they can escalate concerns or ask for advice.

- Was this in place?

## 5. Other

This is for any other factor related to the *leadership, supervision and roles* that it is thought to have contributed to the error. Please be clear 'what' it is and 'why' it is thought to have contributed.



## C. Medicines, equipment and consumables

To administer the *right medicines* at the *right time* by the *right route* the medicines need to be available.

**Were there difficulties obtaining the correct medicines and/or working equipment and/or consumables? For example:**

1. Unavailable medicines
2. Ordering issues
3. Equipment not working
4. Inadequate maintenance
5. Consumables/equipment unavailable
6. Were multi-compartment compliance aid (MCCA) or original packs involved?
7. Other

## 1. Unavailable medicines

Having the medicines available at the time a person needs them is important and forms part of Regulation 12 of [The Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2014](#).

Were medicines unavailable when they needed to be administered? If so, why?

Things to consider:

- Has the medicines been ordered in time?
- Has the prescriber provided a prescription in time?
- Have the medicines been collected or delivered from the pharmacy in plenty of time?
- Has the pharmacy advised that there are supply issues?
- If medicines are affected by a supply issue has an alternative been provided or has advice been sought to see if a decision to omit can be made?

## 2. Ordering issues

There are multiple steps involved in ordering medicines.

Does the care plan state who will be responsible for ordering the persons medicines? (Responsibility for [ordering](#) medicines often stays with the person and/or their family members or friends in domiciliary care services)

- When a vulnerable adult is receiving domiciliary support, a community pharmacy may support the person to re-order their medicines at certain points – was this done correctly and on time?
- In 24hour care services, such as care homes, the care provider is often responsible for re-ordering. Is the re-order process clear? Was the process followed correctly?
- What re-order system is used e.g. paper, secure email, proxy ordering?
- Consider the method the medicines were ordered by and whether this impacted on the error?
- In a care home setting medicines often need to be re-ordered at certain parts of the cycle – was it done on time?



### 3. Equipment not working

Equipment can be anything connected to medicines such as:

- storage areas, e.g. cupboards and cabinets
- trolleys (in care home settings)
- fridges
- consumables such as oral syringes, graduated measuring cups, etc.

If the issue relates to faulty consumable or equipment it may be useful to record the batch/serial number in case of manufacturer issues with a batch. Also consider if you need to report it to the [Medicines and Healthcare products Regulatory Agency \(MHRA\)](#).

### 4. Inadequate maintenance

Equipment needs to be [maintained regularly](#) to ensure it's working correctly. This may be the wheels and locks on the medicines trolley or the fridge where medicines are stored.

- Are maintenance records up to date?
- Have issues been previously reported but not acted upon?

### 5. Consumables/equipment unavailable

Like medicines, any consumables (medicine spoons, graduated measuring cups etc) or equipment (syringe drivers) need to get to the person's location so that they can be used to administer the medicines. If they were not delivered, why?

Things to consider:

- Were they ordered in time to be delivered for when the person needed them?
- Is there confusion over who should be supplying them?
- Were there delivery issues from the supplier or the community pharmacy?
- If so, what were these?
- Were you made aware of them?
- Can they be prevented in the future?

## 6. Were multi-compartment compliance aid (MCCA) or original packs involved?

In 2013, the Royal Pharmaceutical Society (RPS) published 'Improving Patient Outcomes – the better use of Multi-compartment compliance aids'. The RPS recommendation is that the use of original packs of medicines, supported by appropriate pharmaceutical care, should be the preferred intervention for the supply of medicines in the absence of a specific need for an MCCA in all settings.

Where an MCCA is provided to support independence or reablement, a review should be undertaken as part of every transfer of care to another care setting. It should not be assumed that there is a long term need for the use of an MCCA.

MCCAs should only be provided to support a person to maintain their independence. They should not be routinely used to support the needs of the care provider.

More information about MMCA's can be found in ['An interactive guide to what good looks like for assisted medicines taking'](#).

### If the error is linked to an MCCA:

- when was the person supported last risk assessed?
- are the needs of the person still the same or as there been a change?
- is the MMCA still required or are staff administering from the MMCA?
- if the error is linked to original packaging, consider factors around checking the medicines packaging, contents, and pharmacy label against the MAR chart.

## 7. Other

This is for any other factor related to *medicines, equipment and supplies* that it is thought to have contributed to the error. Please be clear 'what' it is and 'why' it is thought to have contributed.





## Domain 3 - Organisational factors

**Organisational factors look at factors that are under the control of the organisation such as the physical environment.**

Please note: Where support is being provided in peoples own homes, these factors may be more difficult to control, but they should still be considered.



## A. Physical environment

Care settings are a physical environment made up of many individual environments such as the person's home, bedroom, personal spaces, communal spaces and in care homes the treatment/medicines room. Factors associated with these environments can contribute to an error.

### Did the working environment hinder the work in any way? For example:

1. Layout
2. Lack of space
3. Storage/environmental issues
4. Poor visibility
5. Poor lighting
6. Poor access to the person
7. Other

## 1. Layout

The layout of the property could be considered as a factor in medicines errors.

- Are the consumables or equipment stored away from the medicines?
- Are staff preparing medicines in a location where there are many distractions?
- In care homes, is the medicines trolley stored somewhere different to the medicines fridge?

