HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Incorrect administration of eyedrop medication for community-based care client

1. On 22 January 2021 HDC received a complaint from Mr A about the care provided to his mother, Mrs B, by Nurse Maude[1] from July 2019 to March 2021. Mrs B was aged 82 years at the time of the events. She lived at home and received in-home support from Nurse Maude until her transition to residential care in March 2021.

2. Mr A raised concerns that Nurse Maude support workers failed to follow instructions in Mrs B's care plan[2] regarding the administration of her prescribed eyedrops. He also raised concerns that in various places there were incorrect instructions regarding the administration of Mrs B's eyedrops, and that staff failed to maintain proper records.

Information gathered

3. Mrs B had been monitored for glaucoma[3] since 2011 and had a diagnosis of vascular dementia.[4] She needed assistance and supervision to administer her eyedrops and other medication. Support workers were responsible for administering Mrs B's eyedrops as per the care plan.

4. Mrs B was prescribed two types of eyedrops. Latanoprost[5] (Teva) was stored in her fridge and administered once a day in the evening, one drop in each eye. Dortimopt[6] was stored in a medication safe and administered twice a day, one drop in each eye (once in the morning with other tablets and once in the evening with the Latanoprost).[7]

5. The instructions in the care plan for the administration of the eyedrops stated:

> 'Daily DHB Eye Drops PM:
>
> "LATANOPROST TEVA — instill[8] one drop into each eye AT NIGHT

[1] Nurse Maude provides an array of healthcare services, including home support and nursing care in the community.
[2] A document prepared by Mrs B's case manager (a registered nurse) and used by support workers to carry out their care tasks. The electronic version of the document provided by Nurse Maude has a printed date of 6 January 2021. It has no cover page, but each page is headed 'HOMECARE SERVICE PLAN'. Mr A provided photos of the hard copy of this document, which was kept at Mrs B's home. This version has a printed date of 15 January 2021 and has a cover page titled 'Home Support Plan'. Each page is headed 'HOMECARE SERVICE PLAN'. While there are some differences in the content of the documents, there appears to be no difference in the instructions regarding the administration of the eye drops.
[3] An eye condition that damages the optic nerve. This damage can lead to loss of vision or blindness.
[4] A general term describing problems with reasoning, planning, judgement, memory, and other thought processes caused by brain damage from impaired blood flow to the brain.
[5] Used for the reduction of elevated eye pressure.
[6] Used to lower raised pressure in the eye and to treat glaucoma.
[7] Mr A agrees that the medication administration details in the care plan at Mrs B's house were accurate.
[8] Administration of a medicine, generally in liquid form drop-by-drop.

Names have been removed (except Nurse Maude and the advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Stored in fridge[9]

DORTIMOPT — instill one drop into each eye

Store in safe

Daily DHB Med/Eye-Drops AM:

Remove from lock box

DORTIMOPT eyedrops instill one drop into each eye after instillation.'

6. Nurse Maude stated that the standard practice at the time was for all medication prescriptions for Mrs B to be collected from the pharmacy by family members or delivered to the house by the pharmacy. Nurse Maude also relied on information about prescriptions from Mr A by email and, on at least one occasion, on a Post-it note. Nurse Maude acknowledged that there is no record of any staff member sighting the original prescription for Mrs B's eyedrop medications.

7. On 8 January 2021 Mr A took Mrs B to Wellington Hospital for her four-monthly specialist eye appointment. He told HDC that the specialist was concerned that Mrs B's eye pressure had increased significantly and queried whether the prescribed eyedrops were being administered accurately.

8. Subsequently Mr A reviewed the progress notes written by the support workers and noticed that some support workers were recording that they were administering two sets of drops in the morning, which was not in line with the prescribing instructions on the Latanoprost packaging, or the care plan. On 13 January 2021 he emailed Mrs B's case manager at Nurse Maude to request that the correct information be set out clearly in the care plan and that further training be provided to support workers to ensure that the Latanoprost was being administered correctly. He also asked for email confirmation that his request had been actioned so that he could inform the eye specialist that the medications would be administered accurately from that point on.

9. The case manager confirmed on 13 January 2021 that the information in the care plan was accurate. She also assured Mr A that she would ask the lead support worker to follow up with the other support workers who regularly administered the eyedrops to Mrs B and ensure that everyone was following the care plan.

10. On 20 January 2021 Mr A emailed the case manager again and said that he had discovered several confusing notes at his mother's home regarding the administration of her eyedrops. These notes appeared in various documentation — the support worker progress notes,[10] on notes taped onto the medication safe and the front page of the care plan, in Mrs B's diary, and on the eyedrop bottles (see Appendix A).

