Department of Corrections

A Report by the

Deputy Health and Disability Commissioner

(Case 13HDC00853)

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Executive summary

1. Mr A was an inmate at Auckland Prison (the Prison). On 11 June 2013, Mr A had a dental procedure, performed by dentist Dr B, to remove his lower left molar.

2. Following his dental procedure, Mr A continued to bleed from the wound, was vomiting, and experiencing hot and cold flushes. Over the following 50 days until 31 July 2013, Mr A continued to experience pain resulting from his dental procedure.

3. Between 12 June 2013 and 27 June 2013, Mr A was prescribed Pamol and Brufen for pain, as well as metronidazole and Augmentin for infection. During that time, Mr A recalls making verbal requests to Department of Corrections (Corrections) custodial staff on a number of occasions for medical review, for pain relief, or for antibiotics to be supplied. On five occasions between 13 June and 18 August 2013, Mr A submitted written requests for clinical review or pain relief.

4. Between 12 June and 27 June 2013, it is documented that Mr A was administered Brufen in accordance with his prescription on only three days. According to the documentation, Mr A was not administered Pamol in accordance with his prescription on any day during that time. It is recorded that he was administered Augmentin and metronidazole in accordance with his prescription on only one day each.

5. Between 4 July 2013 and 30 July 2013, Mr A was prescribed naproxen and Voltaren for pain. There is no record that either naproxen or Voltaren were administered to Mr A on any occasion.

6. There are no progress notes relating to Mr A between 31 July 2013 and 18 August 2013. On 18 August 2013, it was recorded that Mr A continued to experience pain resulting from his dental procedure. There are no further records relating to Mr A's dental concerns after 18 August 2013. Later in 2013, Mr A was released from Prison.

Findings

Department of Corrections

7. Corrections staff consistently failed to provide Mr A with medication in accordance with his prescription, and repeatedly failed to assess Mr A prior to administration of his medication. Furthermore, there was a pattern of suboptimal clinical documentation by multiple staff involved in Mr A's care, which indicated a lax attitude towards documentation within Corrections. Accordingly, Corrections failed to ensure that Mr A was provided services with reasonable care and skill and breached Right 4(1)[1] of the Code of Health and Disability Services Consumers' Rights (the Code).

8. Adverse comment is made about Corrections for placing Mr A on a soft diet for three days without any plan to review him before placing him back on a regular diet.

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

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Dr D

9. Adverse comment is made about Dr D for documentation errors relating to prescribing.

Complaint and investigation

10. The Commissioner received a complaint from Mr A about the services provided to him by the Department of Corrections. The following issue was identified for investigation:

> *Whether the Department of Corrections provided an appropriate standard of care to Mr A in 2013.*

11. This report is the opinion of Deputy Commissioner Ms Theo Baker, and is made in accordance with the power delegated to her by the Commissioner.

12. The parties directly involved in the investigation were:

Mr A	Consumer/Complainant
The Department of Corrections (Auckland Prison)	Provider

Also mentioned in this report:

Dr B	Dentist/provider
RN C	Registered nurse/provider
Dr D	Doctor/provider
RN E	Registered nurse/provider
RN F	Registered nurse/provider
RN G	Registered nurse/provider
RN H	Registered nurse/provider
Dr I	Dentist/provider

13. Independent expert advice was obtained from HDC's in-house nursing advisor, Registered Nurse Dawn Carey (**Appendix A**).

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Information gathered during investigation

Introduction

14. This decision is in relation to the care provided to Mr A following a dental procedure on 11 June 2013, while he was an inmate at Auckland Prison (the Prison), by the Department of Corrections (Corrections) Health Service (the Health Service).[2]

Department of Corrections Health Service

15. Corrections provides primary healthcare to inmates, including general practitioner (GP) services, nursing, and basic dentistry. The Prison has a health centre staffed by registered nurses who are employed by Corrections. Doctors and dentists are contracted by Corrections to provide medical and dental care.

16. To access non-urgent health services, inmates can attract the attention of custodial staff or submit written requests for medical attention called "chits". Chits are collected by custodial staff on a daily basis and triaged by health centre staff, usually the following day. Chits are required to be processed by health centre staff within seven days. Inmates also have access to an emergency call bell in their cells to be used if they require emergency medical attention.

Dentist service

17. At the time of these events, dentist Dr B was contracted to Corrections to provide dentistry care to inmates at the Prison each Tuesday for seven hours. She advised HDC that she remained "on call" to the Prison while she was not working on site, which meant that she would attend if needed outside her regular hours.

Nursing service

18. Corrections advised HDC that the Health Service nurses are on site from 7am until 10pm each day, after which a nurse is on call until 7am the following morning. Corrections stated that the on-call nurse is available and contactable by custodial staff, should an inmate have health concerns after 10pm.

Procedures regarding the supply of medication to inmates

19. Corrections told HDC that it does not require over-the-counter medicines (OTCs),[3] such as Brufen[4] and Pamol,[5] to be prescribed by a doctor, and that these can be provided to inmates by a registered nurse (RN). Custodial staff are permitted to provide Pamol to inmates. However, Corrections advised HDC: "Custodial staff at Auckland prison have been reluctant to administer the liquid paracetamol …"

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[2] Mr A was released from the Prison later in 2013.

[3] Medicine that can be purchased from a retail outlet and does not require prescription.

[4] Ibuprofen, often known under the brand name Brufen, is an analgesic and an anti-inflammatory medication used to relieve mild to moderate pain, inflammation and fever. Throughout Mr A's progress notes, ibuprofen is interchangeably referred to as "Brufen". For the purpose of consistency, it will be referred to in this report as Brufen, other than where quotes state otherwise.

[5] Liquid paracetamol, often known under the brand name Pamol, is used to relieve mild pain and fever. Throughout Mr A's progress notes, paracetamol is interchangeably referred to as "Pamol". For the purpose of consistency it will be referred to in this report as Pamol, other than where quotes state otherwise. Paracetamol is given to inmates at the Prison in liquid, and not tablet, form.

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20. Inmates are not permitted to hold medication in their cells, and medication must be taken immediately in front of the staff member providing it. This is to avoid hoarding of medication by inmates. In accordance with Corrections' policy (outlined below), custodial staff and registered nurses are required to keep a record of all medications prescribed and distributed. Registered nurses are also required to assess the inmate's condition prior to administering medication.

Mr A's dental assessment and procedure

21. In June 2013, Mr A was experiencing pain in his lower left molar, and requested an appointment with the Health Service's dentist. This request was processed and an appointment made with Dr B for 11 June 2013.

22. On 11 June 2013, Mr A attended his appointment with Dr B. Dr B advised HDC that Mr A presented with a painful lower left molar, which was badly decayed. Dr B decided to extract Mr A's tooth, and obtained his consent for the tooth extraction (the procedure). Mr A was given a local anaesthetic, and the procedure took around 45 minutes.

23. Dr B told HDC that she provided Mr A with 1g Pamol, which he took before he left the Health Service. She also gave Mr A "verbal post extraction instructions", which were not documented, and provided him with gauze swabs to take to his cell. Dr B documented in Mr A's progress notes: "Extraction tooth 37 DIFFICULT !! [prescribe] 1g[6] Pamol stat."[7]

Summary of events following dental procedure

24. The following is a summary of the events between 11 June 2013 and Mr A's release later in 2013, following the procedure. Information relating to the administration of medication to Mr A during this time is detailed in **Appendix B**.

