

Aria Bay Senior Living Limited

Caregiver, Mr D

Caregiver, Mr E

**A Report by the
Deputy Health and Disability Commissioner**

(Case 16HDC01162)



Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. At the time of these events in 2016, Mrs A (aged in her late seventies) was a full-time rest-home level resident at Aria Bay Senior Living Limited (Aria Bay).
2. Mrs A had several serious health conditions, and she was prescribed several medications including warfarin.
3. On 16 May 2016, Mrs A was administered another resident's medication.
4. On 4 and 5 June 2016, Mrs A was administered an incorrect dose of her prescribed medication warfarin.

Findings

5. It was found that by failing to ensure that staff followed good medication administration practice and Aria Bay's Medication Management Guidelines; by not having adequate oversight to ensure that the registered nurse on duty and the Clinical Manager adhered to relevant professional standards; and by not having in place adequate systems and processes to prevent medication errors from occurring and re-occurring, Aria Bay failed to provide Mrs A with an appropriate standard of care, and breached Right 4(1) of the Code.

Recommendations

6. It was recommended that Aria Bay:
 - a) Provide a written letter of apology to Mrs A's family for the breach of the Code identified in this report.
 - b) Provide an update about the changes put in place following these medication errors, with regard to:
 - i. administration of medication; and
 - ii. training and requirements for ongoing medication competency.
 - c) Conduct an independent audit on the frequency and nature of medication errors since June 2016 to date, and provide a report on:
 - i. the impact of medication errors (if any); and
 - ii. the steps taken to prevent medication errors from occurring.

Complaint and investigation

7. The Commissioner received a complaint from Mrs B about the services provided to her mother, Mrs A, by Aria Bay Senior Living Limited. The following issues were identified for investigation:

- *Whether Aria Bay Senior Living Limited provided Mrs A with an appropriate standard of care between 1 May 2016 and August 2016 (inclusive).*
 - *Whether Mr D provided Mrs A with an appropriate standard of care between 1 May 2016 and August 2016 (inclusive).*
 - *Whether Mr E provided Mrs A with an appropriate standard of care between 1 May 2016 and August 2016 (inclusive).*
8. This report is the opinion of Rose Wall, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.
9. The parties directly involved in the investigation were:
- | | |
|--------------------------------|-------------|
| Mrs B | Complainant |
| Mr C | Complainant |
| Mr D | Provider |
| Mr E | Provider |
| Aria Bay Senior Living Limited | Provider |
10. Information from Clinical Manager (CM) F and a medical centre was also reviewed.
11. Also mentioned in this report:
- | | |
|------|---------------------------|
| Dr G | General practitioner (GP) |
| Ms H | Village Manager |
| Ms I | Caregiver |
| RN J | Registered nurse |
-

Information gathered during investigation

Introduction

Mrs A

12. At the time of these events in 2016, Mrs A was a full-time rest-home level resident at Aria Bay.
13. Prior to her arrival at Aria Bay and when aged in her late forties, Mrs A had suffered a stroke (a subarachnoid haemorrhage secondary to a berry aneurysm¹), and she had suffered a further aneurysm² approximately 10 years later. Prior to Mrs A becoming a full-time resident at Aria Bay, Mrs A's husband had taken care of her.

¹ A bulge in a cerebral artery that resembles a berry or sac in shape and typically occurs at an arterial junction in the circle of Willis (a ring of arteries at the base of the brain).

² An abnormal blood-filled bulge in a blood vessel, especially an artery, resulting from weakening of the vessel wall.

14. Mrs A had several serious health conditions. At the time of these events, Mrs A was prescribed several medications, including warfarin.
15. Mrs A did not have the capacity to make informed decisions for herself. Her son, Mr C, told HDC that he acted on Mrs A's behalf as her attorney for her personal care and welfare.
16. This report relates to an event on 16 May 2016 when Mrs A was administered another resident's medication, and to events on 4 and 5 June 2016 when Mrs A was administered an incorrect dose of her prescribed medication warfarin.

Aria Bay Senior Living Limited

17. Aria Bay is owned and operated by Aria Bay Senior Living Limited.³ Aria Bay offers serviced apartments and a rest home. At the time of these events, Aria Bay had two GPs, including Dr G, who was Mrs A's GP. Both GPs visited the residents at least twice a week and also provided routine examinations.

Clinical Manager F

18. At the relevant time, Aria Bay had a registered nurse Clinical Manager, CM F.⁴ CM F became an employee at Aria Bay in the nineties, and worked at the facility as a nurse. She was then employed to facilitate doctors' rounds, and in 2016 she was appointed as Clinical Manager.
19. The caregivers and registered nurses reported directly to the Clinical Manager. CM F told HDC that her responsibilities included the management of clinical care plans for the rest home residents; carrying out residents' assessments (interRAI); directing residents' care to the registered nurses and care staff; communicating with the in-house multidisciplinary team, outside services, and families; and the initial investigation into any accident or incident that occurred on site, and reporting these to the Village Manager. CM F was also responsible for ongoing staff education and training, and the development of in-service planning.

