A Rest Home

Registered Nurse, Ms D

A Report by the

Deputy Health and Disability Commissioner

(Case 07HDC11952)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

On Friday 22 June 2007, an 89-year-old woman was transferred from hospital to a rest home following treatment for pneumonia, urinary retention and a rapid and irregular heart rate. She had developed a clot in her right arm while she was in hospital.

Mrs A's hospital discharge forms summarised her condition and treatment at hospital and listed her current medications.

The forms showed that Mrs A had been prescribed warfarin, an anticoagulant, and augmentin, an antibiotic, and indicated the amount of warfarin to be given to her.

However, over the weekend Mrs A did not receive warfarin, or augmentin, as prescribed by the hospital doctors. She received some warfarin on the Friday after she was admitted to the rest home, and again on the Tuesday. She received augmentin from the Monday evening. Her daughter, Mrs B, raised concerns about her mother's medication a number of times.

On Wednesday 27 June, Mrs A collapsed after suffering a further stroke. When she was urgently readmitted to hospital, she was also found to have pressure sores in her sacral area. Mrs A died a few weeks later.

Complaint and investigation

On 4 July 2007 the Health and Disability Commissioner (HDC) received a complaint from a hospital geriatrician Dr C about the services a rest home provided to Mrs A. Dr C's complaint was supported by Mrs B, who stated**:**

> "The family feel that the subsequent deterioration and suffering of [Mrs A] is attributed directly to the lack of care from [the] Rest Home who did not adhere to their own policy of care …. in which medical staff and management badly let [Mrs A] down."

The following issues were subsequently identified for investigation:

- *The appropriateness of care provided by the Rest Home to Mrs A from 22 to 27 June 2007.*
- *The appropriateness of care provided by Ms D to Mrs A from 23 to 25 June 2007.*

The investigation was delegated to the Deputy Commissioner.

The parties directly involved in the investigation were:

Mrs A	Consumer
Mrs B	Complainant
Dr C	Complainant/provider
Ms D	Registered nurse/provider
Mr E	Registered nurse/provider
Ms F	Rest home manager/provider
Dr G	Medical practitioner
Dr H	Medical practitioner
Ms I	Registered nurse
Ms J	Director of Nursing
Rest Home Company	Provider/rest home owner

Information was obtained from:

Mrs B
Dr C
Ms F
Ms J, Director of Nursing, the rest home company
Ms D

Independent expert advice was obtained from Ms Jan Featherston, a registered nurse with experience in aged care. Her report is attached as **Appendix 1.**

What Happened?

Public Hospital

On 9 May 2007, Mrs A was admitted to hospital with pneumonia, urinary retention, and a rapid and irregular heart rate. On 24 May, she was transferred to an assessment, treatment, and rehabilitation ward. Mrs A was reviewed by Dr C, who recorded that she had short-term memory problems, suffered cerebrovascular disease (disorder of the blood vessels of the brain) and ischaemic heart disease (inadequate flow of blood to the heart).

While on the ward, Mrs A developed a blood clot in her right arm, and the clot was surgically removed. Dr C considered there was a significant risk that Mrs A would suffer a further blood clot or clots, and prescribed her warfarin to manage this.[1] Mrs A was also prescribed an antibiotic, augmentin. Dr C considered it unsafe to discharge

[1] Warfarin is an anticoagulant that is used to prevent clots forming in the blood. The dose of warfarin varies according to a patient's INR (coagulation) levels, which are regularly tested during the period of therapy. It is common practice for the prescriber to note the strength of the capsule to be used (1mg) but to then add specific instructions on how many tablets should be given until the next INR test.

Mrs A home, and that following her embolism it was even more necessary that Mrs A receive supported care in a rest home.

Before Mrs A left hospital, Dr C completed a discharge summary. She noted that Mrs A had undergone a thrombolectomy and had a postoperative chest infection. The first page of this document listed Mrs A's discharge medication, including 1mg warfarin to be given daily. Dr C wanted to add an instruction altering the dose over the weekend but she was unable to print out a computerised sheet showing this. She handwrote a note at the bottom of the first page of the discharge summary, instructing that the dose should be 2/3mg alternate nights until Monday, when Mrs A's INR levels were to be tested.

Dr C also printed out a computerised two-page hospital prescription form which accompanied the discharge summary. Warfarin was the last medication listed at the bottom of the first page. This form stated "WARFARIN SODIUM TAB 1MG MAREVAN". Underneath this was the following instruction: "OD [oral drug] according to INR currently 2mg/3mg alternate nights, retest Monday". The augmentin was listed on the second page as well as Metamucil prescribed for bowel regularity.

22 June 2007
On Friday 22 June, Mrs A was transferred to a rest home offering hospital level care. It is owned by a rest home company.[2]

At the rest home, Nurse Manager Ms F and registered nurse Mr E discussed the process for obtaining the medications Dr C had prescribed for Mrs A. The Medications Manual[3] current at this time required that all medications be carefully checked and recorded on a Medication Orders Chart by a GP or Medical Officer. It described the administration and storage of medications, and the procedure when errors occurred. It also required that any medications refused or withheld for any reason must be documented.

Ms F was unfamiliar with the rest home admission systems, having only been appointed as Nurse Manager the previous month. Her job description included the objective that she "ensure the delivery of appropriate and effective care through maintenance of excellent nursing standards and clinical care". She was using Mrs A's admission as an opportunity to familiarise herself with the rest home's procedures.

Mr E had worked at the rest home since 2003. He agreed to fax the prescription form to a pharmacy and to Dr G at a medical centre, where Mrs A's usual medical practitioner, Dr H, was based.

Mr E sent a series of faxes relating to Mrs A's admission that afternoon. These asked Dr G to chart the medications, and asked the pharmacy to prepare the prescribed

[2] References to the rest home in this report include the rest home company.

[3] Issued August 1999 and reviewed in September 2005.

medication, advising that Dr G's "script" would follow. Mr E sent only the first page of Dr C's prescription form to Dr G and the pharmacy, leaving out the page that included the augmentin and Metamucil.

Mr E also sent a fax, and accompanying request form, to the medical laboratory to advise of a new admission requiring INR testing. This form stated "INR lab to dose please 2mg/3mg alternate days currently".

Dr G stated that she was contacted by rest home staff on the afternoon of 22 June and asked to prescribe medications for Mrs A, who was a new admission. Dr G said that she did not have the discharge notes from the hospital at that time. These were requested and, when the summary was faxed to her surgery, Dr G charted the medications. Dr G said that she had no current INR results for Mrs A. The last INR had been taken on 21 June at the hospital.