11 June 2013

25. After the procedure, Mr A went back to his prison cell. He told HDC that he was in shock and having hot and cold flushes. He stated that his jaw was very sore, and that he was spitting out blood, and vomiting.

26. Mr A told HDC that at 1.00pm he informed custodial staff that he was not feeling well and asked to see a nurse. Mr A said that he was informed that he would have to wait until a nurse was able to see him.

27. Mr A said that at 5.00pm a nurse assessed him and gave him Pamol for the pain, and cottonwool balls to stop the bleeding. Mr A stated that neither the pain relief nor the cottonwool balls were very successful. There is no record of an assessment of Mr A at this time, nor is there any record of Mr A being given Pamol.

[6] The strength of the Pamol prescribed by Dr B at 1gram was equivalent to 20ml.
[7] Meaning "immediately".

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12 June 2013

28. Mr A told HDC that at 2.00am on 12 June 2013 he woke up in "complete agony". He stated that he pressed the emergency call button in his cell to ask for more pain relief. Mr A told HDC that he recalls being given Pamol in response to his request; however, this is not documented.

29. Later on the morning of 12 June 2013, RN C began her shift at the Prison and assessed Mr A. She discussed her assessment findings with Dr B. RN C recorded in Mr A's progress notes:

> "Noted that he has had bleeding through the night, blood ++ on pillow case. Blood/Saliva dripping out of mouth during consult. Issued with cotton balls to pack & rang Dentist. Dentist Rx[8]: i) pack with gauze and bite down on to apply pressure ii) administer brufen & paracetamol PLAN: provide gauze, write up brufen & pamol as [Standing Orders[9]]. (R/V)[10] at PM shift."

30. It is recorded in the prescribed medication chart (PMC) that Mr A was prescribed 400mg of Brufen twice daily, and 1g paracetamol or 20ml of Pamol twice daily until 15 June 2013. Both prescriptions were listed under "PRN" (as required) medication. There is no record that Mr A was administered Pamol or Brufen at this time.

31. Mr A stated that, by the evening of 12 June 2013, his mouth was bleeding constantly and his jaw had locked closed. The left lower part of his face and neck were swollen and he struggled to swallow. Mr A told HDC that, at approximately 7.00pm, a nurse attended to assess him on her rounds. According to Mr A, he told the nurse that he felt that his mouth had become infected, and the nurse replied that it was normal to have some swelling, and that it would be better the following day. Mr A told HDC that he recalls being given pain relief medication at this time, but there is no record of this.

32. Mr A told HDC that at 11.00pm he woke up in pain and asked custodial staff to provide more pain relief. According to Mr A, custodial staff advised him that he had to wait until 7am the next morning for a nurse to provide more pain relief. There is no record of Mr A's request.

13 June 2013

33. At 8am on 13 June 2013, Mr A received 20ml of Pamol. Mr A advised that he experienced constant pain all day. He submitted a chit to the Health Service, stating: "Can i please see the doctor asap as my mouth and [throat] have swollen up and I struggle to [swallow]." The request was recorded as being received by the Health Service the following day. Mr A also told HDC that he asked custodial staff three or four times during the day to arrange for him to see a nurse in order to get more pain relief and to check for infection. There is no record of any additional requests by Mr A to see a nurse or obtain pain relief on 13 June 2013.

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[8] "Prescribed."

[9] A set of written instructions from a registered medical practitioner or dentist to other persons to permit the supply or administration of medicines or specified controlled drugs without a prescription, and to provide medical treatment.

[10] "Review."

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34. At midday on 13 June 2013, Mr A was assessed by RN C, who discussed his condition with the doctor on site, Dr D.[11] Dr D advised RN C that Mr A would need regular pain relief and cold compresses. Dr D prescribed Mr A 20ml Pamol three times daily until 20 June 2013, and Augmentin[12] "625g"[13] three times daily until 20 June 2013. It is recorded in Mr A's progress notes:

> "[L]unchtime Pamol. [Mr A] is [complaining of] increased pain … swelling has increased a lot, covering the L) jaw line coming under to the R) chin. Upon talking to the GP [Mr A] has been commenced on Pamol TDS[14] and Augmentin TDS. Have instructed [Mr A] to use cool compression while in cell … swelling +++ jaw."

35. Mr A recalls being provided with pain relief at 7.00pm on 13 June 2013, but this is not recorded. Mr A told HDC that, at 11.00pm that night, he woke to pain and asked custodial staff for more pain relief, but his request was refused. There is no record of Mr A's request. With regard to whether medication was provided to Mr A on 13 June 2013, Corrections told HDC:

> "Nurses do visit the unit that [Mr A] was in at least twice a day, so it is probable he did receive his medication. However, there is no documentation to support this. The documentation has fallen below the required standards."

14 June 2013

36. Mr A told HDC that, at around 11.00am on 14 June 2013, he "yelled" at a member of custodial staff to "either get me a doctor or take me to the hospital as I [have] had enough". Mr A's request is not documented. However, it is recorded in Mr A's progress notes that RN C attended and assessed Mr A on the morning of 14 June 2013. According to Mr A, RN C advised him that he had a temperature, which was caused by an infection. RN C documented that she contacted Dr D, who prescribed Mr A 400mg metronidazole[15] (written as "400" with no unit of measurement) three times daily until 21 June 2013, and Augmentin 625mg three times daily until 21 June 2013, both for infection. RN C recorded in Mr A's progress notes:

> "Upon examination swelling has increased. GP contacted for advice on medications. Medications changed to reflect Augmentin 625mg. 2 tabs TDS Metronidazole 400mg TDS [review] with GP on Monday."

37. Mr A told HDC that he recalls receiving pain relief on the morning of 14 June 2013, and that he was started on antibiotics that night. RN C told HDC that she administered Mr A's prescribed medication on 14 June 2013, but she did not document this.

[11] Dr D is not vocationally registered in general practice.
[12] A penicillin antibiotic used to treat infections caused by bacteria.
[13] The prescription should have read "625mg". As each Augmentin tablet is 625mg, one hundred 625mg tablets would be required to make up a prescription for 625g of Augmentin.
[14] Three times a day.
[15] An antibiotic used to treat infection caused by bacteria. This prescription was written by RN C and later signed by Dr D.

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Further treatment

38. On 15 June 2013, it is recorded that at 8am and again at 1pm, Mr A received Brufen, Pamol, Augmentin and metronidazole, in accordance with his prescriptions. However, there is no record of Mr A receiving a third dose of Pamol, Augmentin or metronidazole, despite those prescriptions being for three times daily.

39. RN E[16] told HDC that, on 16 June 2013, she administered Mr A's analgesia but failed to document this. RN F[17] told HDC that on 15, 16 and 17 June 2013 she saw Mr A for the administration of medication unrelated to his dental procedure, and that it is "highly likely" that she administered Pamol and Brufen while administering his other medication. However, she failed to document this. There is no record of Mr A receiving any medication on 16 June 2013.

40. RN G[18] told HDC that on the morning shifts on both 17 and 18 June 2013 she administered analgesia to Mr A, but failed to document this. On 17 June 2013, RN G recorded that Mr A received Augmentin and metronidazole twice. However, there is no record that he received a third dose of Augmentin or metronidazole despite those prescriptions being for three times daily. On 18 June 2013, it is recorded that Mr A received Augmentin and metronidazole three times, in accordance with his prescription.

