Rita Angus Retirement Village Ltd

Registered Nurse, RN D

A Report by the

Deputy Health and Disability Commissioner

(Case 14HDC00568)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mrs A was aged 89 years at the time of these events and was living in a serviced apartment at a Retirement Village. She received an assisted living package which included medication management. Mrs A was prescribed a number of medications which staff administered to her from blister packs.

2. On the morning of Day 1, coordinator Ms H gave Mrs A medications that were prescribed for another resident. The medications concerned were aspirin, simvastatin 20mg, and dihydrocodeine 60mg, which Mrs A swallowed. Ms H then gave Mrs A frusemide and cilazapril medications. At that point Ms H realised the medication error and asked Mrs A to spit out the additional medications, which she did. Ms H then immediately informed the duty nurse, RN D, that she had given Mrs A the wrong medications.

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

4. Ms H did notify Mrs A's family of the medication error that morning, and observed Mrs A at morning tea and lunchtime. RN D reported that at lunchtime Ms H told her that Mrs A was "OK" and that there were no changes evident. At 1.30pm Mrs A left the Retirement Village with her family, and returned at approximately 3.30pm in an unstable condition. At 3.30pm, RN E assessed Mrs A, took her observations, and instructed Ms H to contact Dr G. Further observations were taken throughout the afternoon.

5. At 6pm Dr G reviewed Mrs A, documented that she had vomited, and made a plan to observe her and send her to hospital if she continued to vomit. At 7.23pm, following further episodes of vomiting, Dr G arranged for Mrs A to be transported to a public hospital, where she was admitted for further treatment and assessment. On Day 2, Mrs A was discharged back into the Retirement Village's care.

Findings

6. RN D failed to follow the Retirement Village's Medications Errors Policy, which required her, as the most senior member of staff, to undertake a number of actions, including taking Mrs A's observations and contacting her doctor. The Nursing Council of New Zealand's *Code of Conduct* required RN D to adhere to such organisational policies. Furthermore, RN D considered it acceptable to delegate her duties to Ms H. Accordingly, RN D failed to provide Mrs A with services in

accordance with professional standards and breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

7. Rita Angus Retirement Village Limited's staff failed to follow appropriate policies when providing services to Mrs A. Accordingly, Rita Angus Retirement Village Limited failed to provide Mrs A with services with reasonable care and skill and breached Right 4(1) of the Code.[2]

8. Adverse comment is made in respect of Ms H regarding her failure to follow the Medication Administration Policy and adequately record the details of her conversations with Mrs A's family or the instructions she received from RN D.

Recommendations

9. It was recommended that Rita Angus Retirement Village Limited review the actions it had taken as a result of an investigation report by its parent company, and report to HDC on the implementation and effectiveness of those actions, including the recently implemented electronic medication system. It was also recommended that RN D undertake further training on medication error management and the principles and requirements for delegating duties to healthcare assistants. Lastly, it was recommended that Rita Angus Retirement Village Limited and RN D provide apology letters to Mrs A. Ms H provided an apology letter for Mrs A following the provisional report.

Complaint and investigation

10. The Commissioner received a complaint from Ms B regarding the care provided to her mother, Mrs A at a Retirement Village.[3] The following issues were identified for investigation:

- *Whether RN D provided Mrs A with an appropriate standard of care on Day 1.*
- *Whether Rita Angus Retirement Village Limited provided Mrs A with an appropriate standard of care in the relevant month.*

11. This report is the opinion of Rose Wall, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

12. The parties directly involved in the investigation were:

Mrs A	Consumer
Ms B	Consumer's daughter

[1] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."
[2] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[3] Mrs A supported the complaint.

Mr C	Consumer's son
Rita Angus Retirement Village Limited	Provider
RN D	Registered nurse/provider
RN E	Registered nurse/provider
Ms H	Coordinator/provider
Dr G	Doctor/provider

Also mentioned in this report:

Mr I	Manager

13. Information from the District Health Board was also reviewed.

14. Independent expert advice was obtained from a registered nurse, Jan Grant (**Appendix A**).

Information gathered during investigation

Background

Mrs A

15. Mrs A (aged 89 years at the time of these events) resided in a serviced apartment at the Retirement Village. Mrs A and her husband had moved to the Retirement Village a few years previously. After her husband died, Mrs A continued to live in the serviced apartment, receiving an assisted living package with a number of service "add-ons", including medication management.

16. Mrs A's medical history[4] included hypertension,[5] ischaemic heart disease,[6] osteoarthritis[7] in her knees, and recurrent urinary tract infections (UTIs). Mrs A was prescribed a number of medications[8] including metoprolol CR,[9] aspirin, oxybutynin,[10] frusemide,[11] potassium chloride,[12] hexamine hippurate,[13] and ranitidine.[14]

17. This report relates to events on Day 1 when Mrs A was administered another resident's medication (the medication error).

[4] Mrs A's family advised that Mrs A has a degree of dementia.
[5] High blood pressure.
[6] Reduced blood supply to the heart.
[7] Osteoarthritis occurs as a result of the mechanical breakdown of the structures of the joints, most often the large weight-bearing joints — the knees, hips and spine.
[8] Mrs A's other medications were laxsol, psyllium powder, Sustagen, paracetamol, glycerol, cyclizine, and glyceryl trinitrate spray.
[9] A beta blocker used to treat high blood pressure.
[10] Used to treat symptoms of an overactive bladder and incontinence.
[11] Used to treat fluid build-up owing to high blood pressure, heart failure, liver scarring or kidney disease.
[12] Used to prevent or treat low levels of potassium.
[13] Used to prevent UTIs.
[14] Decreases the production of stomach acid. It is used to prevent and treat stomach ulcers.

The Retirement Village

18. The Retirement Village is owned and operated by Rita Angus Retirement Village Limited (RARV) and provides a number of residential options, including independent living apartments, serviced apartments, a rest home, and a hospital facility.

Ms H

19. Ms H was the coordinator at the Retirement Village. Ms H had worked as a caregiver at the Retirement Village and moved into the role of coordinator several years before these events.

20. Ms H had completed the ACE Core Programme[15], ACE Dementia, and ACE Advanced. Ms H had also attended training on Medicine Management using the Medico System.[16] Rita Angus advised that Ms H has regularly completed medication competencies and comprehension surveys successfully. Prior to the medication error, the most recently completed competencies and surveys were insulin administration and glucose monitoring, and staff comprehension of medication, diabetes and warfarin.

21. Ms H's job description states that she was "to be responsible for the safe storage, administration of and checking of medications according to [parent company] Protocols and Medicines Act". It also requires that the coordinator keep the doctor informed of residents' conditions and any deterioration/changes as they occur.

