Seniorcare Asset Management Ltd (trading as Rendell on Reed)

Clinical Nurse Leader, CNL C

Registered Nurse, RN D

Registered Nurse, RN E

A Report by the

Deputy Health and Disability Commissioner

(Case 13HDC00405)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mrs A had advanced pancreatic cancer with metastases to her spinal column and liver, and fractured vertebrae as a result of spinal tumours. In 2013, she was admitted to Rendell on Reed rest home, owned and operated by Seniorcare Asset Management (Seniorcare), for palliative care.

2. Multiple times between Day 9[1] and Day 12 of her admission, Mrs A was noted by Rendell on Reed staff as being in pain on movement, and still being in pain after pain relief was administered. On other occasions during this period, Mrs A's daughter, Mrs B, complained that her mother was in pain, but at these times the registered nurse's view was that she was not.

3. At no time during this period did any of the registered nurses complete a Pain Evaluation/Assessment Chart in line with Rendell on Reed's Pain Management Policy. Also contrary to this policy, a pain scale was not used and vital signs were not taken. Therefore, no formal pain assessment was ever carried out when Mrs A was documented as being in pain, or when Mrs B thought that Mrs A was in pain. Likewise, none of the registered nurses sought the advice of a senior staff member or contacted Mrs A's GP or the Hospice.

4. On Day 11, there was an incident where Mrs B brought a bottle of morphine elixir onto the premises from home. Mrs B said that she would administer it to Mrs A herself if RN E would not. RN E did not inform any senior staff member or management, or the Hospice or the GP of this incident.

5. RN D later found the morphine elixir in Mrs A's bathroom, but did not take any further action.

Findings

RN E

6. RN E failed to carry out a formal pain assessment of Mrs A when Mrs B raised concerns about her mother's pain on Day 11. RN E also failed to seek advice or report Mrs B's concerns about Mrs A's pain. Furthermore, when Mrs B brought a controlled drug into Rendell on Reed and advised RN E that she would administer morphine to Mrs A, RN E did not take appropriate steps, in line with legislative requirements. The Deputy Commissioner is critical of the number of failures demonstrated by RN E in regard to Mrs A's standard of care. RN E failed to comply with professional and legal standards and, accordingly, breached Right 4(2)[2] of the Code of Health and Disability Services Consumers' Rights (the Code).

RN D

7. RN D failed to carry out any formal pain assessments of Mrs A on Days 10 and 11, and did not seek advice or report Mrs A's pain on Day 10 or Mrs B's concerns about

[1] Relevant dates are referred to as Days 1 – 12.
[2] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

Mrs A's pain on Day 11. RN D also failed to take any action when she was informed that Mrs B had brought morphine in to Rendell on Reed, or when she found morphine in Mrs A's bathroom.

8. The Deputy Commissioner is critical of the number of failures demonstrated by RN D in regard to Mrs A's standard of care. RN D failed to comply with professional and legal standards and, accordingly, breached Right 4(2) of the Code.

CNL C

9. There was insufficient oversight of staff compliance with documentation. The failure by a number of registered nurses to document adequately demonstrates a lack of clinical oversight or leadership by CNL C. Accordingly, CNL C failed to provide services to Mrs A with reasonable care and skill, and breached Right 4(1)[3] of the Code.

RN F

10. Criticism is made of RN F in that she did not carry out a formal pain assessment or seek advice on how to manage Mrs A's pain.

Seniorcare

11. Seniorcare had the ultimate responsibility to ensure that Mrs A received care that was of an appropriate standard, by ensuring that its policies were adequate and followed appropriately by its staff and in providing appropriate and adequate training to its staff. It failed in that responsibility and, accordingly, breached Right 4(1) of the Code.

12. Seniorcare's responsibility to operate Rendell on Reed in a manner that provided Mrs A with services of an appropriate standard included responsibility for the actions of its staff. Seniorcare's staff consistently failed to document Mrs A's care and treatment adequately and appropriately, and failed to document family member concerns adequately. Very little was documented regarding discussions had with family and the Hospice regarding Mrs A and, even when she was in pain, or her daughter's concerns as to pain were documented, there was no rationale provided in the notes to say why these issues were not escalated. In addition, Mrs A's National Health Index (NHI) number or date of birth was often missing from her notes, and her name was not recorded consistently throughout her documentation.

13. Seniorcare did not comply with the New Zealand Health and Disability Sector (Core) Standards in respect of documentation and, therefore, breached Right 4(2) of the Code.

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

Complaint and investigation

14. The Commissioner received a complaint from Mrs B about the services provided to her mother, Mrs A, by Seniorcare Asset Management Ltd which owns and operates Rendell on Reed rest home. The following issues were identified for investigation:

- *Whether Seniorcare Asset Management Ltd provided adequate and appropriate care to Mrs A in 2013.*
- *Whether Registered Nurse CNL C provided adequate and appropriate care to Mrs A in 2013.*
- *Whether Registered Nurse RN D provided adequate and appropriate care to Mrs A in 2013.*
- *Whether Registered Nurse RN E provided adequate and appropriate care to Mrs A in 2013.*

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

16. The parties directly involved in the investigation were:

Mrs B	Complainant and consumer's daughter
Seniorcare Asset Management Ltd	Provider
CNL C	Provider/registered nurse/Clinical Nurse Leader
RN D	Provider/registered nurse
RN E	Provider/registered nurse
RN F	Provider/registered nurse

17. Information was also reviewed from:

The District Health Board
The Hospice
Dr G

Also mentioned in this report:

Mrs A	Consumer
Ms H	Community Care Coordinator at the Hospice
Dr I	Hospice GP
RN J	Registered nurse
RN K	Registered nurse
Mrs L	Care manager

18. Independent expert advice was obtained from RN Sylvia Meijer, a nurse practitioner (older adult) (**Appendix A**).

Information gathered during investigation

Background

19. Mrs B complained to this Office about the palliative care her late mother, Mrs A, received from rest home Rendell on Reed, owned and operated by Seniorcare Asset Management Ltd (Seniorcare).[4]

20. Mrs A had advanced pancreatic cancer with metastases[5] to her spinal column and liver, and fractured vertebrae as a result of spinal tumours. Mrs A was discharged from hospital to Rendell on Reed for palliative care. At that time she was 57 years of age. Mrs A's care plan, completed on admission, states that at this time she was alert and orientated, talkative, and she communicated well. Her speech is documented as being clear, and it is noted that she needed a walking frame. She required assistance with dressing, cleaning her teeth, and toileting. It is documented that she was incontinent. The section of the care plan relating to recordings (vital signs) is not completed. There is also no reference to pain management.

Rendell on Reed

21. At the time of these events, Rendell on Reed was certified to provide rest home and hospital level care for up to 55 residents (39 rest home and 16 hospital), and it had a palliative care contract with the DHB.

Day 8

22. On Day 8, Dr G, Mrs A's general practitioner (GP) at Rendell on Reed, was informed by registered nurse (RN) and Clinical Nurse Leader (CNL)[6] CNL C at Rendell on Reed, that Mrs A's condition was deteriorating, and that there was a need to adjust her pain relief. Rendell on Reed advised that because of Mrs A's quick deterioration, no further care plan was formulated, and instructions relating to her care were added to her progress notes.

Day 9

23. On Day 9, at around midday, Dr G examined Mrs A. Ms H, the Community Care Coordinator at the Hospice, also reviewed Mrs A at that time.

24. The Hospice is made up of a care team, and provides specialist palliative care to people with a terminal illness in the region. The majority of its care is delivered in the community, whether in the patient's home, a care facility, or a rural hospital. Some of its services include providing specialist assessment and advice to patients, family and health professionals, care coordination and monitoring of patient needs, working closely with other care professionals, and education and support to the public and healthcare professionals. Ms H was responsible for coordinating the provision of

[4] Ministry of Health records show that Seniorcare was certified at the time of these events. Therefore, the New Zealand Health and Disability Sector Standards apply.
[5] Secondary or malignant growths at a distance from the primary cancer site.
[6] The CNL role was to oversee each patient's care as provided by the carers and the registered nurses. The CNL was to work beside the registered nurses to educate them and to assess their clinical skills.

care for Mrs A. Ms H's role also included ongoing assessment and liaison with other healthcare providers involved in Mrs A's care.

25. Dr G wrote a prescription increasing Mrs A's pain relief, adding 50mg of morphine[7] and 12.5mg of levomepromazine[8] to the syringe driver,[9] to be administered over a 24-hour period. In addition, 50mg of cyclizine[10] and 30mg of morphine were charted as PRN[11] medications.[12] Ten ampoules of 10mg morphine and six ampoules of 30mg morphine were dispensed for the weekend. Morphine is a controlled drug pursuant to the Misuse of Drug Regulations 1977 (the Regulations). Controlled drugs are more tightly controlled than other medicines, reflecting the need to restrict access and to minimise misuse. The Regulations place restrictions on the prescribing, supply, and custody of controlled drugs. The Misuse of Drugs Act 1975 (the Act) requires a valid prescription for all controlled drugs, and the regulations require persons authorised to deal in controlled drugs to maintain a Controlled Drug Register (CDR) in relation to all controlled drugs dealt in, possessed or dispensed by the authorised person.

26. Dr G advised HDC that he told CNL C that he could be contacted over the weekend if necessary. However, that information was not documented in Mrs A's progress notes.

27. Ms H notified the care team at the Hospice of Mrs A's deteriorating condition, and asked the team to call Rendell on Reed over the weekend to provide advice and support. General practitioner Dr I was the Hospice doctor on call that weekend, and his name was provided to Rendell on Reed as a further point of contact. That information is documented in Rendell on Reed's Doctors and Visiting Professionals Notes.

28. At 4.30pm, 50mg of morphine and 12.5mg of levomepromazine were loaded into the syringe driver to diffuse at 0.75ml/hr over 24 hours.

29. It is documented in Mrs A's progress notes that at around 6pm, RN J noted that Mrs A was in pain, so she gave her 30mg of morphine, as charted as a PRN medication. Contrary to Rendell on Reed's Pain Management Policy (see below), there is no reference in the progress notes of a formal pain assessment being carried out, or the use of a numeric pain scale to assess Mrs A's pain at that time.

30. It is later documented that at "bedtime" Mrs A was "anxious", so RN J gave her three drops of clonazepam.[13] RN J recorded that Mrs A's daughter, Mrs B, was requesting sedation for her mother to "calm her". RN J informed Mrs B that nothing further could be provided, as it would be beyond the charted dosage that had already been

[7] A narcotic used to treat moderate to severe pain.
[8] Used in palliative care to help ease distressing symptoms such as pain, restlessness, anxiety and nausea.
[9] A pump used to gradually administer continuous medication to a patient.
[10] An antihistamine drug used to treat nausea, vomiting and dizziness.
[11] As required.
[12] On the medication chart, PRN morphine is charted as "for pain", with no indication of intervals for administration or a maximum 24-hour dose.
[13] Commonly used to treat panic attacks and seizures, and also as a muscle relaxant and a sedative.

administered. Nothing was documented in the progress notes about Mrs B's concerns. RN J documented that initially Mrs A refused to take 20ml of paracetamol at bedtime, but that eventually RN J was able to convince her to take it. RN J also documented that, "when checked after bedtime pills", Mrs A appeared to be settled and comfortable in bed.

31. RN J recorded that at 11pm the syringe driver was checked and was infusing well.

32. RN K was working the night shift. She advised HDC that Mrs A appeared to be asleep and settled at each check from when she started at 11pm.

33. The following chart shows the morphine provided to Mrs A on this day:

4.30pm	50mg over a 24-hour period	Syringe driver
6.00pm	30mg	PRN

Day 10

34. During the day on Day 10, the registered nurses who checked on Mrs A noted that she was asleep at every check.

35. Shortly after 5am, RN K documented: "[Mrs A] has been asleep when checked on rounds."

36. CNL C advised HDC that she was off site, but on call, and that at around mid-morning she rang Rendell on Reed to check on Mrs A. CNL C stated:

> "I was informed that [Mrs A] had had a good night, that she was comfortable and sleeping and did not appear to be in pain … I rang again in the afternoon and the evening and was told each time, that [Mrs A] was comfortable and settled."

37. At 2.37pm, RN F documented: "[Mrs A] has been asleep the entire shift." RN F also documented that the syringe driver was in place and infusing well.

38. RN D worked the evening shift. She checked Mrs A between 3pm and 7pm. RN D advised HDC that no concerns were raised, and that Mrs A had no apparent pain or nausea.

39. RN D documented that at 4.45pm the syringe driver was reloaded with the drugs as charted, to diffuse over 24 hours.

40. RN D recorded that Mrs A "was settled and sleepy" until around 7.45pm, when she became agitated when RN D tried to move her in order to change her. It is documented that Mrs A said she did not want to be moved, and that she asked for clonazepam drops. Three drops of clonazepam were given, but it is noted that after 30 minutes "she was in agony". Accordingly, at 9.10pm 30mg of morphine was also given, in accordance with her prescription. At around 10pm, Mrs A was still in pain,

and RN D gave her a 100mcg fentanyl patch[14] (previously prescribed when Mrs A was in hospital).

41. Contrary to Rendell on Reed's Pain Management Policy (see below), the progress notes for this shift contain no reference to a formal pain assessment being carried out, or a numeric pain scale being used to assess Mrs A's pain, and there is no evaluation of the effectiveness of the analgesia administered.

42. RN D did not call the GP, the Hospice, or CNL C to advise that Mrs A appeared to be in pain. RN D told HDC that Mrs A being in pain on movement "was not a new finding". RN D said that Mrs A had a history of vertebral fractures secondary to spinal tumours, and her pain on movement was well known to the doctor. PRN analgesia was charted and given when there was a need for it. RN D further stated: "I always believed that PRN morphine was effective in controlling her pain."

