Registered Nurse, Ms B

Registered Nurse, Ms C

A Rest Home Organisation

A Report by the

Health and Disability Commissioner

(Case 05HDC18726)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer
Mrs A	Complainant/Consumer's wife
Ms B	Provider/Registered nurse
Ms C	Provider/Registered nurse
Ms D	The Rest Home Nursing Supervisor
Ms E	Director of Nursing, the Rest Home
Ms F	Manager, the Rest Home Organisation
A Rest Home	Rest home and hospital
A Rest Home Organisation	Owner of the rest home and hospital

Complaint

On 22 December 2005, the Commissioner received a complaint from Mrs A about the services provided by registered nurses Ms B and Ms C and a rest home. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mr A by registered nurse Ms B on 7 October 2005.*

- *The appropriateness of the care provided to Mr A by registered nurse Ms C on 20 October 2005.*

- *The appropriateness of the care provided to Mr A by a rest home in October 2005.*

An investigation was commenced on 9 March 2006.

Information reviewed

Information received from:

— Mrs A
— Ms B
— Ms C
— Ms E
— Ms F, Manager, a rest home organisation
— The Director, a nursing agency

Independent expert nursing advice was obtained from Ms Jan Featherston, nursing and rest home advisor.

Information gathered during investigation

A Rest Home
The rest home is owned and operated by a rest home organisation (the organisation).

The rest home provides rest home, hospital and dementia level care in separate parts of the facility. The dementia care unit ("the unit"), where the events discussed in this investigation occurred accommodates 20 patients in two ten-bed sections divided by utility rooms.

The dementia unit's patient clinical files are held at the Nurses' Station. There are also quick-reference patient information documents (in duplicate for each patient). One copy is kept in the Nurses' Station and the second copy in the kitchen. There is also a laminated information sheet on each patient (which includes a photograph) displayed on a wall in the kitchen.

The unit has two registered nurses working on the morning and afternoon shifts and one on night shift. Each registered nurse has one hospital aide working with her. At the finish of each shift, the registered nurse gives the oncoming registered nurse a verbal handover regarding each of their patients. If the nurse coming on duty is not familiar with the unit, a walk-round handover is also given.

A registered nurse is on duty at all times in the hospital part of the facility.

The rest home provides a duty list for the registered nurses working on the unit (see Appendices 1 and 2), which covers their duties and responsibilities in relation to the administration of medicines. Page three of the day-shift duty list specifies that after 7am handover and showering of the patients is completed for the morning, the registered nurse will:

> "Assist [the caregivers with] patient feeds. RN to dispense the medications with food and fluid."

At lunchtime the registered nurse's duty is to:

> "Seat patients and commence feeding lunch. … RN to dispense medications."

The unit's afternoon (3pm to 11pm) registered nurse's duty roster specifies that they are responsible for checking the medication folders for changes, and checking and securing medication blister packs between 3pm and 3.15pm. From 3.15pm to 5pm the nurse's duties include:

> "Begin to give out medications. Refer to patient administration preference list for medication, food and fluids located on kitchen cupboard doors for easy reference. See patient identification photo and behaviour profile also on kitchen wall. Kitchen to be locked when not in use to ensure privacy of patient information and to prevent any patient choking on food taken from the kitchen when not being supervised. Sign after administering medications."

There is also a comprehensive drug policy available to guide nursing staff administering medications at the rest home (see Appendix 3). The drug policy specifies that the drug trolley is to be used for all routine medicine rounds. The medicines are to be dispensed directly to the patient from the Medico pack in which they were originally dispensed by the pharmacy. The nurse is to remain with the patient until the medication has been swallowed. The policy also states that when administering medications in the unit, where active confused patients may cause a hazard, the medications are to be kept either in a locked cupboard or trolley to which the patients do not have access, and are to be removed from the secure situation for only one patient at a time.

Medications arrive from the pharmacy in individual blister packs labelled with the patient's name, dose, route and time of administration.

Agency nurses

When the rest home management needs additional nursing staff it contacts a local nursing agency ("the agency'). It requests a registered nurse who has comprehensive or psychiatric training and experience, preferably someone who has worked in the unit previously.

The organisation has an agreement with a nursing agency under which the agency provides registered nursing staff to the rest home when required. The agreement specifies the name of the "client" (in this case, the organisation) and states in clause 2.1:

> "The client must provide the temporary employee with, and ensure that the temporary employee has read and understood, all policies that the client has in place, for example, code of conduct, sexual and racial harassment and health and safety."

And in clause 5.2:

> "They shall provide the temporary employee with supervision and training to ensure the safe completion of each assignment."

The agency's contract with the organisation specifies in clause 2.3:

> "The client accepts that they may not, and only [the agency] can, take disciplinary action against any temporary employee."

The agency provides a handbook for the staff they employ (which includes registered and enrolled nurses and hospital aides). This includes information about professional development and training and medication administration. The agency's newsletter advises staff about education sessions available throughout the year. Staff are expected to undertake the required professional development of 20 hours per year or 60 hours every three years.

Agency nurses are not permitted to administer intravenous fluids or intravenous additives. A medication-checking procedure is also outlined in the handbook.

Mr A
Mr A, aged 74 years, was admitted to the rest home in 2004 for management of behavioural problems. He resides in the dementia care unit. Mr A suffers from Korsakoff's psychosis and NIDD (non-insulin dependent diabetes). He is a double amputee as a result of his diabetes. Mr A requires full nursing cares. His laminated patient profile, displayed on the wall in the kitchen, indicates that he takes his antipsychotic/anti-anxiety medication, lorazepam and haloperidol, whole. This information is repeated elsewhere in documentation relating to medication administration in his clinical records.

First medication error — 7 October 2005
At 3pm on 7 October 2005, agency registered nurse Ms B commenced an afternoon duty on the unit. Ms B was responsible for the overall care of 10 patients from 3pm to 9pm, and 20 residents from 9pm until the end of the shift at 11pm. She had been working at the rest home's dementia unit on a regular basis of two to three afternoons per week for about six months. Ms B qualified as a registered general and obstetric nurse, and does not have comprehensive or psychiatric training.

The afternoon registered nurse's duties include assisting caregiving staff with the patients' hygiene requirements and meals, as well as administering medications and recording clinical information relating to the residents.

Ms B advised that at about 4pm on 7 October she checked the medication folder kept in the dispensary and removed the blister squares containing the patient medication to be administered that afternoon. She placed them into two bowls.

Ms B recalled:

> "At the time of dispensing [I] check with the patient's drug sheet, remove [the tablets] from the blister and crush in a small metal container with pestle. Mix with jam and give to the appropriate patient. Some patients have whole tablets with water. The 1600 [4pm] and 1700 [5pm] tablets are given together. This procedure differs from taking a drug trolley around [as] at most hospitals where most tablets are given whole and not crushed.
>
> The patients were mainly sitting in the dining room where a H/A [hospital aide] and the Divisional Therapist were sitting at one table doing a work assessment. I was about to get [Mr A's] medications ready when another man was wandering

about the dining room looking restless and about to annoy other patients, as he tended to 'sundown'[1] often. Therefore I decided to give his medication first. Having crushed these two packs and mixed in the jam, I inadvertently walked over to [Mr A] and gave them to him instead. I realised the mistake on return to the kitchen."

Ms B explained that, despite Mr A's laminated patient profile stating that he took his medication whole, he had been having trans-ischaemic attacks "a week or so before 7 October". As a result, staff had been crushing his medication "as he was unable to swallow it otherwise". The documentation had not been changed on the kitchen wall.

Ms B had in fact given Mr A the other man's antipsychotic/anti-anxiety medication, chlorpromazine 200mg, lorazepam 1.5mg and quetiapine 200mg. Ms B told the two staff in the dining room that Mr A had been given incorrect medication. She then went to the other side of the unit to inform the registered nurse working there about the medication error.

Ten to fifteen minutes later, Mr A was "slumped over unconscious" in his wheelchair. Ms B telephoned his general practitioner's surgery. She was advised by the locum doctor on duty to arrange an ambulance to transfer Mr A to the public hospital.

Ms B moved Mr A to outside the Nurses' Station where she could observe him while she waited for the ambulance to arrive. Ms B notified Mrs A and the Director of Nursing, Ms E, of the incident.

Mr A was admitted to the public hospital overnight for monitoring. He was discharged back to the rest home on 8 October 2005.

Ms B documented the error in the progress notes and completed an incident form. Mr A was closely observed for the next few days, but did not appear to suffer any ill effects from the medication error.

Second medication error — 20 October 2005

On 20 October 2005, registered nurse Ms C was working the early shift (6.45am to 3pm) on the unit. Ms C had been working as a registered nurse at the rest home since October 2002. She had worked on the unit for three years. She was the sole registered nurse working until 9am when the unit Nursing Supervisor, Ms D, arrived on duty. From 6.45am until 9am Ms C was responsible for all 20 patients on the unit. When Ms D arrived she took over responsibility for half of the patients. Two full-time hospital aides and one part-time hospital aide were also working that morning.

[1] "Sundown" is a term used to describe a pattern of increased agitation displayed by dementia patients, occurring in the late afternoon and early evening.

Ms C advised that the procedure in place on 20 October 2005 was that medications were administered at the same time as breakfast. Her duties included collecting the trolleys of porridge and fruit for the patients from the kitchen. The staff serve the food from the trolleys into bowls and plates and make toast for the patients. The registered nurse is responsible for ensuring that those patients with special dietary needs (such as diabetic patients) receive the correct diet.

