A Rest Home

Nurse - Mrs C

A Report by the

Health and Disability Commissioner

(Case 03HDC17242)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A (dec)	Consumer
Mr A	Consumer's husband
Ms B	Complainant / Consumer's daughter
Mrs C	Provider / Assistant Nurse Manager
Ms D	Personnel Officer / Caregiver
Dr E	General Practitioner
Mr F	Rest Home Administration manager
Ms G	Pharmacist / A Pharmacy
Mrs H	Consumer's sister
Mrs I	Consumer's sister
Mrs J	Consumer's sister
Mr K	Consumer's brother
Mrs L	Consumer's daughter
A rest home	Provider / Rest Home

Complaint

On 17 November 2003 the Commissioner received a complaint from Ms B about the service provided to her mother, Mrs A, by a rest home. The following issues were identified for investigation:

- *The appropriateness of the rest home's management of Mrs A's pain in August and September 2003*
- *The appropriateness of the rest home's management of the deterioration of Mrs A's right great toe from 21 August to 4 September 2003*
- *Whether Mrs A was treated with respect and in a manner that respected her privacy in relation to her toileting.*

An investigation was commenced on 6 April 2004.

Information reviewed

- Information from:
  - Ms B
  - Mrs C
  - Dr E
  - Ms D
  - Mr F, administration manager, the rest home
  - Ms G, pharmacist, a Pharmacy
  - Mrs H, consumer's sister
  - Mrs I, consumer's sister
  - Mrs J, consumer's sister
  - Mr K, consumer's brother
  - Mrs L, consumer's daughter
- Mrs A 's clinical records from the public hospital
- Mrs A 's clinical records from the rest home
- Relevant policies and procedures from the rest home

Independent expert advice was obtained from Ms Wendy Rowe, a registered nurse with specialist knowledge in the care of the elderly.

Information gathered during investigation

Background

Mrs A
Mrs A, aged 72 years, was admitted to a public hospital on 10 June 2003 for assessment and rehabilitation of a left hemiparesis (paralysis) and dysphagia (difficulty swallowing) caused by a stroke.

Mrs A was assessed on 21 July 2003 for her support needs level (SNL) by a support needs assessor, acting on a request by the public hospital for continuing care placement. Mrs A was assessed as SNL 5, requiring hospital care. It was noted that Mrs A had been living with her husband prior to her admission to the public hospital, but he was "struggling to cope". It was found that Mrs A had polymyalgia rheumatica (PMR), which caused her some pain. The support needs assessor noted: "Before CVA [stroke] pain due to PMR was difficult to control. Family feel client is often in pain & is receiving little analgesia."

Mrs A was transferred to the rest home on 24 July 2003.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The Rest Home
The rest home accommodates 25 patients in the hospital part of the facility and 40 residents in the rest home section. On the morning shift, five caregivers and one registered nurse are assigned to care for patients in the hospital, and there are three caregivers and one registered nurse assigned for the afternoon shift. Mrs A was accommodated in the hospital as one of approximately 22 patients.

Mrs A's daughter, Ms B, commenced employment as a caregiver at the rest home in February 2003 and was working in this position during her mother's admission. Ms B worked in the hospital, and there were occasions when her mother was one of the patients assigned to her. Ms B worked with another caregiver at all times.

Admission documentation
The 'Transfer Information' form that accompanied Mrs A from the public hospital to the rest home described the care provided to her while she was at the Assessment Treatment & Rehabilitation (ATR) Unit. Mrs A was assessed by the Speech and Language Therapist in relation to her swallowing difficulties. She was provided with two- to three-hourly pressure area care, and required full nursing care. Her medications were listed as simvastatin and digoxin in the evenings, and she had completed a course of norfloxacin for a urinary tract infection. It was noted that "all medications crushed and given with yoghurt or thickened fluids. Those that are unable to crush are given carefully with yoghurt (to ensure safe swallowing)."

A comprehensive nursing assessment and care plan was included, which detailed Mrs A's nutritional, mobility and hygiene requirements. It was noted that she had a small skin tear to her left lower leg, which had been cleaned and covered with the dressing Tegaderm. She had generalised itching, which was treated in the ATR Unit with DP (hydrocortisone) lotion. Zopiclone 7.5mg, a sedative, had also been given on occasions to control her itching, but had limited effect.

Dr E, Mrs A's general practitioner, was requested to follow up her digoxin levels, review her prednisone regime and repeat urine tests. Dr E was advised that a dietician would follow up Mrs A's nutritional needs.

Assessment on admission
On admission to the rest home on 24 July 2003, Mrs A was noted to have rheumatoid disease, atrial fibrillation, ischaemic heart disease, degenerative lumbar vertebrae, and sciatica, as well as the after-effects of a stroke.

The rest home 'Admission and Discharge' policy (attached as Appendix A) specifies that a registered nurse is to perform an initial assessment on all new admissions. The registered nurse "must gather as much information from the resident and their family/caregivers as is relevant to care planning and individual needs".

A 'Nursing Care Plan' was compiled for Mrs A on 24 July. The plan was not signed by the registered nurse who completed the plan, and there was no date recorded for a review of the plan.

Mrs A's weight, blood pressure, temperature and pulse were recorded as "baseline recordings" on the care plan. Her itching skin problem was recorded, and the management plan was to apply moisturiser and barrier creams as well as DPHC (hydrocortisone cream) and Calamine lotion. The plan noted that she needed assistance/supervision with meals and encouragement with fluids. Her weight and food intake was to be recorded daily. The plan noted that her physiotherapy programme was to be managed by a physiotherapist. There was no record that Mrs A was complaining of pain at the time of her admission or that a physical assessment in relation to skin integrity was performed by the admitting registered nurse.

Medications

Ms B claimed that her mother was not given the medications she was supposed to have by the rest home staff. She stated that there was no notice taken of the notes from the public hospital, which indicated the drugs that Mrs A was to be given.

The daily nursing progress notes completed for Mrs A for 24 July noted that a 'Medication Order' form was completed for Mrs A (by a registered nurse whose signature is not legible) and faxed to Mrs A's general practitioner, Dr E, for him to verify and sign.

Mrs C, who was Assistant Nurse Manager of the rest home in 2003, informed me that when a patient is discharged to the rest home from the public hospital, a prescription for his or her medication is included in the discharge documentation. The prescription is either faxed or hand delivered to a Pharmacy – depending on the time of day – to be made up. The patient's medication order form is completed and faxed, with the hospital discharge summary, to the patient's doctor. Mrs C stated that she faxed Mrs A's prescription order form and discharge summary, to Dr E for him to verify and for his records.

Mrs C provided me with the rest home's Safe Management of Medication' policy (attached as Appendix B), which includes instructions for staff on ordering and receiving medications, and the administration of medications. I note that the policy was signed off on 11 September 2002 and reviewed on 11 March 2003.

Dr E informed me that his usual practice when he receives a request from a rest home for a prescription is to check the patient's notes and details. He then computer generates the appropriate prescription, which is sent to the pharmacy. If the request is for a controlled drug, such as morphine, Dr E hand-writes the prescription and, if the request is urgent, the prescription is faxed through to the pharmacy. Dr E stated, "I have no doubt that I followed my usual practice in prescribing for [Mrs A]."

Ms B, the pharmacist, informed me:

> "The systems in place at [the Pharmacy] for caring for the medication needs of the rest home are of a high quality. I am employed full-time at [the Pharmacy] and the majority of my time is spent looking after rest home patients. …
>
> The dispensing procedures for dispensing of a controlled drug for a rest home patient are exactly the same procedures for dispensing a controlled drug for any patient i.e. off a prescription.
>
> … [I]t is rare that I even do controlled drug prescriptions for a rest home (or any patient) as most of my work is the checking of [rest home drug] charts, packing of medico-packs, correcting packs upon notification of any medication changes for regular medications and also for doing daily antibiotics etc medico-packs that arise on a day to day basis. The medication drug charts are checked once a month prior to making up monthly packs and it is important to note that I will only become aware of any changes outside this time upon notification by staff members [from the rest home]."

