



Prifysgol Cymru
Y Drindod Dewi Sant
University of Wales
Trinity Saint David

Course: BSc (Hons) Health and Social Care

Module: Independent Project (BMHP6020_LON)

Component 1: Element 1 - Project Proposal

**Exploring the Causes and Impact of Medication Errors in Health and Social
Care Settings**

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My project title: Exploring the Causes and Impact of Medication Errors in Health and Social Care Settings

1) Aim:

The aim of this project is to investigate the causes of medication errors in health and social care settings and to explore their impact on service users, staff, and care organisations.

2) Objectives:

- To identify the main causes of medication errors in health and social care settings.
- To explore how medication errors affect service users' health, safety, wellbeing and trust.
- To examine the impact on professionals, including stress, accountability and responsibility.
- Recommend improving communication, training, staffing, and documentation to reduce medication errors.

3) Background/Rationale: Understanding the Causes and Impact of Medication Errors in Health and Social Care

Medication errors are a serious issue in health and social care because they can directly affect service users' safety, health and wellbeing (CQC, 2026). In this topic, the problem is not only that the wrong medicine may be given, but also that errors can happen when staff communicate poorly, are not properly trained, work under pressure due to low staffing, or fail to complete accurate documentation (NICE, 2017; CQC, 2022). For example, unclear handovers can lead to a missed dose, poor training can cause confusion about dosage, staff shortages can increase rushing, and incomplete records can result in medication being given twice. These errors can cause avoidable harm, reduce trust in care services, and create stress for staff who may feel responsible for the mistake (NHS England, 2022; WHO, 2024).

4) Methods:

- This project will use secondary research method to explore the causes and impact of medication errors.

- Reliable sources will include NHS guidance, CQC publications, government reports, books, journals and patient safety resources.
- Sources from 2017 to 2026 will ensure the information is current.
- Key words include communication, training, staffing, documentation and organisational weaknesses.

Inclusion Criteria:

- Sources published between 2017–2026.
- Academic books, journals, and research articles.
- NHS, CQC, WHO, and UK Government sources.
- Sources about medication errors in health and social care.
- Sources covering communication, training, staffing, documentation, and organisational causes.
- English-language sources.

Exclusion criteria:

- Sources published before 2017.
- Blogs, opinion pieces, and unreliable websites.
- Sources not related to medication errors.
- Sources focused only on pharmaceutical manufacturing.
- Duplicate or weak-evidence sources.
- Non-English sources.

5) Resources:

- NHS, CQC, WHO and government sources will be used to understand medication safety.
- Academic journals, books and e-books from 2017 to 2026 will provide reliable evidence.
- ProQuest Central, Google Scholar and college or online library databases will help find relevant academic sources.
- A laptop, internet access, Word/Google Docs and Harvard guidance will support writing and referencing.

6) Timescale:

Type of work	22.07.2026	24.08.2026	18.09.26	21.10.26	25.11.26
Chapter 1: Introduction					
Chapter 2: Background					
Chapter 3: Methods					
Chapter 4: Results and decisions					
Chapter 5: Recommendations and conclusion- proofreading					

7) Self-reflection as researcher (any strengths or challenges):

Strengths as a researcher	Challenges as a researcher
I am interested in patient safety and medication errors, which will help me stay focused and motivated during the project.	It may be challenging to find enough recent and reliable sources directly linked to medication errors in both health and social care settings.
I can use reliable secondary sources such as NHS guidance, CQC publications, WHO reports, academic journals and government sources.	Some sources may focus more on hospitals or pharmacies, so I will need to choose only the most relevant evidence for health and social care.
I understand the importance of accurate communication, training, staffing and documentation when researching medication safety.	Medication errors can be a serious and sensitive topic, so I must write in a professional, balanced and non-blaming way.
This project will help me develop my research, critical thinking, academic writing and Harvard referencing skills.	I will need to manage my time carefully to complete each chapter according to the project timescale.

References:

Care Quality Commission (CQC) (2022) *Reporting medicine related incidents*. Available at: <https://www.cqc.org.uk/guidance-providers/adult-social-care/reporting-medicine-related-incidents> (Accessed: 15 June 2026).

Care Quality Commission (CQC) (2026) *Issue 9: Medicines management – assessment*. Available at: <https://www.cqc.org.uk/guidance-regulation/adult-social-care/learning-safety-incidents/issue-9-medicines-management> (Accessed: 15 June 2026).

NHS England (2022) *The National Patient Safety Improvement Programmes: Medicines Safety Improvement Programme*. Available at: <https://www.england.nhs.uk/patient-safety/patient-safety-improvement-programmes/> (Accessed: 15 June 2026).

NICE (2017) *Managing medicines for adults receiving social care in the community*. Available at: <https://www.nice.org.uk/guidance/ng67> (Accessed: 5 July 2026).

World Health Organization (WHO) (2024) *Medication without harm: Policy brief*. Available at: <https://www.who.int/publications/i/item/9789240062764> (Accessed: 15 June 2026).