Health Care Assistant, Mrs C

A Rest Home

A Report by the

Health and Disability Commissioner

(Case 06HDC10115)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer
Mrs A	Consumer's wife
Mrs B	Consumer's daughter and power of attorney
Mrs C	Provider/Health care assistant
A rest home	Provider/Private rest home
Ms D	Health care assistant
Ms E	Health care assistant
Ms F	Human Resource Manager, the rest home
Ms G	Site Manager, the rest home

Complaint

On 6 July 2006 the Commissioner received a complaint from the Nursing Council of New Zealand about the services provided by health care assistant Mrs C and a rest home, to resident Mr A. The following issues were identified for investigation:

- *The adequacy and appropriateness of the care provided by Mrs C to Mr A, in particular whether, on 17 May 2006 she:*

  — *appropriately administered Mr A's medication as prescribed*
  — *appropriately documented the medication she gave to Mr A*
  — *appropriately reported any error in administering medication to Mr A*
  — *provided accurate information to Mrs A (Mr A's wife) about the medication she administered to Mr A.*

- *The adequacy and appropriateness of the care provided by the rest home to Mr A, in particular whether the rest home:*

  — *had appropriate systems in place for the administration of medication to residents*
  — *provided adequate information to Mr A's family and attorney.*

Mr A's wife, Mrs A, and daughter, Mrs B (who holds Enduring Power of Attorney), were contacted, and they indicated that they supported the complaint.

An investigation was commenced on 1 August 2006.

Information reviewed

- Mrs C's personnel records including in-service training records
- The rest home's investigation report
- Interview with Mrs C
- Interview with Ms D
- Interview with Ms E
- Mr A's relevant clinical notes and medication administration records
- Information on the rest home's medication administration system, restraining policy and accident report policy.

Information gathered during investigation

Mrs C, a health care assistant, had worked in the dementia unit at a rest home for ten years. The unit has 12 residents, including Mr A. Mr A has Alzheimer's disease and is a challenging resident. He is either continually active or asleep. He paces around and around the rooms, and up and down the hall, and bangs on all the doors, particularly the lounge doors. He pushes other residents out of his way when he is pacing, and there is a risk that one of them will fall.

Mrs C said that they had received many complaints about Mr A from visitors and residents of the surrounding cottages (independent living units) at the rest home. She had spoken to the management, the geriatrician and other doctors about his medication but she was told that there was nothing that could be done. She thought that perhaps the rest home was not the right place for him but there were no other suitable facilities in the area.

Medication
On 3 May 2006, Mr A was prescribed the following medication:

- quetiapine 25mg at midday (anti-psychotic medication), and
- lorazepam 0.5mg (half a tablet) at 5pm daily (for the treatment of anxiety and insomnia), and quetiapine 25mg x 2 at 5pm.

This means that one tablet is given at midday, and two and one half tablets are given at 5pm.

System of administration
The rest home manager, Ms G, explained that each resident has medications dispensed in blister packs. All the 8am medication for each patient for that month is dispensed on the one-month pack; the midday medication is in a separate pack; and the 5pm medications are in a third separate pack. Each pack has the resident's name and

identifying details in clear type pasted at the top (see Appendix 1). On the back of each blister (30 per month) is listed the names of the drugs encased in the bubble (see Appendix 2).

All the blister packs for each time (8am, midday, 5pm) are banded together with a rubber band. After all the 8am medications have been administered, these packs are placed in the drug cupboard, and the midday packs are taken out and placed on the medication trolley in preparation for the next drug round. The medication trolley is then locked.

Incident
On 17 May 2006, Mrs C worked a morning duty, from 7am to 3.30pm. It was her responsibility to give the residents their medications at 8am and at midday. At that time Mr A had been on the medication regime for 14 days.

Mrs C said that she followed the same routine on 17 May as at all the other times she gave the residents their medication. She gave out the 8am medication and returned the packs to the drug cupboard. She took the midday packs and placed them on the trolley. It was close to midday when she began the next round, giving Mr A his medication first. After he had taken the medication she realised that she had given him his 5pm medication in error. She had placed all the 5pm packs on the trolley by mistake. She did not give any other medication. She returned the 5pm packs to the drug cupboard and took the midday medications out of the cupboard and continued the medication round. Mrs C did not report the error to the registered nurse on duty, the clinical manager, or the doctor. She did not complete an incident report or document the error in Mr A's notes. When Mrs A visited her husband that afternoon, Mrs C did not tell her about the error.

At 3pm on 17 May 2006, health care assistants Ms D and Ms E came on duty. They received Mrs C's handover report. She told them that she had mistakenly given Mr A his 5pm medications at midday and she asked Ms D to give Mr A his midday medications at 5pm.