11. Nurse Maude advised HDC that support workers who visited Mrs B had completed their medication competencies, including the administration of eyedrops, and that new support

[9] See Appendix A.

[10] The progress notes contain several confusing entries, including incorrect numbers of eyedrops administered and eyedrops administered at incorrect times of the day.

workers would complete the competencies during orientation. While the Medication Management Policy (2018) in place at the time of the incident provided general guidance, it did not include clarification of staff roles, delegation,[11] and transcribing[12] practices. The policy also did not state that medication instructions should be sourced directly from prescribers or pharmacies and did not include information about how support workers should be supervised or assessed.

12. Nurse Maude acknowledged that the processes it had in place in 2021 meant that Mrs B was not provided with optimal care. Nurse Maude apologised and informed HDC that it is reviewing its medication management policies and processes continuously to ensure that a similar incident does not occur again.

Independent advice

13. As part of my investigation, I sought independent clinical advice from registered nurse (RN) Ms Barbara Cornor (Appendix B).

14. RN Cornor acknowledged that all Nurse Maude support workers were well trained in the competencies required for the administration of eyedrops. However, she advised that the support workers consistently failed to follow the instructions provided for medication administration or to document their actions properly, resulting in multiple medication errors. RN Cornor advised that the progress notes[13] were misplaced frequently and, despite concerns raised by Mr A, Nurse Maude failed to implement a consistent system to ensure that the progress notes were secure and accessible.

15. RN Cornor identified several serious departures from accepted standards in relation to medication management. She advised that there was little evidence to confirm that the medication was administered consistently as prescribed in 2020 and 2021. Specifically, she noted the following:

- Instructions were recorded inconsistently;
- Some entries in the progress notes lacked detail, while others failed to specify which drops were given or when;
- Prescription changes were handled inappropriately;
- Pharmacy labels were altered; and
- New instructions were communicated informally, either through Mr A or by text from the coordinator to support workers, who often transcribed these instructions incorrectly in care records.

16. RN Cornor advised that the practices in place during the review period represented significant lapses both clinically and in safe care delivery. They not only breached

[11] Entrusting a task or responsibility to another person, typically someone less senior.
[12] In relation to medication administration, transcribing means copying or transferring a prescriber's instructions onto another document, such as a medication chart, care plan, personal plan, or any other document that will act as a record of medication administration.
[13] RN Cornor uses the term 'daily journal' in her advice instead of progress notes.

professional standards but introduced risks to Mrs B's safety. RN Cornor considered that the delegation of medication responsibilities from the registered nurses to unregulated support workers was managed poorly, with little evidence of supervision or accountability. Nurse Maude updated its Medication Management Policy in 2023 to resolve these issues.

Decision: Nurse Maude — breach

17. Under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code), Nurse Maude had a responsibility to provide services to Mrs B with reasonable care and skill. Mrs B relied on Nurse Maude to administer her eyedrops accurately to treat her glaucoma and prevent it from progressing to vision loss. I accept RN Cornor's advice that several support workers deviated from the instructions in the care plan when administering Mrs B's eyedrops, and that they failed to document accurate details of the medication they administered. Despite the errors being raised with Nurse Maude on 13 January 2021, the same errors continued for another week until 20 January 2021.

18. In my view, the failure by several staff both to administer the eyedrops correctly and to document the administration appropriately was in part a result of a lack of clarity in the Medication Management Policy. As noted by RN Cornor, the policy lacked the structure and clarity required to support safe and consistent medication practices. The policy did not define clearly who was allowed to transcribe, at times resulting in transcription being carried out by staff who should not have done so. In addition, the eyedrop medication administration instructions were not sourced directly from the prescriber or pharmacy, as required by the policy. Instead, the instructions came directly from Mr A, which increased the risk of error. While support workers were involved in medication administration, the policy provided limited guidance on how the tasks should be delegated and monitored.

19. Accordingly, for the reasons outlined above, I find that Nurse Maude breached Right 4(1) of the Code for failing to provide services to Mrs B with reasonable care and skill.

Changes made since events

20. I acknowledge that since this incident Nurse Maude has strengthened its policies and procedures, including updating its Medication Management Policy in 2023. The updated policy clearly defines the roles and responsibilities of registered nurses, enrolled nurses, and support workers. It states that support workers are strictly limited to administering medications by following prescription instructions provided directly by a prescriber or pharmacy, and that any changes to those instructions must also come from the prescriber or pharmacy. The policy includes clear guidance on transcribing. Care plans have been revised to exclude any direct instructions on medication administration, and instead they direct staff to read and follow the pharmacy-issued labels. The policy also outlines specific training and competency requirements with set times for reassessment. A new chart has been introduced to guide support workers in safe medication administration.

