Registered Nurse, RN C

Department of Corrections

A Report by the

Deputy Health and Disability Commissioner

(Case 18HDC01693)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mr A was a prisoner at a correctional facility, and was due for his third and final hepatitis vaccination. Mr A's brother, Mr B, was also a prisoner there, and was due for an intramuscular injection of zuclopenthixol.[1] On 20 July 2018, Mr A and Mr B were both scheduled to be seen at the Health Unit on this date for their respective medications.

2. Mr A told HDC that he was escorted by a custody officer to the Health Unit and seated in the holding cell. Registered nurse (RN) C said that she was advised by a custody officer that "Mr B" was at the Health Unit. She said that she was familiar with Mr B, and believed that it was Mr B she recognised sitting in the holding cell.

3. RN C said that she relayed to RN D that Mr B was waiting for his intramuscular injection, and together they completed the cross-check of the medication in a dedicated locked room. RN C and RN D looked at Mr B's medication chart and went through the "five rights" process of confirming that the correct medication was being administered to the correct patient. The patient was not present in the room when the checks were being completed.

4. RN C reported that she checked the photograph on Mr B's drug chart. Despite it being Mr A at the appointment, RN C said that both she and RN D looked at the photo and believed that it was Mr B, and both confirmed that the medication was correct for Mr B and signed for it on the medication chart.

5. RN C then took the medication to the triage room and asked the custody officer to get "Mr B" out of the holding cell. The custody officer escorted Mr A out of the holding cell and into the triage room.

6. The Medicines Management Policy provides that the registered nurse administering a medicine is responsible for confirming the patient's identity using two identifiers.

7. RN C said that when she called Mr A "Mr B", he answered in the affirmative. Once seated in the triage room, she asked Mr A to state his full name, and she believed "without any doubt" that Mr A told her that his name was "Mr B". Mr A recalled that she then asked him where he would like his injection. RN C said that the photograph on the medication chart cover for Mr B showed a person who looked like Mr B but with a moustache. She was aware that Mr B had shaved off his moustache, and the person present in front of her did not have a moustache.

8. RN C told HDC that Mr B and Mr A look very similar physically, both speak quite quickly, and that in hindsight, what she heard as "Mr B" was obviously "Mr A", and she had misheard him.

9. Mr A was administered an intramuscular injection of 200mg zuclopenthixol, intended for his brother.

[1] An anti-psychotic medication, injected into the muscle in a long-acting form, often used to treat schizophrenia and other chronic psychoses.

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10. RN C told HDC that after administering the medication, Mr A asked her what the injection was for, and she realised that something was not right. It was identified that RN C had administered Mr B's medication to Mr A. RN C advised Mr A and apologised immediately. She gave Mr A information about the medication and potential side effects, and arranged for observation and monitoring.

Findings

11. By failing to confirm identity and provide information adequately, and subsequently administering medication to the wrong person, RN C failed to provide services that complied with legal, professional, ethical, and other relevant standards. Accordingly, RN C breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code). Without information about the medication to be administered, Mr A was not in a position to make an informed choice and give his informed consent to taking the medication. Accordingly, RN C also breached Right 6(2) and 7(1) of the Code.

12. The Department of Corrections (Corrections) was not found in breach of the Code.

Recommendations

13. It was recommended that RN C:

a) Provide a written letter of apology to Mr A for the breaches of the Code identified in this report.

b) Participate in a course/training relevant to the issues raised in this case, provided by the New Zealand Nurses Organisation, and provide HDC with her reflections and learnings from the course/training and this complaint.

14. It was recommended that the Department of Corrections review its policy in light of the issues raised in this complaint, and provide HDC with the outcome of its consideration.

