Sunrise Healthcare Limited

A Report by the
Deputy Health and Disability Commissioner

(Case 19HDC00760)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to an elderly woman by Sunrise Healthcare Limited (trading as West Harbour Gardens) from July to October 2018. On six occasions, the woman was administered the incorrect dose of warfarin, and on another occasion the administration and documentation were incomplete. A systems failure was likely the cause of the errors, as six different nurses made the same mistake. The errors were not identified until almost a year later, following a complaint from the family, and there was a lack of open disclosure of the errors to the family.

2. The report highlights the importance of aged residential care facilities ensuring that the systems they have in place for receiving prescribing instructions from a GP are clear and understood by nursing staff, and that they have appropriate systems in place to identify medication errors in a timely manner.

Findings

3. The Deputy Commissioner found Sunrise Healthcare Limited in breach of Right 4(1) of the Code. The Deputy Commissioner was critical that systems failures at Sunrise Healthcare Limited meant that the woman was administered incorrect doses of warfarin on six occasions, and the errors were not identified until almost a year later following a complaint from the family. When the errors were identified they were not documented in an incident report form, no investigation report was completed, and corrective actions were not documented formally. As such, there was a lost opportunity for learning from the lapse in care and making changes sooner.

4. The Deputy Commissioner made adverse comment about the lack of open disclosure of the errors to the family.

Recommendations

5. The Deputy Commissioner recommended that Sunrise Healthcare Limited audit any medication errors at West Harbour Gardens (over a three-month period); review the Critical Incident Reporting policy and a restorative approach to investigating incidents; review and update the Medication Management Policy and Procedures, and provide a formal written apology to the woman and her family.

Names have been removed (except Sunrise Healthcare Ltd/West Harbour Gardens and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided by Sunrise Healthcare Limited (trading as West Harbour Gardens (WHG)). The following issue was identified for investigation:

- *Whether Sunrise Healthcare Limited provided Mrs A with an appropriate standard of care between July and October 2018 (inclusive).*

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

8. The parties directly involved in the investigation were:

Mrs A	Consumer
Ms B	Complainant/consumer's daughter
Sunrise Healthcare Limited (West Harbour Gardens)	Provider

9. Further information was received from:

Registered Nurse (RN) C	Registered nurse at WHG
RN D	Registered nurse at WHG
Dr E	General practitioner (GP)
HealthCERT	

10. Facility Manager Ms F is also mentioned in the report.

11. In-house clinical advice was obtained from RN Hilda Johnson-Bogaerts (Appendix A).

Information gathered during investigation

Introduction

12. This report concerns warfarin medication errors made on six different occasions over a period of five months from July to November 2018, involving six nurses at WHG. The errors were not identified at the time, and the Medication Management Policy and Procedures and investigation of the errors in 2019 were inadequate.

13. Warfarin is an anticoagulant medication prescribed to maintain a person's blood-clotting function within a therapeutic range. The potentially serious consequence of Mrs A not receiving her prescribed dosage of warfarin cannot be over-emphasised.

Names have been removed (except Sunrise Healthcare Ltd/West Harbour Gardens and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Mrs A

14. Mrs A, aged in her nineties at the time of events, had a medical history of arthritis, chronic kidney failure, mini strokes (transient ischaemic attacks), irregular heart rate (atrial fibrillation), surgery for bowel cancer (a hemicolectomy), borderline personality disorder,[1] cognitive impairment, dementia, high blood pressure (hypertension), hypertensive encephalopathy,[2] cataracts,[3] and hearing impairment.

15. On 5 April 2015, Mrs A was admitted to WHG due to cognitive impairment and a significant change in her health, which required hospital-level care. Mrs A was independent with her activities of daily living,[4] and required minimal support. She was mobile with the use of a walking frame. An enduring power of attorney for personal care and welfare for Mrs A was held by her daughter, Ms B, and had been activated.

Dr E

16. Dr E was Mrs A's GP while she resided at WHG. Dr E was a community practitioner (a GP chosen by the resident), as opposed to the usual facility practitioner (a GP contracted by WHG).

West Harbour Gardens

17. In 2019, WHG rest home and hospital provided rest-home and hospital-level or medical care for up to 74 residents, including younger people with disabilities.

Facility Manager and Clinical Manager

18. In July 2019, Ms F became the Facility Manager. Expectations in the Clinical Manager's job description include ensuring that drugs are administered correctly by registered nurses, and that registered nurses and nursing assistants are safe to administer drugs and manage medication, and nursing staff have an up-to-date education record and competencies. The role reports to the Facility Manager. Under the Medication Management Procedure and the Incident/Accident Reporting Policy (see Appendix B), the Manager/Clinical Coordinator is required to investigate medication errors.

Warfarin medication

19. On 27 May 2018, Mrs A was started on warfarin (a blood thinner) for atrial fibrillation. The medication was later stopped on 16 February 2019 due to falls and bruising.

