

## **Medication errors in a dementia unit (05HDC18726, 27 September 2006)**

*Registered nurse ~ Aged-care hospital ~ Medication management ~  
Registered nurse duties ~ Rights 4(1), 4(2)*

A woman complained about the care provided to her husband in a private aged-care hospital. She complained that on two occasions registered nurses administered another patient's medication to her husband, who was suffering from dementia.

During an afternoon drug round, the complainant's husband was given another patient's antipsychotic/anti-anxiety medication by an agency registered nurse. She was distracted from her medication round by an agitated patient. The nurse also gave him the other patient's 4pm and 5pm medications together. The patient lost consciousness 10–15 minutes later. An ambulance was called and he was conveyed to the public hospital Emergency Department and admitted overnight for monitoring. He was discharged back to the private hospital the following day.

During the morning drug round three weeks later, the patient was again given another patient's medication. The registered nurse who administered the incorrect medication to him on this occasion had been employed by the private hospital for three years. She was serving breakfast and making toast at the same time as administering medications. She notified senior nursing staff of the error, started vital recordings, recorded the incident and arranged for the patient to be transferred to the public hospital, where he was monitored for six hours before returning to the private hospital. The hospital staff were advised to keep him on bed rest and observe him for the next 24 hours. He did not appear to suffer any ill effects from the medication errors.

It was held that the agency registered nurse breached Rights 4(1) and 4(2) of the Code in relation to her two medication errors.

The hospital registered nurse was also found to have breached Rights 4(1) and 4(2) of the Code, for failing in her professional responsibility to notify the organisation of the risks the medication administration systems posed to staff and patients, and for her medication error.

The hospital was found to have breached Right 4(1) and 4(2) of the Code in relation to its medication administration practice.

This case highlights the importance of having a written protocol in place to ensure safe methods of medication administration, and that actual medication administration practice reflects the policies and procedures.