Nursing care

The nursing notes for 24 July include a request for the nursing staff to collect a urine specimen the following day to check that the antibiotics given to Mrs A in the public hospital for her urinary tract infection had been effective.

The following morning Mrs A was showered and a urine specimen obtained.

The daily nursing notes indicate that Mrs A was cared for according to the directions in the Care Plan. Her fluid balance was monitored and charted. She was turned two-hourly and the turns were recorded. On 30 July Dr E saw Mrs A and ordered Lactulose for her bowel maintenance, and increased her prednisone. The following day, apart from reporting slight back pain, Mrs A appeared settled with a "fair appetite".

There is reference in the daily nursing notes to Mrs A being provided with urinary incontinence pads. A '24 Hour Dietary Record' was kept to monitor Mrs A's daily food and fluid intake. Her weight was regularly assessed, and a record was kept of when she was turned in her bed, or changed from her bed to a chair.

A basic 'Ongoing Nursing Care Plan' was written to guide staff in the care of Mrs A in relation to her skin management, diet and nutritional requirements, communication, mobility, hygiene and bowel management. The care plan was not dated or evaluated.

On 14 August the morning shift daily nursing notes state:

> "Washed. All personal cares given. Zinc cream to buttock area. DP lotion back of neck and legs. First time to do [Mrs A's] cares. A very nice lady. Didn't want to be weighed this morning. Has a visit from her doctor."

Dr E saw Mrs A that day and noted: "Appears comfortable today, conversing reasonably well – slight confusion with time and place." He noted her request for cream for her itching

skin. He recorded that her skin was dry but she did not have a rash. Dr E prescribed hydrocortisone 1% cream to be applied twice daily prn (as required).

On 15 August, the caregiver providing Mrs A's hygiene cares was assisted by a registered nurse. The nursing notes record that cream was applied to Mrs A's legs and feet. There is no record at this time of any problems with Mrs A's feet or toes. That morning Mrs C, the assistant nurse manager, faxed Dr E, stating:

> "Panadol not holding [Mrs A's] pain last night and today. Can we look at reviewing her MST dose again. You were going to send something for the itches too. Can we have some notes from your visit yesterday as well."

Dr E recorded his prescription of Sevredol 10mg four hourly/prn for pain for Mrs A, as well as zopiclone 7.5mg, ½ to one tablet at night (a hypnotic sedative to help her settle), and prednisone for her skin irritation. Mrs A was given two doses of Sevredol on 16 August. The Sevredol was given 'as required' after that, and her slow-release morphine was given routinely twice daily.

Pain relief

Ms B informed me that her mother's medication was not adequately managed and after three weeks "the staff were still not familiar with the medication [Mrs A] needed". Ms B said that her mother was in "terrible pain" and although she had been on morphine for 18 months before her admission to the rest home, she was not given the pain relief she needed.

In her letter to Dr E of 24 July 2003, […] detailed the treatment and care provided to Mrs A during her admission to the public hospital. […] did not include any mention that Mrs A was experiencing pain, and the only pain relief listed was paracetamol, 1g, four times daily as required.

On 4 August Dr E recorded, after discussion with her family that Mrs A was in frequent pain, especially when she was moved, and wrote a prescription for 40 MST (morphine) 10mg long-acting tablets to be taken twice daily.

The daily nursing notes record Dr E's discussion with the family, review of Mrs A's condition, and that he had ordered morphine for "the pain the patient is experiencing esp. when being moved". This is the first reference in the notes to Mrs A experiencing pain.

Mrs A continued to be bothered by generalised itching of her skin and, in the afternoon of 6 August, the registered nurse recorded that Ms B "insisted Phenergan to be given and she said she will speak with [Mrs A] in the a.m. regarding itchiness and that Phenergan is badly needed by her Mum". The nurse also recorded that Mrs A was experiencing a "tingling sensation and needle pricking-like pains" all over her body.

Mrs C recorded on 7 August that she had spoken with Ms B to inform her that "Dr E would prefer [Mrs A] not to have an antihistamine because of the prednisone dose". Mrs C recorded that she discussed with Ms B the possibility of increasing her mother's night-time

dose of morphine in an attempt to control her pain. Mrs C faxed Dr E to inform him that Mrs A was distressed by "needle-prick" type pain and requested that he increase her morphine to 20mg. Dr E acknowledged the request the following day and authorised the increase in the evening morphine dose to two tablets (20mg).

The records show that Mrs A was given the morphine twice daily as prescribed. Mrs C informed me that Mrs A did not always require her pain relief four-hourly and that the pain relief was given, in consultation with Mrs A and her family, on an 'as required' basis. The records show that all recorded reports of pain were conveyed to Dr E and that Mrs A's pain relief was increased further on 15 August and 2 September.

Respect and privacy

Ms B claimed that the caregivers at the rest home did not provide her mother with appropriate treatment. She expressed concern about the attitude and behaviour of staff. Various members of the family stated that there was a lack of consideration shown towards Mrs A, and that she was frequently left sitting on a commode or bed pan unattended. The family complained about the lack of respect shown towards Mrs A when she was left in her bed or chair "soaking wet" with urine, and left exposed. They also complained that she was "left to feed herself if a family member was not there to help her".

Ms B claimed that she made a complaint about her father visiting at 2am. She said that the family was "never contacted by the nursing home to hear and never offered the opportunity to meet and discuss [our] complaints".

Mr F, the CEO and Administration Manager for the rest home, responded as follows:

> "We are certain [Mrs A] was treated with respect and given privacy. Our investigations do not show otherwise.
>
> **In regards to her Privacy**
> The room itself is extremely private. It has virtually no visitor or public trafficking past the room. Of the two rooms opposite, there is no view in whatsoever from one, and the other has a very restricted view in and only if the door is wide open.
>
> The door has always been closed when [Mrs A] was toileting.
>
> One letter of complaint as to her privacy when toileting reads as though the lady was naked when seated on the bed pan. This is absolutely not true.
>
> She always had a top on that covered as much as possible. The only part that could be partially exposed while on the bed pan is the leg and perhaps part of the upper leg or thigh, in a room with a closed door only entered by the caregiver concerned. The lady was never exposed in an undignified or unnecessary manner."

Mrs C informed me that the rest home has a 'Personal Grooming and Hygiene' policy (attached as Appendix C) which instructs staff that the patients' privacy and dignity must be

maintained at all times. The protocol notes that in relation to showering or bathing, the resident's choice will be catered for as far as possible and if assistance is required it will be offered in such a way as to preserve the privacy and dignity of the resident.

Family involvement in care
There was reference in the daily nursing notes to Ms B assisting in the care of her mother, for example on 8 August the nursing notes record:

> "Ate well @ tea with husband's assistance. No concern noted. Regular turns by daughter [Ms B]. All due meds given."

Ms B informed me that her family performed a lot of her mother's cares, in particular the regular turns to prevent tissue damage to pressure areas. Ms B said that she thought that it was inappropriate for the family to be expected to provide care. Other family members also expressed their concern about being involved in Mrs A's care.

There is discrepancy in the information provided about the family's involvement in Mrs A's care.

Mrs I (Mrs A's sister) informed me: "Most nights [Mrs A's] daughter [Ms B] and I got her ready for bed as they always said they were too busy, short staffed."

Mrs L (Mrs A's daughter) informed me that she and her husband travelled from their home every second weekend to see her mother. She said that she was frequently asked to put her mother onto the commode or bed without the assistance of the rest home staff. She did not know how to do it correctly without causing her mother discomfort.