Dr G explained that she charted the warfarin 1mg as this was the tablet strength that had been prescribed. However, she would have expected the rest home to act on Dr C's specific instructions regarding how many tablets to give, and to have ordered INR testing for the Monday.

Dr G advised that her practice has an after-hours telephone contact service which the rest home was aware of and could have used to query medication or any problems Mrs A experienced.

Dr C's prescription for 1mg of warfarin was transcribed onto the rest home's 'Resident Medication Profile', which was put on Mrs A's rest home file and signed off by Dr G. It is unclear who did the transcription, but registered nurse Ms I filled in an Anticoagulant Therapy Form, with the instruction that Mrs A was to be given warfarin "1mg as charted until INR Thursday". Neither form showed the instruction to give 2/3 mg of warfarin on alternate nights over the weekend until Mrs A's INR level was tested. Nor did they indicate Dr C's instruction that Mrs A's INR should be retested on the Monday. A medication administration record (signing sheet) was also put on Mrs A's file. This listed all her medications except the warfarin, augmentin, and Metamucil.

A short-term care plan, also completed for Mrs A on admission, noted that she mobilised with a walker, required only to be supervised in the shower, and that she was continent. A registered nurse assessment document noted the site of Mrs A's embolectomy. However, neither document identified whether she required any ongoing clinical management or monitoring following this surgery. In particular, matters highlighted in her hospital discharge summary such as her post-surgical chest infection and the significance of her warfarin therapy were not mentioned. Mrs A scored well on a Norton Pressure Area Risk Assessment, completed on her admission. This indicated that she would be unlikely to develop pressure sores and that pressure area care was not required.

Mrs A's medications were received from the pharmacy at 9.30pm. She was given 1mg of warfarin that night by Ms I.

Mrs B recalls that Ms I also gave her mother phenytoin (an anticonvulsant) that night, and her mother said she needed food with this drug. Ms I noted this. Mrs B said that the hospital had advised them that Mrs A should have her warfarin at "tea time" and the phenytoin must not be given on an empty stomach.

Mrs B also asked when her mother would be showered, and was told by Ms I that it would be on Saturday, Tuesday and Thursday "pm".

23 June 2007
On the afternoon of Saturday 23 June, Ms D was the duty registered nurse. She was responsible for medication administration, oversight of the 48 residents, and supervising staff. Ms D registered as a comprehensive nurse with the Nursing Council of New Zealand in 2003. She started work at the rest home in 2005.

Mrs B recalls having asked Ms I to check her mother's medications, and the times they were issued, as some medications were missing and the phenytoin had not been given with food. Mrs B recalls her mother saying that Ms D told her, "You can have it like this as everyone else does, and they don't complain."

Mrs B said that her mother insisted that the warfarin and phenytoin be separated because she had been told that phenytoin impairs the efficiency of the warfarin.

Ms D stated that when a patient on warfarin is admitted to the rest home, the admitting nurse checks with the patient's doctor about the required dose. Blood tests are requested as soon as possible for INR results. When the patient's doctor receives the INR result, he or she elects to give the warfarin or to have the laboratory advise the rest home staff of the appropriate dose. This information is faxed to the rest home. If the instruction comes from the medical laboratory, it posts the original laboratory forms to the rest home for their records.

Ms D advised that she withheld Mrs A's warfarin on 23 June. She stated:

> "I was unsure how much she should be given. It had been written in her discharge notes from the hospital as 1–2mg and I didn't know whether to give 1 or 2mg. I didn't give the dose as my professional judgement said that if unsure, withhold the dose.
>
> I should have queried this immediately with the on-call person, unfortunately I did not. I was aware the doctor would be coming in on the Monday [25 June] to do his admitting assessment and had every intention of speaking to the doctor about the warfarin."

Mrs B noted that her mother was not showered.

24 June 2007
On Sunday 24 June Mrs B asked a caregiver to assist her mother with washing and dressing. She was advised that her mother was scheduled for evening showers. When she asked what days, she was told Tuesday, Thursday and Sunday.

Mrs B also checked again whether her mother was receiving warfarin. The duty registered nurse, Ms I, told her that a page appeared to be missing from the medication chart and said she would inform Ms F of this. In the form for recording communications with families, Ms I wrote: "[Mrs B] has requested that [her mother] is given a sandwich [with] her evening medication. Also we need to R/V [review] [Mrs A's] Med chart is supposed to be on Abs [antibiotics]. This will be RV Monday 25/6/07."

That evening, Mrs A's warfarin was again withheld by Ms D because she remained unsure about how much Mrs A should be given.

25 June 2007
Ms D was on duty again on the Monday afternoon. She advised Ms F that she had withheld Mrs A's warfarin for two days and asked her advice about the amount that should be given. Ms F replied that Dr H would be calling at the rest home at 5pm to assess Mrs A and she could check this with him then. This conversation was not recorded.

At 5pm, Mrs B met with Ms F to discuss her mother's care. She said she was concerned that her mother had not received the warfarin, augmentin, or Metamucil that had been prescribed. Mrs B had already asked rest home staff about the medication on three occasions. She also complained that her mother had not been showered since her admission to the rest home.

Mrs B recalls that Ms F initially assured her that the "medications were correct as they came in blister packs". Mrs B reiterated that her mother should have the medications. She recalls that Ms F checked with Ms D and then told her that only one page of her mother's medications was on the file. The second page was found and Ms F said it would be faxed to the chemist. She undertook to investigate what had happened.

Mrs B said she was told by Ms F and Ms D that the warfarin was not given "as the instructions were not clear".

Ms F reassured Mrs B that Mrs A's showering "would be done on Wednesday, Friday and Monday". Mrs B noted that "once again the days had changed".

Ms F did not record the conversation.

Also at 5pm, Dr H, accompanied by Ms D, assessed Mrs A. As Dr H was writing up his notes, Ms D told him that Mrs A had not had warfarin since her admission because she did not know what dose to give. Dr H advised Ms D to give Mrs A 4mg of warfarin each evening until the results of her INR were known.

Dr H recorded, "Check up after discharge. Well comfortable, afebrile. No chest symptoms. … Started on warfarin 4mg today as not discharged on it. INR on 28/6/07 [Thursday]. Lab to dose. Augmentin syrup to finish up course."

