Registered Nurse, RN C

Registered Nurse, RN D

Molly Ryan Lifecare (2007) Limited

A Report by the

Deputy Health and Disability Commissioner

(Case 19HDC01150)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to an elderly man by Molly Ryan Lifecare (2007) Limited, the Clinical Manager, and a registered nurse. The report highlights the need to ensure that medication training and policies are sufficiently robust to support all staff (including nonregistered caregivers) to administer medication safely, and that staff are suitably skilled to deliver the standard of care required.

2. The man had multiple existing health conditions and was prescribed morphine for worsening pain. Medication competency was a requirement before staff were allowed to administer stock-controlled medications such as morphine. However, on a night shift, neither the registered nurse nor the two caregivers on duty had met the medication competency requirements set out in the Medication Management Policy.

3. During the shift, the nurse was alerted that the man appeared to be distressed. The nurse drew up 2.5ml of subcutaneous morphine solution without checking the prescribed route of administration or calculating the dose. The subcutaneous morphine solution administered to the man contained 25mg of morphine, which exceeded the maximum quantity prescribed by a factor of five.

4. The nurse administered the solution orally at 4.11am. At 1.49pm it was reported that the man was unresponsive. Sadly, the man died at 8.50pm.

Findings

5. The Deputy Commissioner found Molly Ryan Lifecare (2007) Limited in breach of Right 4(1) of the Code for failing to provide the man with a "service from suitably qualified/skilled and/or experienced service providers", and for failing to ensure that the systems in place were sufficiently robust to ensure that all staff complied with the Medication Management Policy. The Deputy Commissioner was also critical that the Village disclosed the medication error to the man's family members and his Enduring Power of Attorney before consulting with the executor of the man's will.

6. The Deputy Commissioner found the nurse in breach of Right 4(1) of the Code for administering medication without checking the appropriate route or calculating the appropriate dosage, and, as a result, administering a subcutaneous solution orally at five times the maximum dose prescribed.

7. The Deputy Commissioner found another nurse in breach of Right 4(1) of the Code for not ensuring that sufficient medication-competent staff were rostered on duty, as required by the Medication Management Policy.

Recommendations

8. The Deputy Commissioner recommended that Molly Ryan Lifecare (2007) Limited audit every shift at the Village for a period of one month to ascertain whether at least two medication-competent staff members were on duty on each shift; report to HDC any medication errors for a period of three consecutive months, together with a root cause

analysis and mitigation strategies to reduce the likelihood of any such error occurring again; provide HDC with the outcome of its review of its Medication Administration Policy, its system and process for inducting nurses and signing off medication competency for nurses and caregivers, and the competency of its medication-competent staff; and use this report as a basis for staff training and provide HDC with evidence of the training.

9. The Deputy Commissioner recommended that the first nurse provide a written apology to the family, and that the Nursing Council of New Zealand conduct a review of her competence should she return to practice in New Zealand.

10. The Deputy Commissioner recommended that the second nurse provide a written apology to the man's family, and report to HDC on the changes she has instigated to her practice as a result of this case.

11. In accordance with the Deputy Commissioner's recommendation, Molly Ryan Lifecare (2007) Limited provided a formal written apology to the man's family.

Complaint and investigation

12. The Health and Disability Commissioner (HDC) received a complaint from Mr B about the services provided by Molly Ryan Lifecare (2007) Limited to his father, Mr A. The following issues were identified for investigation:

- *Whether RN C provided Mr A with an appropriate standard of care in Month6[1] 2018.*
- *Whether RN D provided Mr A with an appropriate standard of care in Month6 2018.*
- *Whether Molly Ryan Lifecare (2007) Limited provided Mr A with an appropriate standard of care in Month6 2018.*

13. This report is the opinion of Deputy Health and Disability Commissioner Rose Wall, and is made in accordance with the power delegated to her by the Commissioner.

14. The parties directly involved in the investigation were:

Mr B	Complainant/consumer's son
Molly Ryan Lifecare (2007) Limited	Provider/rest home
RN C	Provider/registered nurse (at the time of events)
RN D	Provider/Clinical Manager

15. Also mentioned in this report:

Ms E	Caregiver
Ms F	Caregiver

[1] Relevant months are referred to as Months 1–6 to protect privacy.

16. Further information was received from general practitioner Dr E, the district health board (DHB), the Ministry of Health, a hospice, and the Nursing Council of New Zealand.

17. In-house aged-care advice was obtained from RN Hilda Johnson-Bogaerts (Appendix A).

Information gathered during investigation

18. This report concerns the services provided to Mr A at the retirement village (the Village) on the morning of 26 Month6.

Introduction

Mr A

19. At the time of these events, Mr A was in his eighties. His medical history included metastatic prostate cancer,[2] atrial fibrillation, coronary artery disease,[3] and hypertension.[4]

20. Before his admission to the Village, Mr A lived on his own with external support (including family). On 20 Month1, Mr A was referred to a hospice for palliative care. Between Month1 and Month4, the hospice documented a gradual trend of Mr A's health and capacity deteriorating. On 5 Month3, Mr A decided that it was appropriate for him to enter a rest home.

21. On 29 Month4, Mr A was admitted to the Village for respite care. On 10 Month5, he became a permanent long-term resident.