Ms D, Personnel Officer/caregiver, informed me that Mrs A's family often assisted with her care, but were not expected to do so by the rest home staff. She said that the family members were very anxious for their mother and demanding of the caregivers. Ms D stated that when Mrs A was first admitted, Ms B spoke to Mrs C and expressed her wish to shower her mother in the mornings.

Mr F confirmed Ms Ds' statement. He informed me:

> "At the request of [Ms B], she was allocated to attend her mother's care during her shift along with another caregiver. In addition [Ms B] requested and was permitted to also come in the mornings and shower her mother."

Foot and toe problems
Mrs A suffered a number of foot and toe problems while she was at the rest home. The family complained that these problems were not properly addressed.

Ms B informed me:

> "Prior to leaving [the public hospital] [Mrs A] suffered a toe injury which was treated accordingly and was not a concern at the time. On admission to [the rest home] [Mr A] asked her toe to be examined.
>
> …
>
> [The] knock to her big toe [which occurred in [the public hospital] caused a small blood blister. About 10 days into her stay at [the rest home] my mother complained about her toe, which was very painful. Each day from then on family complained to staff about [Mrs A's] toe, which was deteriorating. Each day we inquired when the podiatrist was going to examine [Mrs A's] toe, we were told the podiatrist would be coming at the end of the week and when [the end of the week] would come we were told next week."

Mrs I, Mrs A's sister, informed me:

> "When [Mrs A] was admitted to [the rest home] she had a [sore] toe, after about 2 weeks we asked for her toe to be seen by a [podiatrist], in the next 3 weeks we were given the run around by all the RN's at the hospital with one excuse after another why it was never seen to."

There was no mention in the discharge summary from the public hospital that there was any problem with Mrs A's toes.

Mrs L, Mrs A's daughter, recalled that her mother had a cut on her toe which was not treated. She stated that the family were told that a "nurse comes in once a month to deal with any problems".

Mrs J, Mrs A's sister, informed me that "on one occasion [after lunch] there had been gauze put … between all her toes". Mrs J was unable to find out why this had been done and recalled being told that the podiatrist called at [the rest home] every fortnight.

The family said that the rest home was made aware of the pain in Mrs A's toe, which was brought to their attention every day by family members.

On 19 August the caregiver who washed Mrs A that morning was assisted by a registered nurse. Hydrocortisone cream was applied to Mrs A's left shoulder and arm, and to her legs. The records note that Mrs A's left foot was "red and felt warm".

The following morning Mrs A was reported to be "tired and lethargic". Her blood pressure, pulse and temperature were checked and found to be within normal range. She was kept warm and comfortable. That afternoon Ms B reported her concern to staff that her mother might have had a "mild stroke". Mrs A's blood pressure, temperature and pulse were rechecked, but again found to be within normal range. Staff were instructed to observe Mrs A overnight. Ms B left instructions to be called if her mother's condition deteriorated overnight.

Mrs A was provided with full nursing cares, including DPHC lotion on her legs and feet, for the next two days, and was noted to be "looking brighter".

On the afternoon of 21 August the on-duty registered nurse recorded:

> "Visited by sister and husband @ tea. Ate fairly as fed by husband. No concern noted. Wheeled around hospital lobby after tea by sister. Requested for podiatrist to check her R big toe tomorrow please. 2 hrly turns maintained."

There is no record that the registered nurse examined Mrs A's right great toe, or that the referral was made the following day as requested.

Ms B continued to be involved in the care of her mother over the next nine days. She expressed concern about slight bruising to her mother's groin on 28 August, recorded in the daily nursing notes, but there is no further mention in the records of any concerns about Mrs A's toe or the requested referral to a podiatrist.

On 30 August, the morning shift registered nurse recorded that she had applied a duoderm dressing to a reddened area "in between [Mrs A's] toenails". The clinical records do not indicate whether this problem was on the left or right foot.

On 1 September Mrs A was seen by a podiatrist, who recorded:

> "Right foot very painful to even light touch. 1st toe apex sq. centimetres of black skin round nail edge. Foot & lower leg cold and ischaemic. Broken skin and bleeding between toes. Toes swollen. Daughter reports in [the public hospital] Rt foot was run over by wheelchair during showering & also on one occasion both feet were knocked against the floor while pt. being wheeled in wheelchair.
> DD [differential diagnosis] ischaemic pain due to DVT [deep vein thrombosis/clot]
> DD pain from toe nail
> DD pain due to past injury sustained in [the public hospital]
> Unfortunately not able to help at this stage, but if Dr requires any podiatric intervention please contact me."

Mrs A was nursed with her legs elevated on pillows. There is no record in the nursing notes of any further assessment of the podiatrist's findings or that the condition of Mrs A's toe had been reported to Dr E.

On the morning of 2 September the nursing notes record that Mrs A's right foot was "very sore". She was reported to be "keen to stay in bed later than usual". Mrs A was given paracetamol as charted, and Dr E was contacted and asked to visit her.

Dr E saw Mrs A that afternoon and noted that he would arrange for her to be admitted to the public hospital for assessment and treatment of her toe.

The nursing notes record:

> "S/E [seen/examined] [Dr E], MST ↑ [increased] (see med profile), R foot seen by GP & to be referred to [the public hospital] for further tx [treatment]. [Ms B] (daughter) wants the MST still to ↑ for pain. Still to confirm with the GP. Pt. described pain in her back as like lying on a ladder. To ff up [follow up] with GP for appt at [public hospital]. Started the new dosage of MST tonight."

Dr E ordered an increase in Mrs A's morphine to 20mg in the morning and 30mg at night in conjunction with the Sevredol. Mrs A was given pain relief as charted and nursed with her legs elevated. On the afternoon of 3 September a bed cradle was provided to keep weight off her legs, and her feet were protected by sheepskin boots.

Ms B informed me that her mother was only seen by Dr E after she asked on two occasions that he be called to look at her mother's foot. Ms B stated that Mrs C never acknowledged that her mother's foot had turned gangrenous. She said that this situation should never have been permitted to develop.

On the morning of 4 September the nursing notes record: "Dr E to visit this afternoon to make some decisions re Mrs A's condition – family to be present." The notes record that the family were "very upset" about the condition of Mrs A's right foot.

When Dr E arrived he informed Mrs A's family that her foot had a severely reduced blood supply. He said that the rest home staff would keep her comfortable until her transfer to the public hospital that afternoon.

Dr E informed me:

> "The conversation I had with [Mrs A] and the family (at the time I think this may have involved her daughter and certainly her husband) was that in view of her very poor prognosis the outcome for her new problem of ischaemic foot was particularly bleak. It was more important that she be kept comfortable rather than go through any extra procedures or investigations that were not going to change the outcome.
>
> … [Mrs A] had suffered a severe stroke and was severely disabled with poor quality of life. She had also said on a number of occasions that she did not wish her agony to be prolonged.
>
> Two days later it became apparent that with her ischaemia, care at the rest home had become difficult and it was more likely that she would receive more adequate care if she was admitted to hospital."

Dr E wrote a referral to the public hospital and stated:

> "See referral of 2/9/03.
> New ischaemia quickly progressing with cold foot.
> Thank you for seeing."

Mrs A was transferred to the public hospital at 4.25pm and seen by an emergency department house surgeon, at 5.30pm. Mrs A was commenced on the intravenous anticoagulant heparin and transferred to Ward 4 at 8.15pm.

On 9 September, Mrs A's family met with the consultant in charge of her care, who discussed with them his recommendation of 'Not for Resuscitation' status for their mother. It was agreed that she should be given a palliative care only coding.

Mrs A's condition deteriorated over the next few days and she died on 15 September 2003. Mrs A's cause of death was recorded as septicaemia/pneumonia, ischaemic/gangrenous right foot, peripheral vascular disease and right cerebrovascular accident with hemiparesis [stoke with paralysis].

