A Residential Mental Health Service

Community Support Worker, Mr A

A Report by the

Deputy Health and Disability Commissioner

(Case 13HDC00298)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. On 1 February 2013, Mr B, aged 61 years, entered a 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.

2. At 9.25pm on 4 March 2013, Mr A, a community support worker, assisted Mr B in taking his evening medication. Mr B's prescribed medications to be taken in the evening were the antipsychotic quetiapine 25mg x 2, Laxsol x2, and risperidone 1mg x1.

3. Mr B had changed rooms before Mr A's shift. Mr A was aware of this change. Medications were stored in drawers according to room numbers, and Mr B's medication had been moved accordingly.

4. Mr A opened a medication filing drawer, removed a blister pack corresponding to the room Mr B had been in previously, and took it to Mr B. Mr A deviated from the service's required medication support procedures, as he did not ensure that all checks to support safe medication taking had occurred. This resulted in Mr A giving Mr B another resident's medication in error, including the antipsychotic clozapine.

5. Mr A 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 Mr B had taken in error was very high for a person who had never taken the medication previously. Mr A immediately contacted senior staff and sought medical help for Mr B. An ambulance was called, and Mr B was taken to hospital. He was extubated after seven hours of ventilation and discharged to a medical ward in a stable condition. He spent two nights in hospital and entered another residential respite service on 6 March 2013, before returning to live in the community on 20 March 2013.

6. Mr A acknowledged his error and that he had not followed policy and procedure. He co-operated fully with his employer's investigation and HDC to identify what had occurred. He undertook collaborative remedial actions to improve his care in future. The service's processes were subsequently altered so that medication storage is solely based on the person's identity rather than association with a room number.

Findings summary

7. Not adhering to well established medication checking processes was a departure from policy. This resulted in Mr B receiving inadequate care. Mr A failed to provide services to Mr B with reasonable care and skill and, accordingly, Mr A breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

8. Adverse comment was made that at the time of the error, Mr B'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

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

found that, overall, the service had appropriate medication administration systems in place. The service was not considered to be directly or vicariously liable for Mr A's error.

Complaint and investigation

9. The Commissioner received a complaint from Mr C about the services provided to his father, Mr B, by a residential mental health service. Mr B supported the complaint. The following issues were identified for investigation:

   - *Whether the Service provided an appropriate standard of care to Mr B in February 2013 and March 2013.*

   - *Whether Support Worker, Mr A, provided an appropriate standard of care to Mr B in February 2013 and March 2013.*

10. An investigation was commenced on 19 September 2013. This report is the opinion of Theo Baker, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

11. The parties referred to in the report are:

The Service	Provider
Mr A	Community support worker
Mr B	Consumer
Mr C	Complainant, consumer's son
Ms D	Team leader
Ms E	Team leader, after hours support
Mr F	Community support worker
Ms G	Community support worker

12. Information was also received from the District Health Board (DHB).

13. Independent expert advice was obtained from mental health nurse practitioner Ms Bernadette Paus (**Appendix A**).

Information gathered during investigation

Background

14. On 1 February 2013, Mr B, then aged 61 years, entered a residential mental health service. Mr B was recovering from a recent deterioration in his mental health, and was making a transition from DHB mental health inpatient services to living in the community. Mr B was being assisted with relationship, communication, and day-to-

day living skills, and it was anticipated that he would stay for a period of about three weeks at the Service. His support plan included being treated for diabetes.

15. The Service provides 24-hour support for people experiencing mental health issues, for periods of up to several weeks. Support is offered by a team of community support workers and team leaders. Staff do not provide clinical treatment or mental health assessment — those services are provided by visiting DHB clinical staff.

16. During his stay at the Service, Mr B's DHB Community Mental Health Team actively reviewed his mental well-being and communicated with staff at the Service.

Medication management

17. As part of ongoing support, community support workers assist clients to take medication regularly as prescribed. Supporting clients to take prescribed medication appropriately is a service requirement of the Service.[2]

18. The process adopted for clients entering the Service is for prescribed medication to be accompanied by a copy of the prescription and signing chart provided by the pharmacy, which is collected by a staff member and scanned into *Recordbase*, an electronic client record.