21. In response to the provisional opinion, Nurse Maude apologised unreservedly to Mrs B and her family, and acknowledged the distress caused. Since 2023 it has also implemented several further improvements, including the following:

- It has adopted the Ministry of Health's guidelines,[14] which state that all non-pre-packaged medications must be accompanied by a current and accurate medication chart completed by the prescriber.
- It has engaged with the New Zealand Nurses Organisation and the Nursing Council of New Zealand to ensure that its prescribing practices align with the Principles for Quality and Safe Prescribing Practice 2024.
- Case managers must undergo their own medication training, which includes a competency check, as well as complete the medication training provided to support workers, to understand the support workers' scope of practice. Case managers also complete a module[15] designed to enhance their understanding of direction and delegation in relation to medication support within home and community care settings. Case managers have also developed a letter to send to prescribers to request a current medication chart if one has not been provided already.
- Support workers now use a mobile app to confirm visits, report concerns, and access real-time updates, enhancing coordination of care by providing live data on visit information and enabling timely follow-up by case managers.
- It has upgraded its client record system, giving clinicians access to detailed care plan data, including timestamps and rationale for changes. Visit instructions are now tracked and shared promptly with the scheduling team, while leadership teams can audit all modifications for improved oversight.

22. I am satisfied that the revised policy and the above improvements provide greater clarity and accountability to support a safer and more consistent standard of care in relation to the administration of medication.

Recommendations and follow-up action

23. Further to the changes made by Nurse Maude, I recommend that Nurse Maude provide a written apology to Mrs B for the failings identified in this report. The apology is to be sent to HDC within three weeks of the date of this report.

24. I also recommend that Nurse Maude provide evidence of the updated client record management system now in place. This should include how version tracking is used to ensure that staff are working from the most up-to-date care plan. Evidence of this is to be sent to HDC within two months of the date of this report.

25. An anonymised copy of this report (naming only the advisor and Nurse Maude) will be sent to HealthCERT and Health New Zealand (Wellington and Hutt Valley District) and placed on the HDC website (www.hdc.org.nz) for educational purposes.

[14] Guidelines for Home and Community Support Service.

[15] Direction and Delegation course — RGQT007 is the course code provided on the Healthlearn portal via Health New Zealand|Te Whatu Ora. The description of the course is that it will assist healthcare staff to make decisions in relation to direction and delegation in a variety of healthcare settings.

Carolyn Cooper
Aged Care Commissioner

Appendix A: Outline of discrepancies in progress notes (13 to 20 January 2021) and in other documentation

Progress notes

A support worker's entry next to an asterisk at the top of the page of the progress notes says, 'Text from Coordinator 13/1/21 pm. Latanoprost is AM now with, (in fridge). Dortimopt (in safe). Only Dortimopt in evening (in safe).' Only the location of the medication is accurate in these instructions from the coordinator.

For the morning of 13 January 2021, the progress note says, 'Morning Medication Taken Eye drops in.' There is no mention of which eyedrops were administered. This is a medication error.

The progress note for the evening of 14 January 2021 says, 'Eye dp x1 in each eye + all good' and also 'Latanoprost eye drops in both eyes.' There is no mention of Dortimopt. This is a medication error.

The evening progress note for 16 January 2021 says, 'Dortimopt in both eyes. All good.' There is no mention of Latanoprost, which should have been administered in the evening. This is a medication error.

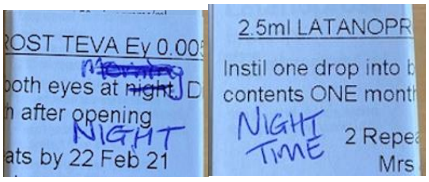
The evening progress note for 17 January 2021 says, 'Dortimopt in both eyes.' There is no mention of Latanoprost. This is a medication error.

The progress note for the morning of 18 January 2021 says, 'x 2 lots of eye drops in.' This may have meant that Dortimopt and Latanoprost were administered, when only Dortimopt should have been administered. The evening progress note says, 'Dortimopt drops in both eyes no latanoprost as these were given this morning,' which confirmed the medication error in both the morning and the evening.

The progress note for the morning of 19 January 2021 says, 'Eye drops done.' Again, there is no mention of which eyedrops were administered. This is a medication error. The evening progress note says, 'Dortimopt drops given as PM drops in fridge were again given in this morning these are for PM visit only,' which confirmed that Latanoprost was administered in the morning instead of the evening and there were medication errors in the morning and evening that day.

