Access Community Health Limited

Support Worker, Mrs D

A Report by the

Deputy Health and Disability Commissioner

Case 17HDC01168

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. Mrs C, then aged 87 years, lived in her own retirement village apartment. Access Community Health (Access) was contracted to provide Mrs C with medication assistance, in particular with taking warfarin, a blood-thinning medication that requires regular administration at the same time each day.

2. On 13, 14, 15, 19, and 20 June 2017, a relief support worker, Mrs D, was engaged to provide support to Mrs C, as Mrs C's regular support worker was unwell. Mrs D was not provided with an adequate handover of where to find Mrs C's warfarin, and she did not alert Access's call centre that she did not provide Mrs C with her warfarin. As a result, Mrs C did not receive her warfarin on a number of days over that time period.

3. On 21 June 2017, Mrs C was admitted to hospital with an ischaemic left leg and required surgical intervention. The ischaemia was thought to have been caused by her missed doses of warfarin.

4. On two previous occasions, Mrs C's family had highlighted to Access the issue of non-compliance with its service contract to Mrs C. During the time period above when Mrs C's warfarin was missed, the family also made several complaints — both verbal and written — but did not receive a response from Access.

Findings

5. Access failed to provide Mrs C with the training required to administer warfarin according to its policies, failed to provide clear handover instructions to Mrs D, and failed to improve its services in light of the family's previous concerns with non-compliance of service provision. For these reasons, the Deputy Commissioner found that Access did not provide services to Mrs C with reasonable care and skill, and therefore breached Right 4(1) of the Code.[1]

6. Adverse comment was made regarding Access's complaints management system. It was noted that complaints can be lodged in a number of ways — in person, by telephone, or in writing — and the Deputy Commissioner expects all complaints to be acknowledged and responded to in a speedy and efficient manner.

7. Adverse comment was also made regarding Mrs D's failure to alert Access's call centre when she did not provide Mrs C with her warfarin. The Deputy Commissioner reminded Mrs D of the importance of effective communication in the interest of patient safety when expected duties cannot be fulfilled.

[1] Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) states: "Every consumer has the right to have services provided with reasonable care and skill."

Recommendations

8. It was recommended that Mrs D provide a written apology to the family, to be sent to HDC within one month of the date of this report, for forwarding.

9. It was recommended that Access Community Health:

a) Provide a written apology to the family for its breach of the Code. The apology is to be sent to HDC within one month of the date of this report, for forwarding.

b) Ensure that all support workers and relief support workers who are required to work with medication have completed medication training and have achieved competency, and that current competency is maintained at all times. Access is to provide evidence of this to HDC within six months of the date of this report.

c) Audit the call centre selection of support workers according to the required competency for the selected job, from 1 June 2018 until 31 August 2018, in order to ascertain whether the updated employee database is providing for the appropriate selection of skilled support workers. If the results do not reflect 100% compliance with appropriate selection, Access is to consider further improvements that could be made to ensure compliance, and report back to HDC within three months of the date of this report.

d) Develop and implement a formal handover policy that ensures a systematic approach to handover that contains all essential information to support and enable staff to provide adequate service. Evidence of the implementation of the policy is to be provided to HDC within six months of the date of this report.

Complaint and investigation

10. The Commissioner received a complaint from Mr A about the services provided to his mother, Mrs C, by an Access Community Health support worker, Mrs D. The following issues were identified for investigation:

- *Whether Access Community Health provided Mrs C with an appropriate standard of care in June 2017.*
- *Whether Mrs D provided Mrs C with an appropriate standard of care in June 2017.*

11. This report is the opinion of Rose Wall, and is made in accordance with the power delegated to her by the Commissioner.

12. The parties directly involved in the investigation were:

Mr A	Complainant
Mrs B	Complainant
Mrs C	Consumer

Mrs D	Support worker
RN E	Registered nurse (RN)
Access Community Health	Provider

13. Independent expert advice was obtained from a registered nurse, Julia Russell, and is included as Appendix A.

Information gathered during investigation

14. Mrs C, then aged 87 years, lived in her own retirement village apartment. Access Community Health (Access)[2] was contracted to provide Mrs C with residential support of one hour per day to assist with showering and medication administration.

