Serco New Zealand Limited

A Report by the
Deputy Health and Disability Commissioner

(Case 17HDC02092)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report highlights the importance of assessing prisoners' medication requirements accurately upon admission to prison, and of ensuring that medication is administered appropriately.

2. On 21 December, a man transferred to another prison with a limited supply of medication for one of his health issues. The man required twice-daily medication for this. A registered nurse undertook a Reception Assessment.

3. On 28 December, the man's wing went into lockdown, and the man was not given his afternoon medication.

4. On 30 December, the man was seen by a GP at the prison as part of his Initial Health Assessment. Additional medication was prescribed, and on 4 January a special authority number was sought so that the medication could be dispensed.

5. On 5 January, the man was not given his morning medication because his medication supply had run out. A new supply arrived in the afternoon.

6. On 13 January, the man was not given his afternoon medication.

Findings

7. The Deputy Commissioner considered that the Reception Health Triage was not sufficiently detailed or thorough; the medication planning was inadequate and meant that the correct medication was not available at the appropriate time; and on two occasions the HCAs were not aware of their obligations when medication was missed, and did not escalate the non-administration of medication to a registered nurse.

8. The Deputy Commissioner considered that Serco New Zealand Limited was responsible for the deficiencies in the care provided to the man, and failed to provide services to the man with reasonable care and skill. As a result, Serco New Zealand Limited breached Right 4(1) of the Code.

Recommendations

9. The Deputy Commissioner recommended that Serco New Zealand Limited apologise to the man, review the policy for Reception Health Triage and provide training on the policy, and provide training on the policy for missed medication.

Complaint and investigation

10. The Health and Disability Commissioner (HDC) received a complaint from Mr B about the services provided by Serco New Zealand Limited. The following issue was identified for investigation:

- *Whether Serco New Zealand Limited provided care of an appropriate standard to Mr B in December and January.*

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

12. The parties directly involved in the investigation were:

Mr B	Consumer/complainant
Serco New Zealand Limited	Provider

Also mentioned in this report:

RN A	Registered nurse
RN C	Registered nurse
Ms D	Head of Healthcare Services
Ms E	Healthcare assistant
RN F	Registered nurse
Dr G	Medical officer

13. Independent expert advice was obtained from Registered Nurse (RN) Vivienne Josephs, and is included as Appendix A.

Information gathered during investigation

Introduction

14. This report considers the care provided to Mr B while he was a prisoner at Prison 2 in December and January.

15. Prison 2 is operated by Serco New Zealand Limited (Serco). Serco has a contract with the Department of Corrections to operate Prison 2.

16. As part of its contract, Serco is required to meet the same standards as public prison sites. It must comply with section 75[1] of the Corrections Act, which provides that prisoners are entitled to receive medical treatment that is reasonably necessary, and that the standard

[1] Section 75 of the Corrections Act 2004 states: "(1) A prisoner is entitled to receive medical treatment that is reasonably necessary (2) The standard of healthcare that is available to prisoners in a prison must be reasonably equivalent to the standard of healthcare available to the public."

of health care must be reasonably equivalent to the standard of health care available to the public.

17. Mr B has various health issues. At the time of these events he was in his fifties, and he required daily medication for one issue, and twice daily medication for another issue. Failure to take some medication consistently can result in the emergence of resistance to the medication. The development of drug resistance would have significant long-term implications for Mr B's health.

Reception Assessment — 21 December

18. On 21 December, Mr B was transferred from Prison 1 to Prison 2.

19. In response to the provisional opinion, Serco stated that Prison 2 received 31 admissions during the week of Mr B's admission, which is outside the normal admission volumes. Serco stated that Mr B was seen by a nurse at 5pm and that processing in the receiving office was completed after 6pm.

20. The Patient Transfer Information Form, which accompanied Mr B from Prison 1, stated that Mr B was being treated for a health issue and that he was receiving a number of medications. The form also stated that a treatment plan was in place and that Mr B was under the care of an Out Patient Department at the public hospital.

21. When Mr B arrived at the Prison 2 Receiving Office he was seen by a registered nurse, RN A, and a Reception Health Triage Form was completed.

22. RN A recorded that Mr B was taking medications but did not record the doses that were prescribed. RN A also did not record the quantity of medication that was sent with Mr B from Prison 1, and told HDC that she cannot recall the quantity.

23. In response to the provisional opinion, Serco stated that it would be unusual for a registered nurse to document the dosage of the medication on the Reception Health Triage Form given that most prescriptions are generated out of the electronic clinical record (Medtech). Serco said that the purpose of the Reception Assessment is to establish immediate health needs, and that a more detailed assessment is undertaken at the Initial Health Assessment.

24. Mr B told HDC that he arrived at Prison 2 with medication for 17 days, and that he also had additional medication stored at his home and secured in his property at Prison 2.

25. Serco said that Mr B had a ten-day supply of medication, and stated:

> "[[Mr B] was] booked to see the General Practitioner (GP) on 30 December (appointment time 1445 hours) as it was noted that [he] had a ten day supply of medication which is reasonably short given the time of the year."

26. In response to the provisional opinion, Serco stated:

> "There are contractual deliverables which include the requirement for scripted medications to be delivered the same day (if ordered prior to 1500 hours) or the following day. Theoretically this would have meant that the medication would have been delivered by 31 December at the latest."

27. Mr B was triaged as "3 — routine". Serco told HDC that this meant that Mr B was to be seen by a doctor within 21 days.

28. Serco told HDC:

> "It is noted that he should have been triaged as a priority 2 category (and seen within 7 days) however he was triaged as a priority 3 category which meant he could be seen within 21 days."

29. Serco stated:

> "Notwithstanding that, he was booked to see the GP five working days after arriving on site (accounting for the weekends and public holidays)."

Verbal handover from Prison 1 on 22 December

30. On 22 December, a verbal handover from Prison 1 to Prison 2 was completed and recorded in the Patient Medical History. It stated:

> "Came with the mass arrival on 21/12/[…].
>
> Received handover from [Health Care Manager] from [Prison 1], reported the above inmate has put a court case against [Prison 1] Health, claiming he is not getting his medication while in fact he has been. Has informed HCA [healthcare assistant] to make sure this inmate receives his medication as per medication chart. […]."

Initial Health Assessment on 25 December

31. On 25 December, an Initial Health Assessment was completed by RN B. RN B recorded Mr B's health status and his medication.

32. Serco told HDC:

> "The details within the assessment are scant but there is evidence that the RN was aware of the diagnosis and the medication prescribed."

33. A file note was made in the Patient Medical History as follows:

> "Has no more repeats left for all of his medication came as a new arrival, 10/7 [10 days] Left of his medication. Name added on the app[ointment] list for GP on 30th Dec[ember] to generate a new script."