Retirement Village

22. The Village is a residential care facility owned and operated by Molly Ryan Lifecare (2007) Limited (Molly Ryan). In 2018, it was audited under the Health and Disability Services (Safety) Act 2001. The audit report noted that the Village was certified by the Ministry of Health to provide rest-home and hospital-level care to 33 residents, and rest-home level care in studio apartments to a further 28 residents. The audit found that the Village's roster provided "sufficient and appropriate coverage for the effective delivery of care and support".

23. Molly Ryan is contracted by the DHB to provide age-related residential care, residential respite services, rehabilitation and support services, short-term residential care services, long-term support for residents with chronic health conditions, home and community support services, and respite care for hospice patients.

[2] Cancer that spreads from the prostate to other parts of the body.
[3] Narrowing or blocking of the heart's major blood vessels.
[4] High blood pressure.

Clinical Manager RN D

24. At the time of these events, Molly Ryan employed Registered Nurse (RN) D as the Clinical Manager of the Village. RN D's position description required her to:

- "[L]ead the clinical team to deliver safe, appropriate and individualised resident care in an environment of continuous improvement."
- Provide "up-skilling, coaching, and mentoring" to her clinical team.
- Provide "ongoing staff education and training" in response to "the changing needs of residents and the needs of the organisation".

25. Molly Ryan told HDC that the Clinical Manager managed the roster (although the roster was mostly a set roster).

RN C

26. RN C joined Molly Ryan as a registered nurse on 1 Month6. Prior to joining Molly Ryan, she had worked for ten months as a registered nurse at another rest home. Her position description at Molly Ryan included:

- "Following doctors' medical instructions and interventions, treatments, medications and therapies and ensuring all instructions and procedures are correctly documented, signed and dated."
- "Understanding and complying with all other relevant policies and procedures."

27. At the time of the events under investigation (the morning of 26 Month6), RN C was the sole registered nurse at the premises of the Village. At this time, RN C had received two days of induction and one day of orientation. RN D stated: "On reflection [RN C's] orientation was very minimal, which didn't provide me with enough opportunity to fully discuss any concerns she may have had."

Morphine prescriptions

28. Dr E, a general practitioner, reviewed Mr A for the first time on 7 Month6. She noted that he had been taking tramadol to deal with pain in his lower abdomen and legs, and that this was not giving him adequate pain relief. She stopped his tramadol prescription and issued him a prescription for morphine. The prescription stated that he was to be administered 10mg of oral morphine (controlled release)[5] twice a day, with a total daily dose of 20mg a day. When needed, he was to be given 2.5 to 5mg of oral morphine (immediate release) with a strength of 1mg per 1ml of solution, up to every two hours.

29. On 7 Month6, Dr E charted the following in Mr A's medication chart:

- 10mg of oral morphine twice daily as a regular medication.
- Between 2.5 and 5mg of oral morphine, via an oral morphine solution with a strength of 1mg oral morphine per 1ml of solution, per two-hour period, as needed.

[5] Controlled-release medication is released at a constant or near-constant rate over a sustained period.

30. Dr E reviewed Mr A again on 22 Month6, following a brief hospital admission with haematuria[6] and cellulitis[7] on his legs. She told HDC:

> "At that point his main issues were related to his metastatic prostate cancer, with possible bladder sphincter involvement and he also had an ischaemic-looking leg. He had low blood pressure and was looking very frail."

31. Because of Mr A's deteriorating condition, Dr E prescribed Mr A morphine ampoules[8] with a strength of 10mg of subcutaneous morphine per 1ml of solution, to be given subcutaneously up to every two hours as needed for pain or shortness of breath. This medication was to be administered if he had difficulty swallowing the morphine elixir.

32. On 22 Month6, Dr E charted in Mr A's medication chart that he was to be given between 2.5 and 5mg of subcutaneous morphine per two-hour period, as needed, for pain and shortness of breath.

Medication Management Policy

33. In Month5, Molly Ryan implemented a revised version of its "Medication Management Policy and the requirements for medication competency". The revised policy stated:

> "Only staff who have been assessed, and have demonstrated evidence [of] assessment competence in medication administration and have been signed off as meeting the essential medication competency are able to administer medications.
>
> …
>
> Stock controlled medication must always be administered by an RN and a second medication competent staff member."

34. The policy also stated that the two staff members were both to be involved for the entire procedure. Oral and subcutaneous morphine are stock-controlled medications.

Morning of 26 Month6

Rostering

35. On the morning of 26 Month6 (during the night shift from 11pm 25 Month6 through to 7am 26 Month6), three staff were rostered on duty at the Village: RN C (as a registered nurse), Ms E (a caregiver), and Ms F (a caregiver). At the time, none of these staff members had met the medication competency requirements set out in Molly Ryan's Medication Management Policy.

36. RN C had met most of the medication competency requirements. However:

- She had not watched a compulsory video about medication management.

[6] Presence of blood in the urine.
[7] Skin infection.
[8] Liquid medication that can be administered by injection.

- She had completed a compulsory mathematics quiz, but the Clinical Manager had not yet marked this. [RN D] marked the quiz subsequently, and recollects: "[T]here were some corrections to be made which I worked through with her."

37. At the time, Ms E incorrectly believed herself to be medication competent.

38. Ms F had also not been signed off as medication competent. However, Molly Ryan told HDC that "she had previously trained to undertake total medication rounds as a senior caregiver in another facility and therefore, understood the requirements of the role". RN D told HDC that Ms F had "completed a medication competency in the past" and had worked at the Village for a number of years.