Ms F stated:

> "Before leaving for the day, I asked RN [Ms D] what warfarin dose the doctor had prescribed, she told me he had told her 4mg as he was leaving. I told her that she could not administer any medication without it first being prescribed, that it was not acceptable for a doctor to tell a nurse to give a medication without charting it; then left for the day making the assumption that RN [Ms D] would follow up the warfarin with the GP."

At 5.30pm, Ms D gave Mrs A her first dose of augmentin since arriving at the rest home.

At 9pm Ms D recorded in the nursing notes, "V/B [Dr G] for admission. To give INR. Lab test on Thursday 28/6/07." This record appears to be incorrect, as it was Dr H and not Dr G who saw Mrs A.

Ms D had entered in the anticoagulant therapy medication sheet, "4mg daily until INR checked 28/6/07" but she crossed this out and wrote a countermanding order, "Not given. Verbal from Dr." No warfarin was given to Mrs A.

That evening a caregiver noted that Mrs A refused to have a shower after dinner, so she had a sponge bath. Mrs A had dinner in her room because she was feeling cold.

26 June 2007

On Tuesday 26 June, Mrs B rang Dr H asking about her mother's warfarin. He told her he had instructed the registered nurse to increase her mother's warfarin to 4mgs.

Ms F asked Mr E to follow up on the warfarin orders. Mr E then transcribed Dr C's original 22 June prescription instructions for Mrs A's warfarin dose. He filled in a new Anticoagulant Therapy Form to instruct that the warfarin was to be given "2mg–3mg alternate days." This change was not recorded in the nursing progress notes. The notes show that Mrs A was washed and assisted to dress that morning but Mrs A later informed the afternoon staff that she had not had a wash that day.

Mrs A was given 3mg of warfarin that night. It appears from the signature on the records that the warfarin was given by Ms D. Mrs A also received augmentin and Metamucil.

27 June 2007

At 2.20pm on Wednesday 27 June, Mrs A was found collapsed on her bedroom floor by a caregiver. A registered nurse was called to assess Mrs A. The nurse recorded:

> "No complaints of pain when asked to move her limbs. Facial cyanosis was evident with slurred speech and a weakness noted on the Lt side. ?Lt side CVA [stroke]. Pulse found to be very weak. Put back to bed and daughter notified."

Mr E also checked Mrs A, taking her pulse, blood pressure and temperature. The registered nurse telephoned Dr G's surgery and a message was left with the practice nurse to advise Dr G of the situation. While the staff waited for Dr G, they monitored Mrs A and completed an "Unwanted Event" form. Mrs A's level of consciousness fluctuated throughout this time.

At 3.15pm Dr G telephoned the rest home and advised the registered nurse to arrange for Mrs A to be transported to hospital.

Mrs B recalls that when the ambulance arrived at the rest home at 4pm they were under the impression that Mrs A was a "simple transfer to hospital, but upon doing their own assessment called in senior paramedic back-up".

Mrs A was readmitted to hospital where it was found that she had suffered a stroke.

Pressure sores

At readmission, Mrs A was also found to have two pressure sores, one on her lower vertebrae and one on her buttock/sacral area. These sores were assessed and identified as Grade 1 and 2.[4]

Mrs B was concerned that her mother was not showered during her time at the rest home and that this contributed to the pressure sores found at the hospital. Mrs B believes the sores may have been discovered earlier if her mother had been showered regularly.

The rest home nursing notes document that Mrs A was washed, and received sponge baths and at least one shower in her five days at the rest home. The notes also record that Mrs A at times refused to be washed and, even when it was documented that she had been washed, she could not recall this. Ms F was unable to explain how Mrs A had developed pressure sores and commented that the nursing notes had no record of any pressure problems.

The rest home's Pressure Area Risk Policy states: "Re-assess all residents' skin integrity and pressure area risk monthly or more often if their medical, physical or psychological condition changes."

[4] The Braden Scale for Predicting Pressure Sore Risk assessment indicated a total score of 8 out of 24. This is considered to indicate a lower functional level and, therefore, that Mrs A was at a higher risk of forming pressure sores. Grade one sores generally indicate a change to skin integrity, grade two refers to breakdown of skin integrity and early formation of blistering.

Mrs A's death
Mrs A subsequently died in hospital. Dr C explained that when the blood clot was surgically removed from Mrs A's arm in June, the doctors were aware that there was a thrombosis sitting somewhere in her body, possibly her heart. This meant there was a much higher risk that Mrs A would have further strokes. The warfarin therapy was introduced to reduce and manage this possibility. The medical certificate gives the cause of death as pneumonia following a stroke. There was no post mortem.

Follow-up actions and responses
On 29 June 2007, a Serious Event Investigation was commenced, authorised by the rest home's Director of Nursing, Ms J. The causal factors for this incident were found to be:

- Ambiguity in discharge documents
- Discharge documentation either not read or understood by RNs
- Care Manager on annual leave
- Lack of clinical experience with RNs
- Lack of accountability with RNs
- New manager unfamiliar with processes in place.

On 4 July 2007, Ms F completed a retrospective "Unwanted Event" report detailing this incident.

On 18 September 2007, Ms J advised that as a result of the investigation the following action had been taken:

a. Medication administration processes and competencies audited
b. Supervision of Registered Nurses' medication administration practices on-going
c. Clinical supervision by Nurse Educator given to Registered Nurses, focussing on reflective practice, one day a week for four weeks
d. All Registered Nurses strongly encouraged to take advantage of education opportunity offered by [the rest home] with [the] Primary Health Care. This is a 10 month, self-directed learning course. Several Nurses are planning to enrol
e. Further and on-going training and support of Nurse Manager."

Ms F
Ms F stated:

> "In my own defence I accept that I was unfamiliar with Rest Home medication procedures at the time and that as a first time Nurse Manager, inexperience played an important role. I have never made it a habit to assume anything but as an inexperienced Nurse Manager I was not only unfamiliar with the processes but also the capacity of the Registered Nurses."

Ms D
Ms D stated:

> "I cannot explain why I did not complete [Mrs A's] progress notes. I must have been called away. I do not think I have ever before not completed or signed notes."

Ms D now realises that she should have been more questioning about the warfarin prescription. She advised that since this incident, the process for warfarin administration at the rest home has been reviewed. A definite dose is now to be obtained from the doctor on the day the patient is admitted. The dose is subject to change after the INR test results are known. All patients on warfarin have their dose and INR result in one folder which reduces administration error. The dose is determined by the medical laboratory or the doctor.

Since June 2007, the nurses at the rest home have completed 17 hours of education on reflection and critical thinking.