43. The following chart shows the morphine provided to Mrs A on this day:

4.45pm	50mg over a 24-hour period	Syringe driver
9.10pm	30mg	PRN

Day 11

44. At 7.11am, RN K noted: "[Mrs A] appears to be asleep every time she is checked." Mrs A's temperature is recorded as 37.1°C.

45. At 8.30am, Mrs B contacted the Hospice and said that her mother was in pain on movement. Mrs B asked for advice regarding the amount of pain medication available for her mother, and requested that the Hospice follow up on this.

46. At 10.00am, a staff member at the Hospice contacted RN F and asked whether Mrs A appeared to be in pain. RN F did not document the conversation with the Hospice in Mrs A's progress notes. However, RN F advised HDC that she told the Hospice:

> "[Mrs A] appears settled, not in pain, and has been asleep since I started my shift at 7AM and only seemed to wake up when we changed the pillow on her neck and that just before I left the room after that she seemed to be drifting off to sleep again … it seems to me that the family is a bit anxious about their mom being in pain but [Mrs A] herself does not appear to be in pain to me at all since she has just been sleeping since I started my shift."

47. At 1.30pm, RN F noted that Mrs A was in pain when staff tried to move her to adjust her pillows, but that once the pillows were fixed, Mrs A settled and did not complain of pain again, was not grimacing, and drifted back to sleep. Contrary to Rendell on

[14] Fentanyl is a strong painkiller. It works by binding to certain receptors (called opioid receptors) in the brain and spinal cord and reduces pain. For patients with chronic pain a patch can be given which contains fentanyl and it is released gradually over a period of time to give continual pain relief.

Reed's Pain Management Policy (see below), there is no reference in the progress notes to a formal pain assessment being carried out, or a numeric pain scale being used to assess Mrs A's pain at that time.

48. RN F told HDC that at around 2.00pm Mrs A was still asleep, and there were no signs of her having pain or discomfort. Mrs B asked RN F whether the Hospice nurse had telephoned, and what they had talked about. According to RN F, she told Mrs B that the Hospice had contacted her, and that she had informed the Hospice: "[Mrs A] appears comfortable at the moment, has been asleep most of the shift, and only appears to be in pain when she is moved." RN F said that Mrs B did not express to her any immediate concern about her mother.

49. RN E told HDC that at 3.00pm Mrs A appeared asleep. Approximately 30 minutes later, RN E administered 30mg of morphine to Mrs A in accordance with "a family member's request". No pain assessment was carried out prior to the morphine being administered.

50. At 4.45pm, the syringe driver was re-loaded as charted and set to diffuse for 24 hours.

51. At 10pm, RN E recorded that Mrs A was "sleeping most of the time this shift".

52. RN E recorded that the family had concerns that Mrs A was still in pain, and that insufficient pain relief was being provided. RN E documented that Mrs B asked for more morphine to be given to her mother and, when RN E advised Mrs B that she could give only what was charted, Mrs B asked if RN E would ring a doctor to have the morphine increased. RN E documented: "Reassurance given that we can see to this in the morning." RN E advised HDC:

> "As per my assessment of [Mrs A] she appeared settled and still sleeping/snoring. I explained to [Mrs B] that as [Mrs A] was settled morphine could be given later in the night to help her get through in case she became unsettled or showed signs of pain … As it appeared that the present dosage [Mrs A] was on had her settled I reassured [Mrs B] [calling a doctor] could be done in the morning, but at the same time [Mrs B] was given a choice that she could ring a Doctor if she wanted to. [Mrs B] appeared to be alright with the explanation …"

53. RN E said that later Mrs B again asked her whether she could administer more morphine. RN E said: "[Mrs B] had a bottle of morphine elixir in her hand which she said she had brought from home." RN E said that she explained to Mrs B that the registered nurses do not administer any drug that is not charted by a rest home doctor, and that Mrs B then said that she would administer it herself. In response to my provisional opinion, Mrs B advised that she was advised by the nurse "on the correct dose".

54. No incident report was filled out relating to these events, and they are not documented in Mrs A's progress notes. RN E did not inform any senior staff member or management, or the Hospice or the GP about these events.

55. RN E did not take any further action in relation to the additional morphine being brought onto the premises.

56. At 10.30pm, the Hospice rang Rendell on Reed, but it is not documented to whom they spoke. The Hospice advised HDC that it was informed that Mrs A's condition was deteriorating further, and that PRN medications, as prescribed, would be used for pain and distress. The Hospice was also advised that Mrs A was "comfortable, sleepy at rest and that incident pain [pain on movement] may be an issue". It was agreed that a member of staff from the Hospice would come to Rendell on Reed to review Mrs A on Day 12.

57. At 10.45pm, Mrs B informed RN E that she had given morphine elixir to Mrs A, but she thought that her mother had not swallowed it. In response to the information gathered section of the provisional opinion, Mrs B stated: "the morphine was impossible to administer as, sadly, mum was no longer able to swallow." RN E did not document this in Mrs A's notes.

58. At handover, RN E informed RN D that Mrs B had brought in morphine that was not charted. RN D did not inform any senior staff member, the Hospice or the GP, and did not talk to Mrs B about the morphine. She also did not document this in Mrs A's notes.

59. At 11pm, RN D checked on Mrs A. RN D advised HDC that Mrs A appeared to be relaxed, comfortable and sleepy. RN D asked Mrs B how Mrs A had been during the day, and Mrs B said that her mother had been in pain and moaning all day, and so Mrs B had requested more morphine for her mother.

60. RN D advised HDC that she assessed Mrs A "for facial grimacing, groaning or any other nonverbal indicators of pain", but Mrs A was fast asleep, so she "did not think there was a need to do any other pain assessment tests". RN D informed Mrs B that she did not want to provide further pain relief at that time, as "[Mrs A] appeared relaxed and pain free".

61. RN D documented in Mrs A's progress notes that Mrs B "was concerned that [Mrs A] is in pain and restless, but she was sound asleep". RN D did not document any of her assessments. In response to my provisional opinion Mrs B stated that when Mrs A was in pain "she would lift her eyebrows to indicate 'yes' to me" … I feel that the nurses' accounts appear contradictory to ours and it is perhaps that they did not have the same means of communication."

62. RN D advised HDC that between 11pm and 12am she checked on Mrs A every 15 minutes, and she was fast asleep and snoring at each check.

63. CNL C advised HDC that she contacted Rendell on Reed several times during that day, and that each time she was told that Mrs A was settled. CNL C advised HDC: "I trusted the clinical judgment of the nurses as they have not hesitated to contact the on call person in the past regarding any concerns."

64. The following chart shows the morphine provided to Mrs A on this day:

3.30pm	30mg	PRN
4.45pm	50mg over a 24-hour period	Syringe driver

Day 12

65. At 12.15am, Mrs A became "a bit distressed", so RN D administered 30mg morphine. No further PRN medication was provided to Mrs A after this time. Again, there is no reference in the progress notes of a formal pain assessment being carried out, or a numeric pain scale being used to assess Mrs A's pain at that time. RN D advised that she then checked on Mrs A frequently throughout the remainder of her shift, and Mrs A still appeared to be sound asleep and snoring at each check.

66. RN D advised that she did not contact on-call senior staff, even though Mrs B was reporting that Mrs A was in pain, because she thought there was no need to do so, as the charted morphine that she gave Mrs A at 12.15am "seemed to have settled [Mrs A's] pain effectively".

67. At 5.10am, RN D gave Mrs A clonazepam drops because, although Mrs A had appeared asleep and relaxed, she was becoming "restless again". RN D documented that Mrs A was in pain "while moving".

68. RN D documented that she found the un-charted morphine in Mrs A's bathroom, but she did not remove it, "as [Mrs B] brought it".

69. At 6.54am, RN D recorded Mrs A's oxygen saturation as being between 85 and 90.

70. At 7.40am, RN F heard Mrs B shouting for help from Mrs A's room. RN F went to Mrs A's room and noted that Mrs A had vomited a little, and that Mrs B was afraid that her mother might choke. In response to my provisional opinion Mrs B also advised that her mother was excreting pus-like fluid from her nose, and that this continued for about an hour.

71. RN F and a carer "wiped [Mrs A] and changed her pillow as it had traces of her vomit". RN F recorded that no grimacing was observed when they took the pillow from behind Mrs A's neck to change it. At around 9.10am, RN F discussed with Mrs B her wish for Mrs A's morphine to be increased. At 9.15am, RN F rang the Hospice and told the staff about Mrs B's concern. RN F was advised that Dr I was in a meeting and would call as soon as it finished.

72. At 10.00am, Mrs B telephoned Ms H at the Hospice and stated that Mrs A was distressed and uncomfortable, and was conscious and groaning. Ms H arranged to visit as soon as possible.

73. At around 10.23am, Mrs L, Rendell on Reed's Care Manager at the time of these events, recorded in Mrs A's progress notes that RN F was trying to arrange medication for Mrs A with Dr I, while she (Mrs L) spoke to Mrs B and her sister.

74. Mrs L recorded that Mrs B stated to her that "the staff ha[d] done a great job", but Mrs B was concerned that Mrs A had been in pain the previous day, and that a doctor was not called to increase her morphine dose. It was recorded by Mrs L that Mrs A had deteriorated rapidly over the weekend.

75. Sadly, about five minutes after the discussion, Mrs A passed away.

Rendell on Reed's policies in place at the time of Mrs A's care

Palliative Care Policy

76. This policy states at point 9(4) — Support of Significant Others and Staff:

> "The Senior Registered Nurse and management should be informed of areas of concern."

Medicine Management Policy

77. Relevant sections of this policy are:

> "4. Medication Storage …
>
> All medications are kept in a locked medication cupboard/drawer or refrigerator
>
> …
>
> All controlled drugs are stored in the locked Controlled Drug Cupboard …
>
> …
>
> 6. Administration of Medicines
>
> Medicines must be prescribed and the Medication Chart signed by the Doctor before being administered. …
>
> A Registered Nurse … must check the medication when administering to ensure the correct medication and dosage is given. …
>
> …
>
> 7. Staff Administration Procedure
>
> …
>
> All controlled drug administration must be recorded on the Medication Administration record and the Controlled Drugs Register and signed for.
>
> 8. Administration of Controlled Drugs
>
> Controlled drugs must be prescribed by the Medical Practitioner on the Medication Chart. …
>
> …
>
> 16. Monitoring and Errors
>
> …

Any variances in medication storage, administration and disposal are to be reported to the Registered Nurse/Person on Call immediately and recorded as soon as possible …"

Pain Management Policy

"**Process**:

Consultation with the resident's family/whanau play an important part in the pain assessment

…

The Registered Nurse makes an assessment of all pain reported/observed. … the pain is assessed to location, characteristics, onset/duration, frequency, severity (0–10 scale, 10 being the most severe) precipitating/aggravating factors and if the pain is new or re-current.

Pain is assessed each time a new episode of pain occurs, documentation will rule out worsening of underlying condition/development of complications. Staff will document these observations and any relevant dialogue with the resident which may assist in the RN/GP assessment of pain and/or treatment.

Vital signs (BP, pulse, temperature, respirations) are monitored as these are usually altered in acute pain.

…

Evaluation and review of pain management

Our evaluation process takes account of the following:

- Resident and family/whanau input into care …"

78. Attached to the policy is a Pain Evaluation/Assessment Chart.

Additional information provided to HDC

Seniorcare Asset Management Ltd

79. Seniorcare provided HDC with written notes made following a discussion with the nurses involved in the extra morphine incident. This documents that RN E was told that Mrs B had stated RN E told her how much of the morphine elixir she should give to Mrs A. It is documented that RN E "strongly denies this".

80. Seniorcare advised HDC: "[W]e had in place a number of policies and procedures that would have, in normal circumstances, been adequate to deal with the situation [of additional morphine being brought onto its premises by Mrs B] … There was no doubt, a deviation from these policies by staff on hand at Rendell on Reed at that time."

81. Seniorcare did not say how its policies would have been adequate. Relevant parts of its Medicine Management Policy, in place at the time of these events, are outlined above at paragraph 77. There is no section dealing with medication/controlled drug medication being brought into the home by a resident or family member. In response to my provisional opinion Seniorcare acknowledged that its policies at the time did

not deal with the issue of medications which were un-prescribed or of unknown origin.

82. Seniorcare provided to HDC a signed letter from Mrs A's father, and several other family members, which stated that, contrary to Mrs B's view, they "never saw [Mrs A] unduly distressed or in unmanageable pain".

83. Mrs A's clinical documentation was provided to this Office. Mrs A's name is not used consistently throughout. For example, the Syringe Driver Prescription record states "[Mrs A's first name but different surname]", with no National Health Index number (NHI) or date of birth (DOB) included. The Medication Signing Sheet states "[Mrs A]" and no NHI or DOB is provided. Rendell on Reed advised HDC that the use of two different names related to different relatives calling her different names. Rendell on Reed acknowledged that staff should have been instructed to use one name.

84. The Syringe Driver Prescription and Administration Record for Day 9–Day 12 recorded that at each handover and four-hourly check by the registered nurses, Mrs A was sleeping and/or settled.

85. When requested by this Office, Seniorcare could not locate individual job descriptions for several positions, including the CNL position. However, Seniorcare advised HDC that the role of the CNL was to oversee each patient's care as provided by the carers and the registered nurses. It stated that the CNL was to work beside the registered nurses, to educate them as well as assess their clinical skills.

