Investigation report

Security and access to drugs at Beaumont Care Aged Care Services

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Investigation report: Security and access to drugs at Beaumont Care Aged Care Services

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1. Introduction

This report outlines the investigation conducted by the Health Ombudsman into the adequacy of systems in place at Beaumont Care Aged Care Services concerning security of, and access to, schedule 4 and schedule 8 drugs.

2. Health service provider

Beaumont Care Aged Care Services is an Australian owned and operated provider of aged care which has three facilities at Kippa-Ring, Redcliffe and Rothwell. The facilities support both low and high care patients, from accommodation assistance through to palliative care arrangements. The two facilities subject to this investigation are the Kippa-Ring and Redcliffe facilities.

3. Background

On 28 October 2014, an unregistered health service provider notified me that he had stolen schedule 8 and schedule 4 drugs from two Beaumont Care facilities (where he was employed) over the previous six months.

The stolen drugs included:

- Endone—a schedule 8 controlled drug
- Ordine—a schedule 8 controlled drug
- Temazepam—a schedule 4 restricted drug
- Oxazepam—a schedule 4 restricted drug
- Diazepam (tablets and intra-muscular ampoules)—a schedule 4 restricted drug.

The unregistered provider said he obtained drugs from the drug safe and the drug room which he was able to access. The unregistered provider said he also obtained leftover drugs from patients who had died, which were often left out of the drug safe in boxes on the floor.

The unregistered provider said he resigned from Beaumont Care after he were confronted about one particular incident of missing drugs. The unregistered provider said the facility assessed the matter but made a determination that about 20 people had access to the room from where the drugs went missing and did not have enough evidence to substantiate the drugs were stolen by him.

The unregistered provider informed my office that since resigning he had sought treatment for his impairment (drug addiction) at a clinic and had been admitted to a hospital for ‘detoxing’. The unregistered provider also advised that he was no longer providing health services in any capacity.

4. The investigation

4.1 Scope of the investigation

On 12 November 2014, my office commenced an investigation into the self-notification by the unregistered provider and also initiated an investigation into the concerns raised about the adequacy of systems in place at Beaumont Care relating to security of, and access to, schedule 4 and schedule 8 drugs.

The scope of the investigation into Beaumont Care was to determine whether:

- adequate policies, procedures and protocols are in place to ensure security, safe storage, restricted access to, and appropriate disposal of schedule 8 and schedule 4 drugs
- staff were compliant with the above policies, procedures and protocols
- Beaumont Care should implement systemic improvements in response to any deficiencies identified above.

Notification was initially withheld from Beaumont Care due to the possible risk of evidence loss, and until further information could be obtained from the unregistered practitioner to clarify details of his complaint.

4.2 Investigation methodology

Investigators from my office attempted to contact the unregistered provider via email, phone, in person and via mail in order to clarify his notification and obtain additional details necessary to progress the investigation. Despite a variety of attempts and cross-checking of addresses and contact details, my investigators have been unable to contact the unregistered provider since receiving the initial notification.

As investigators were not able to obtain further details about the notification, on 14 April 2015, my staff notified Beaumont Care of the investigation and issued a notice under section 228 of the *Health Ombudsman Act 2013* requiring the provision of the following information:

- employment records, complaints history and all documentation concerning investigations undertaken in relation to the unregistered provider
- policies, procedures and protocols concerning security, storage, access and disposal of schedule 8 and schedule 4 drugs, as well as current policies and procedures in place concerning security, storage, access and disposal of schedule 8 and schedule 4 drugs
- results of any audits conducted from 1 January 2014 in relation to compliance with the above policies, procedures and protocols.

4.3 Evidence from Beaumont Care

On 6 May 2015, a representative of Beaumont Care wrote to me in response to the complainant's allegations and provided the following supporting documentation:

- medication management policy
- medication framework
- Beaumont Care Aged Care Services orientation record
- medication administration competency checklist (RN/EN)
- medication competency test RN/EN
- terms of reference for medication committee
- terms of reference Peninsula Aged Care Service—Quality and Care Governance
- Beaumont Care Aged Care Services audit schedule
- Beaumont Care medication audit—revised February 2015
- copies of previous audits for Peninsula Aged Care Service and Redcliffe Aged Care Service.

Policies, procedures and protocols

The representative advised that Beaumont Care maintains a medication system managed by Think Pharmacy, where medications are sachet-packed offsite and delivered to the facility. The representative submitted this process ensured safe and correct medication administration compliant with the medication policy and medication framework. The representative advised that Beaumont Care also maintain an audit schedule and has revised the medication audit tool to improve better triangulation and investigation of the effectiveness of systems.

The representative advised that Beaumont Care has an internal executive quality manager and aged care quality assessor who has been reviewing the policies and processes as part of routine quality reviews over the prior six months, and in the course of that review made improvements in consultation with staff in accordance with regulations. As part of the review of medication management systems, Beaumont Care identified improvements that could be made to the systems. This included instructions to staff and the medication framework being developed to support the policy.