41. On 20 June 2013, Dr D reviewed Mr A owing to his on-going pain. Dr D recorded in the progress notes: "[J]aw healed to some degree L wisdom small open area now some [lymph nodes] [anterior] triangle."[19] Dr D recommenced Mr A on Brufen, recording "400g"[20] three times daily until 27 June 2013.

42. Mr A was administered Brufen on five occasions on 24 June, and on five occasions on 25 June.

43. On 27 June 2013, Mr A's prescription for Brufen ended. Mr A advised that he remained in constant pain, was unable to open his jaw fully, and had rotten tasting pus in his mouth daily. On 28 June 2013, it is recorded in Mr A's progress notes: "Doing reasonably well … However still complaining of tooth pain with swelling …" RN H told HDC that, on the evening of 28 June 2013, he administered Brufen to Mr A. Mr A continued to receive Brufen between 28 June and 3 July 2013 (see **Appendix B**). However, there are no records regarding any medical assessments of Mr A after 28 June 2013, or any information regarding why he continued to receive Brufen between 28 June and 3 July 2013.

X-ray and review by Dr B

44. On 4 July 2013, owing to Mr A's on-going pain, Dr D reviewed Mr A and requested an X-ray of his jaw, to be reviewed by a dentist. Mr A's X-ray was taken the same

[16] RN E told HDC that she was rostered on the day shift, which is between 6.30am and 3pm.
[17] RN F told HDC that she was rostered on the evening shifts between 2pm and 10pm.
[18] RN G told HDC that she was rostered on the day shift, which is between 6.30am and 3pm.
[19] The anterior triangle refers to the area underneath the chin.
[20] Rather than "400mg".

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day. Dr D charted "500g"[21] naproxen[22] once daily until 18 July 2013. There is no record of naproxen having been administered to Mr A on any occasion.

45. On 9 July 2013, Mr A's X-ray became available. The radiologist noted in the X-ray report:

> "? Tooth fragment left inferior wisdom tooth. ? How easy to remove. **Findings:** There is a partially erupted inferior left third molar and this is angled forwards. A dental opinion with regard to removal would be recommended."

46. On 9 July 2013, Dr B reviewed Mr A's X-ray and organised a review for 16 July 2013. On 16 July 2013, Dr B reviewed Mr A. She told HDC that Mr A appeared well but concerned regarding the unerupted tooth. She stated: "We discussed the x-ray, and I advised that the tooth did not require extraction at this stage …"

47. Dr B recorded in Mr A's progress notes dated 16 July 2013 that the X-ray results showed no jaw fracture, and an unerupted tooth next to the tooth that had been removed. Dr B prescribed Mr A 75mg Voltaren[23] for ongoing pain, to be given once daily until 26 July 2013. On 23 July 2013, it is recorded in Mr A's PMC that the prescription for Voltaren was extended until 14 August 2013. There is no record of Voltaren having been administered to Mr A on any occasion.

On-going pain

48. On 26 July 2013, Mr A submitted a chit to the Health Service with a request to see a dentist, stating that it was painful to chew on the right side of his mouth, and he was concerned that a filling had fallen out. It is recorded in Mr A's progress notes on 27 July 2013 that the chit was received by the Health Service and an appointment was booked for Mr A to see a dentist. However, there is no record of the date this appointment was booked for.

49. On 30 July 2013, Mr A submitted a further chit to the Health Service, requesting that he be reviewed by a dentist. The chit was received by the Health Service the same day. As Dr B was away on leave, Mr A was seen by dentist Dr I the same day, and two fillings were done. Dr I advised that there was no inflammation or infection at the site where Mr A's tooth had been removed on 11 June 2013, and that the tooth socket was healing well.

50. On 31 July 2013, it is recorded in Mr A's progress notes that a further chit was received by the Health Service from Mr A, stating:

> "I have to see the doctor to have Voltaren prescribed properly to me because my jaw is still [painful] from the tooth removal on the 11 June, thanks."

51. It is subsequently recorded in Mr A's progress notes:

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[21] Rather than "500mg".
[22] Commonly used for the reduction of pain, fever, inflammation, and stiffness.
[23] An anti-inflammatory.

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> "Got him to see the dentist yesterday, to sort out his fillings which he complained about a couple of days ago. [S]aw him this afternoon to ask him what exactly he wanted the doctor to do regarding the Voltaren, he said he wanted it prescribed once a day (at bed time) which is down on his script. No further action taken."

52. Mr A's prescription for Voltaren was due to end on 14 August 2013. There are no progress notes relating to Mr A between 31 July 2013 and 18 August 2013. On 18 August 2013, it is recorded in Mr A's progress notes that a further chit was received from Mr A, stating:

> "Could I please see the doctor to get my night meds increased as I am not sleeping at all well and can I please be prescribed Voltaren again for my jaw which is still giving me grief from tooth removal."

53. It is documented that Mr A was referred to a doctor for review of his Voltaren that same day. According to Mr A, he continued to experience pain relating to the procedure. However, there are no further notes relating to Mr A's dental concerns after 18 August 2013, including whether he saw a doctor following the referral.

Health Service's management of Mr A's diet after 11 June 2013

54. Following the procedure, Mr A was unable to eat solid food properly. On 13 June 2013, it is recorded in Mr A's progress notes:

> "Upon examination [Mr A] can only open his mouth 1.5cm and is having difficulty eating ([prescribed] soft diet via kitchen yesterday) …"

55. However, Mr A was not commenced on a soft food diet until the evening of 14 June 2013. Mr A advised HDC that, at that time, he was unable to eat even soft food because his jaw was locked closed.

56. On 17 June 2013, Mr A was taken off his soft food diet and placed back on a regular diet. Mr A told HDC that he was not consulted regarding this decision. Corrections told HDC that the soft food diet had been ordered for a period of three days, because:

> "[t]he kitchen staff would have required that a timeframe was stipulated when the soft diet was requested. There was no plan in place to review this request to assess [Mr A's] requirement for a soft [diet] after the three day period expired. [Corrections] is considering a review of procedures governing soft diet requests to avoid this situation in the future."

Summary of medication administration documentation, 11 June 2013 – month of release

57. The following is a summary of the medication administration documentation for Mr A between 12 June 2013 and the month of his release. For a complete list of medication administered to Mr A by Corrections staff during this time, refer to **Appendix B**.

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Documentation regarding the administration of Brufen

58. Over the four days from 12 June 2013 to 15 June 2013, when Mr A was prescribed Brufen twice daily as required, it is recorded that he received Brufen three times in total.

59. Over the eight days from 20 June 2013 to 27 June 2013, when Mr A was prescribed Brufen three times daily, it is recorded that Mr A received Brufen 25 times in total. On 24 and 25 June 2013, it is recorded that Mr A received Brufen five times each day.[24]

60. Over the six days from 28 June 2013 to 3 July 2013 it is recorded that Mr A received Brufen on ten occasions in total.

Documentation regarding the administration of Pamol

61. On 12 June 2013, when Mr A was prescribed Pamol twice daily as required, there are no records regarding the administration of Pamol to Mr A.