19. At the time of these events, medication was stored securely in a designated office at the Service. Medications were stored in filing drawers according to room numbers. Numbered filing drawers were matched with room numbers.

20. When a client required his or her medication, the medication was removed from the filing drawer by staff and checked as required, and the client was supported to take it correctly as prescribed.

21. On 22 February 2013, the DHB sent a prescription for Mr B's medication to his community pharmacy,[3] and his medication was blister packed by the pharmacist as per the service's requirements for people using its services. Mr B was dispensed two weeks' worth of medication.

22. Mr B's prescribed medications at this time were fluoxetine[4] 20mg (one capsule once daily in the morning), risperidone[5] 1mg (one tablet twice daily), quetiapine[6] 25mg (two tablets once daily at night), Laxsol (docusate sodium)[7] tablets (two tablets once daily at night), and metformin[8] 500mg (one tablet twice daily).

[2] The service has certification under Health and Disability Sector Standards. NZS 8134.1.3:2008 Standard 3.12 of *NZS Health and Disability Services (Core) Standards* requires safe and timely medication management to be achieved through a number of criteria.
[3] A copy of the prescription is on Mr B's file at the Service, and a copy was provided to HDC.
[4] An antidepressant.
[5] Prescribed for the treatment of symptoms associated with schizophrenia.
[6] Indicated in adults for the treatment of acute and chronic psychoses, including schizophrenia.
[7] Used to treat constipation.
[8] Used in the management of type 2 diabetes.

Policy and process

23. The Service provided HDC with copies of its policy and process documents governing medication management and administration, together with staff training records.

24. The key documents governing medication management are: "Right First Time", the Service's Medication Induction Package;[9] a Resource Folder for Alerts, Allergies and Medication Support Plans; and document QSM059, "Medication Policy".[10] The Service also utilises Promapp[11] flow charts to assist staff with medication administration. These documents provide instructions and guidance for staff.

25. The Medication Policy document includes the statement:

> "When [staff] take responsibility of supporting a person in any aspect of medication taking (e.g. supervising the taking of medication), it is essential that staff's actions are performed to an exceptional standard.
>
> This includes ensuring that all aspects of … policy and process are carefully followed to ensure no errors are made.
>
> It is absolutely essential that the right first time is followed …"

26. "Right First Time", the Service's Medication Induction Package, incudes a section headed "Medication Safety".[12] Under the heading "The Five Rights of Medication Administration" (often called the "Five Rs") it states:

> "These rights must be completed every time medication of any kind is administered.
>
> The Right Dose
>
> The Right Route — Oral=by mouth
Topical=on the skin
IMI=Intra Muscular Injection
Subcutaneous=just under the skin
Sub-Lingual=Under the Tongue
>
> The Right Person
>
> The Right Medication
>
> The Right Time
>
> …"

27. The Service's support worker "Position Description"[13] includes a table with a *focus* section headed, "Be committed to safety and wellness in the workplace". This

[9] Issue Number 5. 11 February 2005.
[10] Version 5, updated September 2012.
[11] Promapp is a quality assurance tool and flow chart system that can be applied to the recording, communication and improvement of most organisational processes, in this case medication administration.
[12] At page 7 of the document.
[13] Dated June 2013.

includes an associated *activity* section, which states: "Comply with legal obligations and safety and wellbeing policies and procedures." The associated *outcome* stipulated is: "Policies and procedures are understood and followed as designed."

Support worker Mr A

28. On 4 March 2013, Mr A, a part-time employee, was the community support worker who had the primary responsibility for care provided to Mr B for the afternoon/evening shift. Mr A's duties included looking after Mr B, supporting him to take medication from his blistered medication pack, providing meals, prompting his activities of daily living, and monitoring his mental state.

29. Mr A told HDC that at the time of these events he was aware of the "Five Rs" associated with administering medication. He said that he was also aware of the Promapp flowchart for the procedure when storing, receiving, and disposing of medication, as well as the Medication Policy for support workers regarding medication.

30. Mr A had been inducted in June 2012 at another residential service. He had spent four days shadowing an experienced support worker, and he had been shadowed when he supported clients to take medication. He had completed a training module on safe medication administration and induction documents. In September 2012, his annual medication training was signed off as completed.