The representative explained this framework provides guidance on the complete medication management system, legislative requirements, orientation, scope of practise, incident management, audits and storage of medications.

Furthermore, the representative advised that Beaumont Care Aged Care Services were audited by the Australian Aged Care Quality Agency at both Beaumont Care sites since the incident came to my attention. The representative said these audits included comprehensive reviews of the systems, processes and results of the expected outcome in reference to medication management. The representative advised that Beaumont Care Aged Care Services were found to meet all 44 outcomes of the audits at both sites.

The Australian Aged Care Quality Agency was contacted and confirmed that Beaumont Care were audited since the incidents and found to be compliant with the accreditation standards concerning medication management. Further, Beaumont Care's previous audits have shown complete compliance with no adverse comments made.

Medication incident 1—missing controlled drugs

The representative told my office that Beaumont Care conducted an internal investigation in relation to allegations of missing controlled drugs on 7 October 2014 from the Beaumont Care's Peninsula Aged Care Service facility at Kippa Ring. The previous audit of these drugs occurred on 24 September 2014 where all drugs were accounted for. Their internal investigation revealed the following:

- At the time the drugs went missing, Peninsula Aged Care Service was conducting a count of controlled medications fortnightly and complying with the Health (Drugs and Poisons) Regulation 1996.
- The counts of medications are done in conjunction with the single drugs counts (which are routinely conducted when a medication is removed for a resident's use).
- The missing medications were all prescribed *prn*, or *as required*, so were not regularly administered, nor noticed to be missing, as they were not routinely administered.
- Peninsula Aged Care Service increased the frequency of drug counts to a daily count conducted by the clinical manager with another registered staff member.
- The clinical nurse at the time of the incident admitted to giving the keys to the medication room to an unregistered provider. The clinical nurse regretted this incident and was counselled by Peninsula Aged Care Service.

Medication incident 2—missing controlled drugs

The representative told my office that a further three instances of missing controlled drugs were identified on 10, 15 and 19 October 2014, resulting in Beaumont Care conducting a further investigation.

Interviews with staff identified similar concerns being raised about an employee—believed to be the unregistered provider—who was seen to be in the medication room on two occasions without permission from registered staff.

With respect to the incident on 19 October 2014, a count of the controlled drugs identified that 20 Endone 5mg tablets were missing. In response to this, staff were informed not to leave the facility until a search of persons and personal items could be conducted. I was advised that the employee seen in the medication room had already left the premises when the count of controlled drugs was being undertaken, and a search of the remaining staff did not locate the missing Endone.

On this occasion, staff at Beaumont Care also found the door to the medication room to be off its tracks and the bracket was broken. Maintenance were called that afternoon and fixed the broken door. Beaumont Care also reported this matter to the Queensland Police Service.

The investigation into these three incidents identified the keypad on the controlled drug safe, which is located inside a file room containing resident records, had four worn numbers on it, making it clear that they were the four numbers regularly pushed to open the safe. The representative advised this was a contributing factor to the compromised safety of the controlled drugs and the pin code was immediately changed in response to that risk. Furthermore, Beaumont Care implemented a protocol to change the pin code regularly and commenced a process to have the safe changed to a key lock safe.

The unregistered provider

The representative stated that, while investigations undertaken by Beaumont Care did not prove who was responsible for the missing drugs, the unregistered provider was identified as a suspect.

The unregistered provider was requested to attend a meeting with management on 24 October 2014, at which time he tended his resignation without explanation or response to the enquiries about the missing drugs.

Risk management

The representative advised that only registered staff provide medications to residents in compliance with policy and legislation. On commencement of employment, registered staff complete a medication competency. This competency is completed annually and the currency of these competencies is overseen by the education officer.

The representative advised that the biannual medication management audits conducted at Beaumont Care facilities provide a monitoring mechanism for the quality and compliance of medication management. Copies of the most recent audits were attached with the response.

Conclusion

In concluding the Beaumont Care response, the representative submitted:

> *We are confident our processes support safe medication management and that we have a robust continuous improvement process that supports prompt response to practice issues and opportunities to improve our medication management protocols.*

4.4 Accreditation standards—medication management

Providers of residential aged care have responsibilities to provide care and services to meet care recipient needs in accordance with the accreditation standards as set out in the *Quality of Care Principles 2014*. Section 2.7 of the accreditation standards outlines the expectation that medication for care recipients is to be managed safely and correctly. In order to be assessed as compliant with this standard, the following results are expected:

- management demonstrates medication for care recipients is managed safely and correctly
- management can demonstrate staff compliance with the medication management plan
- management can demonstrate the medication management system is safe, according to relevant legislation, regulatory requirements, professional standards and guidelines
- care recipients/representatives confirm they are satisfied that medication is managed safely and correctly.