62. Over the eight days from 13 June 2013 to 20 June 2013, when Mr A was prescribed Pamol three times daily, it is recorded that Mr A received Pamol four times in total.

Documentation regarding the administration of Augmentin

63. Over the nine days from 13 June 2013 to 21 June 2013, when Mr A was prescribed Augmentin three times daily and should have received 27 doses, it is recorded that he was administered Augmentin on 12 occasions in total. It is recorded on only one day that he was administered Augmentin three times as prescribed.

Documentation regarding the administration of metronidazole

64. Over the eight days from 14 June 2013 to 21 June 2013, when Mr A was prescribed metronidazole three times daily and should have received 24 doses, it is recorded that he was administered metronidazole on 11 occasions in total. It is recorded on only one day (19 June 2013) that he was administered it three times as prescribed.

Release from Corrections

65. Later in 2013, Mr A was released from the Prison. In response to the provisional opinion, Mr A advised that he was still taking medication for the pain in his jaw caused by the tooth extraction. He said that since leaving prison he had been taking Voltaren, but that it had upset his stomach, so he was currently taking Nurofen[25] daily.

Corrections' policies and procedures

Documentation of medication

66. The Corrections "Health Services Health Care Pathway" relevant at the time of these events states:

> "**9. Documentation**

[24] The recommended daily dose for Brufen is 400 to 800mg orally every six to eight hours. The maximum recommended daily dose for Brufen is 3200mg, which is equivalent to one 400mg tablet, eight times a day (three hourly).

[25] A brand name for ibubrofen, an analgesic.

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9.1 Policy on Clinical Documentation

…

Document all assessments and clinical interventions in the prisoner's electronic file.

- Document all assessments and interventions before going off duty for the day.
- Document all external and internal conversations that relate to the prisoner's clinical care.

…"

67. The Corrections "Medicines Policy and Procedure" relevant at the time of these events states:

"**7.2 Pre-Administration of Medication Procedures**

…

7.2.2 Clinical Presentation

…

- Assess the patient's current clinical presentation and ensure that it is suitable to proceed with them receiving their medication.
- Record any baseline observations if required in the patient's electronic clinical file.

…

8. Administration of Medication

8.1 Administration of Medication Policy

Our Policy is that:

- Nurses must adhere to the instructions of the prescriber. Deviation from this must be discussed with the prescriber if clinically appropriate as soon as practical. These deviations e.g. withholding medication must be recorded on the medication chart or approved signing sheet. Use clinical judgement to determine if this deviation should be documented in the electronic clinical file.

…"

68. With regard to recording the prescribing and administration of medications, Corrections use the following forms of documentation:

<u>Doctor's Prescribed Medication Chart</u>

69. The PMC is the form on which doctors record prescriptions. The doctor records the date of the prescription as well as the name of the medication, route,[26] times at which the medication should be administered (ie, breakfast, lunch, dinner, bedtime) and the date the prescription is to be discontinued. The doctor is required to sign each prescription.

<u>OTC Medication Log Sheet</u>

70. The OTC Medication Log Sheet (OTC log sheet) is a form on which the administration of OTCs is recorded. The form has a space at the top for the name of

[26] For example, whether the medication is given orally or by injection.

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the OTC medication, the reason for use, recommended dose, precautions and contra-indications. Underneath there is a column each for the patient's name, dose, date, time and reason for the administration. There is a space in which both the patient and the person administering the medication are to sign at each administration. One page is used per medication.

Medication Administration Record

71. Administration of medication is recorded on a medication administration record (MAR), which comes in one of two forms, a monthly cycle chart or a short cycle chart, depending on the length of time the medication is prescribed for. The charts are issued by the pharmacy when medication is ordered and sent. Both charts look similar. However:

a) A short cycle MAR has four columns on it, and each column is individually headed (morning, lunch, dinner and bed) and is signed vertically.
b) A monthly cycle MAR has individual boxes for each week, the four times of the day (morning, lunch, dinner and bed) are printed in each box, and the form is signed horizontally.

Medication administration signing sheet

72. The medication administration signing sheet (MASS) is used for recording the administration of PRN medications. On the MASS the administration of each medication is assigned a separate column under which staff record the date, dose and time the medication was given, and then sign next to each record.

73. The administration of OTCs to Mr A were not recorded in an OTC medication log sheet. The administration of Brufen for Mr A was recorded on a monthly cycle MAR as well as on the MASS, while the administration of Pamol was recorded on the MASS. The administration of prescribed medication, including Augmentin and metronidazole, was also recorded on the MASS.

Further information received

74. On Mr A's MASS it was recorded that on 24 June, 25 June and 27 June 2013, he was given Brufen 400mg at dinner time. Each of these notes have been crossed out and "error" noted next to them, with no further information or explanation documented.

75. Corrections advised HDC that these errors were a result of staff not understanding that they were filling in a monthly cycle chart as opposed to a short course chart, which looks similar. The errors were crossed out and re-written in the correct place on the MASS. Corrections advised that training will be implemented to support staff awareness of the difference in the administration signing sheets.

76. With regard to medication administration documentation for Mr A, RN G told HDC:

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"It is sometimes several hours after administration of medication that we get to sign for them and as he did not have at the time a proper signing sheet[27] I believe this may have contributed to it not being signed for."

77. In response to the provisional opinion, registered nurses RN H, RN C and RN G stated that in 2013, nurses were required to:

"… administer to prisoners in their areas, and then return to the Health Centre to document, for anywhere from about 64 to 150 prisoners, depending on the day and shift concerned.

In this case staff as a group seem to have become confused between the different formatting of the short course and monthly cycle Medication Administration records … There are various entries apparently started in the wrong place, or continued under the last entry in the wrong place. We believe that more of the administrations were documented than may be indicated in the Provisional Opinion or Dawn Carey's advice, but are not obvious to locate on the forms, given these issues …

It seems highly unlikely that [Mr A] was given four or five doses of medication at different times in one day, given that we only do three medication rounds. It appears that some administrations may have been double entered due to the confusion referred to above."

78. With regard to these events, RN E told HDC: "It has made me extremely careful with my signing now."

Actions taken by Corrections

79. In 2013, an independent review of the medication administration documentation practice at the Prison was completed by the Clinical Quality Assurance Advisor. The following actions have been taken as a result of the review:

- The nursing staff at the Prison have completed an in-service education session on medication management. Medication administration is discussed at regular staff meetings.
- Rosters have been changed to provide for two nurses to be rostered on the afternoon shift to manage medication administration.
- Corrections explored options regarding the reluctance of custodial staff to issue Pamol. Single unit doses of Pamol have now been placed in each guard room for custodial staff to issue and document as appropriate. Corrections told HDC that appropriate documentation procedures have been "highlighted" with custodial staff.
- On-going monitoring of the use of paracetamol by custodial staff will be undertaken by Corrections.

[27] Staff were using generic medication signing sheets, rather than a signing sheet provided by the pharmacy and tailored to Mr A.

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80. In addition to the above changes, Corrections advised that it is undertaking monthly auditing, specifically regarding the adequacy of medication administration charts, and documentation audits are now undertaken annually.

81. Health Services staff at the Prison have been engaged in a review of Mr A's complaint, and discussions have occurred regarding the administration of medication and the standards required for appropriate documentation.

82. Corrections advised that training will be provided to all staff at the Prison on documentation standards, to be facilitated by the New Zealand Nurses Organisation (NZNO).

