Caregiver, Ms D

Registered Nurse, RN E

Rehabilitation Service

A Report by the

Health and Disability Commissioner

(Case 14HDC00607)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Since 2010, Mrs A had resided at a rehabilitation service following a stroke. She had multiple co-morbidities and poor vision. Mrs A was on a number of prescribed medications.

2. On 3 May 2014, Mrs A's family were having a celebration. Earlier that day, at approximately 10am, caregiver Ms D, who was feeling unwell and in a rush, had prepared and given Mrs A's son, Mr C, his mother's dinner-time medications to give her that evening. Ms D did not perform the necessary checks of the medication she gave to Mr C and, unfortunately, an error was made. The medications given, namely quetiapine fumarate (an anti-psychotic) and carbamazepine controlled release (an anti-spasmodic), were prescribed for another client.

3. The medications given in error were administered to Mrs A that evening at the party. Mrs A's daughter, Ms B, said that 10 minutes after the evening meal finished, her mother "passed out" for approximately a minute. The family decided to return their mother to the rehabilitation service at about 9pm.

4. At approximately 10.15pm, on-call registered nurse (RN) RN E, Service Leader, was advised by telephone by a caregiver that Mrs A's family had contacted the rehabilitation service to say it was apparent that the medication they had given to Mrs A that evening was meant for another person.

5. At approximately 11.30pm, RN E assessed Mrs A at the rehabilitation service. Mrs A was alert, responsive and conversing. RN E took Mrs A's blood pressure and pulse, both of which were within normal limits. RN E did not take Mrs A's respiration rate or her blood glucose level, despite Mrs A not receiving her usual metformin medication and having consumed alcohol at the dinner. RN E remained at the rehabilitation service until 1.30am on 4 May 2014. She did not call the public hospital's Emergency Department (ED) for further advice, or contact the National Poisons Centre. Instead, RN E instructed staff to monitor Mrs A at half-hourly intervals overnight and, if there was any sign of deterioration, they were to arrange for an ambulance and call her.

6. RN E went into the rehabilitation service later that morning, spoke to the staff on duty, and went to see Mrs A and some of her family members. RN E explained the medication error investigation process. An incident form was faxed to the Quality Health and Safety Advisor of the rehabilitation service. The rehabilitation service reviewed the incident, conducted an audit, and instigated remedial education.

Findings summary

7. By failing to follow safe medication checking practices, Ms D did not provide services to Mrs A with reasonable care and skill. Accordingly, Ms D breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

8. RN E failed to assess Mrs A properly and failed to seek appropriate medical advice, which would have enabled her to respond appropriately to the medication error. RN E

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

failed to provide services to Mrs A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

9. The rehabilitation service was found not to be directly liable or vicariously liable for Ms D's or RN E's breaches of the Code. The rehabilitation service had provided Ms D with competency training on medication management, and the Medication Management standard operating procedure was consistent with accepted standards and included the requirement that all efforts must be made to minimise the impact of a medication error on the client.

10. Adverse comment is made that the documentation surrounding the incident could have been clearer and more accurate.

11. It was considered that an earlier incident when Mrs A's wheelchair fell off the back of a raised van hoist ramp onto the concrete whilst she was seated, was an unanticipated mechanical failure to which the rehabilitation service responded appropriately. The rehabilitation service was found not to have breached the Code.

Complaint and investigation

12. The Commissioner received a complaint from Ms B about the services provided to her mother, Mrs A, by the rehabilitation service. Mrs A supported the complaint.[2]

13. The following issues were identified for investigation:

- *Whether the rehabilitation service provided care of an appropriate standard to Mrs A.*
- *Whether registered nurse RN E provided care of an appropriate standard to Mrs A.*

14. An investigation was commenced on 16 December 2014. On 30 June 2015 the investigation was extended to the following issue:

- *Whether Ms D provided care of an appropriate standard to Mrs A.*

15. The key parties referred to in the investigation are:

Mrs A (dec)	Consumer
Ms B	Consumer's daughter
Mr C	Consumer's son
Rehabilitation service	Provider
Ms D	Caregiver
RN E	Registered nurse, Service leader
Ms F	Caregiver
Ms G	Caregiver
Ms H	Quality Health and Safety Advisor

[2] Mrs A has since passed away.

Ms I	Caregiver
Ms J	Caregiver
Ms K	Caregiver

16. Nursing advice was obtained from HDC's in-house nursing advisor, registered nurse Dawn Carey (**Appendix A**).

Information gathered during investigation

Background

17. Since 2010, Mrs A, who was aged 60 years at the time of the events, had resided at the rehabilitation service following a stroke. She had left-sided weakness, peripheral vascular disease,[3] hypertension (high blood pressure), fatigue, low mood and anxiety. Mrs A also had type 2 diabetes and impaired vision. Mrs A required a stroller frame to mobilise indoors or short distances outdoors, and used a manual wheelchair for longer distances.

18. Mrs A was on a number of prescribed medications including propranolol[4] 20mg, simvastatin[5] 20mg, metformin[6] 500mg, dipyridamole[7] 150mg, Accupril[8] 10mg and levothyroxine[9] 50mcg.

The rehabilitation service

19. The rehabilitation service provides services to people with a range of conditions, including traumatic brain and multi-trauma injuries. The rehabilitation service also provides a range of other specialised services.

Medication management

20. At the time of these events the rehabilitation service had in place a "Medication Management SOP [Standard Operating Procedure]". The Medication Management SOP provides that "before administering medications all nurses/support staff members involved in administration must demonstrate that they have the knowledge, understanding and practical abilities to be considered competent".

21. The Medication Management SOP requires that staff administering medicines have a registered nurse conduct an annual assessment of their medication skills and

[3] Disease of the blood vessels located outside the heart and brain.
[4] Propranolol is used to treat tremors, angina, high blood pressure and other heart conditions.
[5] Simvastatin is a cholesterol-lowering medication that blocks the production of cholesterol.
[6] Metformin is used to treat people with type 2 diabetes. It lowers blood glucose in diabetic patients but does not cause hypoglycaemia in diabetics or normal individuals. It increases the biological efficiency of insulin.
[7] Dipyridamole is a medication that inhibits blood clot formation when given chronically and causes blood vessel dilation when given at high doses over a short time.
[8] Accupril is used to treat high blood pressure and heart failure.
[9] Levothyroxine is used to treat low thyroid activity and to treat or suppress different types of goitres.

knowledge. The assessment includes a clinical audit of medication practices on at least three occasions, prior to competency being achieved.

22. The Medication Management SOP provides under the heading "Administration Management":

> "3.5 Think 5R's + 3 and three checks
>
> **5 Rs + 3**
>
> - Right client
> - Right medicine
> - Right dose
> - Right time
> - Right route
>
> **+ 3**
>
> - Right to refuse
> - Right indication
> - Right documentation
>
> **Three checks**
>
> - Check the unit dose pack, e.g. blister pack, robotic pack, or medicine label when getting the medicine from storage.
> - Check the contents of the unit dose pack or medicine label with the client's medicine chart.
> - Re-check the medicine order and medicine prior to administering."

23. The Medication Management SOP provides a number of steps involved in documenting and reporting medication errors and interventions. These include:

- Notify the senior RN and/or service leader immediately and/or the prescriber, and monitor the client as advised.
- The administrator is to seek advice from clinical on-call staff, pharmacy, GP/afterhours service, and to gain instructions as to what side effects to monitor and be aware of.
- The National Poisons Centre runs a 24-hour 7-day toll free emergency telephone service 0800 POISONS 0800 764 766. See also its website www.poisons.co.nz.
- All efforts must be made to minimise the impact of the error on the client.
- Inform the client or activated Enduring Power of Attorney (EPOA), welfare guardian or designated representative of the error.
- The error must be reported in the client's clinical notes.
- A Client Accident Incident form must be completed.
- Monitor the client for any reactions/ill effects.