In summary, Ms B said that the family knew their mother's quality of life was not good, but that "the way she died in such terrible pain from the gangrene could have been prevented. We feel [Mrs A] would not have died from gangrene if the Dr or the podiatrist had been called when the family ASKED."

Dr E advised me:

> "I remain of the opinion there was never going to be anything salvageable in this case and that the original decision to give palliative and comfort care only was the appropriate decision."

Response to complaint
Mr F, the CEO and Administration Manager for the rest home, informed me:

> "Caregivers and nurses have expressed that … they went out of their way to give [Mrs A] attention. They felt under scrutiny by the family at all times and were made to feel ill at ease as nothing they could do was good enough.
>
> …
>
> [The rest home has a] procedure [which] allows for a staff member to verbally enquire or complain to their immediate senior staff member. (This is the Regd Nurse on duty at the time.) … In the time of her mother's stay with us, the only written complaint received from [Ms B] in relation to her mother, was in relation to a visit to the hospital, at 2am in the morning, by her father.

> There were two written complaints made by family members. One listed five concerns. However, when a meeting was called to discuss these claims there was a refusal to meet. We were not able to substantiate the claims. The other complaint claimed she was left unattended. The family were with her in the room and when the bell was used the caregiver attended."

Ministry of Health audit

A Compliance Audit of the rest home was conducted by a Ministry of Health audit team on 4 February 2003. A number of issues that required attention were identified,[1] which included:

"• Medication: Most aspects of the management of medication did not meet contract attainment levels. There was evidence of poor prescribing, administration and documentation.

…

- Care Plans: Care planning lacked detail, was not current and frequently not signed.
- There were no policies, procedures or protocols for basic cares including Personal Grooming/Hygiene, Skin Management and Wound Care."

The rest home was asked to supply the Ministry of Health with evidence of compliance in areas that required attention by 20 March 2003. Mr F confirmed that "all the requirements set at that audit were fulfilled and completed by the 20 March 2003 deadline".

On 11 February 2004 the auditors reported:

> "The nurse manager [Mrs C] was appointed in April 2002 and still appears to be coming to terms with some aspects of her role and responsibilities.
>
> The Assistant Manager is also the Rest Home Manager. There is also a Personnel Officer responsible for employing all staff except Registered Nurses. She is also responsible for education, orientation and some Performance Reviews. The owner and Business Administration Manager employ the Registered Nurses. The only Registered Nurse who has been at the rest home for an extended period of time is the Assistant Manager.
>
> …
>
> The continuity of quality care, internal systems and established working relationships has been undermined by the replacement of almost all senior staff. There was evidence of

[1] In response to my provisional opinion, [Mr F] noted that some comments in the Auditor's report were not verified with senior management at [the rest home], and were inaccurate. Examples included a statement about the process used in employing registered nurses and the number of senior staff with a length of service.

some staff not fully understanding the current lines of communication and others were quite upset with the standard of care that is sometimes provided by colleagues.

…

The facility lacked quality systems that would add to the efficiency and effectiveness of staff. Having more staff at peak work periods may also help as well as an analysis of the routines and utilisation of staff time. This needs to include meal service as some staff are employed to meet health and care needs of residents and are having to spend time being involved with kitchen duties as there is no designated Kitchen Hand."

Independent advice to Commissioner

The following expert advice was obtained from Ms Wendy Rowe, an independent registered nurse with specialist knowledge in the care of the elderly:

"I have been asked to provide an opinion to the Commissioner on case number 03/17242/WS. I have read and agree to follow the Commissioner's guidelines for Independent Advisors. I am a registered comprehensive nurse with 19 years of nursing experience. I have spent most of my career working in the acute medical/rehabilitation areas, and the past 4 years in the private sector. I work in a large residential care facility in Hamilton. I have a Bachelor of Nursing and a Master of Arts, majoring in nursing.

Expert Advice Required

To advise the Commissioner whether in your opinion:

[Mrs A] was provided with a reasonable standard of care by [the rest home].

In particular:

- Was the management of [Mrs A's] pain in August and September 2003 appropriate?
- If not, what else could staff have done to manage the pain?
- Was the condition of [Mrs A's] right great toe appropriately assessed?
- If not, what should have been done?
- Was the toe appropriately managed when the deterioration was identified on 21 August?
- If not, what else should have been done?
- Were [Mrs A's] personal cares appropriately managed?
- If not, what else should have been done for [Mrs A]?

In addition:

- Are there any other professional, ethical and other relevant standards that apply and, in your opinion, were they complied with?
- Any other comments you consider relevant that may be of assistance?

Supporting Information

- Letter of complaint to the Commissioner from an Advocacy Service on behalf of [Ms B], dated 14 November 2003, marked with an 'A'. (Pages 1 – 8)
- Notes taken during a telephone conversation with [Ms B] on 22 January 2004, marked with a 'B'. (Pages 9 & 10)
- The rest home's clinical records relating to [Mrs A], received from [Mrs C], manager, on 25 February 2004, marked with a 'C'. (Pages 11 – 106)
- Letter of response to the Commissioner from [Mrs C], and accompanying documentation, marked with a 'D' (Pages 107 – 121)
- [The public hospital] clinical records relating to [Mrs A] received 10 May 2004, marked with an 'E'. (Pages 122 – 188)

Additional information requested by independent advisor:

- Re-photocopy of Nursing Assessment, nursing care plan, and ongoing nursing care plan ([the rest home]).
- Admission and discharge – Admission of a new client ([the rest home]).
- Safe management of medication ([the rest home]).

Additional information presented by independent advisor:

- Best practice, Volume 3, issue 1, 1991. Management of constipation in older adults.
- Guidelines for Nurses on the administration of Medicines. NZNO, (1998).

Summary of Events:

- [Mrs A] was admitted to [the rest home] on 24 July 2003 from [the public hospital] after suffering a stroke. She had multiple medical problems. On her right great toe was either an ingrown toenail or a blister.
- Transfer information from [the public hospital] indicates right CVA with left hemiparesis, dysphagia, full nursing care required, bowel continence, bladder incontinence, itchy skin, fluid intake per day 1500 mls, may need subcut fluids. (Transfer information,'C'). Discharge summary from doctor indicates also problems with oral intake and that [Mrs A] may require subcutaneous fluids at times ('C').
- Nursing Assessment, nursing care plan, and ongoing nursing care plans completed on admission by registered nurse. General practitioner faxed on same day.
- General practitioner visited resident on 30/07/03 for the first time, 6 days after her admission to [the rest home].
- Main issues on admission were itchy skin, awake at night talking, poor fluid and food intake, and requirements of full nursing cares.

Questions:

Was the management of [Mrs A's] pain in August and September 2003 appropriate?

NO

- Morphine not given whilst in [the public hospital], but prior to that admission resident on regular morphine dose.
- Clinical progress notes indicate no pain until family spoke to GP on 4/08/03 and morphine MST was commenced.
- Morphine commenced on 4/08/03 (10 days after admission), then increased on 7/08/03 & 2/09/03 and given regularly.
- No additional morphine elixir charted for break through pain. Paracetamol given prn not QID as charted. Sevredol not commenced until 19/08/03 and then given prn only, not 4 hourly.
- Pain only mentioned by night staff when turning resident, pain indicated to be in legs and bottom. Pain in back report 29/08/03 and Sevredol given with effect.

If not, what else could staff have done to manage the pain?

- No pain assessment documentation completed at any time during resident's stay in [the rest home]. A pain assessment on admission would have indicated morphine requirements early for resident.
- Nursing care plan does not mention pain or a plan to monitor the medication given for pain. Clinical progress notes indicate MST given but no indication of effect.
- Documentation on pain is not in enough detail to indicate that the registered nurse assessed, monitored or reported the effects of the pain relief adequately.

Was the condition of [Mrs A's] right great toe appropriately assessed?