## 2. Lack of space

- Is there enough space to prepare the medicines safely?
- Is the storage facility large enough to store all the medicines? In a care home this might include a medicines trolley.

## 3. Storage/environmental issues

Is how the medicines are stored having an impact? This can be anything associated with the storage of medicines such as the cupboard, room, [fridges](#), lockers, and trolley (in care homes).

- Are medicines stored according to the manufacturer's recommendations. e.g. store below 25°C
- Is the [fridge used to store medicines](#) in working order?
- Are the medicines kept in the person's own room or property that is excessively warm? Could there be a better place to store these medicines?
- Have there been any reported problems with medicines been out of a fridge for a prolonged period?

### In care homes:

- Are the [temperature records](#) up to date?
- Has the trolley been kept in a room that was too hot?
- Are medicines awaiting [disposal](#) secure?

### The environment can also have an impact on the staff member administering the medicines.

- Is the environment too warm or too cold for staff members to concentrate properly?
- Is there a flat surface available to measure liquids when using a graduated measuring cup? (to view on a flat surface at eye level)

#### 4. Poor visibility (e.g. position of staff station/office)

- Should the person be monitored for a period after they have had medicines administered?
- In a 24hr care service such as a care home, was the person visible enough to staff for this to happen?
- In a domiciliary setting do visit times allow for monitoring after administration if required?

#### 5. Poor lighting

- Were medicines administered in poor lighting?
- Did this impact of the ability of the staff members to identify the packaging, MAR charts or care plans clearly?

#### 6. Poor access to the person

Some medicines such as transdermal patches and topical preparations like creams and ointments need to be applied in specific places on the person's body.

- Was there enough clear access to apply them in the correct position?
- Was the person in a location that ensures their medicines were administered in a dignified manner?

#### 7. Other

This is for any other factor related to the *physical environment* that it is thought to have contributed to the error. Please be clear 'what' it is and 'why' it is thought to have contributed.





## B. Other departments/ services

This section looks at the interactions of the multidisciplinary team involved in the person's care and how that impacts on the person's medicines.

### Were there any problems involving other departments/services? For example:

1. GP practice
2. Nurse
3. Non-medical prescriber (paramedic, physio, pharmacist, etc)
4. Medicines supplier (hospital, community pharmacy, dispensing doctor, etc.)
5. Hospital department (ward/clinic/pharmacy)
6. Advocate/social worker/family/friends
7. Ambulance service
8. Other

## 1. GP practice

Were there any issues that involved the GP practice? This could be (but not an exhaustive list):

- a difference of opinion around the care pathway
- communication issues such as unable to get through to the GP practice on the phone or GP practice staff not sharing appropriate info due to confusion over GDPR?
- were there any problems getting a GP appointment for the person supported?
- was a GP medicines summary provided in time to support medicines reconciliation?
- was a prescription written in time to get it to a community pharmacy so that the person could take their dose?
- were unclear directions provided e.g. 'take as directed' or 'apply as directed' for a cream?

## 2. Nurse

Some medicines are administered by a community nurse. This can be medicines such as insulin and medicines for end of life care.

- Was the nurse late?
- Was the medicine prescribed by a nurse?

## 3. Non-medical prescriber (paramedic, physio, pharmacist etc)

Was the medicine prescribed by someone other than a doctor? [Other professions](#) are able to prescribe certain medicines.

- Has the care provider been notified that there are medicines prescribed by a non-medical prescriber?
- Were unclear directions provided e.g. 'apply as directed' for a cream?

Identifying which profession or service prescribed the medicines can help to identify all the factors involved in the error as well as who needs to be informed.

## 4. Medicines supplier

This could be the hospital, community pharmacy or dispensing doctor that supplied the person's medicines.

- Have there been any issues with the medicines supplier?
- Have opening times changed?
- Has there been any supply issues?
- How is the communication with the dispenser?
- Has there been a dispensing error?

## 5. Hospital department (ward/clinic/pharmacy)

Has the person been under hospital care recently? This can be either as an inpatient on a ward or as an outpatient at a clinic or the emergency department. Contact with a hospital service such as a clinic appointment or trip to the emergency department may create a change to the person's medicines regime.

- Were medicines changes communicated to the care provider?
- Has a discharge summary of medicines been supplied that clearly identifies what current medicines the person should be taking?
- If required, was the person discharged with a physical supply of medicines?
- Has the person been discharged with enough medicines until a new supply can be obtained from a community pharmacy?

## 6. Advocate/social worker/family/friends

Other people such as social workers, family members and [independent medical capacity advocates \(IMCA\)](#) can be involved in the discussions around a person's medicines, especially if the person lacks capacity to make their own informed decisions around whether to take a medicines or not.

- Has there been a difference of opinion?
- Have everyone's opinions been considered?
- Has the final decision been made to benefit the person supported?
- Is everything well documented?

## 7. Ambulance service

The ambulance service can have interactions with a person that can have an impact on their medicines.

- Did 'patient transport services' transport the medicines correctly when they brought the person back to your care service?
- Did an emergency ambulance crew attend to the person and administer medicines but did not convey the person to hospital? Was this documented clearly?
- Did you place a 999 call for the person supported and were told 'not to give them anything to eat or drink'?

## 8. Other

This is for any other factor related to a *department or service* that it is thought to have contributed to the error. Please be clear 'what' it is and 'why' it is thought to have contributed.



## C. Scheduling

To get the *right medicines* to the *right person* at the *right time*, all scheduling factors need to be right.