24. The Medication Management SOP also has a section governing what process should occur when clients go on official leave, where medications are signed in and out but are not administered by staff.[10] Official leave is considered a situation when a client goes home or elsewhere for an extended period overnight or for a weekend. The Medication Management SOP states that the requirements for medication when the client is on leave include:

- Document in clinical file who is taking responsibility for medicines management while client is on leave.
- A nurse/support staff member who has demonstrated medicines management competency gives a designated person (this may be the client) the medicines for the period of leave only and provides necessary education/information to ensure safety.
- Ensure all medications are appropriately packaged and labelled; liaise with pharmacist as necessary.
- Record and sign off the medication when the person is leaving and returning; see Leave Form.
- Arrange for a record to be kept of medicines administered while the client is on leave from the facility (provide a blank administration signing sheet if required).
- Ensure that medicines are reconciled when the client returns back to the unit.
- Record on the Administration Signing Drug Chart that the client is on leave.

25. At the time of these events, the Medication Management SOP did not specifically refer to the scenario where clients go on informal outings with family or familiar people, such as day trips/outings (as distinct from when clients are on official leave). Clients and family members are given/take medications with them if they are out over the time the medications are normally administered.

Medication error

26. On 3 May 2014, Mrs A's family were having a celebration. At approximately 10am, her son, Mr C, arrived to collect his mother and take her off site for most of the day. The rehabilitation service clarified with HDC that this was not considered to be official leave from the facility.

27. In response to the provisional report, Ms B stated that her mother being picked up early that day had been planned well in advance, because Mrs A had an appointment to get her hair and make-up done for family photos. Ms B also said that she reminded the rehabilitation service staff of the early start closer to the time.

28. Ms D stated that she saw Mrs A being pushed in her wheelchair out of the door by her son and remembered that Mrs A had medications to be taken at dinner time, so she "fast walked" to the medication cupboard to get them out.

[10] Using an associated "Client Leave Form", created June 2009. Copy provided to HDC.

29. Ms I stated that she was also on the morning shift on 3 May 2014. Ms I recalls that when Mrs A's family arrived to collect her they were insistent that she be got ready with no delay as they were in a hurry.

30. Ms D had completed her annual clinical competency to administer medications assessment on 15 January 2014. Ms D had been employed at the rehabilitation service for three years before these events, first as a casual employee and then as a permanent employee.

31. Ms D said that on the morning of 3 May 2014, she had stated at morning handover that she did not want to do the medications that day because she was still sick and trying to get over the flu. She stated: "I felt bullied into doing meds as another staff member was a casual and could not do the meds yet. As for the full time staff member she refused to do them." Ms D said that they were short staffed as another rostered staff member had not arrived. She said that they had a full caseload of clients, including two respite residents who both had high needs, and another client who was unwell. Ms D said:

> "I felt very rushed and stressed. I opened the cupboard and ripped the meds off a med box thinking it was [Mrs A's] med box. I then put the meds sachet in a little plastic bag and sealed it. Then [I] ran to give them to [Mrs A's] son and stated to him that these were her dinner meds. I then went back to the office and signed [Mrs A's] meds off."

32. Ms D added that it was very difficult to see the medications in the drug/medication cupboard as they were on the very top shelf and the cupboard was very dark. She also said that because she needed to give medications to both Mrs A and another resident also attending Mrs A's function, she had both of them on her mind. Ms D stated:

> "All morning we were busy with clients and bells were ringing and a respite client was following me everywhere also. All of the above [are] factors which would have clouded my judgment."

33. Ms I stated that as far as she can remember Ms D stated that she was confident to do the medications that morning.

34. The signing sheet for Mrs A's medication for 3 May 2014 has the entry "S" meaning "self-administered".

35. The medications that Mrs A should have received, but missed, were propranolol 20mg, simvastatin 20mg, levothyroxine 50mcg, Accupril 10mg, dipyridamole 150mg, and metformin 500mg. The medications given to Mrs A in error were quetiapine fumarate[11] 50mg and carbamazepine[12] controlled release 200mg.

36. Ms G stated that she was on afternoon duty on 3 May 2014. She said that when she came on duty at 2.14pm resident X was sitting in a taxi van and was about to go to the

[11] Quetiapine is an atypical anti-psychotic approved for the treatment of schizophrenia and bipolar disorder, and, along with an antidepressant, is used to treat major depressive disorder.
[12] Carbamazepine is a medication used primarily in the treatment of epilepsy and neuropathic pain. It may be used to treat schizophrenia, along with other medications, and bipolar disorder.

same party as Mrs A was attending. Resident X told Ms G that she was waiting to get her "tea meds".

37. Ms G said that she went inside with Ms F to perform handover, and then began getting the medications ready. She noticed that Mrs A's medications were still there, and that resident X's medications were gone, and made a note to remember to give Mrs A her medications when she returned from her party.

Medication given

38. Ms B told HDC that at dinner her mother, who had consumed some alcohol during that time, was given the medications that had been provided by the rehabilitation service. Ms B stated:

> "[A]pproximately 10 minutes after the meal finished, Mum suddenly went slightly green and then passed out cold. [Mr C] and I took her outside and managed to get her to communicate slightly with us, and we decided to return her to [the rehabilitation service] assuming the day had been too big for her."

39. Ms B later elaborated:

> "Mum informed us that she felt tired and immediately slumped forward in her wheelchair, her body was floppy and eyes closed. She was unresponsive … Whilst we wheeled her out of the venue her body remained in a floppy state, until we reached the cold air outside. She stiffened, rested her head in her hand ([with her] elbow on [a] wheelchair arm). [Approximately] a minute has passed at this stage. She remained unresponsive to my questions for [approximately] another minute. We were discussing [taking] Mum to hospital when I had one last try of getting a response from her, [to] which she just kept replying "I'm sleepy". It was decided to return her to [the rehabilitation service] and her bed, as the only logical explanation at this stage was the whole day had just been too much for her."

40. Mr C and his partner returned Mrs A to the rehabilitation service at about 9pm. This is noted in a Medtech[13] entry for 9.38pm as: "[Mrs A] returned home at 9PM, appears to be in a very happy mood, assistance into her bed by her son, settled." Neither Mr C nor his partner could recall whom they spoke to at the rehabilitation service, or what information was passed on to the staff about Mrs A's condition upon returning.

41. Ms G stated that while Mrs A's family member was helping Mrs A get ready for bed, she (Ms G) went in to give Mrs A her medication, and was informed by the family member that Mrs A had already taken her medication.

42. Ms G stated that when resident X later returned from the party, she asked for a drink so she could have her dinner medications. Ms G and Ms F thought that resident X had been given her medication to take with her, and told resident X this. Ms G said: "We even looked in her bag to make sure they weren't in her bag and [she] had forgotten them." Ms G stated that resident X said that she had been told that she would get her pills when she got back. Once it was realised that resident X had not received her

[13] An electronic practice management system.

dinner medication, it was suggested that she take medication packaged for another day, but she made a decision not to do this, and refused.[14] Resident X was given her bedtime medication, and went to bed.

Discovery of error

43. Ms B told HDC that at approximately 11pm that night, family members checked the medication package (sachet) and discovered that they had administered resident X's medication to Mrs A. Ms B stated that they contacted the rehabilitation service and told staff what had happened. The rehabilitation service told HDC that they were notified of the error earlier than this, at around 10pm.

44. Ms B said that the staff member told her that she would contact the on-call nurse to come in, and that staff on duty would monitor Mrs A regularly. Ms B stated: "We continued to check in and see how Mum was doing during the night."

45. Ms F told HDC that once the rehabilitation service was advised that there had been a medication error, staff telephoned the on-call registered nurse RN E.

46. The medication error was recorded on a client incident investigation form (CIIF), dated 3 May 2014. Page 1 of the form was signed by the two on-duty caregivers. The documentation recorded:

> "… phone call at 10pm from family member concerning [Mrs A] tea medication was given, then noticed that the medication belong to [resident X] on call phoned asap …"

47. Page 2 of the CIIF recorded: "… [A]ble to respond to voice and converse. To be monitored closely overnight — ½ hrly checks …" Mrs A's vital sign observations (blood pressure 127/75mmHg and pulse 74bpm) at 11.30pm were also recorded.