Ms D and Ms E said that Mrs C told them that she was trying an experiment. She said that Mr A had been driving her mad all morning and she wanted to see if receiving a double dose of his medication at midday would keep him quiet in the afternoon. They said that Mrs C said that she told Mrs A a "pack of lies". Mrs A had asked Mrs C why her husband was asleep during visiting hours, but she could not tell her the real reason. Ms D said that Mrs C used the expression "out to the monk", meaning that Mr A was fast asleep.

Both Ms D and Ms E had the impression that Mrs C had intentionally given Mr A his 5pm medication at midday. This was particularly upsetting to Ms D because Mrs C expected her to incorrectly administer the midday medications at 5pm, to comply with Mrs C's "experiment".

Mrs C denied that this was how she described the error. She said that this was not "an experiment as such". She meant that perhaps it would suit Mr A to have a double dose at midday rather than 5pm and, as she had made a mistake, they could see how he was affected. Mrs C insisted that her actions were not deliberate. She knew she had no authority to alter medication, and she knew the risks of over-medication in the elderly. She had often spoken to management about reducing medication if she thought residents were too sleepy during the day.

Information to Mrs A
Mrs C said that she did not tell Mrs A "a pack of lies" but simply did not say anything. She believes that relatives do not want to hear anything unpleasant about their loved ones, and she would prefer to give only positive reports when asked.

Ms D said that after Mrs C had gone home she contacted the clinical nurse leader to report the matter. In the meantime, Mr A was particularly sleepy and, when trying to make his way to the toilet, fell at 3.45pm. The incident report read: "… Consequently the resident has fallen due to the extra medication given but not legally charted. A serious incident to be immediately addressed. No clinical [order / staff] advised of this to be given."

Internal investigation
On 18 May, Mrs C was called to a meeting with Ms G and the clinical nurse leader. In the minutes of the meeting Mrs C is said to have stated:

> "She told us that she would like this medication to be trialled, this was because the resident is very restless during the afternoon. [Ms G] informed her that this can not be done before the doctor was consulted and gave consent for this to happen. [Mrs C] admitted that she didn't complete an error form and that was the only mistake she made."

Mrs C completed an incident form on 18 May 2006. At a second meeting on 23 May, Mrs C said that after Mr A has his 5pm medication he is "zonked out" and is given another dose at 8pm. In her view it would be better to have the 5pm medication at midday because he is so restless in the afternoon. She again insisted that she had made a mistake and did not give the 5pm dose at midday deliberately but, as she had, why not "trial it that way". She did not tell Mrs A anything about the medication. Likewise, she would not tell Mrs A about how stressful the other residents found Mr A, because that is something relatives do not want to hear.

Mrs C told the investigating team that she knew of "things that were happening but she never complains or comes down to see [the clinical nurse leader]". She said that she "never reports on her work mates". The records of the meeting state that Mrs C called Ms D a "pimp" for informing Ms G about the error on 17 May. The records also note that Ms G told Mrs C that all errors need to be reported to the family, and "[Mrs C] referred to another error that happened the night before … she asked [Ms G] how

many incidents happened and [Ms G] replied 'none since I've been at [the rest home] because any such incidents will be handled in the same manner by management'. [Mrs C] told us that we do not know what is going on on the floor and [Ms G] told [Mrs C] that if errors are not reported there is no way we will know." Mrs C was suspended on full pay pending the rest home's investigation.

On 30 June 2006, the rest home notified the Nursing Council of New Zealand that Mrs C:

> "was dismissed on 30 May 2006 for a serious breach of our drug administration policy in that she deliberately increased a resident's medication (quetiapine and lorazepam) 'as a trial', failed to advise the Nurse Leader or the family of this, failed to complete the drug chart correctly to record the change, failed to advise the other health care assistant on duty at the time of the change in medication, failed to alert her to the need for observation, failed to use the resident drug administration chart correctly as our policy for this and other residents."

Training in medication administration

Mrs C said that giving out medication was a big responsibility, even with individual packaging. She said until 12 months ago it was the responsibility of the registered or enrolled nurse to administer medications. As trained staff left and had not been replaced, this responsibility had fallen to experienced health care providers. She said she had worked at the rest home for 15 years, five years of which were in the hospital wing at the rest home. She did not give medications there. She has had no formal nursing training.

The rest home's records show that Mrs C was trained to give medication. She successfully completed a medication administration programme on 9 February 2000 and a health care assistant medication administration assessment on 15 November 2004. The assessment included a five point pre-administration check to ensure correct drug administration: ensuring the right person, right drug, right dose, right time and right route. Mrs C correctly answered what she was to do if she made a drug administration error.

On 10 July 2004, the rest home tested Mrs C's knowledge on its restraining policy. The test included a question on four ways to restrain residents. Mrs C included approved medication to take the "edge off a resident's behaviour". This answer was marked incorrect.