86. Education Training & In-Service Records were provided to HDC relating to each of the registered nurses in charge of Mrs A's care while she was at Rendell on Reed. These records document that the following education sessions and training were provided to the registered nurses:

- Basic cares and communication;
- Resident care concerns;
- Hospice in-service;
- Documentation;
- Wounds and medication; and
- Communication.

87. Following Mrs A's death, training was first provided to the registered nurses in relation to dealing with families and palliative care residents. Further training was provided on the following:

- Palliative Care for people with chronic illness;
- Essentials of Palliative Care; and
- Palliative Care for people with dementia.

RN E

88. RN E advised HDC that she "was feeling threatened" by Mrs B. RN E stated that this may have "clouded her judgement" when Mrs B brought in uncharted morphine. RN

E advised: "I know what I should have done ie locked it up or ask her to take it out of the building but I didn't." She advised that, following this incident, she, along with the other registered nurses, received training on morphine procedures and "dealing with grieving and challenging relatives". She stated: "I do not believe I would make the same mistake again. I would lock up the morphine and I would ring for assistance from a senior person." She said that she will comply with the policies and procedures and, in any situation where a family member appears to be challenging or places her in a situation where she feels threatened, she now knows to "always call a senior staff member".

89. RN E acknowledged that she did not carry out formal pain assessments of Mrs A. RN E said that this was because each time she saw Mrs A, she appeared settled and pain free, and was not showing any signs of being distressed, including no signs of restlessness. RN E stated that this was true even when Mrs B complained that her mother was in pain. RN E advised that as she "did not want to unsettle her", she would visually assess Mrs A and, because she did not believe that Mrs A was in pain, she saw no need to "call for advice" from the on-call person. RN E acknowledged that she should have done so "to reassure the relative".

90. RN E also advised this Office:

> "[I am] now doing better documentation, and am ensuring I do the set pain assessment where indicated. I am also seeking advice from senior staff members if I have any doubts. I have attended inservice training related to dealing with grieving and challenging relatives and question myself when making decisions about what I should be doing."

RN D

91. RN D stated that with regard to Mrs A's pain, she believes she assessed her and intervened in accordance with Rendell on Reed's policy, although "it was a time where I was overwhelmed and stressed to a point where I could not document [all of my] assessments and interventions in a timely manner". RN D said that since this complaint, she has learnt the importance of documentation in the nursing profession, and is "putting lots of effort" into improving this area. She has attended a workshop on dealing with families of palliative care patients, "which has given [her] lots of insight in dealing with grieving families".

92. RN D acknowledged that on learning that the family had brought in additional morphine she should have locked it up in the drug room. She said she found the family to be intimidating, and she did not want conflict with them. She thought she could "leave this matter for the management to deal [with] in the morning". She acknowledged that this was a "judgmental error", and stated that she would never do it again.

CNL C

93. CNL C advised HDC that over that weekend she was never contacted about Mrs A while she was on call. CNL C said:

> "The Manager, Care Manager and I were all pro-active in ensuring the nurses had a good understanding about when to call on senior staff … The nurses on shift always knew who was on call, knew that we could be called on at any time day or night, (and they often did) even for minor things … the on call person was also clearly documented on the nurses' roster … I am confident that the nursing staff had [a] good understanding about when and how to contact us during on call as this was put into practice many a time."

94. CNL C stated that, in her view, "[while] staff had excellent clinical skills, their documentation was not always enough at times, and did not adequately reflect their high level of patient care". She said that completion of patient notes "[was] often a challenge to the nurses", owing to English being a second language for the majority of them.

95. CNL C stated:

> "At the beginning of each duty I would read through all the computerised patient notes and observation forms to ensure I was up to date on their condition and could address any concerns. It was through this that I was made aware that the nurses' documentation was not always of a sufficient standard. To address this I would note what clarification was needed and talk to the nurse directly concerned. Also this matter was regularly brought up during our monthly staff RN meetings. … During this time we noticed a slight improvement in the standard of documentation though there was still a need for further education and encouragement in this area."

96. CNL C acknowledged that Rendell on Reed's Pain Management Policy in place at the time of these events discussed the use of an individualised pain assessment form to assess a patient's pain, but that this was not used by the registered nurses who assessed Mrs A. CNL C advised that the form should be used to record the time at which pain was assessed, the pain scale as indicated by a number between 1–10, the pain relief being given, and the effectiveness of the pain relief. She acknowledged that an individualised pain assessment form did not form part of Mrs A's clinical notes, and advised that "it would have been beneficial" if it had.

97. CNL C further stated:

> "Unfortunately, both the staff and I found [Mrs B] and her sister, though mainly the former, intimidating and difficult to work with. Their tone of voice and intimidating body language when speaking with any of us made us feel bullied. I felt they did not listen to clinical explanations and their perspective of what was happening, was often quite different to how the nurses were seeing things. […]. [Mrs A's father] visited his daughter regularly throughout the day and was more than satisfied with the care she was receiving … From my perspective and knowledge of my staff, I find it difficult to correlate [Mrs B's] account with both my own observations and that of my staff. I have no reason to believe that the reports I was given over the weekend regarding [Mrs A's] condition to be

anything other than accurate — that staff observed her to be sleeping most of the time and that she was not indicating pain either verbally or non verbally."

Changes made at Rendell on Reed following these events

98. Rendell on Reed advised HDC that the following changes have been implemented:

- All registered nurses have received increased training on communication with families, and on assessment and care planning.
- Registered nurses now have shifts working in the office, where they spend time with the Clinical Manager, dealing with issues "from the floor", to gain a better understanding of Rendell on Reed's policies and procedures.
- If there is a request for a medication review by the resident or family, there will be a discussion with that person, so that a time frame can be agreed on and a visit by a GP or the Hospice organised.
- A new paragraph about medicines that have not been prescribed being brought in has been inserted into Rendell on Reed's Medication Policy. The policy now states:

"*Medication brought into the home by Resident or family:*
No medications should be brought into the home other than what is provided by our Pharmacies related to the residents' medication orders. If staff find any medications in a residents room they are to report it to the R/N immediately.

The RN —
— Will discuss the policy with the resident/family ie no non-prescribed medication are to be in a resident's room and that includes, because of our contract, over the counter medications
— Will remove the medication and discuss self-medicating if appropriate (follow self-medicating policy)
— If it is a controlled/Dangerous Drug it will be locked up until it can be removed from the building
— If the resident/relative declines to hand over the medication a person from Management is to be contacted
— Full documentation of what happened in relation to this will be in the resident's progress notes."

99. Disciplinary action was taken against RN E and RN D in regard to the morphine issue.

Responses to provisional opinion

100. Mrs B, Seniorcare and relevant staff at Rendell on Reed including CNL C, RN E, RN D and RN F, were given the opportunity to respond to relevant sections of my provisional opinion. Their responses have been incorporated into the report where relevant and further information has been reproduced below.

Seniorcare Asset Management Ltd

101. Seniorcare stated "there have been a number of regrettable errors by our staff at the time, that not only reflected poorly at the time on the company's behalf but also professional staff judgment, (CNL), experience, and effectiveness of training and resultant documentation."

102. It further stated that having "staff members with their own cultural differences presented challenges". It also advised that "All the RNs have since attended further training in palliative care which included dealing with grieving relatives and education is on-going."

CNL C

103. CNL C advised that she has not taken any of the expressed concerns lightly.

104. CNL C noted that "time was spent with the registered nurses… reinforcing to them the necessity of accurate and appropriate documentation, including utilising pain charts when assessing pain." She acknowledged that she should have shown the RNs the Health and Disability Services Standard relating to this to help reinforce what was constantly being told to them.

105. She also advised:

> "I continue to be mindful of the concerns raised here and am even more vigilant with my own practice as a result of this. I made the choice not to continue in the role of clinical oversight of registered staff."

RN D

106. RN D acknowledged that she made a "judgmental error" but noted that she was working very hard to complete her routine nursing care, and stated that this may have clouded her judgment.

Mrs B

107. Mrs B stated "I have spent the better part of the last two years coming to terms with the suffering we were helpless to do anything about, and with the loneliness and desperation we felt as we waited for help from the only people who had any power to ease [Mrs A's] suffering." She also stated "I do agree that we were emotional, and most likely, difficult to work with, but I also think that we were distraught and desperate and in pain and that if Mum's pain and anxiety had been properly managed this wouldn't have been the case. It is, I believe, their job to work with distraught families as well as their patients."

Standards

108. The Nursing Council of New Zealand's Competencies for Registered Nurses (2007) includes the following:

> "**Professional responsibility**
> **Competency 2.3**
> Ensures documentation is accurate and maintains confidentiality of information.
> Maintains clear, concise, timely, accurate and current health consumer records within a legal and ethical framework."

109. The Medicine Care Guide for residential aged care (Published by the Ministry of Health 2011) provides the following:

> "**Controlled drugs:**
> - Keep controlled drugs in a locked controlled drug cabinet accessible ONLY to authorised staff.
> - Record all controlled drugs transactions in a CONTROLLED DRUGS REGISTER.
> - The keys to controlled drugs should be held by ONE senior authorised staff member on each duty.
> - Maintain a list of the staff authorised to handle controlled drugs.
>
> **Storage**
> - It is recommended that controlled drugs be checked in/out by the PERSON DELIVERING/TAKING the stock with the RN on duty and documented in the Controlled Drugs Register.
> - Expired and unused stock should be collected and safely disposed of by the contracted pharmacy.
>
> **Rest home**
> Controlled drugs can only be provided by individual named prescription and must be kept in a controlled drugs cabinet or locked cupboard. It is recommended that two staff, one of whom has demonstrated medicines management competency, check and sign for controlled drugs."

110. The New Zealand Health and Disability Sector (Core) Standards require the following:

> "**Standard 2.2**
> that rest homes ensure that the operation of their services is managed in an efficient and effective manner, which ensures the provision of timely and safe services to consumers".[15]
>
> "**Standard 2.9**
> that consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required".[16]

[15] NZS 8134.1.2:2008.
[16] NZS 8134.1:2008.

Opinion: Introduction

111. During the course of this investigation it has been suggested that Mrs A's family members had differing opinions as to whether she was in pain. In particular, her father indicated that he was satisfied with the care provided. Notwithstanding this, I am concerned about the response of the registered nurses at Rendell on Reed when they observed pain themselves, or when Mrs B expressed concern about her mother's pain.

112. My investigation has not focused on whether Mrs A was experiencing pain; rather, the issue is the process followed to monitor her pain levels generally, and when concerns were raised that she was in pain.

Opinion: RN E — Breach

No formal pain assessments completed

113. At 3pm on Day 11, Mrs A was noted to be asleep. At around 3.30pm, Mrs A's daughter asked RN E to administer morphine to Mrs A. RN E administered the morphine to Mrs A but, contrary to Rendell on Reed's Pain Management Policy, she did not carry out a formal pain assessment.

114. My expert advisor, nurse practitioner Ms Sylvia Meijer, advised me that if a family member's perception is that a resident is in pain, staff should assess the pain and act accordingly. She advised that registered nurses would be expected to undertake a formal, validated pain assessment, even if the registered nurse did not themselves think the patient was in pain. Ms Meijer also advised me that use of formal pain assessments using a pain scale may have in turn "guided discussions with family and provided some indication if additional advice from Hospice or manager[s] should have been sought".

115. I am critical that RN E did not carry out a formal pain assessment of Mrs A on Day 11.

Morphine

116. On Day 11, RN E was aware that Mrs B thought that her mother was still in pain, and that the pain relief being provided was not adequate.

117. At around 10pm, Mrs B asked for more morphine to be given to her mother and, as RN E saw no need for further morphine, she advised Mrs B that she could give only what was charted. However, there was no maximum PRN medication charted and, accordingly, it is unclear on what basis the registered nurse was making this statement. Mrs B asked RN E to ring a doctor to have the morphine increased. However, RN E told her that this could be done in the morning, or that Mrs B could ring the doctor herself if she wished.

118. RN E did not contact the doctor or raise Mrs B's concerns with a senior staff member, such as CNL C.

119. Later, Mrs B again asked RN E if she could administer more morphine. Mrs B was holding a bottle of morphine elixir, which she said she had brought from home. Mrs B said that she would administer it herself if RN E would not. RN E did not inform any senior staff member or management, or the Hospice or the GP of this incident.

120. At 10.45pm, Mrs B told RN E that she had given morphine elixir to Mrs A.

121. RN E failed to report to a senior staff member that a controlled drug that had not been charted by a doctor working for Rendell on Reed had been brought onto the premises, and administered to Mrs A. Ms Meijer advised me that it is expected, when such situations arise, that the registered nurse would seek advice from a more senior staff member and, in this situation, the Hospice or the doctor could also have been contacted.

122. I consider that to fail to seek advice and report such issues was also contrary to Rendell on Reed's Palliative Care Policy, which states that areas of concern should be reported. I am critical that RN E did not identify and report the incident as an "area of concern". This incident clearly should have been reported and advice sought.

123. I note that Rendell on Reed's Medications Policy in place at the time did not deal with uncharted medication being brought onto its premises by patients or family members. Therefore, it did not give any guidance to its staff on how to manage family members bringing in and trying to administer medication.

124. However, Ms Meijer advised me that all registered nurses, through their training, are aware that medications are to be accounted for, and that controlled drugs are to be locked away and entered into a register (Medicine Care Guide, 2011). I note that this is also a legal requirement under the Misuse of Drugs Act 1975, which also requires a valid prescription for all controlled drugs, and the Misuse of Drugs Regulations 1977, which require persons authorised to deal in controlled drugs to maintain a Controlled Drug Register (CDR) in relation to all controlled drugs dealt in, possessed or dispensed by the authorised person.