39. Molly Ryan acknowledged that "on the night in question, there were not two [medication-competent staff members] on duty as is required for the administration of controlled drugs under [the Medication Management Policy]".

40. As noted above, RN D managed the rostering at Molly Ryan. She told HDC that she was responsible for ensuring that staffing levels were appropriate on each shift, and that staff had the required training and resources available. RN D stated:

> "As a village we were in the process of ensuring there was enough medication competent staff on each shift for the requirements of administering controlled drugs, and other medications requiring two staff to check."

41. RN D said that she did not check whether RN C had completed the medication competency requirements before rostering her on duty.

42. RN D told HDC that at the time of these events Molly Ryan's focus was on training all of its staff to be compliant with the revised Medication Management Policy (introduced the previous month), rather than on ensuring that staff on every shift were able to comply with the policy. She accepts that she "should have been more aware of where the gaps were and not looked at this as a whole". RN D noted that at the time she felt "overwhelmed" by the prospect of training all Molly Ryan's staff to be compliant with the policy.

Medication error

43. RN C said that in the early morning of 26 Month6, Ms E approached her about Mr A, who appeared to be distressed. RN C stated:

> "I asked [Ms E] if she was medication competent [to which she replied] 'yes'. I then asked 'are you sure?' and a reply of 'yes I am sure' was gained. [Ms E] and I then proceeded to the medication room to start the process of medication administration."

44. Ms E told HDC that when RN C asked her if she was medication competent, she said that she had completed a relevant NZQA Level 4 qualification, so "should be". Ms E stated: "I was not informed or instructed that I needed to do extra training to become medication competent."

45. RN C began filling in the paperwork necessary for administering morphine. She said that while she was doing this, Ms F interrupted her to request her assistance with another patient, but she insisted on finishing the morphine administration first.

46. RN C stated that she "drew up 2.5mls of [the subcutaneous morphine solution] from the vial via syringe without checking the route or calculating the dose beforehand". This involved using three ampoules of the solution. RN C recollects that while she was drawing up the morphine, she remarked to Ms E, "[T]hat seems a lot," and that Ms E reassured her that it was okay. RN C also said that while she was drawing up the medication, Ms F interrupted her again, and she told Ms F a second time to wait until she had finished administering morphine to Mr A.

47. Ms E told HDC that she recollects thinking that what RN C was doing was "different to what other RNs had shown [her] before", but did not discuss this with RN C.

48. At 4.11am, RN C and Ms E documented in Molly Ryan's Controlled Drugs Register that they had withdrawn 2.5ml of oral morphine solution for Mr A, but not that they had withdrawn any subcutaneous morphine solution. However, also at 4.11am, RN C and Ms E documented in the "Controlled Drugs Signing Sheet" that they had administered 2.5ml of subcutaneous morphine solution to Mr A. RN C stated that she and Ms E signed the signing sheet before they proceeded to administer the medication.

49. RN C said that she administered the subcutaneous morphine solution to Mr A orally using a syringe, and recalls that Mr A consumed all of the solution given.

50. Ms E told HDC that she was not actually present while RN C administered the medication to Mr A, as she was called to see another resident who was ringing the bell.

51. RN D stated that RN C told her that administering subcutaneous morphine solution orally was "usual practice" at her last place of work. RN D told HDC that she had never before heard of anyone doing this, and did not understand how it could be considered normal practice.

52. At 5.59am, RN C documented in Mr A's progress notes: "PRN morphine oral given at 4.11hrs for pain with good effect."

Deterioration

53. At 6.15am, Ms F documented that Mr A was asleep.

54. At 1.49pm, a registered nurse documented that Mr A was not responding to commands, and that he had stopped breathing for a few seconds. She gave him comfort cares. Members of Mr A's family were present at this time.

55. Sadly, Mr A died at 8.50pm. A registered nurse documented that he had been unconscious throughout her duty, which had begun at 3pm.

Discovery of error and internal investigation

56. On 28 Month6, RN D reconciled the controlled drugs book with the drugs in stock for Mr A. She documented in the progress notes that she had found only two ampoules of Mr A's morphine, plus 0.5ml drawn up in a syringe, whereas the controlled drugs book indicated that there should be four ampoules left, plus 0.75ml drawn up in the syringe. RN D saw that RN C had documented in the controlled drugs book that she had given oral morphine to Mr A, but had documented in Mr A's medication chart that she had given him subcutaneous morphine. RN D checked the video footage of the medication room, and saw that it showed RN C drawing up two ampoules of subcutaneous morphine solution.

57. Molly Ryan conducted an internal investigation of what had happened. It learned that RN C had administered Mr A 2.5ml of subcutaneous morphine solution, containing 25mg of subcutaneous morphine, orally through a syringe, and also that neither RN C nor Ms E were medication competent. The internal investigation found that "[a] significant departure from policy and procedure in regard to controlled drug administration ha[d] occurred", and that RN C had "failed to execute her professional duties in accordance with best practice procedures".

58. Molly Ryan removed RN C's ability to administer medications and required her to undergo a three-month performance improvement plan. It also told the Nursing Council about the medication error and gave the Council RN C's name. Subsequently, RN C voluntarily surrendered her nursing practising certificate, resigned her position with Molly Ryan, and left nursing.

