Decision 21HDC01331
29 July 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Poor medication management practices within dementia unit

Complaint

1. This Office received a complaint from Miss A regarding the care provided to her late grandmother, Mrs B, by Bupa Liston Heights Retirement Village and Care Home (Bupa). Mrs B had dementia and was aged 94 years at the time of events.

2. It is alleged that Mrs B, along with two other residents within Bupa's dementia unit, were administered clonazepam [1] (a sedative) without a prescription on the evening of 15 September 2020 by a caregiver (Caregiver 1). This report focuses on the medication management practices at Bupa and is not intended to address the conduct or actions of Caregiver 1.

Background

3. On the evening of 15 September 2020, Caregiver 1 and Caregiver 2 were working within the dementia unit. Clinical oversight of the dementia unit was provided by a registered nurse who was working in another unit of the care home.[2] While this practice aligned with Bupa's contractual obligations, it is not known what level and frequency of oversight the nurse provided due to an absence of nursing documentation over this shift.

4. Caregiver 1 was the more senior caregiver of the two and was 'medication competent[3]'. As Caregiver 2 was not 'medication competent', Caregiver 1 was responsible for administering medications over the course of the evening.

5. Clonazepam is a Class C[4] controlled drug under the Misuse of Drugs Act 1975 (the Act). The Act states that service providers must store all controlled drugs securely. At the time of the events, most medications, including clonazepam, were kept in a locked medication trolley. The trolley was kept inside a locked room[5] when not in use, and there was only one set of keys for the medication trolley, which was carried by Caregiver 1 at the time of the medication round. Bupa said that normally the medication keys are carried by the most senior member of the team, and the medication trolley was accessible only by those who had medication competency. Bupa stated that this process complied with legislative requirements. At the time of the events, Bupa's certification audit report (dated 2019) had

[1] Falls under a class of drugs known as benzodiazepines, which have a sedating effect.
[2] Medication competent caregivers were working under the direction and delegation of a registered nurse, but this did not mean that a registered nurse was present in either a shadowing capacity or on a continuum.
[3] Refers to individuals who have undertaken relevant medication training and have been assessed as being competent to administer medications.
[4] Drugs that pose a 'moderate risk of harm' to consumers.
[5] This is locked by a keypad.

found that the medicine management complied with the Health and Disability Services Standards 2008 (HDSS).

6. Caregiver 2 said that she saw Caregiver 1 pre-dispensing orange paracetamol liquid for three residents at the same time, rather than one by one. Caregiver 1 accepted that she pre-dispensed paracetamol and that this goes against Bupa's medication management protocol. Caregiver 1 stated that pre-dispensing was common practice amongst caregivers and registered nurses at Bupa.

7. Caregiver 2 observed that the orange liquid included a further dark green or blue liquid (later suggested by Bupa to be clonazepam). Caregiver 2, who was not trained to administer medication, considered it unusual for paracetamol to have this colour, but did not raise any concerns about this with Caregiver 1 or a registered nurse on 15 September 2020. Caregiver 2 has accepted that this should have occurred.

8. A few hours after the paracetamol (with the alleged addition of clonazepam) had been administered to the three residents, Caregiver 2 found Mrs B 'slumped' on the couch and looking drowsy, which was unusual for Mrs B. This was escalated to Caregiver 1, who stated that Mrs B was simply tired and transferred her to bed. Bupa told HDC that any changes in a resident's condition should be reported to a registered nurse. However, despite Caregiver 2 escalating her concerns to Caregiver 1, who was her senior, Caregiver 1 did not then escalate the change in Mrs B's physical state to the registered nurse, who was working in another unit of the rest home at the time, and therefore no assessment of Mrs B's condition was undertaken. The next day, Mrs B experienced an unwitnessed fall and suffered a hip injury, requiring transfer to hospital. There is no reference to the condition of the two other residents who allegedly were also administered the same liquid medication as Mrs B.

9. There is no documentation from the evening or night shift of 15/16 September 2020. It is therefore not known how often Mrs B or the two other residents were checked visually, if at all, over this time by either caregivers or registered nurses. Bupa told HDC that there was no expectation for routine visual checks to be documented, unless there were findings to report.

10. Caregiver 2 reported the above events to the clinical manager the following day, on 16 September 2020. Subsequently, Bupa escalated the issue to the Police and dismissed Caregiver 1, following an HR investigation into Caregiver 1's conduct. Bupa provided a formal apology and completed open disclosure to Mrs B's family. Bupa also completed a thorough investigation into the events and noted the following issues:

- There was incomplete documentation over 15/16 September 2020.
- There was a lack of oversight by the clinical manager and registered nurse.
- Changes in the residents' health status were not reported to a registered nurse.
- Significant amounts of clonazepam liquid (more than 10ml)[6] were unaccounted for.

[6] Miss A said that during Bupa's investigation, she asked about the amount of clonazepam missing multiple times and was 'brushed off'.

11. A compliance risk assessment by Bupa on 30 October 2020 found the following:

- Medication trolleys were left unlocked and unattended in the hallway and/or dining areas.
- Staff were interrupted frequently during medication rounds.
- Controlled medications prescribed for one resident were administered to other residents.
- Not all controlled drugs were part of the controlled drug register.
- There were discrepancies in the controlled drug register, particularly for morphine (a controlled drug).
- There were variations on medication signing sheets and illegible signatures.
- Medicines for residents who had left the facility were found in the medication trolley.