**Did any time or bed pressures play a role in the incident?  
For example:**

1. Too many people per staff member
2. Discharged from hospital with little notice
3. Short notice admission in to the care service
4. Short notice administration required
5. Other

### **1. Too many people per staff member**

- Is one staff member expected to administer medicines to a lot of people?
- Does this have a negative impact on timely administration of time-critical medicines?
- Can the workload be shared between other suitable trained and competent staff members?

### **2. Discharge from hospital with little notice**

It is not uncommon for care providers not to be made aware of a person's imminent discharge from hospital especially if it's from an emergency department or ambulatory care ward.

- Did their arrival at the care service at short notice cause an impact on administration of medicines for the person themselves? i.e. they are late with a dose due to being in transit from the hospital or their medicines may not have been reconciled in a timely manner.
- Did their arrival at the care service have an impact on the administration of medicines to other people? i.e. were staff busy settling in the person into the service and this resulted in people receiving their medicines late (especially if staff members are limited)?
- Was a discharge summary or an up-to-date list of medicines provided?

### **3. Short notice admission into the care service**

Care services that offer respite services often accept new people at short notice. Like the factors in 'Discharge from hospital with little notice' this can have an impact of the new person and other people using the care service. Did this happen for this error?

### **4. Short notice administration required**

Have the person's medicines changed, meaning that a dose has to be given outside of the normal medicines round or scheduled visits?

### **5. Other**

This is for any other factor related to *scheduling* that it is thought to have contributed to the error. Please be clear 'what' it is and 'why' it is thought to have contributed.

# D. Staff training, education and competency

[Training and education around medicines](#) are integral to safe management and administration of medicines. Training resources should be regularly reviewed and updated to make sure that they are robust and fit for purpose. Staff should have their competence assessed to ensure they are managing and administering medicines safely.

Checklists are available to support care providers when checking their training processes and the quality and content of their medicines management training. The checklists can be found at: [Skills for Care – Medicines management resources](#).

Free medicines management training for adult social care services is available: [Catalogue \(learninghub.nhs.uk\)](#)

**For more information, please see the flyers:**

[Medicines E-Learning for ASC Flyer](#)

[How to use NHS Learning Hub Flyer](#)

## Were there any issues with staff skills or knowledge?

### For example:

1. New medicines
2. Inadequate training
3. No protected time for training
4. Inadequate competency assessments
5. Training/competency assessment not standardised
6. No regular refreshers
7. Other



## 1. New medicines

If a person is prescribed a new medicine this may be the first time that staff members have ever administered it.

- Does it need to be administered in a particular way?
- Are administering guidelines/instructions clearly recorded on the MAR or in the support plan?
- Are there side-effects that should be considered?

## 2. Inadequate training

The [training](#) that the staff members responsible for administering medicines undertake should meet the needs of your care service and the people being supported.

Have the training course materials been reviewed recently? Are they up to date?

## 3. No protected time for training

Training time needs to be protected and free from distractions so that staff can get the most from it and the trainer/supervisor can be assured that the learning has taken place.

[NICE NG67 'Managing medicines for adults receiving social care in the community'](#) says

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When social care providers are responsible for [medicines support](#), they should have robust processes for medicines-related training and competency assessment for care workers, to ensure that they:

receive appropriate training and support

have the necessary knowledge and skills

are assessed as competent to give the medicines support being asked of them, including assessment through direct observation

have an annual review of their knowledge, skills and competencies.

#### 4. Inadequate competency assessments

Have staff member(s) who are responsible for managing and administering medicines been assessed and deemed competent?

- Is the competency assessment tool sufficiently detailed?
- Do competency assessments include at least one direct observation?
- Who has assessed the competency of the staff member to say that they are able to administer medicines independently? Do they have the knowledge and skills to do this advanced role?

#### 5. Training or competency assessment not standardised

- Do you have a standard [training](#) course with agreed competencies that all your staff members go through to administer medicines safely?
- What format is the training? Is it appropriate for the needs of your service
- Have other staff members that have done the same training in the same format and achieved the same competencies had the same issues?

#### 6. No regular refreshers

In order for [competence](#) to be maintained it should be used often and regularly updated.

- Do your local guidelines state how often medicines management and administration skills should be refreshed?
- If not, why not?
- Was the member of staff involved up to date with refreshers?

[NICE guide SC1](#) 'Managing medicines in care homes' says: "Care home providers should ensure that all care home staff have an annual review of their knowledge, skills and competencies relating to managing and administering medicines'.

#### 7. Other

This is for any other factor related to *staff training and education* that it is thought to have contributed to the error. Please be clear 'what' it is and 'why' it is thought to have contributed.



## Domain 4 - Latent/external factors

**Latent factors are hidden in plain sight and can contribute to medicines errors without being obvious. External factors are factors that are not under total control of the care service.**



## A. Design of packaging/ equipment/consumables

Was there any characteristics about the packaging, equipment or consumables that was unhelpful? For example:

1. Design of packaging
2. Equipment design
3. Equipment not fit for purpose
4. Similar medicines names
5. Similar names (of the people supported)
6. Ambiguous labelling/directions
7. Incorrect reconciliation
8. Other

## 1. Design of packaging

Packaging of medicine can lead to errors. If the packaging is faulty, staff may not be able to administer the medicines at all. If the packaging is hard to open it may lead to the medicine being damaged which may mean the full dose is not able to be administered.