Ms D stated:

> "I am very sad for [Mrs A] and her family and I would like to express my deep regret for any part I might have played in this sad event. This unhappy event has made me realize that I must not hold back and must question things when unsure. This has been a very hard lesson."

The rest home response
Ms J acknowledged that there were operational issues with the management of the rest home prior to the employment of Ms F in May 2007. There had been no manager for several months[5] and this had placed strain on the nursing staff. Ms J said that Ms D had taken on extra responsibilities and provided the rest home with good service throughout the transition to Ms F's employment. Ms J noted that since this complaint Ms D has undertaken a primary care nursing course.

Ms J provided a copy of a 9 October 2007 Health and Disability Sector Standards Audit, which found a high standard of care at the rest home and that staff education was of a high quality.

In September 2007, in response to this complaint, the rest home developed a Warfarin Administration Policy. It outlines the procedures expected to be followed by registered nursing staff to minimise the risk of a medication error occurring. It includes a specific checklist of steps to follow in reading and understanding discharge/prescription documentation that includes warfarin therapy.

[5] The Ministry of Health HealthCERT report of 14 November 2007 identifies that there were six managers in the previous three years prior to this incident.

Lastly, a letter was sent to all the GPs who provide care to the rest home's residents. This clarified the rest home's procedures for administering and charting medications, and the GP's role in admitting and reviewing residents. The aim of this letter was to standardise medication procedures, and ensure that the rest home's registered nurses are present when a GP clinically reviews a resident.

Subsequent events
On 14 November 2007, the MOH (HealthCERT) conducted an unannounced site visit on the rest home. The report noted that Ms F, with the support of the management team, had taken control of the facility and was "implementing sound systems and processes". HealthCERT's report concluded that:

> "The service acknowledged the issue without external intervention, and has proactively identified the issues and taken steps to address the non-compliances. … HealthCERT reviewed the identified corrective actions with the manager and obtained corroborative evidence (e.g. physical inspection, review of documentation). HealthCERT was satisfied that the corrective actions identified by the provider have been completed, or are in process. The provider is not required to undertake any remedial action and HealthCERT considers the matter closed."

Provisional responses

Two provisional opinions were issued in relation to this complaint. As a result of the new information provided by the parties to the first opinion, it was found to be necessary to issue a second opinion. The responses to these are summarised below:

Registered nurse Ms D's response

Ms D accepted the provisional findings in my first report and provided a letter of apology for Mrs A's family. Ms D stated that, following this incident, she has reviewed her practice and is now more reflective in her work. Ms D is engaged in on-going education (the Nursing Practice Development Programme Primary Health Care) to improve her levels of practice and competence.

Mrs B's response

Mrs A's family acknowledged the improvements, training and educational programmes that have occurred since their mother's death. However, they believe the rest home and individual staff members did not provide Mrs A with appropriate care. Mrs B remains convinced that her mother died prematurely because serious errors occurred, and were not picked up on in a timely fashion.

Mrs B is concerned that the rest home and the nurse manager have still not fully understood that what occurred during Mrs A's residence at the rest home was a dereliction of professional nursing care. Mrs B emphasised that this happened despite

her constantly raising issues with staff (and the nurse manager). Further to this, she believes the actions taken to address her concerns were insufficient to prevent her mother from deteriorating and collapsing. This was further compounded by what appeared to be a delay in the rest home calling for an ambulance, when it was apparent to Mrs B that her mother was already gravely ill. Mrs B noted that her mother wanted to live to celebrate an early 90th birthday function with her extended family. This did not happen.

Mrs B further responded that "it defies belief" that Mrs A's pressure sores were missed when she was apparently being either sponged or showered, and that no explanation was given for their occurrence. She stated that the fact that obvious pressure sores were missed would "bring into doubt" that showering actually took place. Mrs B stated, "This was an incident bound to happen given the failure of duty of care of 3 nurses and the nursing manager."

Rest home's response

In response to my first provisional opinion, Nurse Manager Ms F informed me that the rest home has undergone four audits since the time of this complaint. These include: ISO 9001,[6] Health and Disability Sector Standards, a Ministry of Health issues based audit and a District Health Board audit. The rest home met the requirements of these audits and obtained a three-year certification.

All registered nursing staff have undergone further training through the "Nursing Practice Development Programme". Ms F has now completed 12 months as manager of the rest home and with the support of the Operation Manager and Director of Nursing (Ms J) is more confident in her role and duties.

Ms F sent a letter of apology to Mrs A's family stating that she had considered resigning from her position because of her errors of judgment in what occurred. However, she believes she and her staff have reflected deeply on the incident and have made constructive changes to individual practice and the systems in place at the rest home. Ms F believes this has made her a better manager.

Ms F subsequently clarified that while she agreed to complete the admission documents for Mrs A, it was the registered nurse's responsibility to admit a resident, not usually the Facility Manager. As a result of these events, she has adopted a "critical thinking approach" with all the registered nurses at the rest home, and "reflective thinking is now accepted practice". She said that this incident has caused her many sleepless nights, and she has had "many hours of soul searching" and "reflected considerably and continue to do so".

[6] The AS/NZS 9001:2000 is a Quality Management System (QMS) which requires a company to meet certain standards in order to comply with the system. A Quality auditor has to be satisfied that the quality system manual is an accurate description of business operations in line with the standards set down in the QMS.

Ms F stated that she has made various attempts to arrange a meeting with the family. On one occasion, Mrs B was agreeable to a meeting and was to contact Ms D with a time and date that would suit all the family members to meet with management. This has not eventuated. Ms F remains open to meeting with the family, but believes that any further overtures from her would be perceived as harassment. She stated that she would like the family to "understand that the changes at [the] rest home since the incident have been vast and that the impact my mistake has made is ever lasting".

The rest home's response

Ms J said that, in general, the rest home accepted the first provisional report and its findings but asked for some small changes to be made to the body of the report to clarify some information and provide further context to events that occurred, and highlight the changes that have taken place subsequent to the incident. I have, on the whole, met this request.

Ms J acknowledges that this was a serious incident, and the rest home regrets the pain these events have caused Mrs A's family. The rest home would also like to meet with the family to express this face-to-face. Ms J noted that although this investigation has identified that the incident occurred because of human error, and the systems that were in place were sound, this complaint has resulted in systemic changes to all of the company's rest homes. Furthermore, the rest home took affirmative action almost immediately to address the issues raised in this complaint. Ms J said that the staff and management deeply regret what occurred, at both a professional and personal level, and have co-operated fully and openly with the investigation.