Ms C recalled:

> "Where a patient could not take [their tablets] whole we opened the blister pack in the kitchen and crushed the contents using a mortar and pestle and placed the crushed medicines in a tablespoon. We took a bowl of porridge and put the tablespoon on top of the bowl of porridge for that person. Still holding the blister pack we took the bowl of porridge to the patient and checked the patient's identification against their photograph. The patients are often confused and cannot identify themselves and so we have a photographic identification.
>
> On 20 October 2005, I decided to crush [Mr A's] tablets as he has a tendency to spit them out and sometimes does not swallow them. He was able to take them normally, but that morning he seemed agitated and was still in bed and had not had a shower and was confused. I made a judgement call that it would be better for him to have his medicine crushed at that particular time.
>
> I took the blister pack for that time with his medicines in it and checked its pharmacy dispensed label against the prescription chart for [Mr A]. I confirmed that the medicines were correct and I took them out of the pack and crushed them and placed them in a tablespoon on top of the bowl of porridge to take to [Mr A].
>
> It was at that moment that I realised that the toast was burning (I was responsible for making the toast as well as [administering] the medications) and I turned to see to the toast to stop it burning further. When I turned back, I picked up what I thought was [Mr A's] porridge bowl. It had the tablespoon of crushed medications on top of it. I still had [Mr A's] blister pack in my hand and I went to his room and identified him from his photograph and gave him his porridge along with the crushed medicines.
>
> As soon as I came back into the kitchen, I realised my mistake. I saw that there was a bowl of porridge with a spoon on top of it with medicines in it. I could see that the medicines that were in the spoon were crushed and that they were red. I realised that the redness was from an iron tablet and that was one of the medicines that [Mr A] was prescribed.
>
> I realised straightway what had happened. On that particular morning I had earlier crushed the medicines for another patient, … and put his on his porridge in a tablespoon. I took it to him but found him asleep and I couldn't wake him up at that time. I went back to the kitchen with [the other man's] medicines and put the porridge with the bowl and spoon on the bench.

> I was extremely distressed for [Mr A] and as soon as I realised my mistake I immediately went to [Ms D], the nursing supervisor in [the unit], and told her what had happened. I completed a set of recordings and [Ms D] contacted the doctor."

Ms C recorded the incident in the progress notes, noting that Mr A had been given another patient's allopurinol 100mg, felodipine 5mg, galantamine hydrobromide 12mg, simivastatin 20mg, bezafibrate 400mg, Cartia 100mg and metroprolol SU 47.5mg. She completed an incident form.

Mr A was transferred to the public hospital's emergency department. He was admitted and monitored for six hours before returning to the rest home. The rest home staff were advised to rest Mr A and observe him for the next 24 hours.

Mr A was reviewed by his general practitioner the following day. Mr A's general practitioner contacted Mrs A and her son later that day to explain the situation to them.

Response to medication errors

Ms B
Ms B advised:

> "I deeply regret my actions and inconvenience to all concerned. Hopefully this has been a lesson for myself and other nurses from [the unit]. More care will be taken with procedures, which may be modified if necessary."

The local nursing agency
The Director of the nursing agency advised:

> "When a complaint is made to us by a client regarding one of our employees we can discuss the complaint with the person involved, find out as much as we can about the cause of the complaint [and], based on the nature and severity of the complaint, decide what action should be taken.
>
> We asked [Ms B] to attend a meeting to explain how the medication error occurred. We were concerned about [Ms B's] actions and decided to seek guidance through the Nursing Council regarding [Ms B's] competence. We decided not to offer [Ms B] further assignments until we received a recommendation from the Nursing Council. While awaiting this [Ms B] left our employment."

Ms C
Ms C advised that as a result of this incident, changes have been made to the administration of medicines at the rest home. Ms C stated:

> "[The rest home] has changed its practices, and I have reflected on my practice and made changes as well.
>
> I now ensure that I only deal with the medicines and nothing else at the time. Although we still administer the crushed medicines with the porridge we do not make the toast now until later when the medicine round is finished.
>
> Aprons were ordered and have now arrived for us to wear whilst dealing with the medicines. On the apron it says 'RN Drug Round in progress'. I am now wearing this. The reason for this was because the hospital aides asking questions about what to do were always disturbing us when trying to do the medicine round.
>
> I have ensured that the hospital aides know that I am not to be disturbed whilst I am dealing with the medicines.
>
> Now a new Nursing Unit Manager comes in at the same time as I do at 0645. Since the new Unit Manager has arrived at the earlier time, they are now responsible for the replacement of staff who are sick, dealing with the doctors arriving to visit patients, answering phone calls, allocation of staff to patients, orientation of [the agency] staff and dealing with emergencies. All of these tasks I was handling myself prior to the Unit Manager coming on board after 0800. [Ms C] on earlier stated that [Ms D] came on duty at 9am] …
>
> I have apologised to [Mr A] and to his son and his wife. I am extremely distressed for [Mr A] that I made this mistake."

The rest home

Ms E, Director of Nursing at the rest home, advised that as a result of this incident she engaged a nurse consultant from an aged-care facility to review the rest home's medication policy. The consultant reviewed the policy and interviewed staff. Ms E was advised that the rest home medication policy was safe if staff followed the policy, and that no change to the policy was required.

Ms E explained that staff collect the required medications in the dispensary and then take them through to the kitchen because most of the unit's patients take their medications with food.

The rest home has now changed aspects of the medication procedure. The medications are dispensed by the pharmacy into blister packs. The unit accommodates 20 patients. Instead of taking all 20 blister packs out for the morning medication round, the administering nurse divides this into two lots, taking out only 10 blister packs at a time.

Ms E confirmed that at the time of these events the nurses were administering the 4pm and 5pm medications at the same time, "to save time". This was discovered when Mr A was admitted to hospital on 7 October 2005, and this practice has been stopped.

Independent advice to Commissioner

The following expert advice was obtained from a registered nurse specialising in the care of the elderly, Jan Featherston. Ms Featherston advised:

"I have been asked to provide an opinion to the Commissioner on Case 05/18726/AM and that I have read and agree to follow the Commissioners Guidelines for Independent Advisors.

Enclosed is a copy of my qualifications which outline my training and experience relevant to the area of expertise to be called upon in compiling this report.

I have read the supporting information

Supporting Information

- [Mrs A's] letter of complaint to the Commissioner, dated 15 December 2005, marked with an 'A'. (Pages 1 & 2).
- Response to the Commissioner from [Ms E], Director of Nursing, [the rest home organisation], dated 24 January 2006, marked with a 'B'. (Pages 3 to 77)
- Response to the Commissioner from [the Chair of the rest home organisation], dated 27 March 2006, marked with a 'C'. (Page 78)
- Response to the Commissioner from [the Director of the nursing agency], dated 27 March 2006, marked with a 'D'. (Pages 79 to 97)
- Response to the Commissioner from [Ms C], dated 30 March 2006, marked with an 'E'. (Pages 98 to 104)
- Response to the Commissioner from [Ms B], dated 11 April 2006, marked with an 'F'. (Pages 105 to 107)
- Response to the Commissioner from [Ms E], Director of Nursing, [the rest home organisation], dated 21 March 2006, marked with a 'G'. (Pages 108 to 141)

Did [Ms B] comply with accepted standards when she administered the incorrect medication to [Mr A] on 7th October 2005? If not, what else should she have done?

I am of the view that there are two issues in relation to the medication administration error. One that the medication was given to the wrong patient and two that the medication was administered at the incorrect time.

[Ms B] administered medications that were meant for one patient to another patient. She also gave medications that were prescribed at specific times at the incorrect time which meant that the medications given to the wrong patient were a strong dose of antipsychotic and benzodiazepine (for moderate to severe anxiety).

Custom and practice meant that registered nurses had many other tasks to do as well as give out the medication. Assisting demented patients with their meals, ensuring patients get the correct meals with the support of caregivers giving out medications.

It is my opinion that [Ms B] did not meet the Competencies for the Registered Nurse Scope of Practice — Nursing Council of New Zealand, June 2005.

> 'Professional Responsibility — Competency 1.1 — [Indicator —] Demonstrates knowledge of, and accesses, policies and procedural guidelines that have implications for practice.
>
> Management of Nursing Care — Competency 2.1 — [Indicator —] Administers interventions, treatments and medications, (for example: intravenous therapy, calming and restraint), within legislation, codes and scope of practice; and according to authorized prescription, established policy and guidelines.'

I believe that [Ms B] acted correctly when she found out that she had made a mistake and contacted another registered nurse as well the medical officer being contacted.

I am of the opinion that the error would be viewed with moderate disapproval from peers.

Did [Ms C] comply with accepted standards when she administered the incorrect medication to [Mr A] on 20 October 2005? If not what else should she have done?

[Ms C] administered another patient's medication to [Mr A]. The mistake was noted straight away, an action put in place to notify the nursing supervisor and the medical officer. A set of recordings were taken and an incident form completed. I am of the opinion that [Ms C] did what was required in the event of an error occurring.

I am also of the opinion that [Ms C] failed to meet:

> 'Management of Nursing Care — Competency 2.1 — [Indicator —] Administers interventions, treatments and medications, (for example: intravenous therapy, calming and restraint), within legislation, codes and scope of practice; and according to authorized prescription, established policy and guidelines.'

I believe that this error would be viewed as mild by my peers.

Did [the rest home] have adequate systems in place to ensure the safe administration of medicines to patients? If not what additional measures should have been in place?

With the documentation presented I am of the opinion that [the rest home] did have adequate formal policies and procedures in place.

The policy is in four sections

- Section One — Custody and storage of medications
- Section Two — Ordering and receiving medications
- Section Three — Administration of medications
- Section Four — Pharmaceutical Service Contract, Abbreviations, Medication Order Sheet, Administration Records, Standing orders and Misuse of Drugs Act.

