Kingston upon Thames Safeguarding Adults Board

Safeguarding Adults Review Report

For Minnie

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1. Executive Summary

Minnie was an active, healthy and fully capacitated 89-year-old woman who enjoyed regular contact with her family, socialising with friends and being a very active member of her local choir. She moved into a residential care home in September 2020 when, after consultation with her family, she made the decision that living independently at home without support was becoming increasingly difficult.

Minnie's overall physical and mental health was good, although she was taking some prescribed medications to enable her to keep physically well due to being diagnosed with Atrial Fibrillation and at high risk of having a stroke.

One of these prescribed medications was Edoxaban, which is an anticoagulant used to reduce the risk of stroke, heart attack and deep vein thrombosis.

Minnie was prescribed this medication to reduce the risk of having a stroke and she had been managing her own medication for the past 12 years up until she moved into the residential home. On moving into the home Minnie handed over responsibility for all management of her medication to the care team and managers.

Up until the morning of the 4th November 2021 there are no reported incidences of Minnie suffering any major untoward health issues or signs of having a stroke.

Starting on the 1st November 2021 Minnie did not receive her anticoagulant medication Edoxaban up until the evening of the 3rd November 2021.

Due to a series of errors and missed opportunities Minnie's monthly medication repeat supply did not arrive at the residential home in time for her to continue with her prescribed routine for taking the medication. This resulted in her being without the medication for around 76 hours.

On the morning of the 4th of November 2021, when care staff went into Minnie's room to see her, they noticed that she was not presenting as her usual self and was having difficulty in communicating, she had also become incontinent of urine which had never happened before.

Due to Minnie's overall presentation, care staff became concerned and after consulting with nursing colleagues they called for an ambulance and took Minnie's vital signs.

Minnie was taken by ambulance mid-morning on the 4th November to a local acute hospital trust where diagnostic testing indicated that she had suffered a stroke.

The stroke had life changing effects for Minnie and as a result she was no longer able to walk independently, her speech and communication were negatively impacted, and her mood and life spirit became withdrawn and depressed.

This Safeguarding Adult Review (SAR) looks at the events that led up to Minnie missing her medication for 76 hours and addresses where there were mistakes and missed opportunities.

This SAR looks at the immediate action that was taken by all involved services following the incident and reduce the risk of a similar incident happening again in future.

This SAR makes 4 Recommendations for further action by the Kingston Safeguarding Adults Board, Kingston Care Governance Board and Care and Nursing Homes to ensure that lessons are learned.

2. Acknowledgements

The author would like to offer condolences to the family of Minnie and to thank them for raising their concerns regarding the care of their mother which has led to the undertaking of this safeguarding adult review.

The author would also like to thank the family for their time, effort, and dedication in supporting this review and for their openness and engagement at a difficult time.

The author would also like to thank the current manager of residential home, practice manager at the GP surgery and Integrated Care Board Pharmacy team for their candidness and support with this SAR.

3. Introduction

Circumstances leading to the Review.

This SAR is about Minnie an 89-year-old woman who was a self-funding resident at a residential home in the London borough of Kingston upon Thames.

Minnie had full mental capacity and was a well, happy, and active person who was very much loved by her family and had strong family connections.

Minnie was very engaged in social activities and was an active member of the local choir and took delight in singing.

Minnie was ambulant and was able to mobilise using support from a Zimmer frame.
She was able to maintain all activities of daily living with minimal assistance.
She was very involved with her family who were in regular contact with her and visited her often.

Minnie moved into the residential home in September 2020. Prior to moving into the home, she had lived in her own home but was finding managing living alone becoming increasingly difficult and a decision was made with her to move into a residential home where she could receive 24-hour care and support.

Prior to moving into the home Minnie had had full responsibility for her own medication. When she moved into the home, she handed over this responsibility to the care team.

For 12 years Minnie had been prescribed anti-coagulation medication (Edoxaban) on a daily regime to reduce the risk of her having a Cerebral Vascular Accident (CVA/Stroke)

Through a series of events and missed opportunities Minnie did not receive her medication from the 1st November 2021 to the 3rd November 2021 (approximately 76 hours) and despite receiving the medication on the evening of the 3rd day she sadly suffered a stroke on the morning of the 4th day.