Disclosure to Mr A's family

59. On 31 Month6, Molly Ryan organised a meeting between some of its representatives, some of Mr A's family members (one of whom had held Mr A's Enduring Power of Attorney),[9] and Mr A's GP, Dr E. Molly Ryan's representatives described the medication error to the family members and apologised for what had happened.

60. Molly Ryan told HDC that it should have disclosed the medication error to the executor of Mr A's will, rather than to Mr A's family members.

61. Dr E documented that at this meeting she explained that the dose given to Mr A did not exceed his prescribed daily dose of morphine, that Mr A's death occurred more than 12 hours after the dose, and that there was no evidence of respiratory suppression following the dose.

Communications with Mr B

62. Mr A's son, Mr B, told HDC that he emailed both Molly Ryan and Molly Ryan's parent company asking questions about the medication error. He provided HDC with what appears to be a copy of the email addressed to a valid Molly Ryan address. However, Mr B did not receive a response to his email.

[9] An Enduring Power of Attorney, or EPOA, is a legal instrument that allows a person (an attorney) to act on behalf of another person (a donor). An EPOA is effective only while the donor is alive.

63. Molly Ryan told HDC that it cannot find any history of Mr B's email, including in its "Quarantined" and "Spam" folders. Molly Ryan also said that it had tried to call Mr B but had been unsuccessful, and that a family member of Mr B said that she would ask him to call Molly Ryan. Molly Ryan stated that following this, it decided to stop trying to contact Mr B, as it did not want to harass him.

Further information

RN C

64. RN C told HDC that at the time of the incident she had felt overwhelmed. She submitted that she had had only one orientation day at Molly Ryan; she had only recently returned to nursing; there was no physical support for the sole registered nurse during night shifts; and she had been interrupted by Ms F during the medication administration process.

65. RN C stated that after the incident she recognised that she needed further training. She undertook to call the Clinical Manager or Facility Manager for advice if she was ever unsure about any situation regarding medicine administration, and said that she would not work a night shift until she had more experience and confidence.

66. RN C told HDC: "I did not knowingly administer the incorrect dose and route of medication to [Mr A]; I would never intend to place a resident at risk."

RN D

67. RN D stated: "I understand there was a responsibility of myself to follow up with required paperwork from [RN C], instead of thinking just because it was given it will be done." She told HDC that she reflects on this medication error frequently, and works toward ensuring that staff who administer medication are competent and appropriately trained.

Molly Ryan

68. Molly Ryan told HDC that since the medication error:

- It has reviewed the competency of all current Village medication-competent staff to ensure that they are aware of their role and responsibilities.
- It has directed staff to ensure that all ampoules are disposed of when their full contents are not administered, and to cease the practice of leaving syringes containing drugs in the controlled drug cupboard.
- It has reviewed its processes for inducting registered nurses, and the induction programme now has a "more structured agenda".
- Its parent company reviewed its medication competency system with particular reference to controlled drug competency, medication calculations, use of and documentation in the Controlled Drug Register, and the requirements for second checkers. The review identified that "Molly Ryan's procedures were not as robust as they should have been and that the medication management competency requirements had not been followed". Following the review, all medication-competent Molly Ryan staff were required to repeat their medication competency training using new assessment tools.

- Its parent company further reviewed its Medication Administration Policy and competency assessment requirements, and concluded that both the policy and competency assessment requirements were robust.

69. Molly Ryan told HDC that currently it employs six registered nurses, two enrolled nurses, and 30 caregivers, and that all the registered nurses and enrolled nurses, and 17 of the caregivers, are medication competent.

70. Molly Ryan stated:

- "We accept that [RN C's] actions that day were a significant departure from accepted practice."
- "We note and concur that it is the responsibility of the Clinical Manager to ensure safe and appropriate staffing on every duty."

Responses to provisional opinion

71. Mr B, RN C, RN D, and Molly Ryan were all given the opportunity to respond to the relevant sections of my provisional opinion.

72. Mr B made no comment in response to the "Information gathered" section of the provisional report.

73. RN C apologised to Mr A's family for the distress caused to them by the incident. She stated that she has been greatly affected by these events.

74. RN D told HDC:

> "I understand I failed to meet the requirements for training and education for staff as a clinical manager in this instance, and accept that I am found in breach of the code as mentioned, with the proposed recommendations and follow-up actions to be carried out."

75. Molly Ryan stated that Ms E had no further comment to make in response to the provisional report. Molly Ryan told HDC:

> "We thank you for your thorough investigation. We consider that the opinion is fair and balanced and accept it as written. We are comfortable with your conclusions and proposed recommendations and follow up actions … [We] will ensure your further recommendations are completed."

Relevant standards

76. The *Health and Disability Services (Core) Standards* (2008) specify that "[c]onsumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers".[10]

Opinion: RN C — breach

77. Dr E had prescribed Mr A both oral morphine and subcutaneous morphine to be taken as needed. Both prescriptions allowed Mr A to be given doses of between 2.5mg and 5mg of morphine per two-hour period. For administration of oral morphine, this meant oral consumption of between 2.5ml and 5ml of an oral morphine solution, with a ratio of 1mg of oral morphine per 1ml of solution. For administration of subcutaneous morphine, this meant injections of between 0.25ml and 0.5ml of subcutaneous morphine solution, with a ratio of 10mg subcutaneous morphine per 1ml of solution.

