Medication administration in corrections facility
16HDC01713, 28 March 2019

Prison health care ~ Medication administration ~ Documentation ~ Right 4(1)

A 58-year-old man was received as a prisoner at a corrections facility. The man had been discharged from a public hospital the previous day, following an admission for chest pain. He required daily medication for coronary vascular disease, and twice daily medication for HIV, and brought with him his own supply of medication for these conditions.

At the receiving office, a registered nurse recorded the man's medical conditions and that he had brought his own supply of medication. The nurse did not record the man's recent hospitalisation for chest pain, or evaluate the importance of his medication, and did not update the medication chart to record that the man had brought his own supply of medication. An initial health assessment was not completed at this time or at any other time during the man's incarceration.

The man's medication was placed in the medication room. The health care assistant (HCA) on duty was unsure what to do with the medication, and it was not given to the man on the following two days.

Over the next three months, the corrections facility failed to administer the man's prescribed medication on 15 separate occasions. On five of these occasions, the corrections facility accepted that the doses had been missed. The HCA who failed to administer the medication on each occasion did not escalate the issue to a registered nurse for review.

The corrections facility stated that on the remaining occasions, its records indicate that the medication was administered. However, it acknowledged that at the time of events, pre-signing of the medication sheet was normal practice, and therefore it was not necessarily a record of the medication given.

Findings
The man had no control over his access to medication, and was reliant on staff to provide him with adequate care. The missed doses of HIV medication may have significant long-term implications for the man.

It was held that the corrections facility did not comply with its policies, and did not complete an adequate assessment of the man's condition, medication, and ongoing care requirements. A number of staff failed to administer prescribed medications, and placed the man's health at risk. The practice of pre-signing for the administration of medication meant that the medication record was not necessarily an accurate reflection of the medication administered. Accordingly, the corrections facility failed to ensure that the man was provided with services with reasonable care and skill, and breached Right 4(1).

Recommendations
It was recommended that the corrections facility conduct an audit of receiving office documentation and administration of "own supply" medication, administration of prescribed medications, and completion of initial health assessments.

It was also recommended that the corrections facility provide training to health services staff on the importance of accurate documentation and the unacceptability of pre-signing documents.