Complaint and investigation

15. The Health and Disability Commissioner (HDC) received a complaint from Mr A about the services provided to him at the correctional facility. The following issues were identified for investigation:

- *Whether RN C provided Mr A with an appropriate standard of care in July 2018.*
- *Whether the Department of Corrections provided Mr A with an appropriate standard of care in July 2018.*

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

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17. The parties directly involved in the investigation were:

Mr A	Consumer
RN C	Provider/registered nurse
Department of Corrections	Provider/prison health services

Also mentioned in this report:

Mr B	Mr A's brother
RN D	Registered nurse

Information gathered during investigation

Background

18. In July 2018, Mr A, in his twenties at the time of events, was a prisoner at the correctional facility, and was due for his third and final hepatitis vaccination. At this time, Mr A's brother, Mr B, was also a prisoner at the correctional facility, and was due for an intramuscular injection of zuclopenthixol.

19. On 20 July 2018, RN C[2] was rostered on a 6.30am shift, which involved completing the medication rounds, and then seeing patients in the Health Unit. Mr A and Mr B were both scheduled to be seen at the Health Unit on this date for their respective medications.

Care provided 20 July 2018

20. Mr A told HDC that at approximately 9am he was escorted by a custody officer to the Health Unit and seated in the holding cell (where prisoners wait until Health Unit staff are available to see them).

21. RN C told HDC that she was advised by a custody officer that "Mr B" was at the Health Unit. She said that she was familiar with Mr B, and believed that it was Mr B she recognised sitting in the holding cell.

Cross-check of medication

22. RN C said that when she was aware that Mr B had arrived, she relayed to RN D that Mr B was waiting for his intramuscular injection, and asked RN D to complete the cross-check of the medication with her.

23. RN C told HDC that all Health Units have a dedicated locked room for the storage, preparation, and cross-checking of medicines.

[2] RN C is a registered nurse with an annual practising certificate from the Nursing Council of New Zealand. She is also a member of the New Zealand Nurses Organisation. At the time of the events, RN C was an employee of the Department of Corrections.

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24. RN C said that as was the practice at the time, while in this room she and RN D looked at Mr B's medication chart and went through the "five rights" process of confirming that the correct medication was being administered to the correct patient. As per the Department of Corrections' "Medicines Management Policy — Corrections Health Services" (2018), this process is:

> "RIGHT patient
> RIGHT medicine
> RIGHT dose
> RIGHT route
> RIGHT time"

25. RN C said that she also went through Mr B's previous notes, checking when he had last had the medication, how it was given, and noting whether he had tolerated it well.

26. RN C said that the patient was not present with her in the same room when these checks were being completed.

27. RN C reported that she checked the photograph on Mr B's drug chart. Despite it being Mr A at the appointment, RN C said that both she and RN D looked at the photo and believed that it was Mr B. RN C further advised that they both confirmed that the medication was correct for Mr B, and signed for it on the medication chart.

Identity check and administration of medication

28. RN C told HDC that she then took the medication to the triage room and asked the custody officer to get "Mr B" out of the holding cell. The custody officer escorted Mr A out of the holding cell and into the triage room.

29. The Medicines Management Policy provides that the registered nurse administering a medicine is responsible for "[c]onfirming the patient's identity using two identifiers, most usually by asking their name and date of birth, or using a photograph or prisoner identification number (PRN) or National Health Index (NHI) number".

30. RN C told HDC that when she called Mr A "Mr B", he answered in the affirmative. She said that once seated in the triage room, she asked Mr A to state his full name, as per her standard practice. She told HDC that she believed "without any doubt" that Mr A told her that his name was "Mr B".

31. RN C said that the photograph on the medication chart cover for Mr B showed a person who looked like Mr B but with a moustache. She said that she was aware that Mr B had shaved off his moustache, and the person present in front of her did not have a moustache.

32. RN C told HDC that Mr B and Mr A look very similar physically, both speak quite quickly, and that in hindsight, what she heard as "Mr B" was obviously "Mr A", and she had misheard him.