Ms G advised that as far as she was aware, the rest home had complied with all legislative and contractual requirements in relation to teaching health care providers to give medications correctly. All staff have to complete the medication management and training programme as stated in the rest home manual. They have to demonstrate competency before they are allowed to give medications. All medication errors have to be reported, as stated in the manual, be investigated by the clinical nurse leader, and

have remedial action taken as required and data collected to identify trends. This is "benchmarked monthly" with other facilities of the organisation.

Incident reporting policy
The rest home's Accident/Incident Report, Investigation and Analysis policy states that an "incident" includes a medical error and that the family must be notified of the error.

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.

RIGHT 6
Right to be Fully Informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, …

Other Relevant Standards

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

"*Message*
Every manager of a residential care facility must take all reasonable steps to ensure that at all times the storage, administration and disposal of medicines are strictly controlled and that safety, efficacy and accuracy are maintained with respect to 'the right dose being administered to the right person in the right form at the right time', as prescribed by the medical practitioner.

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."

Opinion

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

Opinion: Breach — Mrs C

Under Right 4(1) of the Code of Health and Disability Services Consumers' Rights Mr A had the right to services provided with reasonable care and skill. Mr A's daughter, Mrs B, who holds enduring power of attorney, had the right to information about his care that a reasonable consumer would expect to receive (Right 6(1)).

On 17 May 2006, Mrs C, a health care assistant at the rest home gave the 8am medications to the residents of the dementia unit. She placed the 8am packs back into the locked drug cupboard and placed what she thought were the midday packs in the drug trolley in preparation for the medication round at midday.

However, when Mrs C gave the medications to Mr A, the first resident to receive his medication at midday, she gave him the 5pm dose. She then noticed that these were the 5pm packs, realised her error and returned the packs to the cupboard, retrieved the midday packs and continued her drug round. Mrs C had given Mr A two and a half tablets instead of half a tablet (twice the amount of anti-psychotic medication and a dose of a sedative that he normally had only in the evening). Clearly Mrs C did not complete the five-point pre-administration check as she had been trained to do to confirm the right patient, right dose, right drug, right time, and right route. She made two mistakes: the wrong dose at the wrong time.

Mrs C's next mistake was not reporting her error to Mr A's doctor, the clinical nurse leader, her colleague on duty, Mrs A or Mrs B, as required by the rest home's incident

reporting procedures. She did not report it to anyone. She signed the midday medications as being correct, and did not record the matter in Mr A's clinical notes or complete an incident form. She stated that as Mr A had been particularly noisy and active that morning she would try "an experiment" and see if increasing his midday medication affected his behaviour.

Ms D and Ms E came on duty at 3pm and received a handover report from Mrs C. She told them that she had made a mistake but wanted to "experiment" to see if Mr A was quiet in the afternoon after having the double dose of quetiapine, plus the lorazepam at midday instead of 5pm. Ms D was scheduled to give the 5pm medication, and Mrs C asked her to give the midday quetiapine 25mg at 5pm. After Mrs C left for the day, Ms D reported the error. Ms D was very upset that Mrs C would ask her to falsely document Mr A's records.

Ms D and Ms E had the impression that Mrs C gave Mr A the wrong medication deliberately, but Mrs C denied this. Mrs C said that her mistake had been genuine but she thought Mr A would be better with the larger dose of quetiapine during the day. If that proved to be the case, she thought they could ask the geriatrician or doctor to alter his medications.

Mrs C's failure to report her mistake put Mr A at risk. Allowing Mr A to be mobile under that level of sedation put him at increased risk of injury. After Mrs C finished for the day, Ms E found Mr A on the floor, having fallen while trying to get to the toilet.

Mrs C told the rest home investigating team that she knew of lots of mistakes that are made by care assistants at the rest home, but she does not report them. In my opinion, Mrs C's loyalty is misguided. Her primary responsibility is to the residents in her care and keeping them safe. Errors can only be prevented if each incident is investigated to find the reason it occurred. It is not a matter of telling on your mates, but creating a culture of learning. Making mistakes is a part of human nature, and each mistake, if examined openly and honestly, provides a forum for learning about how improvements can be made, thus improving the quality of care.

Ms D acted appropriately in reporting the error. Although Mrs C said that her action in giving Mr A his medication at the wrong time was not deliberate, I find it surprising that she would not have noticed the different number of tablets in his usual lunchtime dose. It was a serious error, and her subsequent actions show an alarming lack of judgement. Mrs C seems to have no insight into her responsibilities to Mr A or the other residents in the dementia unit.