34. Ms D, Head of Healthcare Services at Prison 2, told HDC that she was advised on 25 December that Mr B had been sent to Prison 2 with a 10-day supply of medication. She told HDC:

> "The team were aware of the urgent nature of this medication and the importance of not interrupting the supply."

Events of 28 December

35. On 28 December, Mr B's morning medication was administered.

36. Afternoon medication is administered between 3.30pm and 4.30pm by a healthcare assistant. Serco told HDC:

> "The process entails the prisoners attending the triage [medication hatch] where they will have their fingerprint read at the biometric reader outside triage [medication hatch] before being issued their medication by the Health Care Assistant."

37. Serco told HDC that at 3.30pm that day Mr B did not attend the medication hatch for his medication. Serco stated:

> "A review of camera footage and intercom logs demonstrated that the men from [Mr B's] wing had attended the medication hatch for their medication. [Mr B] was noted to be playing cards and walking around the wing at the time he should have been attending the medication hatch."

38. Mr B told HDC that he was at the door with his medication cup and that he was next in line for medication.

39. At 3.38pm, Mr B's wing was placed in lock-down following a disturbance (Code Blue). All prisoners were locked in their cells.

Actions taken by Mr B

40. At approximately 3.40pm, Mr B contacted Master Control to say that he had not received his medication. A number of other prisoners also complained that they had not received their medication.

41. In his complaint to Serco, Mr B said that he spoke to Master Control on four occasions during the evening, and that he also spoke to a custody officer. He did not receive his medication.

42. Serco told HDC that at 4.35pm Mr B's cell was opened and he was given his evening meal. Serco stated:

> "[F]rom the [CCTV] footage it does not appear that [Mr B] spoke to the officers (evidenced by no delays in them providing the meal or locking the door compared to the other cells).
>
> …
>
> The intercom log shows [Mr B] requested his medication in the middle of the code blue (which was not possible), again at [8.07pm] and [8.56pm]. At this time the afternoon nurse was dealing with a full caseload and was not able to attend [Mr B's] cell."

Actions taken by Health Services staff

43. Ms E was the healthcare assistant on duty. She said that Mr B did not receive his medication, and that she put an "A (absent) on his signing sheet" and gave a verbal handover to the evening registered nurse.

44. Ms E stated:

> "I did a verbal hand over to the late nurse who was working up to 8.30pm period. Because my nurse on duty was the early nurse which she finished around 4.14pm."

45. Serco conducted an internal review of the non-administration of medication on 28 December. Serco stated:

> "As [Mr B] had been marked as absent, protocol would dictate that the HCA then briefs a RN as to his refusal to attend and decision is then made by the RN as to the next course of action. In this case neither [RN B] nor [RN F] received a briefing from [Ms E] as to [Mr B's] refusal to attend."

46. RN F[2] was the registered nurse on duty on the evening shift. She said that the control room advised her that some of the prisoners had missed their medications, and she provided one prisoner with his medication. RN F stated:

> "I did not go back to the other two people [one of whom was Mr B] who I was not sure whether they really missed their meds or was just trying to interfere/interrupt during late medication round as can be expected at times because I had not received any formal/informal handover from the nursing staff on throughout the day for the following incident and we had no call for code blue on the radio. Due to tight time constraints and working by myself I carried on with the rest of my work before I could finish on time."

47. In response to the provisional opinion, Serco stated:

> "We do not advocate that the nurse makes an assumption that prisoners are attempting to interfere with a medication round."

48. At approximately 9pm, Ms D received a call from the control room advising her that Mr B had called to say that he had not received his medication. She told HDC:

> "As this did not constitute an emergency I asked the staff to apologise to him and advise him that I would look into it in the morning, but that I would not be attending the site."

49. Serco told HDC:

> "The clinical services were not able to provide [Mr B] with his medication on the evening of the 28 December. An apology was offered and open disclosure occurred.

[2] RN F resigned from Serco.

> The staff member who failed to provide the medication [the HCA] was formally sanctioned following a formal investigation."

30 December

50. On 30 December, Mr B attended his appointment with Dr G, the medical officer at Prison 2.

51. Dr G told HDC:

> "I first saw [Mr B] on 30/12/[…] for his new arrival check. I reviewed his past medical history and a script for his regular medications was generated."

52. Dr G did not record whether Mr B had an existing supply of medication or how long that supply would last.

53. In response to the provisional opinion, Serco stated that it was not necessary for Dr G to record this information as it had been recorded in Mr B's notes five days earlier, and Dr G would have seen this.

54. The prescription was sent to the pharmacy following the appointment. Serco stated:

> "[Mr B was] seen by the GP on 30 December (a Friday) and she completed [the] prescription for the medicine. This was sent to the [prison] pharmacy on the same day."

4 January

55. Serco stated:

> "Because of the impact of the public holidays the next working day [after the doctor's appointment on 30 December] was 4 January. The [prison] pharmacy contacted our team on 4 January advising of the requirement for an updated special authority number (required for specialist medication). This was obtained from [the public] Pharmacy and the information conveyed to our pharmacy on the same day. The pharmacy communicated some possible delays in obtaining the medication as their supplier did not standardly carry this level of specialist medication."

56. The following note was recorded in the Patient Medical History on 4 January: "Called [the public] Pharmacy for […] Special Authority Number[3]."

5 January

57. Mr B did not receive his morning dose of medication on 5 January because his supply of medication had run out and the supply from the pharmacy had not arrived.

[3] A Special Authority Number can provide access to a Government subsidy or can waive certain restrictions present on medication.

58. The Patient Medical History records:

> "[E]xplained [to] patient that due to the public holidays and specialist requirement, his medication has not arrived and the HCM[4] [Health Care Manager] is doing her best to arrange it to be sorted out and delivered today urgently. [Mr B] said he knew it's gonna happen. The writer was still talking to [Mr B], he picked up the phone and rang his family to ask if there are medications [for] him at the home. [Mr B] stated that he gets repeats delivered to his home from the pharmacy. [Mr B] asked the family if they can deliver it to reception."

59. Ms D, Head of Healthcare Services at Prison 2, told HDC:

> "I was not made aware that [Mr B] had a current supply of medication in his property [at Prison 2] as he had been in prison for some time and he did not disclose that to my staff. [Mr B] did mention that he would get his family to bring his medicine into the prison on 5 January but we were confident it would be delivered by the end of the day (which it was) so advised him we would come back to him if there were any further delays around his medication."

60. Mr B's medication arrived from the pharmacy in the afternoon and he received his afternoon dose. Serco continued to administer Mr B's medication over the following days.