48. The medication administration error is acknowledged in a Medtech entry by RN E on 4 May 2014. The reason for the delay in recording that Mrs A had received unprescribed medications is reported as: "… [N]ot able to be written up as medtech shutting [down] at time available to scribe to write up report …"

Assessment by RN E

49. RN E has been a nurse for many years. She has been employed by the rehabilitation service since early 2009 as the service leader responsible for the day-to-day management of the facility in supporting clients and residents. She stated that she works five days a week and every second week on call.

50. RN E stated that she was on duty as the on-call RN for the weekend of 3 to 4 May 2014 and was available by telephone if the staff on duty needed support, advice or help.

51. RN E stated that at approximately 5pm on 3 May 2014, she went to the rehabilitation service and was advised by Ms F of an apparent signing error because resident X's

[14] The rehabilitation service advised HDC that resident X was competent to make her own decisions in this regard.

medications were not there but had not been signed out. Ms F stated: "I assumed that at this point that this was an error and that she had been given her medications when she left but these had not been signed out for."

52. The clinical notes for 3 May 2014 record that at 10.25pm RN E received a telephone call from Ms F informing her that Mrs A's family had contacted the rehabilitation service and spoken to Ms F to say that the tablets given to Mrs A that evening were meant for another person, and that Mrs A's family would come in to see RN E in the morning.

53. RN E stated that she was not told that Mrs A had fainted or passed out. Similarly, both Ms F and Ms G also stated that the family did not tell them that Mrs A had passed out.

54. RN E stated that at the time of the telephone call, she was at the public hospital's Emergency Department (ED) with another client and, although she was aware that she needed to return to the rehabilitation service to assess the situation regarding Mrs A, she had to wait until she could safely leave the resident who was in the ED.

55. RN E said that she returned to the rehabilitation service and then assessed Mrs A at approximately 11.30pm. RN E said she found Mrs A alert, responsive and conversing. RN E took Mrs A's blood pressure and pulse, and found they were within normal limits. RN E checked the MIMS medicine reference[15] to assess the possible side effects associated with the medication Mrs A had taken in error.

56. RN E stated that she did not take Mrs A's respiration rate, but her observation on speaking to Mrs A was that her breathing did not appear to be altered from any other occasion on which she had seen her. RN E said that Mrs A "was not distressed with her breathing, was not experiencing dizziness or pain, was orientated to person and place". RN E said that she did not assess whether Mrs A was orientated to time, as often Mrs A was uncertain of time and where she was, owing to her poor eyesight, combined with complications from her stroke. However, Mrs A was able to say that she was in her bed at the rehabilitation service and was able to move all her limbs freely despite her stroke. RN E said that Mrs A's responses and reactions were no different from other times on which RN E had seen her.

57. RN E did not take Mrs A's blood glucose level, and told HDC that she accepts that she should have done so. RN E said: "[Mrs A's] blood glucose was not regularly monitored by staff and I missed checking her glucose levels. I was aware that she had not taken her evening medication."

58. RN E stated that the accident and emergency centre was closed at the time of the incident and could not be contacted, and her previous experience of the public hospital was that staff were reluctant to provide advice over the telephone, so the only option was to call an ambulance.

[15] A well recognised reference publication detailing medical product and medicine information.

59. RN E said she considered calling an ambulance to take Mrs A to the ED for further assessment but, because her blood pressure and pulse were within normal limits, and four hours had elapsed since dinner, RN E made the decision that the night staff could monitor Mrs A at half-hourly intervals overnight. RN E instructed staff that if there was any sign of deterioration they were to arrange for an ambulance and also to call her.

60. The rehabilitation service later advised HDC that having reviewed the medication administration charts and spoken to RN E, it was able to confirm that Mrs A was not given her "normal" dinner-time medications once it had been established that she had not received these.

Handover

61. Ms K told HDC that on 3 May 2014, she arrived at work at 10.45pm, and at handover with Ms F and Ms G, she was told that there had been a medication error with Mrs A, and that RN E had been notified and was at ED with another client.

62. Ms K said she took the call when RN E rang to see how Mrs A was, and that shortly after that, RN E arrived on site. Ms K said she observed RN E take Mrs A's observations and ask her a series of questions.

63. RN E said:

> "I handed over to night staff[16] [Ms K] and [Ms J] to check [Mrs A] half-hourly for increased drowsiness, alertness, nausea, changes to movement. [Ms K] commented that it was like checking a person with head injuries so I was confident that regular checks would be done and expected the observations be written up in the night report notes. I anticipated that they would wake her up every half hour sufficiently to obtain a response from her. My understanding is that occurred because I recalled the [caregivers] later mentioning her agitation at being woken up regularly."

64. Ms K said RN E told her to maintain half-hourly checks on Mrs A during the night and inform her (RN E) immediately of any changes. The caregivers did not record the half-hourly checks they made of Mrs A.

65. RN E stated that she did not instruct the caregivers to take baseline recordings as these are not routinely taken by caregivers at the rehabilitation service. She said that she had taken the baseline recordings, except the respiration rate, earlier in the evening and would not usually leave the caregivers to take these recordings, because although some of the caregivers would be able to take the signs, they would not necessarily be able to interpret the results.

66. RN E stated: "[I]f I had considered that at that stage that half-hourly baseline recordings needed to be taken, then it would have been better for [Mrs A] to be taken to the Emergency Department for monitoring in hospital overnight." RN E said that she was confident in the ability of the caregivers to rouse Mrs A each half hour, and

[16] The afternoon shift runs from 2.45pm to 11.15pm.

spoke to them regularly until 1.30am, when she was told that Mrs A was becoming agitated at being woken every half hour.

67. RN E stated that she opened Mrs A's file on Medtech but the computer screen went opaque and the system shut down. She stated that she completed the client incident investigation form (CIIF) with the recordings of her observations but was unable to record the notes for Mrs A on Medtech at that time.

Overnight checks and morning follow-up

68. RN E remained on site until about 1.30am on 4 May 2014. Ms K said that RN E checked on Mrs A before leaving at 1.30am. RN E cannot recall whether she saw Mrs A herself prior to 1.30am, but she does recall having conversations with the caregivers who were completing the checks.

69. Ms K stated: "I had maintained half-hourly checks for the rest of my shift in which I woke [Mrs A] every half hour to assess her and felt she was behaving in a way that was normal for her. I, in poor judgement, did not document on a monitoring sheet."

70. Ms J stated that she worked the night shift with Ms K and that she was also advised by RN E to check on Mrs A every half hour.

71. RN E stated that on the morning of 4 May 2014, she checked the Medtech notes for Mrs A from home and noted that nothing had been written up for the night report. RN E said she expected that the observations would be documented in the Medtech notes, but that "the form for taking half-hourly recordings was not available at the rehabilitation service at that time".

Subsequent events

72. RN E said she went into the rehabilitation service on the morning of 4 May 2014, spoke to the staff on duty and went to Mrs A's room. Mrs A was sitting up in her bed, and her son, Mr C, his partner and his son were present in the room.

73. RN E stated that she explained the investigation process with regard to the medication error, and Mr C asked to be kept informed. RN E stated that at that time the family mentioned that Mrs A's "energy flattened" after dinner, and she later recorded that fact on the back of the CIIF.

74. That morning the CIIF was faxed to the Quality Health and Safety Advisor, Ms H. RN E stated that usually the second page of the form would be signed by her as service leader on completion of the investigation and, once further action had been completed by the Quality Health and Safety Advisor and general manager, either she or the general manager would sign off the CIIF.

75. Ms B stated that on 4 May 2014, she contacted the rehabilitation service at approximately 8.30am to see how her mother was, visited her mother with friends at 11am, and returned again at approximately 2.30pm. Ms B said she asked to view the monitoring chart but it could not be found. She stated that she then packed her mother's bag and took her mother to her (Ms B's) home. Mrs A did not return to the rehabilitation service.

