Melody Enterprises Limited (trading as Rhapsody Lifecare)

A Report by the

Deputy Health and Disability Commissioner

(Case 13HDC00196)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In Month1[1] Mr A, aged 83 years at the time of these events, was admitted to Rhapsody Lifecare (operated by Melody Enterprises Limited) for rest home level care. He had a diagnosis of prostate cancer, as well as other co-morbidities, but was mobile, relatively independent, and prescribed pain relief medication only on an as-needed basis.

2. In mid-Month4, Mr A's condition deteriorated. On 16 Month4, Rhapsody Lifecare's general practitioner Dr G prescribed Mr A regular pain relief medication and, two days later, on 18 Month4, end-of-life care was commenced for Mr A. Standing orders, which allowed for Mr A to have more medication to keep him comfortable, were commenced the next day. The Liverpool Care Pathway was commenced on 21 Month4. Mr A died in the early hours of 22 Month4.

3. Although there was some care planning for Mr A on his admission to Rhapsody Lifecare, no update was made to his care plan when his condition changed. Mr A's progress notes record that, while he was receiving end-of-life care, on a number of occasions he was in pain. The documentation shows that, rather than being actively and consistently assessed, monitored, and documented, pain management was provided in an ad hoc manner.

4. The Deputy Commissioner found that the standard of care provided to Mr A by Melody Enterprises Limited (trading as Rhapsody Lifecare) fell below an appropriate standard. The lack of appropriate care planning, Mr A's inadequate pain management, and the general lack of understanding amongst staff about end-of-life care amounted to a failure to provide services with reasonable care and skill. Responsibility for that failure lay with Melody Enterprises Limited as the overall service provider. Accordingly, Melody Enterprises Limited breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[2]

Complaint and investigation

5. The Commissioner received a complaint from Ms B about the services provided to her late grandfather, Mr A, at Rhapsody Lifecare. The following issue was identified for investigation:

> *Whether Melody Enterprises Limited (trading as Rhapsody Lifecare) provided Mr A with an appropriate standard of care between 19 Month1 and 22 Month4.*

[1] Relevant months are referred to as Month1-4 to protect privacy.
[2] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."

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

7. The parties directly involved in the investigation were:

Ms B	Complainant/consumer's granddaughter
Ms C	Complainant/consumer's daughter
Rhapsody Lifecare	Rest home services provider
RN D	Clinical Services Manager
RN E	Registered nurse
RN F	Registered nurse

Also mentioned in this report:

Dr G	General practitioner
RN I	Registered nurse

8. Information from the District Health Board was also reviewed.

9. Independent expert advice was obtained from registered nurse Margaret O'Connor (**Appendix A**).

Information gathered during investigation

Background

10. Mr A, aged 83 years at the time of these events, had a diagnosis of prostate cancer as well as diabetes, stroke, hypertension,[3] chronic obstructive pulmonary disorder,[4] hepatic fibrosis,[5] angina,[6] a previous myocardial infarction,[7] and depression. During 2012, Mr A's wife died, and his health deteriorated.

11. On 19 Month1, Mr A was admitted to Rhapsody Lifecare for rest home level care. He was under the care of Rhapsody Lifecare general practitioner Dr G.

Rhapsody Lifecare

12. Rhapsody Lifecare provides rest home and hospital level care for up to 70 people under the Age Related Residential Care Services Agreement between Melody Enterprises Limited (trading as Rhapsody Lifecare) and the District Health Board (the DHB).

[3] High blood pressure.
[4] Also known as chronic obstructive respiratory disease, a type of obstructive lung disease characterised by chronically poor airflow.
[5] Build-up of excessive connective tissue in the liver.
[6] Chest pain/discomfort caused by reduced blood flow to the heart.
[7] Heart attack.

Care planning for Mr A

13. Mr A's records include an Initial Risk Assessment and a Risk Summary dated 19 Month1, and a Nutritional Assessment dated 20 Month1. They also include a number of undated documents that appear to have been completed at the time of Mr A's admission,[8] including a Coombes Falls Assessment Form, an Indwelling Catheter Care Plan, and a Norton Scale Risk Assessment — Pressure Area Risk (the Norton Assessment). The Norton Assessment ranks a resident's physical condition, mental condition, activity, mobility, and incontinence on a scale of 1 to 4, and states that any resident with a combined score of less than 14 is "at risk". Mr A's Norton Assessment score was 20, indicating that he had a low risk for pressure sores.

14. On 27 Month1, a "Resident Lifestyle Plan" was completed for Mr A by an enrolled nurse (EN).[9] The Resident Lifestyle Plan included assessments of Mr A's needs relating to skin care and pain and comfort (among other things), and how those would be addressed while Mr A was a resident at Rhapsody Lifecare. The "Pain/Comfort" section states that Mr A had a history of angina, and would be given pain relief as needed. At the time, Mr A had 50mg tramadol[10] and 1g paracetamol[11] prescribed up to four times daily as required, but no regular pain medication. The "Skin Integrity/Care" section of the Resident Lifestyle Plan states that the area around Mr A's suprapubic catheter,[12] which was prone to redness, would be monitored.

15. Mr A's records also include an Advanced Directive Form,[13] which was completed on 6 Month2 and reviewed (with no change) on 10 Month4. It is signed by Mr A, Dr G, and the EN. It states:

> "Have you thought about the sort of things you would want done or would like people to know about in relation to dying? To be kept comfortable."

Prescription for regular pain medication

16. On 16 Month4, Mr A's daughter, Ms C, telephoned Dr G because she was concerned about her father's pain management.[14] Dr G recorded in the clinical records that he agreed that Mr A required regular pain medication, and prescribed Mr A, on a trial basis, regular tramadol and paracetamol four times daily.