13 January

61. Mr B told HDC that his medication was not administered on the afternoon of 13 January. He said that he had his medication cup and was watching new prisoners arrive, and that an hour later he was locked in his cell even though he had not received his medication. He stated:

> "I didn't push the intercom [inside his cell] due to the response last time 5/1/[…] and overhearing [the medication] would be brought to us [the prisoners who did not receive their medication]."

62. He also stated:

> "[The next day] I asked the nurse why she didn't bring me my meds. She responded she waited a long time for me yesterday. I responded I was locked up."

63. The HCA who was administering medication stated:

> "As I recall I gave [Mr B] his medication in the morning, and did not give [it] in the afternoon as he did not come to [the medication hatch] to collect his medication that afternoon.
>
> I remember [the wing] being unlocked that afternoon and [Mr B] chose not to come to collect his medication while I was waiting for the men to collect their meds that afternoon.

[4] Ms D, Head of Healthcare Services.

> As a Health Care Assistant (HCA), we try and encourage the men to take responsibility to come and collect their meds hence we do not chase them to collect their meds as you take responsibility for your own meds on the outside.
>
> I do remember telling [Mr B] this the next morning when he came to collect his medication as he assumed that we would hand deliver to the cell if he did not come to collect his medication.
>
> When I informed him of his expectation from the health staff, he did start to take responsibility of coming to the Triage to collect his medication regularly."

64. Ms D told HDC:

> "[Mr B] did not attend the medication hatch for his afternoon medication on 13 January. The [HCA] had waited behind to allow him as much time as possible to attend for his medication. After he made a complaint I reviewed CCTV footage and he was observed playing cards and walking around the wing. [Mr B] was aware of the requirements for attending the medication hatch for his medication and had demonstrated his awareness of this by successfully attending for his medications for more than two weeks."

65. Serco stated in a letter to Mr B dated 17 January:

> "I have reviewed the footage for the 13 January … You went to your cell approximately 20–30 minutes before most of the wing was locked for the evening and on review you do not appear to interact with the officers (your cell door was closed without any delay or response from the officer). This appears to be different to your complaint where you state that you asked the officer about your medication. In fact prior to your lock you spent significant periods of time standing at the window (along with a number of other men) when new men arrived to [the block]."

66. Serco told HDC that the medication signing sheet for January is not in Mr B's medical file and could not be located. The Patient Medical History does not record whether or not medication was administered on 13 January.

67. Serco told HDC that the registered nurse responsible for administering medication on the afternoon of 13 January, left Serco.

Serco policies in place at time of events

68. The Medicines Policy states that when a prisoner has his own medication on admission, the following procedures must be followed:

> "15.1.1 Record the medication name in the patient's electronic clinical file in the daily record.
>
> 15.1.2 Assess:
>
> - the type of medication

- clinical indicators for the use of medication.
- safety of the medication provided.
- purpose for prescription and impact if withheld."

69. The Medicines Policy also states that when medication is refused or missed, the following procedure must be followed:

> "13.1.4 Record in the patient's electronic file:
>
> — why medicine was refused/missed and when to restart medication."

70. Serco provided HDC with a copy of the Local Operating Manual, which it stated was relevant to the events in this case.

71. The Local Operating Manual outlines the procedure when medication has not been administered, as follows:

> "22.5.4 At the completion of each medication round the HCA and RN will meet to establish who has missed the medication round and the RN will make a decision whether the prisoner should be asked to come to the hub for medication. If the decision is not to administer then this will be written on the medication chart and will be initialed by both the RN and HCA. The HCA will also make a note in Medtech [Patient Medical History].
>
> …
>
> 22.5.6 If there is an emergency or restrictions in the […] block (such as a code blue) the HCA must contact the RN and discuss any medication that has not been administered. This must be completed prior to the end of the morning or afternoon session. The HCA and RN will discuss the urgency of medication administration and a list will be provided to the officers of men who must be unlocked to receive their medication. If it is not safe to unlock the men but is safe to administer at the cell door this must be discussed with the nurse in charge and approval sought to do this."

72. The Local Operating Manual also outlines the policy for new arrivals, which includes completing a Reception Health Triage (RHT) form. The RHT requires a triage category to be assigned:

> "A triage category is assigned to each prisoner and this denotes the time period in which the IHA [Initial Health Assessment] and doctors clinic must be completed. It reflects the clinical stability of the prisoner."

73. The Initial Health Assessment Policy states:

> "2.6 All health assessments and interactions by Healthcare Services staff are to be recorded in the electronic clinical file.
>
> …

> 4.2.7 All patients who have a triage score of 2 will have an IHA/UHA [Updated Health Assessment] completed within 7 days.
>
> All patients who have a triage score of 3 will have an IHA/UHA completed within 21 days."

Changes made by Serco

74. Serco stated that since these events the Local Operating Manual has been updated. Information from the transferring prison, provided in the Patient Transfer Register, must be reviewed and saved to a shared drive so that it can be accessed by the healthcare team.

75. Serco told HDC:

> "We also have more experience with special authority medications and with patients under specialist services such as for those men with […]. We can reach out to the services prior to their [the prisoner's] arrival and ensure the specialist is aware of the patient's transfer so care is streamlined."

76. Serco stated that its Local Operating Manual has also been updated as follows:

> "Where the patient has a special authority medication the approval number must be recorded in the alerts tab in Medtech. If the patient's special authority number is unknown the pharmacy must be called as they have access to an on-line database that provides the details and expiry date. A recall must be put in place with the expiry of the special authority, bearing in mind that at least one month leeway will be required to ensure all relevant assessments and documentation has been completed."

77. Serco said that prisoners' medication charts are now stored securely in a plastic sleeve at the back of each prisoner's file, and that Mr B's medication is now prescribed by the specialist at the public hospital, and is delivered by courier every three months.

Responses to provisional opinion

Mr B

78. Mr B was given an opportunity to comment on the "information gathered" section of the provisional opinion. Mr B did not provide a response.

Serco New Zealand Limited

79. Serco New Zealand Limited was given an opportunity to comment on the provisional opinion. Where relevant, its response has been incorporated into the "information gathered" section above.

Opinion: Serco New Zealand Limited — breach

Overview

80. Serco has a responsibility to operate its health service in a manner that provides consumers with services of an appropriate standard. The standard of health care that is available to prisoners in a prison must be reasonably equivalent to the standard of health care available to the public.

81. Prisoners do not have the same choices or ability to access health services as a person living in the community. They do not have direct access to medication or to a GP. They are entirely reliant on the staff at the Health Service to assess, evaluate, monitor, and treat them appropriately. If some medication is not taken consistently, a resistance to the medication can develop. The development of a drug resistance would have significant long-term implications for Mr B's health.