Change of rooms

31. Due to another client's needs, Mr B had been asked to change bedrooms, from room 2 to room 4. In accordance with the medication storage system in place, Mr B's blister pack was moved to the tray marked "Bedroom 4" in the medication filing drawer. Mr A had seen Mr B previously when he was in room 2. Mr A told HDC that he could not recall with any certainty the date on which Mr B changed rooms, but believed that the move had occurred by the time he went on shift on 4 March 2013. Mr A accepted that he would have been told of the room change by the start of his afternoon shift at 2.45pm on 4 March 2013.

32. The Service could not confirm from their records the date on which Mr B changed rooms. No entry has been made in the progress notes. When queried by HDC, the Service could find no written evidence in staff handover notes or in Mr B's file when the room change had occurred, other than in the statements given as part of its investigation.

Mr A's previous shift

33. The electronic progress records for Mr B include an entry made by Mr A on 3 March 2013 indicating that he had assisted Mr B to take his medications that evening. The Service later supplied HDC with a copy of Mr A's signed timesheet, which indicates that he had worked on Sunday 3 March from 2.45pm to 11.15pm, the day before the error.

4 March 2013 incident

34. On 4 March 2013, Mr A was working a shift from 2.45pm to 11.15pm. Mr B's prescribed medications to be taken in the evening were his quetiapine 25mg x 2, Laxsol x2 and risperidone 1mg x1.

35. Mr A advised that at approximately 9.25pm, he opened the medication filing drawer, removed a blister pack and took it out to Mr B in the kitchen. Mr A said that he did not look at the blister pack.

36. Mr A said that he took the blister pack from a medication tray marked "Bedroom 2", because he assumed that this tray was for Mr B. Mr A did not check the blister pack before or after passing it to Mr B, nor did he follow the "Five Rs" as per the document "Right First Time".

37. Mr B then ingested the medications. The medication that Mr B was given in error was:

- clozapine[14] 100mg x 3
- sodium valproate[15] 500mg x 2
- simvastatin[16] 40mg x 1

38. That medication belonged to another guest in the Service, and was labelled with the other guest's name on the blister packaging it was dispensed in.

39. Mr A returned to the office, where he placed the blister pack back in the resident's filing drawer. He then noticed that the filing drawer belonged to another guest. Mr A then checked the blister pack and saw that it too belonged to the other guest and not Mr B.

40. Mr A realised that he had made a serious medication error. Mr A said that he also overheard Mr B, who was sitting on the couch, say that his "medications must be new".

41. Mr A acknowledged his error. He told HDC:

> "I had failed to follow [the service's] policy by my actions. I had not adhered to [the service's] Right Person, Right dose and Right Medication policy.
>
> The significant contributing factor was that the wrong blister [pack] was given … [Mr B's] folder had changed places in the filing cabinet due to [Mr B] changing rooms. This however is not my excuse for my negligence but a contributor to why I chose the wrong folder."

42. Fellow support worker Mr F was on shift with Mr A when the medication error occurred. Mr F said that he was made aware of the medication error as he was about

[14] An antipsychotic drug.
[15] Used in the treatment of epilepsy.
[16] Used in the treatment of high cholesterol.

to leave the Service at the end of his shift around 9.30pm. He recalls Mr A making telephone calls and seeking advice.

Calls for assistance

43. Mr A said that he immediately rang Ms E, an after-hours support staff member.

44. Ms E told HDC that she received a call from Mr A at 9.23pm to advise that Mr B had taken medication prescribed for another resident, and that the medication included clozapine.[17]

45. Mr B was prescribed an antipsychotic, quetiapine. Clozapine, however, is an atypical antipsychotic drug with a marked side effect profile (meaning it is usually started on a low dose). The 300mg dose of clozapine Mr B had taken in error is an appropriate dose for a patient accustomed to receiving the drug, but it is very high for an individual who has never received it previously.

46. Ms E's recollection is that Mr A explained that he opened the medication filing cabinet to get the next person's medication out when he realised that he had given medication to the wrong person. She said that she instructed Mr A to call paramedics and CATT (the DHB's Mental Health Services Crisis Assessment and Treatment Team). Ms E contacted Team Leader Ms D, who arranged for the next person on shift to come on duty earlier to enable Mr A to complete a reportable event form.

