Incorrect administration of medication
16HDC01162, 26 November 2018

Rest home ~ Retirement village ~ Caregiver ~ Medication administration ~ Instructions ~ Communication ~ Oversight ~ Right 4(1)

A woman in her late seventies, who had several serious health conditions, was a resident of a rest home. She was prescribed several medications including warfarin. On one occasion the woman was administered another resident's medication by a caregiver. On another occasion the woman was administered an incorrect dose of warfarin by another caregiver over a two day period.

Findings

The rest home was found to have failed to provide the woman with an appropriate standard of care for a number of reasons:

- They had failed to ensure staff followed good medication administration practices or their Medication Management guidelines;
- There was inadequate oversight to ensure the registered nurse on duty and Clinical Manager adhered to relevant professional standards; and
- They did not have adequate systems and processes in place to prevent medication errors from occurring or re-occurring.

As a result, the rest home was found to have breached Right 4(1) of the Code.

Recommendations

It was recommended that the rest home:

a) Provide a written letter of apology to the woman's family for the breach of the Code identified in the report.

b) Provide an update on the changes put in place following the medication errors, and an update on the training and requirements for ongoing medication competency.

c) Conduct an independent audit of the frequency and nature of medication errors over the previous six months, and provide a report on the impact of any medication errors and the steps taken to prevent medication errors from occurring.