17. Also on 16 Month4, Rhapsody Lifecare registered nurse (RN) RN E recorded in Mr A's progress notes:

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[8] Melody Enterprises Limited told HDC that it was unable to advise when these documents were completed, as the relevant staff members no longer work at Rhapsody Lifecare.
[9] The EN completed most of the admission documentation listed above at paragraph 13.
[10] An opioid pain medication.
[11] Widely used pain medication.
[12] A tube inserted into the bladder through a small hole in the abdomen to drain urine.
[13] The Advanced Directive Form states: "An advanced directive allows you to make your attitudes and wishes clear about [what] you want to happen in certain serious situations if you were unconscious or otherwise too sick to be involved in decision-making. It would provide guidance to the people looking after you."
[14] Mr A's records show that he was administered paracetamol and tramadol intermittently between 19 Month1 and 16 Month4, and that he was last reviewed by Dr G on 10 Month4.

> "Daughter [Ms C] raised a concern that [Mr A's] mood remains very low despite recent increase to citalopram.[15] He does not communicate his pain most times and they would appreciate if he is put on regular instead of [as required] pain relief to make him as comfortable as possible. GP was faxed … Response from [Dr G] to try [tramadol and paracetamol four times daily] as regular change of medication forms faxed to pharmacy. Daughter advised."

18. On the morning of 17 Month4, RN F recorded in the progress notes that, despite being given regular pain medication, Mr A had been in an increased amount of pain. She recorded that Mr A had been nauseous but had not vomited. She further noted that Mr A was feeling faint and had been unable to walk after breakfast.

19. That day, RN F faxed Dr G, stating: "[Mr A] has been causing some concern today. Pain over full chest area … ate breakfast but then felt nauseous, retching … Very difficult to get a clear picture from him — ? just [very] depressed or further concerns in health. Would you like us to continue to monitor or for you to review." RN F recorded in the progress notes that [Dr G's] nurse had telephoned and advised them to "[m]onitor at this point and follow up tomorrow am".

20. The progress notes record that, in the afternoon and during the night on 17 Month4, Mr A vomited when given paracetamol and tramadol, that his mood and general condition appeared to be poor, and that he was "confused, not knowing where he was". They also document that Mr A's afternoon tramadol was withheld "as nil pain voiced".

21. There is no evidence that, at this time or later, there was any consideration given to moving Mr A from rest home level care to hospital level care.

Commencement of comfort cares

22. In the morning of 18 Month4, RN F again faxed Dr G, stating: "[Mr A's] mood and general condition remains very low. Vomited x 2, dry retching yesterday evening … Pain levels difficult to judge as said he was pain free but then complained of pain over back of head. Could you please visit to reassess …" The morning progress notes record that Mr A had "pain over complete body on and off. Dry retching this [morning] but no vomiting." There is no record in Mr A's notes that he was given any pain relief medication during the day.

23. At about 1pm, Dr G visited Mr A. Dr G recorded in the clinical notes that Mr A was "more frail and confused", and that he discussed the progression of Mr A's illness with Mr A's family. Dr G recorded: "[Mr A] to have comfort cares[16] … stop non essential medication start morphine[17] oral." Dr G stopped Mr A's prescription for tramadol, and instead prescribed 20mg long-acting morphine twice daily.

[15] An antidepressant.
[16] Care that helps or soothes a person who is dying.
[17] An opiod pain relief medication.

24. The progress notes record that, during the evening, Mr A was commenced on 20mg long-acting morphine[18] and "appear[ed] comfortable. Nil complaints of pain or discomfort. Very confused and difficult to understand verbal communications."

Commencement of standing orders

25. On 19 Month4, standing orders[19] were implemented, which allowed for Mr A to have more medication to keep him comfortable. The "Standing Orders (Palliative and End of Life)" for Mr A are signed by Dr G, and state that Mr A could have 5mg subcutaneous[20] morphine two hourly as required for pain or shortness of breath; 6.25mg subcutaneous Nozinan[21] twice daily as required for nausea/vomiting; 2.5mg subcutaneous midazolam[22] three times daily as required for anxiety, agitation and terminal restlessness; and 0.4mg hyoscine[23] two hourly as required for respiratory secretions. There is no information or instruction about how the patient, his or her symptoms and/or the effectiveness of the medication provided should be monitored or assessed.

19–21 Month4

26. According to the progress notes, on the morning of 19 Month4, Mr A was not able to stand up, and looked "very tired". The progress notes record that Mr A stayed in bed throughout the day. Mr A's Medication Administration Record (MAR) documents that he was given 5mg morphine at 11.45am.[24] RN E recorded that, at 2.05pm, Mr A was turned to a right side lying position and his sheets were changed at his family's request. He also showed signs of pain, and was given 5mg morphine. At 2.30pm, RN E recorded that Mr A remained restless despite the morphine, and was given 2.5mg midazolam. In the evening, Mr A was turned to a left side lying position at his family's request. The progress notes record that he was "very unresponsive", and was given 5mg of morphine at 7.35pm and 2.5mg midazolam at 10pm.

27. RN I recorded at 11.40pm that Mr A's family was concerned about his breathing, and that his bed was elevated as a result, with good effect. RN I recorded that she checked on Mr A frequently during the night and turned him two hourly, and that at 5.15am on 20 Month4 he was agitated and "plucking",[25] and was given 2.5mg midazolam.

28. During the morning on 20 Month4, Mr A was cared for by a caregiver. The progress notes record that Mr A was given 5mg morphine for pain at 10.30am and 2.5mg

[18] Mr A's Medication Administration Record documents that he was given 20mg long-acting morphine at bedtime.
[19] A standing order is a written instruction issued by a medical practitioner that authorises a specified person or class of people who do not have prescribing rights to administer and/or supply specified medicines and some controlled drugs.
[20] Administered under the skin.
[21] Trade name for levomepromazine, an analgesia also used as a sedative, commonly prescribed in the context of palliative care in the drug's unlicensed form at a lower dose as an antiemetic.
[22] A short-acting sedative.
[23] Used to treat abdominal pain and discomfort.
[24] The administration of morphine at bedtime on 18 Month4 and 11.45am on 19 Month4 is not documented in the progress notes — otherwise, all administration of morphine and midazolam is documented in both the progress notes and on the MAR.
[25] Patients who are dying are sometimes seen plucking at their sheets or the air.

midazolam for agitation and stiffness at 2.10pm, both with good effect. The notes also record: "Turns maintained, family present @ all times."