47. Mr A said that CATT staff directed him to call 111. Mr A told HDC that at 9.40pm he called 111 and spoke with ambulance staff, who transferred him to Healthline[18] for advice. Mr A was advised by Healthline staff to call Poison Control.[19]

48. Mr A spoke to Poison Control staff, who advised him to call 111 again to transport Mr B to hospital to have his blood pressure and heartbeat monitored.

49. Mr A said that 111 staff advised him that an ambulance was being dispatched, but that it could take up to an hour to arrive. At 9.50pm, Mr A called Ms E again, to tell her of the actions he had taken.

50. After the telephone calls had been made, Mr A informed Mr B that he had given him the wrong blister pack. Mr B said that he was feeling dizzy and sleepy. Mr A rang Ms E again and was advised to telephone the paramedics to let them know of Mr B's condition, which he did. Mr A was informed that an ambulance was on its way. Mr A told HDC that during the telephone conversations he was monitoring Mr B regularly. Mr A took Mr B into an office to continue monitoring him.

[17] The service was able to confirm that the other resident affected by the error received his appropriate medication at 11.05pm that evening following the events. This was determined by a review of the resident's notes for that evening, and his medication signing sheet, and by speaking with the service and relationship manager for the service.

[18] A telephone service offering health information and advice from a registered nurse, operated by the Ministry of Health.

[19] This is a reference to the National Poisons Centre, which operates a 24-hour freephone number.

Ambulance arrival

51. At 10.25pm the ambulance staff arrived, and Mr A explained what had happened. Ms G, a support worker for the overnight shift, recalls that when she arrived on shift, Mr B was being attended to by two paramedic staff, and that Mr A had supplied relevant information regarding Mr B's medical history and prescribed blister packed medication. Once the paramedics had taken Mr B to the ambulance, Mr A completed the reportable event form.

52. The ambulance departed at 10.40pm, and Mr B was taken to the Emergency Department (ED). During transit, Mr B became comatose and had difficulty breathing. One of the paramedics called back the Service to confirm the dose of clozapine taken.

Hospital treatment

53. On arrival at the ED, Mr B was intubated and ventilated. At 3am on 5 March 2013, Mr B was admitted to the Intensive Care Unit (ICU). Care provided was supportive, as there is no antidote, drug reversal, or mechanism for removing clozapine from a person's bloodstream.

54. At 4.15am a nurse from ICU called to update residential service staff. Hospital staff also updated Mr B's family.

55. Mr B's coma gradually resolved, and he had no cardiac complications. He was extubated after seven hours of ventilation and discharged to a medical ward in a stable condition.

Subsequent events

56. The Service's Regional Manager spoke with Mr B's son, Mr C. Mr C informed the manager that he would be making a complaint. Information was provided about how to do this. The manager expressed his regret at the incident and provided an apology to Mr C. Mr C was advised that an internal investigation would be undertaken.

57. Residential service staff also spoke with Mr B's family, and staff maintained contact with the hospital to check on Mr B's condition.

58. On 6 March 2013, following two nights in hospital, Mr B entered another residential respite service and remained in that service with no further incident until he returned to live in the community on 20 March 2013.

The Service's review

59. On 6 March 2013, Mr A had a disciplinary investigation meeting with the Service Leader and Ms D. A second meeting occurred with the Service Leader and the Service's General Manager to confirm the information documented in the reportable event form. Mr A was stood down from medication support for approximately a month.

60. The General Manager advised HDC that the Service's subsequent review concluded that:

- the incident was very serious and the Service was deeply sorry that it occurred;

- Mr A made a serious medication error on 4 March 2013;
- Mr A did not focus on the task of medication support and acted with a level of complacency which contributed to the "Five Rs" not being followed;
- Mr A agreed with the review's conclusion and willingly acknowledged that he did not check the blister pack at any time during the support;
- Mr A acted immediately upon discovering the medication error;
- disciplinary action was taken in relation to Mr A; and
- Mr A deeply regretted his mistake and extended his apologies to Mr B and his family.