76. The family complained to the rehabilitation service on 5 May 2014. On 15 May 2014, Ms H met with Mrs A, Ms B, and a family friend of Mrs A, to discuss what had happened. This included addressing family concerns that the issue had not been taken seriously, that RN E had not apologised about the error in the first instance, and that communication had not been open. The rehabilitation service acknowledged that an apology was not immediately forthcoming, but had subsequently occurred. The meeting was followed up by Ms H writing to Mrs A on 23 May 2014 and formally apologising on behalf of the rehabilitation service. Respite care was offered to Mrs A while she was awaiting placement elsewhere.

Further comment

77. Ms D advised that she has since completed two in-house medication training modules.

78. RN E stated that in hindsight she should have contacted Mrs A's family on the night of 3 May 2014 to get a clearer history of what had occurred and also to involve them in her decision-making. She considers that she should not have relied on a verbal handover to the caregivers but should have documented a handover and insisted on the use of a monitoring chart.

79. RN E said that if a similar incident occurred again out of hours she would call an ambulance, as there is no registered nurse at the rehabilitation service overnight to take baseline recordings.

80. The rehabilitation service stated that following the incident, on 17 June 2014 it conducted medication refresher training.

81. The rehabilitation service also stated that in retrospect RN E should have sought medical advice regarding the medication error. It stated: "[RN E] has generally been a competent RN who tends on the side of caution …".

82. The rehabilitation service agreed that the documentation regarding the error was inadequate in that the caregivers did not record the half-hourly checks for Mrs A. It stated that the staff would have training on expected standards of documentation and the use of clinical monitoring forms. It also stated that the form is being reviewed and will be amended.

83. Arrangements have been made for senior management from the main centre to visit more frequently to support and monitor the service, and for RN E to visit the main centre to network with other service leaders.

84. The rehabilitation service stated that Medtech closes down for a couple of hours during the night, so RN E wrote the entry for 3 May 2014 on 4 May 2014 but failed to document that this was a retrospective entry for 3 May 2014. The rehabilitation service acknowledged that RN E did not follow the Medication Management SOP.

85. The rehabilitation service stated that Ms D had been stood down from administering medications after the medication error until she had redone her medical competencies.

However, Ms D did not re-sit her medication competencies as she reported that she had lost her confidence.[17]

86. The rehabilitation service stated that it conducted a medication management audit in November 2014 and another in January 2015 and found no matters of concern. It said that there had been no medication incidents in the six months prior to the error of 3 May 2014.

87. The rehabilitation service described the following changes that have been made or are planned:

- The Medication Management SOP and medication competency assessment forms will be reviewed.
- The organisation's priorities in 2015 will include the establishment of a quality governance group, which will include client input.
- In case of Medtech/computer shutdown, paper progress sheets will be held in the client's paper file for easy access.
- As all clients have their own community GPs and attend hospital appointments with staff/relatives, a new form has been developed to ensure that information/recommendations are available to rehabilitation service staff.
- The rehabilitation service introduced a client monitoring form (CMF) template in August 2014. This was later reassessed during the course of this investigation.

88. The rehabilitation service said that it will report to HDC on the progress of its formal training on clinical documentation with audits to ensure better compliance.

89. The rehabilitation service also indicated that as a result of this investigation it would review medication policies and procedures for clients going on informal outings with family or familiar people (as distinct from when clients are on official leave).

Fall in 2013

90. Ms B stated that 6–9 months prior to the medication error, there was an incident in which her mother, while seated in her wheelchair, fell backwards off a raised van hoist onto concrete. She stated: "I am still waiting for an explanation as to how this happened."

91. The rehabilitation service told HDC that an enrolled nurse who had been trained and was experienced in operating the van hoist lowered the van hoist while the van was parked at the front entrance. Mrs A was in her wheelchair, and the ramp flap opened approximately a foot from the ground, causing Mrs A and the wheelchair to fall off the back of the ramp onto the concrete.

92. The rehabilitation service said that Mrs A rolled out of her wheelchair onto her left side. Following the fall Mrs A was able to respond verbally when spoken to, and

[17] In mid-2015, Ms D resigned from her position with the rehabilitation service.

could wiggle her fingers and toes, but had a large haematoma on the back of her head, grazes and bruising to her left ankle and elbow, and displacement of her left elbow.

93. An ambulance was called and Mrs A was transferred to the public hospital for medical attention. Mrs A was collected from the ED having undergone a head CT scan, which showed that there had been no intracranial bleeding. A leaflet was given out regarding care after a mild head injury, and staff were instructed to watch for signs and symptoms indicating deterioration. The staff were told that it was safe for Mrs A to go to sleep, but she needed to be woken occasionally during the night. Mrs A's clinical notes record that Ms B was called and a message left on her answerphone regarding her mother's admission and discharge from the ED.

94. The rehabilitation service advised that following this incident, it gave the nursing staff further training on van hoist safety, and the vehicle hoist was not used again until it was checked by the service contractor. It was found that the approach ramp of the van hoist had released prematurely owing to a damaged catch. The contractor carried out remedial work to correct the matter.

95. The rehabilitation service said that RN E telephoned Ms B again to discuss the incident further. Mrs A's wheelchair was serviced and a lap seatbelt was installed. The rehabilitation service advised that as a result of the incident, RN E developed a standard operating procedure for the operation of the van hoist.

96. The rehabilitation service noted that previously there had not been any similar incidents, and that prior to the accident the cause of the accident was an unknown hazard.

Relevant standards

97. The *NZS Health and Disability Services (Core) Standards* (Standards New Zealand 2008) include NZS 8134.1.2:2008 — Standard 2.2, which states:

> "The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers."

98. The *NZS Health and Disability Services (Core) Standards* (Standards New Zealand, 2008) also include the Medicine Management standard 8134.1.3:2008 — Standard 3.12, which states:

> "Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.
>
> *Criteria* The criteria required to achieve this outcome shall include the organisation ensuring:
>
> 3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and

medicine reconciliation in order to comply with legislation, protocols, and guidelines.

…"

99. The Nursing Council of New Zealand (NCNZ) publication *Code of Conduct for Nurses* (2012) states:

"6.8 When you delegate nursing activities to enrolled nurses or others ensure they have the appropriate knowledge and skills, and know when to report findings and ask for assistance."

100. The NCNZ publication *Guideline: Delegation of care by a registered nurse to a healthcare assistant* (2011) states:

"Healthcare assistants are also legally accountable for their actions and accountable to their employer. They must therefore have the appropriate skills and knowledge to undertake activities, and be working within policy and the direction and delegation of a registered nurse. They must be careful not to lead health consumers to believe they are a nurse when undertaking aspects of nursing care.

…

Delegation is the transfer of responsibility for the performance of an activity from one person to another with the former retaining accountability for the outcome.

…

The principles of delegation

1 The decision to delegate is a professional judgment made by a registered nurse and should take into account:

(a) the health status of the health consumer

(b) the complexity of the delegated activity

(c) the context of care, and

(d) the level of knowledge, skill and experience of the health care assistant to perform the delegated activity.

2 The decision to delegate must be consistent with the service provider's policies.

3 The registered nurse must ensure the health care assistant who has been delegated the activity:

(a) understands the delegated activity

(b) has received clear direction

(c) knows who and under what circumstances they should ask for assistance

(d) knows when and to whom they should report.

4 The registered nurse is responsible for monitoring and evaluating the outcomes of delegated nursing care.

The responsibilities of the registered nurse

The scope of practice of registered nurses can be found in Appendix 1.

1 Assessment and monitoring of the health status of the health consumer

(a) The health consumer must have a plan of care developed by a registered nurse who has undertaken a comprehensive assessment.

(b) The registered nurse must determine the level of skill and knowledge required to ensure the safety, comfort and security of the health consumer before delegating care. This must be based on an assessment of the health consumer including consideration of the complexity of the care required rather than the tasks to be performed.