The stroke led Minnie to have several negative life changing impacts on her which included left sided weakness of her body and right sided weakness of her face. This affected Minnie's continence and mobility, reducing her ability to get around independently and impacting on her speech and her ability to sing. This meant that she was not able to join in with the choir which was something that she greatly valued and something that brought her happiness.

All of these disabling events led Minnie to become more dependent on others for her care, to be less physically active and limited her ability to socialise and do the things she used to enjoy. Not only did this impact on her physically but this also affected her mental state causing her to become saddened and depressed.

Sadly, after suffering the stroke Minnie had a decline in her health and six weeks post stroke, due to cardiac failure, compounded by other health issues Minnie passed away.

4. Statutory Duty to Undertake a SAR

Safeguarding Adults Reviews are a statutory requirement for Safeguarding Adults Boards in the UK.

The care act 2014, section 44 (1), (2) and (3) requires that a safeguarding adults review is undertaken where and adults with care and support needs has died or suffered serious harm and it is suspected or known that the cause was neglect or abuse, which includes self-neglect, and there is concern that agencies could have worked better to protect the adult from harm.

The purpose of the SAR is to identify what is hindering safeguarding work to tackle barriers to good practice and protect adults from harm.

Safeguarding Adults Reviews are normally undertaken when multiple agencies have been involved in a person's care and where learning from incidents can be shared.

The purpose of a SAR is to understand what happened, what didn't go well and to look at actions and changes in process and procedures that would ensure should a similar situation arise the same thing would not happen to another person.

"SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council". (Care and support guidance UK Gov 4.168)

5. Purpose, Aims and Objectives of the SAR

The aims and objectives of this SAR are to

- Address concerns from Minnie's family and provide a more detailed analysis of the events that led up to her missing her medication for approximately 76 hours.

- To provide points of learning and recommend clear actions to be addressed and developed by Kingston Safeguarding Adults Board and partner agencies to prevent this type of incident reoccurring.

6. Methodology

Due to the nature of the incident and the short timescale over which it occurred the reviewer chose to use a systems analysis model.

A systems analysis model is investigator led and is designed to look at what happened and why and reflects on gaps in the system to identify areas for change.

The model works with families and involves services by gathering information from interviews and uses integrated chronologies.

In this model there is no requirement for single agency management reports.

This model is based on the "National Patient Safety Agencies Root Cause Analysis Process". See appendix 1.

6.1 Information gathering to support the review.

For the reviewer to get a clear understanding of the events that led up to Minnie missing her Edoxaban medication for 76 hours they had access to local authority safeguarding records, a root cause analysis report compiled at the time of the incident by previous manager and staff at the residential home and information regarding the incident and timeline information from the GP surgery.

The reviewer also had an online meeting via Microsoft Teams with Minnie's son to discuss what happened to Minnie from the family's point of view.

Minnie's son gave information regarding the incident and his thoughts and feelings regarding the safeguarding process and final safeguarding report.

The reviewer had telephone calls with the current practice manager for the GP surgery who wasn't working at the surgery at the time of the incident, but they were able to provide a timeline and discuss policies and procedures regarding medication prescription requests from the home.

The reviewer had several telephone calls with the current manager of the residential home who was very open and candid and provided a detailed timeline and root cause analysis from the time of the incident.

The Pharmacy branch that was supplying the medications to the residential home at the time of the incident is no longer in existence and therefore no information was available from them.

The timeline and root cause analysis provided by the residential home does contain information which was recorded at the time regarding the Pharmacy involvement in the incident and action taken following the incident.

The reviewer would like to note that the residential home has used a new Pharmacy since 20/2/2023 to supply all the residents' medications.

However, the reviewer was able to engage with senior pharmacists from the medications management team from the Integrated Care Board for Southwest London who were able to provide current policies and guidance that community pharmacies follow in the event of medications being out of stock.

6.2 Organisations that contributed to this review.

- Residential Home
- GP Surgery
- SW London Integrated Care Board Kingston and Richmond Pharmacy Team

6.3 Key Themes

The key themes that were picked out for this SAR are:

- Clarity of medication policies and protocols
- Action in the event of missing medication

7. Chronology of events

The reviewer has read and analysed all reports, timelines, and root cause analysis that were undertaken following Minnie missing her Edoxaban medication for 76 hours.

