Department of Corrections

A Report by the
Deputy Health and Disability Commissioner

(Case 16HDC01713)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. On 11 October 2016, Mr B, then aged 58 years, was received as a prisoner at a corrections facility. He had been discharged from a public hospital the previous day, following an admission for chest pain. Mr B required daily medication for coronary vascular disease, and twice daily medication for HIV. He brought with him his own supply of medication for these conditions.

2. At the Receiving Office, a registered nurse recorded Mr B's medical conditions and that he had brought his own supply of medication. The nurse did not record Mr B's recent hospitalisation for chest pain, or evaluate the importance of his medication, and did not update the medication chart to record that Mr B had brought his own supply of medication.

3. An Initial Health Assessment was not completed at this time or at any other time during Mr B's incarceration.

4. Mr B's medication was placed in the medication room. The health care assistant (HCA) on duty was unsure what to do with the medication, and it was not given to Mr B on either 12 or 13 October 2016.

5. Over the next three months, Corrections failed to administer Mr B's prescribed medication on 15 separate occasions. On five of these occasions, Corrections accepted that the doses had been missed. The HCA who failed to administer the medication on each occasion did not escalate the issue to a registered nurse for review.

6. Corrections stated that on the remaining occasions, its records indicate that the medication was administered. However, Corrections acknowledged that at the time of events, pre-signing of the medication sheet was normal practice, and therefore it was not necessarily a record of the medication given.

Findings

7. Mr B had no control over his access to medication, and was reliant on the staff at Corrections to provide him with adequate care. The missed doses of HIV medication may have significant long-term implications for Mr B.

8. The Deputy Commissioner found that Corrections did not comply with its policies, and did not complete an adequate assessment of Mr B's condition, medication, and ongoing care requirements. A number of staff at Corrections failed to administer prescribed medications, and placed Mr B's health at risk. The practice of pre-signing for the administration of medication meant that the medication record was not necessarily an accurate reflection of the medication administered.

9. Accordingly, Corrections failed to ensure that Mr B was provided with services with reasonable care and skill, and breached Right 4(1).

Recommendations

10. The Deputy Commissioner recommended that Corrections conduct an audit of Receiving Office documentation and administration of "own supply" medication, the administration of prescribed medications, and the completion of Initial Health Assessments.

11. The Deputy Commissioner also recommended that Corrections provide training to Health Services staff at the corrections facility on the importance of accurate documentation and the unacceptability of pre-signing documents.

Complaint and investigation

12. The Commissioner received a complaint from Mr B about the services provided by the Department of Corrections. The following issue was identified for investigation:

- *Whether the Department of Corrections provided care of an appropriate standard to Mr B.*

13. This report is the opinion of Kevin Allan, Deputy Commissioner, and is made in accordance with the power delegated to him by the Commissioner.

14. The parties directly involved in the investigation were:

Mr B	Consumer/complainant
Department of Corrections	Provider

Also mentioned in this report:

Dr C	General practitioner

15. Independent expert advice was obtained from a registered nurse (RN), Vivienne Josephs, and is included as Appendix A.

Information gathered during investigation

Introduction

16. This report considers the care provided to Mr B while he was a prisoner from 11 October 2016.

Receiving Office at the corrections facility

17. Mr B has HIV, coronary artery disease, and peripheral vascular disease. At the time of these events he was 58 years old and he required daily medication for coronary vascular disease, and twice daily medication for HIV.

18. On 10 October 2016, Mr B was discharged from a public hospital. He had been admitted with chest pain.

19. On 11 October 2016, Mr B was received as a prisoner at the Receiving Office.

20. Mr B was seen by a registered nurse, and a Reception Health Triage was completed. A Reception Health Triage is the first opportunity for the Health Services staff to obtain information about prisoners who need health services while they are in prison, and it is to be completed on the day of reception.

21. The nurse recorded that Mr B had been diagnosed with HIV eight years previously, and that he had brought with him his own supply of medications for both HIV and coronary artery disease. However, the nurse did not document on Mr B's medication chart that he had his own supply of medication. Mr B was under the care of a specialist at the public hospital regarding his HIV.

22. Mr B was assessed as "triage priority 2 — semi urgent need". This assessment means that a prisoner requires follow-up for his medication. The nurse recorded in the Reception Health Triage: "Booked to see GP tomorrow for review and meds prescription."

23. Mr B's discharge from hospital the previous day was not recorded in the Reception Health Triage. The importance of retroviral[1] medicines and the impact if they are withheld was also not recorded.

24. The Complaint Review[2] stated: "[The registered nurse] advised he gave a dose of the medications to Mr B. The RN recorded in the RHT [Reception Health Triage]: 'Due afternoon medications given'."

