Provider/Owner/Manager of a Rest Home, Mrs C

Registered Nurse, Mrs D

General Practitioner, Dr E

A Rest Home

A Report by the

Health and Disability Commissioner

(Case 00HDC11595)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Complainant / Consumer's daughter
Mrs B	Consumer
Mrs C	Provider / Owner / Manager of the rest home
Mrs D	Provider / Registered Nurse at the rest home
Dr E	Provider / General Practitioner
Mrs F	District Nurse
Dr G	Consultant Geriatrician
Mr H	Pharmacist
Mr I	Manager of the pharmacy

Complaint

On 7 November 2000 the Commissioner received a complaint from Mrs A about the standard of service her mother, Mrs B, received from a rest home. An investigation was commenced on 4 December 2000 and Mrs C, owner and manager of the rest home, was notified of the complaint in relation to her involvement in Mrs B's care.

On 23 January 2001 the investigation was extended and Mrs D, a registered nurse, was notified of the complaint in relation to her involvement in Mrs B's care. On 2 November 2001 Mrs C and Mrs D were notified that the investigation relating to their involvement in the treatment and care of Mrs B covered the following issues:

- *Failure to provide an appropriate standard of care and in particular:*

  – *failure to advise Mrs B's power of attorney of her deteriorating condition and in particular, failure to obtain informed consent to the administration of sedation (Imovane)*

  – *failure to act appropriately to address Mrs B's deteriorating condition and in particular, to seek advice and/or refer Mrs B for medical assistance following a fall on 18 August 2000. (Mrs B was admitted to a public hospital with a suspected fractured hip on 22 August 2000.)*

  – *dispensing uncharted drugs and/or writing unauthorised instructions to nursing staff in respect of drugs to be administered (Imovane)*

  – *failure to act appropriately or address Mrs B's deteriorating condition and in particular, weight loss, dehydration and increasing numbers of falls over the period April to August 2000.*

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On 5 November 2001 Dr E was notified of the complaint in relation to his involvement in Mrs B's care as follows:

- *failure to provide an appropriate standard of care to Mrs B over the period April to August 2000, and in particular:*
  - *failure to appropriately assess and adequately monitor Mrs B's general health and wellbeing*
  - *failure to appropriately prescribe, assess and follow up the prescription of Imovane tablets to Mrs B.*

Information reviewed

- Mrs B's clinical records from the rest home
- The rest home's policies and procedures
- Ministry of Health Licensing Office August 2000 audit report for the rest home
- Safe Management of Medicines, A Guide for Managers of Old People's Homes, published by the Therapeutics Section, Ministry of Health 1994
- The Old People's Homes Regulations 1987
- The Heart Foundation 'Assessment of Overweight and Obesity' chart
- Copies of prescriptions for Mrs B supplied by the Health Centre
- Independent expert advice from Mrs Jan Featherston, a registered nurse specialising in the care of the elderly, and Dr Tessa Turnbull, a general practitioner with a special interest in the care of the elderly

Information gathered during investigation

Overview

This investigation concerns the care of Mrs B at the rest home during the period April to August 2000 when Mrs B was 90 years old.

Mrs B was admitted to the rest home on 13 December 1998 because of her increasing frailty and early dementia. The placement was initiated by Mrs F, a district nurse who provided support visits to Mrs B in her home and was a close neighbour. During 1998, Mrs F became increasingly concerned about Mrs B's safety, her propensity to fall, her decreasing weight and increasing frailty. She also reported early signs of dementia. Mrs F discussed these matters with Mrs B's daughter, Mrs A, and Dr E, and gained their agreement for Mrs B to be assessed with a view to placement in a rest home. Mrs A lives in a city and held an enduring power of attorney in respect of her mother's property and personal care and

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welfare. Dr E was Mrs B's general practitioner for seven years, both in her own home and at the rest home.

Mrs B's mental condition began to deteriorate shortly after her admission to the rest home and staff found it increasingly difficult to control her wandering and challenging behaviour. It appears that staff were unable to implement effective strategies to manage Mrs B's care. A number of interventions were trialled, including diet, bowel management and diversion, with little effect.

In March 1999, Mrs D, the registered nurse for the rest home, approached Dr E for sedation for Mrs B. Dr E prescribed Imovane 7.5mg to be given at night.

Mrs B was a small woman who weighed only 42kg on admission to the rest home. The combination of sedation and the other strategies employed to manage her impacted on her general wellbeing. During the 18 months she was at the rest home she lost 10kg in weight. She also had a large number of falls. Some were "near misses" where staff caught her in the act of falling, but she often fell against furniture and bruised herself. Mrs C admitted that not all of Mrs B's falls were documented or reported to Dr E.

Up until July 2000, Imovane was given intermittently.

From June 2000 (when Mrs B was moved to a new room at the rest home), Mrs B's behaviour became even more difficult for staff at the rest home to manage. Despite this, Mrs C, as owner and manager of the rest home, did not refer Mrs B for reassessment or seek expert advice on her management, nor did she specifically discuss the difficulties with Dr E or Mrs A.

In July 2000 Mrs D and Mrs C planned to take leave. They were concerned about the ability of the staff at the rest home to cope with Mrs B while they were away. Without consulting Dr E, Mrs D made out a prescription for further Imovane for Mrs B, altering the instructions on the Imovane from "take half a tablet to one tablet at night as directed" to "take half a tablet each morning and at night". She sent the prescription forms to their regular pharmacy, with the intent that the pharmacy would send it on to Dr E to check and authorise by signing. Dr E admitted that he signed the prescription without checking it. When the dispensing pharmacist noted the alteration, he contacted the rest home and advised that it was an unusual and potentially unsafe usage. He was reassured by the person he spoke to that the change had been authorised, and supplied the Imovane as requested.

In August 2000 Mrs D instructed the staff to administer Imovane to Mrs B in the morning and at lunchtime, in addition to the night-time dose. Subsequently, Mrs B fell three times in the second week of August, sustaining bruising and loss of mobility. Mrs B's left foot swelled, and she complained of pain intermittently from 15 August. Panadol four hourly was instituted by Mrs D on 17 August. Despite this, Dr E was not informed or asked to review Mrs B's condition until 22 August. He visited, assessed her condition and suspected that she had fractured her left hip, and arranged for her admission to hospital. X-rays confirmed a fractured hip and Mrs B was admitted and subsequently underwent surgery to repair the hip on 23 August.

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Mrs B was transferred to another rest home following her discharge from hospital.

The rest home

At the time of this complaint the rest home was licensed for 19 residents. The residents were all frail and elderly, requiring assistance with daily living tasks. Mrs C, an enrolled nurse with a Rest Home Caregivers Certificate and Rest Home Manager's Certificate from a polytechnic, and her husband established the rest home in 1979 when they became joint licensees. Mrs C stated that the rest home runs at 90% plus occupancy at all times. The rest home employs seven to eight staff on the morning shift, including the cook, cleaner, and at least four caregivers. On the afternoon shift there are three staff working from 3.00pm to 8.30pm, and two from 8.30pm until midnight. The sole night shift caregiver works from midnight until 6.00am.

Mrs D was employed as the registered nurse for the rest home in 1998. Mrs D gained her general nurse registration overseas in 1980. Before commencing work at the rest home, Mrs D was employed as a registered nurse on night shift at a private geriatric hospital. She has a Rest Home Manager's Certificate and has completed a number of courses relating to the care of the elderly. Mrs D was employed at the rest home for approximately 25 hours per week as a registered nurse. Her job description is attached as an appendix. She lived on the adjoining property and was available on an 'on call' basis.

Mrs B

Prior to her admission to the rest home in December 1998, Mrs B was living in her own home with support services. She was independently mobile within her home, but her eyesight was failing and she had had a number of falls. Mrs F, a district nurse, was concerned about Mrs B remaining in her home alone. Mrs F, who had cared for Mrs B for a number of years and was her neighbour, often visited to dress wounds sustained by Mrs B in falls in her home. She had also noted that Mrs B was not feeding herself properly, despite receiving "Meals on Wheels". She expressed her concerns regarding Mrs B's safety and weight loss to Mrs A and to Dr E.

Mrs B was referred for assessment for admission to a rest home because of her "increasing frailty and early signs of dementia". Before residents are admitted to a facility in the area, an assessment is undertaken by Disability Support Link.

A staff member from Disability Support Link assessed Mrs B on 10 December 1998. The assessment summary noted that Mrs B was unsafe living at home alone and indicated that she required rest home care. Mrs B was assessed as being Support Needs Level (SNL) 4. Support Needs Level assessments determine the physical, social and psychological functioning level of frail elderly persons who have been referred for rest home care, with scores from 2 to 5. A person scored as being SNL 5 requires hospital level care, whereas SNL 2 to 4 indicates rest home care is appropriate.

On 13 December 1998, Mrs B was admitted to the rest home. On admission Mrs B was suffering from congestive heart failure and early onset dementia. Her mental condition deteriorated from the time she was admitted. The nursing notes record that she frequently

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wandered into other residents' rooms and displayed inappropriate behaviour, such as removing her clothing, and blowing her nose on the tablecloth in the dining room. She was incontinent of urine and faeces and frequently smeared faeces over walls and fittings.

The efforts various members of staff made each day to establish a routine for Mrs B's bowel evacuation are well recorded. A variety of interventions were undertaken, including diet, enemas and frequent toileting. Mrs B's bowel management was compounded by her behavioural problems. Mrs D informed me that Mrs A was "spared the indignity of knowing some of the more unpleasant aspects of her mother's condition for example defaecating and/or urinating in food receptacles".

Mrs A

Mrs A was granted an enduring power of attorney (personal care and welfare) for her mother on 12 November 1997.

Mrs A visited monthly and telephoned to enquire about her mother's wellbeing three to four times per week. During the initial period of Mrs B's residence at the rest home, it appears that the relationship between the rest home and Mrs A was positive. Mrs C described the relationship as follows:

> "Throughout all of this period [December 1998 to August 2000] I had a close association with [Mrs A]. I frequently spoke with [Mrs A] at the rest home, my own home if I was not on duty and by telephone at the rest home or at my own home. [Mrs A] has my private home phone number. I do not feel that I could have availed myself more than this. However, regardless of the frequency of our communications regarding her mother's condition, I do not recall any complaint or negative criticism about her mother's treatment or care being discussed. [Mrs A] and her husband … regularly commended myself and the staff on the excellent service and care provided."

Management of Mrs B's care

Mrs A alleged that the rest home and, in particular, Mrs C and Mrs D, failed to act appropriately or address Mrs B's deteriorating condition in relation to weight loss, dehydration and falls. She was also concerned about the failure of the rest home staff to advise her of their concerns about her mother, to obtain her consent to sedate her mother with Imovane, and to seek timely advice and/or refer Mrs B for medical assistance after her mother's series of falls in August 2000. These issues are discussed in detail below.

Weight loss

On admission to the rest home on 13 December 1998, Mrs B's weight was recorded as 42kg. The assessment by Disability Support Link of 10 December 1998 comments that Mrs B required assistance to eat and drink, and records weight loss. Mrs F, the district nurse, recalled that Mrs B was very frail and extremely thin prior to her admission to the rest home. It was one of the concerns that prompted her admission into care.

On 28 December 1998, Mrs D noted that Mrs B's weight had dropped 1kg, to 41kg. In Mrs B's Resident Care Plan for January 1999, she recorded that Mrs B lacked appetite, and

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directed staff to "encourage [Mrs B] with small meals. Offer crackers and cheese between meals." On 25 April 1999 Mrs D advised staff to provide Mrs B with Complan and soup between meals as well as the crackers and cheese. The Care Plan written in June 2000 noted that Mrs B was displaying inappropriate behaviour at meal times and had trouble chewing. She was provided with puréed food, and staff were directed to assist her with her meals. Staff were instructed to ensure that Mrs B had her meals in her room as she "has more concentration and is less agitated when she eats alone".

Mrs A informed me that her mother was approximately 165cm (5'5") in height. Mrs B's body mass index (BMI) calculated on her height and weight at that time, based on the Heart Foundation's BMI specifications, was 15.4. (Underweight is classified as less than 18.5.)

Mrs A also informed me that while she had noticed that her mother had lost weight, she was unaware how much she had lost as her mother was a tiny lady, felt the cold and wore several layers of clothes. Further, Mrs A said that if the weight loss had been brought to her attention, and Mrs C or Mrs D had suggested that her mother's condition be investigated (for example, by an x-ray), she would have agreed.

There is no record that Mrs A was made aware that her mother was not eating and had lost a large amount of weight since her admission. Further, there is no evidence that the matter was specifically brought to Dr E's attention or that a geriatrician or dietician was consulted.

In response to my provisional opinion, Mrs C stated:

> "The truth is that neither [Mrs A] nor [Dr E] could have been in any doubt about the extent of [Mrs B's] weight loss throughout the time she was at the rest home. I clearly recall discussing [Mrs B's] weight loss with [Mrs A] from time to time. In addition to relevant discussions that were relatively clinical, I very clearly recall emphasising the extent of [Mrs B's] weight loss to [Mrs A] with reference to the need for me to purchase for her mother progressively (much smaller clothes). I clearly remember mentioning sizes and thereby emphasise just how much weight [Mrs B] had lost."

Mrs C further stated:

> "It was my personal opinion throughout that [Mrs B] had bowel cancer and that that was the probable cause of her steady weight loss/physical deterioration. I know that [Mrs D] was of the same opinion. I personally discussed my opinion with [Mrs A] and I am aware that [Mrs D] discussed the matter with [Dr E]."

Dr G, consultant geriatrician, who provided an affidavit in support of Mrs C's response to my provisional opinion, stated:

> "I agree that [Mrs B's] weight loss, as described in the provisional opinion, was ***significant*** and also agree that the management of this problem ***could*** *have included referral to a psycho-geriatrician and consultant dietician.* However, the same question arises as to whether the responsibility is that of the resident's medical practitioner or of the resthome proprietor."

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Dehydration
On 20 February 2000 the nursing notes record that Mrs B had physically deteriorated. Mrs D noted potential dehydration and requested Dr E "stop" Mrs B's frusemide medication, which was actioned. Mrs A was informed of the deterioration in her mother's condition, and visited. Over the next two weeks staff recorded that Mrs B was passing bright orange or very dark urine and very many fluid bowel motions. By the beginning of April, Mrs B was eating and drinking normally and the records show that her condition started to improve. She was reluctant to take food and fluids and had a number of very fluid bowel motions. Mrs D stated:

> "[Mrs B's] urine was 'dipsticked' [tested for abnormalities] and proved normal. When [Mrs B's] urine proved to be dark in colour, a note was put on the fridge to push fluids into [Mrs B]. I do not believe that [Mrs B] was dehydrated. [Mrs B] received a good deal of fluids."

Mrs C agreed that Mrs B was almost certainly dehydrated at times over the period December 1999 to February 2000. She understood that this was probably a side effect of the diuretic frusemide, prescribed by Dr E on 10 December 1998, and recalled that Dr E cancelled the frusemide and instructed staff to encourage Mrs C to take fluids.

During April to August 2000 there are various entries in the notes that indicate that staff had difficulty encouraging Mrs B with fluids because she was often tired and sleepy. However, there is no evidence that blood tests were taken or that a specific assessment was undertaken to actively manage Mrs B's dehydration, nor that Dr E was asked to specifically consider intervention for potential dehydration.

Dr G stated:

> "It appears that in February 2000 [Dr E] believed [Mrs B] to be dehydrated – probably as a result of the Frusemide (diuretic) that he himself had prescribed for [Mrs B] and that he cancelled. So far as I am concerned there is nothing particularly surprising or unusual about this sequence having regard to all that is known about [Mrs B].
>
> The specific criticism here appears to be that there is no evidence that blood tests were taken or that specific assessment and positive steps were taken to actively manage [Mrs B's] dehydration. I would expect the resthome/nursing role to be that of encouraging appropriate fluid intake and recording results. Further concern might then be reported to the medical practitioner for further intervention. This intervention would not normally include blood tests."

Repeated falls
Mrs C advised me that Mrs B was admitted to the rest home because "all those responsible for her – [Mrs A], [Dr E] and perhaps most particularly, [Mrs B's] district nurse, [Mrs F] were concerned about her safety because she was falling in her own home".

Mrs F stated in her unsworn affidavit: "During 1998 I became concerned about [Mrs B's] safety while she remained in her own home. This was largely because it was clear to me that she was falling in and about her home and suffering minor injuries as a result."

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However, the Disability Support Link Client and Assessment Details, completed by its staff, in the presence of Mrs F, when she assessed Mrs B for rest home care on 10 December 1998, noted: "Has not had any falls yet. If she did ? whether she could get herself up."