15. Mrs C was taking the medication warfarin,[3] which requires regular administration at the same time each day. It is noted in her Access Support Plan, dated 13 September 2016, that warfarin cannot be missed. A contingency plan was in place for a family member or private carer to provide assistance if a support worker was not available to ensure that the warfarin was taken.

16. It is written in the Access Support Plan, which is electronically accessible by the call centre staff, that Mrs C's medication is stored in a locked box along with the Support Plan.

17. On 13 June 2017, Mrs C's regular support worker was sick. Therefore, Access relief support worker Mrs D was engaged to provide the service to Mrs C on 13, 14, 15, 19, and 20 June 2017.

18. Mrs D was given a handover for Mrs C via a telephone call. Mrs D was given Mrs C's address and the location of the medication box key, but no instructions were given regarding the location of the medication box, or regarding the administration of warfarin.

19. On 13 June 2017, Mrs D could not find the key to the medication box, so she alerted the call centre, which organised for an Access registered nurse, RN E, to give Mrs C her medication. RN E signed the medication assist form[4] at 2.30pm.

20. On 14 June 2017, Mrs D found the key to the medication box but could not find the medication box. She told HDC that she forgot to telephone the call centre to advise that she had not given the medication.

[2] Access Community Health is a healthcare provider that specialises in home-based health care and support.
[3] An anticoagulant (blood-thinning medication) that should be administered regularly at the same time each day. Dose is according to the international normalised ratio (INR) level, which requires a therapeutic range to provide the benefits of anticoagulation while avoiding haemorrhage. An extra or missed dose can affect the therapeutic range, putting the person at risk of clotting or haemorrhage.
[4] Form to sign to confirm that medication has been given.

21. Mrs D told HDC that on 15 June 2017 she located the medication box high up on a shelf in the second bedroom, and gave Mrs C her medication. However, the medication assist form was not signed.

22. Later on 15 June 2017, Mrs C's daughter, Mrs B, telephoned Access and complained that Mrs C's medication had not been given for two days. Mrs B told HDC that Mrs C's private caregiver visited her on the afternoon of 15 June 2017 and saw that the blister pack still contained the medication for both days. Mrs B instructed the private caregiver to give Mrs C her warfarin on 15 June 2017.

23. Mrs B's telephone call led to an incident report being logged on 22 June 2017. RN E wrote in the investigation incident report on 29 June 2017:

> "Email from contact centre re missed medication on the 13th June. Visited and supervised medication on the 13th around 2pm. Informed family. Another call on the 15th, from family that medicine wasn't given. Called support worker, who couldn't fin[d] the key. Explained precisely where to find it, she would be going back the next day. Changed warning message to reflect where to find the key …"

24. On 16 June 2017, Mrs D administered the medication and signed the medication form at 7.40am.

25. Mrs B contacted Access on 19 June 2017 and complained that Mrs C's medication was not administered on 17 June 2017. She told HDC that Mrs C's private caregiver visited her on 19 June 2017 and saw that the medication for 17 June 2017 was still in the blister pack. Access advised HDC that a different support worker was assigned on 17 June 2017. The support worker stated that she was aware that Mrs D required assistance with medication, and said that she assisted "as required" but did not sign the medication form.

26. On 18 June 2017, the medication was given and the form was signed at 10am.

27. On 19 June 2017, Mrs D administered the medication and signed the medication form at 7.45am.

28. On 20 June 2017, the form was signed by Mrs D at 8am. That morning, Mrs C complained of a sore leg, so Mrs D rang the retirement village to inform the on-site nurse.

29. On 21 June 2017, Mrs C was admitted to hospital. Her international normalised ratio (INR) level[5] was sub-therapeutic, thought to be caused by missed doses of warfarin, which resulted in an ischaemic left leg requiring surgical intervention.

Access Community Health's medication policy

30. At the relevant times, the medication policy in place (version 5.1) provided medication management support for support workers to ensure the safety of clients during the

[5] A test that times the clotting of blood to inform the warfarin dosage.

provision of medication support. The support workers' section of the policy contains a note that states:

> "SWs [support workers] must always have 1:1 JIT [just in time[6]] training by the CRN [community registered nurse] until the individual SW is assessed as competent, and a competency form completed before administration/oversight of ***high risk medications*** eg [w]arfarin, [i]nsulin."