From the reviewers understanding there were a series of events, which can be described as system failures and human error, that if they had occurred as a single event may not have led to medication being missed. However collectively they led to medication not only being missed but also once the discovery regarding missed delivery had been realised there was further delay in obtaining the medication.

a. Ordering repeat medication, Minnie prescription missed from the order list.

Considering the timelines and safeguarding adult investigation report, the first issue appears to be around the ordering of the repeat medication.

At the time a new online system was recently introduced which has been confirmed by the current manager of the residential home. She reported that residential home was the last of this group of homes owned by this particular company in the area to have this system set up. On reviewing the notes, it seems that there were some technical issues with the system leading to Minnie's repeat prescription not being requested. The reviewer cannot find explicit information in regard to what the technical issues were.

Notes taken from adult safeguarding investigation report date 19/11/21 on interview between investigating officer and staff at the residential home.

"Care Home Manager explained that they have a new system in place and said, unfortunately, Minnie got missed off that repeat prescription"

"Deputy manager explained that Minnie's medication was ordered via Proxy, a new online system for ordering medication. She said the medication was missed due to a technical error. Unfortunately, they were not able to know until all medications were delivered and said it could have been that the system was overloaded and there was a glitch in the system and said no human error was involved."

b. Delay in residential home receiving ordered medication.

From accounts it appears that the residential home ordered the medication in a timely manner however looking through the timeline there were delays in the home receiving the delivery of medication from the Pharmacy. This then impacted on the time taken to undertake checking that all medication had been received.

Notes taken from residential home Root Cause Analysis and timeline dated 10/11/21.

13/10/21 there are reports that the staff from the residential home emailed the GP surgery to confirm ordering of prescriptions which was not responded too.

19/10/21 Care home staff made a call made to the Pharmacy for an update but were told prescriptions were still being processed from the GP surgery so confirmation of receipt of prescriptions unable to be confirmed.

25/10/21 Residential home staff called the Pharmacy again to check all requested prescriptions had been received they were informed that Pharmacy still working through prescription order no update given.

28/10/21 The residential home was visited by the regional director and concerns raised with them by the home staff about the Pharmacy and late deliveries and Pharmacy not following original agreement for medication delivery.

29/10/21 Medications received at Care home. They should have been delivered by the 27/10/21. Noted that this impacted on checking medication which was delayed until the 30/10/21 and 31/10/21.

Notes taken from adult safeguarding investigation report dated 19/11/21 on interview between investigating officer and staff at the residential home.

"Regarding the procedure for ordering medication, the deputy manager explained that they usually send a request to the nominated GP Surgery via Proxy. When the Surgery receives the request, it is then sent to the doctors to sign. The prescriptions are then sent to the Pharmacy electronically via Electronic Prescription System (EPS) when they have been signed. The Pharmacy then aim to deliver medication to the care home 3 days before the start of the new cycle to allow time for checking and raising concerns, if any."

Notes taken from Residential home Root Cause Analysis and timeline dated 10/11/21

"On the 12th and 13th October 2021, the Home requested their usual monthly medications for the month of November 2021".

"On the 13th of October the home emailed X at the GP Surgery confirming that all prescriptions had been ordered for all their residents. The email was not acknowledged by X at GP surgery."

"On the 19th October the Pharmacy was contacted to find out if all prescriptions had been received but the home was unable to gain this information as the pharmacy stated that they were still processing the orders from the GP Surgery."

"On the 25th October the Pharmacy was contacted again, they spoke to someone called X regarding any missing prescriptions that were sent by the GP Surgery – They were advised that they were still working through the prescriptions received."

"On the 28th October the home was visited by the Regional Director. The home stated that they had concerns about the Pharmacy. This included late delivery and Pharmacy not following the original agreement of the delivery of medication and had also discussed data transfer issues onto the eMAR system."

"On the 29th October the requested medications were received by the home. The medication should have been received on Wednesday 27th October so the home could check that all ordered medication was received."

"On the 30th and 31st October the medication received was being checked in and concerns were raised to the Duty Manager (DM) due to other missing medications."

c. Delay in checking received medication.

From notes and timelines, it is reported that due to the late arrival of the medication order the actual checking in of the order was delayed. The medication order appears to have been received on Friday 29th October 2021. It is not clear why the medication could not be checked as soon as it was delivered and why it took three days to check?