The policy states that all medications are to be stored in 'a locked cupboard in treatment/dispensary room'.

The informal rostered duty list state that 'take medications & lock in metal cabinet located in either the kitchen'. This is not what the formal drug administration policy states. If staff are taking medications from the designated treatment room to another locked cupboard in the kitchen and administering them from there, there is a higher risk of an error. It is also documented that there is a patient preference list on the wall in the kitchen, 'refer to patient administration preference list for medication, food and fluids located on kitchen cupboard doors for easy reference'.

Having medication preference lists other than in the medication chart is also a 'risk'. It is my opinion that all activities relating to medication administration should be identified on the medication sheet contained in the drug chart and this would ensure that when staff are giving medications out then they are able to view the patient's preferences.

[Ms B] in her statement … dated the 4th April 2006, 'the 1600 and 1700 tablets are given together'. This is not in line with the medication policy which states that:

> '2. Confirm the drug, the dose and the route of administration and the time for administration on the drug sheet and Medico pack'.

Where drugs are charted at different times they must be given at the time they are prescribed for. This is especially important in units where many of the patients are on antipsychotic medications. These medications are charted at a time to ensure that the patients receive the most therapeutic effects from the drugs. It is very difficult for staff either nurses or medical officers when assessing the patients behaviour to know [whether] the drugs have [or have] not been given at the time they were charted. This could have an effect on what other medication is charted or withdrawn.

If it is common practice for all afternoon medication to be given at once then it is my opinion that this practice is unsafe and does not meet the legal requirements of either the Competencies for the Registered Nurse Scope of Practice or the Medicines Act.

Were there adequate systems in place to orientate agency nurses to the rest home and ensure that their practice was of an acceptable standard? If not, what else should have been done?

It is my opinion that the Agency Nursing Personnel Orientation Checklist is satisfactory to cover the issues that may arise when an agency nurse is on duty.

The contract that the agency has with the Client ([the organisation]) is in my opinion common to most other contracts from other agencies.

Any hospital or rest home hiring agency staff assumes that the nurse sent will be registered with Nursing Council and have an annual and current practising certificate.

This is, in my opinion, the responsibility of the agency to confirm this.

At times agency staff are called in at late notice and arrive when other staff are due to go of duty. At times handovers are quick. It is also challenging for agency staff to work in specialised units such as dementia units. It is my opinion that if a nurse is arriving for the first shift and they are the only registered nurse on duty there is never enough time to read all the required information. As identified at [the rest home] the duty list means that the nurse is extremely busy from the time they arrive at work. [Ms B] was employed by an agency but her employment was ongoing and she had done a number of shifts at [the rest home].

Summary

Medication errors do occur in a variety of clinical settings. All of the errors are avoidable if the policies and procedures are followed. Registered Nurses have the responsibility of supervision and delegation in aged care as they work with mostly untrained staff. Management should be made aware of their Registered Nurses' responsibilities and not expect staff to attend to domestic tasks when they have a professional responsibility to fulfill."

Responses to Provisional Opinion

Ms B
In response to the provisional opinion, Ms B stated:

"Although I have had considerable experience working in this unit, I am only qualified as a registered general and obstetric nurse [and do not hold comprehensive or psychiatric qualifications] as the agency would have been aware. … I felt competent enough and comfortable to work in [the rest home's] moderately severe dementia unit until a few weeks before this incident. It was

then, that a patient was admitted who caused considerable upheaval and serious concern with his dangerous behaviour, while I was trying to dispense the medication to other patients. The Unit Manager, although mostly efficient at her position, was working under stress at the time, and was less than supportive to my reactions. …

I regret the incident with [Mrs A's] husband. …

Where it says, 'his (Mr A's) laminated patient profile notes that he takes his medicine whole', this is what we had been doing while he was able to take them. … He had been having episodes similar to transient ischaemic attacks a week or so before the 7 October. It had been easier to give his medication crushed during this time, as he was unable to swallow it properly otherwise. As this may have been a temporary procedure, the documentation hadn't been changed on the kitchen wall."

Ms C

In response to the provisional opinion, Ms C stated:

"Firstly I believe there was a factual mistake. There are eleven Competencies for the Registered Nurse scope of practice. You imply I have breached them all. This is incorrect….Ms Featherston said only (page 10) that she was of the opinion I failed to meet one of the competencies: Competency 2-1. She did not state that I failed to meet any of the other Competencies. She also was not of the opinion that I failed to meet Competency 1-1, which is the only one you have set out on page 13. That does not apply to me but to Ms Featherston's advice about [Ms B].

I consider that yes, I made a medication error, but it was not of such a magnitude that it should be regarded as a breach of Right 4(2) of the Code for the following reasons:

It was only Competency 2-1 that Ms Featherston says I failed to comply with. Ms Featherston's advice was that my error in failing to meet this would be viewed as mild by my peers. Are all failures that meet with mild disapproval only by peers in breach of the Code? I believe not. Medication errors are very, very common.

Your decision has, I believe, been coloured and magnified by the errors of [Ms B] being investigated at the same time. … Her errors and failings seem to be of far greater magnitude than my own single error and were not caused by the same contextual systems as the circumstances that led to my error. … I believe that if [Ms B] was removed from the picture and I had been investigated in isolation you would not have found me in breach of the Code.

Ms Featherston's advice to you was that medication errors do occur in a variety of clinical settings and that they could be avoided by management not expecting their RNs to attend to domestic tasks when they have a professional responsibility to fulfil.

> I believe I took reasonable action in the circumstances to comply with Competency 2-1, but I could not do this properly because of the circumstances where I was expected to make breakfast and administer the medicines with the food. In all other aspects relating to the medicine for [Mr A] I complied with my professional competence requirements and with all legal requirements and the policy of [the rest home]. Thus the checking and preparation of dispensing the medication was carried out appropriately. … I followed through with all the correct procedures when I realised straightaway that a medication error had occurred. …
>
> I have reflected on what happened and reviewed my practices and made changes, which I set out in my initial report to you. Finding me in breach of the Code will not mean that I will make *more* changes; I have already made the changes. It will mean that I am left feeling that the threshold for being in breach of the Code is low. I will be worried about working in an environment where the circumstances are beyond my control, such as having to make meals while administering medicines. There are many registered nurses like me, working in rest homes on low rates of pay and having to carry out domestic duties in order to hold onto our jobs. … [T]hey will be dismayed to find out that they can be found in breach of the Code for a failing that would be viewed only as mild by their peers. Reading [this] opinion is likely to lead many good nurses feeling that they are unable to carry on working in rest homes."

The rest home organisation

The organisation's manager, Ms F, responded to the provisional opinion as follows:

> "It is not and never has been, common practice for registered nurses in any of our facilities to administer drugs charted to be given at different times, together. It appears that the statement by [Ms B] that this was the case, has been taken as establishing the truth of the allegation. It may have been [Ms B's] practice, but it was not and never has been our practice. As soon as we discovered that she had done this, we notified the [nursing agency] and requested that she not be sent to work in any of our facilities again. There may have been a misunderstanding during a telephone conversation with [Ms E], who intended to convey that she did not find out that [Ms B] had been doing this until after the event. Our own staff were quite categorical that they had never adopted this practice and expressed their more than moderate disapproval.
>
> Our system for administering medications in [the unit] is different from that in the hospital. … It was this policy that was reviewed by a nurse consultant on the Psychogeriatric Team at [the aged-care facility] and advised to be safe, provided it was followed. …
>
> I believe there is insufficient understanding on the part of your nurse expert, Ms Jan Featherston, of the challenges faced by [the organisation] in managing a psychogeriatric unit for mobile, aggressive, severely demented patients, many of whom present with complicated medical and psychiatric conditions requiring multiple medications. Taking a drugs trolley around the two wings to the patients

is not practical — they are quite likely to grab it and use it as a weapon. Many of the patients will refuse pills and because of their conditions it is not appropriate to mark their charts as 'refused' and destroy the medication. In these cases the medication is given with food, and this is why the registered nurse is involved with serving food or drinks with medication mixed in. This is clearly a different situation from 'expecting staff to attend to domestic tasks when they have a professional responsibility to fulfil'. All patients who have their medication given this way have given written consent for this procedure through their welfare guardian and normally we would have received advice from the Psychogeriatric Team prior to admission that this medication process will be required. …

Underlying the report seems to be the view that [the unit] is understaffed and that registered nurses are too busy to be able to perform their professional duties. Registered nurses are *not* involved in making meals. They are supplied by tray-line service from our central kitchen on site, and delivered in two trolleys by kitchen staff to the door from which the two hospital aides pick them up and take to the servery kitchen on each side of [the unit]. For the morning and afternoon shifts, there is one RN and one caregiver per ten patients, plus a cleaner and activities co-ordinator. While the complement of registered nurses includes [the unit supervisor], additional aiding hours of three hours daily Monday to Friday are allocated to enable paperwork to be caught up. Administrative and further nursing support is provided. … We believe this coverage is adequate and is greater than what is provided in other psychogeriatric hospital[s]. We accept that occasionally, because of the type of patient we are dealing with in [the unit], incidents and emergencies may erupt out of the blue, but our staff are trained to anticipate these and are experienced in de-escalation. We are more likely to have problems when an inexperienced bureau nurse is supplied and for this reason, we request an RN with comprehensive or psychiatric training, and for preference, one who has worked on [the unit] before.

We are committed to improving our practices on a continuous basis and have made a number of changes as a result of these two incidents. … We do not accept that because we have made improvements, our previous practices were therefore inadequate and such as to confer vicarious liability upon us.