Medication error

22. Ms H told HDC that on Day 1 at approximately 8.15am she removed the medication trolley from the locked cupboard at the nurses' station on Level 1 of the serviced apartment facility, in preparation for the serviced apartment residents' medication round.

23. Ms H stated that she took out a blister pack that she thought was Mrs A's, removed the morning medication from the blister pack, and placed the medication in a kidney dish to be checked against Mrs A's medication chart. Ms H said:

> "[A]t this point, I was interrupted by a resident who wanted some help to find a pair of trousers he wanted to wear. He thought they may be in the main laundry. As there was no staff nearby, I locked the medication trolley and went to assist the resident. We found the trousers he was looking for."

24. Ms H told HDC that just before 8.30am, she returned to the nurses' station, collected the kidney dish, and went to Mrs A's room on Level 2. Ms H stated: "[U]nfortunately, I did not check the medication against the medication chart and did not take the medication folder and trolley with me."

[15] The ACE programme for support workers contains 10 unit standards towards the National Certificate in Health Disability and Aged Support (Level 3).
[16] An electronic medication management system.

25. Ms H stated that when she got to Mrs A's room she gave her three medications with yoghurt — simvastatin[17] 20mg, dihydrocodeine (DHC)[18] 60mg and aspirin, which Mrs A swallowed. Ms H then gave Mrs A two further medications (comprising three tablets).

26. Ms H told HDC that it was at this point:

> "I realised the medications were different to those that I normally gave [Mrs A] as the shapes were different. I quickly looked at the back of the blister pack and realised the medications belonged to another resident. I asked [Mrs A] to spit out the three [tablets] in her mouth, which she did. I put these medications in the blister pack. The tablets that were spat out were cilazapril[19] and frusemide."[20]

27. In her complaint to HDC, Ms B stated that her mother queried the different sizes of the medications she was taking with Ms H, who instructed Mrs A to spit out the last three tablets she had been given. When contacted by HDC, Mrs A stated that she was no longer able to remember what occurred during the medication error.

28. At 8.30am it is recorded in Mrs A's progress notes: "[T]his morning [Mrs A] was given wrong medications. She was given Simvastatin 20mg *1 + DH Conti 60 mg LA *1. No adverse reaction."

Discussion with RN D

29. Ms H told HDC that she immediately went to see RN D, who was the most senior person on duty at the time, and told her: "I've made a mistake; I've given the wrong medications to [Mrs A]." RN D examined Mrs A's blister pack and the other resident's blister pack and identified the medication Mrs A had taken in error. Both RN D and Ms H recall that RN D then advised Ms H to give Mrs A her usual medication, excluding aspirin, as she had already been given the other resident's aspirin.

30. According to RN D, Ms H asked her whether any of the medication would affect Mrs A badly. RN D said that she reassured Ms H and told her to keep a close eye on Mrs A and let her (RN D) know if she noticed any changes. RN D stated that she also told Ms H:

> "to do all the things required for a medication error — to keep a close eye on [Mrs A], take her observations, let the family and the GP know [of the error] and [complete a] medication error/incident form".

[17] A cholesterol lowering medication. Side effects include dizziness, fainting and fast or irregular heartbeat.
[18] An opioid analgesic prescribed for pain. Side effects include impairment of mental and physical abilities, itching and flushing. DHC is a controlled drug.
[19] This medication is used to treat high blood pressure.
[20] RARV clarified that the medications Mrs A spat out were two cilazapril tablets and one frusemide tablet.

31. In contrast, Ms H told HDC that she was not told to keep a close eye on Mrs A, contact the GP, or take observations. Ms H said she was unsure whether RN D told her to notify Mrs A's family or complete an incident report form.

32. At the time of these events, Ms H recorded in Mrs A's progress notes that the medication error was reported to RN D. No further detail was recorded regarding this conversation.

Subsequent events

33. Ms H told HDC that after giving Mrs A her usual medication, she rang Mrs A's daughter, Ms B, and told her that Mrs A had been given the wrong medication, that she was "OK", and that they would keep an eye on her.

34. Ms B stated that Ms H told her that her mother had been given two wrong medications, a mild painkiller and an anti-cholesterol drug. Ms B said that she asked for a doctor to be contacted to check for any interactions with her mother's usual medications, and told Ms H that she would be seeing her mother that afternoon to take her out. Ms H said: "I do not remember [Ms B] asking me to make sure that the GP was notified." The progress notes record that the medication error was "reported to family", but no detail of this conversation was documented.

35. Ms H stated that when Mrs A came to the lounge area for morning tea and the dining room for lunch she "seemed to be fine". RN D told HDC that during lunch she went to the serviced apartments' dining room and observed Mrs A eating her lunch, and spoke with Ms H "to see how [Mrs A] was". RN D stated that Ms H reported that Mrs A was "OK" and that there were no changes evident.

36. Ms B stated that at 1.30pm she and other members of her family arrived to pick up her mother. Ms B told HDC that on return to the Retirement Village, her mother was "unresponsive and in a state of collapse". She further commented:

> "[W]hen we arrived back at the village front entrance, we thought our mother was asleep, which was most unusual for her during a car trip. However, when we could not rouse her, we realised she was not asleep but in a semi-conscious state. Our first thought was that she had been overcome by the impact of a sad day. Her son-in-law … went inside and obtained a wheelchair to place our mother in … It was family, not [Ms H], who took our mother up to her apartment …"

37. At 3.30pm Mrs A's progress notes state:

> "[T]his afternoon family returned [Mrs A] from a drive, they said she was unresponsive but she appeared to be overdressed. Brought to room in wheelchair, undressed and fluids were given."

38. RN D stated that she was not aware that Mrs A was going out that afternoon, and said: "[I] would have suggested that she not go if I had known." Ms H also stated that she was not aware that Mrs A was going out that afternoon until she was asked to come to

the ground floor entrance because the family had returned with Mrs A. Ms H said that the family told her that Mrs A had been "unconscious". Ms H further stated:

> "I put [Mrs A] in a wheelchair and took her upstairs to her room. It was a hot day and I thought maybe [Mrs A] was overheated, particularly as she had a jacket and hat on. I gave her fluids and took her top layer of clothing off. I [then] quickly sought the help of RN [D] who handed over to RN [E] as it was the end of the morning shift."

39. Ms B stated that her mother wears layers of clothing even in the summer as she feels the cold, and noted that on Day 1 they had been outside on a windy day. Ms B further stated that her mother had just come from afternoon tea, so "she should not have been dehydrated".