125. I note Mrs B stated that she was advised by the nurse "on the correct dose" and that RN E "strongly denies this". I am unable to form an opinion on this matter.

126. Ms Meijer advised that it is expected practice for registered nurses to have conversations with families, to explain the legal requirements, and to reassure them that additional advice to manage symptoms can be sought from a doctor, so that the resident is comfortable. She said that if discussions with the family cannot resolve their concerns, it is generally accepted that further advice should be sought from a senior staff member or manager. I accept Ms Meijer's advice, and note that, in this particular instance, advice could also have been sought from the Hospice.

127. I am highly critical of how RN E dealt with this matter. She took no action on finding that morphine, a controlled drug that was not charted by a rest home doctor, had been brought in to Rendell on Reed, and there were attempts to administer it to Mrs A. In particular, she did not report the issue to the Clinical Nurse Leader, the doctor, management, or to the Hospice, she did not have a conversation with Mrs B about the legal requirements for morphine control and administration, and she did not take appropriate steps in relation to the controlled drug, as required by the Medicine Care Guide. I consider that RN E's poor response to this matter demonstrated a serious lapse in her professional judgement.

Conclusions

128. RN E failed to carry out a formal pain assessment of Mrs A when Mrs B raised concerns about her mother's pain on Day 11. RN E also failed to seek advice or report Mrs B's concerns about Mrs A's pain, and placed limitations on the PRN medication that was not in accord with the charted medication. Furthermore, when Mrs B brought a controlled drug into Rendell on Reed and advised RN E that she would administer morphine to Mrs A, RN E did not take appropriate steps, in line with legislative requirements.

129. Overall, I am critical of the number of failures demonstrated by RN E in regard to Mrs A's standard of care. I consider that RN E failed to comply with professional and legal standards and, accordingly, breached Right 4(2) of the Code.

Opinion: RN D — Breach

No formal pain assessments completed

130. At around 7.45pm on Day 10, Mrs A became agitated when RN D tried to move her. It is documented that Mrs A said that she did not want to be moved, and that she asked for clonazepam drops. Three drops of clonazepam were given, but it is noted that after 30 minutes "she was in agony". Accordingly, 30mg of morphine was administered in accordance with her prescription. At around 10pm, Mrs A was still in pain, and RN D gave Mrs A a 100mcg fentanyl patch. Contrary to Rendell on Reed's Pain Management Policy, there is no reference in the progress notes of a formal pain assessment being carried out, or a numeric pain scale being used to assess Mrs A's pain at any time during this shift.

131. RN D advised HDC that at 11pm on Day 11 Mrs B told her that her mother had been in pain and moaning all day. RN D advised that she assessed Mrs A "for facial grimacing, groaning or any other nonverbal indicators of pain" but, as Mrs A was asleep, she "did not think there was a need to do any other pain assessment tests". None of this was documented.

132. At 12am, Mrs A became distressed, so RN D administered 30mg of morphine. At 5.10am, she gave Mrs A clonazepam drops because she was becoming "restless

again". It is documented that Mrs A was in pain "while moving". However, RN D did not carry out a formal pain assessment.

133. Ms Meijer advised me that when a patient is in pain, or when a family member's perception is that a resident is in pain, staff should assess the pain and act accordingly. She advised that registered nurses would be expected to undertake a formal, validated pain assessment, even if the nurse did not think the patient was in pain. Ms Meijer also advised that use of formal pain assessments using a pain scale may have in turn "guided discussions with family and provided some indication if additional advice from Hospice or manager[s] should have been sought".

134. I am critical that RN D did not carry out any formal pain assessments of Mrs A on Days 10 and 11, as required by Rendell on Reed's Pain Management Policy.

Not reporting "areas of concern" or seeking advice

135. As stated, on Day 10, Mrs A was noted as being in pain at 7.45pm, 30 minutes later, and at 10pm. However, RN D did not call Dr G, the Hospice, or the Clinical Nurse Leader, to advise them that Mrs A still appeared to be in pain after being provided with her charted medication. RN D said that she did not do so because pain on movement was "not a new finding" in respect of Mrs A, and because Mrs A's pain was being controlled effectively by her PRN morphine.

136. On Day 11, RN E told RN D that Mrs B had brought in morphine that was not charted. RN D did not inform any senior staff member, the Hospice, or the GP about this. Later, RN D also saw the morphine elixir that Mrs B had brought in to Rendell on Reed in Mrs A's bathroom, but RN D took no action on finding it, and did not inform the Clinical Nurse Leader, who was on call.

137. Ms Meijer advised me that it is expected, when such situations arise, that the registered nurse would seek advice from a more senior staff member. In this situation, the Clinical Nurse Leader, the Hospice, or the doctor could also have been contacted.

138. I consider that not seeking advice and reporting these issues was also contrary to Rendell on Reed's Palliative Care Policy, which states that areas of concern should be reported to the senior registered nurse (the Clinical Nurse Leader) and management. In my view, that Mrs A remained in pain on the evening of Day 10 after having been provided with her charted medication, and that Mrs B had brought in morphine that was not charted, were "areas of concern" that should have been reported.

139. I note that Rendell on Reed's Medications Policy in place at the time did not deal with uncharted medication (including controlled drugs) being brought onto its premises by patients or family members, and therefore did not give any guidance to its staff on how to manage this. However, Ms Meijer advised me that all registered nurses, through their training, are aware that medications are to be accounted for, and that controlled drugs are to be locked away. Controlled drugs should not be accessible to any other patients, nursing or cleaning staff, or visitors, and they should be entered

into a register (Medicine Care Guide, 2011). I note that this is also a legal requirement under the Misuse of Drugs Act 1975.[17]

140. I am highly critical of how RN D dealt with this matter. She took no action on finding a controlled drug in Mrs A's bathroom that had not been prescribed by the rest home doctors, she did not remove it, and she did not report the issue to the Clinical Nurse Leader, the doctor, management, or the Hospice. This is contrary to the Medicine Care Guide, 2011 and to Rendell on Reed's Palliative Care Policy. RN D failed to ensure that her nursing practice and conduct met the standards of the profession and relevant legislated requirements. This was a serious lapse in professional judgment.

Conclusions

141. RN D failed to carry out any formal pain assessments of Mrs A on Days 10 and 11, and did not seek advice or report Mrs A's pain on Day 10, or Mrs B's concerns about Mrs A's pain on Day 11. RN D also failed to take any action when she was informed that Mrs B had brought morphine in to Rendell on Reed, or when she found morphine in Mrs A's bathroom.

142. Overall, I am critical at the number of failures demonstrated by RN D in regard to Mrs A's standard of care. I consider that RN D failed to comply with professional and legal standards and, accordingly, breached Right 4(2) of the Code.

Opinion: CNL C — Breach

Introduction

143. As the Clinical Nurse Leader, CNL C's role was to oversee Mrs A's care provided by the carers and the registered nurses. She was to work beside the registered nurses and educate them, as well as assess their clinical skills. I acknowledge that CNL C contacted the facility around mid-morning on Day 10, and several times during the day on Day 11, to ascertain Mrs A's condition, and was not told of any concerns.

Documentation

144. Mrs A's care and treatment was inadequately documented in the progress notes by the registered nurses. The following issues were frequently absent from Mrs A's notes:

- Documentation of any discussion with Mrs A's family when her daughter voiced concern that their mother was in pain.
- Rationale outlining why further advice was not sought from senior staff members, the Hospice, or the GP, when Mrs A was in pain or when family voiced concerns.
- Documentation of the availability of the GP over the weekend.

[17] The Misuse of Drugs Act 1975 requires a valid prescription for all controlled drugs, and the Misuse of Drugs Regulations 1977 require persons authorised to deal in controlled drugs to maintain a Controlled Drug Register (CDR) in relation to all controlled drugs dealt in, possessed or dispensed by the authorised person.

- Summaries of conversations between the Hospice and the registered nurses.
- Documentation outlining that Mrs B brought in morphine elixir and tried to administer it to her mother.

145. Ms Meijer advised me that Mrs A's progress notes do not consistently show rationale for care, and show a weakness on the part of the registered nurses with reporting conversations, incidents, and pain assessments. Ms Meijer advised that this "has the potential to lead to fragmented care provision and delayed recognition of the resident's deteriorating condition".

146. Ms Meijer advised that there should have been rationale in the progress notes documenting why further advice from Mrs A's GP, the Hospice, or the Clinical Nurse Leader was not sought for the management of Mrs A's episodes of agitation. In addition, Mrs B's concerns about her mother, and any discussion with family about their concerns, should also have been written in the progress notes. Ms Meijer advised: "The progress notes are pivotal in a resident's care to identify issues of concern. Inaccurate or delayed notes result in fragmentation and delay of care." I agree.

147. In addition to the problems relating to Mrs A's progress notes, I note that Mrs A's NHI number, her date of birth, and her name, were not recorded consistently throughout her documentation.

148. Ms Meijer advised me that the use of different names, and often no use of an NHI number or date of birth, could have caused fragmentation and errors in delivery of medication.

149. I note that CNL C advised HDC that she was aware of the documentation problems evident among the registered nurses. I also note her response that she had recognised a need for further education around this. In my view, she should have taken greater steps to lift the quality of documentation at Rendell on Reed.

150. I consider that CNL C's failure to ensure that Rendell on Reed's registered nurses were documenting Mrs A's care appropriately allowed a fragmented documentation system to develop and continue. Overall, I am of the view that staff either did not understand what was required of them in documenting a patient's care, or there was a culture of not documenting care adequately. As a result, Mrs A's progress notes were incomplete. This had the potential to lead to oversights in her clinical care, and to a lack of continuity of care.

151. In my view, there was insufficient oversight of staff compliance with documentation. As outlined above, registered nurses' professional standards outline that they must maintain clear, concise, timely, accurate and current health consumer records within a legal and ethical framework. CNL C had a responsibility to ensure that staff at Rendell on Reed complied with professional standards with regard to documentation. CNL C should have identified that standards were not being met by staff and, not withstanding her attempts to improve the standard of documentation, should have taken further steps to improve the quality of documentation at Rendell on Reed. In my

view, as this was not occurring, CNL C, as Clinical Nurse Leader, must take some responsibility. The failure by a number of registered nurses to document adequately demonstrates a lack of clinical oversight or leadership by CNL C. Accordingly, I find that CNL C failed to provide services to Mrs A with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: RN F — Adverse comment

152. At 1.30pm on Day 11, Mrs A was in pain when staff tried to move her to adjust her pillows. RN F did not carry out a formal pain assessment or report this to the doctor or to a senior staff member.

153. Not carrying out a formal pain assessment was contrary to Rendell on Reed's Pain Management Policy. Likewise, in my view, not seeking advice when Mrs A was in pain was contrary to Rendell on Reed's Palliative Care Policy, which states that areas of concern should be reported.

154. Ms Meijer advised me that when a resident is in pain, staff should assess the pain and act accordingly. She advised that registered nurses would be expected to undertake a formal pain assessment and seek advice from a more senior staff member. Ms Meijer also advised me that use of formal pain assessments using a pain scale may have in turn "guided discussions with family and provided some indication if additional advice from Hospice or manager[s] should have been sought".

155. Although I note that RN F informed the Hospice that Mrs A "only appear[ed] to be in pain when she [was] moved", I am critical that RN F did not carry out a formal pain assessment on these occasions, or seek advice on how to manage Mrs A's pain.

Opinion: Seniorcare Asset Management Ltd (trading as Rendell on Reed) — Breach

Introduction

156. In accordance with the Code, Seniorcare had a responsibility to operate Rendell on Reed in a manner that provided its residents with services of an appropriate standard. Ministry of Health records show that Seniorcare was certified at the time of these events. Therefore, the New Zealand Health and Disability Sector Standards (NZHDSS) apply. NZHDSS require that rest homes ensure that the operation of their services is managed in an efficient and effective manner, which ensures the provision of timely and safe services to consumers.[18]

[18] New Zealand Health and Disability Sector (Core) Standards (NZS 8134.1.2:2008, Standard 2.2).

157. Seniorcare had a palliative care contract, which meant that it had an obligation to have systems and staff training in place to manage palliative care patients. This duty is particularly vital when end-of-life care is being provided to a patient with a condition that is known to cause pain that is difficult to treat. Ms Meijer advised me that pain is closely associated with Mrs A's diagnosis, and that if she showed signs of pain, such as moaning, grimacing and not wanting to move, it would be usual to use a consistent, evidence-based assessment to assess the pain, identifying the type, place, intensity and duration. Furthermore, the effectiveness of the pain relief provided should be recorded.

158. With regard to the organisational responsibilities of rest homes, this Office has previously noted:

> "That responsibility comes from the organisational duty on rest home owner/operators to provide a safe healthcare environment for residents. That duty includes ensuring that staff comply with policies and procedures, and that any deviations from good care are identified and responded to. It also includes responsibility for the actions of its staff."[19]

159. I consider that Seniorcare failed in its organisational duty to ensure that Mrs A received services of an appropriate standard while at Rendell on Reed over the period of Day 9–Day 12, for the reasons set out below.

Standard of care

No formal pain assessments

160. During Day 9 and Day 11, there were times when it was documented that Mrs A was in pain, most notably on movement.

161. At no time during this period did any of the registered nurses complete a Pain Evaluation/Assessment Chart in line with Rendell on Reed's Pain Management Policy. Also contrary to this policy, a pain scale was not used, and vital signs were not taken. Therefore, no formal pain assessment was ever carried out when Mrs A was documented as being in pain, or when Mrs B thought that her mother was in pain.