Added to this, the checking in of received medication was undertaken by 2 separate people each appearing to be responsible for 50% of checking in the medication, not checking the medication as a whole together.

Notes taken from adult safeguarding investigation report dated 19/11/21 on interview between investigating officer and staff at the residential home.

"Deputy manager informed me (safeguarding investigating officer) that the medication was checked over the weekend and had to raise the issue with the GP on a Monday because the Surgery was closed over the weekend."

Notes taken from residential home Root Cause analysis report 10/11/21.

"The home reports that two Team Leaders had ordered this medication for this month but ordered half of the unit's residents' each rather than one Team Leader ordering

and the other Team Leader checking that it has been done [in summary, one person should take responsibility for the ordering of the medication]. At present, the Team Leader informs the OM that the orders have been completed. It appears that this is done on trust rather than having evidence to state that the task has been completed."

d. Delay in Prescription being signed for at the GP Surgery

When the missing medication was finally realised action was taken by staff at the home to obtain another prescription from the GP.

Issues arose here when there was missed communication and follow up and delay in getting a new prescription signed and sent to the Pharmacy.

It appears that the prescription was left in the in tray for a GP to sign whose clinic day was not until the following day adding yet another delay in obtaining Minnie's Edoxaban

Notes taken from the residential home Root Cause Analysis Report 10/11/21.

"On the 1/11/21 it was reported to the DM that Minnie had not received her monthly medication.
A list of missing medication for a number of residents was sent to the Pharmacy via email by the DM in the morning as she was unable to get in touch with the Pharmacy as they were not answering the phone. The DM finally managed to speak to the pharmacist in the late afternoon, who informed her that no prescriptions had been received from the GP Surgery for Minnie. GP surgery was called by the Senior Team Leader on the 01/11/2021 but unfortunately there was no answer (not documented on Caresys).
On the 2/11/21 the Senior Team Leader contacted GP surgery receptionist by telephone and was reassured by the receptionist that the prescription would be sent to pharmacy as soon as possible. The GP Surgery receptionist left this for the doctor to sign but this doctor was not on duty until the following day. Dr X works Tuesday and Thursdays."

e. Medication being out of stock at the Pharmacy.

When the prescription was finally signed and sent to the Pharmacy it was discovered that the Pharmacy didn't have the required medication in stock.

It was at this point that the staff at the residential home took the decision to give Minnie the exact same medication from another resident's supply as that resident was currently in hospital.

Notes taken from residential home Root Cause analysis report 10/11/21.

"The DM then made several phone calls to the Pharmacy and GP Surgery to ascertain where the prescription was. The DM was advised that pharmacy had received the prescription request on the 3rd November. pharmacy advised the DM that the medication would be with them that day. Reassured that the prescription was enroute the Quality Delivery Manager left the home at around 1600hrs.
The home still had not received the medication at 1640hrs on the 3rd November, so the DM then contacted pharmacy to find out where the medication was and she was

informed by the locum Pharmacist on duty that they did not have Edoxaban in stock and this was at 1644hrs. pharmacy advised the DM that they were ordering the Edoxaban and it would be with the home on the 4th November. The home actually received the Edoxaban on the late afternoon of the 5th November.
Once the DM was aware that they were not going to receive the Edoxaban the decision was made to give 323294 the Edoxaban from another resident's stock – this was given in the teatime medication round on the 3rd November (the other resident was in hospital).
The Edoxaban was also given the following morning of the 4th November. Shortly afterwards 323294 the incident occurred – Please see Serious incident details below."

8. Summary and Conclusion

Considering all reports available, the root cause analysis documents, timelines, and discussions with Minnie's son the reviewer has identified 5 key points that impacted on the supply and delivery of Edoxaban for Minnie that left her without vital medication for approximately 76 hours.

The first point is the trigger where Minnie's medication appears not to have been ordered on the newly installed electronic system. It is not absolutely clear, as far as the reviewer can see, why this error occurred. This is the most fundamental error as without that first error occurring the following issues may not have occurred.

The 4 other points highlighted exacerbated the delay in obtaining the medication and highlighted weak points in the system which could lead to the same event re occurring.