Mrs C informed me that during the time Mrs B was at the rest home she had a number of falls. In response to my provisional opinion Mrs C stated:

> "From the very first day we discovered that the risk that [Mrs B] would injure herself in a fall was greater than anyone had anticipated. There were several factors contributing to this. Firstly, she was unsteady on her feet at the best of times. Secondly, she was, at times, very mobile and, because of her dementia, unpredictable. Thirdly, her preferred footwear was socks only and there was a constant risk of slipping on polished floors. (I purchased rubber adhesive which I applied to the soles of [Mrs B's] socks.) …
>
> I believe that all significant falls were recorded although I acknowledge that it appears that separate incident reports were not always written up.
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> Minor incidents and near misses were not recorded. I refer to the hundreds of occasions when [Mrs B] bumped into things or tripped but did not fall to the ground or when she most probably would have fallen on the floor but for the intervention of a staff member – often myself. Because of the risk of injury from falls and knocks, [Mrs B] was supplied with arm and leg protectors – padded sheaths. Often on days when [Mrs B] appeared particularly agitated and was particularly mobile, I personally spent the best part of the day with her on a one-on-one basis, walking with her in the garden and in and about my own home. I regularly took her out with me in my car and, on occasions, took her to the supermarket so as to provide some distraction."

Mrs D confirmed that Mrs B had a lot of "near misses" and said that she was covered in bruises, but this was mostly because she was very unsteady and fell against furniture. Mrs D said it was impractical to write up all the incidents when Mrs B bruised herself.

The Resident Care Plans, formulated by Mrs D to guide staff in the care of Mrs B, noted the actions to be taken by staff to control Mrs B's wandering, such as frequent checks and diversion.

In response to my provisional opinion Mrs D stated, "A number of strategies were implemented in an effort to reduce [Mrs B's] wandering at night." Mrs D stated that Mrs B was taken for walks during the day and staff would keep her occupied with conversation, massage and reading to her. However, Mrs D did not document her plan for interventions to prevent Mrs B's repeated falls. The only intervention relating to Mrs B's safety recorded in the Residents' Care Plan written in April 1999, was to curtail Mrs B's tendency to wander. Accident/Incident reports were completed by staff to record some of Mrs B's falls and these forms were signed off by Mrs D.

In May 2000 two incident forms were completed recording falls Mrs B sustained. However, not all falls were recorded. For example, the nursing notes for 6.15am on 2 June 2000 recorded:

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> "3.00am. I investigated a loud bang and found [Mrs B] on her bedroom floor. She had tripped on the plastic and hit her head on her bench. A large skin tear to forehead. [Mrs D] came in and did the dressing. 2 Panadol given. [Mrs B] spoke clearly and was able to describe what had happened."

No Accident/Incident form was completed for this fall.

On 14 July Mrs B sustained a further fall. When Mrs D asked Dr E to see Mrs B on 18 July 2000 regarding a swollen ankle there is no evidence that she told him about Mrs B's recent falls.

Falls – fractured hip
On 11 August 2000 Mrs B fell twice, at 6.40am and 7.15pm.

On 15 August the nursing notes report that she "appeared stiff and in pain". Staff further reported that her right shoulder hurt and that she had trouble raising her spoon to her mouth. (At this time Mrs B appears to have been receiving Imovane three times a day.)

On 17 August Mrs B was noted to have abrasions and bruising on her left knee and shin. The nursing notes for this date report that Mrs B was very stiff and appeared fearful of moving from her bed to the chair. Mrs D instructed staff to give Mrs B Panadol four hourly for "a few days".

On 18 August Mrs B's left foot was observed to be very swollen and the caregiver reported that Mrs B "was unable to stand, cringed when [left foot] placed on floor. Body stiff and achy."

Mrs A informed me that when she telephoned the rest home at 8.00pm on 18 August, she was told by the caregiver that her mother had suffered several falls and was being given Panadol four hourly for pain. Mrs A did not speak to her mother as she was asleep.

Mrs A and her husband visited Mrs B on three occasions during the weekend of 19/20 August 2000. On these visits they found Mrs B either asleep or drowsy. Mrs A recalled that her mother was incoherent and they were unable to communicate with her.

On 21 August, Mrs B had a further fall at 7.40am and injured her right elbow. Another caregiver completed an Accident/Incident form and reported this incident to Mrs D when she arrived on duty that morning. At 5.00pm that day Mrs D noted in the nursing notes that Mrs B was to continue to have "one full tablet at breakfast and bed plus half tab at lunchtime".

On 22 August, the night staff reported to the morning staff at handover that Mrs B had been in considerable pain during the night and had required assistance to go to the toilet. Mrs D telephoned Dr E at about 9.00am and asked him to visit and assess Mrs B. Dr E saw Mrs B at 12.30pm that day and transferred her to the public hospital with a suspected fractured left femur.

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The hospital confirmed the fracture of Mrs B's left hip and operated to repair the fracture on 23 August 2000.

Mrs C informed me that it was difficult to assess Mrs B's level of pain because of her dementia. She said, "If you asked her where her pain was she would point anywhere."

In response to my provisional opinion Mrs C stated:

> "The opinion wrongly records [Mrs B's] broken hip was not acted upon for several days by requesting a visit from [Dr E]. The true position is that over a number of days prior to 22 August 2000, [Mrs B] complained of a number of aches and pains. That was a common pattern. Every such complaint or comment was investigated carefully. On 21 August [Mrs B] fell and hurt her elbow. I spent some time with her that day as a result of that fall and possible injury. I was satisfied that there was no injury that justified calling [Dr E]. [Mrs B] was fully weight bearing that day. I do not believe that there is any possibility that her hip was broken that day, or earlier. The following day [Mrs B] could not get out of bed and was unable to stand. I believe that she may have fallen during the night or, more probably, that a fracture had occurred spontaneously. [Mrs D] and I decided to call [Dr E]."

Mrs D informed me that Mrs B was always stiff when she got up in the morning and staff had to judge if she was very different from usual.

Mrs D said that they examined Mrs B's leg and checked for abnormal rotation and its length in relation to the other leg. (Mrs D did not inform me when this examination took place, and there was no record in Mrs B's notes of this examination.)

Mrs D, in her response to my provisional opinion, stated that "despite the fracture, [Mrs B] was still getting in and out of bed and walking about. I believe it fair to say that [Dr E] did not consider a fracture had been sustained." She said that if they had known that Mrs B's leg was broken they would not have left her.

Medication management – Imovane
As Mrs B's behaviour became more disruptive, staff recorded their frustration at trying to control her behaviour.

On 8 July 1999 a third caregiver noted in the nursing notes for Mrs B:

> "Can't she have something to settle her, it's beyond a joke now in my eyes! I know we are meant to be professional to the best of our ability but we can't keep chasing her all night."

Although Mrs B's behaviour continued to cause problems for staff, there were no further entries in relation to medication management (Imovane) in the Resident Notes or the Medication Administration Records until June 2000. The records show that the staff attempted to control her wandering by offering sweet foods such as bananas, Milo and biscuits as an alternative to sedation. For example, Mrs D directed staff on 3 May 1999 to

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take Mrs B out for daily walks (weather permitting) in an effort to control her behaviour, and recorded on 15 May 1999:

> "Please try giving [Mrs B] a sweet drink or biscuit if she wakes at night – low blood sugar levels in the elderly cause them to become wandery and confused especially in the middle of the night. Report each night on effect."

In her response to my provisional opinion Mrs D stated:

> "Imovane was given to [Mrs B] to settle and calm. It was our understanding that [Dr E] had not prescribed Imovane to cause [Mrs B] to be '*drugged*' in any way.
>
> …
>
> [Mrs C] and I aimed to manage in particular [Mrs B's] behaviour by day rather than any objective to cause [Mrs B] to sleep at night. I specifically described to [Dr E] [Mrs B's] propensity to move about and hurt herself."

On 26 March 1999, Dr E prescribed "Imovane 7.5mg take half to one tablet at night, as directed". He noted on the Prescription Card that this medication was "to help sleep. May increase confusion, if it does let [Dr E] know so he can try something else." There was a note in brackets "(not being given as yet)". Imovane is a sleeping tablet with minimal residual effects, but can cause drowsiness on waking.

The Medication Administration Records show that the Imovane was included in the drug pack dispensed by the pharmacy for the month 7 April to 4 May 1999. As the staff member signing for Mrs B's daily medications signed for the blister and not the individual drugs contained in the blister, there is no indication whether a half or a whole tablet of Imovane was given, or in fact whether Imovane was withheld. It must be assumed, in the absence of any information to the contrary, that the medication was given as Dr E had directed, at night.

I note that Mrs C advised me that the sedative Imovane was first administered on 7 April 1999. However, Mrs D, in her response to my provisional opinion, stated:

> "It is wrong to '*assume*' that Imovane was given every evening and according to [Dr E's] instructions during this period. This is not the case at all. … Though the Imovane was prescribed by [Dr E] in April 1999, the drug was not included in [Mrs B's] medico blister pack, rather it came in a pharmaceutical small blister pack within a small box. Imovane was not actually administered to [Mrs B] until June 2000."

However, an entry in Mrs B's Resident Notes on 10 June 1999 by Mrs D records "half Imovane added to bedtime packs. Please continue to report on all that happens with [Mrs B]." I note that this entry subsequently had a line drawn through it.

The Medication Administration Records from 5 May 1999 to 13 June 2000 in relation to the blister packs do not include reference to Imovane. However, on the Medication Administration Record for 7 June to 4 July, an unsigned hand-written entry records "half a

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tab Imovane bedtime prn" and a further note "Imovane x half Breakfast/Bed". These notes were crossed out and the direction "Imovane 7.5mg ½ Breakfast and Bed" written at the top of the page. Mrs D confirmed to me that she had written this note. The medication record notes that half a tab 7.5mg Imovane was given on 30 June, 1 July and 2 July 2000.

In June 2000, Mrs D initiated regular Imovane for Mrs B. In response to my provisional opinion, Mrs D stated:

> "I had mentioned to [Dr E] that we did not want any drug prescribed that would cause [Mrs B] to become '*dopey*' and increase the number of falls. Rather, we wanted to reduce her falls. I had experienced elderly dementia patients at [the geriatric hospital] and I was all too well aware that it was a bad choice to '*drug*' a patient with dementia. Those were my words to [Dr E]. Given that [Dr E] had prescribed Imovane in April 1999, I believed that there was nothing out of order in June 2000 to administer Imovane to [Mrs B] given the circumstances."

A copy of a prescription form dated 1 July 2000 (supplied by the Health Centre) shows that Dr E signed a pharmacy generated prescription for 20 Zopiclone [Imovane] 7.5mg tablets for Mrs B, to be given "half to one tablet at night to help sleep".

On the Medication Administration Record for 5 July 2000 there is an unsigned hand-written note entered at the top stating "Imovane 7.5mg x half breakfast and bed prn". A further entry on the bottom of the record has been crossed out. The medication record itself records Imovane ½ breakfast and bed given on 4/7, 5/7, 8/7, 9/7, 10/7, 11/7, 12/7 and 22/7, although a hand-written note after the 12/7 records "sign on front now in pack".

A copy of a further prescription form dated 18 July 2000 (supplied by the Health Centre) shows that Dr E signed a prescription for 14 Zopiclone 7.5mg, and on 27 July another prescription for 28 Zopiclone tablets. The instructions on these forms was "Take half a tablet each morning and at night".

The medication administration record notes that from 19 July to 2 August 2000 Mrs B was given Imovane three times daily at breakfast, lunch and bedtime, except for 19, 20, 22, 31 July and 1 August, when the lunchtime doses were withheld.

Mrs D recorded in the nursing notes at 1.55pm on 21 August 2000 that staff were to discontinue the lunchtime Imovane, but to give Mrs B half a tablet at breakfast and to settle. (There is no previous reference in the nursing notes to Mrs B being given Imovane at lunchtime except for a staff's note that she gave the medication at lunchtime on 22 July.)

At 5.30pm on 21 August Mrs D amended her earlier instruction to staff and noted:

> "[Mrs B] will have to stay on Imovane for next 3–4 weeks: One full tab at breakfast and bed + ½ a tab at lunch time."

Mrs D informed me that she and Mrs C were going on holiday in August/September 2000. She said she wrote the instructions about increasing the Imovane to three times daily for

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three to four weeks, so that the staff would know how to handle Mrs B while they were away.

Mrs D stated that the use of Imovane was effective in that Mrs B did not get up and wander at night, which in turn reduced her falls and meant she was safer at night.

Mrs D provided no evidence that she had verbal or written authority from Dr E to alter the administration instructions or increase the dosage of Imovane for Mrs B. In her response to my provisional opinion Mrs D confirmed this and stated:

> "Given [Mrs B's] state of confusion and agitation as a result of her room changing in June 2000, I wrote on [Mrs B's] medication administration record '*Imovane x half at bedtime prn*'. I did this upon the basis and authority of [Dr E's] prescription issued in April 1999. On 30 June, Imovane was administered to [Mrs B] upon the basis of [Dr E's] prescription. Indeed, [Mrs B] was not given the full allowable dose as prescribed by [Dr E] but a half tablet at that time … Given that [Dr E] had prescribed Imovane in April 1999, I believed that there was nothing out of order in June 2000 to administer Imovane to [Mrs B] given the circumstances. We had avoided its use for over a year since it was prescribed by [Dr E] …
>
> As I understand it, prn means '*when necessary*' or '*as required*'. [Dr E] prescribed ½ to 1 tablet per night. Rather than increase the dosage over and above one tablet, a ½ tablet was given to [Mrs B] in the morning and a ½ tablet at night. Accordingly, frequency was increased as against the dosage. Later, on occasion a ½ tablet was included at lunchtime and thereby the dosage was increased by a ½ tablet. In the result, [Dr E's] prescription was mistakenly interpreted by me as a ½ tablet as required. Imovane certainly appeared to calm [Mrs B] and did not increase her confusion …
>
> I wrote up [Mrs B's] prescription card which was effectively an order form to maintain stocks of [Mrs B's] medication. The form was faxed to the pharmacy and the pharmacy would send it on to [Dr E] to check and authorise by signing. [Dr E] confirmed [Mrs B's] medication order by signing off the prescription card. It was for [Dr E] to determine [Mrs B's] medication including the amount and frequency of dosage.
>
> Had [Dr E] read [Mrs B's] medication notes, he would have been well aware of the times during the day that Imovane was administered. [Mrs B's] resident notes would reflect that she was administered a half tablet of Imovane in the morning, a half tablet at lunch and a half tablet at bedtime. … It is not true to state that [Mrs B] received one full tablet of Imovane at breakfast and a half tablet at lunch over three to four weeks. … That I misinterpreted [Dr E's] prescription, was by genuine mistake.
>
> As to the effect that Imovane had on [Mrs B], [Mrs B] was not in a drugged or knocked out state. It seemed to us that the drug had the desired effect of settling and calming her. [Mrs B] was not in a state of drowsiness. Indeed, we did not want that as we wanted to limit her falls as was reasonably possible in an effort to keep [Mrs B] safe. At times, [Mrs B] really was a risk to herself."

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Dr E admitted that he signed the prescriptions without checking them. He said that the only difference between the prescription he signed on 1 July and those for 18 and 27 July was the time that the medication was to be given. He said that he relies on the integrity and reliability of the nurses sending through the prescriptions.

Mr H, the pharmacist for the pharmacy, informed me that when the prescriptions came through for Imovane twice daily he contacted the rest home to ask that Dr E check the prescription, as it was not normal to prescribe Imovane in this manner. He advised that he was reassured by the person he spoke to that the alterations had been authorised, and supplied the Imovane as requested.

In her response to my provisional opinion, Mrs C stated:

> "… I am surprised that [Mr H] did not specifically ask to speak to [Mrs D] or me. We both know him and I do not understand it to be suggested that he spoke with either of us. However, I find it very hard to accept that any of my staff could have spoken to [Mr H] in the manner stated. Further, I am greatly puzzled as to why [Mr H] phoned the rest home rather than [Dr E]."

Mrs C also informed me that she had not understood that the administration of Imovane during the day to Mrs B was chemical restraint. She said: "[It] was not for our benefit, we thought we were keeping her safe." She said that she should have considered having Mrs B reassessed and moved to another facility: "We had intended to do this. We realised that we could not cope with her, but [Mrs A] did not want us to do that [move her to another rest home]. We have only genteel frail elderly here and we were out of our depth with [Mrs B]."

In response to my provisional opinion, Mrs C's lawyer stated:

> "At all relevant times [Mrs C] believed Imovane to be a drug prescribed by [Dr E] as a sedative that could be used by day or night and that it was specifically prescribed with reference to [Mrs B's] propensity to become agitated by day, move quickly and either fall or bruise herself on furniture. … [Mrs C] does not accept that the use of Imovane had any harmful consequences. To the contrary, she believes that on the days when it was used it reduced the risk of injury. … With the wisdom of hindsight she accepts without question that Imovane was not the correct drug in the circumstances. … [Mrs C] acknowledges that a mistake was made. On her behalf, I suggest that mistake must be considered in the context of comparable mistakes being made every day in hospitals and resthomes throughout New Zealand."

Informed consent

Mrs A advised me that she wanted her mother to be kept comfortable and safe without intrusive intervention. However, if she had been told about her mother's weight loss and it had been suggested that her mother have investigations (such as x-rays) to identify the cause, she would have consented. She also informed me that when Mrs C had suggested that her mother try a new drug for Alzheimer's and described the after effects of the medication, she declined to give her permission.

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Mrs B suffered two acute episodes of ill health while she was at the rest home, in June 1999 and February 2000. Mrs A was informed of these episodes but said that she was not informed of other matters relating to her mother's management, weight loss, and slowly deteriorating mental and physical condition. Mrs A said that the first she knew that her mother was acting inappropriately was when she read a portion of the nursing notes in October 2000, after Mrs B had left the rest home.