162. I note that the registered nurses said that on most checks, even when Mrs B complained that her mother was in pain, Mrs A appeared to be settled and sometimes was asleep. Although the registered nurses and some family members did not always share Mrs B's concerns as to Mrs A being in "unmanageable pain",[20] Ms Meijer advised me that a registered nurse would still be expected to undertake a formal, validated pain assessment.

163. Ms Meijer said that any complaint of pain with regard to a palliative care patient requires follow-up. She advised that this includes when a member of a patient's

[19] See Opinions 10HDC01286 (18 November 2013) and 12HDC07091 (13 June 2014), available at www.hdc.org.nz.

[20] There is a letter to Rendell on Reed from Mrs A's father and other family members stating that Mrs B appeared to have a negative and aggressive attitude towards the rest home in general and that they "never saw [Mrs A] unduly distressed or in unmanageable pain."

family indicates that the person is uncomfortable and in pain, even if the nurse does not think the patient is in pain. Ms Meijer said that if a family member's perception is that a resident is in pain, staff should assess the pain and act accordingly.

164. Ms Meijer also advised me that "[f]ormal and validated pain assessments could have aided a consistent approach to manage [Mrs A's] pain and may have guided discussions with family and provided some indication if additional advice from Hospice or manager[s] should have been sought".

165. In my view, Mrs A's pain was not being assessed appropriately at Rendell on Reed. Not only does this indicate a lack of care, but it was also contrary to the organisation's policies. I am concerned that multiple staff failed to comply with Rendell on Reed's Pain Management Policy, and consider that Seniorcare failed to ensure that its policies and procedures were implemented appropriately by the registered nurses at Rendell on Reed.

Registered nurses not reporting "areas of concern" or seeking advice

166. There were several instances where incidents occurred that, contrary to the requirement in Rendell on Reed's Palliative Care Policy, were not reported as "areas of concern", and where the incident should have been escalated and advice sought, but was not. Examples of these incidents are outlined below:

- Mrs B's concerns that her mother was still in pain and required increased analgesia, often contrary to the nurses' views;
- Mrs A being "agitated" or in pain at times, particularly when staff tried to move her;
- Mrs A being in pain even after her prescribed pain relief had been provided; and
- Two registered nurses knowing that Mrs B had brought uncharted morphine onto the premises with the intention of administering it to her mother.

167. It was contrary to the organisation's Palliative Care Policy not to report areas of concern. These could have been reported to the Clinical Nurse Leader, or to management, the Hospice or the GP.

168. Ms Meijer advised me that when Mrs A was still experiencing pain after pain relief had been administered, and when a family member had the view that the patient was still in pain, even if contrary to the view of the registered nurse, it is expected in such situations that the registered nurse would (after carrying out a formal, validated pain assessment) seek advice from a more senior staff member — in this situation, the Clinical Nurse Leader, the Hospice, or the doctor.

169. I acknowledge that individual registered nurses are responsible for their own actions and omissions. I also note that Seniorcare stated in response to my provisional opinion that the RNs had their own cultural differences which presented challenges. However, I am concerned that all the registered nurses at Rendell on Reed involved in Mrs A's care during this period failed to report Mrs A being "agitated" or in pain, particularly on movement; failed to report Mrs A sometimes being in pain even after her prescribed pain relief had been provided; and failed to seek additional advice in

relation to Mrs B's concerns regarding her mother. That multiple staff failed to report or escalate these matters as "areas of concern" suggests that staff were not adequately informed of Seniorcare's expectations in that regard.

170. Seniorcare failed to ensure that its Palliative Care Policy was being followed adequately. Accordingly, I consider that Seniorcare bears ultimate responsibility for these failings.

171. I also note that prior to these events, Seniorcare failed to ensure that the registered nurses at Rendell on Reed were being adequately trained on palliative care, including communicating with family members.

Additional morphine brought in by Mrs B

172. As described above, on Day 11, Mrs B brought some morphine elixir into Rendell on Reed and said that she would administer it to her mother if RN E would not do it for her. Later, RN D also saw the morphine in the bathroom, but took no action on finding it, and did not inform the Clinical Nurse Leader or any other senior staff member.

173. Ms Meijer advised me that all registered nurses are aware that medications are to be accounted for, and that controlled drugs are to be locked away and entered into a register (Medicine guide, 2011). I acknowledge Ms Meijer's advice that it is also expected practice that registered nurses have a conversation with families, to explain the legal requirements (as per the Misuse of Drugs Act 1975 and the Misuse of Drugs Regulations 1977).[21]

174. Ms Meijer advised that if discussions with a family cannot resolve their concerns, it is generally accepted that further advice is sought from a senior member of staff (in this instance, for example, the Clinical Nurse Leader), and I note that in this particular instance, advice could also have been sought from the Hospice or the GP.

175. I note that Seniorcare advised that its policy in place at the time dealt adequately with uncharted medication, including controlled drugs being brought onto its premises. In my view, however, it did not give any guidance to staff on how to manage family members bringing in and trying to administer uncharted medication. Ms Meijer advised me that an organisational medication management policy would usually deal with the management of medication brought in by the family, and I am critical that, at the time of these events, Rendell on Reed's policy did not address this issue.

Conclusion

176. I consider that Seniorcare failed to meet its organisational duty of care to Mrs A, in that it failed to ensure that its policies and procedures were implemented appropriately and followed adequately by the registered nurses at Rendell on Reed. No pain evaluation/assessment charts were completed, or any formal pain assessments

[21] The Misuse of Drugs Act 1975 (the Act) requires a valid prescription for all controlled drugs and the Misuse of Drugs Regulations 1977 require persons authorised to deal in controlled drugs to maintain a Controlled Drug Register (CDR) in relation to all controlled drugs dealt in, possessed or dispensed by the authorised person.

performed, as required by Rendell on Reed's Pain Management Policy, and the registered nurses did not report any "areas of concern", contrary to Rendell on Reed's Palliative Care Policy.

177. As this Office has stated previously, "failures by multiple staff to adhere to policies and procedures suggests an environment and culture that do not sufficiently support and assist staff to do what is required of them".[22] In addition, without staff compliance, policies become meaningless.[23]

178. Seniorcare also failed to ensure that Rendell on Reed's policies and procedures were adequate in dealing with the issue of uncharted medication being brought onto Rendell on Reed's premises, and it failed to ensure that there was adequate palliative care training. This is particularly significant, as the DHB contracted it to provide palliative care services and, as such, would be expected to be familiar with all aspects of the care required for such complex situations.

179. While I acknowledge that individual registered nurses are responsible for their own actions and omissions, Seniorcare had the ultimate responsibility to ensure that Mrs A received care that was of an appropriate standard and complied with the Code. This includes responsibility in ensuring that its policies were adequate and followed appropriately by its staff, and in providing appropriate and adequate training, particularly in palliative care, to its staff. In my view, it failed in that responsibility and, accordingly, failed to provide services to Mrs A with reasonable care and skill and breached Right 4(1) of the Code.

Documentation

180. The NZHDSS require that consumer information is "uniquely identifiable, accurately recorded, current, confidential, and accessible when required".[24] As noted in a previous opinion, "this includes ensuring good clinical records are kept and documentation remains up to date. This is essential to providing good care of an appropriate standard."[25]

181. The following issues were frequently absent from Mrs A's notes:

- Discussion with Mrs A's daughter when she voiced concern that her mother was in pain.
- Details of availability of the GP over the weekend.
- Rationale outlining why further advice was not sought from senior staff members, the Hospice or the GP, when Mrs A was in pain or when family voiced concerns.
- Summaries of conversations between the Hospice and the registered nurses.
- Documentation outlining that Mrs B brought in morphine elixir and administered it to her mother.

[22] Opinion 10HDC00308 (29 June 2012), available at www.hdc.org.nz.
[23] Opinion 09HDC01974 (21 June 2012), available at www.hdc.org.nz.
[24] NZS 8134.1:2008, Standard 2.9.
[25] See Opinion 11HDC00883 (11 June 2014), available at www.hdc.org.nz.

182. In addition, I note that HDC was advised that owing to Mrs A's rapid deterioration, no further care plan was formulated. Her initial care plan completed on admission therefore gives no instructions for care and monitoring or pain relief once her condition deteriorated.

183. I am critical that there were no updated care plans or specific instructions documented in Mrs A's progress notes relating to instructions for her care and monitoring once her condition deteriorated. As advised by Ms Meijer, this was important, "particularly monitoring related to pain, agitation and end of life care".

184. Ms Meijer advised that Mrs A's progress notes do not consistently show rationale for care, and show a weakness on the part of the registered nurses with reporting conversations, incidents, and pain assessments. She said that this "has the potential to lead to fragmented care provision and delayed recognition of the resident's deteriorating condition".

185. Ms Meijer advised that the progress notes should have documented the rationale for not seeking further advice from Mrs A's GP, the Hospice, or the Clinical Nurse Leader, on the management of Mrs A's episodes of agitation and pain, and regarding Mrs B's concerns around her mother. Ms Meijer advised: "The progress notes are pivotal in a resident's care to identify issues of concern. Inaccurate or delayed notes result in fragmentation and delay of care." I agree.

186. In addition to the problems relating to Mrs A's progress notes, I note that Mrs A's NHI number or date of birth was often missing from her notes, and that Mrs A's name was not recorded consistently throughout her documentation.

187. Ms Meijer advised me that it is a legal requirement that medication is signed for on an administration chart. She also advised that the use of different names and no use of an NHI number or date of birth on Mrs A's documentation had the potential to cause fragmentation and errors in delivery of medication. I accept this advice, and find these omissions concerning.

188. I am of the view that Mrs A's care and treatment while at Rendell on Reed was inadequately documented. I accept that individual registered nurses are responsible for ensuring that their own documentation is comprehensive and accurate. However, as these failings were evident across all of the registered nurses involved in Mrs A's care during this time, I consider them also to be due to systemic issues. A culture had been allowed to develop at Rendell on Reed where inadequate documentation was common place, and this created an incomplete picture of the patient's care and treatment.

Conclusion

189. Seniorcare's responsibility to operate Rendell on Reed in a manner that provided Mrs A with services of an appropriate standard included responsibility for the actions of its staff. Seniorcare's staff consistently failed to document Mrs A's care and treatment adequately, and failed to document family members' concerns adequately. Very little was documented regarding discussions had with family and the Hospice regarding Mrs A and, even when pain or family concerns as to pain were documented, no

rationale of why these issues were not escalated was provided in the notes. In addition, there was no documentation outlining that Mrs B had brought morphine elixir into Rendell on Reed to administer to Mrs A, Mrs A's NHI number and date of birth were often missing from her notes, and her name was not recorded consistently throughout her documentation.

190. These failures meant that there was an incomplete picture regarding Mrs A's care and treatment in the clinical records, and the clinical records fell below an acceptable standard. Accordingly, I find that Seniorcare did not comply with the New Zealand Health and Disability Sector (Core) Standards in respect of documentation, and therefore breached Right 4(2) of the Code.

Recommendations

191. I recommend that Seniorcare Asset Management Ltd undertake the following:

a) Provide a written apology to Mrs A's family for its breaches of the Code. The apology is to be sent to HDC within **three weeks from the date of this report,** for forwarding to the family.

b) Provide evidence that its Medication Policy has been updated, and report to HDC on its implementation at Rendell on Reed, **within three months of the date of this report**.

c) Provide palliative care training to all new registered nurses at induction, and refresher training to all other registered nurses, and provide HDC with evidence that the training has been arranged and/or conducted, **within six months of the date of this report**.

d) Provide training to staff about the importance of having comprehensive documentation of a resident's care, including communication with family in the palliative care setting, and provide HDC with evidence of the training, **within three months of the date of this report**.

192. I recommend that the Nursing Council of New Zealand consider conducting a review of RN D and RN E's competence, particularly around controlled drugs, and report back on this recommendation within six months of this report.

193. I recommend that CNL C provide a written apology to Mrs A's family for her breaches of the Code. The apology is to be sent to HDC within **three weeks of the date of this report**, for forwarding to the family.

194. RN D has provided a written apology to Mrs A's family for her breaches of the Code. The apology has been forwarded to the family.

195. I recommend that RN E provide a written apology to Mrs A's family for her breaches of the Code. The apology is to be sent to HDC within **three weeks of the date of this report**, for forwarding to the family.

196. I recommend that RN F provide a written apology to Mrs A's family for her failings in this case. The apology is to be sent to HDC within **three weeks of the date of this report**, for forwarding to the family.

Follow-up actions

- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Seniorcare Asset Management Ltd (trading as Rendell on Reed), will be sent to HealthCERT (Ministry of Health).

- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Seniorcare Asset Management Ltd (trading as Rendell on Reed), will be sent to the District Health Board and the Nursing Council of New Zealand, and they will be advised of CNL C, RN D and RN E's names.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Seniorcare Asset Management Ltd (trading as Rendell on Reed), will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent Nursing advice to the Commissioner

The following expert advice was obtained from RN Sylvia Meijer, an older adult nurse practitioner:

"[Date on which advice provided]

Thank you for the opportunity to provide advice on the care provided to [Mrs A] at Rendell on Reed, between [Day 9] and [Day 12];[26] HDC reference C13HDC00405.

I have been asked to provide an opinion to the Commissioner's office and I have read and agree to follow [the] Commissioner's guidelines for Independent Advisors. I do not have a conflict of interest with the parties involved.

This report will begin with an overview of my professional qualifications and clinical experience, followed by an outline of events and my professional opinion on each posed question. The findings, as documented, are a result of reading through the information provided by the Health and Disability Commissioner's Office, reviewing the relevant literature and my own professional clinical experience of working with older adults.