Other documentation

On the right-hand side of the prescription label on the Latanoprost box someone has crossed out the type-written word 'night' and handwritten 'morning'. This was then crossed out, and the word 'NIGHT' has been handwritten underneath. On the left-hand side of the prescription label the words 'NIGHTTIME' have also been handwritten.



Names have been removed (except Nurse Maude and the advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

On Monday 18 January 2021 Mrs B recorded in her diary, 'fridge eye drops done this morning' (Latanoprost is stored in the fridge and is to be administered in the evening only).

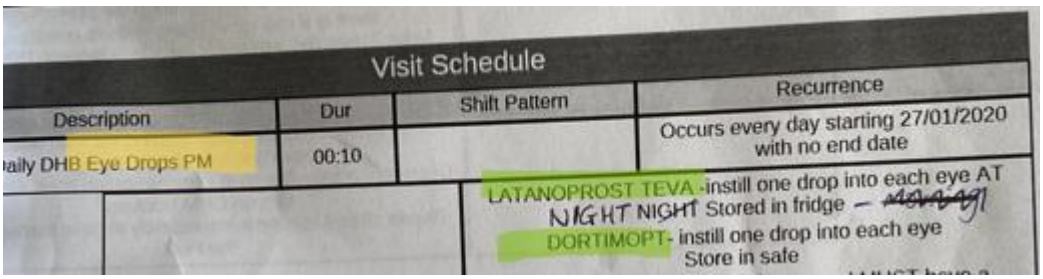
On 21 January 2021 Mrs B wrote, 'x 2 eye drops in morning x 1 eye drops at night' (it should be x 1 (Dortimopt) in the morning and x 2 (Dortimopt and Latanoprost) at night).

A handwritten note clipped to the front of the care plan reads, 'Please read Care Plan. Confirmed eyedrop LATANOPROST TEVA in fridge is to be given in the PM evening visit — NOT the morning Thanks [first name of RN] — Case Manager RN.' This information is correct. Another handwritten note has then been taped onto that note, partially covering it. This note reads, 'only use drops from safe for AM visit dont (sic) touch ones in fridge.' While that information is correct, it is unnecessary and creates more confusion.

A sign above the safe reminding support workers to keep it locked has a handwritten note taped to it, which reads, 'Drops in Here are to be given for morning visit only.' This instruction has the potential to be confusing because, while the drops in the safe were the only ones to be given in the morning, they were also given at night.

The hard copy of the care plan kept at Mrs B's home says:

> 'Daily DHB Eye Drops PM
> LATANOPROST TEVA — instill one drop into each eye AT NIGHT
> (handwritten) ~~NIGHT~~ [type written and crossed out by hand] Stored in fridge -~~morning~~ [handwritten and crossed out by hand]'



Appendix B: Independent clinical advice to Commissioner

The following independent advice was obtained from Registered Nurse BJ Cornor (Master Nursing) — T051169:

'**Complaint: Mrs [B] / Nurse Maude 21HDC00129**

The Commissioner has sought my opinion on the care provided by Nurse Maude to Mrs [B] between July 2019 and March 2021.

1. Whether the service plan for Mrs [B] was adequate/appropriate, including the appropriateness of directions given for managing possible challenging behaviour in a dementia client, and instructions for the eye drops.
2. Whether the administration of Mrs [B]'s eye drops in 2020 and 2021 occurred as prescribed.
3. Whether the nurses' delegation of their responsibilities to the support workers in relation to eye drop administration was reasonable.
4. Whether the policy/guidelines around obtaining up-to-date prescription changes was adequate/appropriate.
5. Any other issues you consider warrant comment or amount to a departure from accepted standards.

Nurse Maude Homecare Nursing Plan

- Dementia

The service plan for the appropriateness of directions for managing possible challenging behaviour in a dementia client appears to have been met. Mrs [B]'s Homecare Service Plan was specific to her current condition. It is difficult to determine how adequate or appropriate this was and what could have been done better (or not). Mrs [B]'s characteristics, behaviours and daily plans were identified. Support workers reported any issues and how they were resolved by them and/or her family. Statements provided by the support workers, support their care and their knowledge of Mrs [B] both professionally and personally over a period of time.

Apart from time discrepancies by Mrs [B], not being home on some visits and missing items there appears to be no unresolved issues. This is reflected in the daily journal completed by Support Workers (SW) following a visit. Although Mr [A] (Mrs [B]'s son) suggested the journal be kept in one place, it is noted there was a safe available and wonder if it would support the journal being locked away by the SW following their visits. A review of the missing journal and how to ensure its availability daily had not been conducted. It is recommended in future cases, to ensure daily reports and any changes can be recorded, this should occur.

