Registered Nurse, RN D

Hutt Valley District Health Board

A Report by the

Health and Disability Commissioner

(Case 14HDC00794)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In April 2014 Mrs A was admitted to the surgical ward of a public hospital. Mrs A brought her personal medications with her.

2. During her admission, Mrs A's medications were kept in the Medication Room in an unlabelled bag and placed in a container marked with Mrs A's name and room number.

3. Following treatment, Mrs A was discharged from the surgical ward.

4. Registered nurse (RN) RN D was responsible for Mrs A's discharge. Mrs A's son asked RN D for the medications Mrs A had taken to the public hospital to be returned to her. RN D went to the Medication Room and took the unlabelled bag from the container labelled with Mrs A's name and room number.

5. RN D did not check that the bag contained Mrs A's medications. The bag contained both Mrs A's medications and another patient's medications, which Mrs A took home, unaware that some were not her own. Mrs A took both sets of medications and became unwell, requiring a further hospital admission.

6. It was held that by having inadequate systems in place for the storage and return of medications brought in to the public hospital by patients, Hutt Valley District Health Board did not provide services to Mrs A with reasonable care and skill, and therefore breached Right 4(1)[1] of the Code of Health and Disability Services Consumers' Rights.

7. Adverse comment is made about RN D's failure to check the medications she was returning to Mrs A.

Complaint and investigation

8. On 10 June 2014 the Commissioner received a complaint from Ms B about the services provided to her mother, Mrs A, at the public hospital. The following issue was identified for investigation:

   - *The appropriateness of the care provided to Mrs A by registered nurse RN D.*

9. On 10 August 2015 the investigation was extended to include the following issue:

   - *The appropriateness of the care provided to Mrs A by Hutt Valley District Health Board.*

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

10. The parties directly involved in the investigation were:

Mrs A	Consumer
Ms B	Complainant
RN D	Registered nurse
Hutt Valley District Health Board	Provider

11. Also mentioned in this report is Mr C, Mrs A's son.

12. Independent expert advice was obtained from HDC's in-house nursing advisor, registered nurse (RN) Dawn Carey (**Appendix A**).

Information gathered during investigation

13. Mrs A, aged 86 years, is deaf in one ear and understands only a limited amount of English. Her medical history includes ischaemic heart disease, congestive heart failure, hyperlipidaemia,[2] recurrent urinary tract infections, and chronic back pain.

14. On 2 April 2014 Mrs A was admitted to the surgical ward of the public hospital owing to rectal bleeding.

15. Hutt Valley District Health Board's (HVDHB's) Medicines Management Policy (the Policy) in place at the time of these events stated:

> "6.6 Medicines brought to hospital by patients
>
> Patients are asked to bring their medication into hospital when they are admitted. This enables the medical, nursing and midwifery staff to determine the patients' current drug therapy … Medicines brought into hospital are the property of the patient to whom they are supplied, and cannot be taken from them without their consent …
>
> If these medicines are no longer required for treatment in hospital and the patient agrees, they must be sent home in the care of a responsible adult or stored in a tamper-evident drug storage bag, within a locked cupboard until the patient is discharged."

16. The practice at the public hospital at the time of these events was that patients' own medications brought into hospital on admission were stored (with the patient's consent) in the Medication Room in an unlabelled plastic bag in a container labelled with the patient's name and room number.

17. Mrs A brought the following medications with her on admission:

[2] Abnormally elevated levels of cholesterol or related lipid levels in the blood.

- Aspirin EC 100mg[3]
- Candesartan 8mg[4]
- Cilazapril 5mg[5]
- Metoprolol CR 95mg[6]
- Felodipine ER 5mg[7]
- Isosorbide mononitrate 60mg[8]
- Atorvastatin 40mg[9]
- Simvastatin 40mg[10]
- Diltiazem 180mg[11]

18. In accordance with usual practice, Mrs A's medications were placed in the Medication Room in an unlabelled plastic bag, which was put in a container labelled with Mrs A's name and room number.

Discharge

19. On 4 April 2014 Mrs A was cleared for discharge. The discharge summary states that Mrs A had recovered well and the bleeding had settled.