- **Ordering repeat medication, Minnie prescription missed from the order list.**
- **Delay in Care home receiving ordered medication.**
- **Delay in checking received medication.**
- **Delay in Prescription being signed for at the GP Surgery**
- **Medication being out of stock at the Pharmacy.**

Looking through the timelines and focusing on each of the key points where problems arose in supplying the medication, the main thing that stands out for the reviewer is that there were delays at each stage.

The reviewer notes that it appears there wasn't any checking done on the ordering system itself to see if all the medication requests had been ordered and gone through on the system.

The reliance seems to be on waiting for feedback from the Pharmacy and this feedback was again delayed.

The initial contact to the GP surgery was made on the 13th of October to find out if prescriptions had been received, but no response was received from the initial email.

On the 19th of October the home contacted the Pharmacy regarding the medication order receipt. Care home records state that no contact was made by the pharmacy in response. They repeated this again on the 25th of October and were informed by the Pharmacy that the medication requests were still being checked through.

The medication order was eventually received on the 29th of October (Friday) but final checks not completed until 31st October (Sunday).

In total there are 18 days between the initial order going out via the electronic system and the discovery that Minnie's medication was missing.

Although the staff at the residential home made attempts to get through to the surgery and Pharmacy for updates to see if the prescription had been signed for and received, there seems to be no overall sense of urgency to obtain the missing and vital medication up until one of the Quality Delivery Managers (QDM) visited the service on the 3rd of November. The Quality Delivery Manager is noted to request that a safeguarding concern be raised with the local authority and efforts to obtain medication be made that day.

Further to this, as was later discovered in the day, the medication would still not be available then the decision was made to use the medication of another resident who was in hospital at the time and was having the same dosage.

Notes taken from residential home Root Cause analysis report 10/11/21.
"On the 3rd October (**N.B.** this appears to be an error regarding date in the notes) the home was visited by the regions QDM. During the visit the QDM noticed that medication was not given to 323294 for three consecutive days. The QDM then advised the DM that this was a safeguarding concern and advised the home to get the prescription that day and to submit a safeguarding concern. The QDM advised the DM that she should make contact with the next of kin to advise him of the situation, which was done. The DM then made several phone calls to the Pharmacy and the GP Surgery to ascertain where the prescription was."

The reviewer concludes that the two main contributory factors to Minnie not receiving her Edoxaban anticoagulant medication for almost 76 hours were

Firstly, that her medication order for a repeat prescription was missed from the original order.

Secondly; there was avoidable delay in discovering the missing medication and avoidable delay in obtaining the medication once the discovery of the missing order came to light.

9. Learning and Action

Taking account of the root cause analysis undertaken on 10/11/21 the reviewer can see that actions were taken by the management team at the residential home, the practice manager at the GP surgery and staff from the Pharmacy to meet and go through the findings of the root cause analysis and implement required actions by each service.

The following actions are recorded.

Residential Home

- To ensure the checking process has been followed ensuring all medications have been

ordered using the proxy service.
- Bypass number for GP surgery to use in emergency.
- Staff to escalate concerns to senior management and to senior management at the Pharmacy.
- To have one team leader to check meds instead of having 2 doing 50/50
- Staff to have a refresher training session on the medication policy.
- Care home to give copy of Medication Administration Record (MAR) chart to driver on 8th day of meds cycle and this MUST be received by the pharmacist prior to dispensing the medication.
- Should the care home find that medication is for any reason unobtainable they should contact 111 for an emergency one off prescription
- Request the Pharmacy to put the medication back on the spine (NHS records system) for release.
- Request the GP surgery to issue a paper prescription.

The GP Surgery
- The surgery will notify the care home to let them know what prescriptions have been processed and of any that haven't been processed as can be seen on the proxy system for ordering.
- When changing the nominated Pharmacy, the surgery will change it back to the usual Pharmacy
- All tokens for all medications ordered will be delivered to the care home by the Dr who runs and is responsible for clinics at the care home.
- The surgery has supplied the care home with a bypass number so in case of an emergency such as the one in question the care home can bypass reception and speak to someone senior who can instigate required actions

The Pharmacy
- Care home to give copy of MAR chart to driver on 8th day of meds cycle and this MUST be received by the pharmacist prior to dispensing the medication.
- Pharmacy to send copies of tokens to care home on day 11/12 and if the home does not receive these they must contact Pharmacy immediately
- Pharmacy to double check prescriptions when they arrive from the home to see if meds are in stock and if not notify the home immediately.