29. During the afternoon, Mr A was cared for by an RN. The progress notes record that Mr A was given 2.5mg midazolam at 4.50pm because he was twitching and restless, and 5mg morphine at 6.45pm and 8.30pm with good effect. Again the progress notes record: "Turns maintained. Family present all the time." In addition, the notes record that Mr A's family requested a syringe driver[26] be commenced, and that the RN would notify Dr G of that request in the morning.

30. During the night, Mr A was cared for by RN I and a caregiver. RN I recorded that Mr A's family left at midnight on 21 Month4. The caregiver recorded in the progress notes that she turned Mr A onto his right side at 1.30am. She recorded: "A little [fidgety] & jumpy after turning. 0215 seemed restless, kept putting his hand up to his head & screwing his face up, quite jumpy, asked RN to check on [him]." RN I recorded that at 2.30am Mr A was grimacing and agitated, and was given 5mg morphine. The caregiver recorded that she turned Mr A onto his left side at 3.30am and onto his right side at 5.30am. She recorded that, after the 5.30am turn, Mr A was "restless, throwing blankets off, moving around a lot, RN informed". RN I recorded that at 5.40am she gave Mr A 2.5mg midazolam because he was agitated and restless, and that, at 6.30am, she gave him 5mg morphine because he was agitated with facial grimacing. There is no record that Mr A was given any further pain relief until 12.45pm (discussed further below).

31. During the day on 21 Month4, Mr A was cared for by RN F. RN F recorded that, in the morning, Mr A's condition was "very low but comfortable with no agitation, restlessness". She recorded that, at 9.30am, she changed his sheets and turned him on his left side. Also in the morning, RN F faxed Dr G stating that Mr A's family were requesting a syringe driver.

32. At 11.45am Dr G visited Mr A. He documented that Mr A was to have a syringe driver with 10mg/1ml morphine, 25mg morphine, 6.25mg Nozinan and 7.5mg midazolam over 24 hours.[27]

Commencement of Liverpool Care Pathway (LCP)

33. On 21 Month4, Dr G also completed a form titled "Medical Health Care Professional documenting the decision to use the LCP [Liverpool Care Pathway] following a full MDT [multidisciplinary team] assessment" [the LCP form].

34. The LCP is a care pathway covering end-of-life care options for patients in their last days or hours of life. It is designed to help practitioners provide quality end-of-life care. The LCP is organised into sections or "goals" designed to ensure that care and evaluation of the patient's condition is continuous and consistent.

[26] A small infusion pump used to administer medication gradually.
[27] The syringe driver was not commenced until 3.45pm, discussed further below. Rhapsody Lifecare told HDC that this was because the pharmacy had to draw up the medication, and Rhapsody Lifecare staff needed to pick up the medication from the pharmacy.

35. During the course of HDC's investigation, Rhapsody Lifecare provided three separate copies of the LCP form. The first copy is signed by Dr G, and there is a section on the form titled "Goal 8: The patient's skin integrity is assessed", which has not been completed. The second and third copies of the form are signed by both Dr G and RN F, and, in the section titled "Goal 8: The patient's skin integrity is assessed", the "Achieved" box has been ticked.

36. Once the LCP was commenced at 12pm on 21 Month4, Mr A's observations were documented in a separate set of records specific to patients on the LCP. Those records include an "Ongoing Assessment of the Plan of Care", a "Variance Analysis Sheet", and "Ongoing Assessment Multidisciplinary Progress Notes". They prompt for staff to record four hourly whether 19 goals (including that the patient is not in pain, the patient is not agitated, and the patient's skin integrity is maintained) have been "achieved" or whether there has been "variance".

37. At 12.45pm, Mr A was given 5mg morphine as he was "becoming a little restless", and was turned on to his back. RN F recorded in the progress notes that, at 2pm, Mr A was turned onto his right side and was comfortable. There is no record that Mr A was turned again until 6.30pm, as noted below.

38. During the afternoon, Mr A was cared for by an RN. At 3.45pm, Mr A was given 2.5mg midazolam owing to restlessness, and the syringe driver was commenced.[28] At 4.55pm the progress notes record that Mr A was given 5mg morphine because he was in pain, was grimacing and was restless, but that it had little effect. At 6.30pm, Mr A was still agitated and grimacing, and was repositioned, and at 7pm he was given 5mg morphine as the progress notes record that he was "clearly in pain groaning & [grimacing]". At 7.30pm, Mr A was given 2.5mg midazolam and, at 8pm, the notes record that he was settled and sleeping. According to the notes, Mr A was again repositioned and remained settled at 11pm.

39. During the night, Mr A was cared for by another RN. At 1.25am on 22 Month4, the notes record that Mr A had been repositioned and appeared to be in pain with facial grimacing. He was given 5mg morphine but settled for a short period only, and was "cont[inuing] to moan on & off". The notes record that at 3.20am Mr A still appeared to be in pain, and that he was given 5mg morphine with some effect. At 4am, Mr A was turned on his left side and was "moaning/groaning".

40. Mr A died between 4am and 4.15am on 22 Month4.

Complaint to HDC

41. Mr A's granddaughter, Ms B,[29] complained to HDC about the care provided to Mr A. In particular, she expressed concern about the pain relief administered and its monitoring, and pressure area management. In her complaint she stated:

[28] There is a "Syringe Driver Check" in Mr A's records, which documents that the syringe driver administered 0.7ml/hour.
[29] Ms B is a registered nurse with experience in end-of-life care.

> "I felt like [Mr A] was only given pain relief on request from the family during the day. I felt it was plain to see [Mr A] was experiencing a lot of pain … I felt we were constantly fighting a battle for pain relief to the point where we felt unhappy to leave him there alone … [T]he only thing the family I believe should have to deal with when [they] are losing [their] loved one is the love and memories of that person, not when the next lot of pain relief is due."

Rhapsody Lifecare's response

42. Following initial notification from HDC that it had received a complaint about the care provided to Mr A, Rhapsody Lifecare carried out an internal review of his care. [Rhapsody Lifecare] advised HDC that [the] review identified "a lack of communication between staff, a lack of understanding by staff of palliative care, and a lack of overview [by] the Clinical Services Manager".