82. The Health Service's staff at Serco did not undertake an adequate Reception Assessment, they did not think critically and develop a plan for replenishing Mr B's medication supply, and they failed to administer medication on two occasions. This meant that Mr B was not able to take his medication consistently, which placed him at risk of developing long-term complications. While individual providers have responsibility for these failures, in this case there were multiple failures by multiple providers, which is the focus of this report.

Reception Assessment

83. On 21 December, Mr B transferred from Prison 1 to Prison 2. The Patient Transfer Information Form from Prison 1 stated that Mr B had various health issues, and that he was receiving medications for these.

84. The Medicines Policy requires the nurse to record the names of all medications in the prisoner's electronic file, and to assess the impact if the medication is withheld. RN A was the registered nurse at reception. She recorded that Mr B was taking three medications in the Reception Triage Form and on the electronic file, but not that he was also prescribed two other medications. There is no evidence that an assessment of the medication was undertaken to determine the impact on Mr B should the medication be withheld.

85. RN A also did not record the quantity of medication that was transferred with Mr B from Prison 1. Serco told HDC that there was a 10-day supply, while Mr B said that he had a 17-day supply. I am not able to determine the exact amount of medication that Mr B had with him when he arrived at Prison 2, but I accept that he arrived with a limited supply.

86. Mr B was triaged as "routine", priority 3. Priority 3 meant that Mr B was to be seen for an Initial Health Assessment (IHA) and a doctor's appointment within 21 days. Serco stated that Mr B should have been triaged as a "semi-urgent" priority 2, to be seen within seven days. Mr B was seen four days later for his IHA, but the doctor's appointment, which formed part of the IHA, was not scheduled until 30 December, nine days after the assessment at reception.

87. My expert advisor, RN Vivienne Josephs, was concerned about the documentation of Mr B's medication and that Serco did not expedite the doctor's assessment given the limited supply of medication. She advised that the management of Mr B's medication on admission to Prison 2 was a departure from the accepted standard.

88. I note that the Reception Assessment is an initial assessment. However, it is also an opportunity for Serco to obtain accurate information about Mr B's health status and requirements and establish a baseline for all subsequent assessments and clinical decisions. However, the information recorded was not sufficiently detailed or thorough — not all of Mr B's medications were recorded, the quantity of the medications were not documented, and the impact on Mr B of withholding medication was not recorded.

89. I accept Serco's statement that the registered nurse mistakenly triaged Mr B as a routine patient who did not require semi-urgent intervention, and that because of this Mr B was not seen by a doctor for nine days. However, I am critical that a robust and accurate assessment was not undertaken at reception, and that as a result Mr B's health status was not documented accurately, and the urgency of his clinical situation was not recognised.

Issue of prescribed medication on 28 December

90. At 3.30pm on 28 December, the healthcare assistant began to administer medication from the medication hatch. At 3.38pm, Mr B's wing was placed in lock-down, and all prisoners were locked in their cells. Mr B's medication was not administered at the medication hatch, nor was it delivered to his cell after lock-down.

91. The non-administration of medication was noted on Mr B's medication chart as an "A" for absent, but this information was not recorded in the Patient Medical History.

92. During the course of the afternoon and evening, Mr B contacted Master Control on at least three occasions to ask for his medication. He may also have told the custody officer that he needed his medication when his dinner was delivered at 4.35pm. I note that Serco does not accept that a conversation of this nature took place.

93. The policy in this situation is that the HCA who is administering the medication must report the non-administration of medication to the registered nurse on duty. I note that HCA Ms E stated that she did notify a registered nurse. The internal investigation by Serco and subsequent review found that this did not occur, and that Ms E did not notify a registered nurse. I accept the finding of the review and am satisfied that Ms E did not notify a registered nurse of the non-administration of medication.

94. The registered nurse on duty, who was contacted by the control room, was unsure whether the medication had been missed, because she had not received information to that effect at handover. Her response was to continue with her duties. She did not administer the medication or escalate the matter to the HCM. When the control room advised the HCM of the failure to administer Mr B's medication, the HCM's response was that she would not be attending the site and would look into the matter in the morning.

95. Serco told HDC that the process in the event of a lock-down is that those prisoners who require medication may have the medication administered at their cell. The policy states that if it is not safe to unlock the prisoner, then the approval of the HCM must be sought to administer medication at the cell door.

96. The HCA did not advise the registered nurse on duty that medication was not administered because of a lock-down, nor did she record the information in the Patient Medical History. As a result, the registered nurse and the HCM were unaware that Mr B's medication had not been administered until they were contacted by the control room. The registered nurse was confused about the status of the medication administration and took no further action. It appears that the HCM was also not able to determine whether the medication had been administered, and decided to wait until the morning to attend the site and resolve the issue.

97. I am critical that the policy was not followed and that the HCA did not notify the registered nurse that Mr B's medication had not been given, and did not enter the information on the Patient Medical History. This caused confusion for other health providers and meant that an opportunity to administer the medication at a later time was missed. I am also concerned that the registered nurse did not take any further action to investigate the matter when she was notified by the control room. It is unclear whether she checked the medication chart, which recorded that the medication had not been administered, but it appears that she took no further steps to clarify the situation. Had the registered nurse checked the medication chart, I would have expected her either to administer the medication or escalate the matter to the HCM.

Administration of medication on 5 January

98. On 5 January, Mr B did not receive his morning dose of medication. The supply from the pharmacy had not arrived, and the supply he had brought with him from Prison 1 had run out.

99. On 21 December, the Health Services staff were aware that Mr B's medication supply was limited, but the Reception Assessment did not record the impact of withholding the medication, and did not record the supply. The HCM said that on 25 December she was advised that Mr B had a 10-day supply. She stated that additional medication was prescribed by the doctor on 30 December, and the special authority number for the medication was sought on 4 January. The medication was delivered to Prison 2 on the afternoon of 5 January, and the afternoon dose was administered.

100. RN Josephs advised that the medication planning was poor because Prison 2 did not appear to anticipate that a special authority number would be required and that Mr B's supply would run out. She considered the poor planning and the non-administration of medication to be a departure from the accepted standard of care.

101. I accept that Serco did take steps to ensure that Mr B's supply of medication was replenished, but in my view these steps were not adequate. Serco staff were aware that Mr B's supply of medication was limited, but the plan for replenishing the supply did not take account of the need to obtain a special authority number. It appears that the plan

also did not take account of a number of public holidays during this period. In addition, as outlined above, the Reception Health Triage did not reflect the urgency of Mr B's health situation accurately, and the appointment with the doctor did not occur within seven days of reception. As a result, Mr B's medication supply ran out, and Serco was not able to administer his morning dose. I am critical that Serco failed to ensure that Mr B had an adequate supply of medication.

