



Disciplinary Investigation

*****Member of Staff (MOS)*****

*****date*****

Introduction

This independent disciplinary investigation was commissioned by *** on ***.

John Woodhouse led the investigation. John is a qualified Social Worker registered with Social Work England. With a background originally in residential childcare, he has worked to service manager level in a local authority and currently runs a company specialising in leadership, management and safeguarding training for children's homes. John also runs networks to support and train registered managers, responsible individuals and regulation 44 visitors.

Jackie Thompson is a Customer Support Manager working with **dialogue**. She witnessed the interviews and took notes.

Terms of reference

The author was commissioned to investigate allegations that ***MOS***:

1. Failed to follow the Residential Home medical procedure for administering medicine. They administered medication to a young person without any member of staff to witness her doing this on ****.
2. On *** they accessed the medication cupboard. As a Residential Support Worker, the expectation is that they do not have access to the medication cupboard.

Process of investigation

The investigation is running alongside a wider review of the medication processes at ***. This disciplinary investigation report is focused on the specific allegations in respect of the member of staff. Sufficient information has been gathered to determine the outcome of the disciplinary investigation, although the wider review continues in terms of improving practice in the home.

Interviews:

- **,Residential Support Worker, **date**
- **, shift leader, **date**

Documentation reviewed

- MAR sheet for **date** for the young person
- Medication administration witness sheet
- ** medication policy
- ** safeguarding policy
- Witness statement, **who**, **date**
- Witness statement, **who**, **date**
- Witness statement, **who**, **date**
- Medication Audit, **date**

MOS was suspended from work on **date**. A letter was sent to ** confirming she could return from suspension on **date**. She was written to on **date** inviting her to attend an interview on **date**. ** waived the offer

of a person to support her at the interview. She also waived five working days' notice for this interview as she was keen to get the matter resolved.

The investigation findings

All parties cooperated with the investigation and the importance of trust and relationship with the young person was central to their approach. There was acknowledgement from all parties that practice fell short of the standards required and there was little dispute about the facts. There was however, substantial mitigation in respect of training, culture and wider practice across the home.

Allegation 1

*That **MOS** failed to follow the Residential Home medical procedure for administering medicine. **MOS** administered medication to a young person without any member of staff to witness her doing this on **DATE**.*

The Medication Policy states:

"Two staff members (who have received medication and in-house training) must be present whenever medication is dispensed and administered. All homes will have an appropriate system of Medication Administration Records. (MAR)... They must be completed for each administration of Medication to a young person and signed by both members of staff involved, clearly detailing what had been dispensed and the time using 24-hour clock. Both staff should ensure that they administer the Medication to the correct young person." (p3)

The ***MOS's*** name was not listed on the "Staff Signatures for Medication Policy" document, so it is not clear she had verified to managers at the home that she understood the policy.

The medication administration record for the young person has the MOS's initials for the 0730h administration. The witnessing medication form is separate to the Medication Administration Record. The shift leader has initialled to witness the medication. At interview both the MOS and the shift leader acknowledged that the MOS dispensed and administered the medication without a witness present.

The MOS explained that shift leader "asked if I would mind doing [the young person's] medication by myself as he was in supervision and he would sign for it all... Stupidly I said yes, and I know I should not have done". In his interview the shift leader denies he instructed the MOS to administer the medication on her own, rather that he had asked her to do the medication and expected her to find another member of staff to witness. While there is uncertainty on this fact it does not materially alter the outcome of this investigation as the MOS was aware dispensing and administering medication without a witness was in breach of the medication administration procedure.

The MOS pre-prepared the medication, storing it first in the medication cabinet and then on a work surface locked in the young person's kitchenette (we acknowledged at interview this was also dangerous practice).

There was a problem with the young person's monitor which is in place to hear if he has a seizure – it had somehow been turned off:

"Breakfast was cooking – I realised the monitor was turned off completely. I wasn't sure if he was awake or had a seizure or anything. I had to go in to check he was ok. I told the shift leader I was doing this... I got [the medication] from the kitchenette. As soon as you open his bedroom door he is out, ran straight to the bathroom and initiating his bath and starting his routine. If he has a change in routine it's difficult. As I was by myself and didn't want challenging behaviour I administered the medication myself."

Disciplinary Investigation Interview, *DATE**

It is established that the MOS administered medication to a young person alone and that the MOS was aware this breaches the medication administration procedure. The threshold is met for disciplinary action but given the widespread malpractice and lack of suitable training it is recommended the organisation handle this matter informally (see below).

Allegation 2

*On *DATE**, the MOS accessed the medication cupboard. As a Residential Support Worker, the expectation is that they do not have access to the medication cupboard.*

The Residential Homes Medication Policy states:

"The shift leader is responsible for the security of the medication cabinet keys, at all times." (p2)

"Two staff members (who have received medication and in-house training) must be present whenever medication is dispensed and administered." (p3)

"The shift leader has overall responsibility for ensuring medication is dispensed and administered to the young people." (p5)

The policy states "staff" may dispense medication, which implies they must have access to the medication cabinet. While the shift leader has "overall responsibility" for dispensing, administration and security the policy does not prohibit any of these responsibilities being delegated to others.

Both the MOS and the shift leader advised that staff routinely use the keys to access the medication cabinet and that she was delegated to administer the young person's medication that morning.

This allegation is not upheld and I recommend no further action is taken.

Conclusion

The allegation in respect of the MOS administering medication on her own was acknowledged by the MOS during her disciplinary interview. However, it quickly became clear the errors were part of a wider malaise around medication practice with a lack of suitable medication training and gaps around leadership and management as significant factors.

I have therefore recommended this allegation is addressed informally. I suggest the organisation write to the MOS setting out that while the criteria for disciplinary action was met the organisation will not be taking these allegations to a disciplinary hearing on this occasion, but that further breaches of the policy may lead to disciplinary action. I recommend the following actions:

- The MOS, along with all staff, should receive face-to-face medication training prior to administering medication.
- There should be significant and robust improvements to the medication administration process at the home
- All staff should be made familiar with the new systems and processes and in particular expectations on shift leaders should be made clear.

John Woodhouse

Managing Director

dialogue

DATE*