31. Mrs D did not receive any medication training or competency checks after starting work with Access. Access advised HDC:

> "[Mrs D] was a level 3 [s]upport worker, who achieved her qualification in medication management in 2007. Although [Mrs D] underwent updates like handwashing and professional boundaries, Access did not complete JIT training for medication management with her …"

32. The policy also states that in the case of omission of a medication, the support worker must report the omission to the contact centre. Further, the policy states that the client's family must be informed "openly and honestly" and must be informed of "what is being done to prevent reoccurrence".

Access Community Health's warfarin policy

33. The warfarin policy in place at the relevant times states that support workers can oversee clients taking warfarin if they have "completed and achieved the Medication Unit Standard through [a training organisation], and if they have a Level 3 medications competency done by a Registered Nurse".

Further information — Mr A

34. Mr A had addressed the issue of missed medication with Access on two previous occasions. On 27 October 2016, he wrote to Access stating:

> "[T]he key role for Access is to supervise mum taking her medication, which includes [w]arfarin, a blood thinning medication. Without this mum runs a serious risk of having a stroke. Please ensure that if for any reason mum is not going to be visited by an Access carer on any day, that we are notified immediately so we can make arrangements for her medication …"

35. On 29 November 2016, Mr A wrote the following to Access:

> "On Sunday, 27 November, it would appear that again no Care Worker attended my mother. I assume this because my mother has not taken her medication for Sunday when I visited her that night, and also the Care Worker had not signed the ACCESS register form … This is the second time this has happened. When it happened the first

[6] Learning that is available at the point of need.

> time I stressed the importance of notifying us if the Care Worker will not attend, as there is significant risk if my mother does not take her medication."

Further information — Mrs B

36. As noted above, Mrs B verbally complained to Access on 15 and 17 June 2017 when Mrs C did not receive her medication. On 23 June 2017, Mrs B made a further complaint by telephone, and reassurance was provided that Access would return the call. Access did not respond, so Mrs B made a complaint in writing on 26 June 2017. Although this triggered an internal investigation, Access did not advise Mrs B of the steps taken.

Further information — Mrs D

37. Mrs D stated:

> "I was extremely upset and sorry that this has happened, I feel that the method of handover could have been better given the nature of the client's circumstances as I did not intend any harm to [Mrs C] …
>
> I found it disappointing and frustrating that the call centre gave me instructions on where to find keys to enter the room, where to find keys for the medication box, but no specific instructions of the Service Delivery Plan and medication box. A phone number for the nurse so that contact can be direct may help to avoid future incidents … Handovers for high needs clients should be done with a nurse on site to avoid any confusion and not rely on the call centre …"

Further information — Access Community Health

38. Access has offered its sincere apologies to the family.

39. Access advised HDC that it has since conducted further training with its support workers and has updated its employee database, which allows after-hours coordinators to select an appropriately trained relief support worker who has medication oversight training, when required.

40. In addition, Access reviewed and updated its medication policy, which came into effect on 29 May 2018. The updated policy includes the provision of training and competency assessment for support workers who are involved in medication support.

41. With regard to Mrs B's verbal complaints, Access accepts that it did not acknowledge the complaints, and that the complaints management process was implemented only once the written complaint was received.

Responses to provisional opinion

42. Mr A and Mrs B (Mrs C's family) were given an opportunity to comment on the "information gathered" section of the provisional opinion. Mr A had no comment to make. Mrs B reiterated that Mrs C's medication was not given on Thursday 15 or Saturday 17 June 2017. Mrs B also told HDC that the family was not contacted by Access Community Health on 13 June 2017 when Mrs C's medication was administered late.

Mrs D

43. Mrs D was provided with an opportunity to comment on the provisional opinion, as it related to her. Mrs D did not have any comment to make, but will provide Mrs C's family with an apology.

Access Community Health

44. Access Community Health was given an opportunity to comment on the provisional opinion, and confirmed with HDC that it will comply with the recommendations made.

Opinion: Mrs D — adverse comment

45. Mrs C did not receive her warfarin medication on at least two occasions during the week of 13 June to 20 June 2017 when her regular Access support worker was sick.

46. Mrs D was the Access relief support worker who provided cover during that period. On 13 June 2017, Access provided a handover via the call centre, but Mrs D could not find the key for the medication box, so did not administer the warfarin. She informed Access, and provision was made for RN E to visit Mrs C and administer the warfarin. On 14 June 2017, Mrs D found the key but could not find the medication box. She forgot to alert the call centre, and Mrs C did not receive her warfarin that day.

