Registered Nurse, RN B

A Report by the

Deputy Health and Disability Commissioner

(Case 21HDC00205)

Contents

Executive summary 1
Complaint and investigation 1
Information gathered during investigation 2
Opinion: RN B — breach 8
Opinion: Ms C — adverse comment 9
Opinion: Disability service — adverse comment 10
Changes made 10
Recommendations 11
Follow-up actions 11
Addendum 12
Appendix A: Relevant standards 13

Executive summary

1. This report highlights the importance of the informed consent process in relation to the administration of medication to a woman with a disability.

2. At the time of events, the woman was living alone and receiving residential support, including medication oversight, from a disability service.

3. On 27 and 29 May 2020, a support worker administered the woman her usual morning medications, and also gave her half a tablet (0.5mg) of clonazepam without her knowledge, under the direction and supervision of a registered nurse.

Findings

4. The Deputy Commissioner found the nurse in breach of Right 7(1) of the Code for authorising the provision of medication to the woman without her informed consent, and in breach of Right 4(2) for failing to provide her with services that complied with professional and ethical standards.

5. The Deputy Commissioner was critical of the support worker's involvement in the administration of the medication, and reminded her that it is not acceptable to administer medication to a competent consumer without the consumer's informed consent.

6. The Deputy Commissioner was critical of the disability service's escalation of care process and its complaints process.

Recommendations

7. In response to the Deputy Commissioner's provisional recommendations, the nurse provided an apology for her breaches of the Code, and evidence of having undertaken training in medication management. The Deputy Commissioner recommended that the nurse also undertake training on informed consent. The nurse was referred to the Director of Proceedings.

8. In response to the Deputy Commissioner's provisional recommendation, the support worker provided evidence of having completed HDC's training on informed consent.

Complaint and investigation

9. The Health and Disability Commissioner (HDC) received a complaint from Te Kaunihera Tapuhi o Aotearoa|Nursing Council of New Zealand about the services provided by Registered Nurse (RN) B. The following issue was identified for investigation:

- *Whether RN B provided Ms A with an appropriate standard of care in June 2020.*

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

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

11. The parties directly involved in the investigation were:

Ms A	Consumer
RN B	Provider/registered nurse

12. Further information was received from:

Disability service	Provider
Ms C	Support worker
Ms D	Support worker
Ms E	Support worker
Ms F	Support worker

Information gathered during investigation

Introduction

13. This report concerns the care provided by RN B to Ms A (aged in her forties at the time of events). In particular, the report discusses whether Ms A was provided with an opportunity to give informed consent for a medication she was administered.

Background

14. At the time of events, Ms A was living alone. She has multiple sclerosis and uses a wheelchair.[1] The disability service[2] was contracted[3] to provide 66 hours a week of residential support to assist Ms A with household management and personal care. This included medication oversight, monitoring of skin integrity, exercises under a physiotherapist's direction, meal preparation, and cleaning of Ms A's home. Ms A's service agreement[4] listed medication oversight as one of the tasks included in her personal care.

15. Support workers visited Ms A five times per day, seven days a week (some visits were carried out by two support workers to assist with transfers). The disability service told HDC that all support workers undertake medication prompting/administration training before assisting clients with medication.

[1] A disorder of the central nervous system that includes the brain, spinal cord and optic nerves.
[2] A healthcare service that provides disability and wellbeing support.
[3] Ms A's services are funded through a referral from the Ministry of Health, and she had been receiving them since April 2018.
[4] Dated 31 July 2019.

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

16. Ms A's medication[5] was prescribed by her general practitioner (GP), and it was dispensed in blister packs.[6] Ms A was prescribed clonazepam,[7] which she asked for in the evenings to help her to sleep. Support workers took Ms A's medication out of the blister pack and gave it to her. Ms A's service plan[8] did not include any instructions about her medication.

17. Ms A's service plan stated: "[Ms A] gets anxious and would like s[upport] w[orkers] to keep any conflict they have with each other away from her."

RN B

18. RN B was the sole registered nurse for the disability service in the region.[9] RN B told HDC that she was responsible for ACC and non-ACC clients' short- and long-term care needs. She said that she visited clients in their homes, assessed their needs and monitored their support, and liaised with ACC in relation to the client's needs.

19. RN B stated that support workers provided the day-to-day care to clients and discussed with her any concerns or questions about the clients. RN B said that the majority of her follow-ups with clients were completed by telephone, but she also visited clients if a support worker reported an issue that she believed required an in-person assessment.