In conclusion, [Ms E and Ms D] have already met with [Mrs A] and the advocacy services. At this meeting both apologised and expressed our regret that these incidents happened. They also discussed with [Mrs A] measures being taken to ensure incidents of a similar nature did not happen again."

Additional expert advice

On 4 July 2006, Jan Featherston was asked to comment on Ms F's submission that the use of medication trolleys in a psychogeriatric unit is not practical as mobile, aggressive, severely demented patients are "quite likely" to grab the trolley and use it as a weapon.

Ms Featherston advised that it is not necessary to use a medicine trolley, but the registered nurse must be able to secure the medications in the case of an emergency. She stated that at the private aged-care hospital where she is Nursing Director, they take the medications out in sealed plastic containers on a tray, for only six patients at a time. She acknowledged that it is acceptable to administer medications with food and fluids.

Ms F questioned Ms Featherston's understanding of the challenges and complexities of managing a psychogeriatric unit. Ms Featherston has been the Nursing Director at an aged-care hospital since 1990. She is currently an advisor at the Manukau Institute of Technology, and a member of the National Gerontology Nurses Association (USA) and the Gerontology Association, Auckland. Ms Featherston has been a surveyor for Quality Health New Zealand since 1996. She represents the New Zealand Nurses Organisation on Standards New Zealand in relation to specifications for residential aged care.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

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

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

Other Relevant Standards

The Nursing Council of New Zealand's "Competencies for the registered nurse scope of practice" (June 2005) state:

"**Professional responsibility**

Competency 1.1	Accepts responsibility for ensuring that his/her nursing practice and conduct meet the standards of the professional, ethical and relevant legislated requirements
Indicator:	Practices nursing in accord with relevant legislation/codes/ policies and upholds client rights derived from that legislation.

…

Indicator:	Demonstrates knowledge of, and accesses, policies and procedural guidelines that have implications for practice."

Management of Nursing Care

Competency 2.1	Administers interventions, treatments and medications, (for example: intravenous therapy, calming and restraint), within legislation, codes and scope of practice; and according to authorized prescription, established policy and guidelines.'

The Ministry of Health's "Safe Management of Medicines, A Guide for Managers of Old People's Homes" (1994) states:

"**Administration of Medicines**

Under no circumstances give a medicine to anyone except the person it was prescribed for.

Check prepared daily doses against the Resident Medication Profile and enter them on the Medication Administration Record for signing off as the dose is administered.

Use the original dispensed container or unit dose pack to administer medicines.

If this is not possible management must arrange a suitable alternative system which ensures that the right dose is administered to the right person at the right time. Take all reasonable steps to ensure strict control of storage and administration of medicines — even during the Medication Round.

…

PART 3

Written Protocol for the Safe Management of Medicines in Old People's Home.

A written protocol providing guidelines for the home is necessary to:

- Ensure high standards of care for the residents
- Protect residents and staff ensuring safe methods of medication administration
- Enable home and public accountability
- Encourage a standard code of practice for all staff."

Opinion: Breach — Ms B

Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) state that every consumer has the right to have services provided with reasonable care and skill, and in compliance with professional standards.

The Nursing Council of New Zealand's "Competencies for the registered nurse scope of practice" states that registered nurses must accept responsibility for ensuring that their practice meets "the standards of the professional, ethical and relevant legislated requirements". The registered nurse must also demonstrate knowledge of relevant policies and guidelines.

On 7 October 2005, registered nurse Ms B worked the afternoon shift at the rest home. Ms B was an agency nurse supplied by the nursing agency, which was contracted to supply registered nursing staff as required.

The medications at the rest home are kept in the dispensary, and there are policies regarding the safe storage and administration of medicines. The policy regarding the administration of medication from the prescribed Medico pack specifies that the "drug trolley is to be used for all routine medicine rounds". However, the rest home's Director of Nursing Ms E advised that in practice the registered nurses transfer the medications from the dispensary to the kitchen for administration to the patients with their food. The patient administration preference lists are located on the kitchen cupboard doors. The nurses administering medication on the unit do not use a drug trolley in the unit because of concern that some of the more severely demented patients might use the trolley as a weapon.

At 4pm Ms B checked the medication administration folder and removed, from the locked medication storage cupboard, the blister squares containing the patient

medication to be administered that afternoon. She placed the medicines into two bowls.

Ms B removed the 4pm and 5pm tablets from the blisters, and crushed and mixed the tablets with jam, ready to be administered as per the patient administration preference lists. Ms B stated that giving the 4pm and 5pm medications together was accepted practice at the rest home.

According to the organisation, "it is not and never had been, common practice" at the rest home for registered nurses to administer drugs charted to be given at different times together. The organisation claimed that this practice was confined to Ms B; the rest home's own staff were "quite categorical" that they had never adopted this practice.

Ms B was about to give Mr A, who was in the dining room with other residents, his antipsychotic and anti-anxiety medications lorazepam and haloperidol, when she noted that another male patient was exhibiting disturbing behaviour. Ms B decided to give the other patient his medication first. Having crushed and mixed two lots of medicines with food according to the patient administration preference lists, Ms B confused the medications. She gave Mr A another resident's antipsychotic and anti-anxiety medications — chlorpromazine, lorazepam and quetiapine.

Ms B discovered her mistake when she returned to the kitchen. Ten to fifteen minutes later Mr A lost consciousness. Ms B reported the medication error to a locum doctor at Mr A's usual GP's surgery and was advised to arrange to admit him to hospital for monitoring. Mr A was admitted, but discharged the following day. He suffered no long-term ill effects from the drug administration error.

My independent nurse advisor, Jan Featherston, advised that where drugs are charted to be given at different times they must be given at the time they are prescribed, to ensure that patients receive the most therapeutic effects. This is especially important in dementia units where many of the patients are on antipsychotic medication to control their behaviour. Medications are prescribed at specific times to manage specific behavioural patterns. Ms Featherston stated, "[T]his practice is unsafe and does not meet the legal requirements of either the Competencies for the Registered Nurse Scope of Practice or the Medicines Act."

Ms B acted correctly when she discovered her mistake. However, Ms B not only gave Mr A the wrong medication, but when she administered the 4pm and 5pm medications together, he was also given the medication in a manner that was not prescribed. In these circumstances, Ms B did not exercise reasonable care or skill, or comply with professional standards, and thereby breached Rights 4(1) and 4(2) of the Code.

Opinion: Breach — Ms C

On 20 October 2005, registered nurse C was working the early shift. The procedure at the rest home at that time was to give out the morning medications with breakfast. The registered nurse's duties also included collecting food trolleys from the kitchen, serving food and making the toast for the patients.

Ms C took the blister pack for Mr A and checked the label on the pack against his prescription chart to confirm that the medications were correct. She crushed the tablets and put the crushed medicine into a spoon placed on top of the bowl of porridge for Mr A. (This procedure was repeated for other patients.) The usual practice was for the nurse to take the bowl of porridge to the patient with the medication blister pack. When Ms C was about to take Mr A his medication, she noticed the toast was burning. After retrieving the toast Ms C inadvertently picked up another patient's porridge bowl and spoonful of crushed medication and gave this to Mr A.

Ms C recognised her error and immediately notified the nursing supervisor. She took appropriate recordings and completed an incident form.

Ms C submitted that medication errors are "very, very common". She believes she took reasonable actions in difficult circumstances where she was expected to make breakfast and administer medicines with the food. Ms C stated that my decision to find her in breach of the Code, in light of my nursing expert's advice that her medication administration error would be viewed as mild, has been "coloured and magnified" by Ms B's "errors and failings which seem to be of far greater magnitude" than her single error.

I agree with Ms C that medication errors are common right across the spectrum of health professional groups. However, this does not make them more acceptable. Medication errors are highly preventable. Their prevention depends on safe systems and adherence to those systems by individual clinicians. Ms C is a registered nurse and should be well aware of the dangers of administering incorrect medication to a patient. Every health professional involved in a patient's care has a duty to take care in the administration of medication. The administration of the wrong medication is not consistent with good nursing practice. I acknowledge that Ms C was placed in a difficult position preparing toast at the same time as the medicines. However, in a busy, complex environment, distractions will occur. Reasonable steps could and should have been taken to minimise the risk of such an error following the distraction. For example, when the other patient's porridge bowl and medication was returned to the kitchen earlier (before the distraction), it could have been clearly labelled to ensure that patients received the correct meal and medication. I accept Ms Featherston's advice. In my opinion, Ms C breached Right 4(2) of the Code by administering the wrong medication to Mr A.

Opinion: Breach — The Rest Home Organisation

The rest home is owned and operated by a rest home organisation. The organisation has an agreement with a local nursing agency for the provision of registered nursing staff to the rest home as required. The agency requires that its clients (in this case the rest home) provide temporary employees with supervision and training to ensure that they are able to safely complete their assignments.

The Ministry of Health requires rest home managers to have a written protocol in place to ensure safe methods of medication administration. Medication should be administered directly from the original dispensed container. If this is not possible, management must arrange a suitable system which ensures that the right dose is given to the right person at the right time.

There were three separate medication errors in this case. The wrong medication was given to the wrong patient on two occasions, and once also at the wrong time. As previously mentioned, Ms B's practice of administering the 4pm and 5pm medications together only came to light on 7 October 2005 when Mr A was admitted to hospital. My expert expressed concern about the apparent practice at the rest home for the 4pm and 5pm medications to be given at the same time. However, the organisation denied that this was common practice. The rest home's own staff were "quite categorical" that they had never adopted this practice.