(c) The registered nurse must provide ongoing monitoring of the health status of the health consumers for whom he/she is responsible. This must be planned along with the necessary support and guidance that will be provided to the health care assistant performing the delegated activity.

(d) The registered nurse must be directly involved with the health consumer when the health consumer's responses are less predictable or changing, and/or the health consumer needs frequent assessment, care planning and evaluation."

Responses to provisional opinion

101. A submission from Ms B in response to the "information gathered" section has been incorporated into the report where appropriate.

102. Ms D's feedback has been incorporated into the "information gathered" section of the report where appropriate. She had no additional comments.

103. RN E advised that she had no additional comments to make in response to the provisional report. She provided a letter of apology for forwarding to Mrs A's family.

104. The rehabilitation service responded: "We appreciate and acknowledge [HDC's] decision and take it as an opportunity to improve the services at [the rehabilitation service]. We will continue to work with staff to ensure that the best care is provided to our clients." The rehabilitation service provided a copy of its new Client Monitoring Form, which has now been rolled out for piloting at its regional centre and is currently being reviewed for every client.

Opinion: Ms D — Breach

105. Ms D had completed her annual clinical competency assessment to administer medications on 15 January 2014.

106. At approximately 10am on 3 May 2014, Mrs A's son, Mr C, arrived at the rehabilitation service to collect his mother. Ms D stated that she went to the medication cupboard to get Mrs A's medications, opened the cupboard and ripped medications off the medication box, thinking they were Mrs A's. She stated that she put the medications sachet in a plastic bag, sealed it, and gave the bag to Mr C.

107. There is no dispute that Ms D gave Mr C medications that were prescribed for another client. The medications given in error were quetiapine fumarate 50mg and carbamazepine (controlled release) 200mg.

108. Ms D said she told Mr C that they were Mrs A's dinner medications. Ms D then went to the office and signed off Mrs A's medications. The medication sheet for Mrs A's medication has the entry "S" meaning "self-administered".

109. That evening, Mrs A took the medications provided in error.

110. The medications that Mrs A should have received at dinnertime, but did not, were her simvastatin 20mg, levothyroxine 50mcg, Accupril 10mg, dipyridamole 150mg, metformin 500mg, and propranolol 20mg.

111. My in-house nursing advisor, RN Dawn Carey, advised me that medication errors are, unfortunately, commonplace. She noted that Ms D has submitted that she was feeling unwell and under pressure, and that there was poor lighting in the drug cupboard. Despite acknowledging that distraction and lack of concentrated focus play a role in medication errors, Ms Carey stated:

> "[W]hilst research highlights the common nature of medication errors, they cannot ever be deemed an acceptable part of practice."

112. I accept that advice. The rehabilitation service's Medication Management SOP made it clear that when administering medication, staff were required to check the unit dose packs such as the blister pack or robotic pack or the medicine label when getting the medicine from storage, and check the contents of the unit dose pack or medicine label with the client's medication chart. Staff were required to do the five right check (right person, right medication, right time, right route and right dose).

113. Ms Carey advised that the need to complete such checks "still applied to [Ms D] even though she was not directly administering the particular medication". Ms Carey further advised that the failure to do these checks was "a significant departure from safe medication practice". I agree.

114. If that process had been followed, Ms D would have realised that the medication she was handing to Mr C was not prescribed for Mrs A. I note that Ms D advised that she has since completed two in-house medication training modules. However, in my view, Ms D's error was a significant departure from accepted standards.

115. In my view, by failing to follow safe medication checking practices, Ms D did not provide services to Mrs A with reasonable care and skill. Accordingly, Ms D breached Right 4(1) of the Code.

Opinion: RN E — Breach

Standard of care

116. RN E has been employed by the rehabilitation service since January 2009 as the service leader responsible for the day-to-day management of the home.

117. At approximately 5pm on 3 May 2014, Ms F told RN E that there had apparently been a signing error, because resident X's medications were not at the rehabilitation service but they had not been signed out. I accept that at that time there was no evidence available to RN E that a more significant medication error involving Mrs A had occurred.

Assessment

118. At 10.15pm RN E received a telephone call from Ms F informing her that Mrs A's family had contacted Ms F to say that the tablets they had given to Mrs A that evening were for another person, and that Mrs A's family would come in to the rehabilitation service to see RN E in the morning.

119. Based on the evidence provided to me, I accept that RN E and other staff were not told at that time that Mrs A had fainted or passed out after taking the medication at dinner.

120. Following her attendance at ED with another client, RN E returned to the rehabilitation service to assess Mrs A.

121. Ms Carey advised that, once notified of the error, RN E was then responsible for the comprehensive assessment of Mrs A's clinical status and liaising with other clinical staff as to the appropriate next actions.

122. RN E assessed Mrs A at 11.30pm. Mrs A was alert, responsive and conversing. RN E took Mrs A's blood pressure and pulse, and found they were within normal limits.

123. However, RN E did not take Mrs A's respiration rate or blood glucose level, despite her having missed her metformin medication. I note that RN E said she did not assess whether Mrs A was orientated to time, as often Mrs A was uncertain of time and where she was, owing to her poor eyesight combined with complications from her stroke, but that Mrs A was aware and able to say that she was in her bed at the rehabilitation service.

124. Ms Carey was critical of RN E's incomplete vital signs assessment. Ms Carey stated that, in her opinion, "the evaluation of a person's condition is dependent on comprehensive assessment which requires all vital signs being taken". Ms Carey further advised that she considered that the respiration rate and blood glucose level were pertinent to the management of a diabetic resident who had ingested prescription medicines that were not prescribed for her.

Advice following assessment

125. I acknowledge that RN E checked the MIMs medical reference regarding possible side effects associated with the medication. The rehabilitation service's Medication

Management SOP included the requirement that all efforts be made to minimise the impact of a medication error on the client. I do not consider that RN E's actions in response to the medication error were consistent with the Medication Management SOP.

126. Ms Carey noted that the Medication Management SOP refers to the National Poisons Centre as an option for advice. While acknowledging RN E's statement that her previous experience with the public hospital was that staff were reluctant to provide advice over the telephone, Ms Carey advised:

> "I note that the Medication Management SOP (MMSOP) refers to the 24 hour National Poisons Centre (NPC) as an option. In my opinion [RN E] should have consulted [the ED] or NPC for advice …".

127. I agree. Ms Carey also advised me that RN E should have sought advice concerning the likely effects of the medications coupled with alcohol, which Ms Carey advised can heighten possible side effects. Ms Carey considered it reasonable that staff did not administer Mrs A her "usual" evening medications when they were aware that she had received quetiapine fumarate and carbamazepine in error.

128. RN E remained at the rehabilitation service until 1.30am on 4 May 2014. At handover, she instructed non-registered caregiver staff to monitor Mrs A at half-hourly intervals overnight, and told them that if there was any sign of deterioration they were to arrange for an ambulance and call RN E.

129. Ms Carey noted that the ingested medications (quetiapine fumarate and carbamazepine controlled release) have a particular half-life which meant they were still active when RN E left at 1.30am. Half-hourly checks would not halt the effects of the ingested prescription medications.

130. Ms Carey stated:

> "[T]he instruction that the [caregivers] rouse [Mrs A] at half-hourly intervals allows for a timely detection of collapse, but does not prevent such an adverse event. I remain concerned and critical of this and continue to consider the care provided by [RN E] to be a departure from the accepted standards of nursing care[18] following a medication error. I consider that my peers would also hold this opinion."

Conclusion

131. I accept and agree with Ms Carey's advice. In my view, RN E failed to assess Mrs A properly and failed to seek appropriate medical advice, which would have enabled her to respond appropriately to the medication error. In my opinion, RN E failed to provide services to Mrs A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

[18] Nursing Council of New Zealand (NCNZ), *Code of Conduct for Nurses* (Wellington: NCNZ, 2012). Standards New Zealand (NZS), *8134.1:2008 Health and disability (core) services standards* (Wellington: NZS, 2008). NCNZ, *Guideline: delegation of care by a registered nurse to a health care assistant* (Wellington: NCNZ, 2011).