25. Mr B told HDC that he did not receive any medication on 11 October 2016.

26. Corrections told HDC:

> "[W]hen prisoners bring their own medications with them, the medication is stored in a container. This container is labelled with the name of the medication, the dose required and the time that the medication needs to be administered. The Health Care Assistants [HCAs] administer the medication by taking the containers with them on the medication round and administering the medicines to the patient in the unit."

[1] Retroviral medicines treat HIV.

[2] Corrections conducted a Complaint Review following a series of complaints made by Mr B about having not received his prescribed medication.

27. Corrections also told HDC :

> "The [registered nurse] then labelled the medications as being for [Mr B] and stored the medication bottles in the medication room. A standard medication file was also created."

28. The Complaint Review stated:

> "Once the RO [Receiving Officer] duties were complete he (the RN) took the bottles of medication and put them on the counter in the medication room and made a 'blue medication file' up and left a note on the medications that these medicines were for [Mr B]."

29. An Initial Health Assessment was not completed at this time, or at any other time during Mr B's incarceration at the corrections facility. An Initial Health Assessment is to be completed by a registered nurse after the Reception Health Triage, and is required for all new prisoners. An Initial Health Assessment may include a referral to a medical officer if indicated. The timeframe for completion of the Initial Health Assessment is based on the triage scale guide allocated during the Reception Health Triage. The Complaint Review stated:

> "As a triage 2, an Initial Health Assessment (IHA) would be completed within 24 hours. [Mr B] did not receive an Initial Health Assessment or assessment by the Medical Officer regarding his HIV status, his medications or his recent hospitalisation for chest pain in the 10 weeks he was incarcerated at the corrections facility."

30. Corrections told HDC that the Receiving Officer sent an "Advice of Prisoner Health Status Form" to custodial staff, advising: "[Mr B] was discharged from hospital yesterday due to chest pain. Can we please put him under 60 min obs ARU [At Risk Unit] for medical reasons until seen by GP tomorrow." This information was not recorded in the Reception Health Triage.

Administration of medication on 12 and 13 October 2016

31. On 12 October 2016, the Administration Support Officer requested medical records from Mr B's specialist at the public hospital, and from his general practitioner (GP).

32. Mr B was not seen by the corrections facility GP on 12 October 2016. Dr C told HDC that he was one of the doctors involved in Mr B's care at the corrections facility. Dr C stated:

> "I formally charted and prescribed all his medication on 12 October 2016 after verifying his own supply after checking his medication history and allergies etc. He had been triaged by a reception health nurse on arrival, he had a stable medical condition with no acute medical issues and he was under regular review by nursing staff. [Mr B] met all the criteria for starting his medication without seeing a doctor in the first instance.

> To my knowledge, medication from the patient's supply is used until packaged medication arrives from our contracted pharmacy."

33. Mr B did not receive his medication on 12 and 13 October 2016. This was noted in the Medication Administration Record, but the HCA who recorded the information did not bring it to the attention of a registered nurse or other health provider.

34. The Complaint Review stated:

> "The HCA rostered to do medication administration in [Mr B's] unit on the 12 and 13 October 2016 did not administer the medication to him. When interviewed the HCA described finding [Mr B's] 'medications' in a brown paper bag in the medication room and said she did not give the medications nor did she escalate this to an RN. *She said she saw them there but was not sure what to do with them*."

35. The entry on the Patient Medical History dated 12 October 2016 records:

> "Arrived last night with own medication which is being charted by GP today. Has missed [main] dose of HIV medication."

Administration of medication from 14 October 2016

36. The medication prescribed by the corrections facility GP arrived from the pharmacy on the evening of 13 October 2016.

37. On the morning of 14 October 2016, Mr B complained that he had not received his medication. The Patient Medical History records:

> "[Mr B was] irritable and angry … Demanded an explanation from me as to why he had not received his medication since coming to prison … Not willing to accept any answer I could give and became more irritable and elevated thus interview terminated."

38. The Medication Administration Record documents that the morning medications for 14 October 2016 were given, but that the afternoon medications for 14 October 2016 were not given.

39. Mr B told HDC that his medication was not given on 19 and 20 October 2016.

40. The Medication Administration Record documents that the medication was given on 19 and 20 October 2016.

41. Mr B told HDC that he did not receive his medication on 23 October 2016.

42. The entries on the Medication Administration Record for 23 October 2016 were completed and annotated. Corrections told HDC:

> [The annotation for the morning of 23 October 2016] records that the medication was refused by [Mr B]. The HCA involved in this administration process […] has since left. Therefore an explanation regarding the specific annotation cannot be obtained."

43. Corrections stated that in respect of the afternoon dose on 23 October 2016:

> "The annotation made by the HCA for the evening of 23 October 2016 records that the medication was withheld. The explanation provided by the HCA in the electronic health record is that there was an insufficient number of custodial staff available to provide the support required to conduct a safe medication administration round. In this instance, the missed medication was not escalated to the registered nursing staff on duty, nor the Health Centre Manager."