61. Mr A stated:

> "I have looked upon this incident with a deep sense of regret [and] I acknowledge my actions as negligent. I desire to take full responsibility for my actions. I am very willing to do whatever it takes to make things right. [Mr B] had been in our service for quite sometime and I felt as if we had rapport. I genuinely care for [Mr B] …"

Training review

62. Mr A repeated his medication administration induction with the Service's Registered Nurse "medication champion", and re-reviewed the medication safety process from the "Right First Time" document.

63. During Mr A's medication support stand-down period, Ms E and the medication champion observed Mr A's performance and progress. He also attended a second medication safety session held by the medication champion, and a DHB nursing workshop on clozapine.

64. Staff in all acute and residential settings were re-familiarised with the "Five Rs" process for supporting safe medication taking.

65. Medication training packages were reviewed with a view to introducing electronic learning modules to further support induction and ongoing training.

66. Mr A also told HDC: "I [now] wash my hands before medication, as a way of mentally preparing myself for medication support and going over the 5 Rs in my head." He stated that he asks people, "Is this your blister?" and, "What day is it?" before observing medication being taken. Mr A said: "This reiterates the 5 Rs for myself and for [the] guest." Mr A now performs triple checks before giving any medication.

Changes to process

67. The service advised HDC of the following:

- Storage of medication at the Service is now solely based on the person's identity rather than association with a room number.

- Each resident at the Service now has his or her own locked medication tin for blister packs. The tins are kept in a locked filing drawer in the Recovery Office. They are clearly labelled with the guest's name on the outside of the tin. Care is taken to ensure that new labelling occurs at the entry of each new resident.
- "Five R" stickers are placed on tins and in resident folders.
- A medication signing sheet exists for staff coming on shift to check previous medication. This ensures that oncoming staff are familiarised with the medication. Staff must check the tins/blister packs at handover (three times a day) to ensure that the medications have been taken as prescribed, and must sign a communication book to confirm that this has occurred. This is designed to be an extra check.
- Medication signing sheets and the key to the locked boxes all remain in the Recovery office.
- Registered nurses are responsible for the oversight of medication alerts in Recordbase, and the training of support staff to ensure that all people supported on psychotropic medication, particularly clozapine, have medication alerts incorporating action plans (in the event of any adverse medication issues).

Relevant standards

68. The *NZS Health and Disability Services (Core) Standards* (Standards New Zealand, 2008) includes NZS 8134.1.2:2008 — Standard 2.2, which states: "The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers."

69. The *NZS Health and Disability Services (Core) Standards* (Standards New Zealand, 2008) also includes the Medicine Management standard 8134.1.3:2008 — Standard 3.12, which states:

> "Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.
>
> *Criteria*
> The criteria required to achieve this outcome shall include the organisation ensuring:
>
> 3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.
> …"

Responses to provisional report

70. In response to the provisional report, the Service confirmed that it agreed with and accepted the findings and recommendations, and had no further comments to make. Mr A responded that he did not wish to comment any further other than to emphasise his apologies to the family.

Opinion: Mr A — Breach

71. The sequence of key events leading to the error in this case is not in dispute. Mr A has acknowledged that he made a serious error, and has taken responsibility for his actions.

72. I am mindful that the exact date that Mr B changed from room 2 to room 4 has not been able to be firmly established by the Service. However, I accept that on 4 March Mr A was aware of Mr B's room change. Nevertheless, he inadvertently removed the medication blister pack from the tray for room 2 and gave it to Mr B.

73. Regardless of the room change, prior to administering medication to Mr B on 4 March 2013, Mr A failed to carry out the appropriate "Five Rs" checks, as outlined in the Service's medication administration document "Right First Time". It was this omission that resulted in Mr A administering another resident's medication to Mr B.

74. My expert advisor, nurse practitioner Ms Bernadette Paus, stated:

> "If [Mr A] had done the required 5R checks he would have realised he had the wrong resident's medication regardless of what drawer it was placed in. It is my opinion that there was only one serious failure in the care provided to [Mr B] in relation to this investigation and that was [Mr A's] failure to adhere to [the Service's] policies for checking medication prior to administering to residents."

75. I acknowledge that as soon as Mr A realised that he had made a significant error, he took immediate and appropriate steps to alert other staff and seek medical help for Mr B.