43. RN D was the Clinical Services Manager at the time of these events. In a statement to HDC, she advised that she was on annual leave from the evening of 17 Month4 to the morning of 21 Month4, and that RN E "covered call" during that time. RN D further stated that, when she saw Mr A on 17 Month4, he appeared comfortable, and neither his family nor staff raised any concerns. RN D stated that, when she was next at Rhapsody on 21 Month4, she "would have been advised of [Mr A's] decline … but [does] not remember the exact conversation", and "had no further involvement in [Mr A's] care".

44. RN E told HDC that she was on site on 19 Month4 and on call for the rest of the weekend, and that she did not receive a call advising her of any change in Mr A's condition.

45. When asked to provide policies and protocols relating to the admission of new residents, assessment and care planning, pain management, pressure area care, documentation, and the use of the LCP in place at the time of these events, Rhapsody Lifecare provided its "Guidelines for the Completion of Admission Documentation" and an information sheet provided to relatives or carers of patients on the LCP. It also provided a "Deterioration in Health Status Care Plan" document, which states:

> "In the event of sudden deterioration where death is expected this Care Plan is to be individualised and implemented and replaces all other Care Plans for the Resident. … Use for short term only. Assessment of comfort and pain levels is extremely important. …
>
> Pain Assessment
>
> - The registered nurse must make an entry into the progress notes each shift;
> - The registered nurse will use a standard pain assessment tool; …
> - The registered nurse will consult with the resident and [next of kin] about the effectiveness of any comfort and pain measure and take specific wishes into account;
> - On each shift there will be observation and reporting of pain behaviour."

46. Mr A's records do not include a Deterioration in Health Status Care Plan.

47. In addition, Rhapsody Lifecare provided a one-page document titled "Procedure on the care of the dying", which states:

> "… The effectiveness of any pain regime will be monitored and adjusted with the Medical Practitioner … Adequate control of pain, nausea and vomiting and restlessness will be maintained.
>
> … Pressure area cares and turning will be carried out two hourly, or more frequently if required and oral hygiene cares will be done. All cares will be performed by two nurses during this time."

48. When asked to provide information about what training was given to staff about care planning and/or end-of-life care, Rhapsody Lifecare advised that the majority of its staff had attended a one-hour training session about the LCP in March–April 2012. Rhapsody Lifecare advised that it was not able to provide further information about what other training, if any, had been provided to staff, because much of its staff (including managerial staff) has changed since the time of these events.

49. In response to HDC's independent expert advisor's report (discussed further below), Rhapsody Lifecare acknowledged to HDC that:

a) There was no formal assessment of Mr A's pain, and standing order medication was administered without documented evidence of assessment, monitoring and evaluation of its effectiveness at appropriate intervals.

b) Mr A's nausea and vomiting between 17 and 19 Month4, while documented in the progress notes, was not assessed or treated.

c) The assessment of Mr A prior to the commencement of the LCP was incomplete.

d) While the progress notes document that Mr A was turned between 18 and 21 Month4, this was often sporadic, irregular, and at the family's request, rather than pursuant to a clear plan of pressure area management and clear communication between staff.

e) There is insufficient documentation regarding a clear plan of management for Mr A's declining health. There are no entries in his Long Term Care Plan, and no Short Term Care Plan was developed detailing any changes in care with regard to Mr A's declining mobility, pain management, nausea, pressure area management, or changes in directives on managing his care.

50. Rhapsody Lifecare advised that, since these events, it has made the following changes:

a) Staff have been provided education about end-of-life care, and education about care planning is ongoing.

b) Pain assessment tools and Norton Scale Risk Assessment (pressure area assessment) tools have been "fully endorsed to be used". Pain assessment tools are

being used to assess acute pain and at three-monthly intervals to evaluate chronic pain.

c) Pressure area care "has been improved with ensuring that … a short term care plan be developed immediately [when] a resident's care changes, [which is] endorsed on the Long Term Care Plan if continuing".

December 2014 HealthCERT audit

51. All rest home and aged residential care facilities in New Zealand are required to undergo routine certification and surveillance auditing of their services.[30] Rhapsody Lifecare provided HDC with its December 2014 HealthCERT surveillance audit, which identified the following issues of relevance:

a) Not all training required by the Health and Disability Services (Core) Standards 2008, the contracts with the DHB or as described in the organisation's policies and procedures for ongoing training and development had been scheduled and delivered. This was a required improvement from certification in 2013 that had not yet been fully addressed.

b) All residents at Rhapsody Lifecare were not assessed, reviewed and evaluated by a registered nurse as required in the service provider's agreement with the DHB.

c) Care plans did not always describe the required support to meet residents' care needs.

d) Intervention in care plans did not always meet residents' assessed needs and desired outcomes.

Response to provisional report

52. Mr A's family commented on the "Information gathered during investigation" section of the provisional decision, and their comments have been considered during the course of my investigation.

53. Melody Enterprises Limited was given the opportunity to comment on the proposed findings and courses of action. It accepted the proposed findings and advised that it wished to make no further comment.

[30] Certification audits happen every one to four years. After the audit, rest homes are certified for a set period of time (the exact length depends on how well the rest home performed at the certification audit). Once this time is up, the rest home must be re-audited and its certification renewed. An unannounced spot audit (a surveillance audit) happens around the middle of a rest home's certification period. The spot audit is designed to ensure that progress has been made on outstanding areas identified in the earlier certification audit.

Relevant standards

54. New Zealand Standard Health and Disability Services (Core) Standards (NZS 8134.1:2008) include:

> "2.2 The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. …
>
> 3.5 Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. …
>
> 3.8 Consumers' service delivery plans are evaluated in a comprehensive and timely manner."