Ms Featherston advised that the rest home has adequate formal policies and procedures in place regarding medication management including custody and storage, ordering and receiving medicines, administration, and information and record-keeping. However, the practice at the rest home did not comply with the policies. The relevant policy also states that all medicines are to be kept in "a locked cupboard in treatment/dispensary room". However, the registered nurse duty list specifies that the medications are to be transferred to a locked cupboard in the kitchen for administering. The patient administration preference lists are located in the kitchen. Ms Featherston stated:

> "It is my opinion that all activities relating to medication administration should be identified on the medication sheet contained in the drug chart and this would ensure that when staff are giving medications out then they are able to view the patient's preferences."

Having the patient administration preference lists displayed on the wall in the kitchen is convenient when medications are to be administered with meals. But it means that the medication information is in two different places (ie, in the drug chart and on the kitchen wall) and that the medications have to be transferred from one locked cupboard to another. The administering nurse needs to be able to cross-reference the prescription and administration forms. The kitchen is also a distracting environment, particularly if the administering nurse is serving and making meals at the same time. the rest home exposes patients and staff to the risk of error by expecting the registered nurse to undertake other tasks at the same time as administering medications.

The organisation submitted that my report seems to indicate that the unit is understaffed and that registered nurses are too busy to be able to perform their professional duties. It noted that the registered nurses are not involved in making meals. I accept that the meals for patients at the rest home are made in the central kitchen and delivered by kitchen staff. However, Ms C, who has worked at the rest home for three years, stated that the reason she made the error was because she was crushing tablets into spoons, laying the spoons on top of the patient's porridge while also making the toast. As previously mentioned, my view is that Ms C had a professional responsibility to alert management to the potential risk this multi-tasking posed. However, it is the responsibility of management to evaluate the appropriateness of designated tasks when compiling job descriptions for staff. The unit registered nurse duty rosters indicate that the nurses are responsible for numerous housekeeping duties, which include checking the kitchen cupboards and ordering grocery supplies, emptying rubbish bins and cleaning up spills (when there is no cleaner), checking that lights not in use are switched off and putting out rubbish bags. Page three of the rest home "Duty Roster Day shift Registered Nurse [the unit]" (Appendix 1, page 26) states:

"

- Begin breakfast. Check patient profile on the wall in kitchen and food/fluid preferences on the cupboard door. Be aware of patients who are diabetic, at risk of choking or on reduction diets.

- Seat patients in the dining room as you are able, as some may wander off. Ensure you have their food ready to place in front of them. Place green feeders on patients. These are located in the cupboard under the sink.

- Assist with patient feeds. RN to dispense the medications with food and fluid. When breakfast is over place the green feeders and tea towels in the yellow bag hanging on the kitchen door. Wash patients' hands and faces.

- Wipe the tables clean. Rinse dishes, cups, plates, cutlery and place on small trolley and transport back to main kitchen. Ensure old food from the previous day located on the bench and fridge is thrown out in the scrap bucket on the small trolley."

I agree with Ms Featherston's advice that registered nurses should not be expected to undertake domestic tasks when they have a professional responsibility to fulfil. This particularly applies to medication administration, which is complex and potentially high-risk.

As noted above, the rest home had written policies and procedures in place to guide staff in the administration of medications. However, I am not satisfied that it had taken appropriate steps to prevent the sorts of errors that occurred in this case. The duty list instructions meant that the actual medication administration practice at the rest home did not reflect the policies and procedures. The registered nursing staff were instructed to perform a variety of domestic tasks at the same time as giving out

the medications. Medications were sometimes crushed rather than given "whole", contrary to the posted medication lists. These practices contributed to Ms B's and Ms C's errors in administering the wrong medication to Mr A.

In my opinion, the organisation did not provide an environment that enabled the registered nurses administering medications to do so safely, and, accordingly, did not comply with the Ministry of Health medication administration guidelines. In these circumstances, the organisation failed to provide services with reasonable care and skill and in compliance with relevant standards, and therefore breached Rights 4(1) and 4(2) of the Code.

Recommendation

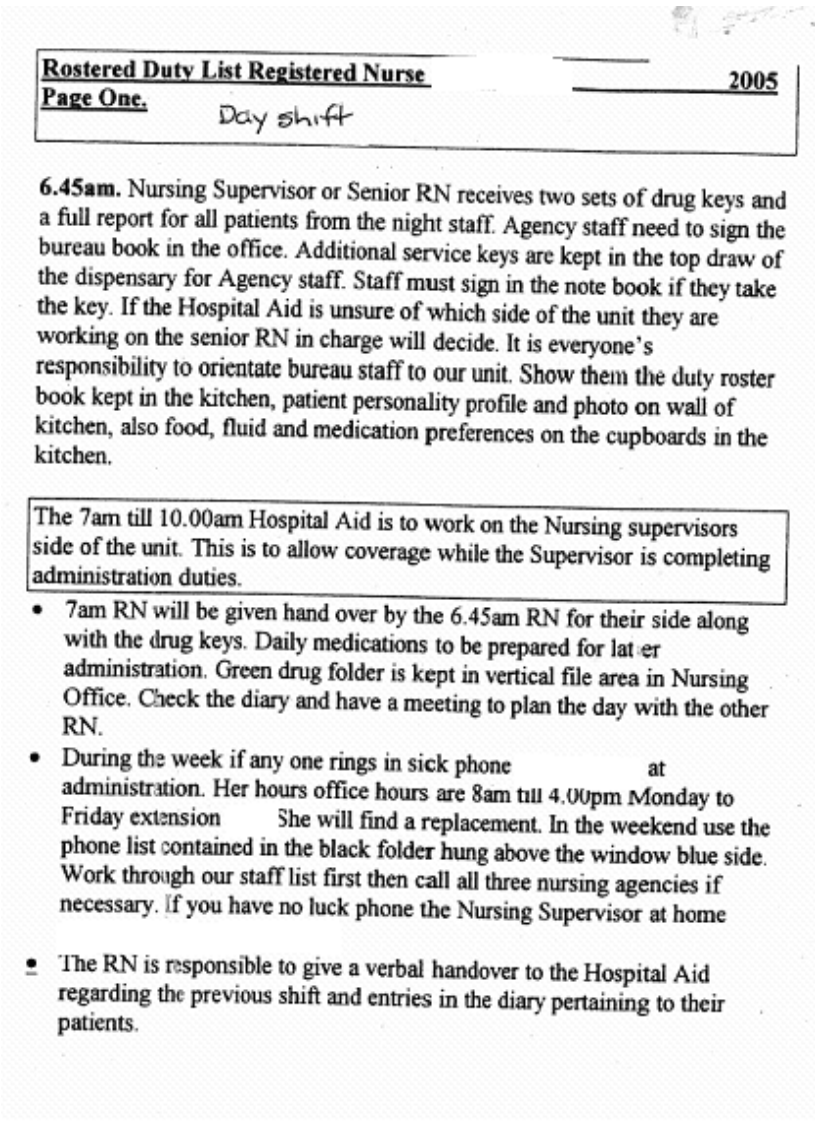
I recommend that the rest home organisation apologise for its breaches of the Code. A written apology should be sent to the Commissioner for forwarding to Mrs A.

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand, the Ministry of Health and the District Health Board.

- A copy of this report, with details identifying the parties removed, will be sent to the Health Care Providers New Zealand, the Quality Use of Medicines Group of DHBNZ, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix 1



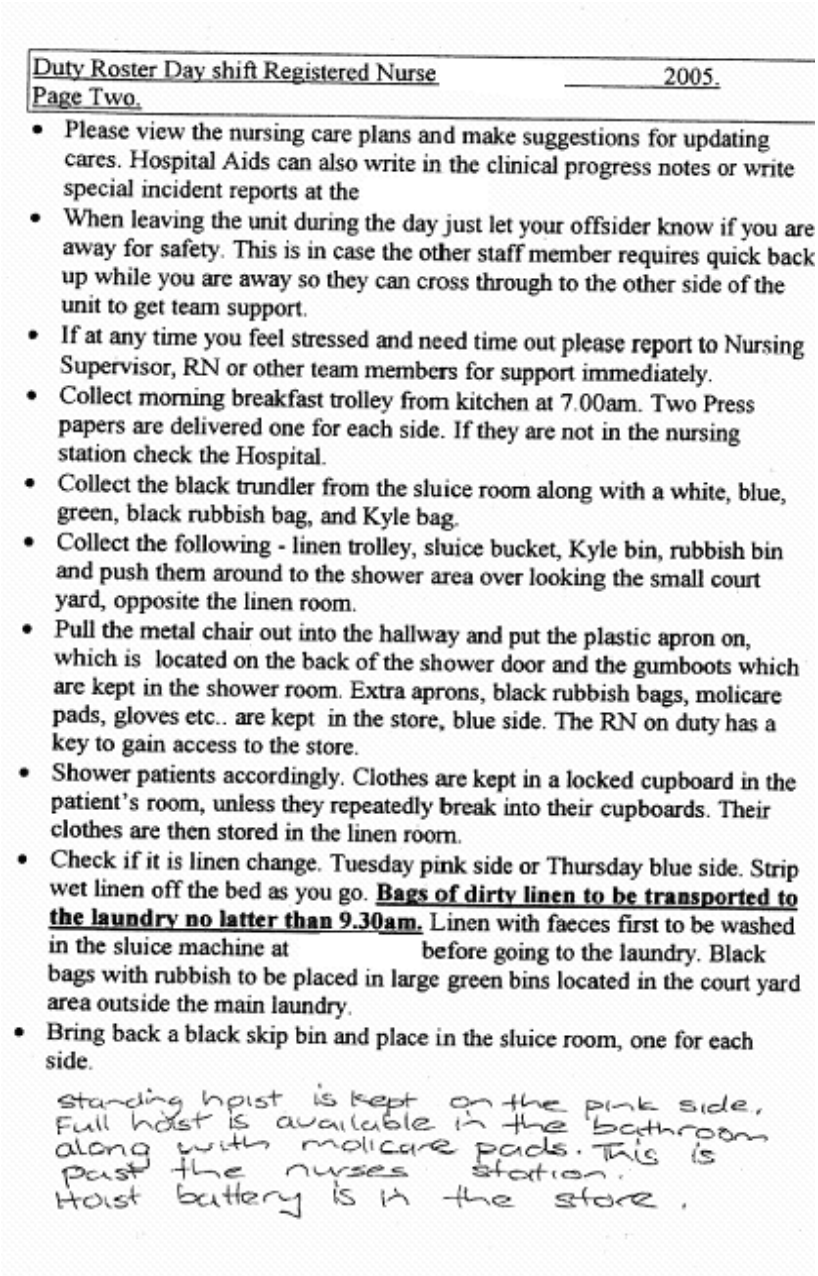
Rostered Duty List Registered Nurse **2005**
Page One. Day shift