47. There are differing accounts of the events on 15 June 2017.

    a) Mrs D recalls that she gave Mrs C her warfarin but the medication assist form was not signed to confirm that.

    b) Mrs B called Access on 15 June 2017 advising that the warfarin had not been given for the last two days.

48. The latter is supported by the incident investigation report initiated on 22 June 2017, which states that following the call from Mrs B, RN E called Mrs D, who said that she could not find the key. RN E advised Mrs D where to find the key.

49. Given that the medication form was not signed and the private carer saw that the medication for 14 and 15 June was still in the blister pack, and that once Mrs D had been instructed by RN E on 15 June 2017 where to find the key, and thereafter the medication

assist form was signed, this suggests to me that on balance it is most likely that Mrs D's recollection is erroneous and she did not administer warfarin on 15 June 2017.

50. My expert advisor, RN Julia Russell, advised that Mrs D's failure to contact the call centre when she had not given Mrs C her medication on 14 June 2017 amounts to poor care and is unacceptable. I agree with that advice and am also critical of Mrs D for failing to contact the call centre when she did not give Mrs C her medication on 15 June 2017.

51. However, I consider that Mrs D was insufficiently equipped by Access to perform her duties adequately. The difficulty Mrs D had in locating the key to the medication box and the box itself demonstrates that the handover instructions from Access were not sufficiently clear. Further, she was not given instructions on the administration of warfarin, nor adequately trained in accordance with Access's policies.

52. It is positive to note that following RN E's conversation with Mrs D on 15 June 2017, she performed her duties correctly, and appropriately alerted the rest home when Mrs C developed a sore leg.

53. In summary, and in full consideration of the circumstances, I remind Mrs D of the importance of effective communication in the interest of patient safety when expected duties cannot be fulfilled.

Opinion: Access Community Health

Administration of warfarin — breach

54. Access is responsible for the adequate provision of its services to clients. It is imperative that Access provide adequate support to its staff in respect of implementation and application of relevant policies and procedures, and provide training to staff to ensure that relevant competency standards and sound decision-making are maintained to ensure client safety.

55. The administration of warfarin, which could not be missed, was a service Access had undertaken to provide. RN Russell advised that the failure to administer medication without follow-up by Access and/or its staff constitutes a serious departure from the acceptable standard of care.

56. RN Russell stated: "The Access policies are adequate and they well describe what needs to occur." I concur with RN Russell's assessment that Access's medication-related policies (which included the support required for the management/administration of warfarin) were adequate. However, I find that Access failed to comply with its own policies to ensure that Mrs D was adequately trained to support Mrs C to take her warfarin.

57. RN Russell advised that the importance of giving warfarin every day at the same time, and the importance of signing the medication form, are matters that would be covered off in medication competency training for support workers.

58. Mrs D had not had any medication training or competency checks since 2007. She did not receive the JIT training that was specified in the medication policy as a requirement to oversee the administration of warfarin. She had not received the training required for support workers to oversee clients taking warfarin, as outlined in the warfarin policy. In this respect, RN Russell stated:

> "The medication assists that SWs would have been checking 10 years ago have changed as has the acuity of the people receiving these services and SW need updated training to understand the specific requirements for complicated medications such as [w]arfarin."

59. Further, I am concerned that the handover instructions from Access's call centre were not sufficiently clear, as reflected by the circumstances that Mrs D could not find the medication box key or the medication box, and she was unaware that Mrs C was on medication that could not be missed.

60. The private carer visited Mrs C on 19 June 2017 and noted that the medication for 17 June 2017 was still in the blister pack. Further, the support worker on 17 June 2017 did not sign the medication form, and my expert has advised that it is common understanding in health that if it is not signed for it was not given, and therefore it is presumed that warfarin was not administered on 17 June 2017. I note that the support worker stated that she was aware that Mrs C required medication and she assisted as required. On balance I consider that the support worker did not administer warfarin on 17 June 2017.

61. I am concerned that two support workers failed to administer Mrs C's warfarin and notify Access, and concur with RN Russell that this indicates a systems issue.

62. I am also concerned that the issue of non-compliance with the service contract was raised on two previous occasions by Mr A, who stressed the importance of Mrs C not missing her warfarin. Access had an opportunity to reflect on those occasions and improve its service provision accordingly. Despite this, a similar event occurred a third time and resulted in a significant and adverse impact on Mrs C's health. This is not acceptable.