Personal and professional profile
Nurse Practitioner Older Adult, with prescribing rights; NCNZ APC 112474 HPI No. 19FMZX

I am [a] Nurse Practitioner, with a Masters Degree (MPhil.Nursing), 2 Postgraduate Diplomas in Nursing and Health of Older People, a Postgraduate Certificate in nursing in addition to postgraduate papers related to palliative care and mental health of older people and a Diploma in Management. My Masters research related to assessment of older people in care facilities. I have worked in health care for 34 years and am currently working across 3 care facilities and the wider community as a Nurse Practitioner, team leader Health of Older People Team, for the Central Primary Health Organisation in Levin. As a Nurse Practitioner I work alongside care staff, registered nurses, managers, GPs and GP teams and secondary care clinicians. My clinical work includes assessments, diagnosing, planning, implementing interventions and evaluating care. Staff education, Quality assurance, research and strategic planning are also components of my daily work. I work in close liaison with the local hospice. Prior to January 2011, I was the Clinical Services Manager of a care facility for nine years, with responsibilities for clinical oversight, resident care, staff management, education and strategic planning. My clinical experience includes working with people with multiple co-morbidities and chronic conditions, as well as employment in palliative care, district nursing, surgical and medical nursing, ICU, ED and after-hours hospital co-ordination. Professional involvement includes national facilitator of the Older Person's Nursing Network for the College of Nurses Aotearoa, Memberships of the College of Nurses, the New Zealand Nurses Organisation and the New Zealand Association of Gerontology. I am involved in national, regional and community health

[26] RN Meijer was provided with all of Mrs A's progress notes, which covered her whole stay at Rendell on Reed, and was asked to comment on the period complained of, and to make any other comments she considered relevant.

projects. Conference presentations include national and international presentation on improving care for older people and appropriate health care delivery.

Outline of events
[Mrs A] had advanced pancreatic cancer with metastases to her spine and liver.

[Mrs A] was admitted to Rendell on Reed for palliative care [in] 2013.

The hospice nurse visited [Mrs A] on [Day 9] and medication changes were made in consultation with the hospice doctor.

[Dr G], the GP, also visited [on] [Day 9] and agreed with the medication suggestions of the hospice doctor.

The hospice called the care facility on [Day 11], care and symptom management was reviewed and no issues identified.

The hospice called the care facility on [Day 12], and was advised by the RN on duty that [Mrs A] was deteriorating but comfortable and sleepy. The RN noted that PRN medication would be used for pain and distress.

On [Day 12] at 10 AM [Mrs B] ([Mrs A's] daughter) contacted the hospice nurse, stating that [Mrs A] was in distress, uncomfortable, conscious and groaning.

The hospice nurse contacted Rendell on Reed at 10.30 AM and found that [Mrs A] had passed away at 10.20 AM.

The referral instructions to me from the Commissioner's office were to comment on:

- The overall care provided to [Mrs A] from [Day 9] to [Day 11]
- The decision not to seek advice when [Mrs A's] daughters raised concerns that their mother was in pain.
- The management of the situation regarding the additional medication brought in by [Mrs A's] daughter
- The clinical documentation
- Remedial action taken by Rendell on Reed
- Any other comment you consider relevant

The overall care provided to [Mrs A] from [Day 9] to [Day 11]
[Mrs A] was admitted to Rendell on Reed for palliative care. The request from the Commissioner's Office is to look at the care for the period of [Day 9] to [Day 11]. This episode of care links to assessments and care provided before and after these dates. Care episodes cannot be seen in isolation, as assessments, plans of care, treatment, communication and evaluation are a continuous process, and were commenced prior to [Day 9] and continued after [Day 11], therefore some of my comments link to assessment and care planning outside the stipulated period.

Palliative care is based on care measures of comfort and minimising pain. Palliative care is an ongoing process, focussed on the best interest for the resident with close communication with families, taking in[to] consideration the vulnerability of the resident and family going through this experience. Generally, care is based on a multidisciplinary and nursing assessment, from which a plan of care is developed. This plan is evaluated at least three monthly or when a resident's condition changes,

as per Aged Residential Care Contract (2012) and best practice guidelines. Neither the assessment nor a care plan was available with the documentation provided to the Commissioner's Office, so that the care provided to [Mrs A] as noted in the progress notes could not be aligned or verified with the assessment or care plan developed for her, which would identify her needs. An initial assessment and care plan would have instructions for care and monitoring, particularly monitoring related to pain, agitation and end of life care. This plan is usually developed with the resident and family. Care plans provide instructions and rationale for management of anxiety, restlessness, pain and general care and are essential for providing care in a continuous and consistent manner.

The care provided to [Mrs A] as described in the progress notes does not consistently show rationale for care and shows weakness in reporting. For example:

On [Day 7], at 22.56, the notes state that [Mrs A] requested to be catheterized. According to the notes the catheter was not inserted until [Day 10] in the afternoon duty. A rationale for the delay was not provided in the notes. On [Day 12] in the 05.19 report, there is a note that the catheter 'came off'. It is not obvious from the notes if the catheter came out completely or if the catheter disconnected from the tubing. If the catheter came out completely, any trauma, if the balloon was inflated and the subsequent urinary output can be expected to be reported on.

The notes indicate that a second subcutaneous line for medication was inserted at 16.35 on [Day 7]. This appears to be in preparation for the 6 AM administration of Dexamethasone the next morning. The rationale for inserting this line 12 hours prior to use is not obvious in the progress notes, however the care plan may provide an indication for this.

One of [Mrs A's] diagnoses indicated that she had varying bowel habits, with at times diarrhoea or constipation. In view of use of pain relief and possible associated constipation, regular monitoring and reporting on bowel movement would have been appropriate. As residents become terminally ill, constipation or diarrhoea can attribute to restlessness. The notes indicate that at times [Mrs A] became restless and agitated, however the notes do not indicate if an assessment took place to address if causes contributing to this agitation could be eliminated.

In the morning shift on [Day 8], [Mrs A's] family mentioned to staff that additional Dexamethasone was required in the pump to support other medications. The family was made aware that staff could only provide what the doctor prescribed, which is correct. However there is no mention in the notes that this concern of the family was addressed and discussed or followed up with senior staff, the GP or the hospice doctor or nurse.

The notes show that some observations were taken. There is mention of temperature and oxygen saturation recordings. Pain is mentioned in general terms. There is no evidence in the notes that pain is consistently assessed, or the use of a validated pain assessment format and a pain scale. As pain is closely associated with [Mrs A's] diagnosis and she showed signs of pain, such as moaning, grimacing, not wanting to move, the exclusion of a reference to a pain assessment scale in the progress notes is unusual. In view of a palliative care approach, a consistent, evidence based assessment for pain, identifying the type, place, intensity and duration of pain is usual

practice. The effectiveness of pain relief, when provided with PRN medication, is not consistently reported on.

Involvement from hospice staff support[ing] the facility in caring for [Mrs A] is evident. Pain management for residents with pancreatic cancer with metastases is challenging and a number of different pain medications were prescribed for [Mrs A]. On [Day 8] [Mrs A] indicated pain and PRN medication was used. In the report it stated [Mrs A's] complaint of pain at 8.25, the pain relief was signed out one hour later at 9.25. There is no mention in the report why there was an hour delay in providing pain relief or if the pain relief was effective.

On [Day 9], in the afternoon, medication was administered via the subcutaneous chest line. The chart does not indicate if the line was flushed/ primed. When using a longer line, this would effectively leave medication in the line and the patient would not receive the charted amount of medication. This may well have been accounted for but was not evident in the notes or medication chart. As required by the Aged Related Residential Care Contract clause D5.4, the management of medication is outlined in a medication policy and would include the guidelines for administration as well as the qualification and competency of staff managing the medications. The hospice may have given specific instruction for the management of the subcutaneous line. The organisational policy and staff competency records would verify if staff followed procedure as outlined in their policy.

The use of non-pharmacological intervention for pain management is not mentioned in the notes and would generally be addressed in the care plan and reported on in the progress notes. As required by the Aged Related Residential Care Contract clause D5.4, the organisational policy on pain management guides staff through this process. Sighting of the policy may provide an indication of how pain management is addressed and communicated in the resident's notes.

The notes show that at times [Mrs A] refused medication, often followed by increased agitation, which is not unusual for palliative care patients. Generally when this occurs, advice is sought from hospice or GP as changes to the medication in the syringe driver could assist with the resident being more comfortable and less agitated.

Care planning is based on assessments and the development of a care plan includes [the] resident's and families' wishes, values and goals. The communication around the development of the care plan is also an opportunity to discuss the resident's and families' understanding of the illness, prognosis and likely progress. There is an expectation that a registered nurse would assess a resident if concerns occur and as [Mrs A's] condition changed, adjustments or validation to the plan of care could have been expected. Assessments and care planning are within the scope of the registered nurse. The Nursing Council of New Zealand competency 2.2 notes that the registered nurse undertakes comprehensive and accurate assessments to guide the care. The CNL Care Guide (2009) is one example of best practice information on palliative care and pain management. The local hospice and DHB palliative care services are usually available for advice.

The overall care provided to [Mrs A] is in my opinion a moderate departure from expected standard of practice.

The decision not to seek advice when [Mrs A's] daughters raised concerns that their mother was in pain.

Family members are advocates for patients. Communication with families is an essential part of caring for a resident. If the families' perception is that a resident is in pain, staff should assess the pain and act accordingly. This could include providing pain relief if pain was present and/or reassure the family that every effort to keep the resident comfortable was made and advice was sought from senior staff, GP or hospice doctor. Pain management could include non-pharmacological interventions or pain relief. [Mrs A's] family reported that their mother was in pain and requested additional pain relief. At that time the staff responded that there was 'only one ampoule left' and suggested that this should be saved for the night-time. Although the family agreed with this, generally, using a patient centred approach and forward planning, it could have been anticipated that a person admitted for end of life care and with pancreatic metastasised cancer, could require more pain relief and medication should be available. In these instances, advice should be sought from hospice or GP. Follow up is required for a palliative care patient in pain or when their family indicate that the person is uncomfortable and in pain. The notes do not indicate if pharmacist, hospice or GP advice was sought when the medication stock was getting low. [Mrs A's] GP notes indicated that the hospice could be contacted 24/7. Pain management and palliative care advice can be accessed via the RN care guide (2009), hospice and DHB clinical staff. The organisational policies on pain management and care planning and communication would usually guide staff through this process.

The decision not to seek advice when [Mrs A's] daughters raised concerns that their mother was in pain is in my opinion a moderate departure from expected standard of practice.

The management of the situation regarding the additional medication brought in by [Mrs A's] daughter.

An organisational medication management policy would usually guide staff with the management of medication brought in by family. The registered nurse indicated correctly that medication can only be administered when charted, but at time patients bring in their own medication and self-administer this. Patients who self-administer, are assessed for their capacity to do so by an RN or prescribers. Staff can only administer according to the prescription (Medicine guide 2011). [Mrs A's] family showed concern about the management of pain and felt it necessary to bring in medication. In such circumstances, staff would usually seek advice and closely communicate with family to alleviate their concerns. When residents bring in medication, this is usually discussed with the patient, their family and the GP. In this instance advice could have been sought from the GP or hospice. The progress notes on [Day 12] state that Morphine elixir was found in the toilet of [Mrs A's] room and it was left there. Facilities are required to keep controlled drugs in a locked cupboard. Controlled drugs should not be accessible to any other patients, nursing or cleaning staff or visitors and be entered into a register, (Medicine guide 2011). The organisational medication policy is likely to provide guidance on the management of brought in medication and the storage of controlled drugs. Staff competency on the management of medication is usually part of the annual competency checks and education. Neither the organisational medication management policy nor the staff

medication competency record was available to ascertain staff's knowledge and organisational procedures.

The management of the situation regarding the additional medication brought in by [Mrs A's] daughter is in my opinion a moderate departure from expected standard of practice.

The clinical documentation

The organisation appears to use electronic progress notes. Accurate documentation is the basis to deliver continuous and appropriate care. Documentation of care was not completed in a consistent manner; this has the potential to lead to fragmented care provision and delayed recognition of the resident's deteriorating condition. For example:

On the medication chart, PRN Morphine is charted as 'for pain' with no indication of intervals for administration or maximal 24 hour dose. Perhaps the organisation specifies this in the medication policy or has a written understanding with the hospice. As part of risk mitigation and transparent guidance, it is generally considered good practice that the maximal 24-hour dose and intervals are specified. (Medicine care guide, 2011)

The medication-signing chart; the signing register on the left hand side of the chart has the sample signature of one RN, while the actual chart has more than one RN signing this, this implies that not all RNs have signed the signing register.

The PRN 30 mg morphine given is written in the controlled drug register but a medication-signing chart for this PRN medication is not available. It is a legal requirement that medication is signed for on the administration chart.

The resident's name on the medication chart is not consistent and the patient is not identified with a unique identifier such as NHI number or date of birth (DOB). For instance, the NIKIT34 syringe driver prescription record states '[Mrs A's first name and different surname], no DOB or NHI. The medication signing sheet and one of the unpackaged signing sheets states [Mrs A], No DOB or NHI. The other unpackaged signing sheet has no name, DOB or NHI, in essence not identifiable as [Mrs A's] chart. The use of different names and no NHI or DOB may cause fragmentation and errors in delivery of medication. At times when people are known by two names, this is well documented and identifiable on charts. It is generally common practice to use one name (the resident's preferred name) and consistently use this name on all care related documentation. An organisational documentation policy guides staff through the correct process and sighting of this policy may indicate if staff followed organisational procedure for this. Additional advice on documentation is available via DHBs and NZNO (1997).