40. Ms B told HDC that it was not Ms H but another caregiver who removed her mother's clothing, and that RN D told the family that Mrs A's condition was due to the medication error. Ms B also stated that she had ascertained that a doctor had not been called earlier that morning as she had requested, and, upon discovering this fact, insisted that a doctor be called.

RN E

41. RN E told HDC that she worked as a registered nurse at the Retirement Village five days per week, and was on duty from 3.15pm–11.15pm on Day 1. RN E stated that she received handover from RN D that Mrs A had been given incorrect medication during the morning shift but was "OK", and that Mrs A had been out with family and had collapsed while out.

42. RN D told HDC:

> "[At around 3.30pm I] handed over to [RN E] about [Mrs A's] medication error. [RN E] was going to check on [Mrs A] after our handover. [RN E] also phoned me just as I arrived home to get some more details about the medication error. She wanted to know what had happened and whether the GP was notified. I said that I told [Ms H] to inform the GP."

43. RN E stated that she assessed Mrs A at around 3.30pm. At 3.30pm, Mrs A's observations were recorded as follows: oxygen saturation 98%, heart rate 65 beats per minute (bpm), temperature 36.5°C and blood pressure 188/49mmHg.[21] The progress notes record that after observations had been taken Mrs A was "alert and coherent" and "lying on bed with [her] feet elevated". It is recorded that a plan was made for "fluids to be pushed" and the "[d]octor [was] informed".

44. With regard to her assessment of Mrs A, RN E told HDC:

[21] Normal oxygen saturation in an otherwise healthy individual is over 95%; normal resting heart rate is between 70 and 100 bpm; normal body temperature ranges between 36.1°C and 37.2°C; and normal blood pressure for adults aged 60 years or older is below 150/90mmHg.

> "[W]hen I went to see [Mrs A] around 1530, [Ms H] was with [Mrs A] at the time. [Mrs A's] granddaughter was also in the room. I took [Mrs A's] observations … her feet were elevated on bed. I recall [Mrs A] being alert and coherent. I advised [Mrs A], [Ms H] and [Mrs A's] granddaughter that it was important that [Mrs A] drink plenty of fluids. [Ms H] went away to make contact with [Mrs A's] GP."

45. RN E stated that she did not consider Mrs A needed urgent medical intervention, but planned to monitor her closely and await a GP review.

46. Mrs A's family told HDC that RN E did not communicate that she had telephoned RN D regarding Mrs A but did tell the family that her blood pressure was very low. Ms B also stated that RN E told her that she would have to talk to either Ms H or a manager, Mr I, about her mother.

47. Ms H stated that after RN E's review at 3.30pm she (Ms H) sent a fax to Mrs A's doctor (Dr G) "advising what had happened and requesting that he visit". Ms H then telephoned the medical practice and spoke to the receptionist, who put her through to Dr G. Ms H stated that she told Dr G what had occurred, and he said that he would visit Mrs A.

48. RN E said that around 4pm she went to see Mrs A again and completed another set of observations and "reinforced the importance of fluid intake". At 4pm, Mrs A's progress notes record that her blood pressure was 88/40mmHg. The notes also record that RN E was "questioned by [Mrs A's] daughter [Ms B] regarding the medication error".

49. RN E stated that she and Ms H went to see Mr I, and requested that he come to see Ms B. RN E stated that Mr I came to Mrs A's room and spoke with Ms B while she (RN E) left the room to do a medication round. Ms B told HDC that Mr I was not "fetched" by Retirement Village staff, and that she had to find him, which meant that she was away from her mother for over 30 minutes.

50. RN E told HDC that she took Mrs A's observations at 4.30pm and at 5pm. The progress notes record that Mrs A's blood pressure was 114/59mmHg at 4.30pm and 124/64mmHg at 5pm.

51. At 5.30pm, observations were taken and recorded as follows: blood pressure 124/66mmHg; temperature 36.4°C; respiratory rate 18/minute, oxygen saturation 97%, and pulse 66bpm. It was also documented that Mrs A had passed urine, which was clear, and that she looked comfortable but was "still a bit nauseated".

Dr G review

52. Dr G stated that he was alerted to the medication error by Retirement Village staff by fax on Day 1. Dr G told HDC:

> "I ascertained that [Mrs A] was stable enough to be assessed at the conclusion of my work session that evening based in part on the information given to me by

> [Retirement Village] registered nurse about [Mrs A], but also my knowledge of the medications given, and [Mrs A's] medical history."

53. Dr G assessed Mrs A at 6pm. He documented that Mrs A was "very nauseous" and had "vomited 300mils of digested food + fluid" with nil bile or blood. He also recorded that Mrs A denied chest pain, shortness of breath, palpitations, headaches or abdominal pain. Dr G's clinical assessment of Mrs A's presentation was "adverse effects from DHC 60mg (delayed metabolism) due to age, not clinically dehydrated". Dr G made a plan to observe Mrs A and "if vomiting send to ED [Emergency Department] for IV/IM antiemetic[22] +/- IV fluids". Dr G also prescribed an oral antiemetic "in [the] meantime" and "frequent sips of clear fluid".

54. At 7.23pm Dr G documented: "[P]atient vomited again and no IM antiemetic available → to ED." An ambulance was arranged, and Dr G informed the public hospital's ED of Mrs A's condition.

Public hospital

55. At 8.26pm Mrs A arrived at the ED. In the early hours of Day 2, following a medical review and a period of observations, Mrs A was admitted for further treatment and assessment. An internal medicine physician told HDC that he reviewed Mrs A at 9.30am on Day 2. The physician stated:

> "At the time that I saw her, she was able to give a good account of events, her nausea had abated and she was able to walk with a shuffling gait with the aid of her walking stick; reported to be at her usual level of mobility."

56. The physician said that his opinion was that the DHC may have induced the confusion and nausea/vomiting, on the background of the extensive drugs prescribed for various chronic and recent acute problems such as a UTI. The physician said that Mrs A improved over the day and, after review by the multidisciplinary team and discussion with her GP, she was discharged back to the Retirement Village's care.

Incident form

57. Ms H stated: "I do not recall exactly what time I completed the incident form for the medication error however I do know it was some time on [Day 2]." Ms H recorded on the incident form that she had reported the medication error to the registered nurse at approximately 8.30am on Day 1 and noted: "[N]o obs were taken at the time of incident." Ms H also recorded on the incident form that the GP was not informed until 3.30pm.

Policies

58. At the time of these events the Retirement Village had a clinical services manual, one section of which was titled "Medication — Administration Of" (28 May 2013) (the Medication Administration policy). The Medication Administration policy stated:

[22] IV (intravenous); IM (intramuscular); an antiemetic is a drug used to treat vomiting and nausea.