102. I also note that Mr B said that he had a supply of medication in his property at Prison 2 and a supply at his home. Serco stated that it was not aware of a supply in Mr B's property, and that it was confident that the pharmacy supply would arrive on 5 January and the supply from home would not be necessary. I am satisfied that the alternative supply from home was discussed, but am unable to determine from the information before me whether there was a supply of medication in Mr B's property at Prison 2, or whether the decision to wait for the pharmacy supply was the appropriate one.

Administration of medication on 13 January

103. Mr B's medication was not administered on the afternoon of 13 January. Mr B said that he was locked up before he received his medication. Serco stated that Mr B was engaged in other activities, and that he did not present at the medication hatch for his medication.

104. The HCA responsible for administering the medication stated that Serco expects prisoners to take responsibility for their own medication, and it appears that she discussed this expectation with Mr B the following day. It also appears that when the HCA realised that Mr B was not going to present for his medication on 13 January, she did not escalate the matter to a registered nurse because she believed that it was Mr B's responsibility to attend for his medication.

105. In addition, I note that Serco could not locate Mr B's medication chart, and the non-administration was not noted in the Patient Medical History by a registered nurse.

106. RN Josephs advised:

> "If staff were aware that [Mr B] had not received his evening medication and did not bring his medication to the cell following lockdown, that would be considered a mild departure from accepted standards."

107. It was understandable for Serco to expect Mr B to take reasonable steps to collect his medication. However, Serco had overall responsibility for ensuring that the medication was available to Mr B. Serco's policy requires the healthcare assistant to discuss any missed medication with a registered nurse, and for the nurse to decide whether or not to administer the medication. A decision not to administer must be written on the medication chart and in the Patient Medical History. I am concerned that the healthcare assistant appears to have been unaware of the obligation to escalate non-administration of medication to a registered nurse, and that she did not do so in this case. I am critical that as a result, Serco failed to administer Mr B's medication.

Conclusion

108. RN Josephs concluded that aspects of the care provided to Mr B represented a departure from the appropriate standard. As outlined above, the following aspects of Mr B's care are concerning:

- The Reception Health Triage was not sufficiently detailed or thorough;
- The medication planning was inadequate and meant that the correct medication was not available at the appropriate time;
- On one occasion an RN, and on two occasions the HCAs, were not aware of their obligations when medication was missed, and did not escalate the non-administration of medication to a registered nurse.

109. It is important that Mr B receive his prescribed medications consistently. As a consequence of the omissions outlined above, Mr B did not receive his required medication on three occasions. A number of staff failed to provide Mr B with an appropriate standard of care, and ultimately I consider Serco to be responsible for the deficiencies in care. In my opinion, Serco failed to provide services to Mr B with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.[5]

Recommendations

110. I recommend that Serco:

a) Provide a letter of apology to Mr B for its breach of the Code. The apology should be provided to HDC within three weeks of the date of this report, for forwarding to Mr B.

b) Review, and update if appropriate, its policy and procedures for Reception Health Triage to ensure that the appropriate information is captured. Evidence of the review of the policy is to be provided to HDC within three months of the date of this report.

c) Provide training on the updated Reception Health Triage policy and provide HDC with evidence of the training within four months of the date of this report.

d) Provide training to healthcare assistants and registered nurses on the policy for missed medications. Evidence of the training is to be provided to HDC within four months of the date of this report.

[5] Right 4(1) of the Code of Health and Disability Services Consumers' Rights states: "Every consumer has the right to have services provided with reasonable care and skill."

Follow-up actions

111. A copy of the final report with details identifying the parties removed, except the expert who advised on this case and Serco New Zealand Limited, will be sent to the Office of the Ombudsman, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from a registered nurse, Vivienne Josephs:

"**DATE : 19 March 2018**

Thank you for the request that I provide clinical advice in relation to the complaint from [Mr B] about the care provided by [Prison 2]. 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.

1. Documents reviewed

- Complaint from [Mr B]
- Responses from [Ms D] (dated 10/12/[…] and 17 January)
- Prescription Chart and Medications Administration Chart
- Clinical records from 26 December [...] to 15 January
- Serco Medicines Policy and Procedures (last updated 8 December 2015)
- Response by [Mr B] dated 16 February […] in response to [Ms D]
- [Prison 2] Fact Finding Review.

2. Complaint

On 18 October [...], [Mr B] made a complaint regarding the refusal of [Prison 2] to supply medication relating to the treatment of […]. He describes three separate incidents (occurring on 28/12/[…]; 5/01/[...] and 13/01/[...]) where he alleges that the prison health services failed to dispense his […] medication according to the prescription.

3. Clinical advice

I have been asked to provide nursing advice on the following:

a) <u>Management of [Mr B's] supply of […] medication upon admission</u>

[Mr B] arrived at [Prison 2] on 21 December. According to the response from [Ms D], [Mr B] was seen by the nurse for his reception assessment at 4.54pm. There was no reference to his medications or documentation of this in the clinical notes. A booking was made to see the GP on 30 December as it was noted that he only had a ten day supply of medication and it was over a public holiday period. He was also seen by an RN on 25 December for an Initial Health assessment. There was no reference to his medications at this assessment.

He was seen on Friday 30 December by [Dr G], the medical officer at [Prison 2], for his new arrival check. She reviewed his past history and 'generated' a script for his regular medications. [Ms D's] response stated that this was sent to the pharmacy the same day. On the next working day, 4 January, the pharmacy contacted the [Prison 2] health team advising that an updated speciality authority number was required for [Mr B's] […] medications. This was obtained from [the public] pharmacy and the [Prison 2]

pharmacy informed the health team that they would endeavour to source the specialist medication by 5 January.

[Ms D], in her response of 5 December [...], stated that she was made aware on the 25 December that [Mr B] had arrived with a ten day supply of medication and was booked to see the GP on 30 December. She stated that the team were aware of the importance of this medication and not interrupting the supply. She stated that she collaborated with their pharmacy to source the medication which was difficult due to the specialist nature of the medication and the impact of the public holidays.

[Mr B] and [Prison 2] differ in their accounts of the number of days medications were available on arrival at [Prison 2]. [Mr B], in his response to [Prison 2], stated that he arrived at [Prison 2] with 17 days of pre packed medications. The [Prison 2] review stated that there was 10 days supply. Clinical notes state that they ran out of [Mr B's] medications on 5 January.