20. RN D was assigned to care for Mrs A on 4 April 2014, but had not cared for her previously. RN D has been a registered nurse in New Zealand since 2003, and has worked at the public hospital since 2006.

21. RN D told HDC that Mrs A told her that her son (Mr C) would collect her. RN D said that when Mr C arrived, she discussed with him the follow-up appointments for Mrs A. RN D then left Mrs A to change into her own clothes, and began her duties with the other patients she was assigned to care for. RN D said that she was in the middle of another task when Mr C approached her to ask about the medication Mrs A had brought with her to the public hospital. RN D stated:

> "I hurriedly went back to the medication room. At that time, we stored medications which patients brought from home, in unlabelled plastic shopping bags in [containers]/basins. Each container/basin had a patient's name and room number on it. I took the bag from the container which was clearly labelled with [Mrs A's] name and room number. I handed the bag to [Mrs A's son]."

22. RN D said that she did not check that the medications she gave to Mrs A were Mrs A's own medications brought in at admission. RN D said that her regular routine was

[3] A medication used to treat pain and reduce fever or inflammation. It is also used to reduce the risk of blood clots.
[4] A medication used to treat high blood pressure.
[5] A medication used for the treatment of hypertension and congestive heart failure.
[6] A medication used to treat high blood pressure.
[7] A medication used to treat high blood pressure.
[8] A medication used to prevent angina attacks (chest pain).
[9] A lipid lowering agent.
[10] A lipid lowering agent.
[11] A medication used to treat high blood pressure.

to "check with patients their own medications" when returning their medications.[12] However, on this occasion, RN D said that "due to the thought of [her] other patient waiting for his pain relief and [Mrs A] being on her way out in the corridor, [she] never had a chance to do this". RN D told HDC: "It never crossed my mind that the bag which I was handing over might have been a different bag of medication …"

23. Mrs A was given her own medications plus another patient's medications.[13] The medications Mrs A was given in error were:

- Felodipine 5mg ER tablet[14]
- Metoprolol AFT Ta 95mg[15]
- Aspirin 100mg EC[16]
- Atorvastatin 40mg[17]
- Candestartan cilexetil TA 8mg[18]
- Isosorbide mononitrate TA 60mg CR[19]

Deterioration and further admission

24. Mrs A took her own medications and the other patient's medications for two days, unaware that the latter were not intended for her.

25. On 6 April 2014 Mrs A became very unwell with light-headedness, nausea and hallucinations, and she was transported back to the public hospital by ambulance. On 7 April 2014 staff discovered that Mrs A had been taking another patient's medications in addition to her own, and her symptoms were likely caused by these medications. The clinical record shows a primary diagnosis of bradycardia[20] and hypotension[21] secondary to medication, and a secondary diagnosis of polypharmacy.[22] At the time of this admission Mrs A had a decrease in her kidney function, which was thought to be a result of the polypharmacy overdose. Mrs A was treated in the Coronary Care Unit and monitored closely.

26. On 7 April 2014 an incident form was completed electronically,[23] and HVDHB staff met with Ms B and Mr C and apologised for the error.[24] On 8 April 2014 a further

[12] HVDHB stated that this was the first such error made by RN D.
[13] HVDHB advised that this patient was discharged after Mrs A, and her medications could not be found. A search of the ward was unsuccessful in locating the medications. The patient was given a new prescription to replace all of her medications.
[14] See footnote 7.
[15] A medication used to treat high blood pressure and angina.
[16] See footnote 3.
[17] See footnote 9.
[18] A medication used to treat high blood pressure.
[19] A medication used to treat high blood pressure and angina.
[20] An abnormally slow heart rate.
[21] An abnormally low blood pressure.
[22] The use or effects of taking a number of medications concurrently.
[23] On 15 April 2014 the Incident Report was reviewed by the Clinical Nurse Manager, who noted that RN D "is going to be involved in a quality improvement project to improve safe storage of patients' own medications".
[24] Ms B asked that her mother not be present at this meeting, as it could be upsetting for her.

meeting was held with Mrs A, Mr C and Ms B, with an interpreter present. The clinical notes show that during this meeting HVDHB staff conveyed apologies for the error, outlined the process of investigating the incident and the corrective actions taken, and attempted to address any ongoing concerns from Mrs A and her family.