Responses to provisional opinion

83. The parties were given an opportunity to respond to the provisional opinion. Their responses have been incorporated where relevant.

84. Corrections advised HDC:

> "We wish to acknowledge that there were a number of failures by the Department of Corrections that led to a standard of care lower than expected being provided to [Mr A] while he was resident in Auckland Prison."

85. With regard to his documentation, Dr D told HDC: "my handwriting is poor but you can see that my milligrams is very similar to the milligrams above it but missing an initial squiggle. The intention is clear".

Opinion: Department of Corrections — Breach

Overview

86. The Corrections Act 2004 (the Act) states that "a prisoner is entitled to receive medical treatment that is reasonably necessary". The Act requires that "the standard of health care that is available to prisoners in a prison must be reasonably equivalent to the standard of health care available to the public".[28] In addition, in accordance with the Code, Corrections has a responsibility to operate its health service in a manner that provides consumers with services of an appropriate standard.

87. A person being held in custody does not have the same choices or ability to access health services as a person living in the community. They do not have direct access to OTCs or to a GP and are entirely reliant on the staff at the health centre to assess, evaluate, monitor, and treat them appropriately.

88. Following Mr A's dental procedure, there were a number of failures within Corrections that led to him receiving care and treatment that was below the accepted

[28] Corrections Act 2004, section 75.

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standard of care. While individual providers have a responsibility for the failures that occurred, in this case there was a pattern of failures by multiple providers responsible for Mr A's care. I am of the view that these failures were largely a result of broader systems issues at Corrections. Accordingly, the focus of this report is on the systems in place at Corrections, and how they impacted on the quality of care Mr A received while an inmate at the Prison.

Administration of prescribed medication

89. On the following occasions there is no evidence that Mr A received his prescribed medication (see **Appendix B**). Mr A does not recall receiving medication on those occasions, and Corrections has not provided any evidence to the contrary (see my discussion regarding documentation below). Accordingly, I find that on the following occasions, Corrections staff failed to administer Mr A his prescribed medication:

- 13 June 2013 — First and third dose of Augmentin.
- 14 June 2013 — Second dose of Brufen.
  — Second and third dose of Pamol.
  — First and second dose of metronidazole.
  — First and second dose of Augmentin.
- 15 June 2013 — Third dose of Pamol.
  — Third dose of Augmentin.
  — Third dose of metronidazole.
- 16 June 2013 — Second and third dose of Pamol.
  — Augmentin.
  — Metronidazole.
- 17 June 2013 — Third dose of Pamol.
  — Third dose of Augmentin.
  — Third dose of metronidazole.
- 18 June 2013 — Third dose of Pamol.

- Between 4 July 2013 and 18 July 2014, there is no record of naproxen having been administered to Mr A at all.
- Between 16 July 2013 and 14 August 2013, there is no record of Voltaren having been administered to Mr A. On 31 July 2013, Mr A submitted a chit requesting to have Voltaren prescribed "properly", as he was still experiencing pain.

90. On both 24 June 2013 and 25 June 2013 it is recorded that Mr A received Brufen on five occasions each day, despite his prescription being for 400mg three times daily. Between 28 June 2013 and 3 July 2013, it is recorded that Mr A continued to receive Brufen two or three times a day (11 occasions in total).

91. Mr A indicated on a number of occasions to both custodial and clinical staff, through the channels available to him, that he continued to experience pain resulting from the procedure, and that he thought he had an infection. Had Mr A not been an inmate he would have been able to go to a pharmacy to purchase pain relief such as Brufen or Pamol without a prescription and take it as required. He also would have had the option to contact a GP directly when he needed to.

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92. However, as an inmate in a Corrections facility, Mr A did not have direct access to OTCs or to a GP, and was reliant on Corrections to ensure that such access was available. He was also reliant on Corrections staff to administer any prescribed medications to him. Following the procedure, both Dr B and Dr D determined that Mr A's condition warranted prescriptions for analgesia and antibiotics. However, as outlined above (and in **Appendix B**), registered nurses employed by Corrections repeatedly failed to administer medication to Mr A in accordance with his prescriptions.

93. I note that Mr A's prescriptions for Pamol and Brufen dated 12 June 2013 were listed under "PRN medications". With regard to the prescribing of PRN medications in a prison setting, my in-house nursing advisor, RN Dawn Carey, advised:

> "The purpose of the prescription in this case is to enable [Mr A] to source the medication. As he is in prison and has no other means by which to obtain analgesia the prescription gives him a means to request/obtain medication … I would expect the prescription to be followed. There is an expectation by the Doctor that [Mr A] would be receiving as much analgesia as is prescribed."

94. I accept my expert's advice that Mr A's prescriptions should have been followed. At a minimum, I would have expected Corrections staff to offer Mr A medication in accordance with his prescription and document on each occasion whether the medication was administered, and, if not, document why. According to Corrections' "Medicines Policy and Procedure", deviations from the prescription, for example, withholding medication, must be recorded on the medication chart or approved signing sheet and on the electronic file if appropriate. On the occasions outlined above at paragraph 89 there is no record that Mr A was offered medication in accordance with his prescriptions, or why his medication was not administered in accordance with his prescriptions.

95. I am also concerned that staff failed to assess Mr A prior to administration of medication. The Corrections' "Medicines Policy and Procedure", current at the time of these events, stated with regard to pre-medication administration assessments that clinical staff were required to: "Assess the patient's current clinical presentation and ensure that it is suitable to proceed with them receiving their medication"; and "Record any baseline observations if required in the patient's electronic clinical file."

96. There is no evidence that pre-administration assessments of Mr A were undertaken. I am particularly concerned that staff failed to assess Mr A prior to the administration of Brufen on 24 and 25 June 2013 (when he was administered Brufen in excess of his prescription), in order to determine whether the administration of Brufen was clinically indicated on those occasions.

97. Mr A's prescription for Brufen expired on 27 June 2013, but he continued to receive Brufen daily until 3 July 2013. Clinical staff sought a medical review of Mr A on 4 July 2013. I accept that nursing staff at Corrections are able to administer Brufen without a prescription as an OTC. RN Carey advised that while it was appropriate to

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continue to administer OTCs once Mr A's prescription had ceased, "consideration needed to be given to whether another assessment was warranted by the Doctor".

98. RN Carey advised:

> "As a RN peer, I view the nursing care in relation to safe medication administration to be a severe departure from the expected standards."

99. I agree with my expert's advice, and consider that Mr A's care in this respect was severely inadequate. Without having made appropriate assessments of Mr A's condition, and by failing to seek timely medical review, the registered nurses risked being unable to identify any improvement or deterioration in Mr A's condition.

100. By consistently failing to provide Mr A with medication in accordance with his prescription, and by repeatedly failing to assess Mr A prior to administration of his medication, Corrections staff failed to ensure that Mr A was provided with care of an acceptable standard. In my view, Corrections is ultimately responsible for the multiple medications administration shortcomings of its staff, which represent a lax culture towards medicine administration within the Health Service.