12. In addition, the Police stated that Bupa did not conduct a blood test on the three residents within 24 hours of the alleged offending, despite knowing about the allegation regarding clonazepam administration.

Response to provisional report

13. Miss A was given the opportunity to comment on the provisional report. Miss A acknowledged the changes made by Bupa and is thankful for the strong measures that have been taken to rectify the storage and medication processes. Miss A also thanked Caregiver 2 for being brave and reporting her concerns to management.

14. Bupa was given the opportunity to comment on the provisional report. Bupa's comments have been integrated elsewhere in this report.

My decision — breach

15. Having reviewed all the information in this case, I consider that Bupa breached Right 4(2)[7] of the Code of Health and Disability Services Consumers' Rights (the Code) for its lack of compliance against the HDSS, its poor medication management practices, its incomplete record-keeping, and its lack of registered nurse oversight within the dementia unit.

16. Regarding Bupa's medication practices, I am critical of the lack of staff compliance with its internal medication management policy, and this includes staff leaving the medication trolley unattended, the non-adherence with safe medication administration practices, the pre-dispensing of medications, and the suboptimal monitoring of the controlled drug stock, which was not in line with standard 3.12[8] of the HDSS.

[7] Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
[8] Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

17. I am also critical of the lack of documentation on the afternoon/evening of 15 and 16 September 2020, which is not in line with standard 2.9[9] of the HDSS.

18. Finally, I am critical of the lack of direct registered nurse oversight within the dementia unit. While I cannot determine whether the physical presence of a registered nurse in the unit (be it limited to regular 'ward rounds' or visits to the unit over the course of the shift) would have prevented Caregiver 1's aberrant actions, it may have presented an opportunity for Caregiver 2 to react more readily and escalate her concerns, either at the time or shortly after she observed the unusual blue liquid being administered. Without a registered nurse to consult with readily, the caregiver lacked clinical judgement or authority to recognise the severity of the issue and take appropriate action in response to the event and the ensuing change in Mrs B's health.

19. Bupa did not accept the criticism that there was a lack of registered nurse oversight, stating that there had been a registered nurse within the neighbouring unit of the dementia unit, which met its contractual obligations at the time and was noted in Bupa's certification audit report in 2019. I acknowledge that Bupa met its contractual obligations, and, while I accept that there was a registered nurse in the neighbouring unit, I disagree that the nurse being 'readily available' constituted sufficient oversight within the dementia unit. Had this been the case, there may have been earlier intervention with respect to addressing the changes in the residents' condition on 15/16 September 2020. It is expected that adequate oversight would require the registered nurse to attend the dementia unit physically at some point of the shift.

Changes made

20. Bupa made the following changes after the events:

- PRN[10] benzodiazepines and antipsychotics were removed from the medication trolleys and moved into a locked cupboard in a locked room within the hospital wing of the care home. In addition, a new process was implemented wherein only a registered nurse can access clonazepam, and training was provided to staff on the new process.
- Reordering of benzodiazepines from the pharmacy is completed only by a registered nurse.
- A regular report on what drugs are ordered and by whom is sent to the clinical manager. Further, the monthly controlled drug stocktake is completed by the clinical manager, and a report on 'as required' medication usage for residents is completed by the clinical manager on 1Chart[11] on a six-weekly basis.
- A debrief of the event and on-site education days were completed to reiterate the medication management process.

[9] Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.
[10] As required.
[11] A cloud-based medication management system.

- A review of the staff rosters was completed in each area of the care home to ensure that staff numbers were adequate at the time of medication rounds.
- A medication audit was completed across all Bupa care homes. Following this, the medication management processes were reviewed.
- Bupa introduced security cameras in the medication storage areas.
- Bupa implemented VCare (an electronic patient management system) to allow greater oversight of the resident journey in real time.

Recommendations and follow-up actions

21. I acknowledge that Bupa recognised the gravity of the situation and acted accordingly at the time and has accepted responsibility for this concerning incident and made significant changes in response. I recommend that in addition, Bupa Liston Heights:

a) Complete an unannounced and silent medication audit[12] at Bupa Liston Heights, using Bupa's internal audit template. As part of this audit, the auditor should observe the extent to which pre-dispensing of medications is being undertaken and whether the medication trolley is left unattended, particularly after hours. A report on the audit findings, including any corrective actions, is to be provided to HDC within three months of the date of this decision.

b) Complete a review of all medication-competent staff, including for staff carrying out 'second checks' and staff administering controlled drugs, to ensure that annual competencies are current. A report on the review findings, including any corrective actions, is to be provided to HDC within three months of the date of this decision.

c) Consider introducing a policy that stipulates completion of a blood test following adverse medication events, as per the comments made by the Police in paragraph 12. An update on this consideration is to be provided to HDC within three months of the date of this decision.

d) Provide information to HDC regarding the follow-up care provided to the two other residents who allegedly were also administered clonazepam. As part of this information request, Bupa is to outline what steps were taken to monitor and manage the residents' health status, and whether open disclosure occurred with the residents' families. This information request is to be provided to HDC within three months of the date of this report.

22. A partly anonymised copy of this report, naming Bupa Liston Heights Retirement Village and Care Home, will be sent to HealthCERT at the Ministry of Health and to Health New Zealand | Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Nāku iti noa, nā

[12] The audit should be discreet and conducted without prior notice.

Rose Wall
Deputy Health and Disability Commissioner