78. In the early morning of 26 Month6, RN C learned that Mr A appeared to be distressed. Without checking the appropriate route or calculating the appropriate dosage, she drew up 2.5ml of subcutaneous morphine solution into a syringe and administered it to Mr A orally from the syringe.

79. The 2.5ml of subcutaneous morphine solution contained 25mg of morphine. This exceeded the maximum quantity allowable under Dr E's prescription per two-hour period (5 mg) by a factor of five.

80. I note that although 1mg of morphine consumed orally affects a person in an equivalent way to 1mg of morphine injected into the bloodstream subcutaneously, oral morphine is designed to be stronger than subcutaneous morphine. This is because injected morphine enters the bloodstream directly, whereas orally consumed morphine first passes through the digestive system, neutralising a significant proportion of its potential effect before it is absorbed into the bloodstream. My in-house medical advisor, Dr David Maplesden, advised: "The conversion from oral to [subcutaneous] morphine is 2–3:1, i.e. 30mgs oral morphine is equivalent to 10–15mgs [subcutaneous] morphine." Therefore, the effect of the 25mg of subcutaneous morphine consumed orally by Mr A would have been approximately equivalent to between 8mg and 15mg of oral morphine consumed orally, or of subcutaneous morphine injected.

81. My in-house aged-care advisor, RN Hilda Johnson-Bogaerts, advised:

> "This was a significant departure from adherence to policy and would be seen by my peers as a **significant deviation from accepted practice.**

[10] Standard 2.8.

…

The analysis of this medication error identified that there was a failure by the registered nurse to do the basics well, she didn't read the prescription chart, did not do the dosage calculations, did not read the label, and did not follow process in terms of the second checker. Choosing not to follow due process can compromise the provision of safe and competent care and is in breach with the nurses' code of conduct."

82. I agree with this advice. I am critical that RN C:

- Did not check the appropriate route or calculate the appropriate dosage.
- Administered 25mg of subcutaneous morphine to Mr A, which was five times more than the maximum quantity that his prescription allowed.
- Administered subcutaneous morphine solution orally to Mr A with a syringe.

83. I note that RN C raised several factors that contributed to her feeling overwhelmed at the time of the incident: she had had only one orientation day at Molly Ryan, she had only recently returned to nursing, there was no physical support from other registered nurses during the night shift, and she was interrupted several times by Ms F during the medication administration process. I also note that Ms E incorrectly told RN C that she was medication competent.

84. I accept that RN C was placed in a difficult position as the sole nurse at the Village on the morning of 26 Month6. However, medication management is a core competency for a registered nurse. Furthermore, "[f]ollowing doctors' medical instructions" was a requirement of RN C's position description; it is also a basic expectation of a registered nurse.[11] This expectation should have been met.

85. Molly Ryan's "Medication Management Policy" states that only staff who meet its medication competency requirements can administer controlled medications (including morphine) to residents. At the time of the medication error, RN C had completed most, but not all, of Molly Ryan's medication competency requirements. RN Johnson-Bogaerts advised:

"It is my opinion that [RN C] had the responsibility to notify the employer that she was not signed off as medication competent when being rostered as in charge of medication management. She completed the eLearning course that shift however her test was not assessed before she commenced administering medication. This would be seen by my peers as a moderate deviation from accepted practice."

86. I accept this advice to the extent that RN C shared responsibility for informing her Clinical Manager that she was not medication competent, and therefore could not be rostered as

[11] New Zealand Nurses Organisation, *Guidelines for Nurses on the Administration of Medicines* (2018), at 4.3.1; Ministry of Health, *Medicines Care Guides for Residential Aged Care* (2011), p 5; and Nursing Council of New Zealand, *Competencies for registered nurses* (2007), Competency 2.1.

the sole registered nurse on shift by herself. However, I recognise that responsibility for ensuring that Molly Ryan knew whether RN C was medication competent did not fall on RN C alone.

87. Considered together, RN C's errors comprise a significant departure from the standard of care expected of a registered nurse. As a consequence of RN C's errors, Mr A received a dose of morphine that was five times the maximum quantity prescribed. Accordingly, I find that RN C did not provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[12]

88. I note that following the medication error, RN C agreed to practise under a supervision plan with Molly Ryan, and that subsequently she surrendered her practising certificate and left nursing.

Opinion: RN D — breach

89. RN D's position description as the Village's Clinical Manager required her "to lead the clinical team to deliver safe, appropriate and individualised resident care". This included managing the Village's staff roster. Her position description also required her to organise appropriate education and training for Molly Ryan's staff.

90. At the time of the medication error, three staff members were rostered on duty: one registered nurse (RN C) and two caregivers (Ms E and Ms F).

91. None of these three staff members had met the requirements in Molly Ryan's Medication Management Policy to administer controlled medications — which include morphine — to residents. The policy required two medication-competent staff members, including one registered nurse, to be involved in the administration of any controlled medication. It follows that at the time of the medication error, the rostered staff were unable to administer controlled medications in accordance with Molly Ryan's policy. This occurred in the context of at least one of the residents at the time requiring regular administration of a controlled medication.

92. RN D did not check whether RN C was medication competent before rostering her on duty. RN D told HDC that the Village was still in the process of training its staff to ensure that sufficient medication-competent staff capable of complying with the Medication Management Policy could be rostered on each shift. Molly Ryan's focus was on training its staff as a whole, rather than on ensuring that staff on every shift were medication competent. RN D stated that she had felt overwhelmed by the training programme, but accepts that she should have paid more attention to the gaps in training.