6.45am. Nursing Supervisor or Senior RN receives two sets of drug keys and a full report for all patients from the night staff. Agency staff need to sign the bureau book in the office. Additional service keys are kept in the top draw of the dispensary for Agency staff. Staff must sign in the note book if they take the key. If the Hospital Aid is unsure of which side of the unit they are working on the senior RN in charge will decide. It is everyone's responsibility to orientate bureau staff to our unit. Show them the duty roster book kept in the kitchen, patient personality profile and photo on wall of kitchen, also food, fluid and medication preferences on the cupboards in the kitchen.

The 7am till 10.00am Hospital Aid is to work on the Nursing supervisors side of the unit. This is to allow coverage while the Supervisor is completing administration duties.

- 7am RN will be given hand over by the 6.45am RN for their side along with the drug keys. Daily medications to be prepared for lat er administration. Green drug folder is kept in vertical file area in Nursing Office. Check the diary and have a meeting to plan the day with the other RN.
- During the week if any one rings in sick phone at administration. Her hours office hours are 8am till 4.00pm Monday to Friday extension She will find a replacement. In the weekend use the phone list contained in the black folder hung above the window blue side. Work through our staff list first then call all three nursing agencies if necessary. If you have no luck phone the Nursing Supervisor at home
- The RN is responsible to give a verbal handover to the Hospital Aid regarding the previous shift and entries in the diary pertaining to their patients.

Names have been removed to protect privacy. Identifying letters are assigned and bear no relationship to the person's actual names.



Duty Roster Day shift Registered Nurse 2005.
Page Two.

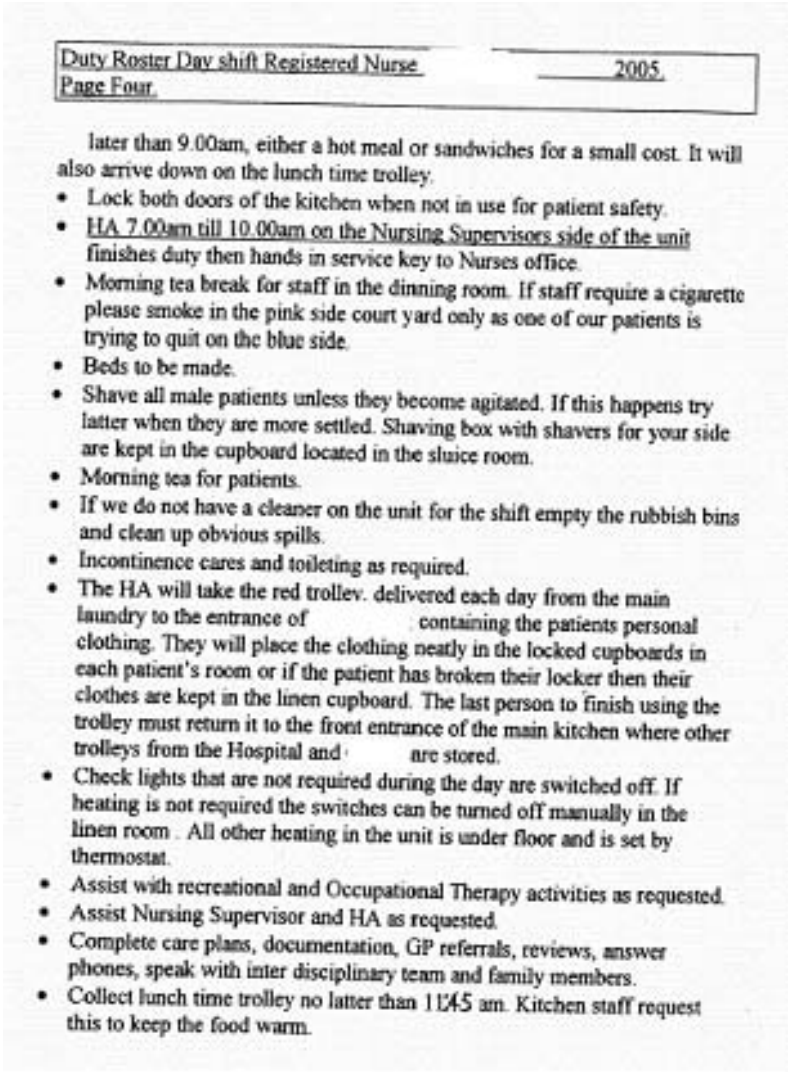
- Please view the nursing care plans and make suggestions for updating cares. Hospital Aids can also write in the clinical progress notes or write special incident reports at the
- When leaving the unit during the day just let your offsider know if you are away for safety. This is in case the other staff member requires quick back up while you are away so they can cross through to the other side of the unit to get team support.
- If at any time you feel stressed and need time out please report to Nursing Supervisor, RN or other team members for support immediately.
- Collect morning breakfast trolley from kitchen at 7.00am. Two Press papers are delivered one for each side. If they are not in the nursing station check the Hospital.
- Collect the black trundler from the sluice room along with a white, blue, green, black rubbish bag, and Kyle bag.
- Collect the following - linen trolley, sluice bucket, Kyle bin, rubbish bin and push them around to the shower area over looking the small court yard, opposite the linen room.
- Pull the metal chair out into the hallway and put the plastic apron on, which is located on the back of the shower door and the gumboots which are kept in the shower room. Extra aprons, black rubbish bags, molicare pads, gloves etc.. are kept in the store, blue side. The RN on duty has a key to gain access to the store.
- Shower patients accordingly. Clothes are kept in a locked cupboard in the patient's room, unless they repeatedly break into their cupboards. Their clothes are then stored in the linen room.
- Check if it is linen change. Tuesday pink side or Thursday blue side. Strip wet linen off the bed as you go. **Bags of dirty linen to be transported to the laundry no latter than 9.30am.** Linen with faeces first to be washed in the sluice machine at before going to the laundry. Black bags with rubbish to be placed in large green bins located in the court yard area outside the main laundry.
- Bring back a black skip bin and place in the sluice room, one for each side.

standing hoist is kept on the pink side. Full hoist is available in the bathroom along with molicare pads. This is past the nurses station. Hoist battery is in the store.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Duty Roster Day shift Registered Nurse 2005.
Page Three.

- We have a podiatrist book and hair cut book located in the office. If you think any one needs attention please write in the patients name. HA to report to RN wounds, pressure areas, bruising and assist with treatment of patients during cares as directed.
- If we have run out of sundries and ordering is not urgent either write the list of requirements in the diary or inform at Maintence. Cell phone number is in the black folder (Monday to Friday) for black bags, sundries, molicare pads. at administration for aprons, wound care products and gloves (Monday to Friday) to be contacted through the Nursing Supervisor.
- After showers are completed put the metal chair and gum boots back in shower. Lock the door after restocking shower with sundries.
- Begin breakfast. Check patient profile on the wall in kitchen and food / fluid preferences on the cupboard door. Be aware of patients who are diabetic, at risk of choking or on reduction diets.
- Seat patients in the dinning room as you are able, as some may wander off. Ensure you have their food ready to place in front of them. Place green feeders on patients. These are located in the cupboard under the sink.
- Assist with patient feeds. RN to dispense the medications with food and fluid. When breakfast is over place the green feeders and tea towels in the yellow bag hanging on the kitchen door. Wash patients hands and faces.
- Wipe the tables clean. Rinse dishes, cups, plates, cutlery and place on small trolley and transport back to main kitchen. Ensure old food from the previous day located on the bench and fridge is thrown out in the scrap bucket on the small trolley.
- Ensure the porridge ladle, sharp knife, pill crusher, jam bowls and patients built up spoon is not sent back to the main kitchen.
- Check the kitchen cupboards for grocery supplies and order extra items on Friday for the weekend as none will be given during the weekend. It is the HA responsibility to get the order book from the nurse's office and order groceries. When ordering, write whether it is for the blue or pink side. The food will come down latter on the lunch time trolley. Check in with the other side before sending your order in with the small breakfast trolley, no latter than 10.15 am. You can order your lunch from the main kitchen no



Duty Roster Day shift Registered Nurse 2005
Page Four.

later than 9.00am, either a hot meal or sandwiches for a small cost. It will also arrive down on the lunch time trolley.