Mr D — caregiver

20. Mr D commenced employment as a caregiver at Aria Bay in 2015. Prior to the occurrence of relevant events described in this report, Mr D completed internal training in medication competency. Mr D also received training in medication administration through an external organisation.

Mr E — caregiver

21. Mr E commenced employment as a caregiver at Aria Bay in the nineties. Mr E's Individual Education Records record that he completed internal training in medication competency in 2015, and medication administration competency in 2016.

³ Aria Bay is part of a retirement village group.

⁴ CM F is no longer employed as the Aria Bay Clinical Manager.

Employment agreements for caregivers

22. Mr D's and Mr E's employment agreements stipulated that they were to carry out the duties and responsibilities of their position with reasonable skill, care, diligence and to the best of their ability, to observe and comply with all rules, policies, and procedures in force and as updated from time to time, including in any Employee Handbook, and to take all practicable steps to perform their job in a safe and healthy way for themselves, their fellow employees, and any other person.

Medication error, 16 May 2016

23. On 16 May 2016, caregiver Mr D administered letrozole⁵ 2.5mg to Mrs A, when the medication had been prescribed for another resident.
24. That morning, Mr D had arrived at Aria Bay for the 6.45am to 2.30pm work shift, and started administering medications to residents around 7.30am. Mr D stated:
- "I check the right drug, right dose, right route, right time, right person and I also counted the pills. As I am about to give the scheduled medication of [Mrs A] I saw her talking to another carer ... I opted not to enter her room and decided to give her medication right after her talk with [the] other carer. So, I brought back her blister pack to the drug trolley and started checking the medication of my next resident ..."
25. Mr D said that he was about to enter the next resident's room to administer medication when he heard yet another resident choking. He went to that resident's room immediately, and assisted her and made sure that she was safe. Mr D stated that he was anxious and distracted by the incident. He said that he returned to the trolley, picked up the medication he had already put out for the next resident and, instead of administering the medication to that resident, he walked into Mrs A's room and gave her the other resident's medication.
26. Mr D told HDC that he realised the error almost immediately. He said: "I noted that there were only [three] pills on her hand which supposedly it should be [four] pills." He asked Mrs A to stop taking the medication. However, he stated: "Unfortunately, of the ... pills she was able to swallow one of [them]. And so I immediately informed my manager and the nurse and prompt proper intervention was done."
27. Mr D told HDC:
- "I would like to sincerely acknowledge my mistake in making a medication error in relation to [Mrs A]. It was an honest mistake which is why I immediately informed my manager and the nurse and explained to them what happened. I know on my part that I have committed an error ..."
28. CM F told HDC that after arriving at Aria Bay on 16 May 2016, and during a handover with the Village Manager, Ms H, Mr D arrived and alerted her and Ms H to the medication error.

⁵ An anti-oestrogen drug used for women who have undergone treatment for oestrogen-positive breast cancer.

CM F stated that she and Ms H checked Mrs A and directed Mr D to do “a set of baseline observations”. However, CM F did not document her directions to Mr D. Mr D told HDC that he was asked to report the incident in an Accident/Incident Report Form.

29. Aria Bay told HDC that Mr D did not take any specific observations, and that Mr D stated that he had been instructed by the Clinical Manager to “observe for any changes to the resident”. Mr D said that he was not asked to do any recording, and did not understand that any further recordings were required, as the Clinical Manager had already assessed Mrs A. Aria Bay and Mr D told HDC that he checked for any changes in Mrs A’s cognition every 30 minutes, and that after an hour he took her to reception, where she could be observed by the receptionist.
30. On the same day at 8.02am, CM F sent a fax to Dr G advising that Mrs A had taken letrozole 2.5mg that morning, when it had been prescribed for another resident. The fax also stated that CM F had not given Mrs A her usual morning medications and would await directions from Dr G. On a copy of the fax that was provided to HDC by Aria Bay, the following instructions are noted: “Fill in incident report. Continue with regular medications.”
31. CM F documented in the Accident/Incident Report Form: “Staff member not following process. This should not happen ... Dr G directed to continue [with] normal meds.” CM F also documented: “Staff member will complete a medication [competence]. Staff member will have a one on one teaching session with the Clinical Manager, Wednesday [18 May 2016]. [Mr D] not to perform any further medication rounds.”
32. In the progress notes, CM F documented: “[Mrs A] received a wrong medication this morning. Son informed. Dr G informed. With held Quetiapine this am ...”
33. CM F told HDC:

“[Dr G] directed that one of [Mrs A’s] morning medications be withheld, Quetiapine, but to give the other usual medications as prescribed ... I sighted [Mrs A] multiple times that morning, and I saw her going out with her husband just after lunch had finished ...”
34. CM F also told HDC that she telephoned Mr C and informed him of the medication error. According to the information recorded in the Aria Bay Accident/Incident Report Form dated 16 May 2016, Mr C was informed of the incident at 8.45am.
35. Directly after being informed of the medication error, Mr C made a formal complaint to the Aria Bay management. On 24 May 2016, Ms H formally wrote to Mr C and informed him that Mr D had given Mrs A medication that had been prescribed for another resident.
36. Ms H also informed Mr C that the incident had been investigated fully, and described the following as the outcomes and follow-up:

- During the monthly Registered Nurse meeting on 18 May 2016, the Clinical Manager led a reflective practice meeting to discuss this incident and to explore ways to reduce medication errors, and strategies to avoid interruptions during medication rounds.
- Further reflective practice meetings were held by Ms H on 16, 17, 18, 19, and 20 May 2016 with morning and night duty staff to discuss the medication error and to explore strategies to improve the safety of medication administration. Staff on duty were asked to respond to bells and in the first instance respond to emergencies to minimise interruptions to the staff member undertaking the medication round.
- The delivery of the medication management lecture for caregivers and registered nurses who administer medications was increased from once a year to three times a year.
- A toolbox teaching programme was set up by Ms H to enable the Clinical Manager and the on-duty registered nurse to provide medication administration training at the morning and afternoon handovers.
- To help to minimise interruptions, vests labelled “Medication Round in Progress” were to be purchased and used by the staff member undertaking medication rounds.
- The evening shift was increased from two to two and a half hours to permit the tea shift attendant to help to serve the evening meal so that the caregiver not administering medications could supervise the floor and be available to respond to residents’ queries.

Medication errors, 4 and 5 June 2016

37. Mrs A was prescribed 1mg of warfarin during the weekends and 2mg of warfarin during week days, to be taken at dinner time.
38. On 4 and 5 June 2016 (a Saturday and Sunday), caregiver Mr E documented on the Aria Bay PRN⁶ and/or Non-packed Medicine Signing Sheet for monitoring warfarin that he had administered Mrs A 2mg warfarin at 5.00pm on each of these days.
39. When checking Mrs A’s warfarin monitoring chart on 6 June 2016 (Monday), caregiver Ms I observed that Mr E had documented that he had administered 2mg of warfarin to Mrs A on 4 and 5 June 2016. She recorded this in an Accident/Incident Report Form. Ms I also telephoned the on-call registered nurse, RN J, for her advice.
40. RN J documented in the Accident/Incident Report Form that she had received a telephone call from Ms I about the medication errors, and had advised Ms I to withhold Mrs A’s warfarin for the night of 6 June 2016. RN J also documented that she advised Ms I “to do Mrs A’s observations”. Ms I documented in the Accident/Incident Form that RN J advised her “to take [Mrs A’s] recordings [observations] but [Mrs A] refused only managed to take [saturation of peripheral oxygen] ...”.

⁶ As required medication.

41. In a statement made to Aria Bay on 7 June 2016, RN J said: “I told [Ms I] to document any adverse symptoms or behaviour that [Mrs A] may be displaying and to take her recordings ...”
42. RN J also documented in the Accident/Incident Report Form that she telephoned CM F, who asked her to arrange an urgent INR⁷ for Mrs A the following morning. In response to my provisional opinion, RN J told HDC that she relayed this information to Ms I. It was also recorded on the form that the family had been informed of the medication errors at 10.30am on 7 June 2016 (Tuesday), and that the doctor had been informed, although the date and time at which the doctor was notified is not documented.
43. CM F told HDC that she was not on duty or on call and did not document her precise steps. She also stated:
- “I was phoned by the on call RN, [RN J]. [S]he explained what had happened with the Warfarin, and the error, we agreed that we would withhold the Warfarin dose for that evening 6 [June] [20]16; we would get a blood test for an INR the following morning.
...
On my return to work on Wednesday [8 June 2016], I did not document my discussion with [RN J] ...”
44. In response to my provisional opinion, CM F told HDC that at the time, Aria Bay did not have medical after-hours cover. The Aria Bay GPs were not available to take telephone calls after clinic hours and over the weekend.
45. Medication records provided by Aria Bay confirm that Mrs A’s warfarin was withheld on 6 June 2016.
46. In her statement to Aria Bay, RN J said:
- “I phoned [Dr G] [Mrs A’s] GP and informed him of what had happened. He was unhappy about the mistake that had been made and felt his instructions had been quite clearly written ... I phoned [Mrs A’s] son [Mr C] and also informed him of the incident ... [Mr C] called into Aria Bay around 12.10 to see [Mrs A] and ... [h]e said that we should have got medical advice in view of the fact that [Mrs A] had a previous stroke ... He suggested that it would have been better if we had the urgent INR done yesterday ... and also informed her [next of kin].
...
In hindsight this should have happened and I apologised to [Mr C] that we hadn’t sought medical advice or notified [next of kin] ...”
47. In response to my provisional opinion, RN J said that when she spoke with Dr G he also had told her that medical advice should have been obtained and an urgent INR carried out, and that the next of kin should have been informed earlier. RN J also told HDC that Aria Bay’s

⁷ International normalised ratio — a blood test to determine how well blood clots.

two GPs were not always available for advice because of their busy practices, but that Ms H had worked towards obtaining comprehensive medical cover for Aria Bay residents.

48. In a letter dated 10 June 2016 to Ms H, Dr G stated:

“I had already expressed how upset I was with the news, to the nurse who called me on Tuesday morning. This is a formal letter to register my concern and to seek written feedback from yourself on this incident ... I would have expected the interventions you put in place following the first incident, would have been sufficient to prevent what happened with the wrongful Warfarin dose.”