Documentation

Failure to document administration of medication

101. On the following occasions, and for the following reasons, I find that Mr A was administered medication, but that the administration was not documented:

- At 5.00pm on 11 June 2013 — Mr A recalls that a nurse gave him Pamol for his pain.
- At 2.00am on 12 June 2013 — Mr A requested pain relief. Mr A told HDC that he was given analgesia at this time.
- At 7.00pm on 12 June 2013 — a nurse assessed Mr A. Mr A recalls that he was given analgesia at this time.
- At 7.00pm on 13 June 2013 — Mr A recalls being provided with pain relief.
- On the morning of 14 June 2013 — Mr A recalls receiving pain relief. RN C told HDC that she did not document the administration of Mr A's analgesia on this occasion.
- On the night of 14 June 2013 — Mr A recalls that he was started on antibiotics.
- On 16 June 2013 — RN E told HDC that she administered analgesia to Mr A during the day shift but failed to document this.
- On 17 June 2013 — RN F and RN G told HDC that they administered analgesia to Mr A but did not document this.
- On 18 June 2013 — RN G told HDC that she administered analgesia to Mr A but failed to document this.

102. As noted in a previous report, providers have an obligation to ensure that "good clinical records are kept and documentation remains up to date. This is essential to providing good care of an appropriate standard."[29] Corrections' documentation policy,

[29] See Opinion 11HDC00883 (11 June 2014), available at www.hdc.org.nz.

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which was valid at the time of these events, required staff to "[d]ocument all assessments and clinical interventions in the prisoner's electronic file … before going off duty for the day". That policy also required staff to document the administration of medication to inmates.

103. With regard to the registered nurses' failures to document the administration of medication to Mr A (as outlined above), RN Carey advised:

> "As a RN, I consider the submitted MAR to demonstrate a level of incompetence to a standard that I find professionally embarrassing."

104. In addition to failing to document the administration of medication to Mr A on multiple occasions, on those occasions when medication administration was documented, this was often difficult to read or inaccurate. For example, on Mr A's MASS it was recorded on 24 June, 25 June and 27 June 2013 that he was given Brufen 400mg at dinner time. Each of these notes has been crossed out and "error" noted next to them. Corrections advised HDC that these errors were as a result of staff not understanding that they were filling in a monthly cycle chart as opposed to a short course chart, which looks similar. The errors were re-written in the correct place on the MASS. Furthermore, on the occasions that the administration of medication to Mr A was documented, it was recorded on his MAR or MASS, which was appropriate. However, the administration of OTC medication to Mr A was not recorded on an OTC log sheet.

105. In explanation for some of the documentation errors, RN G told HDC that it is "sometimes several hours after administration of medication" that registered nurses are able to record the administration on the patient's electronic file. RN Carey advised: "In my opinion, accurate documentation is a fundamental part of safe medication management and is an expected part of RN/EN [Enrolled Nurse] care." Furthermore, RN Carey stated: "I am concerned at the reported delay between medication administration time and recording time. In my opinion, such a system facilitates errors and nursing care not reflective of professional competencies …"

106. I accept that the individual registered nurses are responsible for ensuring that their own documentation is comprehensive and accurate. Custodial staff are also required to document the administration of medication to inmates, in accordance with Corrections' policy. Furthermore, in an investigation by the Ombudsman regarding prison health services,[30] the Ombudsman stated:

> "[I]n a prison setting where nurses are not usually unit based, the issuing of mild pain relief by [custodial] staff is appropriate. Nonetheless, [custodial] staff must be particularly vigilant in recording the names of prisoners receiving paracetamol and the dose they receive."

[30] Investigation of the Department of Corrections in relation to the Provision, Access and Availability of Prisoner Health Services (2012). Available at http://www.ombudsman.parliament.nz

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107. I am concerned about the systematic failings with regard to documentation by registered nurses in this case. However, I consider that the environment in which those staff members were operating contributed considerably to the documentation failures in this case. In my view, the pattern of poor clinical documentation by multiple staff involved in Mr A's care indicates a lax attitude towards documentation within the Health Service.

Summary

108. Corrections failed to provide Mr A with an appropriate standard of care. While I accept that individual providers have responsibility for the failures that occurred in this case, there was a pattern of failures by multiple providers responsible for Mr A's care. These included the failure to ensure safe administration of medication, including failing to administer prescribed medication, and failing to undertake pre-administration assessments. Systems issues within Corrections meant that registered nurses failed repeatedly to keep comprehensive and accurate records. Accordingly, Corrections failed to ensure that Mr A was provided services with reasonable care and skill and breached Right 4(1) of the Code.

Custodial staff reluctance to administer Pamol — Adverse comment

109. Corrections told HDC that custodial staff are permitted to provide Pamol to inmates, but that custodial staff at Auckland Prison have been reluctant to do so. Corrections further advised that nurses are on site at the Prison from 7am until 10pm each day, after which a nurse is on call until 7am the following morning. As the inmates' first point of contact, it is custodial staff responsibility to ensure that inmates are referred to the Health Service in a timely manner. If custodial staff were reluctant to provide Pamol, I consider that, on the following occasions, Corrections should have ensured that Mr A was referred for clinical review in a timely way:

- At 11.00pm on 12 June 2013. Mr A requested pain relief from custodial staff. Mr A advised that custodial staff told him that he had to wait until 7am the next morning for a nurse to provide more pain relief.
- Mr A advised that at 11.00pm on 13 June 2013 he asked custodial staff for more pain relief, but his request was refused.

110. Custodial staff are not clinically trained, and are not expected to make clinical decisions. However, Mr A was reliant on custodial staff to ensure that he received health services, including pain relief. For this reason it is essential that custodial staff, as the first point of contact for inmates, respond appropriately to requests for clinical review.

Care plan regarding Mr A's dietary requirements — Adverse comment

111. After the procedure, Mr A had difficulty eating. On the evening of 14 June 2013, he was commenced on a soft food diet. Mr A advised that, at that time, he was unable to eat even soft food because his jaw was locked closed. Corrections told HDC that the soft food diet was ordered for a period of three days, because:

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"[t]he kitchen staff would have required that a timeframe was stipulated when the soft diet was requested. There was no plan in place to review this request to assess [Mr A's] requirement for a soft [diet] after the three day period expired."

112. Consequently, once his soft food diet lapsed, Mr A was placed back on a regular diet without further review. There is no record that he was consulted or assessed before being placed back on a regular diet. I consider that this was suboptimal care.

Opinion: Dr D — Adverse comment

Documentation of prescriptions

113. On 13 June 2013, 20 June 2013, and 4 July 2013, Dr D prescribed Augmentin, Brufen and naproxen (respectively) for Mr A. In response to the provisional opinion, Dr D told HDC that "my handwriting is poor but you can see that my milligrams is very similar to the milligrams above it but missing an initial squiggle. The intention is clear". However, I remain of the view that these prescriptions could be read as "g" (grams) rather than "mg" (milligrams). Furthermore, on 14 June 2013, Dr D signed a prescription for Mr A for "Metronidazole 400", with no unit of measurement recorded.

114. The Medical Council of New Zealand's "Good prescribing practice" outlines that in writing prescriptions, providers should be vigilant in preventing medication errors.[31] I accept that, in the circumstances of this case, the administration of Augmentin, Brufen or naproxen in grams rather than milligrams in accordance with Dr D's prescriptions was unlikely.[32] However, I am concerned that Dr D made similar documentation errors on more than one occasion, and consider that this is indicative of careless prescribing practice.

115. I am critical that Dr D made similar documentation of prescription errors repeatedly that, in different circumstances, could have led to significant administration errors.