- Lock both doors of the kitchen when not in use for patient safety.
- HA 7.00am till 10.00am on the Nursing Supervisors side of the unit finishes duty then hands in service key to Nurses office.
- Morning tea break for staff in the dinning room. If staff require a cigarette please smoke in the pink side court yard only as one of our patients is trying to quit on the blue side.
- Beds to be made.
- Shave all male patients unless they become agitated. If this happens try latter when they are more settled. Shaving box with shavers for your side are kept in the cupboard located in the sluice room.
- Morning tea for patients.
- If we do not have a cleaner on the unit for the shift empty the rubbish bins and clean up obvious spills.
- Incontinence cares and toileting as required.
- The HA will take the red trollev. delivered each day from the main laundry to the entrance of containing the patients personal clothing. They will place the clothing neatly in the locked cupboards in each patient's room or if the patient has broken their locker then their clothes are kept in the linen cupboard. The last person to finish using the trolley must return it to the front entrance of the main kitchen where other trolleys from the Hospital and are stored.
- Check lights that are not required during the day are switched off. If heating is not required the switches can be turned off manually in the linen room . All other heating in the unit is under floor and is set by thermostat.
- Assist with recreational and Occupational Therapy activities as requested.
- Assist Nursing Supervisor and HA as requested.
- Complete care plans, documentation, GP referrals, reviews, answer phones, speak with inter disciplinary team and family members.
- Collect lunch time trolley no latter than 11.45 am. Kitchen staff request this to keep the food warm.

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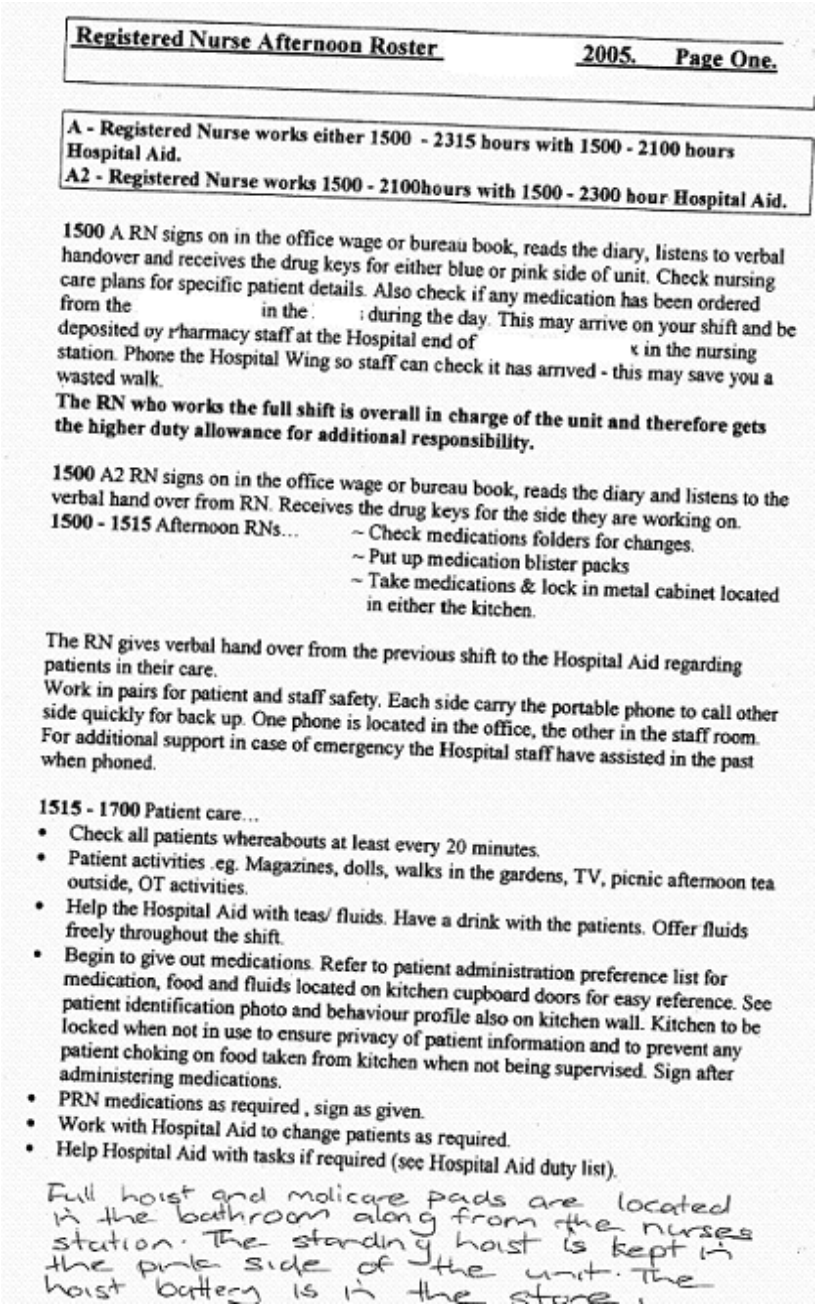
Duty Roster Day shift Registered Nurse 2005.
Page Five.

- Seat patients and commence feeding lunch. Food may be saved for afternoon tea as required. RN to dispense medications.
- Clean patients face and hands after lunch.
- Clean table tops while other staff member pushes trolley down to main kitchen once lunch is completed.
- Staff meal break in dinning room. If you wish to take a break off the unit please negotiate.
- Please seek a second opinion if you feel necessary with patients who display any violent, aggressive, sundowning behaviours during the shift. Any injury of patients requires special incident report and an entry in the clinical notes. The relatives also need to be contacted.
- Please record any bowel movements in the green folder located in the Nurse's office by the end of your shift.
- Ensure unit is tidy.
- Toileting cares ongoing.
- Write up clinical notes or special incidents.
- Ensure medication changes have been faxed through to [redacted]. The medications requiring adjusting need to be removed from the folder and taken down to the Hospital Nursing station pharmacy out box.
- Afternoon tea and medications for patients 2.00pm.
- RN finishing at 3.00pm to give their hand over first along with medication keys to the afternoon shift.
- Agency day staff return service key to main office 14.55pm.
- **End of duty for 3.00pm RN. THANK YOU.**
- **RN 3.15pm finish gives verbal hand over to afternoon shift.**
- **THANK YOU.**

Appendix 2



Registered Nurse Afternoon Roster **2005.** **Page One.**

A - Registered Nurse works either 1500 - 2315 hours with 1500 - 2100 hours Hospital Aid.
A2 - Registered Nurse works 1500 - 2100hours with 1500 - 2300 hour Hospital Aid.

1500 A RN signs on in the office wage or bureau book, reads the diary, listens to verbal handover and receives the drug keys for either blue or pink side of unit. Check nursing care plans for specific patient details. Also check if any medication has been ordered from the in the ; during the day. This may arrive on your shift and be deposited by rharmacy staff at the Hospital end of x in the nursing station. Phone the Hospital Wing so staff can check it has arrived - this may save you a wasted walk.

The RN who works the full shift is overall in charge of the unit and therefore gets the higher duty allowance for additional responsibility.

1500 A2 RN signs on in the office wage or bureau book, reads the diary and listens to the verbal hand over from RN. Receives the drug keys for the side they are working on.

1500 - 1515 Afternoon RNs…
- ~ Check medications folders for changes.
- ~ Put up medication blister packs
- ~ Take medications & lock in metal cabinet located in either the kitchen.

The RN gives verbal hand over from the previous shift to the Hospital Aid regarding patients in their care.
Work in pairs for patient and staff safety. Each side carry the portable phone to call other side quickly for back up. One phone is located in the office, the other in the staff room. For additional support in case of emergency the Hospital staff have assisted in the past when phoned.

1515 - 1700 Patient care…
- Check all patients whereabouts at least every 20 minutes.
- Patient activities .eg. Magazines, dolls, walks in the gardens, TV, picnic afternoon tea outside, OT activities.
- Help the Hospital Aid with teas/ fluids. Have a drink with the patients. Offer fluids freely throughout the shift.
- Begin to give out medications. Refer to patient administration preference list for medication, food and fluids located on kitchen cupboard doors for easy reference. See patient identification photo and behaviour profile also on kitchen wall. Kitchen to be locked when not in use to ensure privacy of patient information and to prevent any patient choking on food taken from kitchen when not being supervised. Sign after administering medications.
- PRN medications as required , sign as given.
- Work with Hospital Aid to change patients as required.
- Help Hospital Aid with tasks if required (see Hospital Aid duty list).

Full hoist and molicare pads are located in the bathroom along from the nurses station. The standing hoist is kept in the pink side of the unit. The hoist battery is in the store

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Registered Nurse Afternoon Duty Roster **2005.**
Page Two.

16:45 **hours** Patients Teas

Trolley to be picked up from main kitchen 16:45 hours due to extra feeds.

- Put feeders on the patients
- help feed patients as required - give them time to enjoy their meals.
- give out & help with drinks after the meal.
- refer to drink preference list stuck to cupboard door in kitchen.
- clean up spills & wash kitchen dishes

1745 hours Once meal is completed and area clean.

- Meet with RN from opposite side in office for update.
- A time for discussion, support regarding unit matters.
- Sign for medications that have been given.
- If any reported injury of patient on afternoon shift entry must be made in clinical notes, special incident form and notify family if significant injury. If too late to contact family in shift or if they are not answering phone leave message in diary for day shift to contact family.
- If any medication has arrived from pharmacy during your shift ,enter into blister pack folders after checking & signing if correct dose was received.

1800 - 1900 hours Staff 30 minute meal breaks.

1800 - 1900 hours Observations of patients. Aim to maintain a safe environment for all.

1900 hours Supper - warm sweet milky drinks to be given. Be aware of diabetics or those on reduction diets. Refer to drink preference list on kitchen cupboard doors. Administer Nocte medications as prescribed. Check drug charts and care plans for times.