A number of documents were available, such as minutes of meetings and staff accounts of the content and context of events. Meeting minutes most often mentioned the attendants' first name only and did not identify if the attendant was family or a staff member, or their designation. The organisation noted in the minutes (attachment 2, not dated, last paragraph), that discussion with family was not always written in the notes and notes 'did not always say what actually happened'. The progress notes are

pivotal in a resident's care to identify issues of concern. Inaccurate or delayed notes result in fragmentation and delay of care.

As previously mentioned in this document, the progress notes made no reference to a pain assessment or numeric pain scale. There is no rational[e] in the progress notes why GP or hospice advice or a second opinion from senior staff was not sought for the management of agitation, pain or family concerns.

It is my opinion that the clinical documentation related to [Mrs A's] care is a moderate departure from expected standard of practice.

Remedial action taken by Rendell on Reed

The organisation is commended for their efforts to address concerns and prevent similar concerns from happening. The pro-active approach to preventative measures and education of staff may assist in the improved management of palliative care residents. It is my understanding that education on communication, the use of LCP [(Liverpool Care Pathway)] and documentation is accelerated and now taking place. Records of education and documentation and education audits would verify this process. Caring for palliative care residents can be challenging for the staff, as families are often grieving and in distress. Communicating with the resident and families, acknowledging concerns and identifying goals is important to keep an open dialogue and provide support.

I would strongly suggest including specific palliative care, assessment and care planning education, promoting a resident centred approach. A review of organisational processes to seek advice and review of policies as well as individual care plans will support the resident, family and the staff to provide accurate and timely care.

The remedial action taken by Rendell on Reed are appropriate to mitigate future concerns but further review of education, policies and processes would be beneficial.

Any other comment you consider relevant

The documentation provided indicated that the family was not always in agreement about the care. The recollection of events as seen by the family differs at times from the staff recollection. For example the view of the family that [Mrs A] was in pain and the staff's view that she appeared free of pain. The family was obviously in distress, grieving and concerned. Family support is integral to palliative care. Staff [were] dealing with a very ill resident as well as the daily care for other residents. This may at times be a challenge for the staff and the organisation; however, there are strategies to employ when dealing with family dynamics. In those circumstances advice can be sought from organisational policies and senior staff, DHB, professional counsellors and hospice.

In-house communication with other residents is usually noted in a communication policy. For residents who are also family, lines and process of communication is usually part of the initial care planning and goal setting.[…] [I]t would be common practice to have a discussion with family as how to best support [Mrs A] and her family[…]. This would commonly take place on admission.

The communication with family acknowledging their concerns, establishing rapport and planning care is in my opinion a mild departure from expected standard of practice.

Thank you for the opportunity to provide advice, please contact me if you require further clarification to my advice.

Yours Sincerely
Sylvia Meijer"

Further expert advice

"[Date on which advice provided]

Thank you for the opportunity to further comment on the care provided to [Mrs A] at Rendell on Reed, between [Day 9] and [Day 12].
My personal and professional profile, qualifications and clinical experience were stated in the initial advice and are therefore not repeated in this document. The findings are a result of reading through the additional information provided by the Health and Disability Commissioner's Office, reviewing the relevant literature and my own professional clinical experience of working with older adults. I have read and agree to follow the Commissioner's guidelines for Independent Advisors. I do not have a conflict of interest with the parties involved.

The initial advice was provided on [date on which advice provided]. The Commissioner's Office requested the following clarifications:

A 'I note your view that the overall care provided to [Mrs A] from [Day 9-11] was a moderate departure from the expected standard of practice. Putting aside the issues of inconsistencies in the progress notes please clarify which aspects of care, if any, are a moderate departure from the expected standard of practice.'

B 'Secondly, I note the section where you conclude that the RN's failure to seek advice when [Mrs A's] daughters raised concerns that their mother was in pain was a moderate departure from the expected standard of practice. Please clarify the following:

1). If the Commissioner were to find that some of [Mrs A's] family raised concerns with the RNs that [Mrs A] was in pain but other family members told the RNs that [Mrs A] did not seem to be in pain, would the RN be expected to seek advice from a Doctor or a senior staff member about [Mrs A's] pain?

2). If the Commissioner were to find that some of [Mrs A's] family raised concerns that [Mrs A] was in pain but when the RNs assessed [Mrs A], on each occasion she was noted as being asleep and settled, would RNs to be expected to seek advice from a Doctor or a senior staff member as to [Mrs A's] pain?'

C 'A copy of the Rendell on Reed's response to your expert advice is enclosed. Please comment if any of the issues raised in that response affects your previous advice and if so, how?'

In my reply, the Commissioner's Office questions are posed in 'bold' with my response directly following each question.

A) **'I note your view that the overall care provided to [Mrs A] from [Day 9-11] was a moderate departure from the expected standard of practice. Putting aside the issues of inconsistencies in the progress notes please clarify which aspects of care, if any, are a moderate departure from the expected standard of practice.'**

The episode of care for the period of the [Day 9-11] links to assessments and care provided before and after these dates. As mentioned in the initial reply, care episodes cannot be seen in isolation, as assessments, plans of care, treatment, communication and evaluation are a continuous process. The inconsistencies in the progress notes, as mentioned in my initial reply, pose a difficulty in assessing what care was actually provided.

Palliative care is based on care measures of comfort and pain management in an ongoing process, with close communication with residents and families, considering the vulnerability of the resident and family going through this experience. Care is based on a multidisciplinary and nursing assessment, from which a plan of care is developed. An initial assessment and care plan would have instructions for care and monitoring, particularly monitoring related to pain, agitation and end of life care. This plan is usually developed with the resident and family. Care plans provide instructions and rationale for management of anxiety; restlessness, pain and general care and are essential for providing care in a continuous and consistent manner. This plan is evaluated at stipulated contractual intervals and when a person's condition changes. Neither the assessment nor a care plan was available with the documentation provided to the Commissioner's Office, so that the care provided to [Mrs A] as noted in the progress notes could not be aligned or verified with the assessment or care plan developed for her, which would identify her needs. One of [Mrs A's] diagnoses indicated that she had varying bowel habits, with at times diarrhoea or constipation. In view of use of pain relief and possible associated constipation, regular monitoring and reporting on bowel movement would have been appropriate. On [Day 8], [Mrs A's] family mentioned to staff that additional Dexamethasone was required in the pump to support other medications. The family was correctly made aware that staff could only provide prescribed medications. There is no indication that this concern of the family was followed up with senior staff, the GP or the hospice doctor or nurse. Observations of temperature and oxygen saturation were taken, however no formal or consistently applied and validated pain assessment was available. As [Mrs A's] diagnosis was likely to be associated with pain, the exclusion of a reference to a pain assessment scale is unusual. In view of a palliative care approach, a consistent, evidence based assessment for pain, identifying the type, place, intensity and duration of pain is usual practice. The effectiveness of pain relief, when provided with PRN medication, is not reported on: for instance when pain relief medication is supplied, such as on [Day 8], there is no mention of the effectiveness of the pain relief. The use of non-pharmacological intervention for pain management is not mentioned and would generally be addressed in the care plan and reported on in the progress notes.

Omitting the inconsistencies in the progress notes, the overall care provided to [Mrs A] is in my opinion a mild departure from expected the standard of care.

B) **'Secondly, I note the section where you conclude that the RN's failure to seek advice when [Mrs A's] daughters raised concerns that their mother was in pain**

was a moderate departure from the expected standard of practice. Please clarify the following:

1). **If the Commissioner were to find that some of [Mrs A's] family raised concerns with the RNs that [Mrs A] was in pain but other family members told the RNs that [Mrs A] did not seem to be in pain, would the RN be expected to seek advice from a Doctor or a senior staff member about [Mrs A's] pain?**

If family members raised concerns about [Mrs A's] pain, or if family members had different opinions about [Mrs A's] pain, the RN would be expected to do a formal, validated pain assessment, explaining this to the patient and the family. This would include assessing all indications of pain and relating this to the instructions in the plan of care as set up and discussed with [Mrs A] and her family. If the pain assessment indicated that a patient was not in pain, but is perceived to be in pain by family members, communication with the family should take place regarding care for a palliative patient, including restlessness, how pain may present as well as communication with family to provide opportunities to discuss their concerns. In some circumstances this communication would [be] most suitably completed by senior nursing staff or with input from senior nursing staff. It is a generally accepted practice that RNs seek advice from senior nursing staff when families present with conflicting views. If a patient is in pain, medical advice from a Doctor or hospice staff should be sought.

2). **If the Commissioner were to find that some of [Mrs A's] family raised concerns that [Mrs A] was in pain but when the RNs assessed [Mrs A], on each occasion she was noted as being asleep and settled, would RNs be expected to seek advice from a Doctor or a senior staff member as to [Mrs A's] pain?'**

If family members raised concerns that [Mrs A] was in pain, but the RNs had completed a validated pain assessment indicating [Mrs A] was settled and asleep, the RNs would not be expected to seek advice from a Doctor. However, as this would indicate that the family's perception differs from the RN assessment, the RN would use this opportunity to communicate with the family about their concerns and provide an explanation about palliative care and possible ways pain and discomfort may present. It is generally accepted practice that this is discussed with a senior staff member.

If a validated pain assessment was completed, and [Mrs A] was not in pain, there would be no need to seek advice from a Doctor. However, in view of differences in perception of [Mrs A's] pain, and ad hoc documentation, there is an expectation that senior nursing advice or advice from hospice staff, about the management of the communication with family would be sought. There is no clear indication in the documentation provided that this occurred.

This is in my view a moderate departure from accepted practice.

C) **'A copy of the Rendell on Reed's response to your expert advice is enclosed. Please comment if any of the issues raised in that response affects your previous advice and if so, how?'**

Thank you for the reply and further explanation to my initial response. Rendell on Reed staff and management are to be commended on their actions following the

complaint by [Mrs A's] family. The actions to mitigate further similar concerns from happening are thoughtful and likely to support appropriate care. The emphasis on staff education is particularly encouraging as this would assist staff to astutely recognize care needs and provide appropriate care, supported by an evidence based practice. Allocated RN time with the clinical manager, medication reviews with GP or hospice and emphasis on appropriate and ongoing communication shows a multidisciplinary team and patient centred approach. I would advise to further monitor the effectiveness and staff compliance of the actions put in place.

Although the actions taken by Rendell on Reed are in my view appropriate to mitigate similar concerns from happening in the future, these actions were not in place at the time of [Mrs A's] care.

Thank you for the opportunity to provide further advice, please contact me if you require further clarification.

Yours Sincerely,

Sylvia Meijer"

Further expert advice

"[Date on which advice provided]
Thank you for the opportunity to further comment on the care provided to [Mrs A] at Rendell on Reed, between [Day 9] and [Day 12] and the additional information provided by Rendell on Reed.

My personal and professional profile, qualifications and clinical experience were stated in the initial advice and are therefore not repeated in this document. The findings are a result of reading through the additional information provided by the Health and Disability Commissioner's Office, reviewing the relevant literature and my own professional clinical experience of working with older adults. I have read and agree to follow the Commissioner's guidelines for Independent Advisors. I do not have a conflict of interest with the parties involved.

The initial advice was provided on [date], with a request for further advice, provided on [date]. On[date], the Commissioner's Office requested further advice on the following:

1 For each nurse:

a. [RN F]
b. [RN D]
c. [RN K]
d. [RN E]

Please state whether there were any individual departures from the expected standard of care, and if so, whether they were mild, moderate or severe. In particular please comment on:

the relevant nurses' actions or omissions in response to the additional morphine brought into the home by [Mrs B]; and

the overall standard of care provided by each nurse to [Mrs A].

2 Please find enclosed relevant Rendell on Reed policies:

Palliative Care last updated 25 September 2012
Pain Management policy last updated 25 September 2012
Medicine Management current as at [time of Mrs A's admission]
Medicine Management last updated [a period of time after Mrs A's admission]

Please provide advice regarding the standard of these policies; and in light of these policies please include your opinion on the management by Rendell on Reed of the additional morphine being brought in to Rendell on Reed by [Mrs B].

Please also consider the assistance provided by the [the Hospice] over the weekend of [Days 9–12], advising whether it was adequate and timely. In particular, should the hospice doctor have visited and assessed [Mrs A] prior to the planned visit of [Day 12].

In my reply, the Commissioner's Office questions are posed in 'bold' with my response directly following each question.

1 For each nurse:

a. [RN F]
b. [RN D]
c. [RN K]
d. [RN E]

Please state whether there were any individual departures from the expected standard of care, and if so, whether they were mild, moderate or severe. In particular please comment on:

the relevant nurses' actions or omissions in response to the additional morphine brought into the home by [Mrs B]; and

the overall standard of care provided by each nurse to [Mrs A].

[RN F]
The progress notes do not indicate that [RN F] was aware of the additional morphine brought in.

Caring for residents with complex and fluctuating health care needs can have challenges and RNs in care facilities are generally advised to seek support from senior staff or managers. There is no reference in the progress notes about a pain scale, despite pain scales mentioned in the Pain Management policy of Rendell on Reed. The progress notes indicate [Mrs A] was in pain on movement. [RN F] noted in her individual report to the Commissioner's Office that the Hospice nurse informed her that staff could phone the Hospice. There was no reference to the hospice call in the progress notes. Formal and validated pain assessments could have aided a consistent approach to manage [Mrs A's] pain and may have guided discussions with family and provided some indication if additional advice from Hospice or manager[s] should have been sought. There is no indication in the progress notes that discussions were held with family as to explain what to expect when a person is dying, such as changes in breathing patterns and terminal restlessness. Advice on how to manage this could be sourced from Hospice, DHB staff or GP. It is my understanding from the

documents supplied that [RN F] was not aware of any additional morphine brought in by family.