20. INR[5] blood tests are undertaken to measure the time it takes for blood to clot, and this is used to monitor blood-thinning medicines such as warfarin. Patients on warfarin, especially elderly people and those with atrial fibrillation who are receiving warfarin to prevent stroke, should be maintained on an INR in the therapeutic range of 2 to 3. If the INR is below the

[1] A mental disorder characterised by unstable moods, behaviour, and relationships.
[2] A general brain dysfunction due to significantly high blood pressure.
[3] Clouding of the normally clear lens of the eye.
[4] Including performing personal hygiene, being able to move about, and toilet use.
[5] The international normalised ratio is a laboratory measurement used to determine the effects of oral blood thinners such as warfarin.

Names have been removed (except Sunrise Healthcare Ltd/West Harbour Gardens and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

target range, there is an increased risk of the blood clotting; conversely, if the INR is too high, there is an increased risk of bleeding, and elderly people also have a higher risk of falls. The following table shows Mrs A's INR test results and Dr E's directed dose of warfarin adjusted in response to the INR results:

Date	**INR**	**Dr E's directed warfarin dose**
28 May 2018	1.0	3mg
1 June 2018	1.3	3mg
5 June 2018	2.4	3mg
8 June 2018	2.1	3mg
13 June 2018	3.2	stop [warfarin] for 1 day, then restart at 2.5 mg
20 June 2018	1.7	Please Give 3mg tues wed thurs sat sun, 4mg Mon Fri
4 July 2018	3.8	**give 2mg Mon Fri, 3mg other days: ie Tues Wed Thur Sat Sun**
20 July 2018	2.7	Same dose as 4 July
2 August 2018	2.3	Same dose as 4 July
15 August 2018	1.8	2mg Mon, 3mg other days: ie Tues Wed Thur Fri Sat Sun
5 September 2018	2.8	Same dose as 15 August
5 October 2018	3.0	2mg Mon Fri, 3mg other days: ie Tues Wed Thur Sat Sun
31 October 2018	2.4	Same dose as 5 October
5 December 2018	3.1	Same dose as 5 October

21. From 4 July 2018, the warfarin dose to be administered was 2mg on Mondays and Fridays, and 3mg on the other days of the week. The exception to this was a change between 15 August and 5 October 2018 to 2mg on Mondays only, and 3mg on the other days.

Warfarin administration errors

22. Warfarin was administered to Mrs A by WHG nurses, and doses were directed by Dr E according to INR test results. Between July and November 2018, there were six occasions on which 3mg of warfarin was administered to Mrs A instead of the 2mg charted. The following table shows the date of medication errors:

Names have been removed (except Sunrise Healthcare Ltd/West Harbour Gardens and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

13 July 2018	20 July 2018	15 October 2018
16 July 2018	12 October 2018	19 November 2018

23. In addition, on 8 August 2018, the warfarin chart indicates that the process of administering was started, but was incomplete, as the dose and signing had not been completed. RN C updated the progress notes that evening with "Phoned [Dr E's] surgery for updated prescription". There is no further entry explaining whether warfarin was administered that evening. None of the medication errors were identified by WHG at the time of events.

24. Six registered nurses were involved in the warfarin administration errors. Statements were obtained from two of these nurses — RN C and RN D.[6] RN C and RN D both stated that they were "shocked and surprised to hear of the errors and cannot explain how the errors came about". The errors were identified approximately a year after they occurred, when WHG was responding to Mrs A's family's complaint.

25. RN C stated that the warfarin prescription was received by fax from Dr E and placed in the medication folder with the signing sheet. RN C commented that the prescription format was different to the way the WHG facility GP[7] prescribed warfarin, i.e., Dr E prescribed different doses for two days out of seven, whereas the facility GP would prescribe the dose only with alternating days. RN C suggested that this unfamiliar way of prescribing, and the different prescribing sheet used by Dr E, may have been a contributing factor to the medication errors. She added that this is not an excuse, but is made more as a reflection on events.

26. The job description for registered nurses includes an expectation that nurses will coordinate the provision of optimal resident care to all residents, including that "[a]ll medication administered, [is] signed for". On the six occasions on which the incorrect dose of warfarin was administered, two nurses were involved in the administration — one to administer the medication and the other to check the dose. This was in line with the administration of medicines requirement in the Medication Management Policy and Procedures (see Appendix B).

27. WHG requires that staff who administer medication must undertake relevant training and complete medication administration competency. This competency can be repeated at any time, but is to be repeated at least annually. The Competency Assessment Register shows that all nurses involved in the errors had a recent medication competency assessment on file (except for one nurse, where no documentation was found).

Discovery of medication errors and internal investigation

28. The medication errors were not realised for 9 to 12 months, and were discovered by Ms F while she was investigating a complaint made by Mrs A's family regarding her care generally.

[6] WHG was unable to obtain statements from the other nurses as they were no longer employed by WHG.
[7] A GP contracted by WHG as opposed to a community GP.