Residential home and GP surgery current practice and procedure regarding medication policy and procedures (please see appendix 1 for current policies)

As stated earlier the Pharmacy branch that was being used by the residential home at the time of the incident is no longer in existence.

The reviewer has been informed by the current manager of the residential home that an online Pharmacy (Remedy Plus) is now used to supply all medication for the homes residents and the same Pharmacy is used by the rest of the wider organisation to supply medications.

This Pharmacy delivers medication within 24hours and uses the Electronic Medication Administration Record (EMAR) system. This Pharmacy company deal solely with care homes and are not a high street Pharmacy.

Following an interview with the current manager of care home they informed the reviewer that significant change had taken place in relation to policies and procedures around the management and oversight of medication in the home.

There is in post a “Quality Development Manager” who is a registered nurse and provides support to local care and nursing homes with regards to clinical matters. This person oversees medication and does spot checks on the care home’s medication stock and administration and ordering. Their role also entails supporting staff with medication training which includes use of the EMAR system.

The home uses the EMAR system which supports the monitoring of medication stock and supply and has replaced MAR charts. This system notifies if there is low stock medication.

The system records when medication was given, by whom with signatures. It shows the supply of medication from the Pharmacy and shows that the received medication has been checked in.

The checking in requires 2 people to do this and for both to sign, there is no possibility that just one person can sign as this is dependent on electronic security measures and personal log in details.

The system records if medication has been missed by a resident and for what reason for example if the person refused the medication or if they are unable to swallow it.

The external directors and company managers also have access to this recording system as well as the Quality Development Manager so there is a high level of medication monitoring.

The reviewer has also viewed current medication policies that are being followed by the residential home (See appendix 1). The reviewer was advised by the current home manager that these policies are reviewed and updated yearly (or sooner) if there are any changes. They have been reviewed and updated on the following dates.

- December 2022 following Quality Assessment visit.
- February 2023 following transition from previous pharmacy to Boots Pharmacy.
- June 2023 following transition from Boots to Ramadi plus Pharmacy.

Further to the information above a very simple action was taken by the care home which was to design a poster that informs what staff should do in the event of any medication being missed or difficulties in obtaining medications.

Ordering prescriptions from the GP

The care home uses the GP Proxy access system to support requests for prescriptions which is an electronic prescription script.

For monthly medications the GP surgery sends a spreadsheet to the care home for cross checking regarding what prescriptions have been issued and which are no longer required.

For one time only or specific treatment medications such as painkillers or antibiotics the home have a special arrangement with the GP surgery that they can get the prescription quickly from the local Asda Pharmacy.

Information provided by ICB Pharmacy team regarding medications out of stock at pharmacies.

The reviewer met and discussed this SAR with a senior pharmacist from the ICB medications management team regarding actions that should be taken if it is found that a Pharmacy does not have medications in stock.

They were informed that in the event of Pharmacy being out of stock.

Under the 'Human Medicines Regulations 2012' an 'emergency supply' can be made to patient, if they have requested it from the pharmacist. Section 225 (2) of the regulation states that:

- the pharmacist must interview the patient
- there is an immediate need for the prescription
- the medicine has been prescribed before for that patient.

For a prescription only medicine that is not a Controlled Drug, a pharmacist can supply up to 30 day's treatment.

Please note that this is not an NHS Service but a private service therefore the pharmacist can charge the patient, or in this instance charge the care home for a supply.

10. Recommendations

10.1. That the care governance board ensures all care home and nursing home medication policies and procedures clearly state what needs to be done in the event of resident medication being missed or being out of stock at the Pharmacy.

10.2. That the findings of this SAR are presented to care home forum and other learning events where care home managers will be present

10.2. For the findings from this SAR to be shared widely across the SW London ICB/ICS

10.4. The reviewer acknowledges that there have been significant delays in undertaking and commencing this SAR. Therefore, the recommendation is that the KSAB should consider and review the governance arrangements surrounding all future SAR's.

11. References

Quick Guide-Effective-record-keeping-ordering-Medicines-1.pdf (nice.org.uk)

https://www.legislation.gov.uk/uksi/2012/1916/regulation/225/made

https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

Appendix 1

CUK Meds Policy (002).pdf

CareUK Local medication process.dc

root-cause-analysis.pdf

BZ and meds local process.pdf