NO

- Clinical entry on 19/08/03 indicates 'left foot red and felt warm' however there is no documented evidence of any action taken by nursing staff.
- First request for podiatrist in clinical progress notes by sister on 21/08/03 to see right 'big toe tom. (tomorrow) please'. No further action taken.
- Next entry on 30/08/03 indicates 'duoderm applied on the redness noted in between toe-nails'. Which foot not indicated.
- Podiatry entry on 9/1/03 (presume mean 1/09/03) stating right toes painful but unable to help (page 101).
- 1/09/03 p.m. staff indicates 'very sore foot' (page 102). Then seen by GP on 2/09/03 and referred to hospital.
- At no time in the course of washing and drying [Mrs A] did the care staff notice the deterioration in her toe, and that the family had to ask for her to be seen by the podiatrist.

If not, what should have been done?

- Clear documented assessment of resident's feet.
- No specific documented evidence available that [Mrs A's] toe was adequately assessed at any stage by the registered nurses that were caring for her every day. This assessment should have been completed when the family requested a podiatrist. It was 10 days before the podiatrist saw the resident.

Was the toe appropriately managed when the deterioration was identified on 21 August?

NO

- As above mentioned sister's request for resident to see podiatrist took 10 days. There is no further mention of the toe until the 30/08/03 when the clinical entry discusses the toe nail (difficult to read). No other entries until the 1/09/03 by the podiatrist.

If not, what else should have been done?

- Comprehensive clinical assessment of [Mrs A's] feet and legs by the registered nurse would have identified her sore toe, ischaemic foot and lower leg sooner, and not left until a podiatrist assessed the resident.

Were [Mrs A's] personal cares appropriately managed?

NO

- Nursing assessment, nursing care plan, ongoing care plan completed by registered nurse, some not dated or signed.
- Nursing assessment indicates that full assistance is required.
- Nursing care plan indicates assistance required with meals, thickened fluids, encouragement with fluids, food record and weight daily or every other day.
- Ongoing nursing care plan indicates resident may need sub cut fluids at times, itchy skin, confusion, bowel continence, urinary incontinence, two person transfers (not signed, dated or evaluation completed).
- Progress notes difficult to read, not able to identify staff member entering information, time not always stated, sometimes not signed at all. Entry on 25/07/03 indicates – 'strict monitoring of fluid intake and charted and total for 24 fluid balance in case the patient needs sub cut fluids. Fluid balance chart for 25/07/03 – 30/07/03 only available indicates no fluid intake over approximately 600mls recorded. No action taken. Repeatedly in notes fluid intake is recorded as poor, but no follow up, nor subcutaneous fluids commenced. Manual evacuation first carried out on 26/07/03, and then five more noted, suppositories given twice and lactulose given regularly.

- No specific pain, mobility, skin integrity, or continence assessments completed by registered nurses.
- Personal cares of washing, turning and pad changes carried out by care staff appropriately.
- Continuous itchy skin managed as best as possible by staff.
- Fluids and food intake inadequate and nothing done to ensure appropriate hydration by registered nursing staff at all.
- No updating, changing, additions made to ongoing nursing care plan over three months of residence. No evaluation of this document completed either.

If not, what else should have been done for [Mrs A]?

- Completion of comprehensive pain, skin integrity, continence, falls assessments to be completed by registered nurses.
- Evaluation and updating of ongoing nursing care plan (policy 116, Section D).
- Legibly dated and signed (giving designation) entries in the clinical notes with content of entry reflective of actions taken to achieve planned care.
- Bowel management programme (additional information – Management of constipation older adults, pages 2 & 5) to ensure resident's constipation was managed effectively as manual evacuations are not best practice, and should only be used when every other option has been exhausted and x-ray indicates faecal impaction still exists.
- Accurate monitoring and replacement of fluids using subcutaneous fluids on a regular basis to ensure good hydration and improve skin integrity and general well being.

In addition:

Are there any other professional, ethical and other relevant standards that apply and, in your opinion, were they complied with?

Any other comments you consider relevant that may be of assistance?

YES

- All members of the multidisciplinary team (including general practitioner) should use progress notes in a chronological order instead of different pages for different disciplines.

- **Registered nurses :**
  - Must not write out prescribed medications to fax to doctor to sign (page 53, nurse manager's handwriting and doctor's signature)
  - Must not write morphine MST on medication order sheet (written by nurse and pp [Dr E], doctor has not signed this, nurse therefore has prescribed controlled medication).

- 2 medication order sheets, not clear as to which one was being used (pages 52 & 53)
- Faxed but not used medication order sheets must be stamped fax and when crossed out signed and dated. (Page 19, 'C'.)
- Medications pp by RN and not signed by General Practitioner at all (page 68, 'C') should not have been given (additional information requested, Safe management of medication, page 40.)

- Daughter should not have cared for her mother as an employee of [the rest home], not ethical as there will always be conflict with other staff. Should have worked in another area of the hospital, especially not assigned mother to care for during working shift.
- Assessments not completed by registered nurses.
- No follow up of concerns made by care staff in clinical notes by registered nurses.
- Limited knowledge of registered nurses of management bowels, skin care, maintaining FBC, fluid intake, and pain management.
- Inadequate and inappropriate documentation in clinical progress notes by some staff.

Overall Comment

The registered nurses failed to meet the standard of care and skill reasonably expected of such a provider, taking into consideration that [Mrs A] was admitted with multiple medical problems. The task of caring for this resident was made more difficult for the staff at [the rest home] as her daughter was also a staff member and was assigned to care for her mother when at work. Specific nursing assessments, which would have improved the delivery of care by the registered nurses were not completed. The ongoing nursing care plan was not updated or evaluated during [Mrs A's] stay at [the rest home]. Entries in the clinical records were often illegible, not always signed, nor designation given and did not reflect in any way the plan of care. There was no evidence of actions taken of events documented. This is not to say that actions did not happen. Attempts were made by the registered nurse to provide some pain relief and good contact with the family was maintained. The registered nurses failed to adequately assess [Mrs A's] sore foot, dehydration, constipation or her obvious deteriorating condition. In my opinion the failure was major, and would incur the moderate disapproval of other peers."

Response to Provisional Opinion

The rest home responded to my provisional opinion as follows:

"Thank you for the copy of your provisional opinion on the complaint made by [Ms B] against [the rest home].

We accept your ruling and [the rest home] and our Nurse Manager agree to offer our written apologies to [Ms B] and her famil[y].

We will also follow the recommendations you have made in your report.

- **Included here are both of those written apologies**.
- The rest home will be assisting Nurse Manager [Mrs C] with her review of her nursing and administration practice.
- In relation to your report [the rest home] will take a further review of our practices, taking into account all parts of the management system for which you have recommended review. (A process, which is repetitive and ongoing.)
- I wish to report that since mid 2003 there has been a major upgrade in the documentation systems used here. This has been undertaken in order to meet the new standard of compliance as set by Certification.

The deficiencies noted in the report have already been remedied.

The entire documentation system has been replaced by an ARCH Quality Assurance Program, the policies and procedures are actively in place. This has required a serious work input in last 18 months.

There has been a series of pre-audits and final audit, which have all taken place here since August 2003. [The rest home] is now a Certified facility.

…"

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*

2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

Other standards

'Standards of Care for Old People's Homes' (Ministry of Health, 1996)

"**Care and Comfort**
Standard 2
The main task of the licensee, resident manager, and all staff is to provide for the care and comfort of those living in the home.

…

Responsibility
- The staff, under the resident manager, are responsible for the quality of care offered in your home.
- Make sure your staff know what standard of care is expected of them."

Opinion: Breach – Mrs C

Pain management
Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) state that every consumer has the right to have services provided with reasonable care and skill and that comply with professional standards. The Ministry of Health in its publication 'Standards of Care for Old People's Homes' states that the manager of an aged care facility is responsible for the quality of care offered in the home and must ensure that staff know what standard of care is expected.