"[A]ll medications administered to residents will follow mandatory checks of 5Rs + 3 and 3 checks as follows:

5Rs + 3

- Right resident
- Right medicine
- Right dose
- Right time
- Right route

and

- Right to refuse
- Right indication
- Right documentation

3 Checks

- Check the medico blister pack
- Check contents of medico blister pack with the resident's medication order
- Re-check the medicine order and medicine prior to administering."

59. The Medication Administration policy states that all medication is to be administered by a registered nurse, enrolled nurse or senior caregiver. The Policy further states:

"The drug trolley and medication folder is to be taken to each resident's room/lounge/dining room as applicable for full medication rounds.

Identify the resident following the correct checking procedure, ie, using the photo.

Only one resident's medication is to be administered at a time, and is to be administered from the medico blister pack in front of the resident.

The RN/EN [registered nurse/enrolled nurse] or Senior Caregiver when administering the medications must check the medication is correct against the GP medication chart."

60. The "Medication Errors Policy" (28 May 2013) states that all errors must be reported immediately to the manager or registered nurse and recorded on the Medication Incident and Error Report form. This policy also states:

"For all incidents related to medicines which could conceivably have resulted in injury or harm, the following actions must immediately be taken by the most senior person on duty, i.e. the RN or senior care giver.

a) Take the resident's pulse, respirations and blood pressure and record in the Progress Notes.

b) Observe the resident for pallor, clamminess, nausea/vomiting, drowsiness, confusion and rash and record in the Progress Notes.

c) Ask the resident how they feel and ask them to report any unusual symptoms.

d) Leave the resident in a comfortable position with the call bell.

e) Special the resident and repeat observations. Record if appropriate.

f) Notify the resident's GP (After-Hours Surgery) of the incident and of the resident's recordings and observations."

61. The Policy also requires the manager, registered nurse or GP to notify the resident's family/whānau/next-of-kin or "enduring power of attorney" of the medication error as soon as possible. If the adverse reaction results in a collapse or distress the Policy requires that an ambulance be called.

62. The Incident Reporting Severity Matrix (31 October 2013) outlines what is considered to be the severity level of incidents. Medication incidents are included twice in this form. First, a "medication incident resulting in serious or potentially serious harm" is listed under the "High" severity level. Second, a "medication incident" is listed under the "Low" severity level. The required actions for both levels of medication incidents include escalating the incident to the clinical manager, who is required to notify the village manager, and completing an incident form.

Internal investigation

63. RARV's parent company conducted an internal investigation into the Retirement Village, which included the following findings and remedial actions:

a) There were frequent interruptions during the medication round.
   - Staff giving out medications now wear "Do Not Disturb" aprons and do not carry the telephone with them. In addition, they have been reminded to follow policy (in particular using the medication trolley) at all times.

b) The geographical location of Mrs A's serviced apartment was a "key factor" because it was the only serviced apartment located on that particular floor. The investigation found that staff did not follow procedure because it was easier to go to Mrs A's room separately from the main medication round.
   - Mrs A's medication and personal care is now provided by rest home care staff rather than serviced apartment care staff.

c) The skill level of Ms H was highlighted as a concern. Ms H was "overly reliant on [registered nurses]".
   - An enrolled nurse has been recruited for the coordinator position.
   - Senior caregiver positions in the Retirement Village's serviced apartment area were reviewed, and further education has been provided to serviced apartment staff.

d) Registered nurse input was lacking. RN D gave incorrect advice to Ms H and did not recognise the seriousness of the incident.
   - An individual improvement plan was put in place for RN D.

e) Medication policy and procedures were not followed.
   - Staff have been provided education on medication management and incident reporting, and medication policies will be reviewed and simplified. In addition, a medication error flow chart will be developed.

- The parent company is investigating a new electronic medication system which will reduce the risk of medication errors.

f) Communication and follow-up with the family were poor.
   - On Day 2, the public hospital told Mr I that Mrs A would return to the Retirement Village later that afternoon. However, she arrived before Mr I was able to speak to staff to provide them with updated details, as he was not expecting her to arrive back at the Retirement Village until around 5pm.
   - Mr I met with Ms B and Mrs A in Mrs A's room shortly after her return from hospital and discussed the care requirements for Mrs A for the week. Mr I confirmed with Ms B that an investigation into the medication error was underway. No further communication occurred that week between Mr I and Mrs A's family.
   - Relevant staff members have been spoken to and are receiving further support and education.
   - the Retirement Village's Incident Reporting Matrix, which was not followed in this case, has been reinforced with all staff.

Further information — the Retirement Village

64. A manager of the parent company told HDC that the internal report regarding the Retirement Village "clearly indicates that we failed [Mrs A] and her family", and acknowledged "the serious nature of the incident, and the specific failings that occurred".

65. With reference to the internal report, that manager also told HDC that at the time of these events it was not routine practice for staff to take the medication trolley to the second floor, "as there was only one serviced apartment on this floor [Mrs A's]".

66. Another manager of the parent company advised HDC that the medication administration signing sheet of the resident whose medications were given to Mrs A in error has been reviewed, and the sheet indicates that on Day 1 residents received their medications as prescribed.

67. That manager advised that the parent company was working to develop an electronic medication administration system, which has been piloted in another retirement village, and that the parent company is working directly to enhance senior carer and leadership training programmes.

Further information — RN D

68. With regard to her actions on Day 1, RN D stated:

> "I am genuinely sorry that the way I responded on [Day 1] has contributed to [Mrs A] being unwell during the day and days to follow and for the distress this has caused [Mrs A] and her family."

69. With regard to why she left Mrs A in Ms H's care once she (RN D) had been informed of the medication error, RN D stated that the resident was a serviced

apartment resident, and she "delegated to [Ms H] as [she] felt she was capable of carrying out the tasks [she] advised her to undertake".

70. RN D said that she had worked with Ms H for two and a half years, and Ms H had asked for her advice in other situations over that time. RN D said: "I felt confident that [Ms H] would do everything I had recommended to her." RN D stated that she would have responded differently if it had been another care staff member in the serviced apartments, and said she would definitely respond very differently in the future if confronted with another similar situation.

71. RN D told HDC that she has made a number of changes to her practice, including undertaking a personal assessment of the patient where there has been a medication error, and would "seek medical advice quickly in the future". RN D also stated: "I have learned the importance of taking charge of potentially serious clinical situations and not relying on others." RN D has since left the Retirement Village and now works in a public hospital. She stated that the ward she works in has a registered nurse coordinator on all shifts, and there are more registered nurses on each shift. She regularly seeks advice if unsure about anything, and takes into consideration the role and competence of staff when delegating work.