76. As Ms Paus advised:

> "In my opinion [Mr A] acted swiftly and appropriately and in accordance with the service medication error policy when he realised (very soon after administering the medication) that he had made an error …"

77. Nevertheless, not adhering to well established medication checking protocols was a departure from policy. This resulted in Mr B receiving inadequate care. Mr A failed to provide services to Mr B with reasonable care and skill and, accordingly, Mr A breached Right 4(1) of the Code.

Opinion: The Service — Adverse comment

78. The Service had a duty to ensure that services were provided that complied with the Code. The Service had a responsibility, in line with New Zealand Health and Disability Services Standards, to operate its facility in a manner that provided residents with timely, appropriate, and safe care.[20]

79. In addition, under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority may be vicariously liable for acts or omissions by an employee. Under section 72(5), it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent acts or omissions leading to an employee's breach of the Code.

80. This Office has previously found providers not liable for the acts or omissions of staff, when those acts or omissions clearly relate to an individual clinical failure made by the staff member.[21]

81. Ms Paus advised that, overall, the Service had:

- an appropriate medication management system whereby prescriptions are sent directly to the pharmacy and the individual's medication is packed by the pharmacist into the "blister-package" system;
- an appropriate medication training module and administration policy;
- ensured that Mr A had completed the organisation's training module on safe handling and administration of medication, and that the modules he had undertaken were reflective of a good staff training and education programme;
- investigated the incident appropriately, communicated with family members swiftly, and taken reasonable steps to discipline Mr A while arranging re-education and supervision in relation to his medication administration; and
- put in place remedial steps around medication storage and checking processes which reflect concern over the incident and demonstrate a commitment to minimising medication errors.

82. I agree with Ms Paus and consider that the Service took steps that were reasonably practicable to prevent acts or omissions such as Mr A's in this event. Accordingly, I do not consider that the Service is directly or vicariously liable for Mr A's breaches of the Code.

83. While the primary responsibility for the error lies with Mr A, there were some organisational factors relevant to the incident.

84. I am critical that the exact date that Mr B changed rooms has not been able to be determined by the Service. The change of room was not documented. I would have expected, particularly when a system was in place at that time whereby medications

[20] Also see Opinion 11HDC00940 (28 November 2013).
[21] Opinion 12HDC01483 (12 July 2013).

were stored in drawers according to room numbers, any change of resident's room would be documented immediately, and all staff made aware of that change.

85. I agree with Ms Paus, who advised:

> "Whilst having numbered drawers matched with room numbers could appear like a protective mechanism designed to reduce errors, it has the potential to increase the risk of errors in the way that has occurred in this investigation, ie a staff member becomes complacent and either assumes the right blister-pack is in the right drawer or does not know that there has been a change of rooms and then administers the medication without doing the required checks."

86. In my view, at the time of the error, Mr B's change of rooms and the storage system in place based on resident room numbers contributed to an increased risk of an error occurring.

Recommendations

87. I recommend that Mr A:

a) Provide Mr B with a formal written apology within three weeks of this report being issued. The apology is to be sent to HDC in the first instance, for forwarding to Mr B.

b) Report back to HDC, within two months of issue of this report, on how the changes to his practice have affected his community support work.

88. I recommend that the Service, in light of this report and Ms Paus's advice:

a) Review its policy and process to further minimise the risk involved in medication storage and administration.

b) Audit its medication administration processes and report back to HDC, within three months of issue of this report, on the effectiveness of the changes to practice it has implemented.

Follow-up actions

89.
- An anonymised copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the DHB, and its designated recipient will be advised of Mr A's name in the covering correspondence.
- An anonymised copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Health Quality and Safety Commission (HQSC), and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent advice to the Commissioner

The following expert advice was obtained from Nurse Practitioner Ms Bernadette Paus:

> "This report is being provided to the Commissioner following a request for independent expert advice on case number C13/00298 regarding the standard and appropriateness of care provided to [Mr B] by [the Service].
>
> I have read and agree to follow the Commissioner's 'Guidelines for Independent Advisors'.
>
> I am a Mental Health Nurse Practitioner with over 20 years clinical experience in Mental Health. Over this time I have held clinical, national leadership, educator and advisory roles. My clinical role is closely aligned to NGOs providing mental health and disability support so I have a good understanding of the standards expected and principles on which the current service is based. Additionally I have a reasonable understanding of the medication storage and administration processes many NGOs use. At the time of writing this report I am employed as a Nurse Practitioner by the Southern DHB working full time in clinical work.
>
> I have read the documents provided and offer the following opinion on the questions requested;
>
> […]
>
> **Expert Advice Requested**
>
> - The standard and appropriateness of care provided to [Mr B] by [the Service].
> - The adequacy of medication administration systems and processes in place in relation to the incident.
> - The standard of care provided to [Mr B] by [Mr A], support worker.
> - The Actions taken by [Mr A] in response to this error.
> - The remedial actions taken by [the service] as a result of this matter.
> - Comment on any aspects of the care provided that warrant additional comment.
>
> **The Standards that apply to this incident are:**
>
> - **National Mental Health Sector Standard (NZS 8143:2001)**
> - **[The Service's] Organisational Policies and Procedures, including Code of Conduct**
> - **Health and Disability Sector Standards (NZS 8134:2001)**
> - **NZS8134.1.1**: **Consumers Rights**: Consumers receive services of an appropriate standard of good practice (.8)
> - **NZS 8134.1.3 Service Delivery**: Consumers receive competent and appropriate services in order to meet their needs (.3); Medicine management — consumers receive medications in a safe and timely manner that complies with current legislative requirements and safe practice guidelines

The standard and appropriateness of care provided to [Mr B] by [the Service].

[The Service] had an appropriate medication management system whereby prescriptions are sent directly to the pharmacy and the individual's medication is packed by the pharmacist into the 'blister-package' system. This blister-package system is a way of minimising medication errors with clear instructions on administration times along with medication signing sheets. This is a common medication management system used by NGOs. Whilst I cannot comment on the national perspective as a whole, it is the system used by all the NGOs in the Southland-Otago area of which one is a national provider.

[The Service's] medication training module and administration policy is appropriate. It covers training on the blister-pack system, general medication safety, medication administration, documentation, side-effects and how to deal with medication errors. It provides clear step-by-step instructions and guidance for staff regarding medication administration. The checks and protocols put in place around medication storage and medication administration are stringent because of the potential seriousness of medication errors. This is generally discussed with staff during these education modules.

[Mr A] had completed the organisation's training module on safe handling and administration of medication. Additionally his education records indicate a good level of appropriate general mental health and health and safety training and education for his period of employment. The modules he had undertaken are reflective of a good staff training and education programme.

[Mr A] failed to do the '5 Rights' check as per [the Service's] medication administration policy, prior to administering medication to [Mr B] on 4/3/2013. This failure resulted in him administering another resident's medication to [Mr B] and this unfortunately had very serious (life threatening) consequences for [Mr B]. If [Mr A] had done the required 5R checks he would have realised he had the wrong resident's medication regardless of what drawer it was placed in.

It is my opinion that there was only one serious failure in the care provided to [Mr B] in relation to this investigation and that was [Mr A's] failure to adhere to [Service] policies for checking medication prior to administering to residents.

- Therefore it is my opinion that the care (regarding medication provision and safety), provided to [Mr B] on 4/3/2013 by [Mr A] as an employee of [the Service] fell below an acceptable standard resulting in a failure to provide [Mr B] with an adequate level of care.
- Not adhering to the medication checking protocols was a serious departure from his organisation's policy and accepted standards of care.

Communication with Family: The family appear to have been informed in a timely manner.

The adequacy of medication administration systems and processes in place in relation to the incident.

I believe the medication storage system that was in place at [the Service] at the time of this error, whereby medications were stored in drawers according to room numbers contributed to the chances of this type of medication error occurring. Whilst having numbered drawers matched with room numbers could appear like a protective mechanism designed to reduce errors it has the potential to increase the risk of errors in the way that has occurred in this investigation, ie a staff member becomes complacent and either assumes the right blister-pack is in the right drawer or does not know that there has been a change of rooms and then administers the medication without doing the required checks.

A system where blister packs are stored within a clearly identified resident folder and folders are stored together in a cupboard or filing cabinet which requires staff to read the resident's name when getting their medication will minimize medication administration errors like this one as the staff member has no option but to do the first of the 5R checks — identifying that it is the right person's medication.