20. The disability service provided a copy of the job description for registered nurses that was applicable in 2020. The job description stated that a principal role, accountability, and expectation of the nurse was to administer, monitor, and evaluate the effectiveness of prescribed intervention, treatments, and medications, and take remedial action and/or refer accordingly. Another key role was to provide appropriate delegation and direction to the enrolled nurses and support workers working within the nursing team across the region. The job description also outlined that the nurse was to provide information to the client to ensure that the client had an understanding of the care being provided, and was supported and able to make informed decisions.

Discussion regarding clonazepam

21. RN B told HDC that in late May 2020, Ms C,[10] one of Ms A's support workers, told her that Ms A was becoming increasingly anxious during the day.[11] RN B told HDC that Ms C told Ms A that clonazepam is an anti-anxiety medication, but she refused to take it at any time other than her bedtime. RN B said that Ms C asked whether she could give the medication to Ms A without her knowledge, and RN B agreed that she could.

---

[5] The disability service told HDC that prescribing of medication falls outside its remit, and it does not keep a record of prescription information.
[6] A card with sealed compartments containing medication to be taken at particular times of the day.
[7] A benzodiazepine used to treat panic disorder and seizures.
[8] Dated 6 November 2019.
[9] RN B was employed by the disability service as a full-time permanent registered nurse from 2016 to 2020.
[10] Ms C completed the disability service's medication training on 29 April 2020.
[11] In response to the provisional opinion, Ms A stated that the only reason she became more anxious was because Ms C made her feel anxious "with her demeanour" and the comments she made.

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

22. RN B stated that Ms C had suggested to Ms A that she take clonazepam on two consecutive days to see if it helped with her anxiety, and Ms A was adamant that she did not want to take it. RN B said that she and Ms C discussed obtaining consent from Ms A, but thought that she would not give it. In an email to the disability service, RN B wrote: "[Ms C] asked me whether she could give the medications without the client's knowledge. I agreed."

23. The disability service told HDC that in the course of its investigation, Ms C stated that she asked whether she could administer clonazepam to Ms A in the mornings, and RN B instructed her to do so on 27 and 29 May 2020. The disability service said that Ms C stated that on 1 June 2020, RN B then instructed her to inform Ms A that she had received morning clonazepam, and to ask Ms A how she had felt on those two mornings.

24. RN B told HDC that in hindsight, she should have contacted Ms A to try to obtain her consent, and if Ms A had refused, she should have contacted Ms A's GP for advice.

25. RN B did not instruct Ms C to report back to her in relation to Ms A.

Administration of clonazepam

26. On 27 and 29 May 2020,[12] Ms C administered Ms A her usual morning medications, as well as half a tablet (0.5mg) of clonazepam without Ms A's knowledge. The disability service told HDC that its investigation showed that Ms C knew that Ms A was unaware that she was taking clonazepam, and that this was under the direction and supervision of RN B.

27. Ms C told the disability service that she was not concerned about administering clonazepam because Ms A had been prescribed the medication and it was a regular medication she had at night-time.

28. Ms A told HDC[13] that Ms C did not tell her what medication she was being given, and she assumed that it was her normal morning medication. Ms A said that she could not see what medication she was being given as she was lying down in bed, and Ms C had refused her request to sit up. In response to the provisional opinion, Ms A told HDC that she used to ask Ms C to raise her bed a bit more so she could sit upright and take her medication without the risk of choking, and Ms C always refused and told her she would be "alright". Ms A told HDC that this used to make her feel anxious.

29. There is no record for the medications given to Ms A on 27 and 29 May 2020 on the medication record signing sheet.

Ms A's discovery of clonazepam administration

30. On 1 June 2020, Ms A became aware that she had been given clonazepam in the morning of both 27 and 29 May 2020.

[12] The disability service told HDC that each time, the medication was administered between 7am and 9.30am.
[13] In August 2021.

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

31. Ms A told HDC that Ms D, a support worker, told her that RN B had told both Ms D and Ms C not to tell her that she was being given clonazepam, and not to show her the medication when giving it to her.

32. The disability service told HDC that in the course of its investigation, Ms C stated that on 1 June 2020, RN B had instructed her to tell Ms A that she had received clonazepam, and to ask how she had felt on 27 and 29 May 2020.

33. However, RN B told HDC that on the third day, Ms C contacted her and said that she had asked Ms A how she was feeling, and told her that she had been given a dose of clonazepam on each of the previous days. RN B said that Ms C told her that Ms A was shocked when she found out that she had been given medication without her consent, but then she confirmed that she had felt good and believed she had benefited from it,[14] and agreed to continue taking it when necessary on an ongoing basis.

34. Ms A told HDC that she did not know that she was being given clonazepam. She was concerned that the administration of clonazepam during the day could potentially have been dangerous to her, as it might have made her feel sleepy in her wheelchair during the day.

