# Medication checking error and management
# (14HDC00607, 22 March 2016)

*Caregiver ~ Registered nurse ~ Rehabilitation service ~ Medication error ~ Monitoring ~ Medical advice ~ Right 4(1)*

A woman had resided for several years at a facility providing rehabilitation services following a stroke. She had multiple co-morbidities and poor vision and was on a number of prescribed medications.

The woman's family was having a celebration. Earlier that day a caregiver, who was feeling unwell and in a rush, had prepared and given the woman's son her dinner-time medications to give her that evening. The caregiver did not perform the necessary checks of the medication 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.

The medications were administered to the woman that evening. Ten minutes after the evening meal finished, the woman "passed out" for approximately a minute. The family decided to return her to the facility at about 9pm.

At approximately 10.15pm, the on-call registered nurse (RN) was advised by telephone by another caregiver that the family had contacted the facility to say it was apparent that the medication they had given to the woman that evening was meant for another person.

At approximately 11.30pm, the RN assessed the woman at the facility. The woman was alert, responsive, and conversing. The RN took the woman's blood pressure and pulse, both of which were within normal limits. The RN did not take the woman's respiration rate or her blood glucose level, despite the woman not receiving her usual metformin medication and having consumed alcohol. The RN remained at the facility until 1.30am. She did not call the Emergency Department for further advice, or contact the National Poisons Centre. Instead, she instructed staff to monitor the woman at half-hourly intervals overnight and, if there was any sign of deterioration, they were to arrange for an ambulance and call her.

The RN went into the facility later that morning, spoke to the staff on duty, and went to see the woman and some of her family members. The RN 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.

It was held that by failing to follow safe medication checking practices, the caregiver did not provide services with reasonable care and skill, breaching Right 4(1). It was also held that the RN failed to provide services to the woman with reasonable care and skill, breaching Right 4(1), by failing to assess the woman properly and failing to seek appropriate medical advice, which would have enabled her to respond appropriately to the medication error.

The rehabilitation service was found not to be directly liable or vicariously liable for the caregiver's or RN's breach of the Code. The rehabilitation service had supplied

the caregiver 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.

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