- If this is an issue has it been raised with your local pharmacy?

## 2. Equipment design

Not all medicines that need to be administered are in tablet format and some need special equipment i.e. insulin pens and inhalers.

- Are they simple to use?
- Are staff trained and deemed competent in their use?

## 3. Equipment not fit for purpose

Some medicines need to have additional equipment to administer them, such as a measuring spoon, syringe, or graduated measuring cup. If these are not used then the person may not get the appropriate dose.

- Was the correct equipment used? If not, why not?

## 4. Similar medicines names

A lot of medicines have similar names and different strengths and doses that if mixed up can have negative consequences for the person's health.

- Do you have a checking process? Was this followed?



## 5. Similar names (of the people supported)

It is not uncommon for people to have similar names. If medicines are mixed up this can have negative consequences for the person's health.

- Do you have a checking process? Was this followed?
- Where medicines are stored, is it clear who they belong to?

## 6. Ambiguous labelling/directions

The directions for administration should be clearly stated by the prescriber and community pharmacy.

- Were directions for administration unclear/ambiguous?

## 7. Incorrect reconciliation

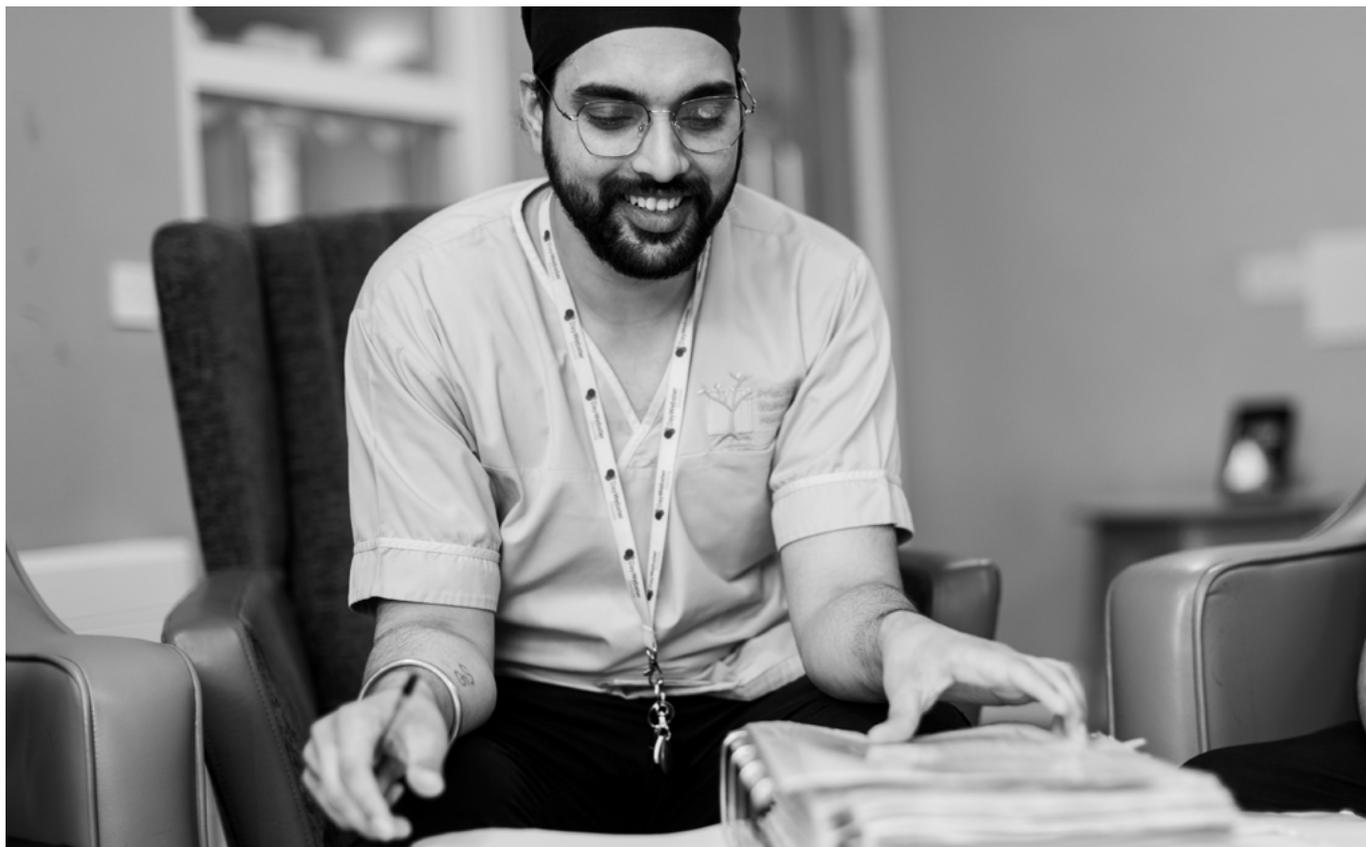
Whenever there is a change in person's medicines, or a transfer of care from another setting medicines [reconciliation](#) should happen.

- Did an error in medicines reconciliation contribute to the error?

## 8. Other

This is for any other factor related to the *design of the packaging, equipment, and supplies* that it is thought to have contributed to the error. Please be clear 'what' it is and 'why' it is thought to have contributed.





