Medication error by community support worker (13HDC00298, 21 January 2015)

Community support worker ~ Mental health residential service ~ Medication administration procedures ~ Medication error ~ Clozapine ~ Right 4(1)

A 61-year-old man was a resident at a community residential mental health service (the Service). He was recovering from a recent deterioration in his mental health and was making a transition from inpatient services back to living in the community.

One evening, a community support worker assisted the man in taking his evening medication. The Service stored residents' medications in drawers according to the residents' room numbers. The man had changed rooms before the support worker's shift, and his medication had been moved accordingly. The support worker was aware of the man's room change.

The support worker opened a medication filing drawer, removed a blister pack corresponding to the room the man had been in previously, and took it to him. The support worker did not ensure that all checks to support safe medication taking had occurred, as required by the Service's medication support procedures. This resulted in the support worker giving the man another resident's medication, which included the antipsychotic clozapine.

The support worker returned to the office, where he placed the blister pack back in the filing drawer. He then realised that he had made a serious error. The dose of clozapine the man had taken in error was very high for a person who had never taken the medication previously. The support worker immediately contacted senior staff and sought medical help for the man. An ambulance was called, and the man was taken to hospital. He spent two nights in hospital, following which he entered another residential service.

The support worker acknowledged his error and that he had not followed policy and procedure. He undertook collaborative remedial actions to improve his care in future. The Service's processes were subsequently altered so that medication storage is now solely based on the person's identity rather than by association with a room number.

Not adhering to well-established medication checking processes was a departure from policy. This resulted in the man receiving inadequate care. The support worker failed to provide services with reasonable care and skill and, accordingly, breached Right 4(1).

Adverse comment was made that at the time of the error, the man's change of room was not documented, and that the medication storage system in place, based on room numbers, contributed to an increased risk of an error occurring. However, it was found that overall, the Service had appropriate medication administration systems in place. The Service was not considered to be directly or vicariously liable for the support worker's error.