Nursing Advice

[Mr B] was transferred from [Prison 1] on 21 December with a medication supply lasting ten days. It doesn't appear to have been appreciated that there could be potential difficulties accessing a continued supply over the Christmas/ New Year holiday period or that the nurse at the receiving office was aware that [Mr B's] […] medications required specialist prescription and may be more difficult or take longer to obtain. It is not documented if there was a handover from the [Prison 1] Prison health care team regarding [Mr B's] medications including the process for procurement and re ordering or regarding the need for a speciality authority number. Although it was acknowledged that the current supply was limited, the medical review (and ordering of medications) was not scheduled till nine days later on a Friday, the last working day before the next public holiday period. Eight days of [Mr B's] current […] medication supply would have passed before the request to pharmacy for additional medication would have been initiated.

Section 27.6 of Serco's Local Operating Manual details the requirement for the nurse at the receiving prison to discuss any medication requirements for patients with complex health conditions and that these must be documented in the electronic clinical file. It is not clear if there was a discussion between facilities regarding the management of [Mr B's] medication.

b) Management of [Mr B's] […] medication including prescription and dispensing process

[Mr B's] original medication order used by [Prison 2] for his medications on arrival on 21 December was prescribed at [Prison 1] on 12 October [...] and was used for dispensing until it was recharted by [Dr G] on 11 January. [Dr G] saw [Mr B] on 30 December [...] and 'generated' a prescription. I am unclear as to the meaning of 'generated' in this context.

[Mr B's] medication administration chart from the time of his arrival at [Prison 2] has been unable to be located.

[Prison 2's] Fact Finding Review and the Medications Policy and Procedures Manual describe the process of how prisoners receive their medications. Medications are dispensed by the Healthcare Assistants (HCAs) at a morning and/or afternoon triage after identification has taken place using a biometric reader. If the prisoner does not attend, the dispensing sheet is marked as being absent and the HCA informs the RN if there is a lockdown or the prisoner has not attended the triage and the medications are then taken to the patient's cell. According to Sections 7.2 and 11.1.15, the HCA must report to the RN if there are issues or concerns, if the medication is not available or if it has not been administered by the end of the shift. The RN must investigate why this has occurred and assess what further clinical intervention is required. This should be documented in the patient's electronic record. Documentation must be made on the medication chart and in the patient's electronic clinical notes. This process was not followed on the 28 December [...] which was acknowledged by [Ms D] and an apology given to [Mr B].

On 5 January, [Mr B] states that a nurse came to his cell and informed him that they had run out of his medication. He informed her that he could have his wife bring in the medications from home. After discussion with [Ms D], the RN returned and informed [Mr B] that his request was declined and that his evening medication would be delivered in time. [Mr B] stated that he had advised staff to reorder his medications on 30 December [...] but there is no documentation of this conversation in the clinical notes.

On 13 January, the HCA recalled giving [Mr B] his morning medication but stated that he didn't receive his afternoon medication as he did not come to triage to collect it. She stated that he assumed that the staff would hand deliver to the cell if he did not collect his medication. [Mr B], in his response to Serco's account, states that he did go to collect his medications that afternoon, but there was a long wait as new inmates had arrived. An hour later, the custody officers called lock up and he overheard the custody officers say they would bring medications to the cells. It is not clear if that comment was directed at a specific inmate or to all the men waiting for medications. He stated he didn't use the intercom to request his medications as he stated that there had been a delay on 5 January when he had called.

Nursing Advice

It could have been foreseen that [Mr B's] medications would run out before the morning of 5 January. [Ms D] states that she was unaware that [Mr B] had a supply at home and there is no documentation stating that [Mr B] informed the healthcare team of his supply when he stated on 30 December [...] that the [Prison 2] supply was running low.

The process for dispensing medications, as described in the Medications Manual by either having the inmate come to the hatch to receive their medication or have it delivered to the cell if the block is in lockdown or the inmate hasn't come to get to his

medication, appears to be robust. The responsibility of medication compliance is then shared both by the inmate and the HCA/RN.

It is difficult to discern from the incidences on the 5 January and the 13 January whether there was a lack of proactivity on behalf of [Mr B] in accessing his medications using the processes in place or whether contextual difficulties including the lockdowns hindered the medications being administered as per protocol.

c) The reasonableness of [Ms D's] response regarding the three incidents referred to in [Mr B's] complaint where he alleges he did not receive his […] medication

[Ms D's] responses dated 10 December [...] and 17 January identify and acknowledge [Mr B's] complaints for the non administration of his medication on 28 December, 5 January and 13 January.

28 December

[Mr B] states that on 28 December he did not receive his evening medication despite three requests to prison staff. This was confirmed by [Ms D], a review undertaken, and an apology given.

[Ms D] describes the review of the camera findings of 28 December as giving the appearance, in [Ms D's] opinion, that [Mr B], unlike the other men in the wing, appears to be engaged in other activities rather than attending the triage hatch for his evening medications. A lockdown was called and [Mr B] returned to his cell. [Mr B] called the Master Control during the lockdown and again twice in the evening requesting his medications. [Ms D] states that it appears from the CCTV that he didn't speak with the officers when his dinner was given at 1635 hours.

Nursing Advice

[Ms D's] response by providing an apology and initiating an investigation into why [Mr B] didn't receive his medication was a reasonable and appropriate one. [Ms D] explained that it was not possible to deliver his medication during the code blue and apologised that his evening medications were not brought to his cell despite his later two requests and as required by the Medications Policy and Procedure document (11.1.5). An incident review was conducted and discussions with the RN and HCA involved took place.

[Ms D] stated that [Mr B], in her opinion, appeared to delay his approach to the triage hatch when the lockdown happened to occur at the same time and thereby allowing his medication to be missed. This could be seen as subjective and open to interpretation. [Mr B] stated in his [date] response, that he was, in fact, at the door with his cup to receive his medications.

5 January

On 5 January, [RN C] stated that she was informed by Head of Health that due to the public holidays and the requirement for the special authority number, [Mr B's] medication had not arrived. She informed [Mr B] who requested that his family be

able to deliver his medication from home. [Mr B] stated that he had repeats of his medications delivered to his home from the pharmacy prior to his incarceration at [Prison 1]. RN B stated that she discussed this with the Head of Health, [Ms D], who declined the request due to safety reasons. [RN C] was advised that the medications would be delivered that day.

Nursing Advice

[Ms D's] narrative of 10 February, [...] stating that '*the delays in acquiring your medication on 5 January ([...]) were reasonable',* in my opinion, is not a reasonable explanation. It could have been foreseen that 10 days of medications would run out on the 31 December [...], that there would be difficulty in procurement of these medications over the holiday period and that an earlier appointment would need to be made for the medical officer review. The clinical notes do, however, document the urgency of obtaining these medications and the efforts made by the health Care Manager and pharmacy to get them delivered as soon as possible.