Mrs D informed me that Mrs A was "adamant that there was to be no intervention on behalf of her mother's symptoms". Further, in response to my provisional opinion, Mrs D stated:

> "It is my clear view that [Mrs A] knew of her mother's declining condition and that [Mrs A] knew of her mother's challenging behaviour. By way of illustration, [Mrs A] objected to the use of doll therapy …
>
> … I do not think that [Mrs A] was prepared to recognise and accept her mother's true condition."

With respect to the administration of medication Mrs D stated:

> "It is my understanding that permission is not strictly required each time there is a change in medication. I understood that the prescribing of the medication was left to the discretion of the doctor."

Mrs D further stated:

> "I specifically told [Mrs A] that if she agreed to her mother being transferred to a secure unit, there would be no need for [Mrs B] to be under any form of sedating medication. [Mrs A] was firm from the outset that we were doing well with [Mrs B] and that we were to keep doing what was required to look after [Mrs B] well. [Mrs A] was adamant that her mother was to stay at the rest home and that was that."

A 'Consent for Restraint Form' for Mrs B, completed by Mrs D and dated 16 June 1999, gave the reason for restraint as "confused, wandering and very unsteady on feet". The type of restraint nominated was "safety vest". However, there was no review date and/or duration for restraint noted, nor was there any record that the family or general practitioner were involved in the decision and consent for restraint.

In response to my provisional opinion, Mrs C conceded that she advised Mr and Mrs A, while Mrs B was in the public hospital (from 22 August 2000), that "we (at [the rest home]) had had to sedate [Mrs B] from time to time".

Mrs A confirmed that she met with Mrs C on 26 August 2000 to discuss why her mother's residency had been terminated. During this meeting she was told that her mother "had been under sedation and that this had been the case for some weeks. This was the first time that the issue of sedation was raised." She said that she had not given permission for her mother to be chemically restrained by the daily use of Imovane.

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Dr G, consultant geriatrician, supplied an affidavit in support of Mrs C's response to my provisional opinion. In relation to the matter of informed consent, Dr G stated:

> "It is impossible to lay down any hard and fast rule with reference to the degree of consultation that should take place between resthomes or medical practitioners and next of kin. …
>
> I believe that this complaint raises two important questions. The first is as to whether it is the doctor's or the resthome proprietor's responsibility to consult with next of kin. The second is as to whether any such consultation is required.
>
> In my opinion, with reference to a person in [Mrs B's] position, a medical practitioner should, where possible, consult with next of kin over all major medical decisions such as (non-urgent) surgery and I believe that resthome proprietors have a duty to assist in this regard or to ensure that such consultation takes place. (In many cases the resthome will have more immediate access than the medical practitioner to information as to who should be consulted.)
>
> However, I do not believe that there is any obligation on either medical practitioner or resthome proprietor to consult over more routine health and management decisions such as alterations or additions to medications. …"

Assessment of Mrs B's general health – Dr E

Mrs A alleged that Dr E failed to appropriately assess and adequately monitor Mrs B's general health and well-being over the period April to August 2000 when her physical condition deteriorated.

By the year 2000, Mrs B had been Dr E's patient for approximately seven years. Dr E advised me that, apart from visits about every three months to rest home patients, he responds to the needs of his patients as he becomes aware of them. In relation to Mrs B, Dr E provided routine three-monthly visits and relied on the rest home to notify him of any deterioration in her condition to prompt him to review her management. Dr E's notes demonstrate that he provided this level of care and was available for telephone and other consultations on request.

Mrs B suffered from congestive heart failure, failing eyesight and age-related dementia for which she was prescribed Renitec, Sotalol, frusemide and Adalat Retard at the time of her admission in late 1998. Dr E advised me that he checked all her medications at the time of routine visits.

On 20 February 2000 Dr E was notified that Mrs B had physically deteriorated. He found that she was dehydrated and instructed staff to encourage Mrs B with fluids and discontinued her diuretic medication, frusemide.

On 24 February 2000 Dr E recorded that Mrs B was "not eating or drinking much". He did not appear to be aware of her significant weight loss.

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Dr E informed me that following this episode he discussed with Mrs C and Mrs D having Mrs B reassessed with a view to alternative placement, but they advised him that the staff could manage her care.

Dr E next visited Mrs B in May 2000 and subsequently recalled:

> "The question of reassessment and alternative placement in another higher level of care rest home had always been a concern for me and this was discussed with the staff at almost every visit. On the 26.5.00 this consideration was mentioned in my notes. At that point the rest home seemed to be able to care adequately for [Mrs B] and this had to be weighed against the trauma of shifting her and the family's wishes. [Mrs B's] health had actually improved since my previous visit 3 months earlier."

Mrs D informed me that she thought that Mrs B might have been suffering from bowel cancer. She said, "I discussed this with [Dr E], but he was not particularly vigorous in discussing this matter with [Mrs A] or in suggesting some interventions for this problem."

With respect to the issue of falls, Dr E informed me that he did not know that Mrs B had had a series of falls. He said that the rest home should have notified him earlier about her falls. However, he was generally not called to see Mrs B outside his usual routine three-monthly visits and the falls were not specifically brought to his attention.

Mrs C informed me that Dr E had access to Mrs B's notes when he called to see her, and he would have been able to see the incident forms recording the falls in the notes. In her response to my provisional opinion, Mrs C commented:

> "Staff at [the rest home], like staff at all rest homes, daily investigate incidents, resident symptoms and what residents have to say about their health including aches and pains. The policy at [the rest home] (in common with most rest homes) has always been to err in favour of involving a resident's medical practitioner unless completely satisfied that such intervention is not warranted. In other words, [the rest home's] policy has always been to err in favour of involving a resident's medical practitioner if there is any doubt at all."

Dr E next saw Mrs B on 22 August 2000 when he was asked to assess her for hip pain. He assessed her and referred her to the public hospital for assessment of a suspected fractured left hip. As noted above, an x-ray at the hospital confirmed a fracture of Mrs B's left hip, which was operated on on 23 August 2000.

Prescription of Imovane – Dr E

Dr E said that he was not aware that Mrs B was causing difficulties for the nursing staff, and that had he known that this was the case, he would have insisted on a new assessment. He said he believed that the family were also unaware of the difficulties.

In contrast, in response to my provision opinion Mrs D stated:

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> "I clearly recall the conversation that I had with [Dr E] when [Mrs B's] medication was addressed. We were in the hallway outside [Mrs B's] room. I asked [Dr E] about the benefits of prescribing something to [Mrs B] in order to settle her. [Dr E] was asked for his recommendation …
>
> It was made patently clear to [Dr E] that [Mrs B] would benefit from being more settled as against being induced into a drugged state."

Dr E recalled that he charted the administration of Mrs B's sleeping medication (Imovane) to be given only if really necessary, no more than half to one tablet at night. It was to be stopped if it caused daytime drowsiness. Dr E said that he subsequently found that half a tablet of Imovane had been given to Mrs B at night and another half tablet given during the morning to help calm her down. He said that there was no verbal or written authority for this and it was a very dangerous practice.

Dr E advised me:

> "It was not and never has been my intention to use Imovane as a means of calming [Mrs B] (or any other patient for that matter). The rest home had no authority to change my instructions and should have informed me that they were doing this (especially given the warnings on the drug sheet). If uncertain they should have contacted me."

Dr E said that the Imovane prescription on Mrs B's drug sheet was self-explanatory. It was clear that he expected the medication to be administered to help Mrs B sleep at night, and only as required.

Dr E further stated:

> "[T]here was no plan whatsoever to use it as a means of daytime sedation. There is even mention on the drug sheet that I would prescribe something else if there were any problems with its intended use.
>
> After writing this out I left the rest home to administer it. I checked all the medications at the time of routine visits and there was no problem regarding this on 26.5.00. Sometime after this visit the rest home altered the instructions of the Imovane from ½ to 1 nocte prn, [at night, as required] to ½ noon, ½ nocte and forwarded it to the pharmacy.
>
> Unfortunately as I have about 50 scripts each month for patients in rest homes for me to sign it is difficult to always pick up small changes despite my best intentions. In this case the only difference was the timing of when the medication was to be taken. I am reliant on the integrity and reliability of the nurses and the pharmacists involved to convey my written instructions carefully and if in doubt to contact myself …
>
> I wish I had noticed the change in prescribing instructions on the script for Imovane sent to me to sign."

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Pharmacy information

The Health Centre supplied three prescription forms for Mrs B dated 1, 18 and 27 July 2000. The prescriptions were signed by Dr E. The prescription of 1 July was for Zopiclone (Imovane) 7.5mg tablets to be taken "half a tablet to one tablet at night to help sleep". Twenty tablets were dispensed. On 18 July the prescription for Zopiclone 7.5mg was increased to half a tablet each morning and night. The prescription was signed by Dr E, and 14 tablets were dispensed. The prescription written on 27 July included Zopiclone 7.5mg "take half a tablet each morning and at night". Twenty-eight tablets were dispensed.

Mr I, manager of the pharmacy, informed me that the pharmacy has supplied the rest home with medications for some years. The practice was for the rest home to fax the charted and signed 'prescription card' to the pharmacy. The pharmacist then converted this to computer generated prescriptions which were sent in batches to the GP to sign.

Mr I provided a copy of a Prescription Details Report which shows that four prescriptions of Zopiclone were dispensed for Mrs B from the pharmacy under Dr E's name, on 26 March 1999 and 1, 18 and 27 July 2000. Mr I recalled that when the prescription for a further 14 tablets of Imovane for Mrs B came in to the pharmacy on 18 July 2000, they had concerns that it appeared to be an excessive amount. Mr I recalled that Mr H, a pharmacist employed at the pharmacy at the time, telephoned the rest home to query the extra prescription.

Mr H confirmed that he telephoned the rest home to query the frequency of the dose of Imovane on the 18 July prescription, which had been changed to twice daily instead of once at night. He is unable to remember who he spoke to at the rest home, but remembers that he explained that the twice daily administration of Imovane was not normal, and cautioned that it might make the resident sleep all day. Mr H asked for the prescription to be checked with the doctor. He recalled that the prescription was confirmed as written and dispensed. He is unable to recall if any other action was taken.

Alteration of clinical records

Mrs C informed me that Dr E visited the rest home at around the end of August or early September 2001 when she and Mrs D were away, and removed Mrs B's clinical records. Mrs C said that during this time Dr E changed the details on the Prescription Card. Neither Mrs D nor Mrs C have provided details of the alleged alterations.

The Prescription Card for Mrs B (provided by Mrs C to me in December 2000) has entries by Dr E dating from 16 December 1998 until 15 June 1999. The Prescription Card (provided by Mrs C in November 2001) subsequently records an order for Microlax enemas, twice, Monday and Friday, and lactulose 20ml at night, dated 4 August 1999. The latter order does not appear to be in Dr E's handwriting and is not signed by him. A further entry for Augmentin 250mg three times daily for one week is recorded for 21 December 1999, signed by Dr E, and crossed out. None of these entries are germane to the issues under consideration in this complaint and, in particular, to the prescription of Imovane.

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Dr E's clinical notes recording his visits to Mrs B correspond to the entries on the Prescription Card, except for the prescription for 4 August 1999. There is no record in Dr E's clinical notes that he saw Mrs B on that date. The nursing notes for Mrs B for 7 August 1999 note that she was given lactulose 20ml that evening.

Dr E informed me that he uplifted Mrs B's clinical records from the rest home and photocopied them. He said that he did not change any of the notes retrospectively. Dr E said that the second Prescription Card, with the prescriptions for Microlax and lactulose for August 1999, and Augmentin for December 1999, were not included in the notes that he uplifted. He said that included in the notes he photocopied was a further Prescription Card written on 18 July 2000, not signed by him, that re-charted Mrs B's medications and specified the Imovane as half a tablet at breakfast and one tablet at night. There is no evidence that Dr E has retrospectively altered any of the details on the Prescription Card.

Ministry of Health audit

A Ministry of Health Licensing Office audit of the rest home in August 2000 resulted in a number of non-compliance findings and requirements relating to documentation and staff training. One of the findings was that although there were six-monthly reviews of resident care plans, there were no specific multidisciplinary meetings to review resident care. The report required that the management introduce a system for multidisciplinary review by 20 December 2000.

Mrs C informed me that the Ministry audit recommended that the home modify some of its policies to make the facility more attractive to Maori clients, and that there were one or two other minor policy adjustments to be made, but that there were no critical non-compliance issues.

Independent advice to Commissioner

Nursing advice
Mrs Jan Featherston, a registered nurse specialising in the care of the elderly, provided the following independent expert advice:

"My advice is based on reviewing supporting information as listed:

- Letter with attached documents to the Commissioner from [Mrs A] received 7 November 2000, marked with an 'A' (16 pages).

- Letter of response to the Commissioner from [Mrs C], Manager/Licensee [of the rest home], dated 15 December 2000, marked with a 'B' (9 pages).

- Copies of [the rest home's] clinical records, and policies and procedures relating to [Mrs B], dated 9 January 2000, marked with a 'C' (95 pages).

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- Transcript of telephone conversation with [Dr E], dated 15 January 2001, marked with a 'D' (1 page).

- Letter of response to the Commissioner from [Mrs D], received 20 February 2001, marked with an 'E' (8 pages).

- Prescription for Zopiclone (Imovane) 7.5mg prescribed by [Dr E], 1 July 2000, marked with an 'F' (2 pages).

Registered Nurses work under the Nurses Act 1997 as set by the Nursing Council of New Zealand.

The Nursing Council of New Zealand is a statutory authority and hence governs the practice of nurses and midwives. The Council's primary concern is public safety. The Nurses Act 1977 sets out conditions for registration of nurses. The Act restricts the right to practise as a nurse [to] those names entered in the Nursing Council Register and who hold a current practising certificate.

The Code of Conduct provides a guide for:

1. Public access to minimum standards expected of nurses and midwives.

2. Nurses and midwives to monitor their own performance and that of their colleagues.

3. Nursing Council to apply its judgement in determining professional misconduct.

There are four principles as criteria for the Code. They are:

1. Complies with legislated requirements.

2. Acts ethically and maintains Standards of Practice.

3. Respects the rights of patients/clients.

4. Justifies public trust and confidence.

[Mrs B] was admitted to [the rest home] on 13 December 1998.

Her reason for admission is listed in the medical notes as 'increasing frailty and early signs of dementia'. This entry is signed and dated 17/12/98.

Before residents are admitted to a facility, an assessment is undertaken by Disability Support Link. This assessment was undertaken on 10/12/98, three days before admission. At this time [Mrs B] was living in her own home with support services.

It lists her mobility as independent inside the home and requiring some assistance outside the home. It noted that [Mrs B] had not had any falls as yet.

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The assessment lists household tasks as being fully dependent and that neighbours had to prompt her to take medications. It lists most activities of living as being independent with the exception of medication taking and bed making.

It notes that [Mrs B] had poor vision – was able to follow and understand everyday conversations and had no hearing deficit. It notes her mental function as severe loss of memory for recent events and that she had some insight into her condition. It is stated: 'No anxiety, observes accepted social standards, had no evident difficulties finding way about, that she didn't wander, that behaviour at night was settled.'

The summary was that [Mrs B] was unsafe living at home and as family lived in [the city], that she would require rest home care. The assessment was discussed and signed by [Mrs B].

On admission to the rest home, the resident's notes entry dated 13/12/98 state that she 'can walk independently sometimes needing a walking stick … Eyesight is beginning to fail.' The entry is signed by [Mrs D].

Entry on 14/12/98 note base line recordings as: BP 130/80, BSL (blood sugar level), 6.2 Pulse 44, Weight 42kg.

The resident's care plan was written on 27 January 1999, 46 days after admission. The three entries list problems as being: 'Confusion due to old age, wanders around day and night'.

The action is listed as 'Give [Mrs B] gentle guidance, know where [Mrs B] is at all times'.

The desired outcome – keep safe and prevent agitation.

The second problem was: 'Prone to constipation'.

The action: 'Offer fresh fruit at meal times. Needs prompting when on toilet to do B.O.'

The outcome – Keep bowels regular, control faecal incontinence.

The third entry: 'Loss of appetite at times'.

The action – Encourage small meals, offer crackers and cheese between meals.

The outcome – Keep well nourished.

The second page of the care plan is written on 25/4/99. Lists 6 problems with appropriate action and desired outcomes. These include:

1. Wanders frequently.
2. Rolls soiled toilet paper up.
3. Increased risk of sacral pressure areas.
4. Prone to constipation.

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5. Unable to attend to self cares.
6. Loss of appetite.

Following the date 25/4/99, there are two entries dated 13/1/99. These list:

1. Sore eyes.
2. Feels the cold due to reduced weight.

The care plan is signed by [Mrs D]. The care plan was again rewritten on 1/6/00. The care plan reflects the progress notes in that [Mrs B] was becoming frailer and that behaviour in relation to wandering and bowel care was a concern for staff.

It is noted that there is no evaluation of the care plan, hence it is difficult to assess whether any of the actions and desired outcomes were met. The resident's progress notes could have been used to evaluate the care plan but it does not specifically specify this through the notes.

