Retirement village resident given medication prescribed for another resident
(14HDC00568, 30 June 2016)

Retirement village ~ Registered nurse ~ Healthcare assistant ~ Supervision ~ Medication error ~ Medication administration ~ Policies ~ Delegation ~ Rights 4(1), 4(2)

An 89-year-old woman, living in a serviced apartment at a retirement village, received an assisted living package which included medication management. The woman was prescribed a number of medications which staff administered to her from blister packs.

One morning a coordinator gave the woman medications that were prescribed for another resident. The medications concerned were aspirin, simvastatin 20mg, and dihydrocodeine 60mg, which the woman swallowed. The coordinator then gave the woman frusemide and cilazapril medications. At that point the coordinator realised the medication error and asked the woman to spit out the additional medications, which she did. The coordinator then immediately informed the registered nurse (RN) on duty that she had given the woman the wrong medications.

The RN and the coordinator both agree that the RN advised the coordinator to give the woman her usual medications excluding aspirin. However, the RN also recalls telling the coordinator "to do all the things required after a medication error — to keep a close eye [on the woman], take observations, let her family and GP know [of the error] and complete a medication error/incident form". In contrast, the coordinator states that she was not told to keep a close eye on the woman, contact the GP, or take observations. The coordinator is unsure whether the RN told her to notify the woman's family or complete an incident report form.

The coordinator notified the woman's family of the medication error that morning, and observed the woman at morning tea and lunchtime. The RN reported that at lunchtime the coordinator told her that the woman was "OK" and that there were no changes evident. At 1.30pm the woman went out with family, and she returned at approximately 3.30pm in an unstable condition. The next registered nurse on duty immediately assessed the woman, took her observations, and instructed the coordinator to contact the woman's doctor. Further observations were taken throughout the afternoon.

At 6pm the doctor reviewed the woman, noted that she had vomited and made a plan to observe her and send her to hospital if she continued to vomit. At 7.23pm, following further episodes of vomiting, the doctor arranged for the woman to be transported to hospital, where she was admitted for further treatment and assessment. The following day, the woman was discharged back into retirement village's care.

It was held that the RN failed to follow the Medication Errors Policy which required her as the most senior member of staff, to undertake a number of actions, including taking the woman's observations and contacting her doctor. The Nursing Council of New Zealand's *Code of Conduct* required the RN to adhere to such organisational policies. Accordingly, the RN breached Right 4(2).

It was also held that staff failed to follow appropriate policies when providing services to the woman. Accordingly, the retirement village breached Right 4(1) of the Code.

Adverse comment was made in respect of the coordinator regarding her failure to follow the Medication Administration Policy and adequately record the details of her conversations with the woman's family or the instructions she received from the RN.

It was recommended that the retirement village review the actions it had taken as a result of an internal investigation report including investigating an electronic medication system to reduce the risk of medication errors. It was also recommended that the RN undertake further training on medication error management and the principles and requirements for delegating duties to healthcare assistants. Lastly, it was recommended that the retirement village, the RN and the coordinator provide apologies to the woman.