1915 hours Judgement call. Start placing patients to bed if they are tired or unwell. You may have to work in pairs if the patients display sundowning or challenging behaviours. Safety first for all.
Remember to communicate and work with your Hospital Aid.
Before bed ...

- clean patient's teeth or dentures.
- Assist with maintence of personal hygiene

Ensure respect, dignity and privacy while changing patients into either night wear or molicare pads. Refer to nursing care plans as some patients become resistive and agitated when placed in night wear or while receiving cares prior to retiring for the night. Call for assistance if you are unsure.

- Ensure patients have extra duvet covers as necessary, and everyone should have three Kyle's on bed.

Manual switches located in the alcove near the dinning room can control the heating in the roof for corridor and small lounge area.

Names have been removed to protect privacy. Identifying letters are assigned and bear no relationship to the person's actual names.

Registered Nurse Afternoon Roster **. 2005. Page Three.**

The temperature control is regulated at 20 degree. Manual switches are located in the linen room for the bedrooms. These switches are controlled by you. Under floor heating is automatic setting in corridors, dinning room toilet, lounge area.

- Check nursing care plans if unsure who has bed rails up overnight to prevent falls. Restraint forms located in patient files must be completed if bed rails are up.
- Care plans also identify, patients who wander, require door alarms activated or need hoist lift transfers.

When Patients are in bed.

- Write reports.
- Check medications Nocte administration, sign as given.
- Sign restraint forms.
- Check Hospital Aid has completed bowel book.
- Complete filing.

If there is any time RNs may help the Hospital Aids with their duties. eg. Cleaning chairs, etc....

RN 1500-2100 hours please hand over drug keys and give a verbal /written hand over to the RN finishing at 2315 hours.

2100 hours Both A2RN and 1500 -2100 Hospital Aid *off duty.*

In the summer some windows/doors may need to be left open for ventilation. Remember roof windows with security bars can safely be left open at all times. **Security is important in the unit as we have had prowlers in the past. Call security Phone or police 1 111 in case of emergency.**

A Registered Nurse and Hospital Aid continue with

- Twenty minute rounds.
- Have a drink.
- Sign for medications.
- Fill out bowel book.
- Write in clinical notes & update care plans.
- Discussion of unit matters with staff
- Leave any messages in diary if any issues need to be actioned by Supervisor or day staff.

2100 - 2300 hours

- Work with the Hospital Aid, team nursing for safety. Complete rounds together.
- Give out late medications (check folder & sign.)
- Patient care to those as required.

Registered Nurse Afternoon Duty Roster 2005.
Page Four.

- Twenty minute rounds.
- Complete Clinical notes & update care plans.

2230 -2245 hours

- Wet round for patients. Check nursing care plans for patients with challenging behaviours. Work as a team for safety of all.
- Final check of any doors, windows previously left open for ventilation.
- Remember roof windows with security bars can remain open.

Towards the end of the shift.

- **Send the Hospital Aid to the laundry with the dirty linen, including patients feeders hanging on the back of the doors both in kitchens (re hang bags on door.) Dirty cups to kitchen. Black rubbish bags to laundry courtyard bins.**

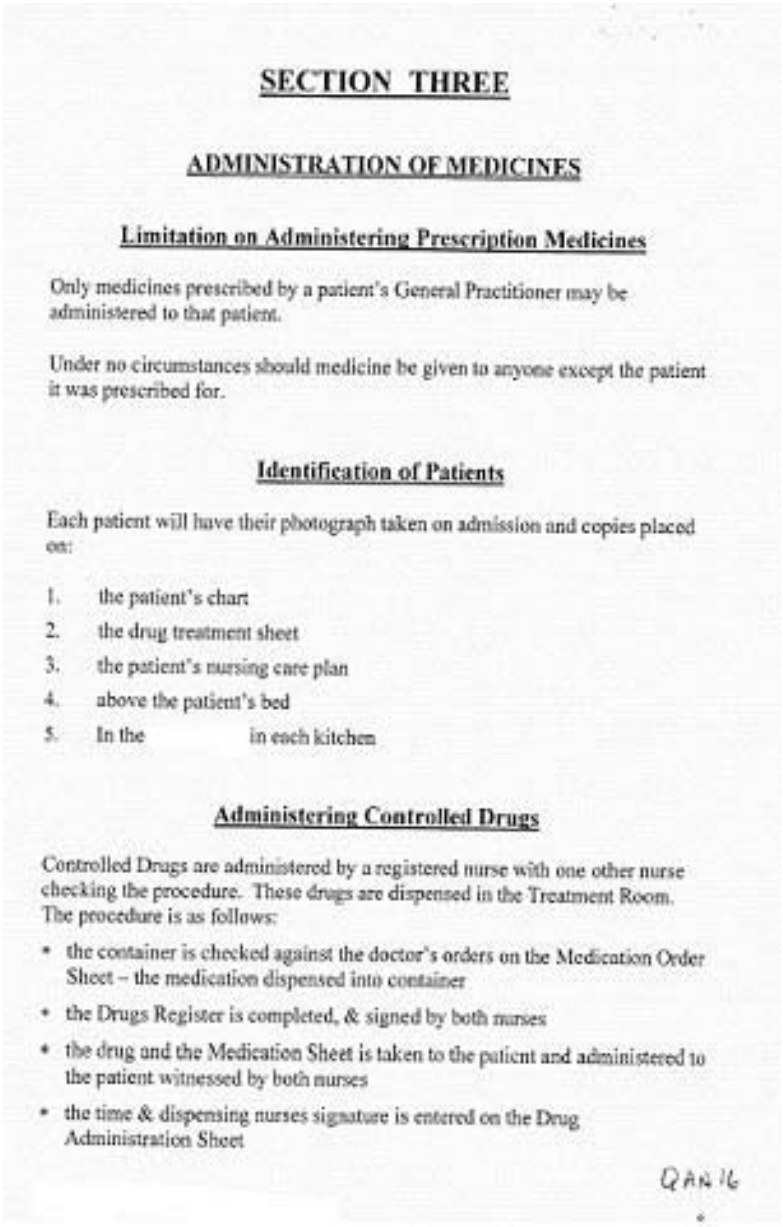
2300 Hospital Aid *off duty*. Thank You. If bureau staff , ward keys need to be returned & signed out in book before leaving.

2300- 2315 hours , Senior RN gives verbal hand over to Night shift. Blue and Pink side drug keys handed over.

THANK YOU.

Names have been removed to protect privacy. Identifying letters are assigned and bear no relationship to the person's actual names.

Appendix 3 The Rest Home Drug Policy



SECTION THREE

ADMINISTRATION OF MEDICINES

Limitation on Administering Prescription Medicines

Only medicines prescribed by a patient's General Practitioner may be administered to that patient.

Under no circumstances should medicine be given to anyone except the patient it was prescribed for.

Identification of Patients

Each patient will have their photograph taken on admission and copies placed on:

1. the patient's chart
2. the drug treatment sheet
3. the patient's nursing care plan
4. above the patient's bed
5. In the in each kitchen

Administering Controlled Drugs

Controlled Drugs are administered by a registered nurse with one other nurse checking the procedure. These drugs are dispensed in the Treatment Room. The procedure is as follows:

- the container is checked against the doctor's orders on the Medication Order Sheet – the medication dispensed into container
- the Drugs Register is completed, & signed by both nurses
- the drug and the Medication Sheet is taken to the patient and administered to the patient witnessed by both nurses
- the time & dispensing nurses signature is entered on the Drug Administration Sheet

QAN 16

Administering Prescribed Medico Pack Medication

The drug trolley is used for all routine medicine rounds. Medicines are dispensed directly to the patient from the Medico pack in which they were originally dispensed from the pharmacy. These packs are not to be opened until they are being dispensed to the patient. They are administered by a registered nurse, with an enrolled nurse's assistance when possible, using the patient's Drug Treatment Sheet and the following procedure:

1. identify the patient named on the Medico pack with the photograph/name bracelet
2. confirm the drug, the dose and the route of administration and the time for administration on the drug sheet and Medico pack
3. check recordings necessary, e.g. pulse for Digoxin *(chart)*
4. administer medication to the named and identified patient - crush tablets if necessary *(N.B. slow release tablets must not be crushed)*
5. all fluid medications are to be measured in a medicine glass
6. stay with the patient until medication has been swallowed
7. sign patient's medication administration record. Initial the appropriate box on the medication administration record when the drug has been taken
8. medications that are refused by the patient are not left on lockers – they are destroyed

If a patient does not take a prescribed medicine this must be recorded as:

R =	Refused	D =	Refused and destroyed
N =	Nausea and vomiting	S =	Social leave
H =	Hospitalised	T =	Transferred
A =	Absent		

and detailed in the Nursing Progress Notes.

Dispensing medications not in Medico pack

- Check the container against medication order sheet signed by the doctor
- Identify the patient by photograph or name bracelet
- Dispense the medication to identified patient
- Sign non packaged or PRN administration record

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Handling Medicines

Hospital

Medicines are taken in the drug trolley to the named patient and are checked and administered by the registered nurse.

Courts

Medicines are taken from the Medico pack to the named patient by H/A. All new supplies to the courts are checked by RN on duty or Hospital RN.

Bush Wing

When handling medicines in an area where confused, active patients may cause hazards with the drug trolley, medicines are:-

1) stored in a locked cupboard or trolley in an area to which patients have no unsupervised access

2) medicines are removed from the locked cupboard or trolley for one patient at a time

Staff

Staff handling medicines are required to maintain themselves in a state of cleanliness.

No person with a communicable disease shall dispense medications.

QAN 16