Names have been removed (except Sunrise Healthcare Ltd/West Harbour Gardens and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

29. The Medication Management Policy and Procedures (see Appendix B) requires that when an error occurs, several steps must be taken, including the reporting of the error to the Manager and GP by a registered nurse, and the completion of a Medication Incident Report Form by a registered nurse. In addition, an investigation is to be undertaken by the Manager/Clinical Coordinator.

30. There is no evidence that a formal investigation ever commenced, and WHG told HDC that it has been unable to locate an incident report, or a record of corrective actions taken. It is unclear whether WHG reported the events to Dr E at the time. Mrs A's daughter, Ms B, told HDC that the family were not informed of the errors, as required by the Incident/Accident Reporting Policy (see Appendix B).

31. However, in response to the errors, Ms F[8] created a document[9] summarising the charted warfarin doses, and highlighted where the incorrect dose had been administered or administration was incomplete (see paragraph 22 for the highlighted dates). There is no date on this document. Ms F shared the analysis of the errors with the staff involved, and advised them to take further action to "ensure medication administration competence remains safe".

32. RN D told HDC:

> "On the day we received the initial complaint from [Mrs A's] family, all nurse[s] were required to update their medication competencies. And if someone had a simple medication error (i.e. RN forgot to put the dates/dosages of medications given) that RN is required to write a reflection letter to be submitted to the [Clinical Manager]. [The Clinical Manager] also checks the medication book daily to ensure that medications were signed properly."

33. RN C told HDC that following identification of the errors by Ms F, Ms F told her to update her medication competency, and to review "all relevant policies".

34. WHG has subsequently raised an incident report for these errors.[10]

Further information

35. RN C and RN D both told HDC that they take any complaint and medication error very seriously.

[8] Under the Medication Management Procedure and Incident/Accident Reporting Policy, the Manager/ Clinical Coordinator is required to investigate medication errors. It is unclear whether "Manager" includes "Facility Manager".
[9] INR Analysis and Administration, 23 August 2019.
[10] There is no date of when this occurred. A letter to HDC received in April 2021 states: "I have been unable to locate an incident report or any corrective actions on our registered nurse record involved in this complaint. (In light of this, an Incident report has been raised for the errors. Follow up actions will include all of what has been learned in this investigation. This will include training, policy reviews, and improvements.)"

Names have been removed (except Sunrise Healthcare Ltd/West Harbour Gardens and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

36. The Service Manager at Sunrise Healthcare Limited told HDC that the Critical Incident Reporting Policy would be reviewed to include consideration, involvement, or notification of the health consumer, family/whānau, and a restorative approach when responding to and investigating adverse events.

37. HealthCERT told HDC that a surveillance audit of WHG in January 2020 found five partially attained standards, one of which was a low-risk finding relating to medication management.[11] HealthCERT confirmed that corrective actions were met and closed in June to July 2020. The latest HealthCERT certification audit, in June 2021, found a low-risk finding relating to medication management.[12]

Responses to provisional opinion

Mrs A's family

38. Mrs A's family was given an opportunity to respond to the provisional opinion. The family said that their motivation for making this complaint was to bring about changes in the systems at WHG and to hold those at fault accountable.

Sunrise Healthcare Limited

39. Sunrise Healthcare Limited was given an opportunity to respond to the provisional opinion. Where appropriate, Sunrise Healthcare Limited's comments have been incorporated into the report.

40. Sunrise Healthcare Limited accepted that medication errors were made, and that it was responsible for the failure to provide an acceptable level of care to Mrs A, and it failed to investigate the incidents appropriately, as required under its policies.

41. Sunrise Healthcare Limited commented:

> "We accept that human error will occur, and the systems are the only means of managing this. These systems are however a backup, rather than an alternative to the need for human input required in the administration of medications."

42. Regarding the recommendation to review and update the Medication Management Policy and Procedures, considering the Ministry of Health Medicines Care Guide for Residential Aged Care, Sunrise Healthcare Limited commented that while a review will be of value, it is unconvinced that any changes will prevent mistakes caused by human error.

43. Regarding the recommendation to review the Critical Incident Reporting policy, Sunrise Healthcare Limited stated: "We take on board the comments regarding our Incident Management policies and work toward a system that ensures desired outcomes."

[11] The medication fridge temperatures had not been recorded in both treatment rooms, and no recording of room temperatures had been completed.

[12] Five packets of eye drops had not been dated when opened. They have a short shelf life once opened and it is expected that they are dated on opening.

Names have been removed (except Sunrise Healthcare Ltd/West Harbour Gardens and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

44. Sunrise Healthcare Limited also stated: "While we accept the significance of the errors, we have no evidence to suggest medication errors were widespread throughout West Harbour Gardens."

45. Sunrise Healthcare Limited commented:

> "From the lack of documentation, we have to assume that appropriate follow up did not occur after the errors were identified. … We don't believe that this, along with the medication errors are in any way indicative of multiple failures within West Harbour Gardens."

