Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Medication error – the importance of complying with policies and guidelines
21HDC01173

The Deputy Commissioner has found two registered nurses in breach of the Code of Health and Disability Services Consumers' Rights (the Code) for their care of an elderly man. Dr Vanessa Caldwell found the nurses failed to comply with the District Health Board (now Te Whatu Ora) policy or the New Zealand Nurses Organisation (NZNO) Guidelines in their care.

The elderly man was admitted to hospital with symptoms resembling a stroke but a CT scan revealed he was having seizures. During his follow-up treatment he received the wrong medication, which was incorrectly prepared and administered by the two registered nurses. The man became unresponsive, was moved to the ICU and passed away three days later from pneumonia following an overdose of the incorrect medication.

Dr Caldwell considered that both nurses failed to identify the errors in preparation despite multiple further opportunities and/or red flags. Dr Caldwell found the nurses in breach of Right 4(1) of the Code, in respect to providing services with a lack of care and skill, and Right 4(2) which provides the right to services that comply with legal, professional, ethical and other relevant standards.

"I accept there were circumstances which contributed to this error. I also consider it possible that confirmation bias played a role in successive opportunities to be alert to the error being missed," Dr Caldwell said.

"Even so, in my view, the nurses failed to comply with the DHB's Checking IV Medication and Fluids — IV Manual by not checking adequately that they had the correct drug in the treatment room/pre-administration check."

Dr Caldwell noted the nurses also failed to comply with the NZNO Guidelines for Nurses on the Administration of Medicines – in that they did not comply with the requirement to check that they had the "right medication".

Dr Caldwell was also critical of Te Whatu Ora's unclear policy and its storage of the medication. "Te Whatu Ora, as a healthcare provider, is obligated to provide care in accordance with the Code, and to support its staff adequately with policies and procedures," she said.

The first registered nurse had provided an apology to the man's family, Dr Caldwell noted. She also recommended the nurse report back on any medication errors that have occurred subsequently and any further changes made to her practice. While

acknowledging that the second nurse is no longer practicing, Dr Caldwell recommended the second nurse also provide an apology to the man's family.

Dr Caldwell made a number of recommendations for Te Whatu Ora including to:

- Provide HDC with a further update on any changes made as result of these events.
- Undergo an audit of all medication errors and compliance with Te Whatu Ora policy over a three-month period.
- Evaluate the practice of independent double-checking, and the education given on how this process should look in clinical practice, and reflect on any changes it considers are required in the relevant policy.
- Ensure that the updated medication policy includes clear definitions of what an "independent double checking process" entails, and what checks are needed and when, and that the policy uses consistent language regarding "treatment room"/"pre-administration check" and "bedside check"/"administration check".
- Consider the setup of safe medication storage, educational initiatives, investigation into medication management/storage systems, and initiatives to improve checking compliance and reduce human errors.
- Evaluate the adequacy of staff education across Te Whatu Ora on the correct procedure for independent double-checking, and the 5+3 medication rights.

Since the event, Te Whatu Ora have taken a number of actions, including leading work to implement Safety and Quality Walkabouts, undertaking an audit of the medication room, approaching Te Tāhū Hauora (Health, Quality and Safety Commission) for advice on safe storage of medication and updating the Checking IV Medications and Fluids Manual.

15 May 2023

Editor's notes

The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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