[12] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

93. My in-house aged-care advisor, RN Hilda Johnson-Bogaerts, advised:

> "Based on the mistaken assumption that [RN C] had been signed off as medication management competent, the night duty roster did not include care staff who were signed off as medication management competent. This included the RN on duty as well as a second person for checking and co-signing who often is a caregiver who has completed the competency. **This would be seen by my peers as a moderate deviation from accepted practice.**"

94. I accept this advice. The rostered staff on the morning of 26 Month6 needed to be able, as a group, to safely and correctly administer controlled medications to residents in accordance with Molly Ryan policy.

95. RN D was responsible both for ensuring that Molly Ryan staff were appropriately trained and for managing the staff roster. In my opinion, RN D was responsible for ensuring that the cohort of staff rostered on each shift included a sufficient number of medication-competent staff capable of administering controlled medication to residents in accordance with the Medication Management Policy. In order to facilitate this, RN D needed to make herself aware of which staff members were medication competent and which were not. Her failure to do this contributed to her not rostering any medication-competent staff on the morning of 26 Month6. Accordingly, I find that RN D did not provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code.

Opinion: Molly Ryan Lifecare (2007) Limited — breach

96. In accordance with the Code, Molly Ryan had a duty to provide its residents with services of an appropriate standard. The New Zealand Health and Disability Services Standards require organisations (including rest homes) to provide consumers with "timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers".[13]

97. At the time of these events, Molly Ryan's Medication Management Policy stated that only medication-competent staff could administer medications to residents. Furthermore, the policy specified that at least two medication-competent staff, one of whom had to be a registered nurse, were required to administer controlled medications to residents.

98. Mr A had been prescribed morphine, which is a controlled medication. Therefore, for Molly Ryan to ensure that Mr A was given his morphine in a way that complied with its own policy, it needed to ensure that there were always at least two medication-competent staff members (including one registered nurse) on the premises.

[13] Health and Disability Services (Core) Standards (2008), Standard 2.8.

99. On the morning of 26 Month6, RN D had rostered two caregivers and one registered nurse — RN C — to be on duty at the premises. RN C had completed most, but not all, of the medication competency requirements. She had joined Molly Ryan only earlier that month, and had had only ten months' prior experience working as a registered nurse. Therefore, based on her prior nursing experience, Molly Ryan was not entitled to rely on her to administer controlled medications appropriately.

100. Neither of the two caregivers had completed the medication competency requirements required by Molly Ryan, although one had considerable prior experience in administering medications, and had "completed a medication competency in the past". As an integral safety-netting mechanism, this omission is concerning. The second staff member involved in the administration of medication had an important responsibility for checking that the medication to be administered was correct, and for identifying a possible medication error. It was extremely important that she too had completed and met the medication competency requirements required of Molly Ryan, so that she was well equipped to identify the error and was confident enough to speak up.

101. Therefore, on the morning of 26 Month6, none of the staff on duty at the Village were able to administer Mr A's prescribed morphine in a way that complied with Molly Ryan's Medication Management Policy. This was an unacceptable situation. While I consider that individually RN D was responsible for making herself aware of which staff members were medication competent and which were not, I am critical of Molly Ryan for not taking more precautions to prevent such a situation. In the context of Molly Ryan revising its Medication Management Policy in Month5, it was foreseeable that temporarily the Clinical Manager might struggle with ensuring that each shift included a sufficient number of suitably experienced staff. Accordingly, it is my view that Molly Ryan failed to provide Mr A with appropriate and safe "service from suitably qualified/skilled and/or experienced service providers", as required by the New Zealand Health and Disability Services Standards.

102. Mr A was given subcutaneous morphine orally, and in a dose that was five times the quantity he had been prescribed. While I consider that individually RN C was responsible for following Dr E's prescription correctly, I also note that a review of Molly Ryan's medication competency system found that its "procedures were not as robust as they should have been". Following the review, all staff were required to repeat their medication-competency training using new assessment tools. I am concerned that at the time of these events, the systems in place at Molly Ryan were not sufficiently robust to ensure that all staff complied with the Medication Management Policy. Medication-competency training had not been fully completed by staff with responsibility for medication management before they were rostered on duty and, as such, the staff concerned were not supported to administer medication safely, and were not suitably skilled to deliver the standard of care required.

103. Overall, I consider that Molly Ryan's failure to provide Mr A with a "service from suitably qualified/skilled and/or experienced service providers", and to ensure that its Medication Management Policy and relevant medication competency training were sufficiently robust,

contributed towards conditions that enabled errors such as RN C's. Accordingly, I find that Molly Ryan failed to provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code.

Disclosure of information to non-executor — adverse comment

104. On 31 Month6, representatives of Molly Ryan met with some of Mr A's family members, one of whom had held Mr A's Enduring Power of Attorney, and disclosed the medication error to them.

105. RN Johnson-Bogaerts advised that "[t]his meeting … should have been with the executor of Mr A's will rather than the EPOA and family members who represented Mr A while he was alive". Molly Ryan accepts this advice.

106. I am critical that Molly Ryan did not first consult Mr A's executor before disclosing this personal information about Mr A to others.