## B. Policies/documentation

**Have any policies or procedures influenced this incident?  
For example:**

1. Care providers medicines policy
2. Commissioners/local authority medicines guidance
3. Relevant NICE guidelines
4. CQC guidelines
5. Covert medicines administration
6. Medicines care plan
7. Medicines administration record (MAR)
8. Other

## 1. Care providers medicines policy

Each care provider is required to have an up to date [medicines policy](#) that is based on current legislation and best evidence. It should detail how medicines are managed including ordering, disposal, storage, administration, and record keeping. It should include guidance on covert administration as well as non-prescription and over-the-counter medicines. Care homes can utilise the '[Principles of safe medicine administration in a care home setting](#)'.

- When was your policy last reviewed?
- Is it internal to your care service or is it one that is used by more than one care service?
- Have staff been given time to read and understand your medicines policy?
- Could the policy have contributed to or prevented this error?

## 2. Commissioners/local authority medicines guidance

Some commissioners or local authority commissioning teams provide a universal medicines policy.

- Does this apply to your care service?
- Are they fit for your purpose?
- Could the policy have contributed to or prevented this error?

## 3. Relevant NICE guidelines

- Were the NICE guidelines such as [NICE SC1](#) and [NICE NG67](#) relating to medicines management within your care service followed?

## 4. CQC guidelines

The CQC sets out expectations around [medicines management](#) in adult social care services.

- Were these followed?

Can you evidence your requirements against the CQC [Single assessment framework](#).



## 5. Covert medicines administration

Covert medicines administration must be in line with the [Mental Capacity Act \(2005\)](#) and covered in DOLs/LPS procedures.

- Was the person receiving their medicines covertly?
- Did this person have the correct documentation in place? e.g. evidence of a mental capacity assessment (specific to task and time), best interest discussion/decision, a DOLs/LPS?
- Are all the documents in date/have they been reviewed recently?
- Do we have guidance that specifically covers the administration of each medicine that the person takes?
- Is covert administration clearly documented in their care plan?

The CQC offer more advice on covert medicines administration on their [website](#).

## 6. Medicines care plan

Medicines should be listed in the care plan along with why they are prescribed and how they should be taken. Any deviation from this should also be documented clearly with reasons why the deviation happened, and the action taken.

- Was the person's care plan documentation up to date?
- If there was an intentional deviation was this documented?
- Were other staff members aware of the deviation and action that was taken?

## 7. Medicines administration records (MAR)

- Was there an issue with the MAR?
- Were the [RPS Principles of safe and appropriate production of medicines administration charts](#) followed?
- Has there been inaccurate transcribing by care staff?
- Have staff been trained and competency assessed for transcribing on to MAR charts?
- Has there been an issue affecting electronic MAR such as problems with the laptop or internet connection?
- Was the MAR file unorganised?
- Are accuracy and use of MARs included in internal audits? (including the use of any reporting and analytics features for electronic MARs)

## 8. Other

This is for any other factor related to *policies and documentation* that it is thought to have contributed to the error. Please be clear 'what' it is and 'why' it is thought to have contributed.



## Domain 5 - Communication and culture



# A. Safety culture

What is the culture like within your care service? Do staff know how and when to report errors? Do they feel supported to do so knowing that they will be treated fairly and the event will be investigated to support learning? Are the chains of communication open?

## Did the safety culture within your care service contribute to this incident? For example:

1. Policies/procedures not followed
2. Fear of reporting errors
3. Attitude to risk management
4. Irregular audits, reconciliation and stock checks
5. Previous concerns/near-misses not actioned
6. Other

“Safety culture is a combination of the attitudes, values and perceptions that influence how something is actually done in the workplace, rather than how it should be done. Poor safety culture has contributed to many major incidents and personal injuries and can be just as influential on safety outcomes as an organisation’s safety management system itself.”

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**Health and Safety Executive, 2020**

## 1. Policies/procedures not followed

[Policies and procedures](#) around medicines management and administration should be clear and explicit to help staff members know what action to take.

- Are your policies and procedures up to date?
- When were they last reviewed?
- Did it cover what action to take when this medicines error happened?
- Did the staff members follow them? If not, why not?

## 2. Fear of reporting errors

Staff members can feel [reluctant to report](#) errors if they feel that they will be automatically disciplined and fear their employment being terminated.

- Do you have a clear, supportive procedure for reporting errors?
- Was the error reported soon after occurrence?
- Did the employee attempt to 'hide' it? If so, why was this?

## 3. Attitude to risk management

[Risk management](#) is a process to identify, analyse and respond to the risk factors that are part of your care service. By proactively working towards preventing these factors where possible, rather than reacting when things go wrong, you can have a more positive impact on your care service.

- Do you review your policies and procedures regularly or just when something happens?
- Are your staff members receiving regular updates regarding working practices to make sure they are knowledgeable and competent even if nothing has changed?
- Do staff understand their role with risk management?
- Do you share learning?



#### 4. Irregular audits, reconciliation and stock checks

Medicines audits should be carried out on a regular basis.

- Is the internal audit tool robust?
- Is the staff member given adequate time to complete a thorough audit?
- Are audits viewed as a 'tick box exercise'?
- Are areas of improvement identified and action taken to rectify?

Are stock checks completed? This helps to ensure that the correct amount of medicines are available for the people supported and can identify if errors may have occurred.