27. Mrs A was discharged on 10 April 2014. The discharge summary includes a further apology to Mrs A, records that a full recovery was anticipated, and notes that Mrs A's medications would thereafter be blister-packed.

Subsequent actions

28. In April 2014 the error was reported to the Health Quality and Safety Commission, and the public hospital contacted its Pharmacy Manager to discuss the error and strategies to prevent recurrence.

29. The Reportable Event Review (the Review) (completed on 29 May 2014) found that the nurse who discharged Mrs A did not check the contents of the plastic bag before giving it to Mrs A's son. HVDHB stated that the Review was unable to ascertain how the other patient's medications came to be in Mrs A's container, as none of the staff interviewed could remember placing them there. The general view was that it had happened accidentally, and was not noticed at the time that it happened. HVDHB stated that the old system of storing medications brought in to hospital by patients was that they were in open plastic boxes on a wall rack with the patient's name on the front. The open nature of the boxes meant that it would have been possible for someone to place the medications in the wrong box without realising they had done so.

30. The Review noted: "Event discussed with the head of pharmacy … Nurse responsible to be the ward champion for the introduction of patient only, labelled, medication bags."

31. RN D led a project aimed at preventing a recurrence of this type of error.

32. The medical and surgical wards now store medications brought into hospital by patients in a green, transparent, sealable plastic bag with the following identifying label on it:

> "PATIENT'S OWN MEDICINES
>
> [Affix patient label here]
>
> Store bag in secure place
>
> Return to patient on leaving hospital (if appropriate)
>
> KEEP OUT OF REACH OF CHILDREN"

33. RN D said that since the error, she has had discussions with Quality Control, her Nurse Manager, and the Nurse Educator. She said that she now ensures that she carefully talks through with patients and their family each medication the patient has

brought into the hospital, including what the medication is and whether the medication will still be prescribed for the patient on discharge. She said she is mindful of the need to focus and complete one task at a time properly, rather than getting distracted.

34. ACC approved cover for Mrs A, noting the treatment injury as an acute kidney injury following hypotension and low heart rate caused by polypharmacy overdose.

Relevant standards

35. The NZS Health and Disability Services (Core) Standards (Standards New Zealand, 2008) include the Organisational Management standard 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."

36. The NZS Health and Disability Services (Core) Standards (Standards New Zealand, 2008) also include 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.
>
> 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.
>
> 3.12.2 Policies and procedures clearly document the service provider's responsibilities in relation to each stage of medicine management.
>
> …"

Response to provisional opinion

37. RN D said that she accepts the provisional report and does not wish to comment further.

38. HVDHB said that it is conscious of the need to continually improve patient safety with respect to medications. It stated that it has a new and improved process for

storage of patients' own medications, and noted that the subject of discharge medications appears on the agenda of the Medication Safety and Patient Care Improvement Group, which meets monthly, "and work is ongoing to improve this aspect of patient care".

Opinion: RN D — Adverse comment

Introduction

39. This opinion concerns the inadvertent provision of another patient's medications to Mrs A at the time of her discharge from the public hospital on 4 April 2014 by RN D.

Standard of care

40. On 4 April 2014 Mrs A was being discharged from the surgical ward at the public hospital. RN D was assigned to care for Mrs A during her discharge, and discussed Mrs A's follow-up appointments with her son, Mr C. RN D said that she was in the middle of a task relating to another patient when Mr C asked her for the medication Mrs A had brought with her on admission.

41. RN D told HDC that at the time of this error, medications brought in to hospital by patients were stored in the Medication Room in unlabelled plastic bags, which were placed in containers labelled with the patient's name and room number.

42. RN D stated that she took the bag from the container labelled with Mrs A's name and room number. RN D said that although she normally confirms patients' own medications with the patient when returning medications brought in to hospital on admission, on this occasion she had another patient waiting for pain relief and did not check the medications she handed to Mr C. The bag contained Mrs A's medications and another patient's medications.