49. Dr G also stated in his letter to Ms H:

“Another concern was that the Warfarin dose was stopped without an INR being done immediately ... That result could have dictated the next plan of action. However, in [Mrs A’s] case her medication was stopped without seeking medical advice as to a suitable course of action. Medical advice was only sought from a GP ([Dr G]) on the next working day following a long weekend!!!”

50. Mr E became aware of his errors on being informed when he returned to work on the night of 6 June 2016. On 10 June 2016, Mr E made a recording of the incidents that had occurred on 4 and 5 June 2016 and stated that at dinner time on 4 June 2016 when he was checking the warfarin sheet for Mrs A’s dose, a resident had asked him a question. He said that he “looked at the box marked medication dose and saw 2mg misreading it”. He next answered the resident’s question. He then realised that Mrs A had gone back to her room, so he finished handing out medications to the residents in the dining room and took Mrs A’s warfarin to her room and administered it.

51. Mr E recorded that on the following day, “dinner was similar to Saturday. [Mrs A] had gone back to her room.” Mr E recorded that the resident who had distracted him the previous day was again restless and distracting. He stated: “As I read the Warfarin as 2mg at dinner on Saturday, I read it as 2mg on Sunday as well.” Mr E documented that he informed Ms H of the medication errors on 7 June 2016.

52. Mr E told HDC:

“I was responsible for ensuring that the right resident received the right medication, following the five rights; [r]ight resident, right medication, right time, right route and right dose. I did not give the right dose ...”

53. On 20 June 2016, Ms H wrote to Dr G and stated:

“The medication error involving the 4th and 5th June regarding the administration of warfarin is distressing and like yourself I was not notified of this incident until Tuesday 7th June when I arrived on duty. I made the instruction for you to be notified immediately.”

Response to the provisional opinion

54. Mrs B was provided with an opportunity to comment on the “information gathered” section of the provisional opinion. Where relevant, Mrs B’s response has been incorporated into the report. Mr C was provided with an opportunity to comment on the “information gathered” section of the provisional opinion. Where relevant, Mr C’s response has been incorporated into the report. Mr C noted that Aria Bay has made changes to its processes and has adopted new processes following these events.
55. CM F was provided with an opportunity to comment on the relevant section of the provisional opinion, and her response has been incorporated into the report where relevant.
56. CM F also told HDC:
- “I greatly regret that my documentation at the time of these events was not up to the standards of the Code of Conduct for Nurses. I have reflected on this many times over the last two years, and have changed my practice in regards to this.”
57. CM F further advised HDC that the events that occurred were experiences that challenged her and led her to re-evaluate her career pathway.
58. RN J was provided with an opportunity to comment on the relevant section of the provisional opinion, and her response has been incorporated into the report where relevant.
59. RN J told HDC:
- “I agree that errors have been made and again, I can only apologise for any part that I may have had in that process with regard to following correct procedure and documentation.”
60. Mr E was provided with an opportunity to comment on the relevant section of the provisional opinion, but did not respond further.
61. Mr D and Ms I were provided with an opportunity to comment on the relevant sections of the provisional opinion, but did not respond further.
62. Aria Bay was provided with an opportunity to comment on the provisional opinion. Where relevant, Aria Bay’s response has been incorporated into the report.
63. Aria Bay also told HDC:
- “A drug error is by its very nature a breach of the Code — we acknowledge that administering the wrong drug to the wrong resident is a failure to provide safe and appropriate care ... we acknowledge that administering the wrong dosage of medication to a resident is a failure to provide safe and appropriate care.”

Medication Management Guidelines

64. Aria Bay had Medication Management Guidelines in place. The relevant parts from the guidelines outline the following:

“Clinical Guideline — Medication Management

Purpose: To administer medications in a safe and timely manner that complies with all current legislation and regulatory requirements.

...

- All residents have the right to a quality medication system ‘the right dose being administered to the right person in the right form at the right time’.
- All medicines have the potential for harm if not prescribed, dispensed and administered correctly.

...

- The person administering the medication must know when and how to administer, as well as why and when to administer.
- The person administering the medication must be able to recognize the adverse effects of these medicines and respond appropriately.
- Medications are administered by Registered Nurses, Enrolled Nurses and Caregivers (who have successfully completed the Medication competency training: written and practical)
- All RN’s EN’s and CG’s with medication competency are tested annually.

...

Medication Administration Procedure for Pre-Packed Bottled Medication

Standard:

Right dose to the **right** person in the **right** form at the **right** time by the **right** route.

...

- Right person: Identify the Resident by name and using the photo identification on the medication chart/sheet then checked against the blister/robotic pack.
- Right time: Check the medication pack is the same as the instructions on the medication chart/sheet and those instructions correspond with the right time.
- Right tablets: Count the tablets and identify tablets against the Medication Prescribed Chart/sheet as correct.
- Right person: Tell the resident that you have their medication, always inform Resident of what their tablets are when they ask.
- Right person: Administer medications directly from the pack to the Resident; ensure the Resident has fluids to take the medication with.