Opinion: Sunrise Healthcare Limited — breach

Introduction

46. Sunrise Healthcare Limited (trading as WHG) had a duty to provide services to Mrs A with reasonable care and skill. This included responsibility for the actions of its staff at WHG, and an organisational duty to facilitate reasonable care. Sunrise Healthcare Limited also has a duty to comply with the New Zealand Health and Disability Services (Core) Standards, which state:

> "**Service Management Standard 2.2**: The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers."

47. Mrs A had been a resident at WHG since 5 April 2015, and in May 2018 she started to take the blood thinner warfarin for atrial fibrillation. Warfarin was prescribed by her GP, Dr E, according to the INR results, and it was administered by nurses at WHG.

Warfarin administration errors

48. On six occasions, from July to November 2018, Mrs A was administered 3mg of warfarin instead of the prescribed 2mg, and on another occasion the administration and documentation were incomplete. These errors involved six different nurses at WHG, and the errors went unnoticed for almost a year, being identified when the family's complaint was being investigated by WHG.

49. Statements were provided to HDC from two of the nurses involved, RN C and RN D. Both nurses said that they take any complaint and medication error very seriously and could not explain how the errors occurred.

50. I note that WHG provided evidence[13] of competency training in medication management for the time of events. I am critical that documentation of competency training in

[13] Documentation was provided for five of the six nurses involved in the errors.

Names have been removed (except Sunrise Healthcare Ltd/West Harbour Gardens and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

medication management was absent for one of the nurses. Double checking of the medicine administration was provided, as per WHG policy, which is meant to safeguard against medication errors being made. However, it is clear that a number of appropriately trained nurses, following policy, made the same warfarin medication error over a period of five months on six separate occasions. My in-house clinical advisor, RN Hilda Johnson-Bogaerts, advised that "[b]ecause several nurses made the same mistake a systems error as a significant contributing factor is likely". I agree that a systems issue is probable, but because of the lack of timely identification of the errors, a comprehensive analysis of what caused them is not possible. I acknowledge that one potential cause was the different prescribing forms and patterns.

51. RN C mentioned that Dr E's prescription form was different from the usual format the nurses were familiar with at WHG. I note that my expert advisor found that "while the format was different it provided the same type of information as the usual WHG document". RN C also commented that the pattern of prescribing differed from the prescribing pattern of WHG's facility GP.[14]

52. Although it is the responsibility of individual nurses to check and double check that doses to be administered are correct, I acknowledge that in Mrs A's case there does seem to have been a system failure, as six nurses were involved in the medication errors over a period of time (as discussed in paragraph 50). I acknowledge that the different prescription form and pattern of prescribing may have introduced some confusion. In my view, it was WHG's responsibility to ensure that the documentation and systems in place for receiving instructions from a GP (not designated to the facility) were clear and understood by all the nurses involved.

53. I note that in April 2021 WHG issued a new policy, the Community Practitioner Policy, which asks GPs to follow procedures adopted by WHG for prescription and supply of medication, and for carrying out testing, and encourages GPs to use WHG's Residents Notes and medication management system (Medi-Map). RN Johnson-Bogaerts advised that these changes are appropriate and may prevent potential confusion when working with different types of documentation and systems. I agree with this advice and consider that this system-level change should enhance medication administration safety for residents at WHG.

Investigation of warfarin administration errors

Adequacy of investigation

54. The medication errors were not identified at the time of administration, but approximately a year later when the Facility Manager, Ms F, was investigating a complaint from the family. As mentioned in paragraph 50, due to the lack of timely identification of the errors, a comprehensive analysis of what caused them is not possible.

[14] RN C explained that Dr E would prescribe different medication for 2 days out of 7, whereas their facility GP would prescribe the dose only with alternating days.

Names have been removed (except Sunrise Healthcare Ltd/West Harbour Gardens and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

55. Once the errors were identified belatedly, Ms F produced an undated summary analysis of warfarin administration compared to the prescribed doses.

56. However, there is no evidence that an investigation, required by the Medication Management Procedure and Incident/Accident Reporting Policy, was ever commenced. WHG could not locate an incident report form, nor any documented details of any investigation of the medication errors or outcomes/corrective actions, which is also required by these policies.

57. In the absence of any documentation, I find it more likely than not that no incident report form was created, or details of the investigation recorded. I note that there have been a number of personnel changes in management at WHG since 2018, so any corrective actions taken by Ms F, if not documented, would not be visible to future managers.

58. In terms of follow-up, from statements provided by Ms F, RN C, and RN D, actions taken in 2019 in response to the errors included sharing the findings with RN C and RN D, and both nurses updating their medication competencies. RN C was also required to review "relevant" policies. RN D stated:

> "On the day we received the initial complaint from [Mrs A's] family, all nurse[s] were required to update their medication competencies. And if someone had a simple medication error (i.e. RN forgot to put the dates/dosages of medications given) that RN is required to write a reflection letter to be submitted to the [Clinical Manager]. [The Clinical Manager] also checks the medication book daily to ensure that medications were signed properly."