I am unclear as to why [Mr B] was not allowed to have his medications brought in from home as an alternative to having to miss out on his morning medication. The Medications Policy and Procedure document for [Prison 2] explains in 14.1 2 that nurses can issue the patient's medication if the pharmacy label is intact, the medication has been dispensed within the last 3 months, it has not passed its expiry date and is in its original packing. 14.1.6 also states that the patient's own medication can be used until supplied by the pharmacy.

[Ms D] stated that, following this incident, [Prison 2] are working with the infectious diseases team at [the] DHB and [Mr B's] medications are now being couriered. [The DHB is] also now responsible for the prescribing of his medications. I am critical as to why this information wasn't available to [Prison 2] when he transferred from [Prison 1] as he appears to have been there since October [...].

13 January

[Mr B] and [Ms D], in her responses, present different interpretation of what occurred and what was viewed on the CCTV on 13 January. [Ms D] describes CCTV footage where [Mr B] was viewed in the dayroom, playing cards and walking around whilst the other men were going out of the wing to get their medication. [Mr B] in his statement of 16 February 2018 states that he looked at the line of new inmates and was weighing up how long it would take for him to wait for his medication.

[Ms D's] assessment in her response was that [Mr B] appeared to be involved in gambling and not focussing on his health needs. She believed that [Mr B] had the awareness that he needed to attend the triage window for his medication as he had done so before, but had chosen not to do so. This could be open to interpretation and may not be a reasonable response to [Mr B's] complaint.

[Ms D] stated that [Mr B] complained that he did not hear the call for medication and did not seek assistance via intercom during the lock down as he believed he would not

be responded to (based on his experience of 5 January). [Ms D] stated that he went to his cell 20–30 minutes before the cell was locked for the evening and that he didn't interact with the officers. She stated that this was different to [Mr B's] account that he had asked the officer for his medication.

Nursing Advice

It does appear that [Mr B] may have had opportunities to access his medications before the lock down but did not do so. [Ms D] explains in her response that the facility aims to have inmates work collaboratively in managing their own medications but it is not clear why [Mr B] was not managing his own medications when he first entered the facility. He had been on his […] medications for some time, and was familiar with the action, dosages and importance of adherence of those medications.

It is also not clear where the RN was waiting with [Mr B's] medication when his cell was in lock up. It appears he was on the medication list for the 13 January but the medication was not brought to his cell. There is a differing account of whether [Mr B] notified staff that he had not received his medication that afternoon.

Additional Advice

[Ms D's] response of 17 January discusses an assessment for [Mr B] to have a weekly contract to manage his own medications. This would, in my opinion, be the best option to avoid missing medications in the future and to allow him to take responsibility for his own administration. His concern for an increased viral load as a result of missed medications indicates knowledge of his medications and the effect of omissions. I agree with [Ms D] about questioning [Mr B's] motivation for not wanting to self administer his own medications which would ensure continuity and his clinical well being. Having to attend the distribution hatch twice a day and sign for medications with consequences for non adherence doesn't appear to be conducive to promoting [Mr B's] autonomy and I am unsure why he would not want to avoid having to have to do this.

d) Recommendations for further information or advice in relation to the issues raised in the complaint.

There is need for further clarification regarding the process of clinical handover of [Mr B] from [Prison 1] to [Prison 2] in regards to procurement and administration of his medications as well as details of any experienced difficulties with medication management. There does seem to have been some issues at [Prison 1] regarding missed medications as noted by [Dr G] in her initial medical review on 30 December [...]. Additionally, the medication administration chart from the date of arrival at the [Prison 2] on 21 December to 13 January needs to be located and reviewed. Without this, there is no record of the medications that were administered or omitted during this period.

The Medications Policy and Procedures Manual would benefit from a policy regarding management of specialist medications requiring a special authority number and a plan and procedure for supply of medications over a holiday period.

The internal report found that the process of giving medications to inmates during lock up had not been followed which resulted in [Mr B] not getting his medication on 28 December. The conclusion was that health staff should receive further training. It appears that [Mr B] missed his medication on the 28 December [...] due to non adherence of current policy. Clarification on the details of the future training that is envisaged would be beneficial.

Departures from Expected Standard

[Prison 2]

The non administration of [Mr B's] medications whilst an inmate at SERCO's [Prison 2] was a significant departure from an expected standard.

1. Non adherence to Policy (**Moderate departure)**

a. Regarding administration of [Mr B's] medication following the evening of the code blue despite his two requests

2. Absence of Policy **(Mild–Moderate departure)**

a. regarding obtaining medications over a holiday period in particular those medications which require a specialist prescription or special documentation or special authority number

b. regarding use of patient's own medications from home if on site pharmacy unable to supply at the time and patient's own medication packaging meets existing policy criteria in 14.1.2.

3. Standard of Nursing Practice (**Moderate departure**)

a. lack of formal clinical handover from [Prison 1] on 21 December to [Prison 2] regarding [Mr B's] medications and requirements for procurement to ensure continuity of medication administration.

Viv Josephs, RN, BHSc, PGCert (Nursing)
Nursing Advisor
Health and Disability Commissioner"

The following further advice was obtained from RN Josephs:

"CLINICAL ADVICE: NURSING (Additional to Advice of 19 March 2018)

28 August 2018

I have been asked to formalise my earlier advice on the following:

1. Whether there was a departure from the expected standard for the management of [Mr B's] medication upon admission to [Prison 2] and, if so, to what extent (mild, moderate, severe).

There was a mild to moderate departure from an accepted standard of care for the management of medication for the following reasons:

Incomplete medication reconciliation on all [Mr B's] current medications on admission specifically […] medications. Medication reconciliation 11.7 of the NZNO guidelines recommend 'medication reconciliation should be carried out for all patients within 24 hours of admission, transfer or discharge from any setting'[1].

Absence of reference in the electronic clinical notes to the […] medications that [Mr B] had brought in with him as required by 15.1.1. Serco Medicines Policy.

Poor medication management in not scheduling an earlier GP assessment to generate the prescription for [Mr B's] medication and ensure procurement of the medication before the current supply was due to run out within the following 10 days. This includes not researching the […] medications and the need for a special authority number.

Delay in notifying Head of Healthcare Services of the 10 day remaining supply of [Mr B's] medications until 25 December despite a recognition of the importance of this medication as noted in the documentation of 21 December requiring the HCA to '*make sure'* that [Mr B] *receives his medication as per the medication chart.*

No documentation on the patient's medication chart of 'using own medication' as required by 15.1.7 Serco Medicines Policy.