[Reconciliation](#) should happen as soon as there has been a change in a person's medicines or they have changed care settings i.e. come back from hospital.

#### 5. Previous concerns/near-misses not actioned

[Evidence](#) has shown that if we deal with the near-misses as soon after they occur we can prevent more significant incidents.

- Has something similar happened or been highlighted before? Was this acted upon? If not, why not?
- Do you log all your near misses/concerns?
- Do you regularly review them and implement changes to prevent them happening again?

#### 6. Other

This is for any other factor related to *safety culture* that it is thought to have contributed to the error. Please be clear 'what' it is and 'why' it is thought to have contributed.





## B. Verbal and written communication

Communication is key to effective team working and is a significant contributor to safety. Communication occurs in many forms such as verbal (including listening) and written. This section looks at different points of communication involved within the person's care.

### Did poor written or verbal communication worsen the situation? For example:

1. Poor communication between staff within the care service
2. Poor communication between the prescriber and the care service
3. Poor communication between the hospital and care service
4. Handover problems within the care service
5. Unclear communication/notes in the care record
6. Other

## 1. Poor communication between staff within the care service

[Effective communication between staff members](#) within the care service is vital to ensure medicines are managed safely.

- What is the method for communicating between the team?
- Do you rely on direct communication between the staff members or share in a [‘Huddle’](#)?
- Do you use written methods such as formal paper handover reports, electronic handovers in electronic care planning systems, email, etc?
- Does communication differ for bank or agency staff? Do they have access to the same communication and recording systems
- Are agency staff ever expected to manage and/or administer medicines? If so, how is information communicated to them?

## 2. Poor communication between prescriber and the care service

The prescriber should support the person (if they have capacity) and staff within the care service to understand the rationale for any changes to their medicines regime.

- Was any clarification required in this instance?
- Were staff able to contact the prescriber or another appropriate healthcare professional?
- Did this contribute to the error?
- Could improved communication with the prescriber have prevented this?

## 3. Poor communication between the hospital and the care service

Any changes to a person’s medicines regime because of a [transfer of care](#) from a hospital should be communicated to the care provider.

- Was a transfer of care implicated in this error?
- Were the changes communicated appropriately?





#### 4. Handover problems within the care service

Do shift handovers in your care service cover changes in a person's medicines?

- If so, was the right information passed over?
- If not, would including this have helped prevent the error?

#### 5. Unclear communication/notes in the care record

Care plans and [MAR charts need to be legible, clear, and detailed](#) enough to give an accurate picture of the person supported.

Relevant events relating to the person supported should be logged within their care record so that they are available for others to read. This is also essential for healthcare professionals such as paramedics, nurses or GP's reviewing the person should they become unwell so appropriate decisions can be made.

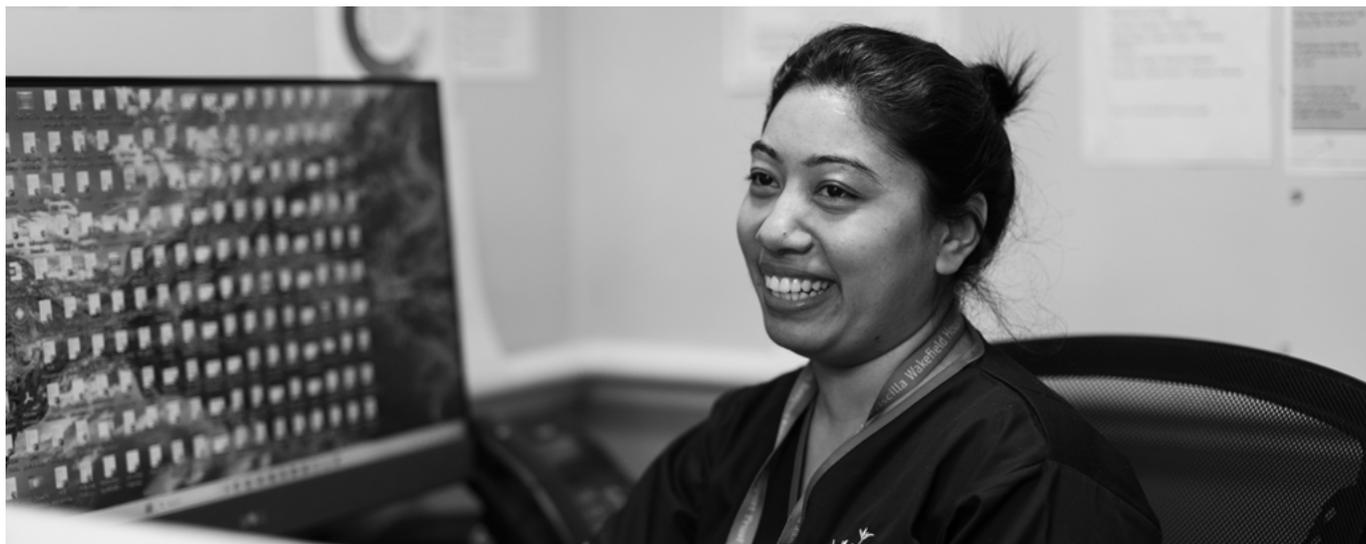
- Have abbreviations been used that may cause confusion?
- Has terminology been used that is inaccurate or out of date?

#### 6. Other

This is for any other factor related to *verbal or written communication* that it is thought to have contributed to the error. Please be clear 'what' it is and 'why' it is thought to have contributed.