59. It is unclear whether the requirement for the reflection letter and for the medication book to be checked by the Clinical Manager was introduced as a response to the errors, or whether these actions were required prior to the errors.

60. My expert advisor, RN Johnson-Bogaerts, advised that she considered "the lack of documentation, investigation, and remedial action by the Facility Manager at the time and in the circumstances a moderate to significant deviation from accepted practice". I agree with this advice. The investigation and follow-up was inconsistent with WHG's own policies, and the corrective actions were limited. I am critical of this departure from accepted practice.

Adequacy of policies

61. RN Johnson-Bogaerts advised that the Medication Management Policy and Procedures should be reviewed against the Ministry of Health Medicines Care Guide for Residential Aged Care (2011).[15] In particular, she advised that the section on Medication Errors is very brief and does not include recommended practice, including Quality and Risk Activities and open disclosure to the consumer. RN Johnson-Bogaerts considers this to be a mild to

[15] https://www.health.govt.nz/system/files/documents/publications/medicines-care-guides-for-residential-aged-care-may11.pdf.

Names have been removed (except Sunrise Healthcare Ltd/West Harbour Gardens and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

moderate departure from accepted practice. I agree, and am critical that the policy at the time did not include this detail.

62. I note that RN Johnson-Bogaerts was also concerned that the Critical Incident Reporting policy "is very process and documentation centric and does not include consideration, involvement, or notification of the health consumer, family/whānau and does not include open disclosure principles". This is concerning, and I have added a recommendation for WHG to review this policy.

63. I acknowledge that WHG has since updated the Critical Incident Reporting policy, the Incident Reporting policy, the Warfarin Policy, the Medication Administration policy, and the Medication Management Audit policy, and has issued a new Community Practitioner Policy. I note that RN Johnson-Bogaerts has commented on improvements that can be made to the Critical Incident Reporting policy, and I have included this in the recommendations section.

Conclusion

64. In my view, Sunrise Healthcare Limited had the ultimate responsibility to ensure that Mrs A received care that was of an appropriate standard and complied with the Code of Health and Disability Services Consumers' Rights (the Code). Systems failures at WHG meant that Mrs A was administered incorrect doses of warfarin on a number of occasions by a number of different clinical staff, and the errors were not identified until almost a year later following a complaint from the family. I cannot over-emphasise the potentially serious consequence of Mrs A not receiving her prescribed dosage of warfarin.

65. I note that Dr E's different prescription form and prescribing pattern, compared to the usual facility GP, may have been unfamiliar to the nurses. I am not critical of the form or the prescribing pattern, and I commend the changes made by WHG to issue the Community Practitioner Policy to remove differences that could contribute to a systems failure.

66. However, I am concerned that these errors were not identified at the time. I am critical that WHG's Medication Management Policy and Procedures did not include recommended practice regarding quality and risk management of medication errors and open disclosure to the consumer. I am also critical that when the errors were identified in 2019, they were not documented in an incident report form, no investigation report was completed, and corrective actions were not documented formally. As such, the opportunity to identify the cause of the medication errors and implement remedial actions in a timely manner was lost. I note that there have been a number of personnel changes in management at WHG since 2018, so any corrective actions taken but not documented would not be visible to future managers. For the above reasons, I find that Sunrise Healthcare Limited breached Right 4(1) of the Code.[16]

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

Names have been removed (except Sunrise Healthcare Ltd/West Harbour Gardens and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Open disclosure to family — adverse comment

67. Once the warfarin medication errors were identified by the Facility Manager, Ms F, the errors should have been disclosed to Mrs A's family, as per the Incident/Accident Reporting Policy (see Appendix B). Mrs A's GP, Dr E, should have been informed of the medication administration errors, as required by the Medication Management Procedure.

68. It is unclear whether Mrs A's GP, Dr E, was informed of the errors. I note that the family were not informed of the errors, and I am concerned about the lack of open disclosure, particularly in the context of the potentially serious consequences of warfarin administration errors. I have recommended that WHG review its policies to improve incident reporting to families.

Changes made since events

69. RN D told HDC that after the complaint was received from Mrs A's family, all nurses were required to update their medication competencies. If a medication error is made, such as forgetting to put the dates/dosages of medications given, the nurse is required to write a reflection letter to be submitted to the Clinical Manager. In addition, the Clinical Manager checks the medication book daily to ensure that medications are signed correctly. RN C told HDC that she reviewed all relevant policies.

70. Staff training on medication administration was provided on 24 July 2018, and controlled drugs and pain medication training was provided on 29 June 2018.

71. From May 2020, WHG started using:

- The electronic medication management system Medi-Map instead of paper-based signing sheets.
- Online Training and Support regarding Safe Medication Practices.