63. I agree with RN Russell's advice as discussed above, and am critical of Access for failing to provide Mrs D with the training required by its policies, failing to provide clear handover instructions to Mrs D, and failing to improve its services in light of Mr A raising the issue of non-compliance with the service contract, on two previous occasions. For these reasons I

find that Access Community Health did not provide its services to Mrs C with reasonable care and skill, and therefore breached Right 4(1) of the Code.[7]

Complaint process — adverse comment

64. I am critical of Access for not formally acknowledging the verbal complaints from Mrs B, and implementing its complaints management process only once a written complaint was received.

65. I remind Access Community Health that Right 10 of the Code does not require a complaint to be made in writing. I note that complaints can be lodged in a number of ways — in person, by telephone, or in writing. I expect all complaints, whether verbal or written, to be acknowledged and responded to in a speedy and efficient manner.

66. Even if Access did not interpret Mrs B's telephone calls as complaints, in the event of missed medication, its medication policy requires communication with the family regarding the steps that have been taken to prevent reoccurrence, and this did not occur.

Recommendations

67. I recommend that Mrs D provide a written apology to the family, to be sent to HDC within one month of the date of this report, for forwarding.

68. I recommend that Access Community Health:

a) Provide a written apology to the family for its breach of the Code. The apology is to be sent to HDC within one month of the date of this report, for forwarding.

b) Ensure that all support workers and relief support workers who are required to work with medication have completed medication training and have achieved competency, and that current competency is maintained at all times. Access is to provide evidence of this to HDC within six months of the date of this report.

c) Audit the call centre selection of support workers according to the required competency for the selected job, from 1 June 2018 until 31 August 2018, in order to ascertain whether the updated employee database is providing for the appropriate selection of skilled support workers. If the results do not reflect 100% compliance with appropriate selection, Access is to consider further improvements that could be made to ensure compliance, and report back to HDC within three months of the date of this report.

d) Develop and implement a formal handover policy that ensures a systematic approach to handover that contains all essential information to support and enable staff to

[7] Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) states: "Every consumer has the right to have services provided with reasonable care and skill."

provide adequate service. Evidence of the implementation of the policy is to be provided to HDC within six months of the date of this report.

Follow-up actions

69. A copy of this report with details identifying the parties removed, except Access Community Health Ltd and the expert who advised on this case, will be sent to the Ministry of Health (Disability Support Services and Health of Older People Team). The report will also be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Julia Russell:

"The purpose of this report is to review the care provided to [Mrs C] between the 13 and 17 June 2017. In preparing this report the following documents were reviewed:

The letter of complaint

- Responses from Access dated 26 July, 8 September and 11 October 2017 which includes Support Worker (SW) certificates and [Mrs D's] (Access Support Worker) response 24 October 2017
- Clinical records from Access from 20 October 2016 to 12 June 2017 Medication management policies and Training policies from Access — SW Competency Guidelines, Learning Guide Pre-Packaged Medication.
- Medication Management, Induction Journey, Record of Just in Time training, Warfarin, Competency Assessment — Medication before starting, Competency Assessment General before starting.

The essence of this complaint is the Family's concerns regarding the long term effects of this incident on [Mrs C]. The result of this incident may be the reason why [Mrs C] enters Aged Residential Care. The Family also indicate in this complaint that there have been other issues with Access and that they have other concerns regarding Access' lack of follow up.

Background

This complaint was received by Access on the 28 June [and the Family wrote to the Health and Disability Commissioner]. Access was to respond to [the Family] by the 7 July 2017, there is no information in this file regarding any feedback to the family by this date and the Access letter of 26 July 2017 acknowledges that they did not meet their own standards for managing complaints.

Prior to this incident [Mrs C] who has a degree of dementia was living independently with support — she was independently mobile and dressing herself. [Mrs C] was prescribed Warfarin daily and in order to take her medications Access provided a medication check service. A medication check is where a trained SW signs that the medication has been taken. [Mrs C's] regular SW called in sick for work. The SW that took over [Mrs C's] care for the following days 13–16 was initially unable to find the lock box with the information she had received.

From the Access signing sheet:
The dose on the 13th was given late as the lock box was unable to be found. [RN E] called to [Mrs C] and provided the medication assist in the afternoon.