Opinion: The rehabilitation service — Adverse comment

132. The rehabilitation service had overall responsibility for ensuring that Mrs A received an appropriate standard of care at the rehabilitation service. It needed to have in place adequate systems, policies and procedures, and to provide appropriate training and guidance to enable compliance with those systems, policies and procedures.

133. In addition to the overall responsibility referred to above, employers such as the rehabilitation service can be found vicariously liable for an employee's breach of the Code.[19] However, it is a defence for an employer to prove that it took such steps as were reasonably practicable to prevent the act or omission of an employee who breached the Code.[20]

134. Ms Carey noted that the rehabilitation service required the medication administration practices to be assessed and passed on three different occasions before competency was deemed to be achieved. She stated that this, plus the written assessment form, demonstrates a robust medication assessment process and that, in her opinion, the Medication Management SOP and competency assessments were consistent with accepted standards.

135. The rehabilitation service's medication management SOP has a section governing what process should occur when clients go on official leave. Ms Carey advised me that she was not critical of the rehabilitation service not having a policy that covered medication management for short outings/day leave, such as in Mrs A's case. I accept Ms Carey's advice.

136. While I acknowledge that Ms D stated that her error was contributed to by being busy, and by the poor lighting in the medication cupboard, I consider that Ms D's failure to provide services to Mrs A with reasonable care and skill on 3 May 2014 was a matter of individual error. She had completed medication competency training and was deemed to be competent in medicine administration. Having adequate documentation and policies in place and having provided Ms D with training on medication management, the rehabilitation service was entitled to rely on Ms D to provide appropriate care in the circumstances. Accordingly, I do not find the rehabilitation service directly liable or vicariously liable for Ms D's breach of the Code.

137. RN E's failure to provide services to Mrs A with reasonable care and skill on 3 and 4 May 2014 was a matter of individual error. The Medication Management SOP was consistent with accepted standards, and included the requirement that all efforts be made to minimise the impact of a medication error on the client. I do not consider that RN E's actions in response to the medication error were consistent with the Medication Management SOP. The rehabilitation service agrees that RN E ought to have sought medical advice in this situation. The rehabilitation service was entitled to rely on RN E to provide an appropriate standard of care in this regard. In the circumstances, I do not find the rehabilitation service directly liable or vicariously liable for RN E's breach of the Code.

[19] Section 72(2) of the Health and Disability Commissioner Act 1994 (the Act).
[20] Section 72(5) of the Act.

138. The rehabilitation service has accepted that the documentation regarding the error was inadequate in that the caregivers did not record the half-hourly checks they made of Mrs A. I note that the rehabilitation service did not have a tailored CMF at that time, but I would have expected the caregivers to have recorded the monitoring. I also note that RN E wrote the entry for 3 May 2014 on 4 May 2014 and did not document that this was a retrospective entry. Ms Carey advised: "I do have reservations about the general standard of clinical documentation evident in this case and referred to by the provider." I agree that documentation surrounding the incident could have been clearer and more accurate.

139. With regard to the incident when Mrs A, while seated in her wheelchair, fell off the back of the ramp onto the concrete, I consider this was an unanticipated mechanical failure to which the rehabilitation service responded appropriately, and did not amount to a breach of the Code by the rehabilitation service.

Recommendations

140. I recommend that Ms D:

a) Provide a formal written apology to Mrs A's family. The apology is to be sent to HDC for forwarding, within three weeks of the date of this report.

b) In the event that she continues to be employed as a caregiver elsewhere, provide HDC, via her new employer, with evidence that she has completed further medication administration competency training.

141. In the provisional report it was recommended that RN E provide a formal written apology to Mrs A's family. In response, RN E provided an apology letter to HDC for forwarding.

142. I recommend that the rehabilitation service:

a) Report on its review of the Medication Management SOP.

b) Report on the progress of the establishment of its quality governance group.

c) Report on the improvements made to the CMF implemented in August 2014 (which it reassessed during the course of this investigation) and staff compliance with its use.

d) Conduct a random audit of a selection of RN and caregiver documentation standards over the last six months and report to HDC on the outcome of the audit.

e) Report on the formal training provided on clinical documentation.

143. The rehabilitation service is to report to HDC on these recommendations within three months of the date of this report.

Follow-up actions

144. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN E's name.

145. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the District Health Board, and it will be advised of the names of Ms D and RN E.

146. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Ministry of Health (HealthCert), the New Zealand Aged Care Association, NZ Pharmacovigilance Centre, and the Health Quality and Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Clinical nursing advice to the Deputy Commissioner

The following expert advice was obtained from RN Dawn Carey.

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms B] about the care provided to her mother, [Mrs A], whilst she was resident at [the rehabilitation service]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the available documentation on file relevant to the focus of my advice: complaint and correspondence from [Ms B]; responses from [the rehabilitation service] including [Mrs A's] relevant clinical file — Medtech notes, medication signing sheet, client incident investigation form — client monitoring form (CMF) template, staff email correspondence, medication competency assessment, medication signing sheet for resident x, complaint outcome report to the Ministry of Health.

3. [Ms B] has complained that on 3 May 2014, a [rehabilitation service] staff member gave the incorrect medication to her brother for administration to their mother later that evening. [Mrs A] had social leave from [the rehabilitation service] to attend a family celebration. As it was not realised that the medication did not belong to [Mrs A], it was given to her. Some time afterwards, she appeared to 'pass out'. Unaware that she had received incorrect medication, her family returned her to [the rehabilitation service] and assisted her to go to bed.

   Later that night the error was realised by a family member and [the rehabilitation service] staff were contacted and told that [Mrs A] had received medication belonging to resident x. The medication administered to [Mrs A] in error was Quetiapine fumarate 50milligrams (mgs) and Carbamazepine Controlled Release (CR) 200mgs.

   As the in-house Nursing Advisor, I have been asked to review the information provided by [the rehabilitation service] (responses to [Ms B], response to Ministry of Health, policies and procedures, response to HDC) in regards to this medication error and advise if there has been a departure from the accepted standards of care. I have also been asked to provide commentary on the adequacy of [the rehabilitation service's] documentation.

4. [The rehabilitation service's] response to the Commissioner acknowledges and apologises for the error. Following an investigation into the circumstances, [the rehabilitation service] acknowledges that the organisational medication policy was not strictly followed. It has also acknowledged that there were shortcomings in relation to evidential documentation and that formal training to manage these shortcomings will be carried out.

[The rehabilitation service] reports:

- that during the morning in question there was an emergency with another resident and the [caregiver] reported feeling rushed when getting the medication for [Mrs A];
- that poor lighting at the drug cupboard has been identified as a contributory factor in the error and this has now been rectified;
- that the family notified [a rehabilitation service caregiver] that they had given resident x's medication to [Mrs A] at 10pm;
- that the Service Leader (SL) — a RN — saw [Mrs A] at 11.30pm, approximately 4 hours after she had been given the wrong medication. Her vital signs were checked and within normal parameters for her. The SL found [Mrs A] to be in a happy mood, conversing and responding as per normal;
- that the SL checked the MIMS medicine reference to assess the possible side effects associated with the medication. Based on the assessment that [Mrs A] did not appear to be experiencing side effects, a decision was made to continue to monitor her overnight. The SL gave a verbal handover to the night staff on the checks to perform — look for signs of increased drowsiness, decrease in alertness, any pain or discomfort, nausea or vomiting, dizziness, any changes in breathing, changes to movement of limbs — with the expectation that staff would document these checks in [Mrs A's] Medtech file;
- that the SL was available to be called to the unit if the night staff had any concerns;
- that the half-hourly observations were strictly carried out;
- in relation to resident x; she returned to [the rehabilitation service] at approximately 9.30pm and requested her evening medications. As the dated 'blister' was not on in the medication cupboard or in her handbag, staff mistakenly assumed that she had taken them whilst out and forgotten.