72. WHG updated the Critical Incident Reporting policy, the Incident Reporting policy, the Warfarin Policy, the Medication Administration policy, and the Medication Management Audit policy. In April 2021, WHG issued a new Community Practitioner Policy asking GPs to follow procedures adopted by WHG, including for prescriptions and supply of medications.

Names have been removed (except Sunrise Healthcare Ltd/West Harbour Gardens and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Recommendations

73. I recommend that WHG provide a formal written apology to Mrs A and her family for the failures identified in this report. The apology should be sent to HDC, for forwarding to Mrs A and her family, within three weeks of the date of this report.

74. I also recommend that WHG:

a) For a period of three consecutive months, audit any medication errors at WHG and provide a root cause analysis of the errors and mitigation strategies to reduce the likelihood of the error occurring again, and report back to HDC within six months of the date of this report.

b) Review the Critical Incident Reporting policy and include consideration, involvement, or notification of the health consumer, family/whānau, and a restorative approach when responding to and investigating adverse events.

c) Review and update the Medication Management Policy and Procedures, considering the Ministry of Health Medicines Care Guide for Residential Aged Care (2011).

75. The information requested in points (b) and (c) above is to be provided to HDC within three months of the date of this report.

Follow-up actions

76. A copy of this report with details identifying the parties removed, except Sunrise Healthcare Limited (West Harbour Gardens) and the expert who advised on this case, will be sent to the district health board, the Ministry of Health (HealthCERT), and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed (except Sunrise Healthcare Ltd/West Harbour Gardens and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A: In-house clinical advice to Commissioner

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

"CLINICAL ADVICE — AGED CARE

CONSUMER : [Mrs A]

PROVIDER : West Harbour Gardens Homes (WHG)

FILE NUMBER : C19HDC00760

DATE : 10 January 2021 **(and addendum 22 October 2021)**

1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by WHG to [Mrs A]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. Specifically I was asked to review the response of WHG and associated clinical records and advise whether the nursing care provided was reasonable in the circumstances, particularly regarding the six occasions when the consumer [Mrs A] was administered the wrong dose of Warfarin.

3. **Documents reviewed**

   - WHG response dated 23 August 2019
   - INR Analysis and Administration document (summary review of the Warfarin administration charts)
   - Warfarin administration Charts for dates between 3 July 2018 and 14 February 2019
   - Medication Management Policy and Procedure, Warfarin Protocol
   - Written statement [RN C]

4. **Review of provided documentation**

Warfarin is a blood-thinning medicine which is used to stop clots forming as a result of specific medical conditions. The dose is different for different people and regular blood tests (INR tests) are needed to support the doctor with working out the dosage which can vary from time to time and so that the INR blood test results are within optimal range for the individual.

The 'INR Analysis and Administration Document' forwarded by the provider indicates medication administration errors were made on the following occasions: 13 July 2018, 16 July 2018, 20 July 2018, 12 October 2018, 15 October 2018, and 19 November 2018. At these dates the documented dose of Warfarin given was 3mg instead of the

Names have been removed (except Sunrise Healthcare Ltd/West Harbour Gardens and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

prescribed 2mg. The dose of Warfarin to be given as prescribed by the GP was to vary depending on the day of the week. These days the dose was to be reduced to 2mg however the nurses had given the same dose on these days as the other days of the week.

According to The WHG Warfarin Protocol, Warfarin is to be prescribed by the GP based on recent blood results (INR results) on the Warfarin Prescription Chart. It was noted by the provider that [Mrs A's] GP used a process that differs from the usual protocol and a different document had been used to fax the GP for the prescribing. Reviewing the alternative prescription document from this GP I found that while the format was different it provided the same type of information as the usual WHG document i.e. INR result, dose to be given, and date of next INR blood test.

The Medication errors procedure includes that when an error occurs this needs to be reported to the Manager and GP, a Medication Incident Report Form needs to be completed and investigation to occur.

I did not find in the provided documentation incident reports or an investigation report into these errors. It is not clear from the documentation if these medication errors were picked up at the time or that these were found as a result of an investigation[1] into the complaint. Reference to the incidents in the provider's response includes that the WHG's analysis of warfarin administration identified the 6 occasions where 3mg of warfarin was administered instead of 2mg. No further information was provided regarding the initiation of an investigation into the possible cause of the errors. It was noted that one of the registered nurses identified in the errors, [RN C],[2] is still a member of staff, others since have left their employment at WHG. Reported action taken as a result of the identified medication errors are the following.

- The findings were shared with [RN C].
- [RN C] has taken action to ensure her medication administration competence remains safe.

[RN C's] statement includes that she has been made aware that she is one of the nurses making '*a couple of errors where warfarin doses of the incorrect amount were administered'*, and '*I have redone my medication competency with the Clinical Manager and new guidelines have been added to medication folders'.*

5. **Clinical advice**

Reviewing the provider's Medication Management Policy and Procedures I have found that these could benefit from a review against the MoH Medicines Care Guide for

[1] They were identified as a result of responding to the complaint.
[2] The RN is no longer employed by WHG.