In my experience most NGOs store blister packed medications in files which have the patient's name on the spine of the file. When medications are put into the patient's file there is a checking system to ensure the right blister packs are going into the right resident's file. Medication files are then generally stored in locked filing cabinets or cupboards. When staff are getting medication for administration there is no ordering system which means they have no option but to get the file and blister packs by reading the resident's name. Additionally, contained within these medication files is all the necessary drug information relating to the resident and their medication history and medicines.

The Actions taken by [Mr A] in response to this error

In my opinion [Mr A] acted swiftly and appropriately and in accordance with [the Service's] medication error policy when he realised (very soon after administering the medication) that he had made an error.

Additionally the actions taken by after-hours staff member Ms E and [the CATT team] were appropriate.

The remedial actions taken by [the Service] as a result of this matter.

[The Service] [appears] to have investigated the incident appropriately. Their decision that [Mr A's] action/failure constituted gross misconduct was appropriate.

Unfortunately and relevant to this investigation is the fact that medication errors nationally and internationally are not uncommon. They are in fact far more prevalent than what we would want to see. They occur in all settings — in hospitals, in primary healthcare, in supported community settings, in the home. 'They involve all routes of administration and all provider groups, and they are

responsible for much serious and costly morbidity (and occasionally even mortality) in patients of all ages' (NZ Medical Journal). In New Zealand we do not have reliable statistics on the incidence of medication errors across the board and whilst DHBs have their own reporting systems and Pharmacovigilance NZ gathers data on medication errors in the primary setting, the information is provided on a voluntary basis. Information reported is often on incidents where there has been a more serious outcome. However, what we do know from the literature is that the best way to minimize medication errors is to have administration systems developed with risk minimization at the center. One of the core principles of medication risk minimization is to eliminate anything in the administration process that could add to the chances of an error occurring.

The remedial steps [the Service] have put in place around medication storage and checking processes reflect concern over the incident and demonstrate a commitment to minimising medication errors. A system of folders where medication is never taken out once checked into the folder, as described above may be worth considering. The tin system will require staff taking in and out of the tins the blister packs. This brings with it the potential to place the wrong blister pack in the wrong tin during medication administration time. Such risk can be eliminated by the folder system where medications get checked into the folder and are not removed.

Comment on any other issues arising.

The following comment does not relate directly to the incident being investigated and is not intended as a criticism of the NGO, but rather an observation and offers something for consideration. In reading the daily notes 'person supported record' on [Mr B] I notice that staff documentation is predominantly narrative in style. Given that [the Service] is taking people at the subacute level of recovery it might be helpful to have a 'person supported record' that is somewhat more focused on symptoms/level of functioning. A large NGO [with] whom I have regular liaison has recently developed a resident record which gets staff to comment on symptom groups by way of prompted headings, for example, mood, level of function, interaction with others, sleep. Something like this might be worth considering at [the Service] given that the people who are placed there are in the early phases of recovery when attention to symptoms/early warning signs are important.

Conclusion:

In conclusion, it is my opinion that the root cause of the problem in this case was:

- [Mr A's] failure to conduct the appropriate checks when administering medication to [Mr B] on 4/3/2013. When failing to conduct these checks he deviated from and therefore failed to meet the organisation's medication administration policy guidelines.
- It is therefore my opinion that the care (regarding medication provision and safety), provided to [Mr B] on 4/3/2013 by [Mr A] fell below an acceptable standard of care.

- Whilst the medication storage system at [the Service] at the time of the incident may have contributed to the chances of a drug administration error occurring the checking processes in place should have prevented this [from] happen[ing]. I therefore see the failure as sitting directly with [Mr A].
- In my opinion there were no serious failures by [the Service].

Yours truly,

Bernadette Paus

June 2014

References

- The New Zealand Medical Journal 18-April-2008 Vol121No1272: Medication Error in New Zealand — Time to Act; Alan F Merry & Craig S Webster
- National Mental Health Sector Standard (NZS 8143:2001)
- [The Service's] Organisational Policies and Procedures, including Code of Conduct
- Health and Disability Sector Standards (NZS 8134:2001)"