55. The Age Related Residential Care Services Agreement states:

> "D5.4 [The service provider] must develop and document policies, procedures, protocols and guidelines for all elements of the Services that [it] must provide under this Agreement. Such policies shall include, but are not restricted to, policies relating to: …
>
> h. Pain management; …
>
> r. Skin management
>
> …
>
> D16.3 Care Planning
>
> [The service provider] must ensure that: …
>
> d. Each Subsidised Resident's Care Plan is reviewed by a Registered Nurse and amended where necessary to ensure it remains relevant to address the Subsidised Resident's current identified needs and health status. […]
>
> h. The Care Plan addresses personal care needs, health care needs, rehabilitation/habitation needs, maintenance of function needs and care of the dying; […]
>
> l. Care Plans are available to all Care Staff and that they use these Care Plans to guide the care delivery provided according to the relevant staff member's level of responsibility.
>
> D16.4 Evaluation
>
> a. [The service provider] must ensure that each Subsidised Resident's Care Plan is evaluated, reviewed and amended either when clinically indicated by a change in the Subsidised Resident's condition or at least every six months, which is the earlier."

Opinion: Melody Enterprises Limited (trading as Rhapsody Lifecare)

Standard of care — Breach

Introduction

56. Mr A was admitted to Rhapsody Lifecare for rest home level care on 19 Month1. Mr A had a diagnosis of prostate cancer as well as multiple comorbidities, but was mobile, relatively independent, and prescribed pain medication only on an as-needed basis. Three months later his condition deteriorated, and comfort cares were commenced. Mr A died in the early hours of the morning of 22 Month4.

57. In accordance with the Code, Melody Enterprises Limited had a responsibility to operate Rhapsody Lifecare in a manner that provided its clients with services of an appropriate standard. In my view, a number of aspects of the care provided to Mr A at Rhapsody Lifecare were poor. In particular, I am concerned about the inadequate care planning for Mr A when his condition deteriorated; his pain management; and the clear lack of understanding amongst staff about end-of-life care. This Office has previously stated[31] that the inaction and failure by multiple staff to adhere to policies and procedures points towards an environment that does not sufficiently support and assist staff to do what is required of them, and the rest home must bear overall responsibility for this. As set out in the New Zealand Health and Disability Sector Standards quoted above, rest homes are required to ensure that the operation of their services is managed in an efficient and effective manner.

58. I note that the deficiencies in the care provided to Mr A were also reflected in Rhapsody Lifecare's December 2014 HealthCERT surveillance audit, almost two years after these events.[32]

Care planning

59. Effective care planning is fundamental to the provision of good residential care. As previously stated[33] by this Office:

> "It is a means by which a resident's physical, mental, social, and emotional well-being is evaluated and acted upon. A documented care plan enables multiple staff to ensure the provision of care consistent with a resident's needs. It ensures that as a resident's needs change over time, care provision is appropriately modified. In settings where care is provided by both registered and non-registered staff, a comprehensive assessment, planning, implementation, and evaluation process is essential. This is the responsibility of registered healthcare providers. It is the proper documentation of this process that ensures continuity of care."

60. When Mr A was admitted to Rhapsody Lifecare in Month1, a Resident Lifestyle Plan was completed, which included assessments of his needs and how those would be addressed while he was a resident at Rhapsody Lifecare. At that time, Mr A was

[31] See Opinions 09HDC01783 and 11HDC00512, available at www.hdc.org.nz.
[32] See paragraph 51 above.
[33] Opinion 11HDC00512, available at www.hdc.org.nz.

mobile, and was prescribed pain relief medication only on an as-needed basis. His condition subsequently deteriorated and, from 16 Month4 onwards, he became progressively less mobile, and his pain levels increased. On 16 Month4, following concern expressed by Mr A's family about his pain levels, Dr G prescribed Mr A regular pain medication four times daily. On 18 Month4, Dr G assessed Mr A, and it was agreed that comfort cares would be commenced, and long-acting morphine was prescribed. The following day, standing orders were implemented.

61. There is no evidence of an updated assessment of Mr A's needs and what planned interventions, if any, were required to meet those needs, until the LCP was implemented on 21 Month4. In my view, the significant change in Mr A's condition necessitated a significant change in the care he required from 16 Month4. For example, his increased pain levels required more intensive pain management, and his decreased mobility required more intensive pressure area management. In addition, the progress notes show that between 17 and 19 Month4 he suffered nausea and vomiting, but there is no evidence that those symptoms were assessed or treated. No changes were made to his Resident Lifestyle Plan, and no short-term care plan was documented. Although Melody Enterprises Limited provided HDC with a Deterioration in Health Status Care Plan document in use at the time of these events, Mr A's records did not contain a completed Deterioration in Health Status Care Plan. I consider that following Mr A's deterioration from 16 Month4, the absence of an up-to-date and documented care plan meant that there was a lack of guidance for staff about Mr A's needs, and how they could be met.

62. I am also concerned that the lack of up-to-date care planning in Mr A's case was contrary to Melody Enterprise Limited's contract with the DHB, the Age Related Residential Care Services Agreement, which provides that care plans must be reviewed by a registered nurse and amended when clinically indicated and where necessary to ensure that they remain relevant to a resident's current needs. It also provides that care plans are available to all care staff and guide service delivery.

63. I note the view of my independent expert, RN Margaret O'Connor, that the lack of up-to-date care planning for Mr A was the result of a lack of clinical overview of his care. RN O'Connor advised:

> "[Rhapsody Lifecare] had both Registered and Enrolled Nurses caring for [Mr A], however there does not appear to be anyone providing a clinical overview and continually updating his care plans to ensure it reflects his current needs hence giving staff information on his current cares … perhaps [Mr A] would have been better cared for in a hospital area where staff are more experienced in providing this level of care."

64. I agree with RN O'Connor. I consider it concerning that, although the progress notes demonstrate that there was continuous registered nurse involvement in Mr A's care, there was nonetheless a lack of clinical overview in his care planning. Consideration should have been given to moving Mr A to hospital level care, to facilitate appropriate management of his deteriorating condition.

65. Melody Enterprises Limited attributed the lack of oversight of Mr A's care to the Clinical Services Manager who, at the time, was RN D. RN D advised HDC that she was on leave from the evening of 17 Month4 until the morning of 21 Month4, and that RN E was "covering call". RN E told HDC that she was not alerted to any concerns about Mr A's condition while she was not on site.

66. While individual registered nurses responsible for clinical oversight should have taken a more active role in Mr A's care, there were multiple other registered nurses involved in Mr A's care, who did not document any changes to his care plan or show any evidence of having considered that his care plan needed updating. I consider the fact that none of the registered nurses involved in Mr A's care took an active approach to his care planning indicates a lax attitude towards care planning at Rhapsody Lifecare, and overall poor staff compliance with Rhapsody Lifecare's contractual obligations and policies and procedures. This is a systemic, service delivery failure, for which Melody Enterprises Limited is responsible.