Mrs A suffered from polymyalgia rheumatica (PMR), as well as a number of other medical problems. When she was assessed for long-term care placement before her discharge from the public hospital on 24 July 2003, it was noted that her family considered that she was often in pain because of the PMR, and her pain was difficult to control.

After Mrs A was discharged to the rest home, her daughter, Ms B, expressed concern to Mrs C, Assistant Nurse Manager, that her mother was not being kept pain free. Mrs A had not been receiving any pain relief while she was in the public hospital, and pain relief was not included in the prescription that was sent with her discharge documentation.

Mrs A's general practitioner, Dr E, saw Mrs A for the first time at [the rest home] on 30 July. There is no evidence that Mrs A complained to Dr E of pain at that time. However, the following day, the nursing notes record that she was reporting slight back pain.

On 4 August, Ms B spoke with Dr E to inform him that her mother was in frequent pain, especially when being moved. Dr E prescribed MST 10mg – long-acting morphine – to be taken twice daily. The records show that Mrs A was given the morphine as prescribed. Mrs A was also given two Panadol tablets up to four hourly when she requested additional pain relief.

Mrs A was troubled by ongoing generalised itching of her skin and "needle-prick" type pain. On 7 August Ms B asked that Phenergan, an antihistamine, be prescribed for her mother to control the discomfort. Mrs C discussed Ms B's request with Dr E. Dr E advised that Phenergan was contraindicated because of the prednisone Mrs A was prescribed. However, Dr E increased Mrs A's night-time dose of morphine to 20mg, which was given as prescribed.

On 15 August the nursing notes record that the current pain relief regime was not providing Mrs A with sufficient cover. Dr E was notified and he prescribed Sevredol 10mg, as required up to four hourly, for additional pain relief. The records show that Mrs A was given two doses of Sevredol over the next 24 hours. The Sevredol was given on an 'as required' basis after that, and her slow-release morphine continued to be given routinely twice daily.

When Mrs A's condition deteriorated and her right foot became ischaemic and painful on 1 September, Dr E reviewed her pain relief and, on 2 September, increased her morphine to 20mg in the morning and 30mg at night. She was also given Sevredol more frequently.

Mrs C stated that Mrs A was not given pain relief four-hourly as she did not require that amount of pain relief at all times, but that pain relief was given whenever she or members of her family requested it.

My nursing expert advised that the management of Mrs A's pain was not adequate. There was no pain assessment documentation completed at any time during Mrs A's admission to the rest home. A pain assessment on admission would have provided an early and accurate indication of the pain relief Mrs A required.

On 6 August Mrs A's condition of 'needle-prick' type pain, which was associated with her generalised itching, was identified but it was not included as an item in the ongoing nursing care plan. There was no evidence that there was a plan to monitor the effectiveness of the medication in relieving Mrs A's pain.

My expert noted that Mrs A was not given additional morphine elixir for break- through pain, and paracetamol was given only on an 'as required' basis, not four times daily as charted. Mrs C stated that Mrs A did not always require pain relief and that it was given in consultation with Mrs A and her family; in any event the prescription of pain relief was Dr E's responsibility, and whether it was appropriate to prescribe additional morphine for breakthrough pain was a matter for his clinical judgment at the time.

I accept my expert advice that although Mrs C and the nursing staff responded to reports of pain by Mrs A and her family and organised for Dr E to review the medication, their management was simply reactive. Better pain management would have been achieved if there had been an early assessment and ongoing monitoring. In my opinion, Mrs C did not manage Mrs A's pain relief with reasonable care and skill and therefore breached Right 4(1) of the Code.

Management of foot and toe problems

There is a discrepancy in the information about when Mrs A's foot condition first developed. There was no indication in the public hospital discharge documentation of 24 July 2003, or in the rest home admission assessment, that there were any problems with Mrs A's feet. However, the podiatrist who examined Mrs A on 1 September noted that her right foot had been injured when she was in the public hospital more than five weeks earlier.

My nursing expert stated that a "comprehensive clinical assessment of Mrs A's feet and legs by the registered nurse would have identified her sore toe, ischaemic foot and leg sooner". It is apparent that Mrs A was experiencing some circulatory problems, because her left foot was noted to be red and warm to the touch on 19 August. However, apart from the entry in the nursing notes recording the caregiver's observation, there is no record that this was considered further or reported to Mrs A's doctor.

On 21 August Mrs A's sister asked that a podiatrist check Mrs A's right big toe. This request was recorded in the nursing notes (although the specific concern about the condition of the toe was not recorded), but there is no indication that the toe was assessed by a registered nurse, or what arrangements were made to notify the referral to the podiatrist.

I note that Ms B was involved in her mother's care over the next nine days until the podiatrist viewed Mrs A's toe. The nursing notes record that Ms B expressed concern about slight bruising to her mother's groin, but there is no further mention of the condition of the toe. It is difficult to establish the exact condition of Mrs A's toe at this time, and whether the family's claim is correct that their repeated requests for a podiatry assessment were ignored.

It is clear that there was a problem on 30 August when the registered nurse noted that she had applied a dressing to the reddened area between Mrs A's toes. Once again there is little information about the condition she found or whether she considered further assessment was required.

When the podiatrist saw Mrs A on 1 September, it was evident that there was a significant problem because the right foot and lower leg were cold and ischaemic. The podiatrist queried a deep vein thrombosis as the cause. Ms B informed me that her mother was seen on 2 September only because she twice insisted that Dr E be notified. When Dr E viewed the foot that afternoon, he wrote a referral for Mrs A to be admitted and assessed by the public hospital. Dr E was of the opinion that Mrs A's prognosis was very poor and was made worse by the ischaemia. He considered it important for her to be kept comfortable rather than go through extra procedures and investigations, which were unlikely to change the outcome. Two days later Dr E spoke to the family about Mrs A's condition and explained that caring for her at the rest home had become difficult, and it was likely that she would receive more adequate care if she was admitted to the public hospital.

My nursing expert stated that there is no evidence that Mrs A's toe was adequately assessed at any stage by the registered nurses who were caring for her every day, and it took ten days from the time the family requested a podiatry assessment to the podiatrist's visit. My expert stated:

> "The registered nurses failed to meet the standard of care and skill reasonably expected of such a provider, taking into consideration that [Mrs A] was admitted with multiple medical problems. The task of caring for this resident was made more difficult for the staff at [the rest home] as her daughter was also a staff member and was assigned to care for her mother when at work. Specific nursing assessments, which would have improved the delivery of care by the registered nurses, were not completed. The ongoing nursing care plan was not updated or evaluated during [Mrs A's] stay at [the rest home]. Entries in the clinical records were often illegible, not always signed, nor designation given and did not reflect in any way the plan of care. There was no evidence of actions taken of events documented. This is not to say that actions did not happen. Attempts were made by the registered nurse to provide some pain relief and good contact with the

> family was maintained. The registered nurses failed to adequately assess [Mrs A's] sore foot, dehydration, constipation or her obvious deteriorating condition. In my opinion the failure was major, and would incur the moderate disapproval of other peers."

The Ministry of Health's 'Standards of Care in Old Peoples' Homes' specify that Mrs C, as the 'resident manager' of the rest home, was responsible for the quality of care provided to patients, and for ensuring that staff knew the standard of care expected of them. I note that the Ministry of Health Audit in February 2003 found that Mrs C was new to her role as the nurse manager at the rest home (she was in fact Assistant Nurse Manager), and that there had been a significant loss of experienced registered nurses from the facility. However, there should have been policies and procedures in place to guide caregivers and to monitor the standard of care being provided. There was patient care documentation such as the Nursing Care Plan, but there was no specific documented plan relating to Mrs A's deteriorating condition and the plan that was in place was not evaluated as her needs changed.