44. Mr B told HDC that he did not receive his medication on 24 October 2016.

45. The Medication Administration Record documents that Mr B received his morning and afternoon medication on 24 October 2016.

46. The Patient Medical History for 24 October 2016 states: "Meds issued this morning."

47. On 31 October, Mr B was moved to a new unit.

48. The Medication Administration Record documents that the morning dose was given but that Mr B was absent for the evening dose.

49. Corrections told HDC:

> "[Mr B] had moved units with no notification and health staff were unable to locate him in the unit during the medication administration time."

50. On 7 November 2016, Mr B was required to appear in court. The Medication Administration Record documents that the morning medication was given but that Mr B was absent for the evening medication round.

51. Corrections told HDC:

> "[Mr B] was marked absent during the afternoon medication administration time as he was at court and not on site."

52. Mr B told HDC that his medication was not given on 22 November 2016.

53. The Medication Administration Record documents that the morning and afternoon medications were given on 22 November 2016.

54. Mr B told HDC that his medication was not given on 23 November 2016.

55. The Medication Administration Record documents that on 23 November 2016 Mr B was absent for the morning medication round but that the afternoon medication was administered.

56. The Patient Medical History for 23 November 2016 states that Mr B "did not come to window for morning [doctor's prescription] today".

Complaint Review findings in respect of Mr B's subsequent care

57. The Complaint Review made the following findings:

- "[Mr B's] care was not at the expected standard of the Department of Corrections Health Services. It would be expected that [Mr B] received a nursing health assessment within 24 hours of his arrival. This assessment would provide a coordinated approach and plan of care to manage his health issues, specifically his HIV status, medication management and secondary level care follow up and his recent hospitalisation for chest pain."

- "The instances of missed medication are not up to the expected standard of care."

- "The Assistant HCM [Health Care Manager]advised that pre signing of medications is normal practice at the corrections facility however this is not considered best practice. It highlights the potential inaccuracies that can occur if an HCA has pre-signed the medication signing sheet, then completed the round and then omitted to update the signing sheet on return from the medication round. At [the corrections facility] a signed medication signing sheet is therefore not necessarily a record of the medication being given. The Medicines Policy and procedure does not support pre signing of medications."

- "On 8 November 2016 the Assistant HCM met with [Mr B] to discuss the issue of missed medications. The explanations given to [Mr B] as to why his medications were missed included — there were no custodial staff available to assist with the medication rounds — he was transferred to a different unit and the health staff were not aware of the move — he was in court. These explanations are reflective of [the staff's] poor compliance to process or no process to enable timely management of care and custodial barriers. They are not in the control of [Mr B] and required the manager to appropriately manage and escalate the issues to ensure [Mr B] received his medications at the prescribed times."

Policies

The Initial Health Assessment Policy and Procedures (IHA Policy)

58. The IHA Policy provides that all prisoners must be referred to a medical officer for assessment where "[t]he prisoner has a health condition that is currently being managed by a secondary or tertiary service" or where a new prisoner is over 45 years of age.

59. The IHA Policy also provides that an Initial Health Assessment is to be completed by a registered nurse for all new prisoners who remain in custody after seven days.

Health Services Medicines Policy and Procedures (The Medicines Policy)

60. The Medicines Policy provides that all nurses are able to issue a prisoner's own supply of medication on reception if the pharmacy label is intact and the medication is in its original packaging. A prisoner's own medication can be used only until medication has been supplied by the pharmacy.

61. The nurse is required to record the medication name in the prisoner's electronic file in the daily record, and assess the type of medication, the purpose for the prescription, and the impact if the prescription is withheld. In addition, the prisoner's own supply of medication is to be stored in the Health Centre medication room, and "using own medication" is to be recorded on the prisoner's medication chart.

62. Paragraph 8.1 outlines the policy for the administration of medicine. It states: "Nurses must adhere to the instructions of the prescriber … Medications must be administered within an hour either side of the prescribed time."

63. Paragraph 8.2 of the Medicines Policy provides: "[I]f a dose [of medication] has been missed the Nurse must investigate why this occurred and assess what further clinical intervention is required."

64. Paragraph 9.2 requires that if a medication dose is missed, refused, or withheld, then that must be recorded on the signing sheet and on the prisoner's electronic file.

65. Paragraph 14 provides that Health Services staff "[a]ssess whether medication is suitable to go to court with the [prisoner], or for Custody staff to provide to the [prisoner] at court".

Further information

66. Mr B's physician at the public hospital supervises the care provided to Mr B for HIV and coronary artery disease. He told HDC:

> "Failure to consistently take medications for HIV infection can rapidly result in the emergence of resistance to these medications. The number of missed doses from [Mr B's] time in [prison] is quite capable of causing this outcome. The development of drug resistance would have significant long term implications for [Mr B's] health. I consider that the failure to provide normal medical care to [Mr B] during the time he has been in [prison] has posed a significant threat to his health."