43. My in-house nursing advisor, RN Dawn Carey, advised that RN D did not provide nursing care of an appropriate standard in relation to safe patient discharge. However, RN Carey noted that contributing factors were that Mrs A's medications on discharge were unchanged (so no education about the management of her medication was required), and the medication storage practices in operation on the surgical ward at the time. RN Carey advised that, taking into account the mitigating factors, RN D's care on this occasion was a mild departure from accepted standards of nursing care.

Conclusion

44. I am critical that by not checking Mrs A's medications as she handed them to Mr C, RN D's care of Mrs A was suboptimal. However, I consider that RN D's culpability is mitigated to some extent by the fact that Mrs A's medications were unchanged on discharge, and in light of the poor systems for medication storage at HVDHB in that the medication was placed in an unlabelled bag (discussed below).

45. In my view, the changes that RN D has instituted in her own practice (talking with patients and their families about each medication they have brought in to hospital, whether that medication remains prescribed on discharge, and focusing on one task at a time), and her involvement in the improvements made at the public hospital, are appropriate.

Opinion: Hutt Valley District Health Board — Breach

Introduction

46. HVDHB was responsible for ensuring that services were provided to Mrs A with reasonable care and skill, which included during discharge. HVDHB needed to ensure that its policies and procedures supported the safe storage of all medications, and to ensure staff compliance with those policies and procedures, so that the care provided to patients was appropriate. The systems that surround the safe storage of medications must be particularly robust owing to the potential seriousness of medication errors.

47. On 4 April 2014, when Mrs A was discharged, she was given another patient's medications as well as her own. While I am satisfied with the timely disclosure and review of this error, I have concerns about the storage of medications brought into hospital by patients, and the practices surrounding this, as discussed below.

Medication storage practices

48. The NZS Health and Disability Services (Core) Standards require service providers to have policies and procedures that clearly document the service provider's responsibilities in relation to each stage of medicine management, including in relation to medicine storage. HVDHB's Medicines Management Policy (the Policy), in place at the time of these events, stated:

> "Patients are asked to bring their medication into hospital when they are admitted. This enables the medical, nursing and midwifery staff to determine the patients' current drug therapy. … Medicines brought into hospital are the property of the patient to whom they are supplied, and cannot be taken from them without their consent. …
>
> If these medicines are no longer required for treatment in hospital and the patient agrees, they must be sent home in the care of a responsible adult or stored in a tamper-evident drug storage bag, within a locked cupboard until the patient is discharged."

49. In this case, Mrs A's medications were not taken home; rather, they were stored in the hospital. The practice at the public hospital at the time of these events was that patients' own medications brought into hospital on admission were stored, with the patient's consent, in the Medication Room in an unlabelled plastic bag in a container that was labelled with the patient's name and room number.

50. Ms Carey advised that, in her opinion, the storage practice on the surgical ward at this time was a contributory factor in the error.[25] She advised that the system of placing medications in an unlabelled bag increased the potential for error. I agree with this advice — a clearly visible label on the bag containing the medication would increase the likelihood that staff and/or the patient would notice an error.

51. I note that HVDHB now stores medications brought into hospital by patients in individual, green, transparent, sealable plastic bags with an identifying label. The bag is then placed in a separate named container for each patient.

Return of medications

52. Ms Carey advised that, in addition, the Medicines Management Policy did not optimise safety and accuracy when returning to patients medications that had been stored at hospital during the patient's admission. I agree, and note that there is now reference to a requirement to take the appropriate steps to verify that the correct medication is being returned.

Conclusion

53. At the time of the error, HVDHB's storage system for medications brought into hospital by patients was inadequate, and increased the risk of an error occurring. Furthermore, HVDHB had inadequate policies and procedures in place for the storage and return of these medications.

54. In my view, by having inadequate systems in place for the storage and return of medications brought into the public hospital by patients, HVDHB did not provide services to Mrs A with reasonable care and skill, and therefore breached Right 4(1)[26] of the Code of Health and Disability Services Consumers' Rights.