I accept my expert advice that in relation to the management of the deterioration of Mrs A's foot and toe problems, Mrs C did not provide [Mrs A] with services with reasonable care and skill or that complied with professional standards, and therefore breached Rights 4(1) and 4(2) of the Code.

Opinion: Breach – The Rest Home

As noted above, aspects of Mrs A's care were not acceptable. The management of Mrs A's pain and the condition of her right foot was not of a reasonable standard, primarily because there were inadequate systems in place to ensure that the registered nurses provided a baseline assessment and monitored and documented her ongoing needs.

In February 2003 the Ministry of Health audit identified non-compliance issues at the rest home. The audit report noted that the rest home lacked quality systems that would add to the efficiency and effectiveness of staff, and that there were some areas of the provision of care that required analysis and better utilisation of staff time.

The report also noted:

> "The continuity of quality care, internal systems and established working relationships has been undermined by the replacement of almost all senior staff. There was evidence of some staff not fully understanding the current lines of communication and others were quite upset with the standard of care that is sometimes provided by colleagues."

Despite the 'compliance' by March 2003, it appears that some of the issues identified by the auditors were not adequately addressed. As a result, while Mrs A was at the rest home there were deficiencies in the standard of care provided, attributable to the management systems

in place at that time. The rest home did not provide Mrs A with service with reasonable care and skill or that met professional standards, and therefore breached Rights 4(1) and 4(2) of the Code.

Opinion: No Breach – The Rest Home

Respect and privacy
Ms B complained that her mother was not afforded respect and privacy during her time at the rest home. Ms B and her family gave as an example finding Mrs A left unattended on the commode and on her bed in a state of undress.

Mr F and Mrs C disputed these statements. Mr F informed me that the room Mrs A was accommodated in was extremely private and there was virtually no through traffic past her room. He said that the door was always closed when Mrs A was being toileted. He noted that one of the family's letters of complaint alleged that Mrs A had been left sitting, naked, on a bed pan. He denied that this occurred. Mrs C submitted a copy of the policy provided to staff to instruct them on preserving patients' privacy and dignity.

The tone of the daily nursing notes does not indicate any lack of respect for Mrs A on the part of staff at the rest home. My expert noted, after a review of the clinical records, that "personal cares of washing, turning and pad changes [were] carried out by care staff appropriately".

Ms B and her family were naturally anxious that the care provided to Mrs A was of a high standard and were sensitive to all aspects of her care. However, there is insufficient evidence to determine that Mrs A was denied respect and privacy during her stay at the rest home.

Other comments

Documentation of clinical records
In her letter of complaint Ms B alleged that there were "discrepancies in recording of clinical notes". She claimed that the "signatures on the medication signing sheets and the two hourly turn charts are forged", because all the signatures were the same, a signature that purports to be her signature is forged and there are turn chart pages missing. These are serious allegations.

I can find no evidence to support Ms B's claim that the two-hourly turn documents or the medication administration sheets have been altered. However, my expert commented that the documentation in general at the rest home could be improved. The progress notes were

difficult to read and the person recording the note was not always able to be identified. Some entries were not signed and on a number of occasions there was no time entered. I recommend that the rest home review the quality of its clinical documentation.

Medication management

I note my expert's comments regarding medication management at the rest home. It is not appropriate for a registered nurse to write out prescriptions to fax to the doctor to sign, nor to write controlled drugs such as morphine onto the medication order sheet and sign (pp) for the prescribing doctor. My expert also noted that the use of the medication administration sheets at the rest home did not comply with accepted standards. It was unclear in what sequence these records were used, and there is nothing to differentiate between the sheets in use and the fax copy.

Mrs C informed me that the usual practice at the rest home when a patient is admitted from the public hospital is that the accompanying prescription is either faxed or hand delivered to their supplying pharmacy, and the 'Medication Order' form, which is completed by the registered nurse admitting the patient (along with the discharge records), is faxed to the general practitioner to verify.

The Pharmacy and Dr E informed me that the prescription and dispensing of medications for residents and patients at the rest home complies with professional standards and legal requirements.

The Ministry of Health, Therapeutics Section has provided guidelines on the safe management of medicines. I urge the rest home to follow the recommendations in this publication and consider incorporating the comments made by my expert into relevant policies and practice.

Family involvement in patient care

My expert commented that Ms B should the rest home, since "there will always be conflict with other staff". I note that Ms B expressly requested that she be involved in her mother's care, and that the other family members were extremely helpful, assisting with meals and other aspects of care.

While it may be comforting for both the family and the patient to involve family in simple cares, I agree with my expert's advice that there is the potential for conflict when an employee of a rest home cares for a family member at the facility. Such an arrangement can result in the caregiver's objectivity becoming impaired, or lead to conflict with colleagues over the care provided to the family member. It may also result in a situation where the caregiver is privy to health information that the patient may not have wanted to share with family members. There is also a risk that record-keeping will be neglected when professional and personal boundaries become blurred.

Actions taken

The rest home and Mrs C have provided apologies to Ms B and her family for the shortcomings in the care provided to Mrs A, and have confirmed that documentation systems have been upgraded and that a further review of practices will be undertaken in light of this report.

Follow-up actions

- A copy of my final report will be sent to the Ministry of Health, Licensing Office and the Nursing Council of New Zealand.

- A copy of this report, with details identifying the parties removed, will be sent to the New Zealand Private Hospitals Association and Residential Care New Zealand, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A

Admission and Discharge

Admission of a New Client

The time of admission of a new client is a very important time because the new Client and their family (if present) will be anxious and very aware of the environment and events going on about, forming first impressions which will stay with them for a long time.

The Admission process is designed to ensure that:

- the new Client is welcomed to the Hospital and assisted to settle in.
- stress and fear of the unknown are minimised.
- the new client is orientated to the facilities.
- that the Client receives appropriate assistance, care and services from the outset.
- that the legal obligations and processing of the payment of fees requirements are met.

Timing the arrival of a new Client

Timing the arrival is a most important aspect of admitting a new client in an appropriate manner.

The arrival time should be planned at a time the senior staff member receiving the client is going to be available to give time and concentration to the person.

Receiving a referral or an inquiry

Calls from prospective residents or their agents should be referred to the senior person on duty.

If the initial receiver of the call is not equipped with the necessary knowledge, the staff member must take the name and contact phone number of the enquirer and relay the message immediately to the person on call. An enquirer should be encouraged to come and see the facility. The services offered and the physical amenities shown or explained. It should be stressed that the Hospital Philosophy encourages individuality and Clients are encouraged to bring their personal possessions including furniture.

The actual prospective Client should always be encouraged to visit as it makes settling in after admission easier.

Before the new Client arrives

1. Prepare the Room.
   Clean linen, freshen room.

2. Prepare necessary chart and forms.
   Complete set of Clinical Notes.

3. Always use an Admission Checklist Form.

When the Client Arrives 3.1.1

1. Greet the Client and those accompanying them.
2. Show to the room.
3. Orientate to the facility
4. Introduce to staff. Staff on successive shifts must make a point of introducing themselves to the new client.
5. Introduce to other clients.
6. Set up a BUDDY support with another resident.
7. Ensure the admission forms have been completed including the Resident Property Form.
8. Organise an initial assessment with the RN. The RN at this time must gather as much information from the resident and their family/caregivers as is relevant to care planning and individual needs. The RN will document from whom the information was obtained.
9. Check that the medication has been ordered and confirmed by GP.
10. Ensure the Resident has seen the Code of Rights and Responsibilities and the Resident Orientation Package- including the Complaints/Comments Protocol.
11. Use the admission checklist to ensure all action is completed. The checklist is to be left in the Resident's file .

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix B

5.5.1

SAFE MANAGEMENT OF MEDICATION

takes very seriously its responsibilities towards the safe management of medications. The following policy sets out how medication is to be supplied, stored and administered in the Home.