Changes made by Corrections

67. Corrections told HDC that the following changes have been made:

- The Local Operating Manual, which outlines the processes within a prison, has been revised and updated to take account of the remand population at the corrections facility.
- All medication is administered exclusively by registered nurses or enrolled nurses. HCA's are no longer involved in the medication management process.

- Medication is administered before the prisoners are unlocked or after the prisoner is locked up, which reduces the risk of the prisoner not being present in his cell.
- The corrections facility has employed additional health staff, including an additional nurse at the Receiving Office and a transfer nurse to arrange the appropriate handover when a prisoner transfers to another prison or is required in court.

Responses to provisional opinion

Mr B

68. Mr B was given an opportunity to comment on the "information gathered" section of the provisional opinion. He advised HDC that he had no further comments to make.

Corrections

69. Corrections was given an opportunity to comment on the provisional opinion. Corrections advised HDC that it supports the investigation and the provisional opinion, and that it would implement the Deputy Commissioner's recommendations.

70. Corrections advised HDC that it has provided Mr B with a formal written apology.

Opinion: Department of Corrections — breach

Overview

71. The Corrections Act 2004 (the Act) states that "a prisoner is entitled to receive medical treatment that is reasonably necessary". The Act requires that the "standard of health care that is available to prisoners in a prison must be reasonably equivalent to the standard of health care available to the public". In addition, in accordance with the Code, Corrections has a responsibility to operate its health service in a manner that provides consumers with services of an appropriate standard.

72. Prisoners do not have the same choices or ability to access health services as a person living in the community. They do not have direct access to medication or to a GP. They are entirely reliant on the staff at the Health Service to assess, evaluate, monitor, and treat them appropriately.

73. The staff at the Health Service did not provide Mr B with adequate assessments and evaluation, and failed to provide him with medication on numerous occasions. While individual providers have responsibility for these failures, in this case there were multiple failures by multiple providers, and that will be the focus of this report.

Assessment at Receiving Office

Assessment of "own supply" of medication

74. On 11 October 2016, Mr B was received at the corrections facility. Mr B has HIV and coronary artery disease, and brought with him his own supply of medication for these conditions.

75. The Medicines Policy requires the nurse at the Receiving Office to assess the medication provided by a new prisoner, and determine its purpose and the impact of withholding the medication.

76. I accept the advice of Mr B's physician that if Mr B's HIV medication is not taken consistently, a resistance to the medication can develop. The development of a drug resistance would have significant long-term implications for Mr B's health.

77. As noted in the corrections facility's Complaint Review, there is no documentation to indicate that there was an assessment of the importance of retroviral medication, or of the impact on Mr B if the medication was withheld.

78. Mr B's medical condition and his medications were documented at the Receiving Office. However, the registered nurse did not comply with policy, and did not evaluate the significance of the medication or the impact it would have on Mr B's health if it were withheld. I am critical of the registered nurse's failure to do so.

Use of "own supply" of medication

79. The Medicines Policy requires the nurse to determine whether it is appropriate for a patient to use his own medication and, if so, to record this information on the medication chart. This is to assist the nursing staff when preparing medication rounds.

80. The nurse who triaged Mr B at the Receiving Office recorded that Mr B brought with him his own supply of medication. However, the nurse did not document this on the medication chart.

81. The nurse took the medication to the medication room so that it could be given to Mr B until the pharmacy supply arrived. The nurse said that he made up a medications file and left the medication on the counter with a note. The health care assistant who was to administer the medication the next day said that she found the medication in a paper bag, but did not know what she was meant to do with it. The health care assistant did not administer the medication or escalate the issue to a registered nurse.

82. I am critical that the registered nurse did not record "using own medication" on Mr B's medication chart. I am also critical that the health care assistant did not administer the medication or escalate the matter to a registered nurse when she was unsure what action she was meant to take. As a result, on 12 and 13 October 2016 the medication was not administered.

Initial Health Assessment

83. The IHA Policy requires a registered nurse to complete an Initial Health Assessment for new prisoners who have been in custody for seven days.

84. Corrections stated that Mr B was triaged as "triage 2", and that in his case an Initial Health Assessment should have been completed within 24 hours of his arrival.

85. Mr B was incarcerated at the corrections facility for 10 weeks, and an Initial Health Assessment was not completed.

86. I am critical that the IHA Policy was not complied with, and that an Initial Health Assessment was not completed.

Assessment by GP

87. Corrections' IHA Policy requires that new prisoners who are over 45 years of age or who are being managed by a secondary or tertiary service must be referred to a medical officer for assessment. Mr B met both criteria and was referred to a medical officer, but was not seen for assessment. Dr C advised that Mr B met the criteria for starting his medication without seeing a doctor.

