Medication administration error
(15HDC01664, 21 June 2017)

Registered nurse ~ District health board ~ Medication error ~ Rights 4(1), 4(2)

A man, aged 73 years, had a complex medical history which included ischaemic cardiomyopathy (significant damage to the heart muscle) and a previous acute myocardial infarction (heart attack). The man was admitted to the emergency department at a public hospital with shortness of breath, leg swelling, diarrhoea and vomiting, and low blood pressure. A registrar completed the man's admission documentation and implemented a "Do Not Resuscitate" instruction, recording that it was "medically indicated".

The man remained in hospital and was later assigned to the care of a registered nurse (RN). At 9am, the RN reviewed the man's medical chart and noted the prescribed medication of 11.875mg metoprolol daily. The RN was unfamiliar with this dose of metoprolol and believed the doctor must have placed the decimal in the incorrect place and intended to write 118.75mg. The RN stated that she meant to check this dosage with a colleague, but became distracted and returned and gave the man 118.75mg.

At approximately 12pm, the RN reviewed the man and took his observations. She noted that his health, including his blood pressure, had deteriorated. The man also scored 4 on the early warning score (EWS) chart. The RN did not document any of these findings. She contacted medical staff regarding the man's observations and was provided with advice. The RN did not document this advice. She also did not notify the ward nurse, ensure that the man was reviewed by medical staff within 30 minutes, or monitor him every 30 minutes as was required by the hospital's EWS policy.

Later that day, at approximately 2pm, the man rang his call bell, and a health assistant attended to him. The health assistant informed the RN, who reviewed him and noted that his condition had deteriorated further. The RN contacted a house officer and requested that she review the man.

Medical staff reviewed the man's medication chart and identified that the RN had provided an incorrect dose of metoprolol. Following the identification of the error, the man was transferred to the Coronary Care Unit, where attempts were made to remedy his low blood pressure. The man's condition continued to deteriorate, and at 11.55pm he passed away.

By failing to provide the correct dosage of metoprolol to the man, by failing to notify the ward nurse of the man's EWS score of 4, and by failing to repeat observations following her identification of the man's EWS of 4, the RN did not provide services to the man with reasonable care and skill. Accordingly, the RN breached Right 4(1).

By failing to record the man's deterioration in health, by failing to document her discussions with other medical professionals, and by failing to document that a medication error had occurred once it was identified, the RN failed to provide services in accordance with professional standards and, as such, breached Right 4(2).

Adverse comment was made about the registrar who implemented the "Do Not Resuscitate" instruction for failing to document the reasons for the decision and any discussion that he had with the man about the decision.

The DHB was not found in breach of the Code.

The Commissioner recommended that the RN undertake further training on professional communication. The RN provided a letter of apology to the man's family for her breach of the Code, as recommended in the provisional opinion.

The Commissioner recommended that the Nursing Council of New Zealand consider undertaking a competence review of the RN.