Recommendations

116. In my provisional opinion, I made the following recommendations, to which Corrections responded:

a) Provide training to clinical and custodial staff at Auckland Prison about the importance of having comprehensive documentation, including but not limited to:

[31] Medical Council of New Zealand, "Good prescribing practice", April 2010 (paragraph 7).

[32] Naproxen and Brufen come in tablet form in the milligram amount prescribed by Dr D, while Augmentin is made up of two drugs. In order to administer the gram amount prescribed by Dr D, 100 tablets would need to have been administered.

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i. the appropriate documentation of the administration of OTC and PRN medication; and
ii. the differences between medication administration signing sheets.

117. In response to this recommendation, Corrections advised that further training of nursing staff, specifically addressing the quality of documentation, has been undertaken. Corrections further advised that discussions about medication management are regularly undertaken at staff meetings.

118. As stated in my provisional opinion, Corrections is to provide evidence of the above training to HDC within **three months** of the date of this report.

119. I also recommend that Corrections:

b) Provide training to custodial staff regarding pain management and evaluation, as well as the appropriate escalation of clinical concerns to clinical staff, and provide evidence of that training to HDC within **three months** of the date of this report.

c) Conduct an audit of three months of administration of prescribed medication to inmates, and provide the outcome of that audit to HDC within **six months** of the date of this report.

d) Conduct an audit of three months with regard to the monitoring of custodial staff supplying paracetamol to inmates, and provide the outcome of that audit to HDC within **six months** of the date of this report.

e) Review its procedures governing requests for special diets, and provide evidence of this review, including any outcomes and proposed changes, to HDC within **three months** of the date of this report.

Follow-up actions

120.
- The Department of Corrections will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, Auckland Prison, and the Department of Corrections, will be sent to the Nursing Council of New Zealand.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, Auckland Prison, and the Department of Corrections, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Addendum

The Director of Proceedings filed proceedings by consent against the Department of Corrections in the Human Rights Review Tribunal. The proceedings were resolved by negotiated agreement which included the Tribunal issuing a declaration that the Department breached Right 4(1) by failing to provide health services to Mr A with reasonable care and skill.

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Appendix A — Independent nursing advice to the Commissioner

The following expert advice was obtained from in-house nursing advisor RN Dawn Carey:

“1. Thank you for the request that I provide clinical advice in relation to the complaint from [Mr A] about the care provided whilst he was an inmate at Auckland Prison. 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: complaints and correspondence from [Mr A]; response from the Prison Service including [Mr A’s] clinical notes.

3. As a RN peer, I have been asked to review [Mr A’s] prescribed analgesia and its administration post a molar extraction, which occurred on 11 June 2013. Therefore my review of clinical care will focus on reports of pain and treatment of it.

4. Review of clinical records

   (i) 11 June 201[3]: The Patient Medical History (PMH) notes that [Mr A] had his left lower molar extracted; that extraction was difficult, and that [Mr A] was prescribed Paracetamol 1gramme (g) stat.

   (ii) 12 June: The PMH reports that [Mr A] [was] complaining of pain. The submitted Doctor’s Prescribed Medication Chart (DPMC) shows that following contact with the dentist, [Mr A] was prescribed:

   Brufen 400milligrams (mgs) twice daily (bd).
   Paracetamol 1gramme (g) bd.

   (iii) 13 June: [Mr A] complained of increasing dental pain. It was noted that he had significant swelling and could only open his mouth 1.5centimetres. His DPMC shows that Paracetamol was increased to three times daily (tds). The time of this amendment is not recorded.

   (iv) 15 June: Brufen was discontinued.

   (v) 20 June: [Mr A] was prescribed:

   Brufen 400mgs tds. The time of this prescription change is unknown. This medication was to be discontinued on 27 June.

   (vi) 28 June–3 July [Mr A] received Brufen 400mgs bd/tds despite having an invalid prescription.

5. Comments

   (i) I have not received a MAR that shows the administration of analgesia before 13 June at 8am.

   (ii) I am unsure whether [Mr A] was prescribed less than the ‘total allowed/24 hours’ doses of Paracetamol and Brufen due to his medical

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history, the Doctor's assessment of his pain or due to organisational issues.

(iii) Contrary to his prescription, [Mr A] received less analgesia than was prescribed on 13 June.

(iv) Contrary to his prescription, [Mr A] received no analgesia on 14 June.

(v) Contrary to his prescription, [Mr A] received less analgesia than prescribed on 15 June.

(vi) Contrary to his prescription, [Mr A] received no analgesia 16–21 June.

(vii) Contrary to his prescription, [Mr A] received Brufen 400mgs on 5 occasions on 24 and 25 June.

(viii) Contrary to his prescription, [Mr A] received less analgesia than prescribed on 27 June.

6. 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[1]. Safe medication administration is an indicator that sits within RN competencies set by Nursing Council (NCNZ)[2]. It is a nursing competency that all RNs are deemed to have achieved following successful completion of their undergraduate education, examinations and registration. As a RN, I consider the submitted MAR to demonstrate a level of incompetence to a standard that I find professionally embarrassing.

I am of the opinion, that 13–27 June, [Mr A] correctly received his prescribed analgesia on three occasions. As a RN peer, I view the nursing care in relation to safe medication administration to be a severe departure from the expected standards.

Dawn Carey (RN PG Dip)
Nursing Advisor
Health and Disability Commissioner
Auckland."

The following further expert advice was obtained from in-house nursing advisor RN Dawn Carey on 26 September 2014:

"I have reviewed my clinical advice dated 26 November 2013; response from Department of Corrections (DOC) dated 6 March 2014 including RN statements, Health Services Health Care Pathway.

[1] For example Health & Disability Services Standards (2008); The Health Practitioner's Competence Assurance Act (2003); The Medicines Act (1981) and associated regulations; The Misuse of Drugs Act (1975) and associated regulations.

[2] Nursing Council of New Zealand (NCNZ), *Competencies for registered nurses* (Wellington: NCNZ, 2007).

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I note that the DOC response reports that Registered Nurses visit the unit that [Mr A] was in at least twice a day and that it was probable that he was administered his prescribed medication more often than the Medication Administration Record (MAR) signing sheet reflects. The RN statements — dated 2014 — also report recollections of being aware that [Mr A] was experiencing pain and of administering analgesia to manage this pain. Consistent across the statements is reportage of documentation failures rather than administration failures. [RN G] reports *... it is sometimes several hours after administration of medication that we get to sign for them ...*

In my previous advice I commented that [Mr A] did not receive his prescribed analgesia on 27 June 2012. The provider identifies that the MAR has three incidences of initials for Brufen administration for 27 June 201[3] and I agree. However, the standard of documentation for this date remains suboptimal. Either two or all three doses are initialled under 'Morn'. My uncertainty relates to the crossing out of printed 'time slots' and handwritten additions.

In my opinion, accurate documentation is a fundamental part of safe medication management and is an expected part of RN/EN care. Whilst I note the recollections that report administration as prescribed and that the regular RN presence in the unit, it is hard to accept recollections of routine tasks over the contemporaneous evidence and complaint. The response acknowledges that the documentation has fallen below the required standards and I agree. The poor standard of MAR documentation is a consistent feature within this file.