72. RN D stated that she is sorry that she did not provide Ms H with the support required on the day of the error.

Further information — Ms H

73. Ms H told HDC that since the medication error she has received a lot of additional education and support, including education sessions regarding medication administration. Ms H stated that she was sorry that the error happened and commented that Mrs A "is a resident who we are all very fond of".

Responses to the provisional opinion

74. The parties were given an opportunity to comment on the relevant sections of the provisional report. These responses have been incorporated into the report where appropriate. Further responses have been outlined below.

Mrs A and her family

75. Mrs A told HDC that she did not wish to comment on the "information gathered" section of the provisional opinion, as she "can no longer recall the medication error", although she remembers being in hospital and "taking some time to recover".

76. Mrs A's children, Mrs B and Mr C provided a detailed response to the "information gathered" section, and their responses have been incorporated into the body of the report where appropriate.

77. Ms B and Mr C stated that their dissatisfaction with the parent company's internal investigation into the Retirement Village, and their "lack of confidence that systems, staffing and training [at the Retirement Village] would change for the better" led them to make a complaint to HDC.

78. Ms B and Mr C stated that on Day 1 they felt "largely ignored". They told HDC that "not only was the initial error unacceptable but the follow up lack of action [was] equally unacceptable". They also stated that they would not have taken their mother out had they been advised correctly by the Retirement Village of the potential seriousness of the medication error.

79. They told HDC that they felt there was "a complete breakdown in following the necessary procedures by all involved", and that they found the Retirement Village's response to an out-of-ordinary event and the "general inability to deal with disruptions" was "not acceptable".

Ms H

80. Ms H stated that she did not wish to make any comment on the provisional opinion.

RN D

81. RN D told HDC that she agreed with the findings and recommendations of the provisional opinion. She also noted that she had undergone further training at the Retirement Village following the medication error.

RARV

82. The parent company responded on behalf of RARV. The parent company stated that management at the Retirement Village became aware that it was not routine practice to take the medication trolley to Mrs A's apartment only during the course of the parent company's internal investigation. The parent company commented that the unique location of Mrs A's apartment "made it an exceptional case, and there was no reason for management to believe that medications were being administered differently to one resident".

83. The parent company further stated that RARV's medication error and incident reporting policies have been in place for many years, and are audited routinely by HealthCERT.

84. The parent company told HDC that RARV accepted the recommendations made in this report.

Relevant standards

85. The Nursing Council of New Zealand (NCNZ) publication *Code of Conduct for Nurses* (June 2012) states:

> "6.8 When you delegate nursing activities to enrolled nurses or others ensure they have the appropriate knowledge and skills, and know when to report findings and ask for assistance.
>
> …

7.4 Act immediately if a health consumer has suffered harm for any reason. Minimise further harm and follow organisational policies related to incident management and documentation. A full and prompt explanation should be made by the appropriate person to the health consumer concerned and, where appropriate, their family about what has occurred and the likely outcome."

86. The NCNZ publication *Guideline: delegation of care by a registered nurse to a health care assistant* (May 2011) [23] states:

"Health care assistants are also legally accountable for their actions and accountable to their employer. They must therefore have the appropriate skills and knowledge to undertake activities, and be working within policy and the direction and delegation of a registered nurse. They must be careful not to lead health consumers to believe they are a nurse when undertaking aspects of nursing care.

Understanding delegation
Delegation is the transfer of responsibility for the performance of an activity from one person to another with the former retaining accountability for the outcome.

Direction is the active process of guiding, monitoring and evaluating the nursing activities performed by another. Direction is provided directly when the registered nurse is actually present, observes, works with and directs the person; direction is provided indirectly when the registered nurse works in the same facility or organisation as the supervised person but does not constantly observe his/her activities. The registered nurse must be available for reasonable access, i.e. must be available at all times on the premises or be contactable by telephone (in community settings).

The principles of delegation
1 The decision to delegate is a professional judgment made by a registered nurse and should take into account:
(a) the health status of the health consumer
(b) the complexity of the delegated activity
(c) the context of care, and
(d) the level of knowledge, skill and experience of the health care assistant to perform the delegated activity.
2 The decision to delegate must be consistent with the service provider's policies.

3 The registered nurse must ensure the health care assistant who has been delegated the activity:
(a) understands the delegated activity
(b) has received clear direction
(c) knows who and under what circumstances they should ask for assistance
(d) knows when and to whom they should report.

[23] Under this Guideline Ms H was a healthcare assistant. The Guideline defines healthcare assistant as follows: "A person employed within a health care, residential or community context who undertakes a component of direct care and who is not regulated in law by a regulatory authority."

4 The registered nurse is responsible for monitoring and evaluating the outcomes of delegated nursing care.

The responsibilities of the registered nurse

1 Assessment and monitoring of the health status of the health consumer

(a) The health consumer must have a plan of care developed by a registered nurse who has undertaken a comprehensive assessment.

(b) The registered nurse must determine the level of skill and knowledge required to ensure the safety, comfort and security of the health consumer before delegating care. This must be based on an assessment of the health consumer including consideration of the complexity of the care required rather than the tasks to be performed.

(c) The registered nurse must provide ongoing monitoring of the health status of the health consumers for whom he/she is responsible. This must be planned along with the necessary support and guidance that will be provided to the health care assistant performing the delegated activity.

(d) The registered nurse must be directly involved with the health consumer when the health consumer's responses are less predictable or changing, and/or the health consumer needs frequent assessment, care planning and evaluation.

3 Evaluating and monitoring of care

(a) The registered nurse retains accountability for evaluating whether the health care assistant carrying out the delegated activities maintains the relevant standards and outcomes. The registered nurse must be able to state the name and designation of the health care assistant they are delegating to.

(b) The registered nurse is responsible for monitoring and evaluating the outcomes of delegated nursing care."

Opinion: Introduction

87. Mrs A was aged 89 years at the time of these events and was living in a serviced apartment at the Retirement Village. She received an assisted living package with a number of service add-ons including medication management. She had multiple co-morbidities and was prescribed a number of medications, which the staff administered to her from blister packs.

88. This opinion considers the care Mrs A received on Day 1 when she was administered another resident's medication, and the subsequent events.

89. On the morning of Day 1, Ms H gave Mrs A medications that were prescribed for another resident. The medications concerned were aspirin, simvastatin 20mg, and DHC 60mg, which Mrs A swallowed. Ms H then gave Mrs A frusemide and cilazapril

medications. At that point Ms H realised the medication error and asked Mrs A to spit out the additional medications, which she did. Ms H then immediately informed the duty nurse, RN D, that she had given Mrs A the wrong medications.