5. Review of submitted documentation
   (i) The Doctor's Prescribed Medication Chart (DPMC) has the following medication prescribed for [Mrs A] at dinner time: Simvastatin 20mgs, Levothyroxine 50m[c]gs, Accupril 10mgs, Dipyridamole 150mgs, Metformin 500mgs, Propranolol [20]mgs. These medications were not administered to [Mrs A] on 3 May 2013.
   (ii) The medication error is recorded on form 4.5.01.02 — client incident investigation form (CIIF) — dated 3 May. Page 1 of this form is signed by the two on duty [caregivers]. Documentation reports … *phone call at 10pm from family member concerning [Mrs A] tea medication was given, then noticed that the medication belong to* [resident x] *on call phoned asap …*
   (iii) Page 2 of CIIF is not dated or signed. Organisational guidelines indicate that this should be completed by a RN/ senior member of staff. Documentation reports … *able to respond to voice and converse. To be monitored closely overnight — ½ hrly checks* … [Mrs A's] vital sign observations *BP 127/75 P74* at *23.30* are also recorded. The handwriting

of these recordings appears to be different from the main scribe of page 2.

(iv) The 'investigation into event' part of the CIIF reports that [Mrs A] was given … *her medication around 9.30pm …* and that she had consumed *… 4 rums during dinner …* The medication administration time is later than suggested in the response to the Commissioner — *the Service Leader (SL) — a RN — saw [Mrs A] at 11.30pm, approximately 4 hours after she had been given the wrong medication.*

(v) The medication administration error is acknowledged in a Medtech entry by the SL on 4 May 2014. The reason for delay in recording that [Mrs A] received unprescribed medications is reported … *not able to be written up as medtech shutting at time available to scribe to write up report …*

(vi) An undated Medtech entry reports *NOCTE half-hourly checks strictly maintained, [Mrs A] was responsive and coherent on all checks …* Based on email correspondence it appears that this entry was retrospective and entered some time after 7.53pm May 4.

(vii) The complaint outcome report to the Ministry of Health reports [Mrs A] returning to [the rehabilitation service] at … *23.15 hours.* This is later than the contemporaneous Medtech documentation … *arrived home at 9pm, appears to be in a very happy mood, assistance into bed by son, settled.*

(viii) The [rehabilitation service's] Medication Management SOP (MMSOP) covers the required steps/checks that need to be carried to reduce the likelihood of a medication error. This is appropriate and expected. Section 5.2 specifies the 'Interventions' that need to be followed when a medication error has occurred. These include:

— *Notify the senior RN and/or Service leader immediately and/or the prescriber, and monitor the client as advised.*

— *The administrator is to seek advice from clinical on-call staff, pharmacy, GP/After hours service …*

— *All efforts must be made to minimise the impact of the error on the client.*

(ix) The submitted CMF template allows for specification of frequency of monitoring but does not detail what 'monitoring' is required e.g. client in room versus check vital signs. In my opinion, delegation of clinical monitoring to a non RN requires more specific instructions than this form supports. I note that the form reports the form creation date as August 2014. Clarification should be sought from [the rehabilitation service] as to whether this form existed when the incident happened or not.

6. Comments

(i) There are slight discrepancies in the reported timings that relate to the sequence of events as reported in the [the rehabilitation service] contemporaneous documentation, report to Ministry of Health and response to the Commissioner.

(ii) I note that the duty [caregiver] acted in accordance with the [the rehabilitation service] policy and alerted the SL as soon as made aware of the error. I agree that this was required and an appropriate action.

(iii) In my opinion the evaluation of a person's condition is dependent on comprehensive assessment which requires all vital signs being taken, including respiration rate. This was not done in this case. I note that the SL verbal advice to the [caregiver] — non RNs — is reported as observing for … *any changes in breathing*. In my opinion this requires a baseline assessment in order to be able to evaluate changes. I am also critical that [Mrs A's] vital signs check at 11.30pm did not include her blood glucose level. I base my criticism on [Mrs A] being a known diabetic who had not received her prescribed Metformin.

(iv) In my opinion the lack of action in relation to resident x meant that two medication errors occurred on 3 May. I am critical that appropriate actions were not taken by the [the rehabilitation service] SL following notification at 10pm that resident x's tablets had been given to [Mrs A].

7. Clinical advice

Registered nurses are accountable for ensuring that all health services that they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards[21] and guidelines[22]. Accurate assessment and evaluation of clinical findings are integral parts of the nursing process. In my opinion, it was appropriate that the [caregiver] escalated concerns and sought advice following realisation of the medication error. Once notified of the error, I consider that the SL was then responsible for the comprehensive assessment of [Mrs A's] clinical status and liaising with other clinical staff as to the appropriate next actions. Evaluating the possible effects of administered Quetiapine and Carbamazepine CR in an elderly person when not indicated, requires knowledge of the person's past medical history etc. The addition of alcohol can also heighten possible side effects. In my opinion either the After hours GP or [the] Emergency Department should have been contacted for advice.

I note the [the rehabilitation service] MMSOP correctly identifies that … *all efforts must be made to minimise the impact of the error on the client* … I disagree that the clinical actions or advice from the SL supported this action. Instructing non registered staff to do half-hourly checks is not going to halt the effects of the ingested medications; nor will it necessarily pick up signs of deterioration when the checks do not include taking vital signs — BP, respiration rate, pulse rate, level of consciousness. In the context of night time and a client who wanted to sleep, the verbal instructions … *look for signs of increased drowsiness, decrease in alertness* … are inadequate. In my opinion the provided care by the SL

[21] Nursing Council of New Zealand (NCNZ), *Code of conduct* (Wellington: NCNZ, 2012). Standards New Zealand (NZS), *8134.1:2008 Health and disability (core) services standards* (Wellington: NZS, 2008).

[22] Nursing Council of New Zealand (NCNZ), *Guideline: delegation of care by a registered nurse to a health care assistant* (Wellington: NCNZ, 2011).Nursing Council of New Zealand (NCNZ), *Guideline: responsibilities for direction and delegation of care to enrolled nurses* (Wellington, NCNZ, 2011).

significantly departed from the accepted standards of nursing care following notification of a medication error.

As noted in section 6 (iv) two medication errors occurred on 3 May 2014. I remain critical that SL did not act on the information that resident x did not receive her prescribed medication.

In my opinion the standard of clinical documentation submitted does not meet expected standards[23] in relation to monitoring and assessment. As part of the learning available in this complaint, I would encourage [the rehabilitation service] to review the CMF template. I would also recommend that [the rehabilitation service] keep the Commissioner abreast on the progress with the formal training on clinical documentation and that auditing to ensure better compliance with the required standards is considered."

Ms Carey provided the following further advice:

"…

1. Thank you for the request that I provide additional clinical advice in relation to the complaint from [Ms B] about the care provided to her late mother, [Mrs A], while she was resident at [the rehabilitation service]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following documentation available on file: clinical advice dated 23 October 2014; response and statement from [RN E]; response and statement from [caregiver] [Ms D]; response and supporting documents — staff statements, policy and procedure documents — from [the rehabilitation service]; further correspondence from [Ms B].

3. I have been asked to provide further nursing advice and comments on:
   i. Whether I wish to make any changes or additions to my initial expert advice in light of the additional information and responses from the providers that I have not previously had an opportunity to review;
   ii. The overall standard of care provided by:
      a. [RN E];
      b. [the rehabilitation service]; and
      c. [Ms D]
   iii. The appropriateness of [rehabilitation service] policies and procedures in place.

[23] Standards New Zealand (NZS), *8134.1:2008 Health and disability (core) services standards* (Wellington: NZS, 2008).