The 14th — the dose was not given as the SW couldn't find the lock box and had to leave in a hurry

The 15th — the SW believes this dose was given but didn't sign for it

17th June 2017 another SW believes she gave the dose but didn't sign for it

It is difficult to determine how many days [Mrs C] did not receive her Warfarin as the SW acknowledges she did not give it on the 14 June as she could not find it and ran out of time but did not report that into the call centre. This had occurred the day before (13 June) however the RN had called later that day and had assisted [Mrs C] with her dose. If the SW had called in to the call centre on the 14 June and advised them of the issue then Access may have been able to get a staff member to do the medication check and ensure the relief SWs knew where the lock box was.

Elements requiring comment on —

1. ***The overall reasonableness of care provided to [Mrs C]?*** Access quickly responded to replacing the sick SW. However it appears that the replacement [Mrs D] did not know where the lock box was. In the 26th July letter from Access point 3 under Findings on page 3 states that medication management was required and the process was in [Mrs C's] support plan and Access Controller. [RN E] advises the call centre on the 13 June by email reminding the call centre to ensure [Mrs D] had the information required. From [Mrs D's] inability to find the lock box on the second day it is probable either that the call centre did not follow this up or the instructions were not explicit enough to ensure the task was able to be understood and completed. In her response [Mrs D] felt the handover could have been improved unfortunately she also doesn't detail how the handover usually occurs or how it could have been better.

   Covering staff on leave is a regular part of the call centre's work and they had a staff member available for [Mrs C] which meets the expectations of care. Given that [Mrs D] could not find the lock box and then both SWs neglected to sign for the administration indicates a deeper level of issue than a problem with the SWs. This is seen as not meeting the expectations for the care that Access had a service agreement to provide.

2. ***The appropriateness of actions taken by the SWs following the failure to administer the medication****?*

   The SW advised the call centre that she could not find the medications on the 13 June 2017 therefore the RN was able to act and went and did the medication check herself. [RN E] indicates in her email that the call centre needed to ensure [Mrs D] knew where the lock box was. The location of the lock box was again a problem on the 14 June as this was the first day the medication was actually not given but the second day that [Mrs D] could not find the lock box. [Mrs D] should have rung the call centre to advise them she had not completed the medication

check so an alternative action could be taken. Advising the call centre was regular protocol in such circumstances and failure to do so was an episode of poor care and not acceptable.

There are 2 alternative scenarios regarding whether the medication was given on the days — the 15 and 17 June that the SWs claim to have given it —

a) [Mrs D] believes she administered the medicine on the 15 and 16 June but was unsure if she had signed for it. In reviewing the medication assist form she did not sign it on the 15 June but did sign for it on the 16 June at 7.40am. Given that she was working with [Mrs C] on the 19 and 20 June and did sign for it on those days [Mrs D] would have seen that she had not signed for it the previous week on 15 and if she had given it on the 15 June then she would have been able to sign the sheet retrospectively. Presumably she would have advised the call centre that this was the case and this would have ensured the GP could be advised of the missed dose (as is Access procedure detailed in their Medication Policy). This was not done and as is common understanding in health — if it is not signed for it was not given. It is also not signed for on the 17 June when another SW did the visit to [Mrs C], so again it is presumed this was not given.

b) The Warfarin would have been packed in some sort of daily or weekly packaging to enable administration — it is not clear if this is done in a multi dose box or other sort of packaging and there is no comment from the Access, the SW or the Family if there was still Warfarin in the lock box after [Mrs C] was hospitalised — 20 June 2017. In the letter of complaint Mr A does not say how he knew the Warfarin was not given — whether he had viewed the lock box to confirm the medications were still there. If they were still in the lock box on the days after a medication check had been missed then the SW would have also noticed them which should have prompted them to advise the call centre regarding missed doses.

Correct doses were given on the 18, 19 and 20 June 2017. When the SW visited on the 20 June 2017 she found [Mrs C] in considerable pain and discomfort. After a nursing and medical assessment she was found to have a deep vein thrombosis in her left leg. This incident has meant that [Mrs C] is no longer mobile and will perhaps not regain her pre incident level of mobility — perhaps requiring full time care in a hospital facility.