Staff have been provided training in understanding and caring for [a]client [with dementia], and it is noted that training has been increased with the introduction of further support through "Understanding Dementia", an Australasian Programme.

Unfortunately, with dementia there is no black and white on how this disease will progress and no plan will be determinate.

Support Worker

Support workers are not regulated and do not have standardised educational preparation. The role is determined by their employer and outlined in their job description. Their activities are asked to be undertaken by a registered nurse who determines that the activity forms part of a nursing plan.

Nurse Maude Homecare Services has provided evidence of their responsibility to ensure the skills mix of the SW provides a safe standard of care to its clients. It is evidenced by job/role descriptions, continued training requirements and annual staff reviews.

- Eye Drop Administration

It is evidenced all Support Workers are well trained and their competency checked in the instilling of eyedrops (Eyedrops Application Competency Checklist and Eyedrop Administration Procedure). The Homecare Service Plan for Mrs [B] also provided support on where to find the procedure for instilling eyedrops and their expectations for reporting any concerns or abnormalities.

- Medication Management Policy

Medication Management knowledge appears limited and support from the Homecare Service Coordinator in the correct procedures was not evidenced.

Eyedrop Prescribing and Administration to Mrs [B]

The necessity for administration of eyedrops to any person commences with the prescriber (Doctor, specialist, nurse prescriber) providing written instructions (a prescription) to a pharmacist. It must be signed by the prescriber. The pharmacist dispenses the eyedrops in accordance with the instruction of the signed prescriber. The eye drops will be dispensed with a label which is attached. The label includes the name of the person who is to receive the drops, the dosage to be given, and the time of application.

Although the instructions were included in Mrs [B]'s plan of care there is minimal evidence the administration of Mrs [B]'s eye drops in 2020 and 2021 occurred as prescribed.

According to the journal it appears eyedrops were given to Mrs [B] twice daily. It is unable to be determined what drops were given as some SW have documented the number of drops given, others just "drops given" and a very small minority have named and numbered the drops they gave. This inconsistency in recording does not provide evidence that Mrs [B] consistently received the right eye drops at the right time.

The policy around obtaining up to date prescription changes was inadequate and not appropriate to ensure the safe delivery of the eyedrops to Mrs [B]. The process of the eyedrops being given as per the prescription was not followed in accordance with the

2020 Medication Management Policy. Instead of a new prescription being dispensed, the changes to Mrs [B]'s eyedrops were made by crossing out the pharmacist instructions on the current bottle and writing the latest instructions as advised by Mr [A] to the Nurse Maude Homecare coordinator. The coordinator also texted a SW with new instructions for application of the eye drops. These were transposed on to the journal, and in fact, were incorrect. Transposing of prescription requirements from a coordinator to a SW is a severe departure from accepted practice. Transposing of any prescription by any Registered Nurse is a severe departure from accepted practice.

The instructions on the Nurse Maude Homecare Service Plan from 06/01/2021 to 21/01/21 documented consistency in the required eyedrops dosage and reiterated the Latanoprost was to be given at night. The reviewer is confused over the process that the journal entry and the service plan are not matching.

Adding to the confusion is the email input from Mr [A] re required prescription changes. Communication was occurring between Mr [A] and Clinical Managers of Nurse Maude Homecare Services, but it is difficult to determine the communication and outcomes of those changes between coordinators and support workers. It appears there was little accountability of the coordinator (Registered Nurse) to evaluate whether the SWs carrying out the delegated activities were maintaining the required standards.

Recommendations for Improvement

- **Medication Management Policy**

Nurse Maude Homecare Services have updated their Medication Management Policy, 2023 to support the prevention of this incident occurring again. All new medicines, change in prescriptions must be received from the pharmacy with the instructions included on the label.

- There can be no transposing of medication changes.
- There can be no direction from client's family re the delivery of their family member's medications.
- All medications will be accompanied by a prescription.

The policy must be audited on a regular basis to ensure consistency in practice of all Registered Nurses and especially those responsible for the practice of their Support Workers.

Along with this, although Registered Nurses are not required to have training in the management of medicines it is recommended that there are regular updates on specific requirements for their roles. It is important they ensure the SW who has been delegated the activity of giving medications/eyedrops understands that procedure, is clear in what is expected and knows when to ask for help.

- **Delegation by a registered nurse**

To ensure all registered nurses at Nurse Maude Homecare are clear about their duties and responsibilities in delegation, it is recommended the skills and confidence are supported and guidance is provided on a formal basis.

Barb Cornor