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33. Mr A told HDC that the nurse asked him to state his full name, and he replied "Mr A" clearly. He said that the nurse then asked him where he would like his injection. He recalled thinking that this was odd, as his previous hepatitis shots had been in his arm, but he thought little of it.

34. Mr A was administered an intramuscular injection of 200mg zuclopenthixol, intended for his brother.

Discovery of error

35. RN C told HDC that after administering the medication, Mr A asked, "What's this injection for?" She said that at that point, she thought that something was not right, and she left the room to speak with the Health Centre Manager and Team Leader. It was identified that RN C had administered Mr B's medication to Mr A.

36. Mr A recalled that after receiving the injection, he was sent back to the holding cell. Several minutes later, one of the custody officers told him that the nurse wanted to see him again, and then the nurse explained that he had been given the wrong injection.

37. RN C said that she advised Mr A that he had been given Mr B's medication in error, apologised immediately, and gave Mr A information about the medication and potential side effects. She contacted other specialists for advice, and, on the basis of this advice, she arranged for an anticholinergic medication[3] to be on standby to counter any adverse effects, and Mr A was kept in the Health Unit for observation. An ECG[4] was also performed. RN C noted that each time Mr A was assessed, he reported feeling fine. He was observed at the Intervention Support Unit (ISU) overnight. No extrapyramidal symptoms were reported or observed at any time.

38. On the same day, RN C completed an incident report, which recorded:

> "*How did the Health Incident happen?*
> *The medication was checked for right medication, dose and route with another RN. The patient was identified by asking his full name. The medication was then given. Post administration it was realised that this patient had a very similar name to the one it was supposed to be given to.*
>
> *…*
>
> *How do we prevent the Health Incident from happening again?*
> *The patient identifiers must be checked properly before administering.*
>
> …

[3] Medication that blocks the physiologic action of acetylcholine.
[4] Electrocardiogram — a test that measures the electrical activity of the heart.

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Outcome notes
No short/long term damage to patient. All appropriate actions undertaken on realisation of the error. Staff reminded of their obligation to correctly identify patients."

Further information

RN C

39. RN C apologises to Mr A for the medication error. She told HDC that she was not aware that both brothers were scheduled to be seen that day in the Health Unit. She said that she was familiar with Mr B, as he was on regular medications, and she saw him as part of medication rounds. She was aware that Mr B was attending that day for his regular injection, as he had mentioned it that morning during the medication rounds. RN C said that she knew of Mr A, but had never dealt with him personally, and noted that she was not certified to give vaccinations.

40. RN C told HDC that the Health Unit tries to ensure that family members are not scheduled to attend the unit on the same day. She noted that this would be especially so for these brothers, given their similarities in appearance, age, and name. She also noted that both brothers often changed their appearance, "for example, they (and other prisoners) will regularly grow facial hair such as a moustache or beard, cut it off, cut their hair into different styles or shave their heads".

41. RN C told HDC that the prisoners do not come in the order in which they are listed to be seen by the Health Unit on the appointment schedule. The time at which a patient is brought to the Health Unit is organised by the Custody Medications Officer, who organises the transfer of patients to the Health Unit. Which prisoners can be brought to the unit at any one time depends on the individual prisoner, and the security and medication factors that relate to the prisoner.

42. RN C told HDC that she has reflected very carefully on the incident, and has booked to attend a Medicine Management training forum. RN C said that the incident has been discussed at length within the Health Unit. She stated that she has become very careful and vigilant about all the medications she handles.

Department of Corrections

43. The Department of Corrections told HDC that both brothers have had alerts added to their clinical records and the Integrated Offender Management System, noting the similarities in their names. The alert reminds health staff to take extra care when confirming their identity.

44. The Health Centre Manager has reminded all nursing staff that all intramuscular injection medications are to be checked and signed by two nurses prior to administration, although Corrections notes that this process was followed on the day that Mr A was administered the incorrect medication. Corrections told HDC that the reminder was sent because the requirement was not reflected in the Medicines Management Policy.