35. The disability service's complaint to the Nursing Council of New Zealand records Ms A as having been upset once she was informed of the situation, and feeling that the trust had been broken.

36. RN B told HDC that she advised Ms A to discuss her medication with her GP so that the PRN[15] dose could be prescribed as a daily morning dose in addition to the daily night-time dose.

37. RN B stated that although Ms A had agreed to continue taking the morning dose of clonazepam, she was upset that she had been given the medication without her knowledge. RN B said that she contacted Ms A to apologise, and Ms A "had seemed to accept" her apology. In response to the provisional opinion, Ms A told HDC that she did not agree to keep on taking clonazepam in the morning and she did not accept RN B's apology as she was angry that she had been given medication that she did not know she was being given.

Continuation of clonazepam

38. RN B said that she asked Ms D to write a note in the communication book requesting ongoing administration of clonazepam in the morning. Ms D wrote:

> "Please include PRN medication (1/2 clonazap tablet) in [Ms A's] breakfast medication. This is the blister packed medication labelled 'As Required medication'. Dosage is ½ a tablet, so each one can be broken in half. This is being trialled at [RN B's] request. Please contact [RN B] if any concerns/clarification."

[14] In response to the provisional opinion, Ms A told HDC that she had not said that she had benefited from taking clonazepam in the morning and that this was untrue.

[15] As required.

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

39. On 2 June 2020, Ms E, a support worker, documented in the communications book that Ms A had "refused ½ clonazepam", and Ms E and Ms F, a support worker, wrote: "It has also not been verified with me officially by [RN B] to give it."

First complaint to the disability service

40. It is documented in the disability service's event notes that on 2 June 2020, Ms E telephoned the branch facilitator and reported that Ms A had been given an extra tablet of "diazepam?" without her knowledge on Wednesday and Friday.[16] The branch facilitator documented that she would pass on the information to "the nurse[17]".

41. The disability service told HDC that escalating the concern to the registered nurse responsible for Ms A was the appropriate escalation process. However, the disability service noted that the registered nurse responsible for Ms A was RN B.

42. RN B did not complete an incident form, and did not make a note of what actions, if any, she took when the branch facilitator informed her that the issue had been escalated.

Second complaint to the disability service

43. On 23 June 2020, support workers submitted to the disability service a list of concerns they had about RN B. The list outlined that Ms A had been given 0.5mg of clonazepam without her knowledge, and that this had not been documented on her medication sheet. It was also noted that at some point between 1 and 6 June 2020, RN B requested Ms A's communication book and it was not returned. The disability service told HDC that Ms A's communication book remains missing.[18] RN B told HDC that the communication book has never been in her possession.

44. On 26 June 2020, the locality manager completed an incident form in relation to Ms A being administered clonazepam in the mornings of 27 and 29 May 2020. The disability service told HDC that the matter was escalated immediately, and an immediate investigation into events was launched. RN B was suspended during the disability service's investigation.

45. The disability service stated that the locality manager and the regional manager visited Ms A at home.

46. RN B told HDC that at the end of June or at the beginning of July 2020, she became aware that Ms A was still unhappy, and she telephoned her to offer another apology and to advise her how she could make a complaint. RN B said that she followed up the telephone call with a home visit to discuss the incident further, and apologised and suggested that Ms A could make a complaint, but she declined.[19] Ms A told HDC that RN B approached her and implied

[16] 27 and 29 May 2020.
[17] RN B.
[18] In response to the provisional opinion, Ms A told HDC that she does not know where the communication book is.
[19] In response to the provisional opinion, Ms A told HDC that this is incorrect and she did not decline to make a complaint, which is evident as she did make a complaint.

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

that it had been a misunderstanding and that the support workers were confused and it should not have happened, and RN B apologised.

47. RN B resigned from her position with the disability service.

Further information

RN B

48. RN B told HDC that she believes her error was due to stress of the COVID-19 national lockdown, and having received bad family news.

Responses to provisional opinion

Ms A

49. Ms A was given an opportunity to respond to the "information gathered" section of the provisional opinion. She stated that she "felt absolutely horrified that she had been given the medication without her knowing".

RN B

50. RN B was given the opportunity to respond to the provisional opinion. RN B's representative stated that she accepted the findings in the provisional opinion.

51. RN B told HDC that she admits that she made a grave error when she agreed that the support worker could administer PRN medication to Ms A at a time in the day when she did not want to be administered the medication. RN B said that she has been remorseful and apologetic since the event, and has undertaken appropriate reflection, and considers that she should not be referred to the Director of Proceedings.