The medication chart was written on 16/12/98. Medication at that time included:

Penitec 2.5mg – used for hypertension congestive heart failure.

Zadine 1mg (antihistamine) – this was discontinued on 26/3/99.

Sotalol 80mg – antiarrhythmic drug.

Adalat Retard 20mg – management of angina in coronary artery disease.

Frusemide (diuretic) – this was discontinued (date unclear due to photocopying).

On 26/3/99 Imovane 7.5mg ½-1 nocte PRN was charted in the comments. It is written to help sleep – not to be given. May increase confusion if it does, let [Dr E] know so he can try something else.

The resident's notes outline the care and ongoing progress of [Mrs B].

It is evident that it took some time for [Mrs B] to settle. Staff have documented the times that she was out of bed and that she was very confused. Only five entries within the first week state that she appeared settled. These dates are: 16/12/98, 18/12/98, 19/12/98.

[Mrs B] constantly wandered into other people's rooms and woke other patients up.

Entry on 28/12/98 states that '[Mrs B's] family are very happy with the change in her, looking much more alert and appears to have put on some weight'.

Throughout the notes there are numerous entries of family and friends' contact. It includes phone conversations with daughter [Mrs A].

Dates include: 25/12/98

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24/1/99
8/99
9/99
11/99
23/1/99
21/2/00
29/2/00
23/3/00
24/3/00
12/4/00
27/5/00
24/6/00
26/6/00
27/7/00

(There may be others not documented.)

The resident's notes also show that [Mrs B's] state of confusion increased. She obviously had sleep problems and many nights were spent wandering around the home going into other people's rooms.

The notes also outline that bowel care was a major issue. There does not appear to have been a regular bowel pattern. Also, [Mrs B] was not orientated to toilet or commode as there are many instances of her smearing bowel motions in clothing, toilets and wrapping bowel motions up in clothing and newspaper.

Although these events are well documented, there is limited evidence that the family was informed of the deteriorating cognitive function. There does not appear to have been a family review, which would have outlined the level of deterioration.

Several entries in the notes state that [Mrs B] did not want to eat and refused meals.

On admission, weight was 42kg. Height was not recorded so it is difficult to determine desired weight. It must be noted that [Mrs B's] weight decreased to 38kg in September 1999, and finally to 32kg on 26/1/00, a loss of 10kg (22lbs). This is a significant weight loss for any elderly resident, but more significant due to the low weight on admission.

As stated, the care plan identifies a loss of appetite, but there is no ongoing evaluation. Such a significant weight loss should have alerted staff to look into the situation more carefully. There is a medical entry on 24/2/00 which states 'not eating, drinking much'.

There is no evidence that a consultant dietician was called. In a case where a resident had lost so much weight in a short time, it would be current practice to seek advice. There is no evidence of high calorie drinks offered.

It is also documented in resident's notes that [Mrs B's] urine output was limited and on 21/12/99: '[Mrs B's] urine very blood orange in colour', and again on 9/12/99 'Urine dark colour', 23/1/00 'Passing small amounts of concentrated urine', 16/3/00 'Urine very bright orange in colour'.

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These comments would indicate that [Mrs B] was dehydrated.

Dehydration in the elderly can cause confusion, tongue dryness, dry mucous membranes, speech difficulty, upper body weakness and loss of appetite. These clinical indicators can also be confirmed with blood tests where one would expect to see high haemoglobin, sodium, osmalility and blood urea.

There is no indication that blood tests or an assessment by a Registered Nurse was undertaken.

Drug administration

As stated previously in this report, drugs were charted on admission.

Imovane was charted on 26/3/99.

Imovane is a hypnotic (sleeping pill) which rapidly initiates and sustains sleep without reduction of total REM sleep. Negligible residual effects are seen the following morning. Imovane has a short half-life approximately 5 hours (this is the time it takes for ½ the tablet to be utilised by the body). Adverse effects are listed as: No serious adverse reactions have been seen. Common side effect is after-taste. Drowsiness on waking can sometimes occur and more rarely uncoordination. (Information taken from New Zealand Ethicals 4th Edition 1992.)

It must be noted that [Mrs B] was a very frail lady who was in her 90th year and that this increases the potential for negative side effects.

The elderly are more sensitive to drugs and studies show the elderly 2–3 times higher risk of adverse effects.

Hence, it is my opinion that the comment 'may increase confusion' was very appropriate and that to let [Dr E] know gave guidance to nursing staff.

In reviewing the medication administration record, Imovane would appear to be included in the drugs pack from 7/4/99. It does not say whether half or one tablet was given. It is assumed the dose of Imovane was given every evening for one month from 7/4/99 to 4/5/99.

There is no evidence in the resident's notes that sleep disturbances improved within that month. In fact there was an entry on 3/4/99, which stated 'good shift, no getting up at all'. On 9/4/99 'Good today', then there is nothing written until 15/4/99. A period of 6 days where no documentation was written.

The next date that the Imovane appears on the medication administration record is 13/6/00 where on the bottom of the signing page is written:

- Imovane ½ a tab bed time PRN.

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Signed over the page are dates:

30/6 ½ 10pm
1/7 ½ 5pm
2/7 ½ 7pm

It is unclear whose writing it is.

Written in the resident's notes:

1/7/00 'Good settled night for [Mrs B]'
2/7/00 '[Mrs B] used bedroom chair instead of commode … assisted back to bed'.

The next drug signing sheet indicates that [Mrs B] received Imovane (dose unclear) at breakfast. This would have been from 5/7/00 to 18/7/00, weeks one and two.

On week 3 and 4, ½ Imovane is written at lunchtime by someone in handwriting at the top of the lunch entry. All lunch entries have been signed for. Some days the drug was withheld and other days it appears to have been given.

It appears to have been:

Withheld on 19/7/00
Withheld on 20/7/00
Given on 21/7/00
Withheld on 22/7/00
Given on 23/7/00
Given on 24/7/00
Given on 25/7/00
Given on 26/7/00
Given on 27/7/00
Given on 28/7/00
Given on 29/7/00
Given on 30/7/00
Withheld on 31/7/00
Withheld on 1/8/00

If the administration chart is correct then [Mrs B] was administered double the dose over the first two weeks from 5/7/00 to 18/7/00, and triple the dose (except for the dates it was withheld) from 19/7/00 to 1/8/00.

The reverse side of the page is the PRN administration record and this lists the dates and times of administration.

4/7/00 ½ 7pm
5/7/00 ½ 7pm
8/7/00 ½ 7pm
9/7/00 ½ 7pm

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10/7/00 ½ 7pm
11/7/00 ½ 7pm
12/7/00 ½ 7pm
Then it is written 'Sign on front now in pack'.

On the entry lists:

22/7/00 ½ 12 noon – the corresponding front sheet states that 'WH' the drug was withheld at that time.

It must be noted that there was no medical order in the medical notes for this time. The last signed documented visit was 24/2/00. On 26/5/00 the entry reads 'V/B (visited by) GP routine' – this is signed by [Mrs D] and another entry 27/8/00 'V/B GP transferred to [the public hospital] for x-ray'.

The final drug sheet which commences on 2/8/00 has at the top Zopiclone 7.5mg (this is Imovane). It reads, 'Take half a tablet each morning & TA' (I am unsure what TA means).

This medication administration record has breakfast, lunch and bed tablets signed for.

It is noted that as the only drug chart for midday was Imovane and so it is assumed that the midday drug administered was Imovane.

It is also noted that it was WH(withheld) on 17/8/00 and 21/8/00.

If the drug medication chart is correct, the Imovane was commenced on a regular basis from 5/7/00. The resident's notes state that on 6/7/00 '½ Imovane tablet found on floor by commode'. An entry was made on 17/7/00 which states '[Mrs B's] Imovane has been added to the blister pack since last week'. This is signed by [Mrs D]. Another entry on 22/7/00 states '½ Imovane given at midday'. The next entry that mentions Imovane is on 21/8/00 which states '… ½ Imovane discontinued for lunch times. Still have ½ breakfast, ½ bed.' This is signed by [Mrs D]. Then at 5.30pm the entry reads: '[Mrs B] will have to stay on Imovane for next 3–4 weeks. 1–2 full tab at breakfast and bed and ½ a tab at lunchtime'. This is signed for by [Mrs D]. There is no evidence that the doctor was consulted.

Throughout this time there is evidence that family rang and spoke to nursing staff. Family in correspondence have stated that they are not aware of any increase in medication. They also noted that [Mrs B] was always sleepy. This would be supported by the amount of Imovane given and her general condition. Also noted was her weight of 32kg (5 stone 2lbs).

Also noted in that time was the number of falls that [Mrs B] had. Falls are listed:

2/6/00 (no incident form completed)
14/7/00
3/8/00

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11/8/00
11/8/00
21/8/00

The fall on 11/8/00 at 6.40 happened in the dining room. Again that day, [Mrs B] fell in her bedroom. The falls caused skin trauma and it is noted in the notes that dressings were applied to affected areas.

It is also noted that at this time [Mrs B] was receiving Imovane three times a day. The notes indicate that [Mrs B] complained of pain and discomfort.

The entry on 18/8/00 states that 'Was unable to stand (l) foot very swollen, cringed when placed on the floor, body stiff and achy'.

The notes show that the family rang the rest home at 8pm on 18/8/00 and visited on 20/8/00. The entry on 20/8/00 indicates that [Mrs B] '… told me her hip was sore'.

[Mrs B] had another fall on 21/8/00.

[Mrs B] was admitted to [the public hospital] on 22/8/00 with a fractured neck of femur.

In a letter by [Mrs A] dated 2/11/00, [Mrs A] states that they were advised by [Mrs C] that they were terminating [Mrs B's] residency.

[Mrs C], in a letter to [the Commissioner] states that she visited [Mrs B] in [the public hospital] on 25/8/00 and it was her opinion that it was not appropriate to return [Mrs B] to [the rest home].

It is my opinion that the care given in [the rest home] was not of reasonable care and skill. The opinion is formed for several reasons:

1. That the general physical condition and cognitive function of [Mrs B] deteriorated markedly over weeks following admission. Although the care plan was written which identified problems, no outside assistance was sought. This could have included psychogeriatrician referral. It was obvious that [Mrs B] was exhibiting extreme behaviour that was unsettling to herself, staff and other residents.

2. Family were not kept informed of [Mrs B's] deteriorating condition in relation to physical and cognitive impairment. This is acknowledged by [Mrs D] in her letter of 14/2/00.

   Family members had a right to know, and [Mrs B's] daughter had enduring power of attorney in relation to personal care and welfare. There is no evidence of informed consent.

3. That [Mrs B's] notes indicate that she had a large unexplained weight loss of 10kg within approximately one year. The notes also indicate that [Mrs B] may have been suffering from dehydration – lack of fluids. Although there was mention of

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concentrated urine, there was no appropriate Registered Nurse intervention, no monitoring of food and fluid intake was evident, apart from mention in progress notes. Current contemporary practice would have included a meal chart, fluid balance chart and once these were completed, an evaluation and appropriate plan.

4. Administration of Medications

[Mrs D] appears to have made medical decisions in relation to dispensing the drug Imovane. There is no evidence that the doctor, [Dr E], had increased this drug. The evidence supports his statement to [the investigation officer] that he was:

'dismayed when he found out that [the rest home] had been giving [Mrs B] Imovane during the day.'

It is my opinion that [Mrs D] failed to meet the competencies for Registered Nurse set by the Nursing Council.

Areas include:

3. Professional Judgement

3.4 Examines nursing situations, identifies and strategises effective nursing care.

4. Management of Nursing Care

4.1 Uses an appropriate nursing framework to assess and determine client health status and the outcomes of nursing intervention.

4.5 Uses professional judgement, including assessment skills, to assess the client's health status and to administer prescribed medication and/or to consult with the prescribing practitioner and/or to refer client to other health professionals.

4.8 Administers and monitors the effect of prescribed interventions, treatments and medications within a framework of current nursing knowledge and knowledge of pharmacology, physiology, pathophysiology, pharmacodynamics and pharmacokinetics.

4.10 Evaluates the effectiveness of the client's responses to prescribed interventions, treatments and medications and monitors prescribing, takes remedial action and/or refers accordingly.

6. Legal Responsibility

6.1 Complies with legislation that impacts on nursing practice within specific health care setting.

6.3 Practises in accord with relevant legislation and codes.

6.5 Ensures that legislation governing medicines is upheld.

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6.6 Administers interventions, treatments and medications within legislation, codes, scope of practice and according to authorised prescription, established policy and guidelines.

7. Ethical Accountability

7.3 Ensures that each client is fully informed to maximise the potential for decision making and choice.

7.9 Appropriately challenges health care practice which could compromise client safety, privacy or dignity.

9. Interprofessional Health Care

9.5 Collaborates, consults and refers to maximum health gains.

9.7 Accurately documents assessments of clients' health status, and decisions made about prescribed interventions, treatments, medications and referrals/follow-up.

9.8 Collaborates and consults with, and provides accurate information to client, client's family and other health professionals about the prescribed interventions or treatments and/or medications."

General practitioner advice
Dr Tessa Turnbull, a general practitioner with a special interest in the care of the elderly, provided the following independent expert advice:

"*Supporting Information*

- 'A': Letter with attached documents, to the Commissioner from [Mrs A] 7/11/2000.
- 'B': Copies of prescription forms for [Mrs B] for Zopiclone (Imovane) 1/7/2000 and 18/7/2000.
- 'C': Transcript of telephone conversation with [Dr E] 30/7/2001.
- 'D': Transcript of telephone conversation with [Dr E] 14/11/2001.
- 'E': Letter of response from [Dr E] to the Commissioner with attached prescription for Zopiclone 15/11/01.
- 'F': Letter of response from [the pharmacy] to the Commissioner with attached prescription for Zopiclone 22/11/01.
- 'G': Clinical records relating to [Mrs B] from [the rest home].
- 'I': Record of interview with [Mrs D], registered nurse [at the rest home].

Background

[Mrs B] was admitted to [the rest home] in … on 13 December 1998 [nearly] aged 89. She had previously lived in her own home with appropriate support. She is a private fee paying resident.

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The rest home licence allows only 5% of its residents to have a support needs level greater than 5 i.e. it caters very largely for level 4 residents.

[Mrs A], [Mrs B's] only child, lives in [the city] and is Welfare Guardian with an Enduring Power of Attorney, in respect of her property, personal care and welfare. She visited her mother at least monthly and was in touch by telephone several times a week.

[Dr E] was [Mrs B's] GP for 7 years, both in her own home, and in [the rest home]. [Mrs B] was classified as being 'level 4'. This is essentially a funding and access criterion for rest homes. It requires a routine GP visit every three months and any urgent visits are requested.

[Mrs B] suffered from controlled congestive heart failure, failing eyesight and age-related dementia for which she was prescribed Renitec, Sotalol, Frusemide and Adalat at the time of her admission in late 1998.

Many older and frailer people, especially with multiple medications are often dispensed these in monthly 'blister packs'. The pills are set out for taking at set times. They are often used in rest homes, either independently by an able person, or by rest home staff for frailer people. 'PRN' medications will be provided in separate bottles with the instructions annotated as per the doctor's instructions. [The rest home's] practice was to fax the charted and signed 'prescription card' to [the pharmacy]. The pharmacist then converted this to computer generated prescriptions which, in batches, were sent to the GP to sign.

On 16/3/99, [Dr E] charted Zopiclone '½ –1 tablet at night to help sleep' with the instructions for this to be given on an 'as required' basis. The chart is clearly annotated 'to help sleep. May increase confusion and if it does, let [Dr E] know so that he can try something else'.

[Dr E's] notes record the change in [Mrs B's] health status at his visit on 24/2/00 with confusion, loss of appetite and weight, constipation and later diarrhoea. Between this and his next visit on 26/5/00, [Mrs B's] health improved marginally, but her bowels and bladder were problems, as was her fluid intake and her increasing confusion became evident. Her support needs level would most likely have been assessed at level 5 at this time, should an assessment have been called for.

[Dr E] says that he checks all medications at the time of his routine visits and that Imovane was being given as directed at his routine visit on 26/5/00.

The 'residents notes' of 17/7/00 state '[Mrs B's] Imovane have been added to the blister pack since last week'. On the drug chart of 18/7/00 in the 'comment column' are the unsigned (by [Dr E]) instructions for '½ Imovane breakfast and nocte'.

On 22/7/00, the 'residents notes' record that ½ an Imovane tablet was given at midday. [Mrs D] admits that she altered the dispensing instructions for the Imovane. She accepts responsibility for this saying that 'she totally misread the PRN' and 'took it in the broadest sense'.

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[The pharmacy] queried the Imovane instruction with the rest home. The pharmacist concerned was sufficiently satisfied with the explanation not to query this further with [Dr E]. They provided extra loose tablets to cover the time until the next monthly blister pack was made up.

On 18/8/00 [Mrs A] phoned and was told her mother had had several falls. She visited three times on 19/20 August 2000 and found her mother either drowsy or asleep. Communication was impossible and this was evident on previous recent visits.

A further fall is documented on 21/8/00. The notes written at 1.55pm indicate that ½ Zopiclone was being given three times daily but the instruction was that it was now to be given twice daily.