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45. More recently, the Acting Health Centre Manager advised staff that the patient must now also be identified by two nurses. This has been implemented as a local quality improvement and safety initiative, which will run until further notice.

Department of Corrections Medicines Management Policy

46. Corrections told HDC that there is no policy specifically for the correctional facility regarding the administration, checking, and reporting of medications. Rather, guidance is provided in the national Medicines Management Policy — Corrections Health Services (2018). The policy provides:

> "13 Administration of Medicines in Corrections Health Services
>
> Standard
>
> 13.1 Medicines administration is undertaken by suitably trained staff, documentation is complete and incidents are reported and investigated.
>
> Policy
>
> 13.2 All patients must receive sufficient information to enable them to provide informed consent before they receive any medication. See the Corrections Health Services Informed Consent Policy.
>
> 13.3 Any patient has the right to refuse any medicine.
>
> 13.4 All patients receiving medication must be offered adequate information about the medicines prescribed for them so they can make decisions about agreeing to receive or refuse the treatment. This will include:
>
> > The uses of the medicine
> >
> > Most likely possible side effects
> >
> > Familiarisation with the administration dose, route and time
> >
> > Answers to the patient's questions
> >
> > Written information if requested by the patient.
>
> ...
>
> 13.12 The registered nurse who will administer the medicine must confirm the prescription meets the following criteria:
>
> > RIGHT patient
> >
> > RIGHT medicine
> >
> > RIGHT dose
> >
> > RIGHT route
> >
> > RIGHT time

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13.13 In addition the registered nurse is responsible for ensuring:

The patient understands they have the Right to refuse the medicines;

…

13.14 The registered nurse administering the medicine is responsible for:

Confirming the patient's identity using two identifiers, most usually by asking their name and date of birth, or using a photograph or prisoner identification number (PRN) or National Health Index (NHI) number."

Relevant standards

47. The Nursing Council of New Zealand's *Code of Conduct* (2012) provides:

"Principle 4. Maintain health consumer trust by providing safe and competent care

Standards

4.1 Use appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care.

…

4.9 Administer medicines and health care interventions in accordance with legislation, your scope of practice and established standards or guidelines.

4.10 Practice in accordance with professional standards relating to safety and quality health care."

48. The New Zealand Nurses Organisation (NZNO) *Guidelines for Nurses on the Administration of Medicines*[5] (2014) provides:

"9.0 The medication process

9.4 Administering medicines

8.4.1[6] Who can administer medicines?

Any person may administer medicines (including controlled drugs), but whoever administers these is required to do so in accordance with the directions of the prescriber, or in accordance with a standing order.

[5] The 2014 version, revised in 2016, was the version of the guidelines in effect at the time of events. The Nursing Council of New Zealand's *Code of Conduct* (2012) standard 4.9 footnotes the *Guidelines for Nurses on the Administration of Medicines* as an established standard or guideline.

[6] The incorrect numbering throughout the version of the 2014 Guidelines, revised in 2016, appears to be typographical error.

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All people in employment who administer medicines must be familiar with their employer's policies and guidelines regarding medicine administration.

…

12.3 Injectable medicines

The preparation and administration of injectable drugs requires additional skills and knowledge over and above the standards outlined in appendix one.

Be familiar with local workplace policies and guidelines on which staff can administer injectable drugs, and what training and certification is required.

…

13. Appendix one: Standards for the administration of medicines

These are generic standards. Refer to local workplace policy and guidelines for further information specific to your place of work.

12.1[7] Training and education requirements

The person administering the medicine or delegating responsibility for administration of the medicine will be satisfied that they:

…

[Are] familiar with local area policy and guidelines related to medicine administration; and

Understands the relevant professional and legal issues regarding medicine administration.