88. Corrections was aware of Mr B's age, his recent hospitalisation with chest pain, his HIV status, his ongoing need for heart and HIV medication, and that he was under the care of a specialist at the public hospital. I am critical that Corrections staff did not ensure that Mr B was assessed by a medical officer in a timely manner.

Summary

89. The policies at Corrections require Health Services staff to record all relevant clinical information, to assess the impact of withholding medication, to record the use of a prisoner's own supply of medication, to refer the prisoner to a medical officer for review when appropriate, and to complete an Initial Health Assessment.

90. My independent expert advisor, RN Vivienne Josephs, advised that the policies that were in place met the expected standard to enable an appropriate initial assessment to be undertaken. However, the policies were not complied with. She stated:

> "There was poor clinical assessment by nursing staff in reception in appreciating the significance of [Mr B's] medications and of his recent admission to hospital with chest pains …
>
> In my opinion, there was a moderate departure from the expected standard regarding [Mr B's] medications. There were policies and procedures in place that were not followed that compromised [Mr B's] well being."

91. A robust initial assessment was critical to enable the Health Services staff to obtain an accurate picture of Mr B's baseline condition and to develop a plan for his care. The registered nurse at the Receiving Office was aware that Mr B was receiving medication for

HIV and coronary artery disease. However, he did not record that Mr B had recently been hospitalised with chest pain. He also failed to record the impact on Mr B if he did not receive his medication, or that he was to use his own supply of medications. A health care assistant did not recognise or question whether Mr B's own supply of medication was to be used. In addition, an Initial Health Assessment was not completed by Health Services staff within the required timeframe or at any time during Mr B's incarceration. I am critical that the corrections facility did not comply with its policies and, as a result, failed to assess Mr B adequately at reception.

Administration of prescribed medication

92. Mr B and Corrections agree that on the following occasions Mr B's own supply of prescribed medication was not administered:

- 12 October 2016 First and second dose
- 13 October 2016 First and second dose
- 14 October 2016 Second dose

93. Corrections policy provides that prisoners can be given medication from their own supply until it is supplied by the pharmacy. The registered nurse at the Receiving Office decided that it was appropriate for Mr B to use medication from his own supply.

94. RN Josephs advised:

> "In not adhering to the [Corrections] policy and not providing [Mr B] with his regular medications, there was a moderate departure from expected practice."

95. I am critical that Mr B was not provided with medication from his own supply on these dates.

96. Corrections stated that on subsequent dates Mr B's prescribed medication was not given for the following reasons:

- 23 October 2016 "First dose was 'refused' [no explanation]. Second dose was withheld because there were no custodial staff available."
- 31 October 2016 "Second dose not given because [Mr B] moved to a new unit and could not be located."
- 7 November 2016 "Second dose not given because [Mr B] was at court."
- 23 November 2016 "First dose not given because [Mr B] was absent and did not come to the window for his prescription."

97. Corrections accepts that on these dates, by failing to escalate the issue of missed doses to a registered nurse for review, staff had "poor compliance to process or no process to enable timely management of care".

98. By 13 October 2016, Mr B's supply of prison-prescribed medication had arrived from the prison pharmacy. There were policies and procedures in place for situations when medication was not administered because the prisoner was absent. This included instances where a prisoner was required at court or was being moved to another location. When a medication dose is missed, a registered nurse must investigate why this occurred and assess whether further clinical intervention is required. Mr B did not receive all of his medication, and the missed doses were not escalated by the health care assistants to a registered nurse for review. Corrections staff were required to administer Mr B's medication as prescribed, and to investigate the reason for a missed dose, and I am critical that staff failed to do so.

99. In addition, Mr B told HDC that he did not receive medication on the following dates:

- 11 October 2016 First and second dose
- 19 October 2016 First and second dose
- 20 October 2016 First and second dose
- 24 October 2016 First and second dose
- 22 November 2016 First and second dose

100. The Medication Administration Record documents that medication was administered on these dates.

101. However, the Complaint Review found that pre-signing of the medication sheet was normal practice at the corrections facility at the time. The Review notes: "At [the corrections facility] a signed medication sheet is therefore not necessarily a record of the medication given."

102. RN Josephs advised that the practice of pre-signing the medication sheet is a moderate departure from the expected standard. In light of the practice of pre-signing, I am unable to rely on the information on the medication sheet, as the practice means that the medication sheet is not necessarily a record of the medication given. I am therefore unable to make a finding as to whether the medication was administered, and I am critical that pre-signing was normal practice.

