Identification of patient prior to administration of injection
18HDC01693, 7 August 2019

Registered nurse ~ Prison health service ~ Vaccination ~ Identification ~ Rights 4(2), 6(2), 7(1)

A man (Mr A) was a prisoner at a correctional facility, and was due for his third and final hepatitis vaccination. His brother (Mr B) was also a prisoner there, and was due for an intramuscular injection of zuclopenthixol. Both men were scheduled to be seen at the health unit on the same day for their respective medications.

Mr A was escorted by a custody officer to the health unit and seated in the holding cell. The nurse said that she was advised by a custody officer that "Mr B" was at the Health Unit. She said that she was familiar with Mr B, and believed that it was Mr B she recognised sitting in the holding cell.

The nurse said that she relayed to a second nurse that Mr B was waiting for his intramuscular injection, and together they completed the cross-check of the medication in a dedicated locked room. The nurses looked at Mr B's medication chart and went through the "five rights" process of confirming that the correct medication was being administered to the correct patient. The patient was not present in the room when the checks were being completed.

The nurse reported that she checked the photograph on Mr B's drug chart. Despite it being Mr A at the appointment, the nurse said that both she and the other nurse looked at the photo and believed that it was Mr B, and both confirmed that the medication was correct for Mr B and signed for it on the medication chart.

The nurse then took the medication to the triage room and asked the custody officer to get "Mr B" out of the holding cell. The custody officer escorted Mr A out of the holding cell and into the triage room.

The Medicines Management Policy provides that the registered nurse administering a medicine is responsible for confirming the patient's identity using two identifiers.

The nurse said that when she called Mr A "Mr B", he answered in the affirmative. Once seated in the triage room, she asked Mr A to state his full name, and she believed "without any doubt" that Mr A told her that his name was "Mr B". Mr A recalled that she then asked him where he would like his injection. The nurse said that the photograph on the medication chart cover for Mr B showed a person who looked like Mr B but with a moustache. She was aware that Mr B had shaved off his moustache, and the person present in front of her did not have a moustache.

The nurse said that Mr B and Mr A look very similar physically, both speak quite quickly, and that in hindsight, what she heard as "Mr B" was obviously "Mr A", and she had misheard him. Mr A was administered an intramuscular injection of 200mg zuclopenthixol, intended for his brother.

The nurse told HDC that after administering the medication, Mr A asked her what the injection was for, and she realised that something was not right. It was identified that the nurse had administered Mr B's medication to Mr A. The nurse advised Mr A and apologised

immediately. She gave Mr A information about the medication and potential side effects, and arranged for observation and monitoring.

Findings

By failing to confirm identity and provide information adequately, and subsequently administering medication to the wrong person, the nurse failed to provide services that complied with legal, professional, ethical, and other relevant standards. Accordingly, the nurse breached Right 4(2). Without information about the medication to be administered, Mr A was not in a position to make an informed choice and give his informed consent to taking the medication. Accordingly, the nurse also breached Rights 6(2) and 7(1).

The Department of Corrections was not found in breach of the Code.

Recommendations

It was recommended that the nurse provide a written letter of apology, and participate in a course/training relevant to the issues raised in this case, and provide reflections and learnings from the course/training and this complaint.

It was recommended that the Department of Corrections review its policy in light of the issues raised in this complaint, and provide HDC with the outcome of its consideration.