90. RN D and Ms H have given different accounts of the instructions provided by RN D. They both agree that RN D advised Ms H to give Mrs A her usual medication, excluding aspirin, as she had already been given the other resident's aspirin.

91. However, RN D also recalls telling Ms H to "do all the things required after a medication error — to keep a close eye [on Mrs A], take observations, let her family and GP know [of the error] and complete a medication error/incident form". In contrast, Ms H states that she was not told to keep a close eye on Ms B, contact the GP, or take observations. Ms H is unsure whether RN D told her to notify Mrs A's family or complete an incident report form.

92. Given the conflict in evidence, I am not able to make a factual finding as to what instructions RN D gave Ms H, other than to give Mrs A her usual medication, excluding her aspirin.

93. I find that neither RN D nor Ms H took Mrs A's observations or notified her doctor of the medication error on the morning of Day 1. However, I note that Ms H contacted Mrs A's doctor later that afternoon at approximately 3.30pm.

Opinion: RN D — Breach

94. RN D was notified of the medication error at around 8.30am. As stated above, I am not able to make a finding as to the precise instructions RN D gave Ms H, other than advising her to give Mrs A her usual medications, except aspirin. However, I note that RN D did not assess Mrs A personally, conduct observations, or contact Mrs A's doctor. RN D said that she saw Mrs A in the dining room at lunch time and, at that time, Ms H told her that Mrs A was "OK".

95. In my view, RN D should have assumed responsibility for Mrs A's well-being and followed the actions set out in the Medication Errors Policy.

96. The Medication Errors Policy in force at the time of these events states that "for all incidents related to medicines which could conceivably have resulted in injury or harm … the most senior person on duty, i.e. the RN or senior care giver" was to immediately take a number of actions, including: take the resident's observations, observe the resident for "pallor, clamminess, nausea/vomiting, drowsiness, confusion and rash and record in the progress notes", ask the resident how he or she feels, ask the resident to report any unusual symptoms, and notify the resident's doctor of the incident and of the resident's observations. The senior person on duty is also required to notify family, whānau or next-of-kin. According to the Incident Reporting Severity Matrix, RN D was also required to report the error to the village manager. RN D did not undertake any of these steps. I also note that the NCNZ *Code of Conduct for*

Nurses requires that registered nurses are to act immediately if a health consumer has suffered harm for any reason, minimise further harm, and "follow organisational policies related to incident management and documentation".

97. My expert advisor, RN Jan Grant, advised me that as the most senior person on duty, RN D should have immediately followed the actions detailed in the Medication Errors Policy. RN Grant stated that RN D's failure to follow documented policies and procedures represented a moderate to severe departure from accepted standards. I accept RN Grant's advice and consider that RN D should have followed the actions detailed in the Medication Errors Policy immediately after being notified of the medication error. I am also critical of the instruction given to Ms H to administer Mrs A's usual medications without first seeking medical advice. I am also very concerned that the only monitoring of Mrs A's healthcare status was during a conversation with Ms H at lunch time.

98. Furthermore, I consider that RN D's statement that she delegated specific duties to Ms H requires further comment. NCNZ's Guideline *Delegation of Care by Registered Nurse to a Healthcare Assistant* (Delegation Guideline) states that a registered nurse's decision to delegate "must be consistent with [the] service provider's policies".

99. Whilst I am unable to make a finding as to the precise content of RN D's discussion with Ms H, I am critical that RN D considered it acceptable to delegate her duties under the Medication Error Policy to Ms H. The Policy was clear that the steps it prescribed were to be taken by the senior person on duty, which in this case was RN D, not Ms H.

100. In my view, as the senior person on duty, RN D should have complied with the Medication Errors Policy and assessed Mrs A, taken her observations, and contacted her doctor. I note that the *NCNZ Code of Conduct for Nurses* required RN D to adhere to such organisational policies. I also consider that RN D should have consulted with Mrs A's doctor before instructing Ms H to administer Mrs A her usual medications. I am also critical that RN D considered it acceptable to delegate her duties to Ms H. RN D is required to ensure that a decision to delegate is consistent with the NCNZ Guidelines and organisational policies. Accordingly, in my view, RN D did not comply with relevant professional standards and so breached Right 4(2) of the Code.

Opinion: Ms H — Adverse comment

101. Ms H had been employed at the Retirement Village for a number of years and had moved into the role of coordinator several years before these events. She had completed medication training, and her medication competencies and comprehension surveys had been regularly completed successfully. Her job description included that she was responsible for the safe storage, administration, and checking of medications.

102. On Day 1 at approximately 8.15am, Ms H began the medication round. She removed the medication trolley from the locked cupboard at the serviced apartments nurses' station, took out a blister pack she thought was Mrs A's, removed the morning medication from the blister pack, and placed the medication in a kidney dish. Ms H then became distracted by another resident and went to help him.

103. After assisting the other resident Ms H returned to the nurses' station at around 8.30am, collected the kidney dish, and went to Mrs A's room. Ms H gave Mrs A three medications with yogurt, simvastatin, DHC and aspirin. After Mrs A swallowed those medications Ms H gave her further medications, but then recognised that these were incorrect and asked Mrs A to spit out the medications in her mouth. The medications Mrs A spat out were cilazapril and frusemide. Ms H then immediately advised RN D of the error.

104. I note that RARV stated that at the time of these events it was not routine practice for staff to take the medication trolley to the second floor, as there was only one serviced apartment resident there — Mrs A.

105. However, the Medication Administration policy required a number of steps to be taken before a resident was administered any medication. These steps included taking the medication folder and trolley to the resident's room, checking the medication against the medication chart, and administering the medication from the medico blister pack in front of the resident. The staff member is also to check that he or she is administering the right medication to the right resident at the right dose. Ms H failed to undertake these steps.

106. As stated above, I am not able to make a finding as to the precise instructions RN D gave Ms H, other than advising her to give Mrs A her usual medications, except aspirin. I note that Ms H did contact Mrs A's daughter, although the details of that telephone call are not recorded. I accept that Ms H followed the appropriate process in immediately notifying RN D. I also accept that the follow-up actions that should have been taken were the responsibility of RN D as the most senior person on duty.

107. However, I am critical that Ms H allowed herself to be distracted and made a medication error. I am also critical that Ms H did not comply with the Retirement Village Medication Administration policy, and note that had she followed the mandatory steps, including checking that she was giving the right medication to the right resident at the right dose, it is likely she would have realised the error before Mrs A ingested another resident's medication. Lastly, I consider that Ms H did not adequately record the details of her conversations with Mrs A's family or the instruction she received from RN D.