103. I note Corrections' advice that pre-signing no longer occurs, and I commend this change in practice.

Conclusion

104. A number of staff at Corrections failed to provide Mr B with an appropriate standard of care. Corrections staff did not comply with its policies, and did not complete an adequate assessment of Mr B's condition and his medication and ongoing care requirements. The practice of pre-signing for the administration of medication meant that the medication record was not necessarily an accurate reflection of the medication administered. In addition, a number of staff at Corrections failed to administer prescribed medications, and

placed Mr B's health at risk. Mr B had no control over his access to medication, and was reliant on the staff at Corrections to provide him with adequate care. It is unacceptable that they did not do so. Ultimately, Corrections was responsible for the delivery of services to Mr B by its staff. I consider that Corrections failed to ensure that Mr B was provided services with reasonable care and skill, and, accordingly, that Corrections breached Right 4(1) of the Code.

Recommendations

105. Following consideration of the changes introduced by Corrections as a result of this incident, I recommend that Corrections:

a) Conduct an audit of the following:

- The documentation and administration of "own supply" medication by the Receiving Office at the corrections facility
- The completion of Initial Health Assessments
- The administration of prescribed medications at the corrections facility

b) Report the outcome of the audits to HDC within six months of the date of this report, including information about the action it is taking to address issues arising from the audit.

c) Provide training to Health Services staff at the corrections facility on the importance of accurate documentation and the unacceptability of pre-signing documents. Evidence of the training is to be provided to HDC within three months of the date of this report.

Follow-up actions

106. A copy of this report with details identifying the parties removed, except the Department of Corrections and the expert who advised on this case, will be sent to the Office of the Ombudsman, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent nursing advice

The following expert advice was obtained from a registered nurse, Vivienne Josephs:

"Thank you for the request that I provide clinical advice in relation to the complaint from [Mr B] about the care provided to him by [a] Correctional Facility. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

Documents reviewed — [The] Health Centre Manager response dated 16 December 2016 — Response of GM Organisational Performance Department of Corrections dated 8 March 2018 — Medical advice from [general practitioner] — Complaint by [Mr B] — Affidavit by [Mr B] — Department of Corrections response dated 8 March 2018 — Medicines policy and Procedure October 2008, reviewed and updated 2016 — Initial Health Assessment Policy and Procedures — June 2010, reviewed and updated June 2013 — Health services Health Care pathway — November 2003, reviewed and updated — October 2015 — Department of Corrections Complaint Review done by […] — undated.

Complaint [Mr B's] complaint concerns omissions in the administration of his regular medications for HIV following his incarceration at [the corrections facility] on 11 October 2016. [Mr B] states he was not given any medication on 11 October 2016, 12 October 2016, and 13 October 2016 and on the afternoon of 14 October 2016. Additionally, there were 4 occasions between 23 October 2016 and 23 November 2016 where [Mr B] did not receive his medications. The reasons given were (i) [Mr B] could not be located (ii) [Mr B] was in court and (iii) no explanation was given.

Clinical Advice I have been asked to advise on:

1. Whether there is a departure from the expected standard for the administration of medication and if so, to what extent?

There is a moderate departure from the expected standard relating to the administration of medication to [Mr B].

[Mr B] arrived at [the corrections facility] on the afternoon of 11 October 2016 with his own packaged and labelled medications. He was seen by an RN and a Reception Health Triage Assessment (RHT) was completed. The RN and [Mr B] discussed his current medications including those for HIV. It was documented that he had his own medications in the clinical notes but no note was added to the Medication record. There is no documentation where his medications were taken. Clinical notes state he was given his afternoon medications but this is disputed by [Mr B]. He was then booked by the nurse to have his medications prescribed the following day and to see the GP.

His medications were charted and ordered on 12 October 2016. There is no documentation on the Medication Administration Record (MAR) or in the clinical notes that he was given his medications on the 12 or 13 October 2016 from either his own supply or the pharmacy supply which arrived on the evening of the 13 October 2016. The Department of Corrections Medication Policy states that prisoners should be given medication from their own supply until the script can be supplied from the facility's pharmacy. This was not documented on the MAR. Clinical notes state that [Mr B] was told by the HCA that he didn't get his medications because they were waiting for the doctor to chart his medications which was not according to policy. In not adhering to the facility's policy and not providing [Mr B] with his regular medications, there was a moderate departure from expected practice.

On 23 October 2016, [Mr B] refused his morning medications (no explanation given) and in the evening it was withheld as there was no custodial staff available to assist with the safe administration of the medication. There doesn't appear to have been a process for escalation of the missed medications to the RN staff on duty or the Health Centre Manager. The work of the HCA is to be guided and overseen by the RN. This lack of escalation, lack of oversight of the HCA and non documentation of the reasons for non administration of medications would be seen as a moderate departure from expected standards.

On 31 October 2016, [Mr B] moved units and the health staff were not notified. They were unable to locate him and the medications were omitted. There does not appear to have been a process of escalation when patients are transferred from units and are unable to be located for the purpose of medication administration.

On 7 November 2016, [Mr B] was in court. He was marked absent on the MAR and missed his medication. There was a facility policy in place for administering of medications whilst at court. There was non adherence to this policy. Absences were notated in the MAR on 7 November 2016, 11 November 2016 and on 14 December 2016. None of these were documented in the clinical notes and no explanation was given of these omissions.