Pain management

67. Mr A's progress notes clearly document periods when he appeared to be in pain and pain relief medication had limited or no effect, but there is no formal assessment of his pain. Although the Deterioration in Health Status Care Plan document provided by Rhapsody Lifecare makes reference to pain assessment and pain assessment tools, as stated above, Mr A's records do not include a completed Deterioration in Health Status Care Plan, and there is no evidence that pain assessment tools were used, or any formal monitoring of his pain was carried out, in the course of his care.

68. The documentation provided by Rhapsody Lifecare shows that, rather than being actively and consistently assessed, monitored, and documented, pain management was provided in an ad hoc manner. For example, Ms B told HDC that she felt she and her family were "constantly fighting a battle for pain relief to the point we felt unhappy to leave [Mr A] there alone", and the clinical records document that the syringe driver was arranged at the request of Mr A's family.

69. In my view, this is unacceptable. While it is appropriate to work together with patients and their families when providing care, it is not a patient's and/or his or her family's responsibility to ensure that appropriate care is provided.

70. I accept RN O'Connor's advice that:

> "Initially, and at intervals as required, a formal pain assessment should have been undertaken … Of concern is the use of standing order medication without documented assessment, monitoring and evaluation of its effectiveness at appropriate intervals."

71. Mr A's pain management was clearly inadequate. The failure by multiple staff, including multiple registered nurses, to undertake appropriate assessment, monitoring and evaluation of Mr A's pain levels demonstrates a systemic failure that I consider is Melody Enterprises Limited's responsibility.

Training in end-of-life care

72. I note that, on his Advanced Directive Form, Mr A recorded in relation to dying that he wanted to be kept comfortable. It is unacceptable that, when the time came, Rhapsody Lifecare rest home staff did not provide the appropriate level of care planning and pain management that he required.

73. In my view, the deficiencies in the care provided to Mr A as set out above demonstrate the inadequate provision of end-of-life care which stemmed from a lack of understanding amongst staff about the importance of care planning and pain management in the context of end-of-life care. I note that, when asked to provide information about what training was given to staff about end-of-life care, Melody Enterprises Limited advised that the majority of its staff had attended a one-hour training session about the LCP in March–April 2012. I consider that training to be inadequate. In my view, Melody Enterprises Limited's failure to provide sufficient end-of-life training for its staff directly contributed to the deficiencies in the care provided to Mr A.

Conclusion

74. As set out above, a number of aspects of the care provided to Mr A by Melody Enterprises Limited (trading as Rhapsody Lifecare) fell below an appropriate standard, including a lack of appropriate care planning, inadequate pain management, and a general lack of understanding amongst staff about end-of-life care. Melody Enterprises Limited had ultimate responsibility to ensure that Mr A received care that was of an appropriate standard. I consider that Melody Enterprises Limited failed in that responsibility and breached Right 4(1) of the Code.

Documentation — Adverse comment

75. As this Office has stated previously, the importance of good record-keeping cannot be overstated.[34] Accurate documentation is the basis for delivering continuous and appropriate care.

76. Rhapsody Lifecare staff made regular and detailed records in Mr A's progress notes. However, much of the other documentation on Mr A's file (such as the Coombes Falls Assessment Form, the Indwelling Catheter Care Plan, and the Norton Assessment) is undated or otherwise incomplete. In the case of the LCP form, Rhapsody Lifecare provided several copies of the same document that differed from one another. I consider that the inadequacies in the documentation of Mr A's care at Rhapsody Lifecare, as provided by Melody Enterprises Limited during the course of my investigation, are concerning and demonstrate a need for Rhapsody Lifecare to review its record-keeping practices.

[34] See, for example, Opinions 11HDC00423, 11HDC00883 and 12HDC01286, available at www.hdc.org.nz.

Recommendations

77. I recommend that Melody Enterprises Limited (trading as Rhapsody Lifecare) provide a written apology to Mr A's family for its breach of the Code. The apology is to be sent to HDC for forwarding, within three weeks of this report.

78. I also recommend that, within three months of the date of this report, Melody Enterprises Limited (trading as Rhapsody Lifecare):

a) Provide HDC with an update about the corrective actions it has taken in response to the issues identified in the December 2014 HeathCERT audit.

b) Review its rest home care plans in light of the comments made in this report, and provide HDC with the outcome of its review

c) Advise HDC of the systems in placed to monitor and audit care planning on an ongoing basis.

d) Provide HDC with an update about the care planning education it has provided to staff (as stated in paragraph 50).

e) Provide evidence to HDC that all staff providing care to residents have received, and will receive, ongoing education and training about end-of-life care (including records of attendance, details about what the education/training involves, and details about how ongoing education/training is scheduled/planned).

f) Review its record-keeping practices in light of the comments made in this report, and provide HDC with the outcome of its review.

Follow-up action

79. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Melody Enterprises Limited (trading as Rhapsody Lifecare) will be sent to the District Health Board and the Ministry of Health (HealthCERT), and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent expert advice to the Commissioner

The following expert advice was obtained from RN Margaret O'Connor:

"**Nursing Advice to Health and Disability Commissioner**
Complaint: Rhapsody Life Care
Reference: C13HDC00196
I have been asked to provide an opinion of whether Rhapsody Life Care (RL) provided an appropriate standard of palliative care to the late [Mr A] at RL for the period of 19–22 [Month4]. I have read the Commissioner's guidelines for independent advisors and agree to follow them to the best of my ability.