Mrs C knew the policy for reporting a medication error (as evidenced by her correct answers on assessment) and told other caregivers about the error, but did not report it. This conduct suggests an attempt to cover up the error. Mrs C's failure to report the incident meant that Mr A was not adequately monitored and suffered a fall. She expected Ms D to give the wrong medication at 5pm. Mrs C failed to provide Mr A

with an appropriate standard of care, and her actions on discovering her mistake were dishonest. Accordingly, she breached Right 4(1) of the Code.

Mrs C did not take the necessary steps to ensure that the matter was brought to the attention of Mrs B or Mrs A when she had every opportunity to do so. Mrs A had visited her husband that afternoon and asked why he was so sleepy. Mrs C could have told her of the mix-up. The information I have gathered suggests that no information about the medication error was passed on to Mr A, his enduring power of attorney Mrs B (Under Right 6(1) of the Code), or his wife (under the rest home's reporting policy). The first Mr A's family heard of the error was when HDC called them to see whether they supported the complaint. In my view, this is unacceptable.

Had Mrs C properly reported the event, as she was expected to do, Ms G could have reported the matter to Mrs B, who holds enduring power of attorney for Mr A. Accordingly, Mrs C breached Right 6(1) of the Code.

Opinion: No Beach — The Rest Home

Direct liability

Residential care facilities are required to provide services of an appropriate standard, and this includes systems for the safe administration of medication to residents. The rest home had its residents' medications dispensed into blister packs by the pharmacy. Each resident's name and the time for administration was clearly marked at the top of the pack, and each tablet contained in the bubble was named on the back of the pack.

The Health and Disability Sector Standards require residential care facilities to have systems that comply with legislative and regulatory requirements. This means that the rest home was required to have systems, policies and procedures for the safe and appropriate management of each step in the process of giving residents their medicines — from prescribing and dispensing medicines to documenting service providers' responsibilities at each stage of the process. At the rest home, caregivers were authorised to administer residents' medication only after they had satisfactorily completed its training programme, and knew the adverse effects of common medicines, and had demonstrated what to do if an error occurred. I am therefore satisfied that the rest home meets its legal and regulatory requirements in this regard.

However, I have reviewed the incident reporting policy and note that the checklist includes a brief requirement to explain the incident to the family. This did not occur in Mr A's case. Although the incident did not cause any significant injury to Mr A, Mrs B was entitled to know that the rest home had adequately assessed the need for any follow-up care and taken steps to ensure that a similar error did not occur again.

My concern is that there may have been some complacency because Mr A lacked the competence to understand any explanation about the error, and Mrs B was not immediately available. A facility has a responsibility to provide the same level of information to an enduring power of attorney as they would a competent consumer. In summary, therefore, the policy at the rest home is not adequate (as it did not require an explanation for the consumer if competent), and I will ask it to rectify the matter.

Vicarious liability
In addition to any direct liability for a breach of the Code, employers may be vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for any breach of the Code by an employee. Under section 72(5), it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from doing, or omitting to do, that which breached the Code.

Mrs C was employed at the rest home. On learning of the error, Ms G met with Mrs C to inform her that an investigation was underway. On 23 May Ms G suspended Mrs C because of concerns about her safety to practise. She has subsequently been dismissed.

I have reviewed Mrs C's training records. The rest home had provided Mrs C with training on the administration of medication, and followed this with a written assessment. The rest home was able to provide documentation of Mrs C's success in this assessment. I am satisfied that Mrs C knew how to administer medications safely. The error was not due to a systems failure but to Mrs C's failure to follow the policy for pre-checking medication before it was administered. Accordingly, in my opinion, the rest home is not vicariously liable for Mrs C's breach of Right 4(1) of the Code.

Adverse comment
When Mr A was admitted to the rest home, Mrs B held an enduring power of attorney for her father's care and welfare, which entitled her to receive information and make decisions on his behalf. Clause 4 of the Code provides that for the purposes of Right 6, "consumer" includes a person entitled to give consent on behalf of that consumer. An effective system of communication between Mr A's wife, his daughter and nursing staff was required because of Mr A's complex care needs. The fact that Mrs A visits her husband regularly and Mrs B lives in another part of the country and does not see her father very often does not preclude this obligation. These factors needed to be included in the communication plan.

It would appear that Ms G did not inform Mrs B or Mrs A of the error in Mr A's medication. Mrs C did not confirm her error until the following day, when she was called to a meeting with Ms G and the clinical nurse leader. By that time, the effects of the medication were known, and Mrs A had been in to visit her husband. Ms G should have ensured that the family was told of the error. Mrs B was entitled to receive this information, as she has the legal authority to make decisions and give consent on Mr A's behalf. To do this, she must have all relevant information in her possession.

Accordingly, I will bring this matter to the rest home's attention and ask that they ensure that appropriate people are promptly informed about errors.