At 5.30pm, it is clearly stated that [Mrs B] 'will have to stay on Imovane for the next 3-4 weeks', this being written by [Mrs D]. 'One full tablet to be given at breakfast and bed and ½ at midday'.

[Mrs D's] explanation for this was because 'we were planning to be away, I wrote the instructions in the notes so staff would know how to handle [Mrs B]. We did not discuss this with [Dr E].'

[Dr E] next visited on 22/8/00 when the fractured hip was diagnosed. However, the 'residents notes' indicate telephone contact between him and [Mrs D] on 18/7/00 with regard to the Frusemide dose to be given on an 'as required' basis for ankle swelling.

[Mrs B] had surgery to repair her fractured hip at [the public hospital] on 23/8/00. On 26/8/00 [the rest home] indicated to [Mrs A] they did not want [Mrs B] to return because of her high level of care need. She now resides in [a city suburb] where her health has improved somewhat.

History of documented falls

15/5/99, fall in puddle of urine in bedroom
29/11/99, fall in hall, no injuries
9/12/99, fall in bedroom, skin tears to leg
16/1/00, fall in hall, bump to head
18/1/00, fall from chair in lounge
21/5/00, fall from commode, minor injuries to head and shoulder
29/5/00, fall in bedroom, no injuries
3/8/00, fall in bedroom, skin split to scalp
11/8/00, second fall in bedroom, skin tear to elbow
11/8/00, second fall in bedroom, skin tear to elbow

The 'residents notes' of 20/8/00 indicate that '[Mrs B] had reported that her left hip was very sore'.

21/8/00, fall in bedroom, skin tear right elbow
22/8/00, noted to have pain with weight bearing

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Checked by [Dr E] and referred to [the public hospital] with a fractured left hip. [Mrs D] says 'it was impractical to write all the incidents up'.

Advise the Commissioner whether the service [Dr E] provided [Mrs B] met professional standards when [Mrs B's] condition deteriorated and she suffered repeated falls

[Dr E] has been in general practice for 15 years and is a Fellow of the RNZCGP. He is enrolled in the MOPS (maintenance of professional standards) programme and in addition, is also involved in teaching and examining programmes for general practice. He is currently providing oversight for 4 GPs who are not yet currently vocationally registered. [Dr E] has continuing responsibility for care for elderly people in all rest homes in …. This included [Mrs B] in her transfer from her home to [the rest home].

Clearly, [Dr E] is a well-qualified GP who is continuing to maintain his standards and up-skill his provision of general practice.

[Mrs B's] classification was 'level 4' which requires a routine GP visit every three months and any urgent visits as requested. [Dr E's] notes demonstrate that he provided this level of care and was available for telephone and other consultations on request.

[Mrs B] suffered from controlled congestive heart failure, failing eyesight and age-related dementia for which she was prescribed Renitec, Sotalol, Frusemide and Adalat at the time of her admission in late 1998.

[Dr E's] management of her medical conditions seems entirely appropriate.

[Dr E's] notes record the change in [Mrs B's] health status at his visit on 24/2/00 with confusion, loss of appetite and weight, constipation and later diarrhoea. Between this and his next visit on 26/5/00, [Mrs B's] health improved marginally, but her bowels and bladder were problems, as was her fluid intake and her increasing confusion became evident. Only one fall is documented in the incident forms.

Her support needs level would most likely have been assessed at level 5 at this time, should an assessment have been called for.

[Dr E's] notes indicate that this was discussed at his visit 'but rest home managing at this stage, may need to be reassessed at some stage'.

[Mrs B's] health problems continued with 7 more falls being recorded as specific events. There may have been even more as [Mrs D] says 'it was impractical to write all the incidents up'.

It seems likely that [Mrs D] independently made the decision to manage this situation by using daytime Imovane as sedation and in increasing doses as time went by. She accepts that she did not consult [Dr E] about this. She did telephone him on 18/7/00 and specific instructions were conveyed and acted upon with the use of 'PRN' Frusemide to manage

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[Mrs B's] swollen ankles. There was no discussion of either the falls or the use of Imovane as daytime sedation.

As [Mrs B] was classified as a level 4 resident, it was [the rest home's] responsibility, as her primary carer, to notify [Dr E] of any change in her health status. He would assume all was well, or at least at the same level as at last seeing [Mrs B], unless he was notified otherwise between the routine three-monthly visits.

[Dr E] next visited on 22/8/00 when the fractured hip was diagnosed. It seems very likely that this occurred on or before 20/8/00 as the 'resident's notes' of 20/8/00 indicate that '[Mrs B] had reported that her left hip was sore'.

Once notified of the problem, he acted promptly and appropriately.

He signed the prescription form for [Mrs B], increasing the Imovane to twice daily when it was faxed to him by [the pharmacy] on 18/7/00.

On 16/3/99 [Dr E] charted Zopiclone '½-1 tablet at night to help sleep' with the instructions for this to be given on an 'as required' basis. The chart is clearly annotated 'to help sleep. May increase confusion and if it does, let [Dr E] know so that he can try something else.'

[Dr E] says that he checks all medications at the time of his routine visits and that Imovane was being given as directed at his routine visit on 26/5/00.

The 'resident's notes' of 17/7/00 state '[Mrs B's] Imovane have been added to the blister pack since last week'. On the drug chart of 18/7/00 in the 'comment column' are the unsigned (by [Dr E]) instructions for '½ Imovane breakfast and nocte'.

On 22/7/00, the 'resident's notes' record that ½ an Imovane tablet was given at midday. [Mrs D] admits that she altered the dispensing instructions for the Imovane. She accepts responsibility for this saying that 'she totally misread the PRN' and 'took it in the broadest sense'.

[The pharmacy] queried the Imovane instruction with the rest home. The pharmacist concerned was sufficiently satisfied with the explanation not to query this further with [Dr E]. They provided extra loose tablets to cover the time until the next monthly blister pack was made up.

[Mrs B's] regular prescriptions were made up in monthly 'blister packs' for dispensing at set times. Both Imovane, and later Frusemide, according to [Dr E's] instructions were 'PRN' medications. They will have been provided in separate bottles with the instructions annotated for dispensing. The chart for Imovane use is clearly annotated 'to help sleep. May increase confusion and if it does, let [Dr E] know so that he can try something else'. The pharmacist has written the computer prescription for [Dr E] to sign 'take ½ a tablet (of Zopiclone) to one tablet at night to help sleep'. This would have been the annotation on the bottle supplied to [the rest home].

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When [Mrs D] changed the instruction and faxed this to the pharmacy, the dispensing pharmacist was sufficiently concerned to query this with [the rest home] staff, but sufficiently reassured by the explanation not to query this with [Dr E].

The writing and dispensing of medications is very much a partnership between doctors and pharmacists. It is a complex field with considerable change. The GP will know their patient's medical condition and the pharmacist will have expert knowledge on the pharmacology side. Most GPs will have a positive working relationship with their local pharmacists and every single day, prescriptions are queried and changed for a variety of reasons e.g. appropriate dosages, drug interactions and so on.

It is unfortunate that the consultation was between the pharmacist and [the rest home] and not directly with [Dr E] as it is clear that [Dr E] had no intention for Imovane to be used as a daytime sedation.

Imovane is never prescribed for daytime use under any circumstance except in anaesthesia or as a drug of substance abuse.

It is common practice for pharmacists to send doctors bundles of prescriptions to be signed and returned. This happens when scripts are changed, for telephoned scripts and it is usual practice for rest home prescriptions.

Doctors usually take it on faith that the scripts are written as discussed with the pharmacist or true to those they signed in rest homes/private hospitals. This means that it would be usual for doctors to do as [Dr E] did i.e. sign the prescriptions in good faith without scrutinising them closely.

However, doctors and other prescribers are legally responsible for the prescriptions they sign. [Dr E] has accepted that his practice in this regard was sloppy. He has accordingly changed this to one of 'best practice' by signing only scripts that have a photocopy of the original drug sheet accompanying them.

In conclusion, [Dr E] accepts that he fell short in his legal responsibility by signing prescriptions without close scrutiny. There is no evidence he directly provided care to [Mrs B] that was below standard except by being drawn unwittingly into a process of collusion and unprofessional care by the rest home.

Any other issues raised by the supporting documentation?

This is an appalling case of elder abuse by a rest home.

It is unclear to me whether the manager [Mrs C] was also involved in the collusion, but her letter to [Mrs A] of 15/9/00 has several false or misleading statements.

[Mrs D] appears to have been the prime instigator of the totally inappropriate use of Imovane as daytime sedation for [Mrs B] and went to considerable lengths to do this. As a registered nurse with considerable experience in the care of the elderly, it is not possible for her to have been ignorant of its side effects. She must have falsely supplied

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the pharmacist information that [Dr E] had given verbal instructions for Imovane to be used during the day and that he would later sign this on [Mrs B's] medication chart.

It seems likely that by instructing in writing the nursing staff at [the rest home] to use increasing doses of Imovane, it was not intended to update [Mrs B's] support need level to the appropriate level of 5.

In addition, [Mrs B's] broken hip was not acted upon for several days by requesting a visit from [Dr E]."

Responses to Provisional Opinion

A lawyer responded on behalf of Mrs D. As part of the response the lawyer submitted an affidavit from Mrs D.

A lawyer responded on behalf of Mrs C and the rest home. As part of his response, the lawyer submitted affidavits from Mrs C, Dr G, a general practitioner, and an unsworn affidavit by Mrs F.

Additional advice to Commissioner

The following additional nursing and medical advice was obtained in light of the responses to my provisional opinion.

Nursing advice
Mrs Featherston provided the following additional advice:

"I have been asked to review evidence provided which includes:

- The Commissioner's provisional opinion
- [The lawyer's] response to the provisional opinion on behalf of [Mrs C] which includes:
  - Sworn affidavit from [Mrs C]
  - Sworn affidavit from [Dr G], geriatrician
  - Sworn affidavit from [the general practitioner]
  - Sworn affidavit from [Mrs F]
- The solicitor's response to the provisional opinion on behalf of [Mrs D] which includes:
  - Sworn affidavit from [Mrs D]
- [Dr E's verbal] response to the provisional opinion
- [Mrs A's] response to the provisional opinion

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and have been asked to advise on:

Whether the treatment and care [Mrs B] received relating to her weight, dehydration and falls was reasonable in the circumstances.

Following reading the affidavits from [Mrs C] and [Mrs D] I am still of the opinion that the Rest Home and staff did not supply [Mrs B] with reasonable care and skill.

Weight Loss

Both [Mrs C] and [Mrs D] state that the family were aware of [Mrs B's] excessive weight loss. Both state that they took all steps to encourage [Mrs B] to eat and drink and despite this she lost weight. There was very little evidence in the documentation provided that anything apart from encouragement to eat and drink was given. As I previously stated an accurate assessment should have been undertaken. This should have included a food chart, fluid balance chart, and alternative action to try to get [Mrs B] to eat. Following this the results should have been discussed with the Doctor and a referral sent to the dietician. The services for the elderly [in this area] may have had a community dietician or the facility could have consulted a private dietician. This action would be normal practice in aged care for such a rapid and large weight loss, in a person obviously underweight on admission. There are also available on the market high protein and high calorie drinks. These are commonly used to provide extra nutritional input for residents and patients that have weight loss or inadequate nutrition. These drinks are available to get without a charge or a minimal charge with a referral from a specialist. The usual action is the GP writes to the specialist and a letter is sent to the appropriate agency and a special authority number is issued with a code, which allows the facility to access the extra nutritional supplement through the chemist.

It would have been common practice for the Registered Nurse and the Licensee to be aware of this. If they were not then the dietician certainly would have been.

Many family members do not understand the significance of weight loss in the elderly, but it would be expected that a Registered Nurse with a number of years' experience should have.

An accurate documentation system would have supported the action that the nursing staff stated they took in relation to [Mrs B's] weight loss. There was very limited documentation in relation to weight loss.

The care plan, which was written, on 27/1/99 stated 'Loss of appetite at times'
The action 'Encourage small meals, offer crackers and cheese between meals'
The outcome 'Keep well nourished'
The second page was written on 25/4/99 and this included 'Loss of appetite'

In [Mrs D's] affidavit (page 11, 4.6) she states that 'both of us knew that [Mrs B] was receiving plenty of meals and fluids'.

If this was in fact the case then the weight loss would be of unexplained origin and this would have alerted the staff to investigate and discuss further the matter.

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There is obviously dispute as to whether the family were aware of this.

I support my original opinion that reasonable care was not taken in relation to weight loss.

Dehydration
I confirm my original opinion that the documentation indicates that [Mrs B] was dehydrated. I was unable to read the date that [Dr E] discontinued the Frusemide and the information supplied would indicate that it was stopped in February 2000. Both [Mrs D] and [Mrs C] state that staff were encouraged to increase [Mrs B's] fluid intake. [Mrs D] stated that she 'dipsticked' [Mrs B's] urine and it proved normal. She goes on to state that when it proved to be dark in colour, a note was put on the fridge to push fluids into [Mrs B].

Again the documentation system did not support this. The care plan should have had the information, which would have showed that the appropriate action had been initiated. I do not have the original documents to view but if this were the case then the documentation would show fluid balance charts, the clinical notes would show accurate assessment and appropriate action.

Falls
My original opinion noted the issues with falls and that [Mrs B] appeared to fall and that a number of times incident forms were not filled out.

The affidavit from [Mrs C] states:

[Mrs C] (page 4, 15) 'Minor incidents and near misses were not recorded.'

(Page 5,18) 'I have no doubt that the use of Imovane – rightly or wrongly, did, on the days it was administered, reduce the risk of falls. It achieved what I believed to be the desired result. It helped us to keep [Mrs B] safe.'

[Mrs D] stated that it was impractical to write up all the incidents when [Mrs B] bruised herself.

I do not accept this as a reason not to document the incidents that occur to residents.

Nurses have a responsibility to ensure that the assessment and care that is given is documented accurately. [Mrs B] was at high risk of falling and any adverse incident should have been recorded. This gives other health professionals an accurate paper trail to view and evaluate. What one nurse considers a near miss another could consider serious. This view is very subjective and does not follow good nursing practice nor does it follow competencies of practice required for nurses.

[Mrs C's] statement that she believed that the administration of Imovane achieved the desired result was in my opinion inaccurate.

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The documentation lists the date of the falls and [Mrs B] sustained injuries on 3/8/00, 11/8/00, 11/8/00, 21/8/00 at the time that Imovane was being administered.

It is my opinion that this statement was incorrect and that the documentation proves otherwise.

Whether [Mrs C] as rest home manager and enrolled nurse (who it appears from her affidavit knew that [Mrs D] had increased the dose frequency and amount of Imovane being given to [Mrs B]):
Should have taken any steps to prevent this?
If so, what should she have done?

[Mrs C] was the licensee for [the rest home] and as such has responsibilities in that role. She also is an Enrolled Nurse and in that role has responsibilities.

[Mrs C] stated (page 1, 2) 'I had never previously had a resident requiring sedation by medication and had no previous experience of the drug Imovane.'

There are many drugs that nurses could and do come across that are uncommon to them. This includes older drugs and new drugs that are on the market. It is the nurse's responsibility to ensure that they acquire themselves with the knowledge of these drugs and if in the event of doing so, they are unsure of the dose and what they are being used for, then they have a responsibility to question the use, dose and any issues related to that drug. The Enrolled Nurse works under the supervision of either a registered nurse or medical practitioner. It would not have been unusual for [Mrs C] to question [Mrs D] or the Medical Officer. The administering of medication should only have been administered from a drug chart documented by the doctor or, in emergency situation, by phone order.

It is my opinion that [Mrs C] had a responsibility as both the licensee and as an enrolled nurse to provide care and if, as appears the case, that she did not have the knowledge then she had a responsibility to acquire herself of the knowledge. This action would be normal practice for an experienced enrolled nurse and licensee."

General practitioner advice
Dr Tessa Turnbull provided the following additional advice:

"To provide further advice about whether [Mrs B] received an appropriate standard of treatment from [Dr E].

- whether the treatment and care [Mrs B] received from [Dr E] relating to her weight, hydration and falls was reasonable in the circumstances.

The new submissions give a clearer picture of [Mrs B's] health problems.

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That of [Mrs F], a concerned and impartial health professional, is very important because:

1. It gives the greatest insight into [Mrs B's] failing health prior to her admission to [the rest home]. It describes a number of falls, poor appetite, weight loss and dementia.

2. There is a clear indication of collaboration between [Mrs A], [Dr E] and [Mrs F] together with friends and neighbours, to support [Mrs B's] general health needs, initially in her own home and then in the decision to admit to [the rest home].

This picture is in contrast to her SNAPs assessment undertaken by Disability Support Link on 10/12/98 prior to her admission to [the rest home] which stated 'that she had not had any falls as yet'.

This discrepancy has probably occurred because the assessor took [Mrs B] at her word and there was not another person present, such as [Mrs A] or [Mrs F], to confirm or deny specific points. Elderly people, with escalating dementia, often present a more positive health picture to assessors than is the reality.

However, health or failing health is a spectrum. [Mrs B] in addition to increasing age related dementia, also had controlled heart failure and failing eyesight, and undoubtedly all the emotional problems inherent in moving from her home to rest home care.