Professional profile
Since registering as a Comprehensive Nurse in 1988 I have completed a Bachelor of Nursing (2001), Graduate Certificate in Hospice Palliative Care (2002) and a Masters of Nursing with a clinical pathway (2009). My initial nursing experience was as a Public Health Nurse after which I moved to the hospital setting first in orthopaedic nursing then acute/general medical in a rural hospital. Following this I embarked on an overseas trip where I worked firstly as an agency nurse in various hospital wards then in the community setting as a district nurse in London. Also in London, I worked for 9 months in a Nursing Home for older people before returning to New Zealand and commencing nearly 5 years in Assessment, Treatment and Rehabilitation. In this setting, I coordinated a 12 bed unit and completed needs assessments for older people in a large geographical area. From 1997 to 2011 I worked for a non-profit charitable organization managing various aged care facilities. Most recently I managed a retirement village of 60 beds; residential, hospital and dementia levels, and 21 cottages. I was chair of the facility's Quality team and the organization's Clinical Practice Group and managed my facility through many changes in care provision and enjoyed successful audits. Currently I am a Nurse Practitioner for Older Persons Health in a joint initiative between a District Health Board and a non-profit charitable organization. I am a member of the New Zealand College of Nurses and enjoy providing education and insight into care of the older person for various groups in my region.

Background

The documentation I have reviewed includes

1. Copy of [Ms B's] letter.
2. [Response on behalf of] Rhapsody Life Care (RL) dated 22 April 2013.
3. [Mr A's] clinical notes from RL including nursing progress notes, GP notes and Liverpool Care Pathway documentation for the period 16–22 [Month4].
4. [Mr A's] Lifestyle Care Plan, Norton Scale Risk Assessment and Standing Orders from RL.

[Mr A] was admitted to RL on 19 [Month1] in rest home level of care. He had a diagnosis of prostate cancer with malignancies. He had a suprapubic catheter and

other diagnoses of Diabetes, Stroke, Hypertension, COPD, Hepatic fibrosis, Angina and previous Myocardial Infarction and Depression. On [16 Month4], [Mr A's] daughter phoned the GP and expressed concern about her father's pain management. In response the GP commenced regular analgesia. [Mr A] is reported to have become unwell on [17 Month4], and was at this time unable to walk and complained of pain in his chest and nausea. The GP was informed as was [Mr A's] daughter. The GP visited on [18 Month4], and noted [Mr A] to be more frail and confused. He recorded that he discussed the progression of [Mr A's] disease with his daughter and granddaughter and the decision was made for 'comfort cares', non essential medications were stopped and oral morphine commenced. Staff reported on [19 Month4], that family were concerned that [Mr A] was less responsive. On [21 Month4], the GP visited [Mr A] again and recorded that standing orders were started on [18 Month4]. He stated that [Mr A] was developing pneumonia and commenced a syringe pump. The Liverpool Care Pathway, for care of the terminally ill, was commenced by the GP and staff on [21 Month4] at 1150 hours. [Mr A] died at approximately 0420 hours on [22 Month4].

Pain Management

The progress notes and medication documentation show that [Mr A] had the following analgesia regime and changes.

1. Prior to 16 [Month4] he had Tramadol 50mg and Paracetamol 1 gram prescribed up to four times a day as required. Tramadol doses were given as follows:

Dates	Doses/day
28 [Month2]	2
29 [Month2]	2
15 [Month3]	1
17 [Month3]	1
20 [Month3]	2
24 [Month3]	1
25 [Month3]	1
26 [Month3]	1
27 [Month3]	3
9 [Month4]	1
12 [Month4]	1
14 [Month4]	1
16 [Month4]	1

2. According to a consultation note by [Dr G], dated 16 [Month4], [Mr A's] daughter had phoned his practice with concerns about her father's pain management. His analgesia was then reviewed to regular Tramadol 50mg and Paracetamol 1 gram four times a day.

3. On 18 [Month4] the Tramadol was stopped and regular long acting oral morphine 20mg twice a day was started.
4. On 19 [Month4] standing orders were implemented. In addition to his regular long acting morphine [Mr A] could have Morphine 5mg subcutaneous every two hourly as required. Doses were given as below.

Dates	Doses/day
19 [Month4]	3
20 [Month4]	3
21 [Month4]	5
22 [Month4]	2

[Mr A] could also have Midazolam 2.5mg subcutaneous three times a day as required. Doses were given as below

Dates	Doses/day
19 [Month4]	2
20 [Month4]	4
21 [Month4]	3

It appears Nozinan 6.25mg subcutaneous twice daily and Hyoscine 0.4mg two hourly as required were also available under the standing orders both of which were not given.

5. On 21 [Month4] a syringe driver containing Morphine 25mg, Midazolam 7.5mg and Nozinan 6.25mg over 24 hours was commenced.

I have reviewed [Mr A's] documentation for reports of pain by staff and subsequent actions and found the following:

Dates — after regular analgesia prescribed	Pain reported by [Mr A] in Progress notes
17 [Month4]	On morning shift
18 [Month4]	AM — Pain over complete body PM — appears comfortable
19 [Month4]	1405 — Groaning on movement ? pain — given prn
20 [Month4]	1030 — complaining pain — given prn
21 [Month4]	0230 — facial grimacing and agitated — given prn. 0630 facial grimacing and agitated — given prn.

Throughout this time I am unable to find a pain assessment tool and/or monitoring chart having been used to establish the extent of [Mr A's] pain and the

effectiveness of any analgesia given. [Mr A's] care plan, dated 27 [Month1], refers to pain associated with angina only. These documents are a form of communication between staff around [Mr A's] analgesia requirements and will help ensure his needs are identified and met by all staff. Certainly [Mr A's] daughter was concerned about the staff's management of his pain and contacted the GP on 16 [Month4] herself. There are conflicting reports from the family member's observations of their father's needs and what is reflected in the staff's notes. Ms B describes a man who she believed, as a Registered Nurse who has experience in end of life care, to be in pain. I agree with Ms B in that there is no evidence that [Mr A's] pain was appropriately monitored. There is no formal assessment of his pain. Initially, and at intervals as required, a formal pain assessment should have been undertaken by the Registered Staff responsible for [Mr A's] care. Of concern is the use of the standing order medication without documented assessment, monitoring and evaluation of effectiveness at appropriate intervals. Another DHB's RN Care Guides recommends two assessment forms depending on whether the resident can verbalize responses or not. The subsequent use of a pain monitoring form would allow the staff to better assess [Mr A's] pain and the effectiveness of analgesia administered. RL's policies and procedures on pain management should reflect this at a minimum. Of course paramount to this is education of Registered Staff on how to assess and manage pain.