## Case studies



# Case study 1 - Administration and record keeping

**As a registered domiciliary care manager you are growing increasingly concerned about one of your staff members, Mark.**

Mark is a new member of staff who has recently completed his medicines management training, completed the mentorship period and has been deemed competent to administer medicines.

It has been brought to your attention that Mark may not be managing or administering medicines as expected.

You have had a complaint from a family member that their relative has been receiving his medicines late.

Concerns have been raised by a staff member that when Mark has administered medicines there does not appear to be any oral syringes used even though people supported are prescribed small quantities of oral liquids.

Mark has also been observed to complete the medicines administration record (MAR) charts before administering the medicine, rather than after the medicines had been taken.

After seeking advice from a health care professional regarding late medicines, completing a stock check, and reviewing the MAR's, you sit down with Mark and the team leader and use the framework to explore the concerns that have been raised.

See the completed form for [Case study 1](#)

## After using the framework they concluded

- The eLearning package did not cover all elements in sufficient detail. The package in its current format is not fit for purpose and needs to be supplemented with additional training.
- Although Mark had completed the eLearning and received the required certificate, the training did not cover everything required.
- The competency assessment tool did not cover all administration techniques, so the gap in Mark's skills had not been identified.
- As Mark had carried out more home visits, he said he felt more confident, and thought that by cutting corners, such as signing the MAR before administration it would save time.
- Mark is under pressure at home which is impacting on his work.
- Although no harm had been identified and all the paperwork was accurate on the audits there was potential for harm, so this was treated as a near-miss. An action plan was completed between the registered manager, Mark and his team leader to prevent future errors.

By involving Mark in the investigation he felt safe opening up as to why he had taken shortcuts and about his pressures at home. Alternative rota plans and welfare checks should support Mark during this difficult time.

Re-reading the medicines policy and procedures with his team leader nearby Mark can ask the clarifying questions and have the answers from his team leader who understands how to apply them in the care setting.

By reminding staff about the support options available and highlighting the need to call the office if running late, staff and people using the service will be better supported.

As there is at least one 'gap' in the training resources, head office decide to use the 'Checklist for Medicines Management Training in Adult Social Care' from the [Skills for Care's medicines management resources](#) webpage to see if there are any other 'gaps'. They also reached out to the local medicines management team to see if they can offer support with oral syringe training.

There was no need to report it to safeguarding or the CQC as there was no harm to the people supported, but it was reported to the commissioning team in their monthly report as part of the local agreement.



## Case study 2 - Gaps on MAR charts

**Donna is performing a medicines round within a care home. She has her red tabard on indicating that she is not to be disturbed.**

She has administered medicines to Gladys and is about to complete the medicines administration record (MAR) when she hears a scream and turns round to find Elsie on the floor holding her hip and screaming in pain.

Donna drops her pen on the medicines trolley, shouts for help and does a quick check on Elsie. She calls for help and a team leader comes to see what the shouting is all about and tells Donna that they are short staffed today and she will have to assist Elsie and call an ambulance.

Donna calls 999 and sits with Elsie to reassure her until the ambulance crew arrive 90 minutes later. After sorting out the documentation and medicines that need to travel with Elsie to hospital and informing Elsie's relatives, Donna resumes the medicines round.

The staff member administering medicines on the next shift notices there was a discrepancy in the number of tablets and a gap on the MAR. After informing a team leader they complete an incident report. A later investigation finds that the medicines were administered in the morning by Donna, but the MAR had not been completed.

Using the framework the registered manager, the day and night team leaders and Donna sat down to discuss the incident and the events around it to try to identify the factors that contributed to the error.

See the completed form for [Case study 2](#)

## After using the framework they concluded

- Staff members were under pressure due to a higher than normal sickness/absence rate.
- Several staff were off duty.
- Attempts by the night team leader to bring in other staff to cover the gaps had been unsuccessful. There was no clear guidance on what to do in these circumstances as the care home had not previously had multiple members of staff on sick leave at the same time. This meant the registered manager had not been informed of the staff shortages so had not arranged suitable cover.
- There had been no shared mental model at handover of what would happen in the case of an emergency.
- The day team leader had been assisting someone with personal care at the time of Elsie's fall to share the workload with her team. She had left the resident to see what the shouting was about but did not feel she could leave her any longer, so told Donna to call the ambulance. This meant that Donna did not complete the medicines round until after the ambulance service left some 90 minutes later. By that time she forgot to record that Gladys' medicines had been administered.

The **root cause** of this was a shortage of staff due to sickness/absence and no clear contingency plan in place for the staff to follow in the policies.

Once the contributory factors had been identified the same group of people then discussed how they thought the event could be prevented and the action plan was agreed so that the learning could be shared.

On this occasion it was decided that the changes to the policy, handover template, and bank staff register could be completed in a short space of time to prevent a recurrence.

The changes were to be conveyed mainly through staff 1-2-1's which also gave the registered manager a chance to check on the welfare of all staff and signpost them to support services if required.

There was no need to report it to safeguarding or the CQC as there was no harm to the person supported, but it was reported to the commissioning team in their monthly report as part of their local agreement.



## Case study 3 - Late/missed dose

**Bill is discharged from hospital after a short stay as an inpatient after a fall. He is brought home by a patient transport service ambulance crew and supported to his bedroom.**

When the care assistant is unpacking his belongings, they come across a discharge letter complete with a medicines list but no medicines. They inform a team leader.