It is clear, therefore, that the falls and the weight loss were part of the spectrum of failing health which started prior to her admission to [the rest home] and continued after her admission, accelerating in the last few weeks prior to her fractured hip.

Both [Mrs D] and [Mrs C] believed [Mrs B] had bowel cancer and discussed this possibility with [Dr E] and [Mrs A]. [Mrs A] did not want invasive investigations undertaken on [Mrs B] and this seems very reasonable under the circumstances of her general frailty and other health problems. [Dr E] supported this decision.

I do not believe that [Dr E] can be criticised for his treatment and care of [Mrs B] relating to her weight loss, dehydration and falls. It is clear [Dr E] was not given full indication of the extent or number of falls. The weight loss and dehydration were health issues discussed and managed appropriately in the earlier part of [Mrs B's] stay at [the rest home]. Furthermore, [Mrs A] had indicated that she did not want active intervention but 'care and comfort' for her elderly and frail mother.

In his affidavit, [Dr G] felt that the weight loss was significant and queried whether the responsibility for management/investigation of this was primarily medical ie [Dr E's] or the rest home. He comments on the various health factors that may have contributed to this and notes [Mrs A] discouraged invasive investigation of her mother.

I agree that [Dr E] had the primary responsibility for decisions regarding investigation of the weight loss but some of these would have needed to be in conjunction with [Mrs A]. He could have decided to take blood tests without [Mrs A's] approval, but would have

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needed to consult with [Mrs A] over a barium enema or referral to a geriatrician or psychogeriatrician.

[Dr G] doubts that dehydration was a major ongoing clinical issue except for times of intercurrent illness or aggravated by medication ie Frusemide. He does not feel that investigations such as blood tests would have been helpful.

I agree with him. There are indications that Frusemide may have been a factor at one stage and this was stopped. There was also intercurrent illness such as the episode of diarrhoea. [The rest home] appears to have taken reasonable steps to push fluids to assist hydration at this time.

- any further comments regarding the apparent collusion between [Mrs D] and [Mrs C] in relation to the prescription and administration of Imovane to [Mrs B].

[Mrs C] is an enrolled nurse and has a Rest Home Carers Certificate and Rest Home Managers Certificate. Her knowledge of medication is likely to be elementary but there was a close relationship between herself and [Mrs D] in the day-to-day care of the rest home clients. For example, [Mrs C] knew Imovane was being used for daytime sedation by [Mrs D] for [Mrs B] and she still feels that 'the use of Imovane ... reduced the risk of falls ... and helped us keep [Mrs B] safe'.

[Mrs D] is a registered nurse with considerable experience in the care of the elderly. [Mrs D] says that '[Mrs C] and I believed' that Imovane was 'a sedative that could be used day or night' and that it was 'specifically prescribed by [Dr E] in regard to [Mrs B's] agitation during the day and her ability to move about, quite quickly at times, and fall bruising herself'.

[Mrs D] made the decision to change a clear instruction by [Dr E] for '½-1 tablet at night to help sleep as required' to one of 'as required day and night'. She acknowledges rewriting the drug chart to include an escalating daytime use of the drug. She forwarded the amended drug chart to [the pharmacy] for dispensing. It is unfortunate that we will never know who the pharmacist spoke to at [the rest home] who wrongly indicated that daytime use of Imovane had been approved by [Dr E].

[Dr G] agrees that daytime use of Imovane was inappropriate. He says, 'That, perhaps fortuitously, this mistake did not have any adverse effects.'

I do not think that we can be sure of that, bearing in mind [Mrs B's] history of increasing falls, culminating in her fractured hip.

In her final few weeks at [the rest home], [Mrs D] and [Mrs C] hoped that by keeping [Mrs B] sedated day and night they would keep her 'safe'.

In these final few weeks, [Mrs B's] health problems outstripped the rest home's ability to care for her adequately. The decision to reassess her SNAPs level and move her to hospital level care should have been made at this time.

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[Mrs D's] decision to use Imovane for daytime sedation, with [Mrs C's] knowledge, and without consulting [Dr E], was not just risky practice but a dangerous one from [Mrs B] and [Mrs A's] point of view.

- any further comments regarding informed consent particularly in light of [Dr G's] affidavit.

I agree with all of [Dr G's] comments with regard to informed consent. The degree of consultation between rest homes, their clients and the doctors involved in providing medical management and care varies a lot according to individual circumstances. It is a partnership based on trust and professionalism and it requires good communication between all three parties.

Some families are content to accept that their involvement in clinical decision making is minimal, others prefer a more hands-on approach.

[Dr G] differentiates consultation over routine clinical decisions such as medication changes or blood/urine tests, where the family is not usually consulted, and that of major medical decisions eg specialist consultation, hospital admission or invasive tests such as a barium enema when the family is usually informed or involved. I agree that this would be normal practice.

When there is a very important decision, for example, to withdraw all medication, or to use or not use antibiotics for pneumonia in a frail elderly person, the family is always consulted.

Who physically makes the contact or talks with the family ie doctor or rest home/hospital staff, will depend on the individual circumstances at the time."

Dr Turnbull commented that she had not received a copy of Mrs C's initial response to the Commissioner and wished to review a further copy of the letter Mrs C sent to Mrs A on 15 September 2000. Dr Turnbull was sent copies of these letters and provided the following additional advice:

"Further comments:

1. I originally said: 'It is unclear to me whether the manager [Mrs C] was also involved in the collusion, but her letter to [Mrs A] of 15/9/00 has several false or misleading statements.'

   In the context of [Mrs C's] letter to [Mrs A] on 15/9/00, these refer to:

   Paragraph 5 discusses the earlier use of Imovane in the correct context. It then omits to mention the escalating, inappropriate and unauthorised use of Imovane for day time sedation initiated by [Mrs D]. This was misleading.

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2. I believe that [Mrs B] was likely to have fractured her hip in a fall as early as 11/8/00 but this was not recognised. The basis for my belief is the information contained in the residents notes:

   '11/8/00, second fall in bedroom, skin tear to elbow

   The "residents notes" of 20/8/00 indicate that "[Mrs B] had reported that her left hip was very sore."

   22/8/00 fall in bedroom, skin tear right elbow

   22/8/00, noted to have pain with weightbearing.

   Checked by [Dr E] and referred to [the public hospital] with a fractured left hip.'

   [Mrs C] says there was 'no indication that [Mrs B] was in pain directly related to a fall'.

   This is false as the residents notes detail.

3. There is ample evidence that [Mrs B] would have been reclassified as a SNAPs level 5, should this assessment have been asked for some weeks before her admission to [the public hospital]."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

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

RIGHT 7
Right to Make an Informed Choice and Give Informed Consent

1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

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Other Standards

Medicines Act 1981

…

3. Meaning of 'medicine', 'new medicine', 'prescription medicine', and 'restricted medicine' –

'Prescription medicine' means that a medicine that is declared by regulations made under this Act or by notice given under section 106 to be one that, except as may be permitted by regulations made under this Act, may be –

…

(c) Administered only in accordance with –

(i) A prescription given by a practitioner, registered midwife, veterinarian, or a designated prescriber; …

Medicines Regulations 1984

41. Form of Prescription –

Every prescription under these regulations shall –

(a) Be legibly and indelibly printed; and

(b) Be signed personally by the prescriber and with his usual signature (not being a facsimile or other stamp), and dated; and

(c) Set out the address of the prescriber; and

(d) Set out –

(i) The title, surname, initial of each given name, and address of the person for whose use the prescription is given; and

(ii) In the case of a child under the age of 13 years, the date of birth of the child; and

(e) Indicate by name the medicine and, where appropriate, the strength that is required to be dispensed; and

(f) Indicate the total amount of the medicine that may be sold or dispensed on the one occasion, or on each of the several occasions, authorised by that prescription; and

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(g) If the medicine is to be administered by injection, or by insertion into any cavity of the body, or by swallowing, indicate the dose and frequency of dose; and

(h) If the medicine is for application externally, indicate the method and frequency of use; and

(i) If it is the intention of the prescriber that the medicine should be supplied on more than one occasion, bear an indication of –

i. The number of occasions on which it may be supplied; or

ii. The interval to elapse between each date of supply; or

iii. The period of treatment during which the medicine is intended to be used; …

Imovane (Zopiclone] is listed in Part I of the First Schedule to the Medicines Regulations.

Safe Management of Medicines. A Guide for Managers of Old People's Homes (Ministry of Health, 1994)

PART 1
Ordering and Receiving Medicines

(a) Medicines must be authorised in writing on the Resident Medication Profile and signed by the resident's medical practitioner.

The Old People's Homes Regulations 1987

37. Obligations of licensee and manager – (1) Every licensee of a home shall take all reasonable steps to ensure at all times –

…

(c) That the home has an adequate procedure to assess the health needs of each resident on admission to the home, and that the home continues that assessment procedure while the resident remains in the home:

…

(2) Every manager of a home shall take all reasonable steps to ensure at all times –

(a) That the residents are adequately cared for with respect to their everyday needs:

…

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(d) That medicines intended for use by residents, and not held by the resident for whom they are prescribed, are kept in a locked cupboard;

(e) That a safe practice is adopted for the separation, dispensing, disposal, and destruction of medicines for use by residents.

NURSING COUNCIL OF NEW ZEALAND, CODE OF CONDUCT FOR NURSES (1998)

PRINCIPLE TWO

The nurse or midwife acts ethically and maintains standards of practice.

Criteria

The nurse or midwife:

…

2.3 is accountable for practising safely within her/his scope of practice;

2.4 demonstrates expected competencies in the practice area in which currently engaged;

…

2.8 observes rights and responsibilities in the prescription, possession, use, supply, storage and administration of controlled drugs, medicines and equipment;

…

PRINCIPLE THREE

The nurse or midwife respects the rights of patients/clients.

Criteria

The nurse or midwife:

…

3.2 provides information to enable the patient/client to exercise informed choice and consent to the delivery of professional nursing or midwifery care;

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COMPETENCIES FOR ENTRY TO THE REGISTER OF NURSES, APRIL 1999

…

4.0 Management of Nursing Care

The applicant manages nursing care in a manner that is responsive to the clients' needs, and which is supported by nursing knowledge.

Generic Performance Criteria

The applicant

4.5 Uses professional judgement, including assessment skills, to assess the clients' health status and to administer prescribed medication and/or to consult with the prescribing practitioner and/or refer to other health professionals.

…

6.0 Legal Responsibility

The applicant practises nursing in accordance with relevant legislation and upholds clients' rights derived from that legislation.

Generic Performance Criteria

The applicant:

6.5 Ensures that legislation governing medicines is upheld.

6.6 Administers interventions, treatments and medicines within legislation, codes, scope of practice and according to authorised prescription, established policy and guidelines.

…

NURSING COUNCIL OF NEW ZEALAND

STANDARDS AND CRITERIA FOR ASSESSMENT OF NURSING PRACTICE FOR ENROLMENT OF NURSES (September 1992)

STANDARD NINE

The applicant for enrolment takes the responsibility for own nursing actions within legislated confines of the enrolled nurse sphere of practice.

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STANDARD TEN

The applicant for enrolment is competent in observational skills which assist the registered nurse to make nursing decisions.

Opinion: Breach – Mrs D

Imovane

Mrs A alleged that Mrs D dispensed uncharted drugs and/or wrote unauthorised instructions to nursing staff in respect of Imovane to be administered to Mrs B.

The Medicines Act 1981 states that prescription medicines must only be administered in accordance with a prescription given by a practitioner or a designated prescriber. Imovane is a prescription medicine.

The Nursing Council of New Zealand has determined a number of performance criteria competencies that must be achieved if a registered nurse is deemed to be safe to practise. One requirement is that the nurse complies with relevant legislation.

Mrs D, as the registered nurse at the rest home, was responsible for the administration of medication to residents. Her job description specifically lists her role as including responsibility for Safe Drug Practice (see Appendix 6).

On 26 March 1999, Mrs B's general practitioner, Dr E, in response to a request by Mrs D for medication to assist in settling Mrs B, prescribed Zopiclone (Imovane) 7.5mg, half to one tablet at night for Mrs B to help her sleep. Dr E added the instruction that it was to be given on an "as required" basis. He also recorded that he was to be notified if any increased confusion occurred, since this is a known side effect of Imovane. If this occurred, Dr E's intention was (as recorded on the prescription card), to trial Mrs B on another sedative.

The Medication Administration Record and the Resident Notes for Mrs B record that Imovane was included in her monthly medication blister pack in April 1999. The administering staff signed that the medication in the blister pack was given, but did not specify whether half or one whole tablet was given, nor whether any specific medication, including the Imovane, was withheld.

Mrs D, in her response to my provisional opinion, stated that the Imovane remained unused in Mrs B's blister pack for some time, despite appearing in the list on the Medication Administration Record. In contrast, Mrs C advised that Imovane was first administered on 7 April 1999. This corresponds with the date on which Imovane was included in the monthly blister pack for Mrs B.

For the period May 1999 to June 2000 there is no record of Imovane being included in the blister pack, nor is there any evidence of it having been given to Mrs B, with the exception

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of the deleted reference to Imovane in the nursing notes of June 1999, which record "half Imovane added to bedtime packs …"

I am satisfied that Imovane was given to Mrs B in the evening during April 1999, in accordance with Dr E's instructions, although the exact date is uncertain. It then appears to have been discontinued – in favour of alternative measures instituted by Mrs D and Mrs C – at some stage prior to June 2000.

In June 2000, Mrs B was moved from a carpeted room to a new room with a vinyl covered floor. This move appears to have escalated Mrs B's confusion and led to extreme difficulty in managing her behaviour. As a result, Mrs D reinstituted the use of Imovane. She stated:

> "Given [Mrs B's] state of confusion and agitation as a result of her room change in June 2000, I wrote on [Mrs B's] medication administration record '*Imovane x ½ a tab bedtime prn*'. I did this on the basis and authority of [Dr E's] prescription issued in April 1999. On 30 June then, Imovane was administered to [Mrs B] upon the basis of [Dr E's] prescription. Indeed, [Mrs B] was not given the full allowable dose as prescribed by [Dr E] but a half tablet at that time.
>
> …
>
> Given that [Dr E] had prescribed Imovane in April 1999, I believed that there was nothing out of order in June 2000 to administer Imovane to [Mrs B] given the circumstances. We had avoided its use for over a year since it was prescribed by [Dr E]."

The records show that Mrs B was given half an Imovane tablet to settle at bedtime on 30 June, 1, 2, 4, 5, 8, 9, 10, 11 and 12 July.

Mrs D further stated:

> "On reflection, I accept that it would have been prudent to have [Dr E] re-endorse his prescription i.e. update it. Nevertheless, I held an honest belief that there was no requirement to refer to [Dr E] in June 2000.
>
> The use of Imovane was causing [Mrs B] not to get up and wander during the night. This in turn had the effect of reducing her falls. [Mrs B] was therefore safer at night.
>
> As I understand it, prn means '*when necessary*' or '*as required*'. [Dr E] prescribed a half to one tablet per night. Rather than increase the dosage over and above one tablet, a half tablet was given to [Mrs B] in the morning and a half tablet at night. Accordingly, frequency was increased as against the dosage. Later, on occasion a half tablet was included at lunchtime and thereby the dosage was increased by a half tablet. In the result, [Dr E's] prescription was mistakenly interpreted by me as a half tablet as required.
>
> …

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> I wrote up [Mrs B's] prescription card which was effectively an order form to maintain stocks of [Mrs B's] medication. The form was faxed to the pharmacy and the pharmacy would send it on to [Dr E] to check and authorise by signing. [Dr E] confirmed [Mrs B's] medication order by signing off the prescription card. It was up to [Dr E] to determine [Mrs B's] medication including the amount and frequency of dosage."

Mrs D admits that she changed Dr E's prescription of Imovane without consultation with Dr E and contrary to his earlier prescription instructions. Mrs D sent the revised prescription to the pharmacy to type up and send to Dr E to sign. Dr E has confirmed that during July 2000 he received three prescriptions for Imovane for Mrs B from the pharmacy to sign. Dr E was unaware of the change to the dosage and did not check the prescriptions before signing, relying upon the integrity of the rest home staff to advise him of any changes.

The supplying pharmacist telephoned the rest home to query the altered instructions and the additional Imovane prescribed for Mrs B. He could not recall to whom he spoke. He explained that twice daily administration of Imovane was not normal and cautioned that this amount of Imovane would make Mrs B very sleepy. The pharmacist was sufficiently satisfied with the explanation he was given not to query the matter further with Dr E, and provided extra loose tablets to cover the time until the next monthly blister pack was made up.

From 18 July the Non Packaged or PRN section of the Medication Record for Mrs B shows that Imovane was given at breakfast in addition to the evening, and from 21 July (apart from a few days) it was increased to three times a day, at breakfast, lunch and bedtime.