Following a further review, I continue to be view the nursing care in relation to safe medication administration to be a severe departure from the expected standards. I am concerned at the reported delay between medication administration time and recording time. In my opinion, such a system facilitates errors and nursing care not reflective of professional competencies. I would recommend that the DOC consider work practices that supports 'real time' medication administration documentation. I note and agree with the remedial actions — education, audit, complaint review, rostering changes — taken to date.

Dawn Carey
Nursing Advisor"

The following further expert advice was obtained from in-house nursing advisor RN Dawn Carey on 12 March 2015:

"a) As Pamol and Brufen are OTCs, what is the purpose of a prescription and would you expect the prescription to be followed?

The purpose of the prescription in this case is to enable [Mr A] to source the medication. As he is in prison and has no other means by which to obtain analgesia the prescription gives him a means to request/obtain medication.

In the community he could walk into a chemist and obtain the medication himself and take it as required. However, he could not do that in this case.

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> The Doctor had prescribed analgesia based on his assessment of [Mr A] and considered him to be in significant enough pain to warrant analgesia X times a day on each occasion.
>
> I would expect the prescription to be followed. There is an expectation by the Doctor that he would be receiving as much analgesia as is prescribed.
>
> Due to the environment that [Mr A] was in, he was not able to hold onto analgesia and take it when he needed it.
>
> b) Was it appropriate to continue to give the OTCs once [Mr A's] prescription had ended?
>
> It was appropriate. However, consideration needed to be given to whether another assessment was warranted by the Doctor."

Ms Carey also stated that she was concerned by the systems in place in Corrections that made documentation so difficult for registered nurses. She said that Corrections has to have systems in place to enable timely documentation, as registered nurses are limited by what they can bring into prisoners' cells.

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Appendix B — Medication table

The following table outlines the medication documented as being administered to [Mr A] between 11 June 2013 and his release, as well as [Mr A's] recollection and the recollections of some providers where these have been provided to HDC.

Date	Analgesia/antibiotics prescribed	Administration recorded[i]	[Mr A's] recollection[ii]	Providers' recollections[iii]
11/06/13			1x 5pm (Pamol)	
12 /06/13	Brufen 400mg 2x daily Pamol 20ml 2x daily	–	1x 2am (analgesia)	
13/06/13	Brufen 400mg 2x daily Pamol 20ml 3x daily Augmentin 625mg[iv] 3x daily	1x 8am 2x 8am, mid 1x mid[v]	1x 7pm (analgesia)	
14/06/13	Brufen 400mg 2x daily Pamol 20ml 3x daily Augmentin 625mg 3x daily Metronidazole 400mg[vi] 3x daily	– – – –	1 x am (analgesia) 1 x pm (antibiotics)	("prescribed medication" administered)
15/06/13	Brufen 400mg 2x daily Pamol 20ml 3x daily Augmentin 625mg 3x daily Metronidazole 400mg 3x daily	2x 8am, 1pm 2x 8am, 1pm 2x 8am, 1pm 2x 8am, 1pm		pm (Brufen and Pamol)
16/06/13	Pamol 20ml 3x daily Augmentin 625mg 3x daily Metronidazole 400mg 3x daily	– – –		am (analgesia) pm (Brufen and Pamol)
17/06/13	Pamol 20ml 3x daily Augmentin 625mg 3x daily Metronidazole 400mg 3x daily	– 2x 7am, 12pm 2x 7am, 12pm		am ("medication" administered) pm (Brufen and Pamol)
18/06/13	Pamol 20ml 3x daily Augmentin 625mg 3x daily Metronidazole 400mg 3x daily	– 3x 7am, 12pm, 7pm 3x 7am, 12pm, 7pm		am ("medication")
19/06/13	Pamol 20ml 3x daily Augmentin 625mg 3x daily Metronidazole 400mg 3x daily	– 1x 1pm 1x 1pm		
20/06/13	Pamol 20ml 3x daily Brufen 400mg[vii] 3x daily Augmentin 625mg 3x daily Metronidazole 400mg 3x daily	– 1x 8am 2x 8am, 1pm 2x 8am, 1pm		
21/06/13	Brufen 400mg 3x daily Augmentin 625mg 3x daily	1x 8am 1x 8am		

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	Metronidazole 400mg 3x daily	1x 1pm		
22/06/13	Brufen 400mg 3x daily	3x morning (morn) /midday (mid) /dinner (din)		
23/06/13	Brufen 400mg 3x daily	3x (morn/mid/din)		
24/06/13	Brufen 400mg 3x daily	5x (3x morn, 2x mid)		
25/06/13	Brufen 400mg 3x daily	5x (3x morn, 2x mid)		
26/06/13	Brufen 400mg 3x daily	3x (2x morn,1x mid)		
27/06/13	Brufen 400mg 3x daily	4x (3x morn, 1x mid)		
28/06/13		3x Brufen 400mg (1x morn, 3x mid)		
29/06/13		2x Brufen 400mg (1x mid, din 1x)		
30/06/13		2x Brufen 400mg (1x mid, 1x din)		
1/07/13		1x Brufen 400mg (morn)		
2/07/13		1x Brufen 400mg (din)		
3/07/13		1x Brufen 400mg (din)		
4/07/13	Naproxen 500mg[viii] 1x daily	–		
5/07/13	Naproxen 500mg 1x daily	–		
6/07/13	Naproxen 500mg 1x daily	–		
7/07/13	Naproxen 500mg 1x daily	–		
8/07/13	Naproxen 500mg 1x daily	–		
9/07/13	Naproxen 500mg 1x daily	–		
10/07/13	Naproxen 500mg 1x daily	–		
11/07/13	Naproxen 500mg 1x daily	–		
12/07/13	Naproxen 500mg 1x daily	–		
13/07/13	Naproxen 500mg 1x daily	–		
14/07/13	Naproxen 500mg 1x daily	–		

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15/07/13	Naproxen 500mg 1x daily	–		
16/07/13	Naproxen 500mg 1x daily Voltaren 75g 1x daily	– –		
17/07/13	Naproxen 500mg 1x daily Voltaren 75g 1x daily	– –		
18/07/13	Naproxen 500mg 1x daily Voltaren 75g 1x daily	– –		
19/07/13	Voltaren 75g 1x daily	–		
20/07/13	Voltaren 75g 1x daily	–		
21/07/13	Voltaren 75g 1x daily	–		
22/07/13	Voltaren 75g 1x daily	–		
23/07/13	Voltaren 75g 1x daily	–		
24/07/13	Voltaren 75g 1x daily	–		
25/07/13	Voltaren 75g 1x daily	–		
26/07/13	Voltaren 75g 1x daily	–		
27/07/13	Voltaren 75g 1x daily	–		
28/07/13	Voltaren 75g 1x daily	–		
29/07/13	Voltaren 75g 1x daily	–		
30/07/13	Voltaren 75g 1x daily	–		
31/07/13 –18/08/13	No progress notes for [Mr A]	–		
Late 2013	[Mr A] released from prison			

[i] Times stated where this is recorded.
[ii] Recorded only where specifically stated.
[iii] Recorded only where specifically stated.
[iv] Recorded as “625g” in error
[v] This prescription was written a midday, therefore a morning dose was not given because Augmentin had not yet been prescribed.
[vi] Recorded as “400”. No unit of measurement noted.
[vii] Recorded as “400g” in error.
[viii] Recorded as “500g” in error.

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