Opinion: Rita Angus Retirement Village Limited — Breach

108. Rita Angus Retirement Village Limited had overall responsibility for ensuring that Mrs A received an appropriate standard of care at the Retirement Village. It needed to have adequate systems, policies and procedures in place, and then ensure compliance with those policies and procedures, so that the care provided to Mrs A was appropriate.

109. As discussed above, RARV staff did not follow appropriate procedures and policies correctly. Ms H failed to follow the mandatory steps of the Medication Administration policy. That is, Ms H did not take the medication folder and trolley with her to Mrs A's room, check Mrs A's medication against the medication chart, or administer the medication from the medico blister pack in front of Mrs A. Ms H also did not check that she was administering the right medicine to the right resident at the right dose.

110. In this respect, I note that despite the requirement in its Medication Administration policy, RARV stated that at the time of these events it was not routine practice for staff to take the medication trolley to the second floor, as there was only one serviced apartment resident on this floor, Mrs A.

111. Upon being informed of the error, RN D failed to follow the steps of the Medication Errors Policy. As the most senior member of staff on duty, RN D did not take Mrs A's observations and record them in the progress notes, observe Mrs A for pallor, clamminess, nausea/vomiting, drowsiness, confusion and rash, or ask Mrs A how she was feeling and report any unusual symptoms. Furthermore, RN D also did not notify Mrs A's doctor of the incident. I also note that the village manager was not notified immediately of the medication error in accordance with the steps outlined in the incident reporting matrix document.

112. I acknowledge the parent company's submissions that RARV's medication error and incident reporting policies have been in place for many years and are audited routinely by HealthCERT. I also note RN Grant's advice that RARV's medication policies were adequate, and "what one would commonly find in aged care facilities throughout the country". Notwithstanding RN Grant's advice, I am concerned that the Medication Errors Policy did not specify that staff should not administer any further medication to a resident unless directed by a doctor.

113. I note that the policies were not followed until Mrs A became very unwell, and that the village manager was not notified of the medication error promptly. In my view, policies are of no use if they are not followed. I am concerned that in this case neither Ms H nor RN D followed the policies in place. I am also critical of the fact that it was not routine practice for staff to take the medication trolley to Mrs A's room. Such failures point to a culture of non-compliance with policies at the Retirement Village. It is RARV's responsibility to ensure that its staff comply with relevant policies, particularly those that are in place to protect the safety and health of residents.

114. In my view, it was the responsibility of RARV to provide Mrs A with services of an appropriate standard. However, its staff did not follow appropriate policies or provide

Mrs A services with reasonable care and skill. Accordingly, I find that RARV breached Right 4(1) of the Code.

Recommendations

115. In my provisional opinion I recommended that Rita Angus Retirement Village Limited provide HDC with an update on the parent company's development of an electronic medication administration system and the enhancement of its senior carer and leadership training programmes. In response to my provisional opinion, the parent company told HDC that it has now implemented an electronic medication system, which is working well. The parent company also stated that a new training programme for staff in leadership positions has been developed, and that the coordinator is a member of the leadership team and involved in the training programme.

116. I recommend that Rita Angus Retirement Village Limited:

a) Review the actions taken pursuant to the parent company's complaint investigation report and report to HDC on the implementation and effectiveness of those actions within three months from the date of this report, including the recently implemented electronic medication administration system.

b) Provide an apology to Mrs A. The apology is to be sent to HDC for forwarding within three weeks of the date of this opinion.

117. I recommend that RN D:

a) Arrange further training through the Nursing Council of New Zealand on the principles and requirements for delegation to healthcare assistants, within three months of the date of this opinion.

b) Undertake training on medication incident/error management and provide HDC with evidence of this training within three months of the date of this opinion.

c) Provide an apology to Mrs A for breaching the Code. The apology is to be sent to HDC within three weeks of the date of this opinion.

118. In my provisional report I recommended that Ms H provide an apology to Mrs A. In response to my provisional report, Ms H supplied HDC with an apology letter for forwarding to Mrs A.

Follow-up actions

119. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Rita Angus Retirement Village Limited, will be sent to

the Nursing Council of New Zealand and Capital & Coast District Health Board, and they will be advised of RN D's name.

120. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Rita Angus Retirement Village Limited, will be sent to the Ministry of Health (HealthCert), the New Zealand Pharmacovigilence Centre, and the Health Quality and Safety Commission, 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 registered nurse Jan Grant:

"I have been asked to provide an opinion to the Commissioner on case number 14/00568 and I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I have no personal or professional conflict of interest in the case.

My full name is Jan Lynnette Grant.
I am a Registered Nurse and completed my training at Waikato Polytechnic Hamilton in 1987, my Certificate of Gerontological Nursing in 1992, My Diploma in Business in Quality Management was completed in 1995 and my Master's Degree in 2000. I have spent time working in Aged Care as Director of a Hospital and Rest Home as well as Clinical Tutor and Guest Lecturer. I have also held roles in professional organizations and represented aged care on a number of Government Working Parties and Standards New Zealand. I have published papers and presented both here and overseas on aged related issues. My present position is as Regional Rehabilitation Coordinator and Clinical Advisor.

Background
[Mrs A] was a resident in a serviced unit being part of the Retirement Village, she was provided with 'add-ons' including medication management.

On the morning of Day 1 [Ms H] gave medication that she thought was [Mrs A's]. This medication was simvastatin 20mg, DHC 60 mg and aspirin. This medication was given with yoghurt. [Mrs A] was then about to be given more medication when the coordinator realised that there had been an error and got [Mrs A] to spit the tablets out which she did.

The coordinator reported the error to the Registered Nurse working in the Rest Home and was advised to give [Mrs A] her normal medication except the aspirin which she had already taken.

Later that day [Mrs A] was out with her family and on arriving back at the facility she became unwell. She was seen by a Doctor and admitted to the Public Hospital.

1. The reasonableness of caregiver [Ms H's] actions in all circumstances:
[Once Ms H] realised she had given the incorrect medications [she] reported this incident to the Registered Nurse in the Rest Home. There is conflicting evidence as to whether instructions from [RN D] were for her to ring the GP or that [RN D] would. In any event the GP was not notified at the time of the drug error.

[Ms H], following reporting to the RN returned and followed advice to give [Mrs A] her normal medication except for her aspirin which she had already had by

mistake.

At approximately 9am [Ms H] rang NOK, daughter [Ms B], and reported to her that there had been a medication error. [Ms B's] statement noted that she advised [Ms H] to contact the Doctor and report the event and to check if there were any interactions with her usual medications.

The doctor was not contacted.

