

**Administration of incorrect medication and  
failure to report the error  
(10HDC01201, 20 September 2012)**

*Registered nurse ~ Public hospital ~ District health board ~ Medication error ~  
Cardiac ward ~ Right 4(1)*

A 69-year-old man was admitted to hospital with severe chest pain on a Saturday. He was diagnosed with a heart attack, severe anaemia, previously undiagnosed thrombocytopenia (low blood platelet count and an increased risk of bleeding) and acute myeloid leukaemia. On Sunday, the man, who was acutely delirious and refusing care, was transferred to a side room in the cardiac/medical ward for symptom management.

The man's condition deteriorated. The senior registered nurse (RN)/duty co-ordinator on duty on Monday did not recognise the significance of his deterioration or request a medical review. The RN obtained the man's prescribed medication using the hospital's automated medication dispensing system. However, the RN inadvertently attached the man's medication administration sheet to the file of another patient. As a result, she mistakenly believed that medications listed on the other patient's file had been prescribed for the man. As those additional medications were not on the man's profile on the automated dispensing system, the RN overrode the system to obtain them. The RN decided to withhold one of the drugs, and subsequently administered three of the other patient's medications to the man, one of which was contraindicated for the man's condition.

Soon after, the RN realised that she had given the man another patient's medication. The RN did not report the error to the duty manager, or ask for the man to be assessed by a doctor. She looked up the additional medications in a pharmacy reference book and, finding that they were cardiac drugs, was reassured and decided that the man was not at risk of harm.

Not long after the man had been given these medications, he became short of breath and cyanotic and, sadly, died on Monday evening. Two days later, the RN admitted her medication error to the DHB.

It was held that by administering incorrect medication, failing to discuss with a prescriber that she had withheld medication, failing to immediately report the medication error and seek a medical review, and failing to recognise the significance of the man's deteriorating condition, the RN did not provide services to the man with reasonable care and skill and breached Right 4(1) of the Code. She was referred to the Director of Proceedings.

The DHB had systems and policies in place to provide training and guidance to staff on medication administration and incident reporting. It was held that the breaches in this case were caused by individual error, and that the DHB did not breach the Code in relation to the man's care.