12.2 Prior to administration

Prior to administration of medication, the regulated nurse or midwife administering the medicine:

Within the limits of the available information, confirms the correctness of the prescription/medication chart, and the information provided on the relevant containers;

Ensures they are aware of the client's current assessment and planned programme of care; and makes a clinical assessment of the suitability of administration at the scheduled time of administration;

…

Checks the five rights + three: the right medicine in the right dose must be administered to the right person at the right time by the right route. The nurse is

[7] As per footnote 6.

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certain the patient is showing the right indications and completes the right documentation before and after administration. The nurse is aware that the person has the right to refuse the medication;

…

[Are] certain of the identity of the client to whom the medicine is to be given;

Informs the client of the purpose of the medicine as appropriate, and provides access to relevant client information leaflets …"

Responses to provisional decision

RN C

49. RN C was given an opportunity to comment on the provisional report, and advised that she had no comment to make.

Department of Corrections

50. Corrections was given an opportunity to comment on the provisional report, and advised that it supports the investigation and provisional opinion, and will undertake the proposed recommendation.

Mr A

51. Mr A was given an opportunity to comment on the "information gathered" section of the provisional report, and advised that he did not have any comment to make.

Opinion: RN C — breach

52. As a registered nurse, it was RN C's responsibility to ensure that she provided services to Mr A that complied with legal, professional, and ethical standards, and the Department of Corrections' Medicines Management Policy.

53. On 20 July 2018, both Mr A and his brother were scheduled to be seen at the Health Unit for their respective medications.

54. RN C believed that the custody officer informed her that Mr B was at the Health Unit, and thought that this was the person she recognised in the holding cell. On this basis, she asked her colleague to assist her to cross-check the intramuscular injection, which included completing the "five rights" process.

55. RN C and her colleague checked the photograph on the medication chart. The prisoner was not present in the room when they checked the photograph.

56. RN C took the medication to the triage room and asked the custody officer to get the prisoner out of the holding cell. She told HDC that she called Mr A "Mr B", and he answered in the affirmative. Once seated in the triage room, she asked him to state his full

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name, and she believed she heard "Mr B". RN C told HDC that the photograph on the medication chart showed a person who looked like Mr B with a moustache, which he no longer had, and the person in front of her did not have a moustache.

57. RN C administered the intramuscular injection of zuclopenthixol, intended for Mr B, to Mr A in error.

Right person

58. The NZNO Guidelines provide that the right medicine in the right dose must be administered to the right person at the right time by the right route. The Guidelines also require that the nurse "[is] certain of the identity of the client to whom the medicine is to be given".

59. The NZNO Guidelines also require familiarisation with employer policies and guidelines regarding medicine administration. Corrections' policy reflects the requirement to check the "five rights", and that the staff member is responsible for confirming the patient's identity using two identifiers, most usually by asking the patient's name and date of birth, or using a photograph or prisoner identification number (PRN) or National Health Index (NHI) number.

60. I accept RN C's statement that she completed the five rights checking process in the medication room. However, Corrections' policy makes it clear that confirmation of the patient's identity is a collaborative process that involves the consumer, separate from other checks.

61. I consider that the requirement to be certain of the identity of the patient to whom the medicine is to be given was not complied with adequately, and that the identification of this particular prisoner with only his full name and an out-of-date photograph, was insufficient. I note the following:

a) RN C was aware that there were two brothers in the prison at the time. She said that they look very similar in physical appearance and in age, although they both changed their appearances frequently.

b) RN C said that she was familiar with Mr B from regular medication rounds. Further, she had seen Mr B that morning on a medication round, and knew that he was due to attend the Health Unit that day because he had mentioned this to her.

c) Although there was a daily schedule for prisoners to be seen at the Health Unit, RN C said that they do not arrive in their allocated order. It therefore follows that care must be taken in confirming the identity of each prisoner.

d) RN C acknowledged that prisoners change their appearance often, and that here, Mr B's photograph was out of date, as he no longer had a moustache. RN C should have been on notice that in this circumstance, a photograph was not a reliable identifier to identify Mr B.