Recommendations

55. I recommend that RN D provide a written apology to Mrs A for the failings identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs A.

56. I recommend that HVDHB:

a) Provide a written apology to Mrs A for its breach of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs A.

b) Review and amend its Medicines Management Policy to optimise safety and accuracy when returning medications to patients, provide training to staff on this

[25] HVDHB told HDC that the same storage practice was generally in use across both medical and surgical wards.
[26] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

policy and on safe medication management, and report back to HDC with evidence of its review, amendments and training, within three months of the date of this report.

Follow-up actions

57.
- A copy of this report with details identifying the parties removed, except HVDHB and the expert who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN D's name.

- A copy of this report with details identifying the parties removed, except HVDHB and the expert who advised on this case, will be sent to the NZ Pharmacovigilance Centre and the Health Quality and Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed (except HVDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A: Independent nursing advice to the Commissioner

The following expert advice was obtained from registered nurse Dawn Carey on 4 May 2015, with an addendum on 3 August 2015:

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms B] about the care provided to her mother, [Mrs A] by [RN D]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following documentation: complaint from [Ms B]; responses from Hutt Valley District Health Board (HVDHB) including [Mrs A's] clinical notes, [RN D's] training records, statement from [RN D], Reportable Event Review and recommendations, Medicines Management policy as relevant to this case.

3. **Background**
[Mrs A] received treatment at [the public hospital] between 2 April and 4 April 2014. On 4 April, [Mrs A] was one of the patients assigned to [RN D]. [Mrs A] was due for discharge from [the public hospital] that day.

The Reportable Event Review (RER) states that on 4 April, [RN D] discussed the discharge summary and advice with [Mrs A's] son ([Mr C]) and gave him a bag of medications believing them to belong to [Mrs A]. According to the Review [RN D] admitted that she did not check the contents of the bag, which was later found to contain medications belonging to a different patient.

After discharge, [Mrs A] took both her medications and the other patient's medications. On 6 April 2014, she was taken to ED by ambulance with profound bradycardia and hypotension. The error was discovered on readmission to [the public hospital]. [Mrs A] was treated in [the public hospital] for four days and discharged on 10 April 2014.

4. **Request**
As the Nursing Advisor, I have been asked to review the care provided by [RN D] to [Mrs A] on 4 April 2014. In particular, I have been asked to comment on the appropriateness of the changes made by [RN D] and HVDHB and to offer any recommendations for further improvements.

5. **[RN D]**
[RN D] has provided a response. She reports that in April 2014, medications that patients brought in to the surgical ward were stored in unlabelled plastic shopping bags which were placed in containers/basins. These container/basins had the patient's name and room number on it.

On 4 April, [RN D] reports that she was involved in completing a request for pain relief for another patient when she was approached in the corridor about

returning [Mrs A's] medication to her. [RN D] explains that on this occasion she did not carry out her usual check of the medications that she was returning but that she took the bag from the container clearly labelled with [Mrs A's] name and room number.

[RN D] reports extensive reflection since this incident and discussing the incident with her nurse manager, quality control staff and the nurse educator. She acknowledges the need to focus on completing one job rather than becoming distracted by other things that arise and ensuring that she now consistently participates in appropriate discussions and checks when returning medications.

6. **HVDHB responses and RER findings**

The DHB acknowledges the distress and worry that this incident caused the patient and her family. Its response highlights that this is the first such error made by [RN D]. RER analysis of this error considered how the ward stored patients' medications as an area for improvement. This led to the development of new bags so that all patient medications are now kept in a labelled single container. [RN D] has undertaken to be the ward champion of this project. Other recommendations included communicating the event with the wider staff team, emphasising the nursing role in ensuring safe discharge of patients and emphasising how safe medication practice is a necessary component of safe patient discharge.