The rest home provided an apology for Mrs A's family.

Code of Health and Disability Services Consumers' Rights

The following Rights are applicable to this complaint:

RIGHT 4

Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

Other relevant standards

The Nursing Council of New Zealand's "Competencies for the registered nurse scope of practice" June 2005 are also relevant to this complaint. In particular:

Competency 1.1: Accepts responsibility for ensuring that his/her nursing practice and conduct meet the standards of the professional, ethical and relevant legislated requirements.

Competency 2.1: Provides planned nursing care to achieve identified outcomes.

Opinion — Breach Rest home

Medication errors
Mrs A was transferred to the rest home on the advice of Dr C because she needed care that included the administration of a number of medications. She had been treated for a blood clot while in hospital and therefore it was important for her to take the anticoagulant warfarin, along with her antibiotic and other medications.

When Dr C discharged Mrs A, she wrote a two-page discharge summary that outlined Mrs A's immediate health conditions. The first page listed Mrs A's discharge medication, which included 1mg warfarin. Dr C also handwrote a note at the bottom of the page recording her specific instructions "2/3mg alternate nights" until Mrs A's INR levels were retested. Dr C indicated that the INR test should be done on the Monday. Dr C's specific instructions for the warfarin dose and the INR test were also typewritten on the first page of the accompanying two-page prescription form.

In my view, Dr C's instructions about Mrs A's warfarin dose were clear and consistent with common prescribing practice. Her handwritten instruction was backed up by the prescription form, which recorded that Mrs A was to be given warfarin 2mg and 3mg on alternate nights until further INR test results were known. Dr C instructed that retesting be done on the Monday.

Despite this, Mrs A did not get her medications as they had been prescribed by Dr C. The most serious omission involved the warfarin, which was withheld for over three days. There was also a three-day delay in Mrs A receiving the augmentin, and it was three days before she received any Metamucil. Furthermore, her INR level was not retested on the Monday and, although RN Ms I had entered this on the Anticoagulant Form as "1mg as charted until INR Thursday", there was no follow-up by registered nursing staff to clarify this order.

In reviewing the information surrounding these events, it is evident that the discharge instructions from Dr C were not correctly followed by the rest home. The Medications Manual describes the process expected for administering medication. However, the

rest home has not provided a satisfactory description of the process used by Ms F and Mr E to manage the hospital discharge instructions and ensure that, as well as receiving her prescribed medication, Mrs A was also assessed and monitored for the clinical problems she had on leaving hospital. I note that the rest home (as part of the company's continuous improvement process) has subsequently developed a site specific policy in relation to warfarin.

Furthermore, the new manager, Ms F, was less than a month into her three-month orientation phase as manager and was unfamiliar with the admission process. I note that the internal sentinel event investigation identified the need for additional training and support for Ms F. The rest home has also stated that prior to her appointment there were operational difficulties at the rest home including several months without a manager, and that HealthCERT identified that prior to this, the rest home had six managers in three years. This undoubtedly put pressure on nursing staff.

Ms F has clarified that it was the registered nurse's responsibility, and not usually the facility manager, to admit new residents. However, she was keen to familiarise herself with the admission processes. She assisted with the admission documents for Mrs A, and the nurse, Mr E, faxed the relevant documentation to the GP and the pharmacy. It was here that the first mistake occurred. Only the first page of the prescription form was faxed to the pharmacy and Dr G. This meant that the medical centre was unaware of the augmentin and Metamucil, and therefore these were not scripted and administered over the following two days.

Dr G has explained that she charted the warfarin according to the prescription amount of 1mg, but expected rest home staff to understand that they should follow Dr C's instructions regarding the dose until the INR levels were retested. However, Dr C's instructions were not correctly interpreted and transcribed onto the "Resident Medication Profile" included in Mrs A's notes by Ms I. Mrs A received only 1mg of warfarin that evening, given by Ms I.

As my expert advisor, Jan Featherston, has noted, and the rest home has also identified, the prescribing errors were caused by "registered nursing staff at [the] rest home not reading all of the discharge documentation thoroughly or with understanding". Neither were any attempts made to clarify the medication orders for Mrs A on admission, nor over the weekend. Incomplete documents were faxed from the rest home to Dr G and the pharmacy.

On Saturday 23 June, the situation was compounded when Ms D, the duty nurse, noted Dr C's directions for administering warfarin to Mrs A, but found them confusing. Ms D decided to withhold the medication until she could check it with Mrs A's doctor, who she knew would visit after the weekend. Ms D did not document this decision or seek clarification.

Mrs A's daughter, Mrs B, was concerned about her mother's medication. She raised this with rest home staff on the Friday when her mother was admitted. She raised it

again on the Saturday and Sunday; yet still Mrs A did not receive the warfarin, augmentin, or Metamucil as prescribed by Dr C.

On Monday 25 June, Ms F was advised both by Mrs B and Ms D that Mrs A had not received an appropriate dosage of warfarin and none over Saturday and Sunday. On Ms F's instruction, Ms D discussed Mrs A's warfarin prescription with the visiting doctor, Dr H.

Dr H advised Ms D to start Mrs A on 4mgs of warfarin until an INR test on the Thursday, and documented this instruction. However, when Ms D told Ms F of the order, Ms F believed this was a verbal instruction only and told her not to give the warfarin until it was appropriately charted. She expected Ms D to contact Dr H that evening, but this did not happen until the following day. Once again Mrs A did not receive any warfarin, although following Ms F's intervention she was started on her augmentin.

The correct warfarin dose for Mrs A was finally recorded on Tuesday 26 June 2007. Mr E went back to Dr C's original 22 June dosage instructions and transcribed them into a new Anticoagulant Therapy Form. There is no suggestion that Mr E queried Dr C's instructions or raised any concerns about ambiguity. This reinforces my view that Dr C's original instructions were clear but simply overlooked by staff at the rest home. I note, however, that even when Mr E did record the correct dose in the Anticoagulant Therapy Form the change was not recorded in Mrs A's nursing progress notes.

Documentation

It evident that, despite the fact that there were appropriate forms available for staff to record communications with residents' family and friends, not all interactions between Mrs B and rest home staff were recorded, and this impacted on Mrs A's care.