4. **Summary of response from [RN E]**

- Reports not being aware that [Mrs A] had 'passed out' while at her [family celebration] until the HDC forwarded her the complaint details.
- Reports being informed on 4 May 2013 by family members that [Mrs A's] 'energy flattened' after dinner at the [family celebration].
- Clarified the timeline involved in the incident; specifically that [Mrs A] was administered the medication at 7.30pm; [RN E] reviewed and assessed her at 11.30pm and remained onsite until 1.30am.
- Agrees that [Mrs A's] blood glucose level should have been checked at 11.30pm.
- Reports that the other resident — whose medication [Mrs A] had taken in error — was offered her evening medication after the error had been communicated to [rehabilitation service] staff but that she refused it. This refusal was managed in accordance with the relevant [rehabilitation service] policy.
- Reports that she did not have the option of contacting [Mrs A's] GP surgery as it was closed and that previously [the Emergency Department was] reluctant to offer telephone advice without reviewing the patient.
- Reports the advice given to the two [caregivers] on duty meant that they would rouse [Mrs A] every 30 minutes and that she was confident that this was occurring based on her continued interactions with the [caregivers].
- Reports the expectation that the [caregivers] would complete documentation reporting these checks and disappointment that this was not done.

5. **Summary of response from [the rehabilitation service]**

- Staff statements from the two [caregivers] on duty report not being told that [Mrs A] had 'passed out' while at her [family celebration].
- Acknowledges that the medication policy was not strictly followed and that staff members have now completed refresher training.
- Acknowledges that there was an error in the timeline reported in the letter to the Ministry of Health.
- Clarified the timeline involved in the incident; specifically that [Mrs A] was administered the medication at 7.30pm, returned to [the rehabilitation service] at 9pm, [the rehabilitation service] notified of the error at 10pm, [RN E] notified at 10.25pm, [RN E] reviewed [Mrs A] at 11.30pm.
- Agrees that the documentation was lacking in this case and report remedial actions including training and audits. Hard copy progress notes are now easily accessible for instances when Medtech shuts down.
- The Clinical Monitoring Form (CMF) was developed after this medication error but [the rehabilitation service] will reassess it.
- Results from two medication audits.
- No medication errors in the six months prior to this error.

6. **Summary of response from [Ms D]**

- Reports that she was unwell on the 3 May 2014 and had asked the other staff member who was medication competent to do the morning medication round instead. [Ms D] reports stating that she … *was not in the right head space to do* [the medication round].
- Reports feeling powerless and unsupported by the other team member's refusal to do the medication round for her.
- Reports feeling very upset about the error and that she would not allow herself to be bullied into doing a medication round again.
- Since this error, [Ms D] has completed further medication training.

7. **Clinical advice**

i. **Whether I wish to make any changes or additions to my initial expert advice in light of the additional information and responses from the providers that I have not previously had an opportunity to review**
There is a discrepancy in the reported details of this case concerning whether [the rehabilitation service] were informed that [Mrs A] had passed out during her [family celebration] or not. I have attempted to address the possible different scenarios below.

ii. **The overall standard of care provided by:**

a. [RN E]
I remain critical of the incomplete vital sign assessments — no respiration rate and no blood glucose level — and consider both pertinent to the management of a diabetic resident who had ingested prescription medications that were not prescribed for her. I acknowledge that [RN E's] continued presence at [the rehabilitation service] meant that there was more RN oversight than I had previously appreciated. While I note that [RN E] did not have the option of contacting an after hours GP for advice I remain of the opinion that she should have sought advice concerning the likely effects of these medications coupled with alcohol. I note that the Medication Management SOP (MMSOP) refers to the 24 hour National Poisons Centre (NPC) as an option. In my opinion [RN E] should have consulted [the] ED or NPC for advice. The half life of the ingested medications — Quetiapine and Carbamazepine Controlled Release — meant that these medications were still active when [RN E] left at 1.30am. The instruction that the [caregivers] rouse [Mrs A] at half-hourly intervals allows for a timely detection of collapse but does not prevent such an adverse event. I remain concerned and critical of this and continue to consider the care provided by [RN E] to be a departure from the accepted standards of nursing care[24] following a medication error. I consider that my peers would also hold this opinion. In my opinion, the practice changes that [RN E] reports making following this complaint are appropriate.

[24] Nursing Council of New Zealand (NCNZ), *Code of conduct* (Wellington: NCNZ, 2012). Standards New Zealand (NZS), *8134.1:2008 Health and disability (core) services standards* (Wellington: NZS, 2008).NCNZ, *Guideline: delegation of care by a registered nurse to a health care assistant* (Wellington: NCNZ, 2011).

— If a findings of facts determine that the [caregiver] was notified that [Mrs A] had passed out I would be very critical that this information was not communicated to [RN E] when the incident was reported to her at 10.25pm. I would amend my previous criticism of [RN E] from significant departure to moderate departure.
— If a findings of facts determine that the [caregiver] was notified that [Mrs A] had passed out and that this was communicated to [RN E] I would view [RN E's] lack of consultation with [the ED] or the NPC with criticism and continue to view the provided care as a significant departure.
— If a findings of facts determine that no member of [the rehabilitation service] staff were notified that [Mrs A] had passed out I would amend my previous criticism of the care provided by [RN E] from significant departure to moderate departure.

b. [The rehabilitation service]

In my opinion, the overall standard of care provided by [the rehabilitation service] was consistent with accepted standards in that their policies and procedures in place at the time were appropriate and appeared to be known and understood by the staff team. I do have reservations about the general standard of clinical documentation evident in this case and referred to by the provider — [Mrs A's] longstanding refusal for diabetic monitoring not being part of her care plan, the [caregiver] referring to having been previously reminded about the need to complete contemporaneous documentation — but consider the identified remedial actions — education, auditing, development/review of supporting forms, increased support from senior management, establishment of a quality governance group — to be appropriate.

c. [Ms D]

On 3 May, [Ms D] gave the wrong medication to [Mrs A's] son. I acknowledge and note that she was feeling unwell, under pressure and that there was poor lighting at the drug cupboard. Within the relevant literature, research has identified factors such as distraction and lack of concentrated focus, as known contributory issues[25] in medication administration errors. The literature also highlights that medication errors are unfortunately commonplace. However, whilst research highlights the common nature of medication errors, they cannot ever be deemed an acceptable part of practice.

[Ms D's] actions on 3 May 2014 departed from the accepted standards of safe medication management. The need to completed the '5Rs+3' checks still applied even though [Ms D] was not directly administering the medication to [Mrs A]. These checks were not done and that failure is a significant departure from safe medication practice. However, while I am critical of [Ms D's] practice I am very mindful that knowledge about the role 'human factors' have in medication errors is not necessarily a part of medication competency training for non registered health providers. Also, even when armed with such

[25] Keers, R.N., Williams, S.D., Cooke, J., & Ashcroft, D.M. (2013). Causes of medication administration errors in hospitals: A systematic review of quantitative and qualitative evidence, *Drug Safety*, *36*,1045–1067.

knowledge, registered health providers continue to make medication errors. In my opinion, my peers would agree that [Ms D's]] practice departed from the accepted standard but that this departure was an unfortunate 'human error'.

iii. **The appropriateness of [rehabilitation service] policies and procedures in place.**

[The rehabilitation service requires] the medication administration practices to be assessed and passed on three different occasions before competency is deemed achieved. In my opinion, this plus the written assessment form demonstrates a robust medication assessment process. In my opinion, the MMSOP and competency assessments are consistent with the accepted standards[26]."

Ms Carey provided the following further comments:

"I would not be critical of [the rehabilitation service] not having a policy that covers medication management for short outings/day leave. [Mrs A's] 'medication' was given to an adult who agreed to take responsibility for administering it to her and I consider this sufficient and consistent with accepted practice in comparable facilities. The medication error did not occur due to the lack of a policy but due to the wrong medication being given to [Mrs A's] family member.

I consider it reasonable that staff did not administer her 'usual' evening medications to [Mrs A] when they were aware that she had received Quetiapine fumarate and Carbamazepine CR in error."

[26] NZS, *8134.1:2008 Health and disability (core) services standards* (Wellington: NZS, 2008).