7. **Review of clinical records**

i. On Friday, 4 April 2014, [Mrs A] was 86 years of age. She had been a patient on a surgical ward at [the public hospital] since 2 April 2014. Nursing documentation reports [Mrs A] as being slightly deaf with English being her second language. However, based on reported interactions it appears that [Mrs A] could understand and make herself understood in English. There are no concerns noted about [Mrs A's] cognitive function.

ii. On 4 April [Mrs A] was cleared for discharge. Her discharge medications were:

Flixotide 250mcg inhaler 2 puffs bd
Aspirin E.C. 100mg PO mane
Cilazapril 5mg PO nocte
Diltiazem LA 180mg PO bd
Simvastatin 40mg PO nocte
Isosorbide Mononitrate SR 60mg PO mane
Frusemide 20mg PO mane
Omeprazole 40mgs PO bd
Doxazosin Mesylate 2mg PO nocte
Cholecalciferol 1.25mg PO monthly (1st of month)

iii. Documentation by [RN D] reports advising [Mrs A] and her son of post discharge follow up appointments and blood tests. A 'Discharge' template

form is also on file and indicates that [Mrs A's] medications were returned to her and she was discharged at approximately 1.30pm. The form requires that *... reason for discharge after 11.00* is recorded.

iv. On 6 April, [Mrs A] was transferred to [the public hospital] by ambulance with complaints of chest pain and nausea. Ambulance staff found her bradycardic and hypotensive. Upon review of her accompanying medications it was realised that [Mrs A's] symptoms were likely caused by these medications.

v. On 7 April the medication dispensing error was fully realised and logged in [the public hospital] Risk Monitor Pro electronic reporting system. A printed copy of the report is included in [Mrs A's] clinical file. This reports *... Subsequent review of medications in plastic bag brought in with patient ([Mrs A]) at time of readmission* identified *some of patient's own medications (Aspirin EC loose, Simvastatin loose, Cilazapril pottle, Diltiazem pottle) plus another patient's medications ... Patient stated had been taking 'medications given to her at discharge' and indicated bag containing mixture of her own and the other patient's medications ...*

vi. Subsequent documentation reports full disclosure of the error to [Mrs A] and her adult children. To ensure full understanding, [a translator] also attended the meeting where the error was explained to [Mrs A] and apologised for. Upon discharge on 10 April, [Mrs A's] medications were dispensed in a unit dose 'blister' pack.

8. **Review of HVDHB Medicines Management Policy**

i. Section 4.6 DISCHARGE MEDICATION (page 22) directs the reader to *section 6.5 for advice on the return of patients' own medication on discharge ...* This is erroneous as section 6.5 (page 34) relates to CLINICAL EMERGENCIES (i.e. cardiopulmonary arrest).

ii. Section 6.6. MEDICINES BROUGHT TO HOSPITAL BY PATIENTS advises staff on what to do if medications are no longer required by the patient upon discharge but otherwise does not guide staff actions when returning medications which have been stored.

9. **Comments**

i. It appears that after two days as an inpatient [Mrs A] was discharged home without any changes having been made to her prescribed medications.

ii. In my opinion, the storage practices on the surgical ward at the time were a contributory factor in this error. I agree that the introduction of a single container for medications that the patient brings into [the public hospital] is part of an appropriate response.

iii. In my opinion, the reviewed HVDHB policy does not optimise safety and accuracy when returning medications to patients.

10. **Clinical advice**

In my opinion, [RN D] did not provide the appropriate standard of nursing care in relation to safe patient discharge practice. Mitigating my criticism of [RN D] are the facts that [Mrs A's] medications on discharge were unchanged

and the medication storage practices in operation on the surgical ward that time. Based on these factors, I consider this to be a mild departure from the accepted standards of nursing care[1].

In my opinion, the reflection and actions of [RN D] post this incident are appropriate.

In my opinion, the timely review and full disclosure of this error by HVDHB is appropriate. **I am however, critical of the ward medication — patients' own — storage practice at the time of this error and also of the reviewed HVDHB Medicines Management (MM) Policy. In my opinion such practice and policy writing is not consistent with required standards[2] and demonstrates a moderate departure.** I would recommend that the MM policy is reviewed."

[1] Nursing Council of New Zealand (NCNZ), *Code of conduct for nurses* (Wellington: NCNZ, 2012).
[2] Standards New Zealand (NZS), *81343.1:2008 Health and disability services (core) standards* (Wellington: NZS, 2008).