- Right form: Make sure the instructions such as, oral, rectal etc and or 'take with food' 'without food' etc are adhered to.
 - Right time: Ensure oral medications are swallowed; remain with the Resident until all the medications are taken. Do not leave for the Resident to take later.
- ...
- If the wrong medication is administered, inform the senior staff member on duty immediately who will then inform the doctor. Complete an Accident/ Incident/CCI/Flash Form ...

Under no circumstances should a medicine be given to anyone other than the resident that it was prescribed for.

...

Medication errors

Aim: To detect and implement effective action immediately when a medication error has occurred to ensure the health and safety of the Residents.

Incorrectly administered medication consists of:

Category

Wrong drug:

- When medications were administered to the wrong Resident or the right Resident is given wrong drug.

Wrong dose:

- When an error was made in the calculation or administration of Medication.

...

Procedure

- Identify the problem with the medication
- Contact the Clinical Manager/Registered Nurse or on call Registered Nurse and relay the problem. You will be instructed as to what to do.
- Follow directives from Registered Nurse as she/he will call the Doctor/Medical Practitioner.
- Attend to the Residents immediate medical needs and ensure their safety.
- Complete the Accident and Incident/Near miss form.
- Incident must be reported on incident/accident/CCI/Flash form.
- [Village] Manager also must be notified, as incidents will be assessed as an in-service programme will be utilized to prevent further occurrence."

65. In terms of training, Aria Bay informed HDC that initially all staff who administer medications are required to undergo comprehensive medication administration training and pass a medication competency test. Thereafter, these staff members complete a medication competency test annually.

Relevant standards

66. The Code of Conduct for nurses states:

“Principle 4: Maintain health consumer trust by providing safe and competent care

...

4.8 Keep clear and accurate records.

...

Guidance Documentation

Keep clear and accurate records of the discussions you have, the assessments you make, the care and medicines you give, and how effective these have been.

Principle 7: Act with Integrity to justify health consumers’ trust

...

7.4 Act immediately if a health consumer has suffered harm for any reason. Minimise further harm and follow organisational policies related to incident management and documentation. A full and prompt explanation should be made by the appropriate person to the health consumer concerned and, where appropriate, their family about what has occurred and the likely outcome.

...”

Further information

67. Mr E told HDC that after the medication error occurred he was not permitted to administer medications until he had completed a further Aria Bay medication competency worksheet and had it signed off by a registered nurse. After the incident he also attended an in-service workshop on drug administration.
68. Mr E also told HDC that following these events, when administering medications to residents, first he administers warfarin to those residents who are prescribed the medication, as there is less distraction. If he is distracted by a resident when administering medication, he directs the resident to another staff member.
69. Mr D told HDC that when administering medications to residents he now makes sure that he is not distracted. He also now double checks to ensure that the correct medication is administered to the correct resident. If an emergency occurs that requires his participation, he locks the medication trolley, and on resuming the medication

administration he remains focused and alert. Mr D also told HDC that he apologised to Mrs A's family in person.

70. Ms H told HDC that on 10 June 2016 she completed a gap analysis. This report identified that a previous instruction from her (following a previous gap analysis done about five years ago) that there be two medication-competent staff on duty in the evening to administer medication, and that care staff competent in medication administration share the medication round in order to prevent the risk of medication errors owing to caregiver fatigue and long periods of concentration, had not been followed. The gap analysis identified a significant risk with permitting only one caregiver to administer medications in the evening to approximately 50–57 residents.
71. A memorandum, to take effect immediately, was sent to all registered nurses and care staff requesting that two people check the administration of warfarin. This requirement was also added to the Medication Administration Competency Assessment. Staff were informed that the nominated person in charge on each shift is responsible for notifying the family of any incident that occurs during their shift, and the Village Manager and the on-call nurse must be notified of serious incidents.
72. In addition, a new question was added to the Medication Administration Competency Assessment asking about the process to be followed by staff in the event of an interruption to the medication administration process.
73. Ms H informed HDC that following the gap analysis referred to above, two caregivers were placed on medication administration duty at additional cost, to minimise the risk of medication errors. Because no medication errors occurred after the system was implemented, in September 2016 the system was reviewed and staff and senior managers were consulted, and a decision was made to discontinue the system and to adopt the previous system of one caregiver administering medications.
74. Aria Bay informed HDC that after the medication errors of 4 and 5 June it was discovered that Aria Bay had been using incorrect signing sheets for warfarin administration. This was corrected, and warfarin administration to residents is now being signed for on the correct sheet.
75. Aria Bay stated that additionally the following changes have been made:
 - In June 2016, it critically reviewed the medication management system and sought an external independent audit, and all the recommendations from the audit have been implemented.
 - It is critically reviewing the system for responding to medication errors and, in particular, the training and requirements put in place to ensure ongoing medication competency, particularly when an error or ongoing errors occur. It is currently consulting with the retirement village group's Wellness and Care team⁸ on this matter.

⁸ The Wellness and Care team is responsible for developing and implementing the company's philosophy.