Recommendations

Mrs C
I recommended that Mrs C take the following action:

- Apologise to Mrs B and Mrs A for her breach of the Code of Health and Disability Services Consumers' Rights.

Mrs C has apologised, and her letter has been sent to Mrs B and Mrs A. She has also confirmed that her new employers have been informed of this investigation and my findings.

The Rest Home
I recommended that the rest home take the following actions:

- Use my report to educate staff on the importance of openly reporting errors in a timely fashion.
- Review its practice in regard to promptly disclosing errors to residents or their representatives, and report back to me on the changes it has made.

The rest home has advised me that it is alerting staff about the importance of advising those holding an enduring power of attorney, about any care issues or changes in a resident's condition.

Follow-up actions

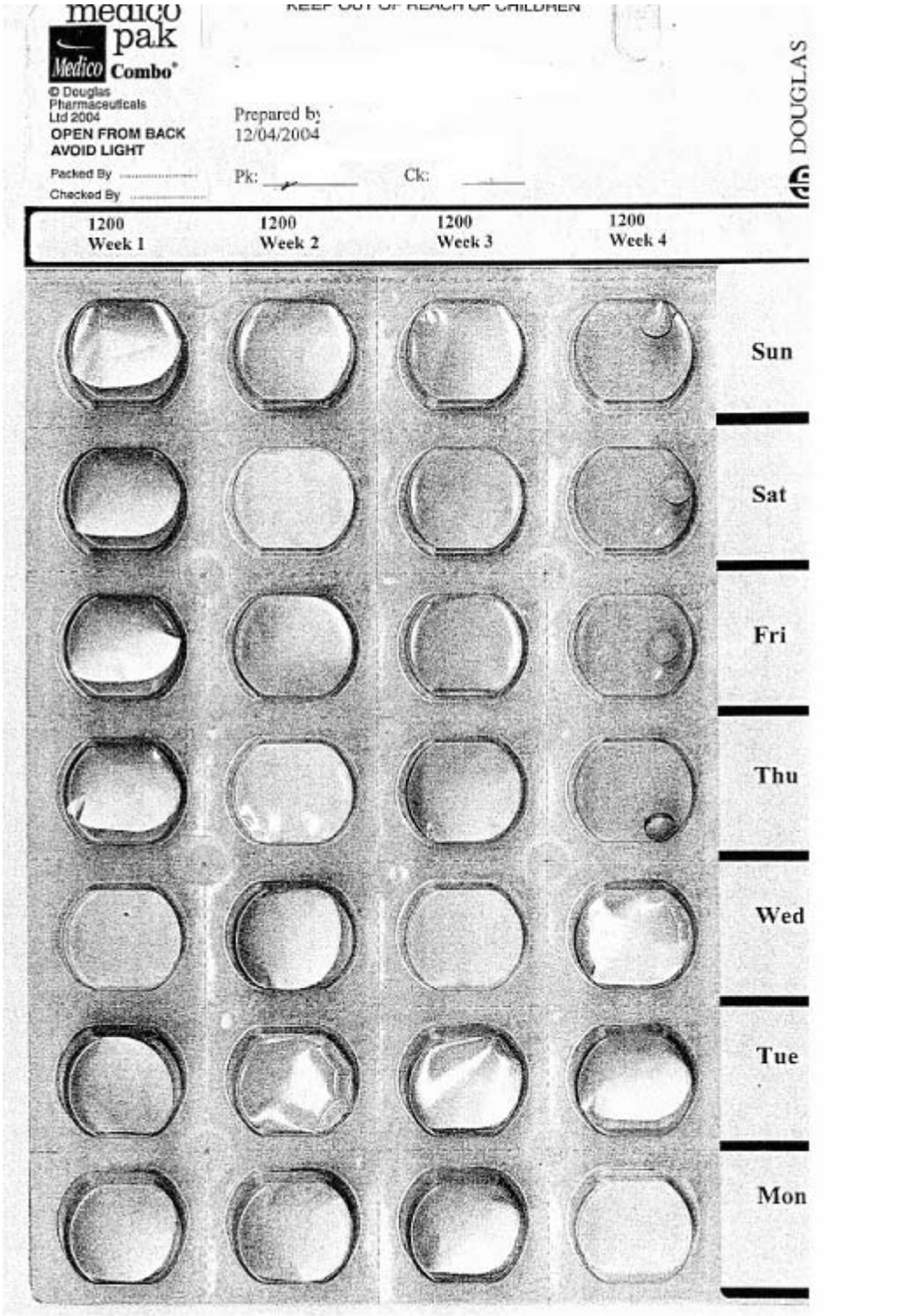
- Mrs C will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