2. Whether the policies and processes for the administration of medication in place at the time are to the expected standards. If there is a departure from the expected standard, to what extent?

In the [corrections facility's] response dated 8 March 2018 and in the Complaints Review, it was agreed that the level of care provided to [Mr B] did not meet the expected standards.

6.1 This policy details the clinical indications for when prisoners should be referred to a medical officer for assessment. It states that this applies when there are prisoners on current medication or 'the prisoner has a health condition that is currently being managed by a secondary of tertiary service'. It states that 'all health centres must have a written process in place for how and who is responsible for actioning any medication requirements following an assessment'. This meets expected standard. It

appears that there was poor clinical assessment by nursing staff in reception in appreciating the significance of [Mr B's] medications and of his recent admission to hospital with chest pain.

7.1.–9.2 Medications Policy and Procedures describes the pre, post and during administration guideline for medications. The policy only mentions the nurse as managing the administration process and the requirements and information required of the nurse during that process. The role of the HCA assisting in the medication process is not documented in this policy. If the HCAs were the main dispensers of medications at the time of this policy it would be considered a mild departure from expected practice that they are not referenced in this policy.

8.1 and 8.2 'Medications must be administered from a central area and must be under the supervision of custodial staff where the environment supports this' and 'if cells must be visited, custodial staff must accompany heath services staff'. There was no reference in this policy as to what action to take if custodial staff not available. It appears the HCA tried three times to contact custodial staff for assistance but was unable to do so. The absence of documentation regarding the process of escalation in the situation where medications cannot be administered due to the lack of custodian support was identified in the Complaints review. Not having an escalation plan for missed medications due to lack of custodial support is a moderate departure from expected practice. This policy also states the need for missed doses to be escalated to the RN on duty so they can be investigated and a decision made on the appropriate clinical action. This policy, had it been complied with, met the expected standard.

8.2 The medication policy only has reference to 'the Nurse' as someone who can administer medications. There is no reference to the HCA's role or responsibility to the RN in relation to medication management. This is a mild departure from the expected standard.

9.2.1 Medications policy and Procedures. Post Administration Documentation states the need to record medication which was withheld or refused, any variation to what was prescribed, and the reasons why medication was withheld/refused or missed. It also requires recording of any clinical assessments relevant to the medication management of the patient. This policy, had it been complied with, met the expected standard.

10.1 Patients on Medication on Reception Policy: This policy detailed the use of the patient's own medications until the prescription was able to be filled by the pharmacy. In [Mr B's] case, there was non adherence to this policy but the policy met the expected standard.

10.2 Patients own Medication on Reception Procedure: This policy required assessment of the medication, details of the medication and the impact if it is withheld. It doesn't implicitly state that this is to be documented in the clinical notes. It also states that the patient must be informed of their medication, the documenting of the same, storage of the medication and that the use of the patient's own medications must be documented on the MAR. This meets expected standard.

14.1 Medications policy and Procedures when going to Court describes the process that all practicable steps are taken to ensure a patient's medication regime is maintained when transferring off site for court appearances. This meets expected standard.

5.11 The Health Services Manual describes the Reception Health Triage Assessment (RHT) which is performed at reception and according to the policy, 'is to ensure that the prisoner's immediate health needs are met in a timely manner'. At this assessment any medication requirements can be identified. This meets the expected standard.

There was no policy or procedure for notification if a prisoner had moved units and was not able to be located at the time of the medication round.

3. Whether the current policies and procedures are to the expected standard

It was acknowledged in the [corrections facility's] response that there was non compliance with the current policies at the time leading to [Mr B] missing his medications. A discussion was held for all staff and plans were made for training and an overview in December 2016 of the Medication Policy and Procedures. Written reminders of the existing policy were also given to health care staff.

Current policies now address the situation where a prisoner does not present for his medication or is absent from the unit by requiring the custodial officer to communicate with the nurse as to the prisoner's whereabouts. 1.13.1 describes the allocation of custodial staff to assist with medication if required. 1.13.6 states the importance of ensuring continuity of medications and explains that if a prisoner has moved units since the previous medication round, this will be delivered to him in the new unit. If the medication is unable to be delivered to him it will be escalated to the RN who will assess the significance of the missed medication. This rationale is to be documented in Medtech by the RN. If the prisoner is absent from the unit, his medications signing sheet will be signed as absent and his name and the reason for his absence will be documented in Medtech and entered into the Daily Log Sheet — Medication Administration. This policy meets expected standard.

In [the corrections facility's] response of March 2018, it was outlined that a meeting in December 2016 outlined the need for a written process to be developed to stipulate the escalation processes for health staff if there are any constraints on administering medications. The process appears to be in place with the new policy and meets expected standard.