- It has completed the transition to the retirement village group's Policies and Procedures.⁹
 - It has introduced the eCase resident management system. It is anticipated that this system, which is being expanded to include the eCase Medication Management Module, will mitigate the risks associated with medication administration by eradicating "paper-based" or outdated systems that can lead to incorrect dosing or timing, distraction, and signature omissions. This is yet to be implemented.
 - It has reviewed, updated, and refined and implemented a group-wide orientation and induction programme in line with best practice across all its villages.
 - It has reviewed overall management and made a number of changes, which are not yet complete. These include the appointment of a new Village Manager, and the appointment of a Senior Clinical Manager to oversee clinical governance at Aria Bay, with a senior registered nurse clinical lead to provide on-site management on a daily basis. The expectation is to increase overall senior registered nurse support to the service and ensure that there is daily on-site registered nurse clinical oversight.
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Opinion: Aria Bay Senior Living Limited — breach

76. In accordance with the Code of Health and Disability Services Consumers' Rights (the Code), Aria Bay had overall responsibility for ensuring that Mrs A received an appropriate standard of care. Aria Bay needs to have in place adequate systems, policies, and procedures, and ensure that they are complied with to support the safe and appropriate administration of medication, and to ensure that staff respond appropriately when errors are made. There were a number of failings with regard to the management of medication and the subsequent care provided to Mrs A.

16 May medication error and subsequent actions

77. On 16 May 2016, caregiver Mr D administered Mrs A letrozole 2.5mg — a medication that had been prescribed for another resident.
78. As outlined above, Aria Bay's Medication Management Guidelines outlined that before administering medications to residents, staff were required to follow steps to ensure that the right resident received the right medication, at the right dose, at the right time, and through the right route.
79. Mr D was required to make sure that he was giving Mrs A medications that were prescribed for her by identifying her by name and by her photo identification on the

⁹ The Aria Group of Retirement Villages was bought by the retirement village group in July 2015, and the new retirement village group clinical policy documents were being finalised at the time of the medication errors. The formal rollout and implementation of the new policies occurred after these errors occurred in May and June 2016.

medication chart/sheet, and then checking against the blister pack. Mr D was also required to count the tablets and identify them against the Medication Prescribed Chart/sheet as being the correct tablets for Mrs A. He was then required to inform Mrs A that he had her medication, and administer Mrs A her medications directly from the blister pack.

80. Mr D told HDC that on 16 May 2016, he made sure that he had Mrs A's prescribed medications to be administered to her. However, because Mrs A was speaking with another caregiver, Mr D made the decision not to administer Mrs A's medication to her straightaway. When he went back to the task of administering Mrs A's medication to her, Mr D failed to refocus and follow the process in the Medication Management Guidelines to ensure that he had identified that the medications he was giving Mrs A were those prescribed for her, and in error he took another resident's medication to her. Mrs A took one of the medications before Mr D realised his error.
81. I acknowledge the challenges that caregivers can experience in performing their duties, including medication administration, and that Mr D was distracted on this occasion. However, for this reason, it is very important that medication administration procedures or guidelines are followed carefully. I am concerned that Mr D did not follow Aria Bay's Medication Management Guidelines properly, in particular by failing to ensure that he was administering the correct medication to Mrs A when he returned to the task after attending to other matters.
82. I acknowledge that Mr D informed CM F and Ms H as soon as he realised his error, and I am not critical of his actions after the medication error occurred. However, the subsequent actions of other members of staff led to the result that care provided to Mrs A on 16 May following the medication error was suboptimal.
83. The registered nurses and caregivers reported to CM F. CM F managed the clinical care plans of the rest home residents and directed their care to the registered nurses and caregivers. She dealt with the in-house multidisciplinary team and outside services, and obtained laboratory tests. CM F also conducted initial investigations into accidents or incidents that occurred on site, and reported these to the Village Manager.
84. CM F told HDC that on 16 May 2016, after being informed that Mrs A had been given another resident's medication, she and Ms H checked Mrs A immediately and asked Mr D to do a set of "baseline observations". CM F did not document the directions she gave to Mr D. Mr D said that he was asked to report the incident in the Accident/Incident Report Form. In addition, Aria Bay told HDC that Mr D advised that he was told to observe for any changes to Mrs A, and that he was not asked to do any recordings and did not understand that any were required. Aria Bay said that Mr D did not take any specific observations.
85. Given the different accounts of the instructions provided by CM F and Mr D, I am not able to make a factual finding as to what specific instructions CM F gave to Mr D. It is also unclear whether Mr D was given any information about the specific side effects that Mrs A might exhibit as a result of taking the incorrect medication. However, it is clear that Mr D

did not take any formal observations. I am concerned that CM F did not communicate her instructions to Mr D effectively, so that he clearly understood what was expected of him.

Documentation

86. According to the Code of Conduct for nurses, CM F was required to keep clear and accurate records of any discussions. In the case of a medication error, I consider that documentation of instructions is important for patient safety and continuity of care. I am therefore critical that CM F did not document her instructions to Mr D.
87. CM F also sent a fax to Dr G advising him of the error and seeking his instructions. The instructions noted on a copy of the fax provided to HDC were: "Fill in incident report. Continue with regular medications." On the same day, CM F documented in the Accident/Incident Report Form: "[Dr G] directed to continue with normal meds." However, CM F documented in the progress notes: "[Dr G] informed. With held Quetiapine this am ...". CM F told HDC that Dr G's directions were to withhold quetiapine but to give [Mrs A] her other medications as prescribed. While the reasons for it are unclear, I am very concerned that CM F's documented actions in the progress notes (that quetiapine was withheld) are inconsistent with the documented instructions she was given by Dr G as recorded in the Accident/Incident Report Form and as written on the fax that was sent to Dr G (that usual medications should be given).