My nursing advisor noted:

> "If the drug medication chart is correct, the Imovane was commenced on a regular basis from 5/7/00. The resident's notes state that on 6/7/00 '½ Imovane tablet found on floor by commode'. An entry was made on 17/7/00 which states '[Mrs B's] Imovane has been added to the blister pack since last week'. This is signed by [Mrs D]. Another entry on 22/7/00 states '½ Imovane given at midday'. The next entry that mentions Imovane is on 21/8/00 which states '½ Imovane discontinued for lunch times. Still have ½ breakfast, ½ bed'. This is signed by [Mrs D]. Then at 5.30pm the entry reads: '[Mrs B] will have to stay on Imovane for next 3-4 weeks. ½ full tab at breakfast and bed and ½ a tab at lunchtime'. This is signed for by [Mrs D]. There is no evidence that the doctor was consulted.
>
> Throughout this time there is evidence that the family rang and spoke to nursing staff. Family in correspondence have stated that they are not aware of any increase in medication. They also noted that [Mrs B] was always sleepy. This would be supported by the amount of Imovane given and her general condition. Also noted was her weight of 32kg (5 stone 21bs)."

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Mrs D apparently believed, at the time she administered the Imovane, that she was doing so in accordance with the "as required" instructions from Mrs B's general practitioner, in order to keep Mrs B "safe". This was a totally inappropriate use of Imovane.

As a registered nurse with considerable experience in the care of the elderly, Mrs D should have known the effect this amount of Imovane would have on a very small, frail elderly woman. I note Mrs D's affidavit where she stated that in 1998 she attended a specific seminar in "medication administration with elderly residents". Mrs D's statement that she "mistakenly interpreted [Dr E's] instructions" indicates a significant lack of knowledge and insight, and seems inconsistent with her educational background and experience. I accept Mrs D's advice that, in administering Imovane to Mrs B morning and night (and at times at lunchtime), she was attempting to keep Mrs B safe. Nevertheless, she altered specific medical instructions in order to sedate a frail, elderly patient and control her challenging behaviour in an effort to keep her "safe".

Mrs D ought to have known that sedation prescribed "at night, prn" means that the medication is to be given at night, as required. It was never intended to be given over a 24-hour period, especially as Dr E had specifically annotated on the prescription, "to help sleep, may cause confusion". By 19 July 2000, Mrs B was being given ½ a tablet of Imovane morning, noon, and night – 1.5 tablets a day – in excess of the limit of one tablet prescribed by Dr E in a script he had not reviewed for over 15 months, and at variance with the evening-only instruction.

On 21 August 2000 at 5.30pm Mrs D noted in the clinical notes: "[Mrs B] will have to stay on Imovane for next 3-4 weeks:- 1 full tab at B/fast and Bed and ½ a tab at lunchtime." Accordingly, Mrs D's instructions to staff were to increase the Imovane to a thrice-daily dose totalling 2.5 tablets – 1.5 tablets more than the maximum ordered by Dr E. This was a significant departure from Dr E's prescription and cannot be described as "a mistake". It could have resulted in a major overdose for an elderly and frail patient. However, Mrs B was transferred to hospital the following day.

Mrs D acted in direct contravention of the Medicines Act, the Medicines Regulations, and the Nursing Council Code of Conduct for Nurses. In my opinion, Mrs D failed to provide Mrs B with services with reasonable care and skill in accordance with legal, professional and ethical standards and breached Rights 4(1) and 4(2) of the Code.

Deteriorating condition

Mrs A alleged that Mrs D failed to act appropriately to address her mother's deteriorating condition, and in particular her weight loss, dehydration and increasing number of falls over the period April to August 2000. She also alleged that Mrs D failed to seek advice and/or refer her mother for medical assistance following a series of falls in August 2000, which resulted in a fractured hip.

Weight loss

When Mrs B was admitted to the rest home on 13 December 1998, she weighed 42kg and was approximately 165cm in height. According to the Heart Foundation's body mass index

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calculations, she was markedly underweight. By September 2000 Mrs B had lost 10kg (nearly a quarter of her already tiny weight) since her admission to the rest home in December 1998.

In June 2000, Mrs B's Care Plan identified that she was displaying inappropriate behaviour at meal times and had trouble chewing. Staff were instructed to provide her with puréed food and to ensure that she ate her meals in her room, to encourage her to concentrate more on her food.

Mrs D advised me that she gave the staff instructions to provide Mrs B with supplementary food and to monitor her intake. However, this did not appear to be formally or regularly documented in either a food chart or fluid balance chart. I acknowledge Mrs D's comment that, given the difficulties with incontinence and bowel management, an accurate fluid balance chart for Mrs B would have been difficult. Nevertheless, there is no indication that a formal assessment was ever undertaken; that food and fluid intake was consistently and regularly monitored; that nutrition management and weight loss (including regular weight measurements) was regularly evaluated; or that Dr E be asked to seek further advice from a geriatrician or a consultant dietician. Nor is there any documented evidence that Mrs D suggested to Mrs C, Dr E, or Mrs A that Mrs B be assessed to exclude an organic cause for her weight loss, even though Mrs D apparently suspected bowel cancer.

My nursing advisor commented:

> "Both [Mrs C] and [Mrs D] state that the family were aware of [Mrs B's] excessive weight loss. Both state that they took all steps to encourage [Mrs B] to eat and drink and despite this she lost weight. There was very little evidence in the documentation provided that anything apart from encouragement to eat and drink was given. As I previously stated, an accurate assessment should have been undertaken. This should have included a food chart, fluid balance chart, and alternative action to try to get [Mrs B] to eat. Following this the results should have been discussed with the doctor and a referral sent to the dietician.
>
> …
>
> This action would be normal practice in age care for such a rapid and large weight loss, in a person obviously underweight on admission."

Dehydration

At various points during Mrs B's residence at the rest home, she was reported as having very dark concentrated urine. Mrs D advised that Mrs B's urine was "dipsticked" and proved normal. When her urine was concentrated, Mrs D instructed staff to encourage Mrs B with extra fluids.

In her response to my provisional opinion, Mrs D stated:

> "Comment is made that dehydration can cause confusion. Frankly, [Mrs B] was in a permanent state of confusion and this was no doubt part of her dementia, not dehydration.

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…

I do not believe that [Mrs B] was dehydrated. [Mrs B] received a good deal of fluids … It was obvious to staff that [Mrs B] was receiving plenty of fluid as evidenced by the volume of urine that [Mrs B] would pass."

My nursing advisor commented that the documentation supports the view that Mrs B was dehydrated. In the absence of fluid balance charts and documented active intervention plans in respect of dehydration, there was no appropriate registered nurse intervention. My advisor noted:

"Current contemporary practice would have included a fluid balance chart and once [these] were completed, an evaluation and appropriate plan."

My advisor also commented that Mrs D could have taken the further step of seeking a review by Dr E and blood tests if the dehydration persisted. I note Mrs D's advice that she did draw Dr E's attention to the dark colour of Mrs B's urine and that the diuretic frusemide was discontinued.

Dr G, who provided an affidavit in support of Mrs C, and my general practitioner advisor, Dr Turnbull, doubted that dehydration was a major ongoing clinical issue in relation to the treatment and care of Mrs B, and did not consider that blood tests would have been helpful.

While I accept the advice of Dr Turnbull and Dr G that dehydration may not have been a major factor in Mrs B's deteriorating condition, it appears clear that Mrs B was dehydrated at times during her stay at the rest home. I concur with the advice of my nursing advisor that Mrs D, as the registered nurse responsible for the care of residents at the rest home,[1] should have ensured that Mrs B's dehydration was regularly monitored and reviewed, particularly in light of her deteriorating condition, escalating confusion and increasing number of falls. Instructing staff to encourage fluid intake, and suggesting that Dr E withdraw Mrs B's diuretic medication, was an inadequate response to the situation.

Increasing number of falls

When Mrs B was assessed for rest home care on 10 December 1998, the assessor noted that although she had poor vision she was independently mobile.

Nursing documentation and incident reports document a history of falls during Mrs B's residence at the rest home. Mrs D and Mrs C admitted that the falls were not always documented because it was impractical to write up all the incidents when Mrs B fell or knocked herself. My nursing advisor did not accept this reason for lack of documentation and noted that it did not follow good nursing practice. My advisor commented:

"Nurses have a responsibility to ensure that the assessment and care that is given is documented accurately. [Mrs B] was at high risk of falling and any adverse incident should have been recorded. This gives other health professionals an accurate paper trail

[1] See Registered Nurse Job Description (Appendix)

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> to view and evaluate. What one nurse considers a near miss another could consider serious. This view is very subjective and does not follow good nursing practice nor does it follow competencies of practice required for nurses."

On 2 June 2000, the nursing notes record that Mrs B fell in her room, sustaining a large skin tear to her forehead. I note that it was in early June, when Mrs B was transferred to an uncarpeted room, that her confusion escalated and her wandering and management became more difficult. In response, regular Imovane, half a 7.5mg tablet morning and night, was initiated by Mrs D. There were no other falls recorded until 14 July 2000. In late July 2000, the dosage of Imovane was increased. Mrs B was reported to have fallen four times in August 2000. There is no evidence that Dr E or Mrs A were notified of the increase in falls.

On 11 August the nursing staff reported that Mrs B fell at 6.40am and again at 7.15pm. The following day she was noted to be stiff and in pain. On 17 August she was noted to have abrasions and bruising on her left knee, and to be very stiff and fearful of moving from her bed to the chair. Mrs D instituted four-hourly Panadol for pain. On 18 August Mrs B's left foot was observed to be very swollen and she was unable to take weight on it, and on 20 August she complained of pain in her left hip. On 21 August, Mrs B suffered a further fall. The night staff reported that she was in considerable pain that night. Mrs D contacted Dr E on the morning of 22 August and informed him of her condition. He visited the home that day, examined Mrs B and, suspecting that she had sustained a fracture of her left femur, arranged for her to be transferred to hospital. The suspected fracture was confirmed by x-ray and Mrs B was admitted for surgical repair.

In my view, Mrs D failed to take positive steps to manage Mrs B's increasing frailty and propensity to fall, particularly after June 2000 when the room transfer clearly increased her level of agitation and the ability of staff to manage her behaviour. There is no evidence of any positive steps being documented in the resident care plan. To the contrary, the evidence is that Mrs D compounded the problem by initiating regular Imovane medication, a sleeping pill that can cause drowsiness on waking and lack of co-ordination. The elderly are more sensitive to drugs, and at higher risk of adverse effects from medication. This was particularly so in the case of Mrs B, who by mid 2000 weighed a mere 32kg.

Mrs D did not consider that the use of Imovane increased Mrs B's risk of falling. She stated:

> "The use of Imovane was causing [Mrs B] not to get up and wander during the night. This in turn had the effect of reducing her falls. [Mrs B] was therefore safer at night."

In my view, Mrs D's interpretation is not borne out by the evidence. There is evidence of increasing falls from July 2000, when Mrs B's Imovane dosage was increased. Furthermore, Mrs B was consistently noted by family and staff to be sleepy, disorientated, confused and shaky. Mrs B was severely underweight, undernourished and, at times, dehydrated, which would have exaggerated the effect of the sedation and increased her risk of falling.

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With regard to the falls in August 2000 culminating in Mrs B's fractured hip, I note that from 11 August Mrs B fell four times in 10 days and was recorded as being in pain with physical symptoms including stiffness, swelling and difficulty with weight bearing.

With respect to the allegation that Mrs D failed to refer Mrs B for medical assistance following a fall in August 2000, notwithstanding Mrs D's and Mrs C's evidence that Mrs B continued to weight bear at times, I consider that Mrs D (who was clearly aware that Mrs B was in pain from 17 August when she initiated regular Panadol for Mrs B) should have sought earlier medical attention for Mrs B.

In failing to respond appropriately to Mrs B's weight loss, her intermittent dehydration, her increasing number of falls and, in particular, the series of falls in August 2000 culminating in Mrs B's admission to hospital with a fractured hip, Mrs D failed to provide Mrs B with services with reasonable care and skill in accordance with professional standards, and breached Rights 4(1) and 4(2) of the Code.

Informed consent

Mrs A alleged that Mrs D failed to notify her of her mother's deteriorating condition and, in particular, failed to obtain her consent to the administration of Imovane sedation.

Deteriorating condition
On 12 November 1997 Mrs A was granted an enduring power of attorney in respect of personal care and welfare for her mother. This authorised Mrs A to consent to treatment for her mother when she was unable to do so for herself. Mrs B's mental condition deteriorated from the time she was admitted to the rest home in December 1998. I am satisfied that during the period under review, it was appropriate for Mrs B's care and treatment to be discussed with and agreed to by Mrs A.

Mrs A informed me that the first she knew of her mother's challenging behaviour was when she had the opportunity to read the nursing notes after her mother left the rest home.

Mrs D explained that she had made the decision not to inform Mrs A about the more upsetting aspects of her mother's condition. Mrs D stated:

> "I believe it is fair to say that [Mrs B's] behavioural decline was made patently clear to [Mrs A]. [Mrs A] was insistent that she was most happy with the care provided to [Mrs B] and that she did not want [Mrs B] sent to [the private geriatric hospital] or [another rest home more specialised for dementia patients].
>
> …
>
> [Mrs A] informed us that she was most happy with [Mrs B's] care. [Mrs A] told us to do whatever was required. Indeed, [Mrs A] wrote a note to the staff of [the rest home] expressing her appreciation for the kindness extended to her mother."

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In relation to consent for tests and treatment for Mrs B, Mrs D stated:

> "[Mrs A] was quite clear that she did not want tests to be done on [Mrs B] to determine in particular whether there was a primary cause for [Mrs B's] loss of weight, and this I understood in part.
>
> …
>
> [Mrs A] instructed us to keep her mother comfortable. [Mrs A] objected to the use of a barium enema with a view to assessing [Mrs B's] bowel."

In contrast, Mrs A said that when Mrs C suggested that her mother undergo various examinations, she declined to give permission because she did not wish to subject her mother to unnecessary examinations, particularly where the side effects or intervention appeared intrusive. Mrs A said that if she had been told about her mother's weight loss, and it had been suggested that her mother have investigations to identify the cause, for example x-rays, she would have consented.

As noted by my nursing advisor, although the events relating to Mrs B's behaviour are well documented, there is limited evidence that the family was informed of her deteriorating cognitive function. When a resident's health status changes, family members should be consulted. My advisor stated that a family review would have outlined the level of deterioration, providing an opportunity to discuss appropriate ongoing management and the need for referral to a facility better able to manage Mrs B's deteriorating mental and physical condition.

The Nursing Council's Code of Conduct for Nurses, Principle Three, states that a nurse must provide information to enable the client to exercise informed choice and consent to the delivery of professional nursing care. In this case, as Mrs B's ability to understand information and exercise choice was significantly compromised by her dementia, Mrs A was the appropriate person to consult.

Mrs D was the registered nurse employed at the rest home to plan, deliver and supervise professional nursing care.[1] She was the person best placed to initiate discussion about the management of Mrs B's condition, by bringing it to the attention of Mrs C and/or Dr E, who could initiate contact with Mrs A as Mrs B's power of attorney in respect of personal care and welfare. Mrs D also had the opportunity to discuss Mrs B's care with Mrs A directly. Mrs D has stated that such discussions did take place and that while "[Mrs A] was spared the indignity of knowing some of the more unpleasant aspects of her mother's condition, … [Mrs B's] behavioural decline was made patently clear to [Mrs A]". There is starkly conflicting evidence as to Mrs A's knowledge of Mrs B's deterioration. In these circumstances, I am unable to conclude that Mrs A was not informed of her mother's deteriorating condition.

[1] See Registered Nurse Job Description (Appendix)

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Imovane
Mrs A informed me that she was unaware that her mother had been sedated with Imovane. Further, she had not given permission for her mother to be chemically restrained by the daily administration of Imovane.

Mrs D, in response to my provisional opinion, stated:

> "With respect to the administering of medication. It is my understanding that permission is not strictly required each time there is a change in medication. I understood that the prescribing of medication was left to the discretion of the doctor."

Dr G (who provided advice in support of Mrs C) commented that families often differ in their desire to be involved in decision making, and whether it is the doctor or the rest home staff who contacts or talks to the family depends on the individual circumstances at the time. Dr G stated:

> "[A] medical practitioner should, where possible, consult with next of kin over all major medical decisions, such as (non-urgent) surgery and I believe that rest home proprietors have a duty to assist in this regard or to ensure that such consultation takes place."

My general practitioner advisor, Dr Turnbull, noted:

> "I agree with [Dr G's] comments with regard to informed consent. The degree of consultation between rest homes, their clients and the doctor involved in providing medical management and care varies a lot according to the individual circumstances. It is a partnership based on trust and professionalism and it requires good communication between all three parties.
>
> Some families are content to accept that their involvement in clinical decision making is minimal, others prefer a more hands on approach.
>
> [Dr G] differentiates consultation over routine clinical decisions such as medication changes or blood/urine tests, where the family is not usually consulted, and that of major medical decisions e.g. specialist consultation, hospital admission or invasive tests such as a barium enema when the family is usually informed or involved. I agree that this would be normal practice.
>
> When there is a very important decision, for example, to withdraw all medication, or use or not use antibiotics for pneumonia in a frail elderly person, the family is always consulted. Who physically makes the contact or talks to the family i.e. doctor or rest home/hospital staff, will depend on the individual circumstances at the time."