The documentation of important aspects of Mrs A's care was not done. Mrs B's conversations with Ms D on 23 June, and Ms F on 25 June, regarding her concern about her mother's medication, were not recorded. Ms D did not record that she had not given the warfarin on 23 and 24 June, despite a requirement in the Medications Manual that withheld medication should be recorded and the reasons given. On 24 June, Ms I recorded that Mrs A's antibiotic had not been given and that her evening medication should be given with food. However, she recorded this information in the family communication section of Mrs A's file. This information was important and should have been recorded in the nursing notes where other staff would see it and take action. When Ms D was directed by Ms F on 25 June to check with Dr H about his directions for the administration of the warfarin, she again did not document her decisions.

Ms Featherston advised that a lack of verbal and written communication contributed to the errors in Mrs A's care, as did a failure by the registered nurses to take responsibility for the administration of medications on their shift.

Conclusion

As Ms Featherston advised, "a series of errors starting at the admission procedure caused the multiple drug errors which led to Mrs A not receiving the correctly charted drugs".

I accept that various actions by individual nurses, and the inexperience and actions of the new manager, contributed to these events, but in my view the rest home (and the rest home company) must share responsibility for these events. There were a number of failings with respect to communication, prescription, and administration of medications at different levels and by different staff members. The systems in place at the rest home clearly required further scrutiny, and I am satisfied that a series of audits has addressed this. However, it is a fundamental requirement that a rest home will administer prescribed medications in a safe and consistent manner to an elderly patient who has been discharged from hospital. The rest home had systems available in June 2007 to meet this requirement, but in this instance it did not do so.

By failing to ensure that Mrs A received services provided with reasonable care, the rest home breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

Opinion – Breach Ms D

All of the events that led to Mrs A failing to receive her warfarin and other medications as prescribed are of concern, but one matter particularly stands out: Ms D's decision to withhold the warfarin over the weekend without documenting this as she was required to do, or seeking medical advice and clarification.

Furthermore, while Ms D appropriately informed Ms F of this on the Monday afternoon, she again withheld the warfarin that night, after failing to correctly interpret and relay to Ms F information about Dr H's instructions.

As my independent nurse expert, Jan Featherston, advised, Ms D's failure to seek support when she was unable to understand the medication orders was "poor nursing judgement". She commented, "Nurses must question if unsure of certain medications".

Ms Featherston stated:

> "To withhold a charted medication for the given reason: that the nurse does not understand the charting — is poor professional judgement and in my opinion does not meet Nursing Council requirements. I believe that RN [Ms D's] actions would be viewed as [moderately serious] by her peers."

I am very concerned that Ms D felt unable to contact either a doctor or a senior member of the nursing staff to discuss her concerns about the prescription of the

warfarin. She had been a registered nurse for two years at the time of these events and should have known the importance of warfarin for patients who have had a blood clot.

Ms D has admitted her errors of judgement, stating that she should have followed up on the warfarin prescription, but she has not explained why she did not do so. She had a responsibility to her patients to use her professional judgement and consult when she needed to. This is even more important in the context of weekend shifts when as the supervising nurse she needed to be particularly alert to situations when she should seek medical advice to ensure vulnerable residents continued to receive appropriate care. Having recognised that she did not understand the medication instructions, it was not good enough simply to wait for almost three days.

Ms D did not provide Mrs A with services with reasonable care and skill and she failed to meet the standard expected of a registered nurse. She also failed to comply with the rest home's own policy for documenting withheld medications. Therefore Ms D breached Rights 4(1) and 4(2) of the Code.

Adverse comment — Ms F

I acknowledge that in June 2007 Ms F had completed less than one month of her orientation into the position of Nurse Manager, and was unfamiliar with admission procedures. However, her job description showed that she was responsible for the appropriate and effective care of patients and the maintenance of excellent nursing standards. Ms F was also already an experienced registered nurse, with hospital-based experience. She should have been on the alert for any "red flag" issues that required particular monitoring or care.

First, there were a number of "red flags" with Mrs A. She was discharged to the rest home with identified clinical problems, one of which required her to receive antibiotics for a post-surgical chest infection. Secondly, Mrs A had undergone surgery to her arm to remove a blood clot and required warfarin therapy to minimise the risk of further clots. This was indicated in the discharge documentation that accompanied Mrs A from hospital. Nonetheless, as an experienced nurse involved in Mrs A's admission, Ms F did not record this information in a way that would have alerted her nursing staff to Mrs A's need for careful monitoring in case of further blood clots, strokes, or increased infection.

Medication errors
Mrs B questioned her mother's medications on 22 and 23 June. On 24 June, she raised this matter again with registered nurse Ms I, who recorded the query in the clinical record. Ms I requested that Mrs A's medication chart be reviewed as she was supposed to be on antibiotics.

On 25 June, Ms F was alerted on two occasions, by Mrs B and Ms D, to the likelihood that Mrs A was not receiving the medications as prescribed. She instructed Ms D, a relatively junior nurse who had already admitted that she did not understand the prescribing doctor's administration instructions, to follow this up. When Ms D came to Ms F again after having spoken to Mrs A's doctor and was still unclear as to what medication she was to give, Ms F should have been alert to the fact that this matter needed her attention.

Although Mrs B and registered nurses Ms I and Ms D had raised concerns about Mrs A's medication administration, there is no evidence that Ms F ever directly checked this herself. This resulted in Mrs A not having her first dose of augmentin (which Dr C had prescribed on 22 June and directed to be given three times daily) until 5.30pm on 25 June, three days after admission. Additionally she did not receive further warfarin, or the Metamucil as Dr C had prescribed, until 26 June.

Although I accept that Ms F has significantly increased her confidence and ability in managing the rest home, I remain concerned by what occurred at the time of this incident. In my view, Ms F missed important signs that Mrs A was not receiving her medications correctly. Ms F did not react proactively, relying simply on nursing staff whose ability she did not yet know.

Ms F has accepted responsibility for her part in these events, apologised to Mrs A's family, and reviewed her practice. However, given the serious nature of these events, I intend to refer Ms F to the Nursing Council of New Zealand for consideration of whether a review of her competence is warranted.

Adverse comment — Mr E

Admission documents
Mr E registered as a nurse in 1997 and had worked at the rest home since 2003. At the time of this incident he was an experienced registered nurse and expected to meet the standards required of him by his professional body.