Medication errors, 4 and 5 June 2016, and subsequent actions

88. Following the errors on 16 May, Ms H, the Village Manager, in her letter dated 24 May 2016 to Mr C, referred to various outcomes and follow-up actions aimed at preventing similar occurrences in the future. These included educating staff about the medication error, discussing strategies for preventing such errors, reviewing the systems in place, and reconfiguring staffing levels.
89. Despite these measures, further medication errors occurred.
90. On 4 and 5 June, Mr E did not follow the Aria Bay Medication Management Guidelines, and on each of these days administered an incorrect dose of warfarin to Mrs A.
91. Mr E told Aria Bay that when he was administering medications at dinner time on Saturday 4 June 2016, he was distracted by another resident while he was checking the medication sheet for Mrs A's warfarin dose, and he read the dosage incorrectly as 2mg instead of 1mg. He said that he then realised that Mrs A had gone back to her room, so he took her warfarin to her room and administered it after he had finished administering medication to the other residents. Mr E stated that he was distracted again on Sunday 5 June 2016 when reading the warfarin dosage, and again incorrectly read it as 2mg instead of 1mg. He again administered the warfarin to Mrs A in her room.
92. These errors were discovered by Ms I when she was about to administer warfarin to Mrs A at dinner time on Monday 6 June 2016. Mr E stated: "I was unaware of my mistake until [6 June 2016] when I came in for the Monday night shift when I was informed ..."

93. As discussed above, I acknowledge the challenges that caregivers can experience in performing their duties, including distractions from other residents. However, for this reason, it is very important that medication administration procedures and/or guidelines are followed carefully. For medications such as warfarin, it is particularly important to ensure that the correct dose is administered, because the effect of an incorrect dose can be profound. It is apparent from the fact that these two errors occurred, and from Mr E's explanation, that he failed to check properly that he was administering the right dose of warfarin to Mrs A. As a result, he administered an incorrect warfarin dosage to Mrs A on both Saturday 4 June 2016 and Sunday 5 June 2016. I find it highly concerning that Mr E, an experienced caregiver, could make the same medication error two days in a row and not realise that he had made the errors until he was advised.
94. Aria Bay's Medication Management Guidelines state that after a medication error occurs, the procedure is: "Identify the problem with the medication. Contact the Clinical Manager/Registered Nurse or on call Registered Nurse and relay the problem. You will be instructed what to do."
95. On 6 June 2016, when Ms I discovered the warfarin medication errors made by Mr E on 4 and 5 June 2016, she contacted RN J, the nurse on duty, for advice. RN J and Ms I both documented on the Accident/Incident Report Form that RN J advised Ms I to take Mrs A's observations and withhold the warfarin that night. In her statement to Aria Bay made the following day, RN J said that she also advised Ms I to document "any adverse symptom or behaviour that [Mrs A] may display".
96. RN J documented that she telephoned CM F, who asked her to arrange for an urgent INR the following morning. CM F told HDC that she agreed with the decision to withhold warfarin and to carry out an urgent INR the following day. Mrs A's warfarin was withheld on 6 June 2016.
97. I acknowledge that CM F was not on duty or on call on 6 June 2016 when she received a telephone call from RN J informing her that Mrs A had been given 2mg warfarin on 4 and 5 June 2016 instead of the prescribed 1mg. However, Aria Bay nurses reported to the Clinical Manager, and CM F was being consulted about the incident in her position as Clinical Manager.
98. The Code of Conduct for nurses requires a nurse to minimise further harm and follow organisational policies related to incident management and documentation. Where appropriate, a full and prompt explanation should be made by the appropriate person to the health consumer's family about what has occurred and the likely outcome. The Accident/Incident Report Form also includes a section for recording when the family is informed of any incident. The form also requires that a medical practitioner be consulted for advice.
99. Dr G expressed his concerns to Aria Bay that Mrs A's warfarin was withheld without seeking medical advice as to a suitable course of action, and before carrying out an

immediate INR. According to Dr G, the INR could have dictated the next steps. RN J told Aria Bay that, in hindsight, medical advice should have been sought or an urgent INR done.

Documentation

100. As outlined above, RN J told Aria Bay on 7 June 2016 that she had given Ms I some additional instructions that were not documented. It is unclear to me why RN J did not document these additional instructions in the Accident/Incident Report Form or the progress notes. According to the Code of Conduct for nurses, RN J was required to keep clear and accurate records of discussions.
101. CM F told HDC that while she did not document her precise steps, during the telephone call she agreed with RN J that Mrs A's warfarin dose for that evening should be withheld and that an INR should be done the following morning.
102. In the case of a medication error, I consider that documentation of instructions is important for patient safety and continuity of care. I am critical that both RN J and CM F did not document all the instructions and steps taken in relation to the errors of 4 and 5 June.