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62. In my view, these factors should have put RN C on notice to exercise caution when confirming identity, and RN C should have asked Mr A for another form of identification, such as his date of birth. Corrections' policy indicates that full name and date of birth is the most usual way of confirming identity.

Information provided before administration, and right to refuse

63. The NZNO Guidelines provide that prior to administration, the nurse is to inform the client of the purpose of the medicine as appropriate.

64. I accept that this was not the first time either brother had received their respective medications. However, in my view, RN C did not give sufficient information to Mr A prior to administration.

65. Corrections' Medicines Management Policy provides that all patients receiving medication must be offered adequate information about the medicines prescribed for them so they can make decisions about agreeing to receive or refuse the treatment.[8] Further, it provides that any patient has the right to refuse any medicine, and that the registered nurse is responsible for ensuring that the patient understands this right.

66. In this case, according to both parties, the information exchanged was:

a) RN C asked the prisoner for his full name; and

b) RN C asked the prisoner where he wanted the injection to be administered.

67. It is clear that RN C did not tell Mr A the specific medication he was to receive. RN C acknowledged that she was alerted to the error because, after administration, Mr A asked her, "What's this injection for?"

68. I consider that had RN C provided Mr A with information about the medication, this safeguard may have enabled her to identify that Mr A was in fact presenting for his hepatitis vaccination and, further, would have enabled Mr A to refuse his brother's medication.

Conclusion

69. The Nursing Council of New Zealand's Code of Conduct required RN C to administer medicines in accordance with legislation, her scope of practice, and established standards or guidelines, and to practise in accordance with professional standards relating to safety and quality health care.

70. In my view, RN C failed to comply with the Department of Corrections Medicines Management Policy, the Nursing Council's Code of Conduct, and the NZNO Guidelines.

71. I find that in failing to confirm identity and provide information adequately, and subsequently administering medication to the wrong person, RN C failed to provide services that complied with legal, professional, ethical, and other relevant standards.

[8] Standard 13 of the Medicines Management Policy — Corrections Health Services (2018).

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Accordingly, RN C breached Right 4(2) of the Code. Without information about the medication to be administered, Mr A was not in a position to make an informed choice and give his informed consent to taking the medication. Accordingly, RN C also breached Right 6(2)[9] and 7(1)[10] of the Code.

72. Following discovery of the error, RN C took steps to inform Mr A of the error and apologise, contact other specialists for advice, and arrange for Mr A to be observed for any adverse effects. I acknowledge the steps she took.

Opinion: Department of Corrections — no breach

73. As a healthcare provider, the Department of Corrections is responsible for providing services in accordance with the Code.

74. Corrections had a detailed Medicines Management Policy in place to guide clinical staff. RN C acknowledged that she was aware of the policy, and that nurses are required to follow and administer medication as set out in the policy. I consider that the error in this case is not indicative of broader systems or organisational issues at Corrections. Therefore, I consider that Corrections did not breach the Code.

75. I note that Corrections has made a change to policy in that patients must now be identified by two nurses. It is positive that the Department of Corrections has taken further actions to address the identification issue identified in this report.

Recommendations

76. I recommend that RN C:

a) Provide a written letter of apology to Mr A for the breaches of the Code identified in this report. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to Mr A.

b) Participate in a course/training relevant to the issues raised in this case, provided by the New Zealand Nurses Organisation, and provide HDC with her reflections and

[9] Right 6(2) states: "Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent."

[10] Right 7(1) states: "Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise."

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learnings from the course/training and this complaint, within three months of the date of this report.

77. I recommend that the Department of Corrections review its policy in light of the issues raised in this complaint, and provide HDC with the outcome of its consideration, within three months of the date of this report.

Follow-up actions

78. A copy of this report with details identifying the parties removed except for the Department of Corrections, will be sent to the Nursing Council of New Zealand, and it will be advised of RN C's name.

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

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