Communication with Mr A's family — other comment

107. Mr B emailed Molly Ryan with questions about the medication error, but Molly Ryan did not respond. It appears that Mr B sent his email to a valid Molly Ryan email address; however, Molly Ryan told HDC that it cannot find any history of the email.

108. In the absence of further evidence, I am unable to make a factual finding about whether Molly Ryan received Mr B's email.

Recommendations

109. I recommend that RN C provide a written apology to Mr A's family. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A's family.

110. I recommend that the Nursing Council of New Zealand conduct a review of RN C's competence should she return to practice in New Zealand.

111. I recommend that RN D:

a) Reflect on her failings in this case and prepare a written report for HDC on the changes she has instigated to her practice as a result of the case. This is to be provided to HDC within three months of the date of this report.

b) Provide a written apology to Mr A's family. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A's family.

112. I recommend that Molly Ryan:

a) For a period of one month, audit every shift at the Village to ascertain whether at least two medication-competent staff members have been on duty on each shift. The

results of the audit are to be provided to HDC within six months of the date of this report.

b) For a period of three consecutive months, report to HDC any medication errors at Molly Ryan, within six months of the date of this report. A root cause analysis of any errors, and mitigation strategies to reduce the likelihood of any such error occurring again, is to be included.

c) Provide HDC, within three months of the date of this report, documentation of the reviews of:

   i. The competency of Village medication-competent staff;
   ii. Molly Ryan's Medication Administration Policy.
   iii. Molly Ryan's processes for inducting registered nurses.
   iv. Molly Ryan's system and process for signing off medication competency for nurses and caregivers.

d) Use this report as a basis for staff training, and provide HDC with evidence of the training within three months of the date of this report.

113. In accordance with the proposed recommendation in my provisional opinion, Molly Ryan provided a written apology to Mr A's family, for forwarding.

Follow-up actions

114. RN C will be referred to the Nursing Council of New Zealand with a recommendation that in the event that she reapply for a practising certificate, the Nursing Council assess the appropriateness of her return to the nursing profession. In the event that RN C does return to the nursing profession, I recommend that the Nursing Council determine any supervision and monitoring, training needs, and necessary conditions on her practice, and advise HDC accordingly.

115. A copy of this report with details identifying the parties removed, except the experts who advised on this case and Molly Ryan Lifecare (2007) Limited, will be sent to the Nursing Council of New Zealand, and it will be advised of RN C's and RN D's names.

116. A copy of this report with details identifying the parties removed, except the experts who advised on this case and Molly Ryan Lifecare (2007) Limited, will be sent to the DHB and HealthCERT, and they will be advised of the name of the Village.

117. A copy of this report with details identifying the parties removed, except the experts who advised on this case and Molly Ryan Lifecare (2007) Limited, will be sent to the Health Quality & Safety Commission, the New Zealand Medicines and Medical Devices Safety Authority, the New Zealand Aged Care Association, the New Zealand Pharmacovigilance Centre, and the New Zealand Nurses Organisation, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house advice to the Commissioner

The following in-house aged-care advice was obtained from RN Hilda Johnson-Bogaerts:

"1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by [the] Molly Ryan Lifecare & Retirement Village to [Mr A] on 26 [Month6]. 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.

2. I was asked to review the provided documentation and specifically comment on:

   a. The appropriateness of the training, induction, policies and procedures for the administration/management of medications.
   b. Whether the policies were adhered to
   c. If the RN/staff involved in the medication error on 26 [Month6] provided an acceptable standard of care to [Mr A] in managing/administering his medication? If not how significant is the departure?
   d. Other comments

3. **Documents reviewed**

   - Medication Management Policy
   - Altura learning Medication Management course information sheet and assessment tools
   - Letter of response from provider to HDC dated 29 July 2019
   - Provider's Investigation Report
   - Copies of relevant pages of the Controlled Drugs Register
   - Medication Chart and relevant Signing Sheets
   - Progress Notes
   - File Note relating to the Disclosure of medication incident to family
   - Correspondence between Hospice clinicians and provider

4. **Complaint**

   26 [Month6] at 0410hrs the registered nurse on duty administered a dose of 25mg Morphine subcutaneous preparation orally to [Mr A]. The prescribed dose was either 2.5mg to 5mg Morphine elixir orally or 2.5mg to 5mg subcutaneous solution injections as required and in addition to the 10mg long acting Morphine two times per day.

   The provider advised he showed no 'ill effects'.

   26 [Month6] 2050hours [Mr A] passed away peacefully.

   28 [Month6] in reconciliation of the drug supply a shortcoming of 20mg Morphine sulphate was discovered resulting in the discovery of the medication error to [Mr

A]. The provider conducted an incident investigation. They note a significant departure from policy and safe nursing practice.

29 [Month6] the provider held a meeting with [Mr A's] family apologising and disclosing the error.

5. **Clinical advice**

a. The appropriateness of the training, induction, policies and procedures for the administration/management of medications.

Reviewing the [parent company's] Medication Management Policy (April 2019) this policy was found to be very comprehensive and in line with the Medicines Care Guide for Residential Aged Care (2011). The Policy includes chapters relating to the medication error: PRN (as required) Administration, Controlled Drug Administration, Education and Medication Competency, Medication Errors.