RL are to be commended on their staff's implementation of standing orders and Liverpool Care Pathway for [Mr A]. This was very appropriate for the timing of his deteriorating health status.

Also of concern is the nausea at breakfast time, retching and vomiting on 17 through to 18 [Month4] that precluded his pain relief being taken. Also on 19 [Month4] it is recorded that his bedtime regular Morphine for pain was withheld due to these symptoms. I can find no evidence of these symptoms being assessed or treated, in that 24–48 hour period, and there is no further mention of them after 19 [Month4].

Pressure Relief Management

On reviewing the documentation provided to me there is a care plan dated 27 [Month1] which contains a section titled Skin integrity/Care. Unfortunately the care plan only refers to the skin where the supra-pubic catheter enters the skin. A Norton Scale Risk Assessment has been completed placing [Mr A] at 'Low risk' of developing compromised skin integrity. However this form is undated but I assume it was completed with his admission documentation. The Liverpool Care Pathway (LCP), which was implemented at 1150 hours on 21 [Month4], does have a very specific assessment for maintenance of skin integrity (Goal M). However the section relating to skin care in the Initial assessment, Goal 8, where the patient's skin integrity is assessed is not completed also there is no Waterlow/Braden assessment recorded as completed in Section 2. According to the LCP Care Plan [Mr A] received four 4 hourly assessments of his skin where the goal was found to be achieved before he died.

Prior to this period there is evidence in the progress notes of [Mr A] being turned from the morning of 20 [Month4] when he is reported as being 'semi conscious'.

Dates	Turns recorded in Progress Notes and LCP notes	Mobility level according to Progress Notes
16[Month4]	None	Still mobilizing
17[Month4]	None	Unable to walk after breakfast day on bed, up in chair for short periods
18[Month4]	None	Possibly up to toilet independently
19[Month4]	1405 — turned at family's request PM — turned to left lateral position at family's request NOCTE — 2 hourly turns made	AM — Not able to stand up during cares — on bed PM — Responsive to voice only. Bedridden
20[Month4]	Reported that turns were maintained during the day. Nocte — 2 hourly turns maintained. 0130 — turned onto Right side. 0330 — turned onto Left side 0530 — turned onto Right side	Bedridden
21[Month4]	0930 — turned onto left side Commenced on LCP 1150. 1245 — turned to back. 1400 — turned onto right side 1830 — repositioned 1930 — repositioned 2000 — turned onto side 2300 — turned	Bedridden
22[Month4]	0115 — turned 0400 — turned onto left side	Bedridden

From his notes I am assuming that [Mr A] was possibly still mobilizing to the toilet on morning of 18 [Month4]. One could question then that he may not have changed from 'low risk'. However from this information I can deduce that on 19 [Month4] [Mr A] did not receive adequate pressure area management according to his mobility level. It appears that 19 [Month4] was his first day wholly on his bed and staff have only provided turning in the first part of the day at the family's request. This was despite [Mr A] being deemed for 'comfort cares' the previous day. Being for 'comfort cares' meant the objectives of his care had changed and he had been deemed terminal. I wonder if this was clearly communicated to staff, certainly not through changes to his Care Plan. There is no evidence of a current assessment of his needs and any planned interventions needed, if any, to meet those needs prior to the LCP being implemented on 21 [Month4] even though he was reported as unwell since the night of 17 [Month4].

Summary

[Mr A's] care plan is dated 27 [Month1] and does not show any changes even though his needs obviously changed since that date and the implementation of the LCP care plan. Under the Age Related Residential Care Services Agreement for the provision of Residential Care (2013), which also reflects the required Health and Disability Services Standards (8134.1.3.5, 2008), providers are required to:

- Develop and document policies, procedures, protocols, and guidelines … Such policies shall include, but are not restricted to, policies relating to: including pain management and Skin management (D5.4)
- Each Care Plan is reviewed by a Registered Nurse and amended where necessary to ensure it remains relevant to address the Subsidised Resident's current identified needs and health status (D16.3)
- The Care Plan addresses personal care needs, health care needs, rehabilitation/habitation needs, maintenance of function needs and care of the dying (D16.3, h)
- Care Plans are available to all Care Staff and that they use these Care Plans to guide the care delivery provided according to the relevant staff member's level of responsibility (D16.3, l)
- You must ensure that each Subsidised Resident's Care Plan is evaluated, reviewed and amended either when clinically indicated by a change in the Subsidised Resident's condition (D16.4, a)

Because [Mr A] was in a residential area and the requirements for registered staff input is supposedly less I do note that RL had both Registered and Enrolled Nurses caring for [Mr A] however there does not appear to be anyone providing a clinical overview and continually updating his care plans to ensure it reflects his current needs hence giving all staff information on his current cares. I note that RL do have a Clinical Services Manager, as [stated in RL's] response, but their oversight was lacking. I agree with [Ms B] in that perhaps [Mr A] would have been better cared for in a hospital area where staff are more experienced in providing this level of care. I do recognize that relocating at this time is generally upsetting therefore as RL chose to allow [Mr A] to stay in residential area they have an obligation to ensure his needs were met. Also the level of information and support provided to the family at this stressful time may have been lacking due to the lack of clinical oversight.

In summary, I have concluded from the information supplied to me, that RL have not provided an appropriate standard of care to [Mr A] with a moderate departure from expected standards. As [RL] rightly states [in its response] the care provided to [Mr A] was not consistent and certainly not documented in accordance with industry standards and requirements. Likewise the nursing process; assessment, planning, implementation and evaluation, was not utilized to ensure [Mr A's] needs were met and a consistent approach was made by all staff. [RL's review also concluded] that there was a 'lack of communication between staff, a lack of understanding by staff of palliative care, and a lack of overview by the Clinical Services Manager'.

The corrective actions appear to be adequate to address these shortcomings however I would recommend that [management] review their policies and procedures around assessment of pain and its subsequent monitoring and management. This also needs to be done with assessment and management of pressure area care. Staff may need to be educated on these and also their responsibilities to documentation particularly care planning.

Margaret O'Connor, NP, MN"