In view of the omission of formal pain assessments while [Mrs A] was in pain, limited evidence on discussion with family and no additional advice sought from Hospice or manager, I consider the overall care provided to [Mrs A] by [RN F] a mild departure from expected the standard of care.

[RN D]
Caring for residents with complex and fluctuating health care needs can have challenges and RNs in care facilities are generally advised to seek support from senior staff or manager. There was no reference to the hospice call in the progress notes. Formal and validated pain assessments could have aided a consistent approach to manage [Mrs A's] pain and may have guided discussions with family and provided some indication if additional advice from Hospice or manager[s] should have been sought. There is no indication in the progress notes that discussions were held with family as to explain what to expect when a person is dying, such as changes in breathing patterns and terminal restlessness.

[RN D's] progress notes ([Day 10]) indicate that [Mrs A] required additional pain relief but was still in pain after this was administered. There is no indication in the notes if this was actioned upon.

On [Day 12] at 5.19 AM, [RN D] found the Morphine elixir in [Mrs A's] room and did not remove this.

In view of the omission of formal pain assessments while [Mrs A] was in pain, limited evidence on discussion with family and no additional advice sought from Hospice or manager, and no action taken on finding morphine in [Mrs A's] room, I consider the overall care provided to [Mrs A] by [RN D] a moderate departure from the expected standard of care.

[RN K]
Caring for residents with complex and fluctuating health care needs can have challenges and RNs in care facilities are generally advised to seek support from senior staff or manager. [RN K's] progress [notes] indicate that [Mrs A] was mostly comfortable and asleep during her duty.

There is no indication in the progress or Commissioner's notes that [RN K] was aware that additional morphine was brought in. There does not appear to be an indication that [Mrs A] was in pain and it would not be expected to do a pain assessment when a resident is not in pain. [Mrs A] asked to [be] catheterized on [Day 7] during [RN K's] shift, with no evidence in the notes why this did not occur, except that a catheter was inserted on [Day 11].

It is my understanding from the documents supplied that [RN K] was not aware of any additional morphine brought in by family.

I consider the care provided by [RN K] of acceptable standard.

[RN E]
Caring for residents with complex and fluctuating health care needs can have challenges and RNs in care facilities are generally advised to seek support from senior staff or manager. [Mrs A] appeared to be sleeping well and free of pain on [RN E's] duty on [Days 8 and 9]. On [Day 11], [Mrs A] was not taking medication orally as she was not rousable. At 10.12 PM, the family voiced concern that [Mrs A] had pain and asked [RN E] to consult a doctor. [RN E] discussed with the family to arrange this in the morning and the family appeared to agree. However, shortly after, [Mrs A's] daughter presented with a bottle of morphine, brought in from home. [RN E] correctly explained that medications not charted could not be given. The situation was clearly of concern to the family. If family members raise[d] concerns about [Mrs A's] pain, or if family members had different opinions about [Mrs A's] pain, the RN would be expected to do a formal, validated pain assessment, explaining this to the patient and the family. This would include assessing all indications of pain and relating this to the instructions in the plan of care as set up and discussed with [Mrs A] and her family. If the pain assessment indicated that a patient was not in pain, but is perceived to be in pain by family members, communication with the family should take place regarding care for a palliative patient, including restlessness, how pain may present as well as communication with family to provide opportunities to discuss their concerns. In some circumstances this communication would [be] most suitably completed by senior nursing staff or with input from senior nursing staff. It is a generally accepted practice that RNs seek advice from senior nursing staff when families present with conflicting views. If a patient is in pain, medical advice from a Doctor or hospice staff should be sought.

In view of the omission of formal pain assessments while [Mrs A] was in pain, and no additional advice sought from Hospice or manager when the family voiced concern, and no action taken on finding morphine in [Mrs A's] room, I consider the overall care provided to [Mrs A] by [RN E] a moderate departure from the expected standard of care.

2 Please find enclosed relevant Rendell on Reed policies:
Palliative Care last updated 25 September 2012
Pain Management policy last updated 25 September 2012
Medicine Management current as at [time of Mrs A's admission]
Medicine Management last updated [a period of time after [Mrs A's] admission]

Please provide advice regarding the standard of these policies; and
In light of these policies please include your opinion on the management by Rendell on Reed of the additional morphine being brought in to Rendell on Reed by [Mrs B].

Palliative Care last updated 25 September 2012

The standard of this policy is generally informative and provides basic guidance to caring for patients with palliative care needs. Usually, the person(s) responsible for providing palliative care are all staff caring for a patient, with guidance from the Registered Nurses and care co-ordinators. In practice, palliative care is best managed when the concept is understood by all staff looking after a patient. A mention about

the link with the local hospice or DHB Palliative care services and information about palliative care specific symptom management would strengthen the policy. This would provide consistent and contemporary information, with guidance from specialist services. The Palliative Care Policy (section B-General comments) states that: 'all palliative care policy and procedures reflect this view'. The organisation may already have addressed specific palliative care symptom management in a procedural document.

Page two, (5.4) refers to a 'Legal Friend'; the organisation may want to consider defining this term, specifically in relation to responsibilities of the EPOA. The policy also refers to 'significant other' however; there is a requirement to include the person holding EPOA. In practice, the significant other may not be the EPOA and transparent communication channels may need to be established. Page two (5.5) states decision making by non-competent residents, with a reference to the Health and Disability Commissioner to seek assistance. The organisation may like to clarify the responsibilities of the person holding EPOA and refer to information about invoking EPOA. Page three states that the GP reviews the order 'regularly', the organisation may like to be more specific with the timeframe to maintain a consistent approach. The policy refers to a consensual understanding of the resident's wishes. A reference to an Advanced Directive or Advanced Care Plan would be suitable to identify and document the patient's wishes in a consistent and transparent manner. Page three, 3rd paragraph, notes '… duty of care to the resident in the delivery of care will minimize pain and comfort'. This is surely a spelling mistake and likely to be 'minimize pain and discomfort' or 'minimize pain and maximize comfort'.

It is considered good practice to have policies references to Best Practice or national guiding documents. In practice, organisations for instance show that Hospice NZ, local hospice documents or DHB policy were consulted or that input from relevant health or legal professionals was sought. Care facilities often source information for policies on EPOA, Advanced Care Planning and Advanced Directives from the NZ Advanced Care Planning organisation, the Ministry of Health, Age Concern, the CNL Care Guide, and local DHB.

I consider this policy could benefit from a review to ensure the inclusion of current best practice information.

Pain Management policy last updated 25 September 2012

This is a generally informative policy, easy to understand and follow. The use of pain assessments and pain scales promotes a consistent approach to assess a resident's pain. The availability of regular pain assessments can assist when discussing and planning pain management with residents, families and other health professionals. Care facilities usually seek information for their policies regarding pain management from local clinicians, the RN care guide and best practice documents and organisation. Rendell on Reed referenced their policy on the findings of the International Association for the Study of Pain.

I consider this policy of an acceptable standard.

Medicine Management current as at [time of Mrs A's admission]

This policy contains most information that would be required to guide staff and manage medications. Page one, the inclusion of a resident's NHI is advisable,

(Medicines Care Guides for Residential Aged Care, 2011). Page one, last paragraph notes 3-monthly and monthly reviews and continues with that the doctor is to sign the 3-monthly review box. It is not obvious if this also applies to monthly reviews, or if there is a monthly review box. The verbal order section states that any order is to be signed by a doctor within 72 hours, however the Medicines Care Guides for Residential Aged Care (2011) promotes that best practice is to have orders signed with two working days. On page two, it is not obvious that controlled drugs received from the pharmacy are to be entered into the controlled drug register at the time they are received.

One of the standard safety guidelines for medicine administration are the '5 Rights' (Right resident, Right medicine, Right dose, Right time, Right route). Throughout the document there is reference to some of these, such as in the controlled drug administration section, page 4, there is mention about correct dose time and medication. There is no reference to the 5 Rights in the general administration section. The organisation however does address this in the Medication Competencies. The Medicines Care Guides for Residential Aged Care (2011) promotes '5+3 Rights' and includes the right to refuse, the right indication, and the right documentation.

Under the heading 'monitoring and errors' page seven, the RN responsibility would include an initial and follow up assessment of the resident, as well as specific instructions to care staff regarding possible adverse reactions and resident monitoring instructions.

The policy was last updated in 2012 and referenced to Legislative documents, including the Safe management of medicine: a guide for managers of Old People's homes and residential care facilities. In 2011, the Ministry of Health provided the Medicines Care Guides for Residential Aged Care. This guide is regularly used by care facilities to align their policies with current legislative requirements. The aim of the Medicines Care Guides is to provide a quick medicine management reference tool for all care staff working in residential aged care in New Zealand. Guidance is provided for key medicine safety topics relevant to the care of older adults. This guidance is based on current legislation, best available evidence and published guidelines, and is consistent with the New Zealand medicines strategy.

I consider this policy could benefit from a review to ensure the inclusion of current best practice information.

Medicine Management last updated [a period of time after Mrs A's admission]
It is my understanding that the only change to this policy from the previous one is the addition of paragraph 20. Therefore my comments as outlined in the Medicine Management policy last reviewed in March 2012 stand.

Regarding the addition of paragraph 20, the organisation may like to consider stating that brought in Controlled Drugs need to be entered in a register. This is to ensure there is a documented and transparent system about controlled drugs on the premises and that staff complied with legal requirements. Care facilities often source advice from the Medicines Care Guides for Residential Aged Care (2011) and or the Ministry of Health or the DHB.

I consider this policy could benefit from a review to ensure the inclusion of contemporary best practice information.

In light of these policies please include your opinion on the management by Rendell on Reed of the additional morphine being brought in to Rendell on Reed by [Mrs B].

At the time the additional morphine was brought in by family, the organisational policy did not guide staff on how to manage this. However, Registered Nurses are aware that medications are to be accounted for and that Controlled Drugs are to be locked away and entered into a register. The policy at the time notes under patient self administration that medications should be locked away. The organisational policy refers to medicine references and website available to gain further information. In practical terms, it is acceptable practice that RNs have a conversation with families, to explain the legal requirements and reassure family that additional advice to manage symptoms can be sought from [a] doctor so that the resident is comfortable. If the discussions with the family cannot resolve their concerns, it is generally acceptable practice that further advice is sought from a senior nurse or manager.

The notes supplied do not indicate that staff consistently used the pain assessments as per their Pain management policy, or made additional contact with the hospice. [Mrs A's] family showed concern about the management of pain and felt it necessary to bring in medication. In such circumstances, staff would usually seek advice and closely communicate with family to alleviate their concerns. When residents bring in medication, this is usually discussed with the patient, their family and the GP. In this instance advice could have been sought from the GP or Hospice or manager.

It is my opinion that the management of the situation regarding the additional medication brought in by [Mrs A's] daughter is a moderate departure from expected standard of practice.

Please also consider the assistance provided by the [the Hospice] over the weekend of [Days 9-12], advising whether it was adequate and timely. In particular, should the hospice doctor have visited and assessed [Mrs A] prior to the planned visit of [Day 12].

On [Day 9] the Hospice Community Care Co-ordinator visited [Mrs A] at Rendell on Reed and contacted the Hospice doctor by phone. On suggestions from the Hospice doctor, changes to the medication regime were made to manage [Mrs A's] symptoms. Rendell on Reed CNL C requested the GP, [Dr G], to visit. The GP agreed with the suggested medication changes and wrote the prescriptions for this. On [Day 10], the Hospice co-ordinator contacted Rendell on Reed and was told that there were no issues identified. On [Day 11], [Mrs A's] daughter called the Hospice with concerns about pain management and the Hospice staff called Rendell on Reed RN to check what was happening. The Hospice coordinator was told that [Mrs A's] condition had deteriorated, that PRN medication would be utilised when [Mrs A] became more uncomfortable but that at the time of the call [Mrs A] was comfortable. The plan of care was discussed and it was agreed that the Hospice nurse would visit on [Day 12]. During the Hospice nurse visit on the [Day 9] as well as during subsequent phone calls over the weekend, Rendell on Reed staff [were] made aware that they could phone the Hospice at any time if concerns occurred. The notes from the Hospice nurse

regarding the phone checks with Rendell on Reed over the weekend indicate that 'no issues were identified' and that [Mrs A] was comfortable at the time. Rendell on Reed staff had the option to contact the Hospice for advice as increasing pain became more evident over the weekend. There is no evidence in the progress notes or the Hospice notes that Rendell on Reed staff sought additional Hospice advice. When family contacted the Hospice and the Hospice subsequently contacted Rendell on Reed, Hospice was reassured that [Mrs A] was comfortable.

It is my understanding that Hospice advice was available via phone at any time and that given the information provided to Hospice staff, the need for an urgent Hospice doctor visit over the weekend was not obvious. I consider the Hospice assistance given to Rendell on Reed adequate and timely.

Thank you for the opportunity to provide further advice, please contact me if you require further clarification.

Yours Sincerely,

Sylvia Meijer

References

Advanced Care Planning Organisation handbook retrieved from the WWW. On 20 January 2014 http://www.advancecareplanning.org.nz/

Age Concerns EPOA information handbook retrieved from the WWW. On 20 January 2014 http://www.ageconcern.org.nz/epa

NZ Palliative care handbook retrieved from the WWW. On 20 January 2014 http://www.hospice.org.nz/resources/palliative-care-handbook

Medicine Care Guides for Aged Residential Care, retrieved from January 2012 from

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

CNL Care Guide handbook retrieved from the WWW. On 10 March 2012

http://www.waitematadhb.govt.nz/HealthProfessionals/RACIPcareguides.aspx"