The Policy states that only staff who have been assessed and have demonstrated evidence of assessment competence in medication administration and have been signed off as meeting essential medication competency are able to administer medications. Competent staff must complete annual refresher and essential medication assessment on Altura.

Altura is an international provider of online employee learning courses for the aged care sector. Altura's Medication Management Course's information sheet was provided and the subjects covered in the course seem to be adequate. The assessment sheets are comprehensive and include a mathematics test for dose calculation.

In conclusion, I have found the Medication Management Policies, Prescription and Signing Sheet and the Medication Management Training and Assessment tools of good quality. I note that while the policy talks about the use of Medimap this … care home uses a manual system.

Deviation from accepted practice — nil.

b. Whether the policies were adhered to

The provider's Investigation Report concluded a significant departure from the organisation's Medication Management Policy. The following issues were identified:

- The registered nurse had not completed the required medication management competency assessment as part of her induction and therefore was not signed off as competent to administer medication.
- The caregiver who checked the medication with the registered nurse had not had any medication management training and was not signed off as competent to check the medication with the registered nurse. She did not comprehend the requirements.

- Due process was not followed by the registered nurse and caregiver in terms of checking out a controlled drug, administration of a controlled drug and the documentation.
- The medication error involved the administration of the wrong dose, wrong medication and wrong route, wrong documentation.

This was a significant departure from adherence to policy and would be seen by my peers as a **significant deviation from accepted practice.**

The medication error was discovered two days later when the Morphine supply was being reconciled by the Clinical Manager. **The subsequent investigation identified the extent of the error, contributing factors were identified and the actions taken were in accordance to the Policy and Medicines Care Guides for Residential Aged Care (MoH 2011).**

The GP was consulted and a meeting was held to disclose the medication incident to [Mr A's] representatives. This meeting however should have been with the executor of [Mr A's] will rather than the EPOA and family members who represented [Mr A] while he was alive.

c. If the RN/staff involved in the medication error on 26 [Month6] provided an acceptable standard of care to [Mr A] in managing/administering his medication? If not how significant is the departure?

The analysis of this medication error identified that there was a failure by the registered nurse to do the basics well, she didn't read the prescription chart, did not do the dosage calculations, did not read the label, and did not follow process in terms of the second checker. Choosing not to follow due process can compromise the provision of safe and competent care and is in breach with the nurses' code of conduct.

The registered nurse identified as a contributing factor that she felt overwhelmed on the day however did not seek available support. As mentioned above this would be seen by my peers as a **significant deviation from accepted practice.**

d. Other comments

There is a responsibility of the Clinical Manager to ensure appropriate and safe staffing on every duty. How was on that duty safe medication administration assured? Both the registered nurse and one of the two caregivers not having achieved medication competency?

6. **ADDENDUM — 6 February 2020**

I was asked to review additional information provided by [the parent company] in their letter of response to HDC dated 20 January 2020, and advise whether it causes me to change, or add to the advice provided above. Specifically I was asked:

a. whether the new information raises any further issues regarding the standard of care provided to [Mr A].

b. where previously a departure from the standard of care was identified, whether those are attributable to systemic factors, individual error, or a combination of both.

c. whether the policies that Molly Ryan has provided are appropriate.

7. The provider's letter of response included that based on their internal investigation they concluded that 'this incident documents a significant departure from the Medication Management Policy and from accepted practice. We accept that [RN C's] actions that day were a significant departure from accepted practice'.

8. Further to the question I posed above in point (d) of this advice ie. how the Clinical Manager ensured appropriate and safe staffing on every duty and how on that duty when the medication error occurred safe medication administration was assured, additional information was provided. The provider noted and agreed that '*it is the responsibility of the clinical Manager to ensure safe and appropriate staffing on every duty'*. [RN D] provided a response and overview of [RN C's] employment induction and medication management competency assessment. It is accepted practice that an employer provides medication management education and assesses the competency before giving medication administration authority. The provider's response includes that [RN C] *'had completed the required components of the medication competency on the date of the incident*'. I note however that the components completed before being rostered on 26 [Month6] did not include the sign off of [RN C's] medication management competency. She completed that day the eLearning and did the math's test which was not reviewed. [RN D] explains that she made the presumption that it was completed at an earlier date, as all parts to the competency were provided to [RN C] much earlier.

9. **Conclusion:**

Based on the mistaken assumption that [RN C] had been signed off as medication management competent, the night duty roster did not include care staff who were signed off as medication management competent. This included the RN on duty as well as a second person for checking and co-signing who often is a caregiver who has completed the competency. **This would be seen by my peers as a moderate deviation from accepted practice**.

It is my opinion that [RN C] had the responsibility to notify the employer that she was not signed off as medication competent when being rostered as in charge of medication management. She completed the eLearning course that shift however her test was not assessed before she commenced administering medication. **This would be seen by my peers as a moderate deviation from accepted practice.**

10. Reviewing the documentation it is my opinion that the [parent company's] systems and processes for medication management are sound and appropriate, that the medication error was attributed to an individual error.

11. Remedial actions taken by the provider were appropriate including the referral of [RN C] to the Nursing Council. It is my recommendation that in addition the organisation improves the visibility of care staff's current competencies.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Aged Care Advisor"

The following further expert advice was obtained from RN Johnson-Bogaerts on 21 June 2020:

"Thanks for giving me the opportunity to review the responses from the provider and the nurses.

I did not find anything that would cause me to change my previous advice."