52. RN B told HDC that she has many years of experience and to date has not received any other complaints. She stated that while she does not want to trivialise the error she made, at that time she was working for the disability service through the COVID-19 pandemic, which placed extra demands on her at work.

53. RN B informed HDC of a family event that occurred in May 2020. She said that in hindsight she should have taken time off work to support her family member, but she did not do so as she was aware that there was no one to replace her, and that she would return to an increased workload. RN B stated that on reflection she should have requested some leave or some more support from her managers when work and life began to get on top of her.

54. RN B said that this was a one-off event in a long career, and such an event will never be repeated.

Disability service

55. The disability service was given the opportunity to respond to the provisional opinion, and confirmed that it had no further comments to make. The disability service provided evidence that Ms C had completed HDC's training module on informed consent.

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

Opinion: RN B — breach

56. Ms A was prescribed clonazepam by her GP. It was provided in a blister pack and, when she requested it, support workers gave it to her. Ms A preferred to take the clonazepam at night-time as it assisted with her sleep. She did not want to take clonazepam in the day-time as she did not want to feel drowsy whilst in her wheelchair.

57. At the end of May 2020, Ms C was concerned that Ms A was feeling anxious during the day, and raised this with RN B. Ms C and RN B discussed the possibility of administering Ms A with her prescribed clonazepam during the day. Both RN B and Ms C were aware that Ms A did not want to take clonazepam in the day-time. RN B told HDC that Ms C had asked her whether she could administer Ms A clonazepam without informing her, and RN B said she could. Ms C's evidence is that RN B instructed her to give Ms A clonazepam in the day-time without her knowledge.

58. Whilst there are differing versions of events between RN B and Ms C, both accounts are consistent in that RN B agreed that Ms A could be administered clonazepam during the day without informing her.

59. Consequently, Ms C administered Ms A 0.5mg of clonazepam on two occasions, without her knowledge or consent.

60. RN B's job description stated that a principal role, accountability, and expectation of a nurse was to administer, monitor, and evaluate the effectiveness of prescribed medications. It also stated that a key role of nursing staff was "to provide appropriate delegation and direction" to support workers.

61. In this case, ultimately RN B was responsible for the administration of clonazepam to Ms A, and provided direction to Ms C that she could administer the drug without Ms A's consent. I am extremely concerned that RN B did so, and consider that she breached Right 7(1) of the Code of Health and Disability Services Consumers' Rights (the Code) by providing services to Ms A when she had not made an informed choice and provided informed consent to receive clonazepam during the day on 27 and 29 May 2020.[20]

62. Further, as a registered nurse, RN B has a responsibility to act with integrity and honesty. The Nursing Council of New Zealand's Code of Conduct (Appendix A) states that being honest, acting consistently, and honouring commitments to deliver safe and competent care is the basis of health consumers' trust in nurses. In particular, it states that nurses must "be open and honest" in their interactions with health consumers.

63. I consider it wholly unacceptable that RN B, as the health professional, approved and allowed Ms A to be given clonazepam by a support worker without Ms A's knowledge. While I acknowledge RN B's submissions regarding her personal circumstances at the time, I do

[20] Right 7(1) states: "Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise."

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

not consider it an excuse for having knowingly allowed a consumer under her care to be deceived. It is a basic right for a consumer to be told of the medication they are about to receive.

64. I consider that RN B acted contrary to the Nursing Council of New Zealand's Code of Conduct, particularly the requirement that nurses are to be honest in their dealings with consumers. Accordingly, I find that RN B breached Right 4(2) by failing to provide Ms A with services that complied with professional and ethical standards.[21]

Opinion: Ms C — adverse comment

65. Ms C was one of the support workers who assisted Ms A with her care, and on 27 and 29 May 2020, she administered clonazepam to Ms A without her knowledge or consent, knowing that Ms A did not want to take clonazepam during the day.

66. At the end of May 2020, Ms C raised concerns with RN B that Ms A was anxious during the day, and Ms C and RN B discussed the possibility of administering Ms A with her prescribed clonazepam during the day. Both RN B and Ms C were aware that Ms A did not want to take clonazepam in the day-time. RN B told HDC that Ms C had asked her whether she could administer Ms A clonazepam without informing her, and RN B said she could. Ms C's evidence is that RN B instructed her to give Ms A clonazepam in the day-time without her knowledge.

67. Whilst there are differing versions of events between RN B and Ms C, both accounts are consistent in that RN B agreed that Ms A could be administered clonazepam during the day without informing her of this fact.