5. Analysis of evidence

5.1 Whether adequate policies, procedures and protocols are in place

The information provided by the representative supports that, in October 2014, Beaumont Care had a range of governance processes in place to deal with medication management at their facilities, including:

- a medication framework which provides guidance on safe and correct medication management in alignment with regulatory obligations and industry standards
- a Medication Advisory Committee whose role includes the development and evaluation of medication management policies and procedures, and review of medication audits and medication related errors and incidents
- ongoing internal medication audits
- medication administration competency tests for registered nursing practitioners.

Although these various governance processes were in place at the Beaumont Care facilities, four incidents occurred in the space of 12 days in October 2014 where controlled drugs went missing from the controlled drug safe. The internal investigations undertaken by Beaumont Care in response to these incidents identified a number of contributing factors including:

- on one occasion a staff member gave the keys to the medication room to an unregistered provider
- the keypad on the controlled drug safe having four worn numbers on it, making it clear that they were the four numbers regularly pushed to open the safe
- damage to the medication room door resulting in the lock not catching properly to secure the door.

Based on the outcomes of the internal investigations and the self-notification of the unregistered provider, the evidence supports a finding that the unregistered provider exploited these deficiencies in the system to gain access to the medication room and controlled drug safe to misappropriate the medications.

I note that Beaumont Care staff appropriately reported and investigated the incidents and initiated corrective actions including:

- changing the pin code to the controlled drugs safe
- implementing a protocol to change the pin code regularly
- the commencement of a process to have the safe changed to a key lock safe
- fixing the broken door to the medication room.

I consider that the corrective actions taken by Beaumont Care, in conjunction with the existing ongoing governance processes, are sufficient to mitigate the risks of the events recurring. This is further supported by Beaumont Care's compliance with the aged care audits subsequently conducted after the medication incidents.

On the basis of the information reviewed, I am of the view that no further action should be taken in relation to this issue, as I reasonably consider that the matter has been appropriately finalised (s44(1)(a)(iv) of the *Health Ombudsman Act 2013*).

5.2 Whether staff were compliant with the policies, procedures and protocols

The internal investigation conducted by Beaumont Care identified the unregistered provider as being in or near the medication room at the time of the incidents. The unregistered provider was suspended by Beaumont Care pending the outcome of the investigation, but subsequently resigned from his position.

As outlined in section 5.1, the evidence obtained during my investigation supports a finding that the unregistered provider exploited the deficiencies in the medication management system to gain access to the controlled drug safe and misappropriate medications. Further, the investigation by Beaumont Care identified that a staff member was non-compliant with policies and procedures, and this has been adequately addressed by the facility.

There is no evidence to suggest that there is a widespread training issue or disregard by staff for the policies, procedures and protocols. Only a small number of instances of theft of medications were identified, relating to the conduct of one staff member.

On the basis of the information reviewed, I am of the view that no further action should be taken in relation to this issue, as there is insufficient evidence to support the allegation and I reasonably consider that the matter has been appropriately finalised (s44(1)(a)(iv) of the *Health Ombudsman Act 2013*).

The issues relating to the health, conduct and performance of the unregistered provider are addressed in the investigation report prepared in relation to the concurrent investigation into the unregistered provider.

5.3 Whether systemic improvements should be implemented

As discussed in section 5.1 of this report, Beaumont Care have responded to the medication incidents by implementing a range of corrective actions focused on ensuring adequate security of the medication room. In conjunction with the existing governance processes, I consider that these corrective actions are an appropriate response to mitigate the risk of the events recurring.

I also note that since the incidents of missing medication were identified, Beaumont Care also underwent Australian Aged Care Quality Agency audits at both facilities and were found to be compliant with all 44 criteria. No other issues have been identified in this matter that justify further investigation or recommendations.

On the basis of the information reviewed, I am of the view that no further action should be taken in relation to this issue, as any systemic improvements necessary have already been implemented by Beaumont Care and I reasonably consider that the matter has been appropriately finalised (s44(1)(a)(iv) of the *Health Ombudsman Act 2013*).

6. Conclusion

The investigation conducted by Beaumont Care identified deficiencies in the systems in place with respect to security of schedule 4 and schedule 8 drugs. The evidence indicates the unregistered provider exploited these deficiencies to obtain drugs for their own personal use.

Beaumont Care subsequently implemented changes to ensure appropriate medication security. Since the incidents of missing medication were identified, Beaumont Care also underwent Australian Aged Care Quality Agency audits at both facilities and were found to be compliant with all 44 criteria.

The actions taken by Beaumont Care show they are cognisant of the importance of medication management and have taken steps to address the identified system deficiencies and mitigate the risk of the events recurring.

It is appropriate that the primary responsibility for ensuring compliance with legislation and audit criteria remains with the Australian Aged Care Quality Agency and, for this reason, I have provided this investigation report to the Australian Aged Care Quality Agency for its records.

Overall, I am of the view that no further action be taken under s44(1)(a)(iv) of the *Health Ombudsman Act 2013* as the identified issues have been resolved or otherwise appropriately finalised.

Beaumont Care and the Australian Aged Care Quality Agency have been advised of my decision to close the matter.

Leon Atkinson-MacEwen
Health Ombudsman

6 January 2016