The Clinical Notes documented on Day 1 stated that

0.830 am [Mrs A] was given wrong medication. She was given Simvastatin 20mg x I+ HDC Conti 60mg LA xI. No adverse reaction, reported to family, [RN D]) informed. Came for morning tea and lunch.
3.30 pm This afternoon family returned her from a drive, they said she was unresponsive but she appeared to be overdressed. Brought to room in wheelchair, undressed and fluids given OBs taken at 3.30 Spo2 98%, BPM 65, Temp 36.5, BP 88/49 Lying on bed with feet elevated She is alert+ coherent. Fluids to be pushed, lemonade given. Doctor informed.

Policies and procedures were in place and these were not followed.

Polices at the time stated that

For all incidents related to medications which could conceivably have resulted in injury or harm, the following actions must immediately be taken by the most senior person on duty, ie the RN or senior caregiver.

[Ms H] did fill in an Incident Report form.

Included in the list is the action to notify the resident's GP of the incident.

It is my opinion that the actions that caused the drug error were as a result of [Ms H] being interrupted when doing the drug round. The sequence of events following the incident in my opinion are as a result of the Organisation's policies and procedures not being followed, and understanding of correct policies and procedures.

In my opinion failure to follow documented policies and procedures is a moderate departure from expected standards of care.

2. The reasonableness of [RN D's] actions in all of the circumstances
[RN D] was notified of the medication error at 8.30 am when [Ms H] brought the medication packs for [Mrs A] and the medication packs of the drug she had given in error. [RN D] stated in her statement to the HDC that she checked the medication packs and advised [Ms H] to go ahead and give her ([Mrs A]) her normal medication except the aspirin which she had already had by mistake. She also stated that she asked [Ms H] to do all the things required for a medication

error such as keep a close eye on patient, take her observations, let the family know and the GP and complete Medication Error Incident form.

There is no evidence that [RN D] visited the client or documented in the client's notes at that time. [RN D] stated that she did see the client in the dining room at lunch time and asked [Ms H] how [Mrs A] was and that she was informed that she was OK.

There does not appear to have been any follow up with [Ms H] to check that all of the requirements had been done.

[RN D] did not follow documented policies and procedures that were current at the time.

It is my opinion that the policy clearly stated that the most senior person on duty must immediately follow the recommended actions.

Once [Ms H] advised [RN D] of the error in medications, policies and procedures should have been followed. She was the senior person on duty.

In my opinion failure to follow documented policies and procedures is a moderate to severe departure from expected standards of care.

3. The reasonableness of RN E's actions in all of the circumstances

[RN E] was the registered nurse who was on duty on the afternoon shift of Day 1. She stated she received a handover from [RN D] and was informed that [Mrs A] had been given incorrect medication in the morning and that she was OK. She had been out with her family and collapsed while out. [RN E] went to see [Mrs A] at 15.30 she stated that [Ms H] was with [Mrs A] at the time and that she took [Mrs A's] observations and they were BP 88/49 Sats 98% pulse 65 and temp 36.5. The end of the bed was elevated. She stated she remembered [Mrs A] being alert and orientated. At this time she stated that [Ms H] went to contact the GP.

At 16.00 another set of observations were undertaken and [Mrs A's] BP was 88/40.

Another RN took observations at 16.30 and these were listed as BP 114/59 and at 17.00 hrs 124/64.

At some time around 16.00 hrs both RN and [Ms H] went to see Manager [Mr I] and to inform him of the events. [Mr I] came to the room and spoke to [Ms B], [Mrs A's] daughter.

It is my opinion that [RN E's] actions in this event were adequate. There is little information as to what was said at handover. There was no written information in the Clinical Notes from the RN on the morning shift — including that action that would indicate the policies and procedures of the facility had been followed.

4. The staffing and supervision at RARV at the time of these events, including the reasonableness of the roles and responsibilities assigned to various staff

It is my opinion that there was some confusion as to everyone's role in this event. Policies and procedures were available at the time and these were not followed. The coordinator was not a Registered Nurse and it is my opinion that as in keeping with the policies and procedures a Registered Nurse should have directed and followed up the error and subsequent actions. Documentation is vital to ensure there is a clear and accurate list of events. Once a medication error has been reported then the Clinical Notes should show what and who took what action, what interventions occurred and the client's response to this. Family communication should also be accurately documented. Also in keeping with policies and procedures the Village Manager should have been notified sooner than he was.

5. The adequacy of the relevant policies and procedures in place at RARV at the time of the events complained of

Policies that were available at the time and included in the information supplied to me include an

- Incident Reporting Severity Matrix
- Medication Errors Policy — as revised 28.5.13
- Clinical Service Manual — Medication — administration of

These policies are what one would commonly find in Aged Care facilities throughout the country.

The policy outlines what actions must be taken in a medication incident.

The Incident Reporting Severity Matrix outlines what is considered the severity level of incidents.

Medication incidents are included twice in this form. Once under HIGH where it states, Medication Incident resulting in serious or potentially serious harm. It is also included in the Low severity level where it records medication incidents.

The action required for both of these events are to report to the Clinical Manager who reports on to the Village Manager.

I am of the opinion that the policies were adequate but at the time they were not followed until [Mrs A] became very unwell and needed to be assessed in hospital.

6. The adequacy of the relevant policies and procedures currently in place at RARV including any further changes that you consider may be appropriate

Policies and procedures in place at the present time are adequate for safe administration and management of incidents. The polices have included actions that include:

- Do not administer any further medication unless directed by GP. The present

policies are clearer and easier to read and would allow staff to follow clear steps in the process of medication errors
- Changes are that the coordinator now wears an apron stating that she is doing a drug round and that she cannot be disturbed.

7. RARV management of this incident and the follow-up actions taken.
The Retirement Village acknowledged there were failings and actions that did not meet their required standard of care. Follow up with the family is noted and RARV have acknowledged that this process could have been improved.

Actions that have been taken will in my view prevent this type of incident occurring. RARV need to be very clear on the process that is to be followed when a medication error occurs. All staff must understand that the documented process needs to be followed.

Follow up actions that RARV has taken are appropriate and in my view acknowledge the problems associated with the event.

Education that has followed this event is in my opinion adequate and appropriate.

Summary
It is my opinion that the sequence of events and the processes that were followed showed that there was lack of clear lines of responsibility. That even though RARV policies and documentation showed what processes to follow this was not known and not done by staff on site at the time.

Importance must be placed on notifying senior management and most importantly medical staff in the event of any medication error as what looked like a simple mistake was a serious event for the client. Unregulated health professions such as support workers and many registered nurses do not have the theoretical knowledge to interpret drug interactions in relation to polypharmacy.

I am also of the opinion that the organisation has evaluated the error and implemented action to prevent such an error from happening in the future

Jan Grant"