No reference to a transfer letter (including details of medications) from [Prison 1] documented in the clinical notes as required in 10.10 and 14.6 of [Prison 2] Local Operating Manual[2].

2. Whether there was a departure from the expected standards for the administration of medication on 28 December, 5 January and 13 January and, if so, to what extent (mild, moderate, severe).

28 December:

There was a moderate departure from an accepted standard for the administration of medications on 28 December for the following reasons:

Non administration of [Mr B's] […] evening medication despite more than two stated requests from [Mr B]. (10.1.6, 10.1.9 Serco Medicines Policy)

Non adherence to the Serco policy that medications must be delivered to the prisoner's door during the process of lockdown.

[1] New Zealand Nurses Organisation (2014). Guidelines for nurses on administration of medicines. Wellington

[2] Prison 2 Local Operating Manual. Version 1.05. 18 May 2015

Non documentation in the electronic clinical notes as to the non administration of [Mr B's] medication (required by 7.2; 10.1.3; 11.1.5, 12.1.7, 13.1, and 22.5.4 in Serco's Local Operations Manual).

The marking of absent on [Mr B's] medication chart by the HCA administering medications and lack of reasoning for the same (documented in Serco's Fact Finding review) and the lack of communication with and documentation by the RN regarding the non administration.

Non escalation by RN to management if she was unable to administer medications due to other events on site.

5 January:

There was a mild to moderate departure from a reasonable standard of care for the following reasons:

Non administration of [Mr B's] morning […] medication on 5 January.

Poor medication planning on arrival at [Prison 2] to anticipate the current supply of anti retro virals running out on 5 January and a lack of knowledge of the need to obtain a special authority number.

Declining of [Mr B's] request to ask his wife to bring his medications from home (providing they met Serco parameters and guidelines for bringing in a prisoner's own medications) in order that [Mr B] not miss his […] medications.

13 January:

There are differing accounts as to the notification by [Mr B] to the staff regarding his non receiving of evening medications on 13 January. If staff were aware that [Mr B] had not received his evening medication and did not bring his medication to the cell following lockdown, that would be considered a mild departure from accepted standards.[3]

3. Whether there was a departure from the expected standard for the prescription of the medication for complex needs prisoners and if so, to what extent (mild, moderate, severe).

In reviewing point 27.6 and 27.7 of Serco's Local Operating Manual (pg 22), there is a requirement by the nurse at the transferring prison to discuss any medication requirements for patients with complex health conditions with the receiving prison and have these documented in the electronic clinical file. There is no policy, however, that the receiving prison ([Prison 2] in this case) is required to contact the transferring prison to obtain this information.

[3] Domain 2.1 of the NZ Nursing Council Competencies for Registered Nurses; 12.2 (Appendix One: standards for administration of medicines; 10.4; NZNO Guidelines for Nurses in the Administration of medicines)

The departure from an accepted standard of care is the absence of acknowledgement in the electronic clinical files of a transfer letter from [Prison 1] to [Prison 2] outlining medication management including the process of procurement of an ongoing medication supply. If there was a transfer letter received from [Prison 1] and it is not acknowledged in [Prison 2's] clinical notes, I would consider this a mild to moderate departure from accepted practice. If there was no transfer letter, the departure on an accepted standard of care would be on [Prison 1].

There was a mild departure from Serco's accepted standard (27.6 in the Local Operating Manual) in that there was no documentation that there had been a discussion by the nurse at the receiving prison ([Prison 2]) with [Prison 1] regarding [Mr B's] medication requirements and the need to obtain a special authority number for ongoing prescriptions.

4. Whether there was a departure from the expected standard for the use of personal medication by prisoners and, if so, to what extent.

If [Mr B] did have an additional supply of medication at home which met the Serco standard (14.1.2, 27.6 in the Local Operating Manual) for being able to be administered by Serco staff whilst pharmacy were filling his script (generated 30 December) and if [Mr B] had informed nursing staff of his supply at home and the ability of his wife to bring these in to avoid missing any medications and this request was declined leading to [Mr B] missing medication, I would consider this a mild departure from Serco's standard 14.1.6 regarding use of a patient's own medication until medication can be supplied by pharmacy).

5. Whether the policies for the management of medication upon admission, administration of medication, the prescription of medication and the use of personal supply of medication are to the expected standard. If there is a departure from the expected standard please advise to what extent (mild, moderate, severe).

There is a mild departure from a reasonable standard in the management of medication upon admission in the absence of documentation within the 'management of medications on admission' within the Medicines Policy and Procedures documents regarding the process for incoming prisoners with medications that require special authority numbers such as […] or medications requiring special monitoring. There is need for a process/guideline for procurement of medications that are not routine or require special management.

Additionally, there is no process regarding planning, ordering and procuring medications prior to and over a holiday period.

<u>Other Comments</u>

Although it is not clear if, on the 5 January and 13 January [Mr B] had opportunity to access his medication but delayed that access, it is still incumbent on the staff administering medications to prisoners to ensure they have the opportunity to accept

medications when offered, including in their cell and that any issues or concerns regarding that administration is to be documented in the electronic clinical notes. Serco's Medicines Policy and Procedures document states in 1.1.3 that [Prison 2] *will manage and administer medicines to ensure that all patients receive access to appropriate medication as clinically indicated, within a custodial environment.*

There is no reference to the amount of his […] medication [Mr B] brought with him to [Prison 1] in October and when that medication stopped being used and he began using pharmacy dispensed medication. There is no reference to a special authority number being obtained. This would have been useful information from the [Prison 2] to have received in the handover.

Section 27 of Serco's Medicines and Procedures Policy discusses the responsibilities for the nurse in transferring a patient. There is a need for an additional process that includes the responsibilities of the nurse receiving a patient including *'assessing the individual medication and health needs'*.

There was reference in the electronic clinical notes to a Reception Health Triage Form and an Initial Health Assessment Form. They were not present in the file. There was no reference to a transfer form in the electronic clinical notes.

The clinical notes of 22 Dec [...] documented 'Received handover from HCM (Health Care Manager) from [Prison 1])' but it was not clear what clinical information was handed over and if that pertained to [Mr B's] ongoing medication management.

Additionally, it is not clear if Serco staff researched the […] medications regarding effects, monitoring, and administration including prescribing requirements and the need for a special authority number.

There is an absence of reference in the medicines policy to education of HCAs and HCA updates of Serco policy regarding medication administration. (This is in reference to the HCA [Ms E's] response in the Fact Finding Review of the incident on 28 December). All HCAs administering medications need to understand their responsibilities and accountabilities (Section 9 of NZNO Guidelines for administration of medicine).

Viv Josephs, RN, BHSc, PGCert (Nursing)
Nursing Advisor
Health and Disability Commissioner"