The team leader called the ward that Bill was discharged from and spoke with the ward clerk who checked Bill's notes. The ward clerk explained that all indications are that Bill had his medicines with him on discharge. They also went away and spoke with the nurse who had been looking after him and she remembered handing the bag of medicines to the transporting crew.

The team leader then called the patient relations department at the ambulance service and asked them to check with the crew. They call back after three hours to say they have found the medicines in the ambulance and will drop it off when they have dealt with their current patient.

By the time the crew arrive back with the medicines, Bill had missed a dose and is late for the next one. The ambulance crew apologised and said the bag had fallen under a chair during transit and had not been noticed by the attendant.

After taking medical advice on how to manage the missed dose and late dose from a health care professional, the team leader and the care assistant sit down to look at the contributing factors.

See the completed form for [Case study 3](#)

The incident and its contributing factors were discussed internally but it was not possible to involve the ward clerk, the staff nurse or the ambulance crew in the conversation. Staff had made notes of the conversations that had taken place at the time of the incident.

The **root cause** was inappropriate storage of the medicines on the ambulance which led to the attendant not noticing they had fallen behind a chair.

Although the error was caused by the ambulance service there are steps that could have been taken at the care service to identify the missing medicines and prevent the error occurring.

The care assistant had not thought to ask the ambulance crew for medicines as they normally hand them over with the person's property.

[Checklists](#) are shown to improve processes in many busy environments. They include simple actions that can be 'ticked off' so items are not missed. By designing, implementing and using a checklist to be included in the care plans of people returning from hospital the risk will be reduced.

After speaking to the wards, care staff will know who is returning and when they are expected to be back at the care service. Any diagnosis and ongoing treatment can be discussed as well as any changes to medicines.

Raising a service-to-service concern with the ambulance service and reporting the concerning discharge to the hospital's safety team allows them to be aware of the outcomes of their procedures and allows them to make necessary investigations and improvements.

When the registered manager and deputy manager attend the local care provider forum meeting they can discuss the case in a safe environment and share how the changes have benefited the care service and people they support.

There was no need to report it to safeguarding or the CQC as there was no harm to the person supported, but it was reported to the commissioning team in their monthly report as part of the local agreement.



## Case study 4 - Out of stock medicines

**You're working with a pharmacy technician from the local medicines team to complete a joint medicines audit.**

During the audit, the pharmacy technician asks you to run a report from your electronic medicines administration recording system (eMAR). They ask to see the time stamps for time critical medicines, a list of medicines that are currently out of stock, and a list of medicines that are being regularly declined.

You're not sure how to run these reports. You check with the service manager and a few other colleagues, but they're also unsure how to do it. After calling the eMAR helpline and looking over the eMAR user manual you manage run the reports. Unfortunately, these specific checks have not been part of your internal monthly audits.

The reports show that people have been receiving their time critical medicines within the prescribed times, there are no current concerns over regular refusal, but four PRN laxative medicines are out of stock for four different people.

The pharmacy is contacted about the out-of-stock medicines. They inform you these medicines were not ordered with the monthly medicines. An urgent order for the missing medicines is placed and the medicines arrive later that day.

The senior staff member (who ordered the monthly medicines) says there were plenty in stock at the time and the medicines were in date and safe to carry forward. eMAR shows infrequent administration in the last 28 days.

The PRN protocols and daily notes indicate people did not require their PRN laxatives while they were unavailable.

The medicines returns log shows these medicines were returned to the pharmacy at the start of the last monthly cycle. The reason for return is 'last month's stock'. You ask Agnes (the staff member who returned the stock) to be involved with the investigation.

### **After discussing the situation with Agnes, a senior carer who completes the internal audits, and using the framework they concluded:**

- Agnes had wanted to get all the monthly medicines booked in before she took her lunch break.
- Agnes started to rush as the task took longer than expected, and she was getting hungry as it was past her lunch break.
- Agnes chose to return the stock as this seemed quicker than carrying it forward. She hadn't realised this had resulted in medicines becoming unavailable/out of stock.
- The out-of-stock issues were not picked up as the medicines hadn't been required during that time AND because senior staff/management were unfamiliar with all the eMAR software features e.g. how/when to run reports.
- As the PRN medicines were not required while they were out-of-stock, this was treated as a near-miss as no harm had been identified. An action plan was completed to prevent future errors.

By involving Agnes in the investigation, she felt safe discussing the problem with getting breaks on time and why she took short-cuts.

See the completed form for [Case study 4](#)

Reminding staff about the importance of taking their breaks at the agreed times and to inform management if this is not taking place will allow the management team to support the staff team better.

Giving relevant staff time to read and understand the 'booking in medicines' section of policy/procedures will refresh their knowledge.

By reviewing and updating the internal medicines audit tool and upskilling staff on the use of the eMAR reports and analytic features, we will be able to identify issues and rectify them in a timely manner. There will also be greater managerial oversight of how medicines are being managed and improved medicines safety within the service.

There was no need to report it to safeguarding or the CQC as there was no harm to the people supported, but it was reported to the commissioning team in their monthly report as part of the local agreement.



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This tool was initially adapted for social care by Kim Toon, a clinical leadership fellow in the North School of Pharmacy and Medicines Optimisation in 2019/2020.

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