Dispensing and administration of medication to rest home resident (13HDC01720, 29 June 2015)

Rest home ~ Nurse Manager/Registered Nurse ~ Pharmacy ~ Pharmacist ~ Dispensing error ~ Dementia ~ Rights 4(1), 4(2), 4(4)

A 77-year-old woman was admitted to a semi-secure aged care facility from another rest home, due to her dementia and wandering.

Soon after the woman's admission, a pharmacist prepared the woman's medications. The pharmacist incorrectly dispensed four times the prescribed dose of risperidone, an antipsychotic which can cause sleepiness. Although the pharmacy had five dispensary staff members on duty that day, the pharmacist did not get anyone to check her work, and did not notice the incorrect dose. The pharmacist had made a number of dispensing errors prior to this incident.

When the medication arrived at the rest home, medication reconciliation was not undertaken by rest home staff. For over a week the woman was administered the incorrect dose of risperidone. During this time, the woman continued to wander into other residents' rooms, was noted to be very sleepy, and was sometimes unresponsive. Her vital signs were not checked, and no clinical assessments (apart from at admission) are recorded. The Nurse Manager/Registered Nurse felt that the woman's drowsiness was caused by a urinary tract infection (UTI) and the antibiotics she was taking for that.

There were instances where the woman's records did not indicate whether medication was given and, if not, the reason for that. Antibiotics were commenced for the woman's suspected UTI, but there was a gap of two days before a second dose was administered. The risperidone dispensing error was subsequently discovered and corrected. The woman was transferred to the public hospital.

It was held that the pharmacist selected the incorrect medication dose and failed to check the medication against the prescription, breaching Right 4(2). Adverse comment was made about the pharmacist's management of the dispensing error once she was notified of it.

It was also held that the pharmacy did not respond adequately to the risk the pharmacist posed to consumers as a result of her repeated dispensing errors. By failing to take appropriate steps to prevent further dispensing errors, the pharmacy placed the woman at risk of harm. Accordingly, the pharmacy breached Right 4(4).

The rest home had the ultimate responsibility to ensure that the woman received care that was of an appropriate standard. There were a number of concerns with the care provided to the woman at the rest home, including staff reliance on the transfer documentation from the previous rest home, as well as poor medication management, medication reconciliation, and documentation. Furthermore, inadequate staffing, in particular insufficient registered nurse hours, contributed to the poor care provided to the woman. Accordingly, the rest home breached Right 4(1). Adverse comment was made about the failure by the rest home staff to undertake an appropriate assessment of the woman's competence, meaning that staff were not in a position to obtain appropriate informed consent for her care and treatment.

The Nurse Manager/Registered Nurse failed to ensure that staff at the rest home provided adequate care and treatment to the woman, failed to maintain adequate care planning as the woman's condition changed and her drowsiness increased, failed to react appropriately to changes in the woman's condition, and did not assess her or monitor her vital signs. The Nurse Manager/Registered Nurse did not ensure that appropriate documentation was maintained by the rest home staff, or that medications were being administered safely in accordance with the rest home's medication policy. Overall, the Nurse Manager/Registered Nurse failed to provide services to the woman with reasonable care and skill and, accordingly, breached Right 4(1).

Adverse comment was made about the Operational Manager's record-keeping.