68. RN B's job description stated that a principal role, accountability, and expectation of a nurse was to administer, monitor and evaluate the effectiveness of prescribed medications. It also stated that a key role of nursing staff was "to provide appropriate delegation and direction" to support workers.

69. While I am critical of Ms C's actions, I note that ultimately RN B was responsible for the administration of medication to Ms A, and for providing direction to Ms C. I also note that Ms C did seek direction from RN B appropriately about how to manage Ms A's anxiety. However, I remind Ms C that it is not acceptable to administer medication to a competent consumer without their informed consent. I expect Ms C to have learned from these events, and to ensure that in the future her practice is at all times consistent with the Code, and in particular Rights 5–7, which discuss communication with consumers and obtaining their informed consent.

[21] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

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

Opinion: Disability service — adverse comment

70. On 2 June 2020, the disability service was first made aware of the incident when a support worker informed the branch facilitator that Ms A had been given medication without her knowledge. The disability service told HDC that this was the appropriate escalation process at the time of these events.

71. The disability service was informed of the incident again on 23 June 2020, and an investigation was commenced and Ms A was visited by senior staff. The disability service told HDC that it has introduced a centralised incident management system to enhance its escalation pathway and governance of incidents, and make it easier for staff to report incidents.

72. I acknowledge that on receipt of the first complaint, the branch facilitator acted consistently with the escalation process current at the time of these events. Unfortunately, this process meant that RN B was responsible for resolving a complaint concerning her own conduct. The fact that this could occur demonstrates an issue with the disability service's complaints process at the time. However, I note that the second complaint was dealt with in a timely fashion, and that the disability service introduced a centralised management system to enhance its escalation pathway and management of incidents and performance concerns. I consider that such steps are appropriate in the circumstances.

Changes made

73. The disability service told HDC that following the incident, the disability service:

a) Amended its medication signing sheet and communication log process and introduced self-addressed envelopes so that medication sheets are returned to the branch.

b) Updated the format of its service plans with specific instructions relating to medications and what level of support a client needs.

c) Centralised and standardised orientation training for all registered nurses.

d) Standardised all position descriptions.

e) Restructured the reporting line for registered nurses to report to senior registered nurses to provide direct clinical supervision and monitoring.

f) Introduced human resource coordinators to manage support workers directly and manage incidents and performance concerns related to support workers.

g) Introduced a centralised incident management system to enhance its escalation pathway and governance of incidents and make it easier for staff to report incidents.

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

74. RN B told HDC that following these events:

a) She undertook considerable reflection and learnt that she needs to discuss her work with colleagues and management and ask for guidance if she is unsure of something, and she learnt not to work when stressed.

b) She completed training on medications, including the Ko Awatea Medication Safety — National course, Ko Awatea Medication Certification WDHB, and Ko Awatea Oral Medication Administration (National Course), and the Code.

c) She discussed the incident with her current employer, who has ensured that she works with a senior member of staff or is aware of the person to whom she should direct enquiries.

d) She undertook an annual medication administration refresher course in November 2019.

e) In 2018 she completed the New Zealand Qualification Authority Unit Standard 20827 — Level 3 — Supporting a person to use prescribed medication in a health or wellbeing setting.

f) She undertook an internal course entitled “Approved Medication Assessor”.

Recommendations

75. In response to the recommendation in my provisional opinion, RN B provided a written apology to Ms A and evidence of having completed training on medication management. I recommend that in addition, RN B complete HDC’s training module on informed consent.

76. In response to the recommendation in my provisional opinion, the disability service provided a certificate to confirm that Ms C had completed HDC’s training module on informed consent.

Follow-up actions

77. RN B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

78. In response to the provisional opinion, RN B asked that I reconsider my proposed referral to the Director of Proceedings, and made a number of submissions, which I have considered carefully. In light of the seriousness of the departures identified in the care RN B provided, I consider that it is in the public interest to make a referral.

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

79. A copy of this report with details identifying the parties removed will be sent to the Nursing Council of New Zealand, and it will be advised of RN B's name in covering correspondence.

80. A copy of this report with details identifying the parties removed will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

81. The Director of Proceedings decided to issue proceedings in the Health Practitioners Disciplinary Tribunal.

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

Appendix A: Relevant standards

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

> "Being honest, acting consistently and honouring our commitments to deliver safe and competent care is the basis of health consumers' trust in nurses. Integrity means consistently acting according to values and principles, and being accountable and responsible for our actions. As professionals, nurses are personally accountable for actions and omissions in their practice, and must be able to justify their decisions.
>
> …
>
> Principle 7: Act with integrity to justify health consumer's trust
>
> …
>
> 7.1 Be open and honest in your interactions with health consumers."

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