Names have been removed (except Sunrise Healthcare Ltd/West Harbour Gardens and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Residential Aged Care (2011)[3] specifically I have found that the part relating to Medication Errors is very brief and does not include recommended practice i.e. Quality and Risk Activities as per the Medicines Care Guide and does not include due open disclosure to the consumer. Deviation from accepted practice minor to moderate.

Human error and systems issues are both significant contributors to medication errors and a systems approach is therefore recommended to be used to look at the cause and development of prevention strategies. In the case that no other actions were taken as a result of the identification of these medication errors than the review of nurse's medication management competency, this would indicate that the WHG's procedure for medication errors was not followed and accepted good practice for the investigation into the cause of medication errors was not implemented.

In this case there were a number of the same medication errors made by different nurses. Moreover, the response suggests that these medication errors were not picked up earlier and only as a result of the review initiated as the result of the complaint. In my opinion both these issues point in the direction that a systems review and improvement is indicated including a review of the effectiveness of WHG medication reconciliation.

In the situation that these medication errors were not further documented and investigated and actions taken were limited to the review of the medication competency of [RN C] this would be seen by my peers as a moderate to significant deviation from accepted practice.

22 October 2021 Amendment to advice after reviewing the provider response dated 30 April 2021

I am asked to review the WHG response dated 30 April 2021 and consider if the response changes my previous advice and if there were departures in care by individual WHG staff. Specifically I am asked to include the nurses involved in the medication error and the individual responsible for the oversight of nursing staff at the time of the incidents.

The provider response included statements from [RN C] and [RN D] who were involved in the medication error and still employed at WHG.

[RN D] said she had not been aware she had made these medication errors and had not been contacted about this before. She said that she cannot explain how the error came about. She explained that on the day the complaint was received from the consumer's family all nurses were required to update their medication competencies and that there was an increased focus from the Facility Manager ([Ms F]) to check and manage errors.

[3] https://www.health.govt.nz/system/files/documents/publications/medicines-care-guides-for-residential-aged-care-may11.pdf

Names have been removed (except Sunrise Healthcare Ltd/West Harbour Gardens and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

She said that at WHG registered nurses update their medication competency annually and since May 2020 are using Medi-Map an electronic medication management system.

[RN C] said that she was made aware of the error in August 2019 when the Facility Manager ([Ms F]) was analysing the error in response to the complaint from the family, which was almost 1 year after the events. [RN C] confirms that the prescriptions were different from how the facility usually receives prescriptions for the medication. She assumes this may have been a contributing factor but not an excuse. The Facility Manager at the time asked her to repeat her medication competency and to review relevant policies. [RN C] also mentions the start of using Medi-Map since May 2020. She said she continues to complete her medication competencies annually.

The provider explained that no statements could be obtained from the following nurses also involved in the medication errors because they are no longer employed by WHG: … The response included evidence that at the time the medication errors occurred these nurses were deemed competent and had completed their competency assessments. No evidence was found relating to [one of the nurses]. The competency assessment included an administration questionnaire with a set of questions also testing the understanding of the Warfarin administration process.

The response explains that Facility Manager [Ms F] found the medication errors as a result of the complaint from the family and that WHG was unable to locate an incident report or any corrective actions on their records. They said that they intend to correct this and their follow up actions will include the learnings in this investigation including training, policy review and improvements.

Further WHG explains that when a medication error is found it is the Manager and Clinical Coordinator's responsibility to investigate, initiate preventative actions and provision of training for staff as well as document the incident in the resident's clinical record, quality risk and update the staff member's file. It is the individual RN's responsibility to ensure safe practice and follow the process stated in the policy.

In conclusion: the additional information provided shows that the registered nurses involved met their medication competency at the time of the errors. Because several nurses made the same mistake a systems error as a significant contributing factor is likely.

The provider could not find evidence that the Facility Manager ([Ms F]) conducted an investigation into the cause of the medication errors once she found that these had occurred. Therefore I did not find cause to change my previous advice and consider the lack of documentation, investigation, and remedial action by the Facility Manager at the time and in the circumstances a moderate to significant deviation from accepted practice.

Since then WHG reported to have implemented the following major changes to medication management.

Names have been removed (except Sunrise Healthcare Ltd/West Harbour Gardens and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

In May 2020 they implemented Medi-Map an electronic medication management system which integrates prescribing, supply and administration of medication. Such electronic medication management systems are recognised for reducing medication errors at any point of the process.

The facility started using online training packages provided by an external provider of aged care staff training.

WHG reported to have updated since then the Critical Incident Reporting, Incident Reporting, Warfarin Policy and Medication Administration policy, Community Practitioner Policy and Medication Management Audit.

Reviewing the included Medication Management Procedure (implemented 2016) my conclusions and advice as before remains unchanged.