The SW who should have signed for the medication on the 17 June also doesn't recall if she signed the medication assist form — this is the same reason that [Mrs D] provided. Given that there are 2 SW making the same/similar mistakes this is indicative that this is not a person error but a system error. This raises concerns about where the medication assist form is kept — what is the understanding of the SWs about the importance of giving Warfarin every day and at the same time and do they understand the importance of signing the sheet and ensuring accurate recording is done. These matters would all be covered off in their medication

competency training and updating of that competency. Because it is not clear if the medication was given on the days it should have this is seen as not meeting the expectations for the care that Access had a service agreement to provide.

3. ***The adequacy of the relevant policies and procedures at Access relating to medication management?***

The Access policies are adequate and they well describe what needs to occur. Access letter of 26 July 2017 identifies the policy and the procedure for obtaining medication competence. However in reviewing the Access training polices there appears to be no details about updating medication competence. [Mrs D] and the [other relief support worker's] qualification/unit standards are recorded as completed between 2007 and 2009. Included in the file are updated competencies for [Mrs D] from early 2017 for showering/dressing and hand washing. There are no updated competencies for medication management. The medication assists that SWs would have been checking 10 years ago have changed as has the acuity of the people receiving these services and SW need updated training to understand the specific requirements for complicated medications such as Warfarin.

On this occasion the departure from the expected level of service with regard to their medication policies is around the lack of reviewing competence of medication trained SW. It appears that medication competence is not done annually/biannually. However the Chief Executive has identified that medication policy and procedure (which are out of date) will be undergoing a review at a national level so it would be expected that a review of the frequency of updating medication competency would be covered within that review.

What is the standard of care/accepted practice

In the Access policies they identify that Warfarin requires close monitoring and as the policy states it needs to be given at the same time each day. Warfarin should never be missed and [Mrs C] had a previous clot in her leg so this was even more important and has resulted in a life threatening event for [Mrs C] and one that has affected her quality of life. This was a service that Access has a service specification and has undertaken to provide therefore no missed doses of any medication are acceptable and if there are missed doses then the expectation is that Access and their staff will follow their own processes. Given the consequences for [Mrs C] were life threatening this is seen as a serious departure from the accepted standard of care.

Given this happened with 2 SWs — both not remembering if they signed the form to acknowledge the check it indicates a deeper system issue which in the corrective actions of the 26 July 2017 letter is being reviewed by Access' Clinical Governance group. As part of this review the training and updating of training/ competence of SW needs to be considered as they are undertaking increasing amounts of responsibility with drugs such as Warfarin when they have limited

pharmacological knowledge — this is the responsibility of the employer in order to meet the requirements of tasks such as medication assists. As well a policy/ procedure review an article was written and shared with all Access staff regarding medication management and SW responsibilities.

Potential possible improvements include:

a) Ensuring medication assists with important medications such as Warfarin that SWs are informed of the special considerations that Warfarin at the time of their assignment rather than looking for the Service Development Plan (SDP) which on this occasion was with the lock box that couldn't be found for 2 days.

b) On this occasion the medication assist form is kept with the SDP which from [Mrs D's] information was with the lock box. To be able to read you needed to know where the lock box was which on this occasion took 2 days to find so perhaps keeping them in a more accessible routine place.

c) A change to the Cautionary and Advisory box on the medication assist form could also include the importance of giving Warfarin at the same time every day.

Conclusion

This file was reviewed to identify if Access met the standards expected by a provider in the service they provided to [Mrs C].

In the areas of 1. — The overall reasonableness of care provided to [Mrs C] Access met the expected standards. The SW could not find the lock box and this was an issue that affected the care provided to [Mrs C] but is covered in points 2 and 3. Point 2. — The appropriateness of actions taken by the SWs following the failure to administer the medication, Access failed to meet the expected standard and in part this may have been due to 3. Point 3 was about Access' medication policies, which are adequate. What leads the writer to determine they have not met the expectations is the length of time since the SWs were initially trained. Access has not provided any information regarding updating medication competence for the SWs nor is it obvious in their policies — medication and training. Reviewing and updating medication knowledge is of paramount importance — SWs need to understand that some medications cannot and must not be missed and to assist them in remembering this appropriate updating of competencies and information should be provided.

In the Access letter of July 2017 they have clearly identified their deficits in the provision of care to [Mrs C] around responding to the complaints and that they need to review their Medication policies. In doing this review they should be able to remedy the areas that have led them to not meet the expectations in this episode of [Mrs C's] care. "