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

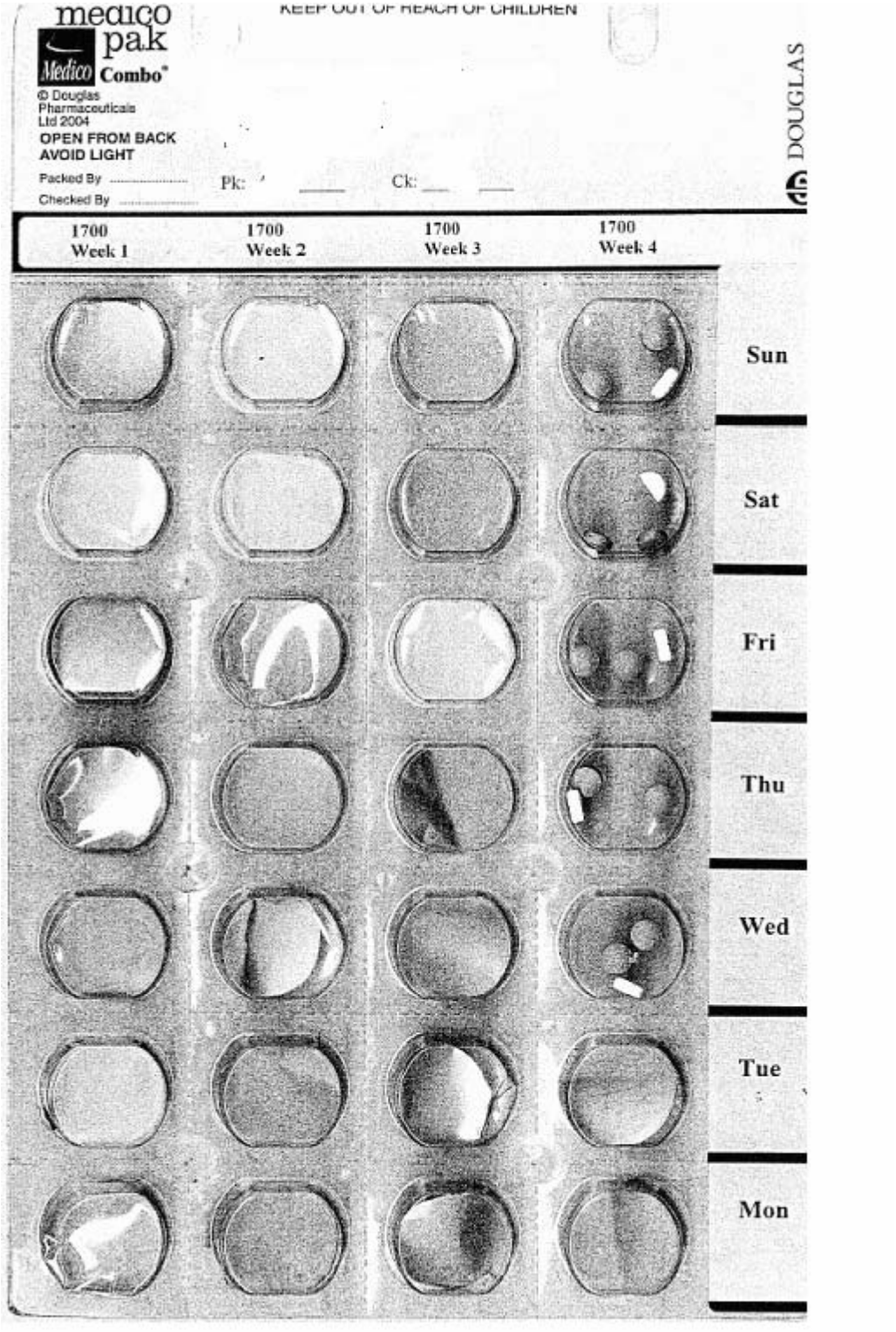
Addendum

The Director of Proceedings filed a claim in the Human Rights Review Tribunal alleging breaches of Right 4 of the Code. The Tribunal found that the health care assistant did not deliberately alter the resident's medication, but that having made a mistake, she then decided to experiment and she failed to report the medication error. The Tribunal therefore declared that there was a breach of Right 4(2) in failing to comply with relevant standards, and 4(5) in failing to co-operate with other providers to ensure quality and continuity of services.