All health staff are now required to report on the conclusion of their medication round prisoners who refuse medications or prisoners that were absent from their cell. The information is then escalated to the nurse on duty who prepares a report that is collected at the end of each shift by the HCM. Medications are now all administered by RNs or enrolled nurses (ENs). A new medication administration process was implemented in early 2017 whereby all rounds are done before or after the patients are unlocked. It is then the prisoner's choice to accept or refuse medications. This reduces the risk of patients not being reviewed in their cells. This new process is

documented in the Local Operating Manual (LOM) and is supported by the Prison Director and custodial staff. This meets expected standard.

The plan that was put in place following the interview of the 8 December 2016 where it was decided that [Mr B] attend the health centre to collect his morning medication, was documented on 12 December 2016 to have been successful and [Mr B] is documented as being *'very satisfied with the plan and requested that it continue'* .

New processes were documented in the [corrections facility's] response letter of 16 December 2016 to have been put into place to ensure there is follow up on those prisoners who are absent or fail to present for medication administration. These incidences go directly to the Prison Director or Deputy Prisoner Director immediately and all health staff must report to the Health Centre manager or Assistant Health Centre manager on completion of their medication round. The custodial officer in the housing unit is notified and then documented in the file. Staff must also document the reasons for missing doses of medication.

The process of health staff being required to report on those prisoners who refused medication or were absent from their cell, at the conclusion of their medication round, and the information being escalated to the nurse on duty who prepares a report that is collected at the end of each shift by the HCM, meets expected standard. The current policy now covers medication management when prisoners transfer between units. This was not present before the complaint and meets expected standard.

For [Mr B], a new process for medication administration was commenced on 12 December 2016 where he presented to the health centre twice a day to receive his medications and sign the register.

The Department of Corrections Complaint Review (undated) clearly identified the nursing issues regarding the medication omissions and, in my opinion, the rectifications have addressed the issues.

<u>Other Concerns</u>

In the Department of Corrections response of 8 March 2018 and in the Complaints Review it describes [Mr B] as being placed in the ARU on admission to [the corrections facility] *as he had been discharged from hospital yesterday* (no date documented) *due to chest pain.* The nurse in the RO sent an 'Advice of Prisoner Health' to custodial staff advising that [Mr B] be put on 60 min observations in the ARU for medical reasons until seen by the GP the following day. There is no documentation in the clinical notes of this or of any clinical observations. The reasons for [Mr B] being in the ARU is not clear from the clinical notes. With this background, as well as the significance of his HIV medication [Mr B] should have been reviewed by the GP on the 12 October 2016 when his medications were prescribed. The clinical notes state that he was for GP review, but this didn't occur. He also had a statin and aspirin as part of his medications for ischaemic heart disease which he also missed on the 12 and 13 October. I would consider this a moderate departure from practice of providing timely care.

There is no discussion in the file regarding the capacity of [Mr B] to administer his own medications since this was his first incarceration. Section 20.4.1 states that the Risk Assessment for Self-Administration of medication Form can be completed to facilitate this. He had been diagnosed with HIV 8 years ago and following discussion with the RN at reception triage was shown to be knowledgeable about his medications.

There is a dispute regarding administration of medications on the afternoon of 19 and 20 October 2016. There are also discrepancies on the 22 and 23 November 2016 between [Mr B] and the MAR. [Mr B] states he did not receive his medications on those days but they have been signed as having been given in the MAR. The Complaints review found that there was a 'normal practice at [the corrections facility] of pre signing medications sheet before the medication had been administered'. This is a moderate departure from expected standard and needs to be documented as being an unacceptable practice rather than 'not considered best practice' as documented in the Review.

Conclusion

It is a reasonable expectation that prisoners in a corrections facility continue to receive their regular medications either from their own supply (as stated in Corrections' health care policy manual) or from the facility pharmacy supply. If there are reasons why this cannot occur, not only do they need to be documented in the clinical notes and the MAR, solutions for the potential omission need to be sought or the difficulty escalated in order for a prisoner's well being not to be compromised.

In my opinion, there was a moderate departure from the expected standard regarding [Mr B's] medications. There were policies and procedures in place that were not followed that compromised [Mr B's] well being.

Following [Mr B's] complaint, the Complaints Review undertaken by [the corrections facility] stated that their analysis 'highlights deficits in their system and processes, in inadequate nurse assessment and documentation and very limited delegation and direction at [the corrections facility]'. It detailed poor staff compliance to process or the absence of procedures for escalation leading to constraints on the timely administration of [Mr B's] medications.

[The corrections facility] now has a regulated nursing workforce of Enrolled and Registered Nurses administering medications and policies that have specific guidelines for delegation and escalation of issues that constrain timely medication administration.

Viv Josephs, RN, BHSc, PGCert (Nursing)
Nursing Advisor
Health and Disability Commissioner"