Aria Bay procedures and guidelines

103. I acknowledge that Aria Bay had the Medication Management Guidelines in place at the relevant time, and that staff received training on medication management. I also acknowledge that after Mr D's medication error, a number of actions were taken in response to the error.
104. Aria Bay Medication Management Guidelines state that the Village Manager should be informed of any incident so that it can be assessed and steps can be taken to prevent a further occurrence.
105. However, during the gap analysis conducted on 10 June 2016, Ms H identified a significant risk in terms of medication errors, in permitting only one staff member to administer medications to approximately 50–57 rest home residents in the evenings. In her gap analysis report, Ms H stated that the same risk had been discovered during a gap analysis undertaken around five years previously, and that an instruction had been given to have two medication-competent staff on duty in the evenings to administer medications to residents. However, Ms H found that this system was not being followed. She recorded that this had left "one caregiver in the evening being responsible for the administration of medications for some 50–57 residents".
106. Following the gap analysis, two medication-competent staff were allocated to check and dispense medication together, to minimise the risk of medication errors. I note with interest that this system was discontinued three months later when no further medication errors had occurred in that period.
107. I also note that there is nothing in the information provided by Aria Bay to HDC, including its Medication Management Guidelines, to indicate that at the time of these medication errors, the instruction that Ms H said had been given — namely that two staff members

administer prescribed medications to rest home residents together in the evenings — was in operation.

Conclusion

108. As I have stated previously in this report, it was Aria Bay’s responsibility to have adequate systems in place to ensure that the care it provided to Mrs A was appropriate. Aria Bay was also responsible for making sure that its staff followed good medication administration practice and followed the policies and procedures in place for the administration of medication. Aria Bay was also responsible for having proper systems in place to prevent medication errors from occurring and re-occurring and, in the event of a medication error, to ensure that appropriate action was taken. There were numerous failings. I find that Aria Bay failed to provide Mrs A with an appropriate standard of care for the following reasons (as outlined above):
- a) On 16 May 2016, Mr D did not follow the Aria Bay Medication Management Guidelines and administered Mrs A a medication that had been prescribed for another resident.
 - b) On 4 and 5 June 2016, Mr E did not follow the Aria Bay Medication Management Guidelines and on each of these days administered an incorrect dose of warfarin to Mrs A.
 - c) On 6 June 2016, when RN J was informed that Mrs A had been administered an incorrect dose of warfarin on 4 and 5 June 2016, RN J:
 - did not document in the Aria Bay Accident/Incident Report Form and the progress notes the additional instructions on next steps she gave to Ms I on that day;
 - advised Ms I to withhold Mrs A’s warfarin on the night of 6 June 2016, without obtaining medical advice and without obtaining an urgent INR; and
 - did not inform Mrs A’s next of kin and Ms H of the medication errors promptly.
 - d) Following the medication errors on 16 May 2016 and 4 and 5 June 2016, CM F:
 - did not effectively communicate her instructions to Mr D so that he clearly understood what was expected of him, and did not document the instructions she stated that she gave to Mr D;
 - documented in the progress notes that quetiapine was withheld. This action is inconsistent with the documented instructions she was given by Dr G (that usual medications should be given), and as recorded in the Accident/Incident Report Form and on the fax that was sent to Dr G; and
 - did not document the precise steps she took subsequent to the event. She also did not inform Dr G of the medication errors and seek his advice before agreeing to the decision to withhold warfarin that night or advise RN J to seek Dr G’s advice.

- e) It failed to ensure that the instruction Ms H gave after her previous gap analysis, to mitigate the risk of medication errors in the evenings, was followed.
109. In my view, by failing to ensure that the staff followed good medication administration practice and its Medication Management Guidelines, by not having adequate oversight to ensure that the registered nurse on duty and the Clinical Manager adhered to relevant professional standards, and by not having adequate systems and processes in place to prevent medication errors from occurring and re-occurring, Aria Bay failed to provide Mrs A with an appropriate standard of care, and breached Right 4(1) of the Code.¹⁰
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Recommendations

110. I note that after these events Aria Bay Senior Living Limited made some improvements to its processes. In light of this report, I recommend that Aria Bay Senior Living Limited:
- a) Provide a written letter of apology to Mrs A's family for the breach of the Code identified in this report.
 - b) With reference to paragraph 75 above, provide an update about the changes put in place following these medication errors, with regard to:
 - i. administration of medication; and
 - ii. training and requirements for ongoing medication competency.
 - c) Conduct an independent audit on the frequency and nature of medication errors since June 2016 to date and provide a report on:
 - i. the impact of medication errors (if any); and
 - ii. the steps taken to prevent medication errors from occurring.
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Follow-up actions

111. A copy of this report with details identifying the parties removed will be sent to the district health board, and it will be advised of the name of Aria Bay Senior Living Limited.
112. A copy of this report with details identifying the parties removed, except the name of Aria Bay Senior Living Limited, will be sent to the Ministry of Health (HealthCERT), Worksafe NZ, and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

¹⁰ Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."