Appendix 1



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



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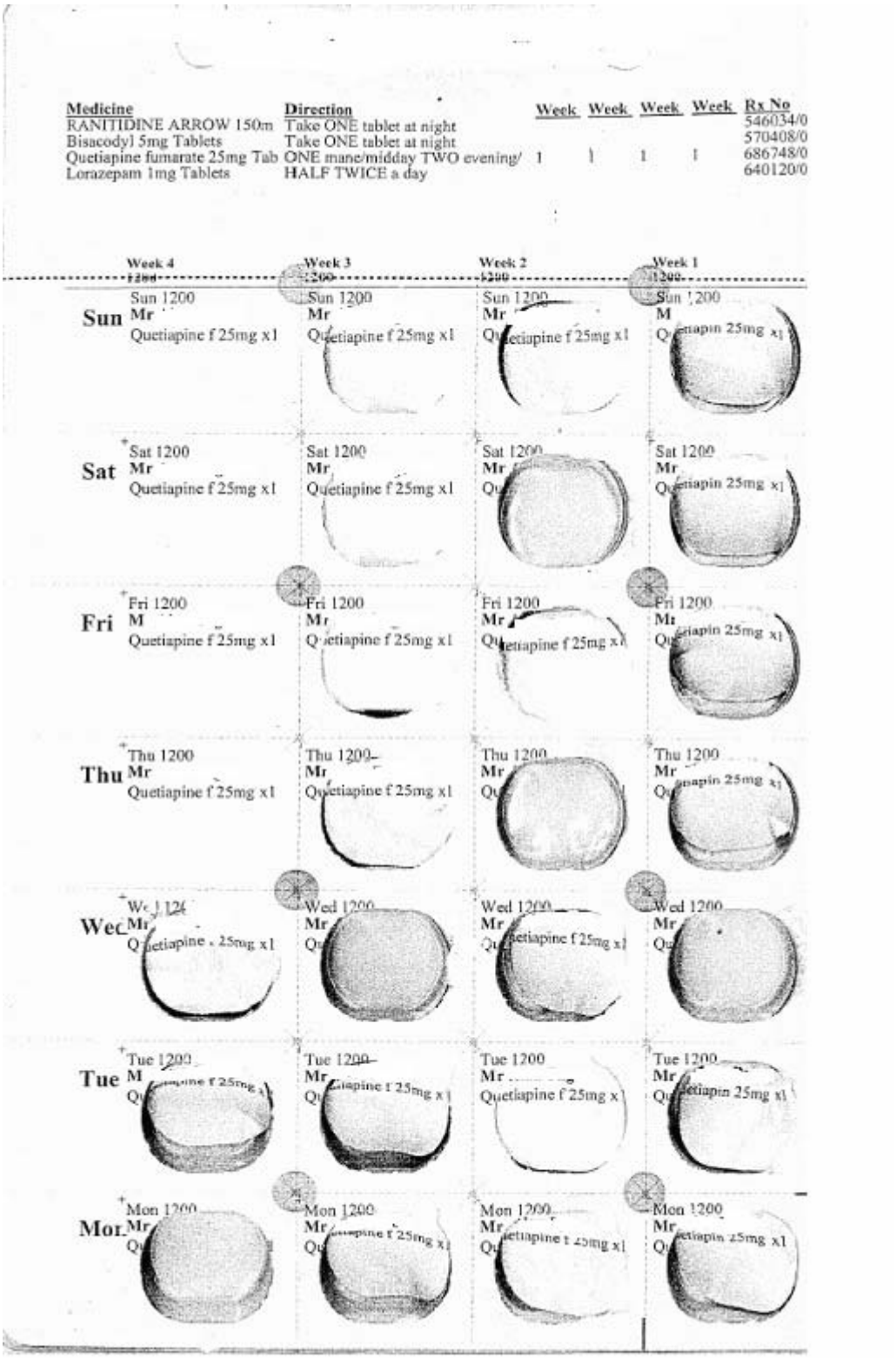
Appendix 2



Medicine	Direction	Week	Week	Week	Week	Rx No
RANITIDINE ARROW 150m	Take ONE tablet at night					546034/0
Bisacodyl 5mg Tablets	Take ONE tablet at night					570408/0
Quetiapine fumarate 25mg Tab	ONE mane/midday TWO evening/	1	1	1	1	686748/0
Lorazepam 1mg Tablets	HALF TWICE a day					640120/0