Reviewing the Medication Management Audit (issued Feb 2021), I consider the Audit to be comprehensive and reflective of accepted practice and it includes space for analysis of results and the identification and follow up of corrective actions.

The Community Practitioner Policy includes that the GP/NP will be asked to follow procedures adopted by the facility for prescription and supply of medication and the practitioner will be asked to follow facility procedures for carrying out testing and will be encouraged to use the facility's Residents Notes (Leecare) and medication management system (Medi-Map). I consider this to be appropriate and prevents potential confusion when working with different types of documentation and systems.

Reviewing the Critical Incident Reporting policy I am concerned that policy is very process and documentation centric and does not include consideration, involvement, or notification of the health consumer, family/whānau and does not include open disclosure principles. In addition it is my recommendation to include the application of a restorative approach when responding to and investigating adverse events.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Aged Care Advisor
Health and Disability Commissioner"

Names have been removed (except Sunrise Healthcare Ltd/West Harbour Gardens and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix B: Relevant standards

INR/Warfarin Protocol

The protocol includes:

> "RN Contacts GP to check instructions re INR result received
>
> Resident's GP faxes updated signed Warfarin prescription chart to include INR result, dose of Warfarin, due date of next INR test
>
> RN to administer Warfarin as per prescription chart and sign chart."

Medication Management Procedure (Version 5, issued December 2016)

The policy includes:

> "**Policy statement**
> To ensure that all processes related to ordering, storage, administration and disposal of medications are controlled and that resident safety is maintained
>
> …
>
> Registered and Enrolled Nurses have a professional responsibility to ensure safe practice relating to medications.
>
> …
>
> **Administering**
> Check against Medication Order Sheet.
>
> To be checked and signed out CD Book by 2 medically competent staff, 1 of whom is recommended to be a Registered Nurse
>
> …
>
> ***When error occurs (RN):***
> — Report to the Manager/Clinical Coordinator/Person in Charge
> — Notify General Practitioner as relevant
> — Manager or CC to notify relatives if appropriate
> — Fill in Medication Incident Report Form
> — Forward form to Manager
> — Participate in any investigation authorized by Manager
> — Record Medication error and monitoring occurring in residents Progress Notes.
>
> ***Manager/Clinical Coordinator***
> — Complete investigation and initiate preventative action as relevant
> — File copy of form in resident's Clinical record, Quality Risk and staff members file if relevant

Names have been removed (except Sunrise Healthcare Ltd/West Harbour Gardens and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

— Collate errors from Medication Incident Report form by date of the following month, as indicated on the T.A.P calendar and enter onto Balanced Scorecard.
— Present results to Branch meeting monthly.

…

Routine checks

Manager/Clinical Coordinator

Annually

— Competency Testing of all staff administering medications and PRN as deemed necessary by the CC/Manager."

Critical Incident Reporting (Version 2, issued November 2020)

"All accidents or incidents involving residents or our staff will be documented as soon as possible after the event using the Incident Management field within People Point.

Serious, potentially serious OR significant incidents/accidents/events [1] must be documented immediately, accurately and concisely to ensure that the incident/ accident can be investigated to prevent reoccurrence of any adverse events."

Incident/Accident Reporting Policy (Version 2, issued August 2016)

The policy includes:

"All accidents or incidents involving our residents/staff will be documented under Incident Management.

Families/NOK[2] will be informed when an incident/accident has occurred — the Facility Manager (FM) is responsible for monitoring that this is occurring

…

Incident/Accident — Initial Report form

This form is used to report initial information about the incident

Staff who complete the form must ensure the information is detailed and accurate

The form must then be given to the Registered Nurse (RN) on duty — refer to responsibilities below.

…

[1] This includes: "Drug administration error — wrong resident/wrong dose/drug reaction."
[2] Next of kin.

Names have been removed (except Sunrise Healthcare Ltd/West Harbour Gardens and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Manager/Clinical Coordinator
Commencing an investigation and debrief with staff (as appropriate) as soon as possible (and within 72hrs).

Documentation of investigation details and outcomes of the incident under 'Incident Review'. Sign off the incident is then captured."

The Community Practitioner Policy (first issued April 2021)

This policy includes:

"Community Practitioner — A General Practitioner or Nurse Practitioner chosen by a Resident.

Facility Practitioner — A General Practitioner or Nurse Practitioner contracted by a Sunrise Healthcare facility.

…

Prescriptions. Community Practitioners will be asked to follow procedures adopted by the facility for the supply of medication. The Pharmacy used will be that contracted by the facility.

Laboratory Testing. Community Practitioners will be asked to follow procedures adopted by the facility for carrying out testing.

Community Practitioners will be encouraged to use the tools used by the facility for managing Resident Notes (Leecare) and Medication (Medimap), as well as other relevant processes."

Names have been removed (except Sunrise Healthcare Ltd/West Harbour Gardens and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.