Custody and Storage

All medication that does not require storage in a refrigerator is stored in the locked medication cupboard situated in wing.

The medication cupboard is to be kept tidy at all times. Contents of the cupboard are checked weekly by R/N to ensure only current medications are on the premises, and that no medications have expired.

Medications requiring to be stored in the Refrigerator are stored in a separate labelled container in the refrigerator in kitchen.

The keys to the medication storage cupboard are held by R/N or E/N.

Controlled drugs along with the Controlled Drug Register are checked and counted weekly by two senior staff.

Controlled drugs recorded in the Controlled Drug Register are checked and counted weekly by senior staff.

Ordering and receiving Medication

All medications administered to a resident at must be prescribed by a qualified medical practitioner. Medications must be authorised in writing on the individual's Prescription Sheet by a medical practitioner.

Medications are ordered from the Pharmacy by fax or phone to the Pharmacy, or taking by hand the Prescription Sheet to the Pharmacy.

The order is either collected by senior staff from the Home, or delivered in person by a responsible adult employee of the pharmacy.

If the change involves the issuing of substitute medications, the old medication should be returned at the same time.

The medication is then stored according to this policy, taking into account any special instructions issued regarding storage.

In an emergency, telephone instructions can be given by the doctor to the Principal Nurse/ Manager,Assisitant Manager,or R/N immediately entered on the Telephoned Medication order form by that staff member, the order being read to the doctor to check the correct order has been taken.

Such orders remain current for up to 24 hours, by which time the doctor must record the entry on the Medication Instruction Sheet.

Prior to storing medication deliveries, a senior staff member must check the medico packs against the Medication Prescription Sheet to ensure the correct medication and dosage has been dispensed. After medico packs has been checked, initial the medico packs and administration sheets.

Administration

The staff member responsible for administering the medication must:

1. Preparation - Collect the Prescription and Drug Record sheets along with medications required.

   These are placed on the Medication Trolley along with glasses and tissues if required.

   Administration - Check the order.

2. Locate the medication, checking the label.

   Identify the resident positively by name and by photograph.

The staff member administering the medication is responsible to ensure the Client has taken the medication, and is not to leave it unattended to be taken at a later time.

If the Client requests to take the medication at a later time the medication is to be held and administered later. The exact time is noted on the Drug Record Sheet, and noted in the Progress Notes.

If a Client refuses to take prescribed medication, the medication is returned to the cupboard, the refusal noted on the Drug Record Sheet, and the Principal Nurse or Manager notified. An Accident/Incident Sheet must be filled out. Procedure to be followed when administering medications is set out in the New Zealand Licensed Rest Homes Association's Clinical Guidelines.

Standing Orders for Household Remedies

A doctor may agree to issue instructions for the administration of household remedies for clients under his care.

The Household Remedies protocol allowing Principal Nurse/Care Manager initiated medications are to clearly list the medications which can be used, and to remain current must be reviewed and endorsed at least 3 monthly.

The protocol must be signed by the Doctor/s giving authority, the Principal Nurse/Care Manager and the Pharmacist.

This protocol is to be strictly adhered to.

Review of Medication Orders

The Doctor and R.N./ assistant manager must review each resident's current medication prescribed on the individual's Prescription Sheet at least once every three months.

Evidence of this is noted either on the resident's Healthcare Review Sheet or in the Doctor's medical progress notes. It is the G.P.'s responsibility to prescribe, initial and date all prescription and non prescription orders.

Discontinue obsolete or surplus medication

G.P. to initial and date ceased medication order.

Any medication discontinued or surplus to the individual resident's requirements is to be returned to the Pharmacy for destruction.

Staff Training, Competency Testing and Inservice Education

All staff administering medication at Bernadette Life Care must complete the self directed learning package relating to safe administration of medication.

The Assistant nurse manager is responsible to ensure that on completion of this module the staff member is competency tested, and competency is recorded on the staff member's inservice education record.

Discrepancies or errors in medication.

In acknowledging the potential serious effects of mistakes associated with medication administration, it is mandatory at Bernadette Lifecare for staff to report any discrepancies or errors in medication to the Registered Nurse or Senior staff member **immediately**. The Registered Nurse or senior Staff member will then be responsible for contacting the Doctor / Family and will oversee the writing of the incident form.

Safe storage and administration of controlled drugs

Receipt and Storage

All Controlled Drugs are stored in the Locked Controlled Drug Cupboard.

All Controlled Drugs received by Bernadette Life Care are entered into the Controlled Drug Register.

The keys to the Controlled Drug Cupboard are to be carried on the person of the R.N./ E/N

Senior staff check and count Controlled Drugs each week / daily when administered.

When an order is discontinued, the medication is returned to the Pharmacy for destruction by the Manager or deputy. An appropriate entry is made in the controlled drugs register by R/N and Pharmacist.

Administration of Controlled Drugs

Controlled Drugs must be prescribed by the Medical Practitioner on the Drug Prescription form (CR6).

Two staff members must check out any controlled drugs being administered.

Using the prescription order, the correct dose of the correct medication at the correct time is taken from the cupboard and administered to the Resident.

This is to be witnessed by two staff members.

The transaction is then recorded:

1. In the Register of Controlled Drugs and signed by the two staff members.
2. On the Individual resident's Drug Administration Record Sheet by the person administering the medication.

Signed: **Dated:**

Review Date:

SELF MEDICATION POLICY

THE CLIENT WILL BE ASSESSED BY THE G.P, REGISTERED NURSE, AND THE FAMILY AS TO THE SUITABILITY OF SELF MEDICATION.

THE CLIENT WILL BE PROVIDED WITH PRE-PACKED DOSES (MEDICO SYSTEM), MONITORED WEEKLY FOR COMPLIANCE AND REVIEWED THREE MONTHLY OR AS CIRCUMSTANCES REQUIRE.

SIGNED: **DATED:**

REVIEW DATE:

AGREEMENT TO ACCEPT RESPONSIBILITY FOR SELF MEDICATION AT LIFECARE

I ..... ACCEPT THE RESPONSIBLITY TO ADMINISTER MY MEDICATION ACCORDING TO MY DOCTORS INSTRUCTIONS. THIS RESPONSIBILITY WILL BE REVIEWED 3 MONTHLY OR AS CIRCUMSTANCES REQUIRE.

SIGNED.....
DATE.....

REF; SELF MED

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix C

Personal Grooming and Hygiene Policy

It is the policy of that the residents in our facility will have their personal grooming and hygiene attended to in an appropriate and resident preferred manner. Privacy and dignity must be maintained at all times.

Protocol

As part of the initial admission process the admitting nurse will determine the preferred time and whether the resident prefers shower or bath. A discussion will be held with the resident/ representative as to how often they will be showered/bathed and what will best fit the needs of the resident. At all times the residents choice will be catered for as far as physically possible. If assistance is required this will be offered in such a way to preserve the privacy and dignity of the resident.

Skin Integrity will be assessed at time of cares being given and any changes will be reported to R.N and documented in clinical notes. R.N. will enter in Nursing Care plan any appropriate information.

At the time of bathing hair, teeth, shaving (if appropriate) and nails will be checked, cleaned and attended to. Toenails are not to be cut by caregivers.

Residents are to be offered the choice of what clothing they would like to wear and assisted with their dressing as needed. Where a resident is unable to make this choice the caregiver will endeavour to ensure that the resident is dressed appropriately for the weather and in a manner to which he/she has previously been accustomed. At all times clothing is clean and well maintained. All clothing is to be named and to be only used by the resident to whom it belongs.

Where resident requests or where necessary a hair appointment can be made with visiting hairdresser for haircuts, sets and perms.

A podiatrist visits our facility on a regular basis. Residents needing the attention of the podiatrist are welcome to enter their name for her list.

Published : March 2003 Signed: (Review: April 2004