	Week 4	Week 3	Week 2	Week 1
Sun	Sun 1200 Mr Quetiapine f 25mg x1	Sun 1200 Mr Quetiapine f 25mg x1	Sun 1200 Mr Quetiapine f 25mg x1	Sun 1200 M Quetiapin 25mg x1
Sat	Sat 1200 Mr Quetiapine f 25mg x1	Sat 1200 Mr Quetiapine f 25mg x1	Sat 1200 Mr Qu	Sat 1200 Mr Quetiapin 25mg x1
Fri	Fri 1200 M Quetiapine f 25mg x1	Fri 1200 Mr Quetiapine f 25mg x1	Fri 1200 Mr Quetiapine f 25mg x1	Fri 1200 Mr Quetiapin 25mg x1
Thu	Thu 1200 Mr Quetiapine f 25mg x1	Thu 1200 Mr Quetiapine f 25mg x1	Thu 1200 Mr Qu	Thu 1200 Mr Quetiapin 25mg x1
Wed	Wed 1200 Mr Quetiapine f 25mg x1	Wed 1200 Mr Qu	Wed 1200 Mr Quetiapine f 25mg x1	Wed 1200 Mr Qu
Tue	Tue 1200 M Qu	Tue 1200 Mr Quetiapine f 25mg x1	Tue 1200 Mr Quetiapine f 25mg x1	Tue 1200 Mr Quetiapin 25mg x1
Mon	Mon 1200 Mr Qu	Mon 1200 Mr Quetiapine f 25mg x1	Mon 1200 Mr Quetiapine f 25mg x1	Mon 1200 Mr Quetiapin 25mg x1

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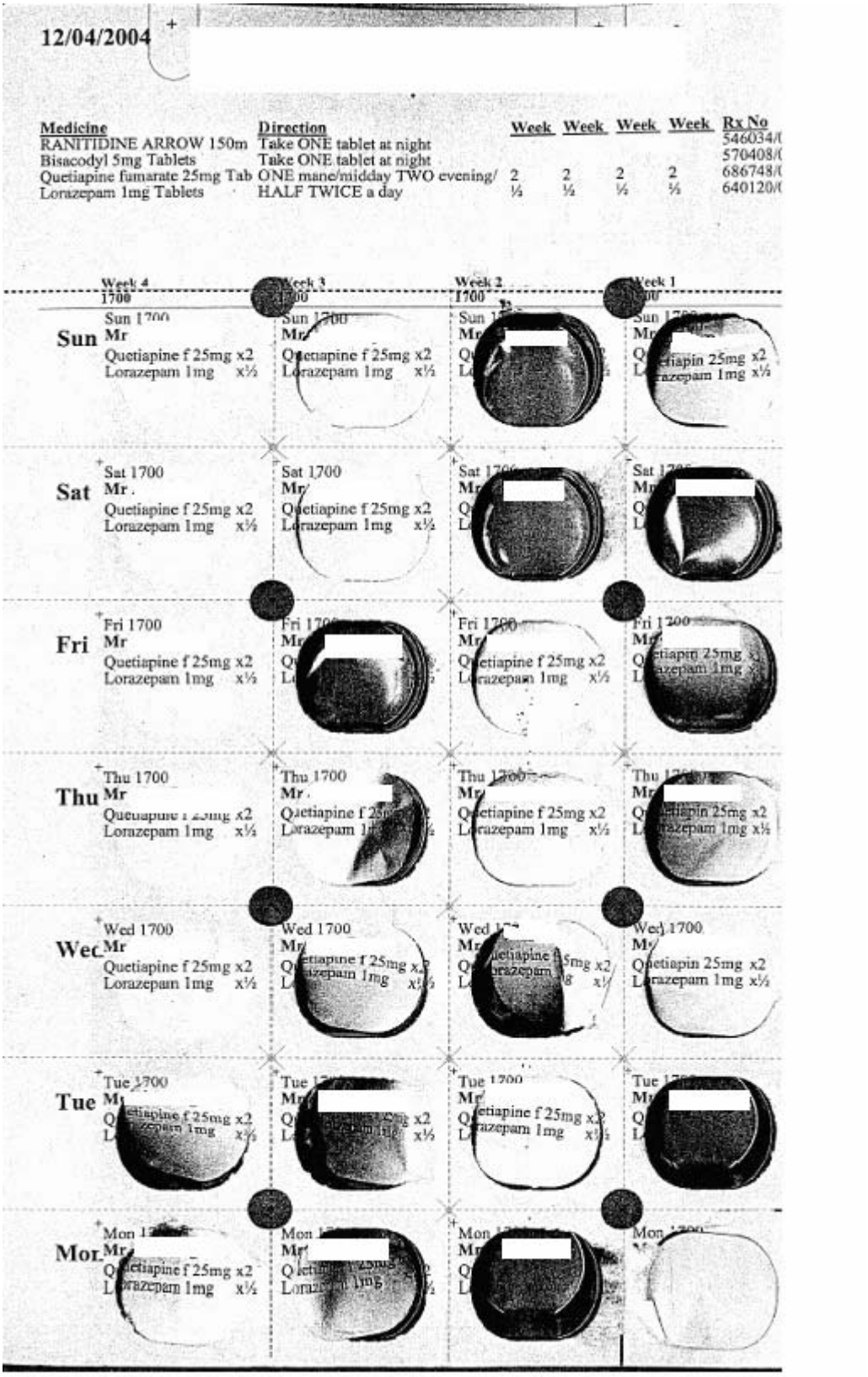

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