Mr E, to his credit, took responsibility for guiding his new Manager, Ms F, through the rest home admissions process when it would normally have been his sole responsibility as the registered nurse. However, in doing so, it appears that a number of errors occurred. I note that the rest home in its investigation identified as a causal factor the fact that the registered nurses did not appear to have read or understood the discharge documentation that accompanied Mrs A. In the Nursing Council of New Zealand's "Competencies for the registered nurse scope of practice" June 2005, competency 2.1 requires that registered nurses provide planned nursing care to achieve identified outcomes. Mrs A required monitoring for warfarin therapy, which included follow-up INR tests, and she had been discharged on antibiotics following surgery. I would have expected Mr E, as an experienced nurse, to have identified these

requirements from the discharge documentation and implemented this in the short-term care plan. I particularly note that on 26 July, Mr E was able to transcribe Dr C's instructions for Mrs A's warfarin on to the Anticoagulant Therapy Form.

Given the serious nature of these events, and Mr E's part in them, I intend to refer Mr E to the Nursing Council of New Zealand for consideration of whether a review of his competence is warranted.

Other Comment — The rest home

Showers
Mrs B was concerned that her mother was not being washed. She asked the staff about this more than once and was given different information about the days when her mother was due to be showered. Her mother told her that she had not been showered.

It appears that Mrs A was on the evening shower list and refused to have a shower on occasion. This is documented, as is the fact that she was sponged instead. The nursing notes record that Mrs A was at times confused and told staff she had not had a shower or a wash when she had.

My advisor, Ms Featherston, advised that the clinical notes indicate that Mrs A's personal cares were appropriate. That said, it does appear that there was some confusion among nursing and care staff as to when Mrs A was due to be showered, and it is easy to see how it could have been overlooked. I also acknowledge Mrs B's point that pressure sores may not have been seen if her mother was not properly washed. I suggest that the rest home review the system in place for recording such information and make appropriate changes to ensure that everyone knows when residents' showers are scheduled.

Pressure sores
Although I accept that Mrs A developed pressure sores in the five days she resided at the rest home, I am not persuaded that this was due to negligence. Mrs A was mobile on her admission to the rest home, and she underwent a Norton Pressure Area Risk Assessment, which did not indicate that she was then at risk of developing pressure sores. I am also satisfied that the rest home has a policy in place to re-assess residents for pressure area risk when there is a significant change in the resident's circumstances. That said, it is also clear that the Braden Scale assessment conducted at the hospital, following Mrs A's readmission there, revealed pressure sores and Mrs A was assessed as being significantly at risk of developing further pressure sores. Pressure sores can develop quickly, particularly in a resident whose health deteriorates suddenly. However, the rest home should reflect further on Mrs B's concern that her mother's pressure sores were not identified while she was under the care of the rest home, and whether closer monitoring was required.

Recommendations

The rest home, Ms D and Ms F have reflected carefully on these events. A new warfarin policy has been introduced; various systems changes have been made; and additional staff training and education have been carried out. The rest home is also working with local doctors to ensure that residents are reviewed more quickly, and medication orders are clear. Ms D is undergoing further training, and Ms F has been provided with greater support.

Apologies have been provided for Mrs A's family.

Follow-up actions

- A copy this report will be sent to the Nursing Council of New Zealand, with a recommendation that it consider a review of Ms D's, Ms F's and Mr E's competence.

- A copy of this report, with details identifying the parties removed, except the name of the rest home, will be sent to HealthCert and the District Health Board.

- A copy of this report, with details identifying the parties removed, will be sent to New Zealand Healthcare Providers, the Association of Residential Care Homes, and the New Zealand Nurses Organisation, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix 1

Independent advice to the Commissioner

The following expert advice was obtained from Ms Jan Featherston:

"I have been asked to provide an opinion to the Commissioner … and that I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

[At this point Ms Featherston provides a list of the supporting information and this has been omitted for the sake of brevity.]

Complaint

The appropriateness of care provided by [the] Rest Home to [Mrs A] from 22 to 27 June 2007.

Expert Advice Required

1. *Please comment generally on the standard of care provided to [Mrs A] at [the] rest home from 22 to 27 June 2007*
2. *Please comment on the management of [Mrs A's] medication by the registered nurses at [the] rest home, and including documentation.*

Background:

[Mrs A] has been admitted to [the public] Hospital on the 24 May 2007. She had multiple medical problems, these have been listed as:

- Cerebrovascular disease.
- Post CVA epilepsy.
- Ischaemic heart disease.
- Atrial fibrillation.
- Severe aortic stenosis.
- Recent embolus to right arm.
- Significant cognitive impairment.

Following her admission she was assessed as requiring rest home care and was subsequently discharged to [the] Rest Home on the 22 June 2007.

[Mrs A] had a supportive family.

On admission nursing staff carried out an initial assessment. Documents which support this are:

Resident Admission Form (…) outlined the general information required in relation to next of kin etc.

A short term care plan was undertaken (…) this form is tick sheet in which staff ticked to show what activities of daily living [Mrs A] could do by herself and what cares she needed supervision with.

Both forms are signed and dated

Resident Dietary information form (…) lists dietary information.

Registered Nurse Assessment form (…) this four page assessment covers issues such as:

- Communication — Mental status
- Mobility — Bathing and dressing
- Sleep patterns
- Nutrition
- Skin integrity
- Elimination
- Assessment of pressure risk using 'Norton Scale'
- Pain and discomfort
- Respiratory cardiovascular
- Falls risk assessment

Base line recordings are listed. This form is signed and dated.
Subsequent nursing documentation is listed in the nursing progress notes.
The entries start on the 22 June 2007, following admission.

3. *Please comment generally on the standard of care provided to [Mrs A] at [the] Rest Home from the 22 to 27 June 2007?*

The admission appears to be a routine admission.
The documentation received from [the DHB] includes:
Discharge Summary, clinical notes and management documentation and prescription.
This is very typical of what an aged care facility would expect to receive from a public facility. There is usually also a verbal handover from a registered nurse in the discharging ward to the registered nurse in the age care facility.

On admission to [the] Rest Home a number of forms were completed.

The front sheet of the clinical notes is administration information. The next page is a short term care plan which outlines the initial information required. Other information collected includes dietary information, registered nurses assessment. Also included in this information are assessments which identify Falls Risk as well as Pressure Area Risk Assessment.

Staff have documented in the clinical notes that [Mrs A] was admitted and that that scripts had been faxed to [Dr G] as well as pharmacy, Admission agreement had been given to the family.

The admission documentation is very typical of what one would expect to find in a Rest Home. What is completed is signed and dated with the designation of the person completing this information.

Personal Cares:

Staff identified on admission that [Mrs A] needed supervision with bathing and showering and dressing. The term 'supervision' would indicate that [Mrs A] was able to accomplish these tasks on her own with a staff member close by to ensure she did not fall or that if needed staff were close by.

She was reported to be continent with both bladder and bowels — which would indicate she did not need assistance, although she did wear a pad for accidents. The clinical notes have a tick box on the side of each page which would indicate that when cares are given then the care staff would tick to document that a care had been achieved or given.

The notes indicate that [Mrs A] had a sponge on the morning of the 23 June. The notes also show that she had a sponge on the morning of the 24 June. There is an added note on the 24 June in which [Mrs A's] daughter has asked staff to ensure that [Mrs A] has assistance with her washing and dressing.

The notes go on to say that 'Is on PM showers full assistance'.

On the afternoon shift the notes indicate that [Mrs A] refused a shower and care staff fully sponged her.

On the 26 June, [Mrs A] was washed and assisted with dressing. Staff documented in the clinical notes that [Mrs A] appeared confused stating that she 'did not have a wash'.

On the 27 June, [Mrs A] was showered. The notes indicate that she said it was her 'first shower since being here (but she has had others)'.

In reviewing the clinical notes in relation to [Mrs A's] personal cares I am of the opinion that adequate cares were given and that cares were documented. The clinical notes are very typical of what would be seen in any [the] Rest Home.

Communication and Medications:

Documentation that was received by [the] Rest Home on admission appeared to be:

Drug script — 2 pages.

Patient Discharge summary

The patient discharge form had a hand written note to say that the warfarin had been expanded to 2mg/3mg alternate nights until Mondays INR test.

As [Ms F] stated (…) she had been in her position for a short time and was not fully aware of the admission process so chose to gain the experience by admitting [Mrs A]. She asked RN [Mr E] what process should be followed in relation to medications and requesting medications from pharmacy. RN [Mr E] offered to complete this part of the admission process for her. When faxing the script and information part of the script was not sent through to the GP and subsequently [Mrs A] did not receive medication that was required.

It is my opinion that this error occurred because of two issues.

1. The original drug script was sent without a written order by [Dr C] on the discharge summary to increase the warfarin to 2mg/3mg alternate days.

2. Staff at [the] Rest Home did not send the copy of both pages of the script as well as the copy of the discharge summary to [Dr G] which would have alerted her as to the increase in the warfarin.

It is unclear who wrote the drug chart up with the medications listed. Was it the nurse who then faxed this to the GP to sign? Or was it the GP [Dr G] who copied the drugs from the drug script — the one page that was faxed.

The chemist then dispensed the medications as per the resident's medications profile. This sheet had the warfarin dose as 1mg.

Nurse [Ms I] administered warfarin 1mg on the evening of the 22 June.

No Augmentin or Metamucil was administered, as these were not on the resident's medication profile.

It is my opinion that the original prescribing errors were caused by:

1. Registered Nursing staff at [the] Rest Home not reading all of the discharge documentation thoroughly, or with understanding.

2. If staff did not fully understand the orders, then no one followed this up with the original prescriber [Dr C].

3. Staff not faxing a full set of documentation to [the] Rest Home GP.

The next error was caused by RN [Ms D] not giving the warfarin on the 23 or 24 June. The reason she has given is that she did not understand what the order was and hence did not administer any.

She did not document this nor did she seek support from any other Medical Officer, RN or the Nurse Manager. Her action is, in my opinion, poor nursing judgement. To withhold a charted medication for the given reason: that the nurse does not understand the charting, is poor professional judgement and, in my opinion, does not meet Nursing Council requirements.

I believe that RN [Ms D's] actions would be viewed as moderate by peers. A Registered Nurse has a duty of care and includes:

'Uses professional judgement, including assessment skills, to assess the client's health status and to administer prescribed medication and/or consult with the prescribing practitioner and/or to refer client to other health professionals.'

From: Competencies for Entry to the Register of Comprehensive Nurses: The Nursing Council of New Zealand 2002.

The next issue in communication was the event on Monday the 25 June, when the GP had advised RN [Ms D] to administer 4mg of warfarin. RN [Ms D] did not check what the doctor had written in the medical notes, and it appears that she only viewed the drug medication sheet. She then mentioned this to her manager, and [Ms F] advised RN [Ms D] not to administer this as it was not charted.

[Ms F] stated that she was under the assumption that the RN would follow up on the order and contact the GP. This did not happen and [Mrs A's] medication was not given.

On the 25 June, when [Dr H] visited, to admit [Mrs A], I am unsure if a nurse accompanied the doctor, and there is only one entry in the integrated notes stating that [Mrs A] was visited by [Dr G].

The entry read:

'V/B [Dr G] for admission, to have INR Lab test on Thursday 28.6.07.' This entry is incorrect and is not signed nor is a designation documented.

[Dr H] had written on a page of Medical notes:

'Started on warfarin 4mg today as not discharged on it, INR on 28/6/07'.

The nursing staff obviously did not read this entry or were not aware of this when RN [Ms D] asked Manager [Ms F] what she should do as the doctor had only given a verbal order. The correct action would have been for the RN to have read the Doctor's medical notes and if not sure to contact him to clarify the order.

It is my opinion that a number of errors occurred due to a lack of verbal and written communication and that registered staff did [not] take responsibility for the administration of medications on their shift. Nurses must question if unsure of certain medications.

Fall:

[Mrs A] fell in her room at 2.10 pm on the 27 June.

The clinical notes state that staff found her at the foot of the bed with her left arm under her. Notes state that there were no complaints of pain when she was asked to move her limbs. Facial cyanosis was evident with slurred speech and a weakness noted on her left side. Her pulse was very weak.

Base line recordings were done at 2.30pm. Her BP 92/38. P — 90 Temp 35.6. The GP was notified via the practice nurse.

At 3.30pm GP advised to send to [hospital], Family were with [Mrs A] when she was admitted via ambulance.

Clinical notes indicate that at 4pm: 'In [hospital] daughters are with her'.

The family in their statement state (…) that [Mrs A] was visited in [the] Rest Home by the '[the] Rest Home Doctor'. I could find no evidence of a Doctor visiting [Mrs A] on the 27 June.

[Dr G] states that [the] Rest Home contacted her and on her advice was to send [Mrs A] to the public hospital urgently.

Emergency Department documentation notes the time of arrival at 4.35pm.

The senior staff of [the] Rest Home conducted an investigation of [Mrs A's] fall and the drug errors.

Conclusion

It is my opinion that a series of errors starting at the admission procedure caused the multiple drug errors which led to [Mrs A] not receiving the correctly charted drugs."