Mrs D was the registered nurse employed at the rest home with primary responsibility for safe drug practice. By her own admission, she initiated discussions with Dr E regarding sedation for Mrs B in April 1999. As such, she was the person best placed to initiate discussion with Mrs A regarding medication management. She did not do so. Arguably, at that point, night-time sedation with Imovane may not have constituted a major decision for which consent was required. However, in initiating a significant increase in Mrs B's

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Imovane medication between June and August 2000, in an effort to manage Mrs B's escalating confusion, wandering and challenging behaviour and keep her "safe", Mrs D made a major decision, which required Mrs A's consent. In taking these actions without the explicit knowledge and authority of Dr E (as Mrs B's general practitioner) or Mrs C (as the rest home manager), she not only denied Mrs A the opportunity to give consent, but also prevented any meaningful consultation or discussion between Mrs A and Dr E and/or Mrs C.

Mrs D clearly believed that Mrs A trusted the professional decisions of the team at the rest home, and that in taking the steps she did in relation to Mrs B's deteriorating condition, she was acting in Mrs B's best interests. However, as Mrs B's daughter and power of attorney, Mrs A was entitled to be informed of any major decisions in relation to her mother's care. In denying Mrs A this opportunity, Mrs D administered sedation to Mrs B without consent and therefore breached Right 7(1) of the Code.

Opinion: Breach – Mrs C

Mrs A alleged that Mrs C failed to respond appropriately to Mrs B's deteriorating condition and, in particular, her weight loss, dehydration and increasing number of falls. She also alleged that Mrs C failed to seek advice and/or refer Mrs B for medical assistance after a series of falls in August 2000.

Mrs C was responsible under the Old People's Homes Regulations 1987 for the day-to-day care of residents at the rest home. She was on the premises daily and was best placed to discuss with Mrs A the issues relating to Mrs B's care. Mrs C was responsible for planning Mrs B's day-to-day care and seeking medical advice when necessary. She was assisted by the registered nurse, Mrs D.

Management of care

Weight loss
As the manager of the rest home with responsibility for managing the day-to-day care of residents, Mrs C should have been aware of Mrs B's ongoing health problems and management, and of her significant weight loss. It was her responsibility, in conjunction with her staff, to respond appropriately to any issues about the welfare of residents.

In response to my provisional opinion, Mrs C confirmed that she was aware of Mrs B's weight loss and that she could "clearly recall discussing [Mrs B's] weight loss with [Mrs A] from time to time". Mrs C further stated:

> "It was my personal opinion throughout that [Mrs B] had bowel cancer and that that was the probable cause of her steady weight loss/physical deterioration. I know that [Mrs D] was of the same opinion. I personally discussed my opinion with [Mrs A] and I am aware that [Mrs D] discussed the matter with [Dr E]. [Mrs A] acknowledged my opinion and [Dr E] did not disagree. However, [Mrs A] expressly prohibited any

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> invasive investigation into the cause of her mother's deterioration. Contrary to what [Mrs A] has said, I clearly recall discussing with her the possibility of exploratory x-rays in the hope that the cause of [Mrs B's] deteriorating condition might be identified in that way. [Mrs A] told me that she believed x-rays would be too invasive and, in the circumstances, were unnecessary."

Mrs C was assisted in the management of the residents' care by the registered nurse, Mrs D. As noted above, Mrs D directed the staff to offer Mrs B supplementary food. It is reasonable to assume that Mrs D would have discussed this with Mrs C. While I acknowledge that Mrs C felt unable to take any further steps to arrange investigation of Mrs B's weight loss, there is no evidence in the nursing records or in the Resident Care Plan that Mrs C or Mrs D considered a specific plan to respond to Mrs B's weight loss. Only three entries in the Resident Care Plan for Mrs B refer to diet with the desired outcome of ensuring good nutrition. The guidance to staff is restricted to directions to ensure Mrs B ate her meals in her room, that foods be puréed where possible, and that Mrs B be offered crackers and cheese between meals, and Complan and soups where required.

My nursing expert advised me that when significant weight loss in a resident has been identified, particularly where the resident is significantly underweight on admission, it is appropriate for the issue to be raised with the GP, who can obtain special authority for extra nutritional supplementation. There is no documentary evidence that this issue was discussed with Dr E or that there was any plan to refer Mrs B for further assessment by a geriatrician and/or consultant dietician.

Dehydration

Between December 1999 and March 2000 Mrs B was reported as having very dark concentrated urine from time to time. Her food and fluid intake declined in February 2000. Mrs C has accepted that Mrs B was almost certainly dehydrated at times over the period December 1999 to February 2000. Mrs C stated: "I understand it to be acknowledged that this was probably a side effect of the diuretic Frusemide prescribed by [Dr E] and that, accordingly, [Dr E] cancelled the Frusemide. At the same time, staff were instructed to increase [Mrs B's] fluid intake." I accept that these were appropriate steps. However, it is well known that dehydration in the elderly can cause confusion, upper body weakness and physical deterioration. All of these factors would have increased Mrs B's confusion, falls and general deterioration. The ultimate responsibility for the welfare of Mrs B lay with Mrs C, as manager at the rest home. Mrs C appears to have relied solely on Mrs D to manage Mrs B's dehydration.

In my opinion, Mrs C should have taken positive steps to ensure that Mrs D was regularly monitoring and reviewing Mrs B's hydration status, and documenting the required actions for staff. Consideration should have been given to referral for assessment by a geriatrician and/or more regular review by the general practitioner. This did not occur.

Repeated falls

It is not disputed that Mrs B was admitted to the rest home because of the concerns of the district nurse, Mrs F about her safety in the home. Notwithstanding Disability Support Link's assessment form suggesting that Mrs B was independent with mobility and "has not

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had any falls as yet", Mrs F's evidence indicates that Mrs B had fallen in her own home prior to her admission to the rest home.

The nursing records and incident forms provided to me show clearly that Mrs B continued to fall or knock herself frequently at the rest home.

Mrs C had been the manager of the rest home since 1979. She is an enrolled nurse with considerable experience in the care of the elderly. In my view, she ought to have known that the number of falls by Mrs B was of concern, and ensured that the rest home responded with an appropriate management plan.

In her response to my provisional opinion, Mrs C stated:

> "From the very first day we discovered that the risk that [Mrs B] would injure herself in a fall was greater than anyone had anticipated. There were several factors contributing to this. Firstly, she was unsteady on her feet at the best of times. Secondly, she was at times very mobile and, because of her dementia, unpredictable. Thirdly, her preferred footwear was socks only and there was a constant risk of her slipping on polished floors. (I purchased rubber adhesive which I applied to the soles of [Mrs B's] socks.) On days when she was particularly active, she moved quickly when not supervised on a one to one basis and was often found in unfortunate circumstances …"

I acknowledge that Mrs C took some steps to minimise the danger of Mrs B slipping on polished floors. Mrs B was supplied with arm and leg protectors/padded sheaths and, on days when she appeared particularly agitated, was provided with one-to-one diversion therapy.

Nevertheless, where there is identified risk of falling, positive measures must be taken to monitor and evaluate the risk. One measure is to consistently record the circumstances of falls and develop strategies to minimise risk, in consultation with the resident's doctor and family.

Mrs C acknowledged that separate incident reports were not always written up for falls. Nor does there appear to have been a planned approach to the management of falls. Instead, Mrs D initiated the use of regular Imovane to sedate Mrs B in an effort to keep her "safe" and reduce the risk of her falling. Mrs C confirmed that she was aware of the use of Imovane for Mrs B, in the following statement:

> "I have no doubt that the use of Imovane – rightly or wrongly, did, on the days it was administered, reduce the risk of falls. It achieved what I believed to be the desired result. It helped to keep [Mrs B] safe."

With respect to the series of falls in August 2000, it is clear that Mrs C was aware that Mrs B was complaining of pain over a number of days prior to 22 August 2000. Nursing documentation recorded complaints of pain, swelling, and reports of hip pain over this period. Such consistent complaints were not a feature of earlier nursing documentation for Mrs B.

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Mrs C has stated that "the true position is that over a number of days prior to 22 August 2000, [Mrs B] complained of a number of aches and pains. That was a common pattern. Every such complaint or comment was investigated carefully." However, the documentation does not support Mrs C's submission that careful investigation of Mrs B's concerns was initiated.

Mrs C also stated that she spent some time with Mrs B on 21 August and was satisfied that, at the time, there was no injury that justified calling Dr E. Mrs C recalled that Mrs B was fully weight bearing on 21 August and commented: "I do not believe that there is any possibility that her hip was broken that day or earlier."

My general practitioner advisor, Dr Turnbull, stated:

> "I believe that [Mrs B] was likely to have fractured her hip in a fall as early as 11/8/00 but this was not recognised. The basis to my belief is the information contained in the resident's notes."

I accept Dr Turnbull's advice. In my opinion, Mrs C should have ensured that Dr E was called to assess Mrs B, at least by 17 August when she was noted to have abrasions and bruising on her left knee and shin and reported to be "very stiff and fearful of moving from her bed to the chair" and receiving Panadol four hourly for pain.

I consider that Mrs C failed to ensure that Mrs B's day-to-day care was managed effectively. I concur with Dr Turnbull's advice that in the final weeks, Mrs B's health problems "outstripped" the rest home's ability to care for her adequately, and that the decision should have been made to reassess her support needs levels and have her moved to hospital level care. In addition, with respect to the series of falls in early August, it is my view that Mrs C did not initiate a GP assessment early enough in response to the obvious signs of pain and injury.

Summary

In summary, Mrs C did not provide services with reasonable care and skill in accordance with professional standards. She failed to provide Mrs B with services that complied with her legal obligations as the manager of a rest home.[2] Accordingly, in relation to these aspects of care, Mrs C breached Rights 4(1) and 4(2) of the Code.

[2] See Old People's Homes Regulations 1987

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Opinion: No breach – Mrs C

Imovane

As set out above, a number of aspects of Mrs B's care raise concern – significantly, the inappropriate administration of Imovane, and Mrs D's alteration of instructions for its administration. Mrs D was employed by Mrs C as a registered nurse to take responsibility for the safe administration of drugs at the rest home. As manager of the rest home, Mrs C should have been able to rely on her registered nurse to ensure that any sedation given to Mrs B was appropriate and in accord with the doctor's prescription.

Mrs C understood that Dr E had prescribed Imovane "to help settle [Mrs B], when necessary, by day or night". She advised me that she had no previous experience of caring for a resident who required Imovane for sedation, and was unaware that it was being used inappropriately.

There is no evidence that Mrs C was involved in altering the prescription instructions or administering the Imovane. Accordingly, in my opinion, in relation to the management of Mrs B's Imovane prescription, Mrs C did not breach the Code.

Informed consent

Mrs A alleged that Mrs C failed to notify her of Mrs B's deteriorating condition and, in particular, failed to obtain consent for the administration of Imovane sedation.

Mrs C was the manager of the rest home. As such, she had primary responsibility for the interface between residents, their families and the rest home. Mrs C was aware that Mrs B was admitted with early signs of dementia and that her daughter, Mrs A, held an enduring power of attorney for personal care and welfare.

Deteriorating condition
Mrs B's mental condition deteriorated during her stay at the rest home and, although Mrs A visited frequently and was in regular telephone contact with her mother and the rest home, she was allegedly not informed about her mother's difficult behaviour and consequent management problems. Nor, it seems, was she consulted when Mrs D requested Mrs B's doctor to prescribe night-time sedation to control her wandering.

Mrs A lived in the city and travelled to see her mother infrequently, but she did telephone her mother and the staff at the rest home at least weekly. Mrs C maintains that Mrs A was aware of her mother's deteriorating condition. Mrs C, in her affidavit, sets out the content of her discussions with Mrs A regarding Mrs B's weight loss, the possibility of reducing falls by employing distractive therapies, and the issue of investigation of Mrs B's symptoms.

There is no documented evidence that Mrs C gave Mrs A the opportunity to be involved in the decisions relating to the ongoing management and care of her mother. However, there is starkly conflicting evidence about Mrs A's knowledge of her mother's general deterioration. In these circumstances, I am unable to conclude that Mrs A was not informed of her mother's deteriorating condition. Nevertheless, it is unfortunate that Mrs C did not

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arrange a formal family review to allow the family an opportunity to discuss appropriate ongoing management and make more informed decisions as to appropriate placement.

Imovane
Dr G and my expert general practitioner advisor commented that routine decisions, where it is not usual to consult family unless there is a prior instruction to do so, should be differentiated from situations where the decision relates to a major medical decision.

Shortly after her admission to the rest home, Mrs B exhibited wandering behaviour, which was upsetting to other residents, and staff found her particularly difficult to manage at night. After discussion with Mrs D, Mrs B's doctor prescribed the sedative Imovane "half to one tablet at night to settle" on a trial basis. I am satisfied that at this point, Mrs A's consent to the Imovane sedation may not have been a major decision for which consent was explicitly required. However, when Mrs B's Imovane medication was significantly altered between June and August 2000, this was a major decision for which Mrs A's consent was required. While it is clear that, as the manager of the rest home, Mrs C had a responsibility to inform Mrs A and seek her consent before any major treatment intervention for Mrs B, she could not do so if she was unaware of it. Mrs C has conceded that while Mrs B was in hospital (ie, well after the administration of Imovane was instituted and the events from which this complaint arose), she told Mr and Mrs A that "we (at [the rest home]) had had to sedate [Mrs B] from time to time". However, I am not satisfied that Mrs C was aware of the significance of the alteration to Mrs B's medication, such that consent was required. In these circumstances, in relation to the specific issue of failing to obtain informed consent from Mrs A to the administration of Imovane to sedate Mrs B, I conclude that Mrs C did not breach Right 7(1) of the Code.

Opinion: Breach – Mr and Mrs C, Licensees

Vicarious liability
Under section 72(1) of the Health and Disability Commissioner Act 1994 employers are vicariously liable for any breaches of the Code by employees. Under section 72(5) of the Act it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from doing or omitting to take any action that breached the Code.

Mr and Mrs C were the licensees of the rest home. They employed Mrs D as the registered nurse for the rest home. Mrs C also had a dual role as manager of the rest home. Mrs D breached Rights 4(1), 4(2) and 7(1) of the Code and Mrs C breached Rights 4(1) and 4(2) of the Code. There is no evidence that, as licensees, Mr and Mrs C took steps to prevent the breaches relating to the treatment and care of Mrs B. Accordingly, Mr and Mrs C are vicariously liable for Mrs D's and Mrs C's breaches of the Code.

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Opinion: Breach – Dr E

Prescription of Imovane
The practice at the rest home, when ordering medication, was for the registered nurse or manager to fax the Prescription Cards, which recorded the prescribing doctor's signed and dated changes, to the pharmacy. The pharmacist then converted these to computer-generated prescriptions, which were sent in batches to the doctor to sign.

I am advised that when prescriptions for rest home residents are changed or telephoned through to the pharmacy, it is common practice for pharmacists to send doctors bundles of prescriptions to be signed and returned for processing. Doctors usually take it on faith that the scripts are written as discussed with the pharmacist or true to those signed in the rest home. It is common practice for doctors to do as Dr E did and sign the prescriptions without scrutinising them carefully. However, doctors and other prescribers are legally responsible for the prescriptions they sign.

Mr H, a pharmacist at the pharmacy, telephoned the rest home on 18 July 2000 to query the additional Imovane prescribed for Mrs B. He could not recall who he spoke to, but was satisfied, from the information he received, that it was not necessary to discuss the increase in medication with Dr E personally. The pharmacy provided extra loose tablets to cover the time until the next monthly blister pack was made up.

Copies of the prescriptions signed by Dr E for Mrs B were obtained from the Health Centre. On 1 July 2000 Dr E signed a prescription for Mrs B for Zopiclone (Imovane) 7.5mg tablets, "take half a tablet to one tablet at night to help sleep". Twenty tablets were dispensed. On 18 July the prescription for Zopiclone 7.5mg was increased to half a tablet each morning and night. The prescription was signed by Dr E, and 14 tablets were dispensed. On 27 July, included in a prescription listing several medications for Mrs B, signed by Dr E, was Zopiclone 7.5mg tablets "take half a tablet each morning and at night". Twenty-eight tablets were dispensed.

Dr E advised me as follows:

> "It was not and never has been my intention to use Imovane as a means of calming [Mrs B] (or any other patient for that matter). The rest home had no authority to change my instructions and should have informed me that they were doing this (especially given the warnings on the drug sheet). If uncertain they should have contacted me. I wish I had noticed the change in prescribing instructions on the script for Imovane sent to me to sign."

I accept Dr E's explanation that he signed Imovane prescriptions in July 2000, unaware that they had been altered by Mrs D. Dr E had given no authority to Mrs D or any staff member at the rest home to alter his original March 1999 instructions for the administration of Imovane to Mrs B. As my general practitioner advisor, Dr Turnbull, noted:

> "Doctors usually take it on faith that the scripts are written as discussed with the pharmacist or true to those they signed in rest homes/private hospitals. This means that

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it would be usual for doctors to do as [Dr E] did i.e. sign the prescriptions in good faith without scrutinising them closely."

It is unfortunate that the pharmacy did not consult Dr E when the prescription change was noted, but this does not absolve Dr E's liability in this regard. As my advisor has noted, "Doctors and other prescribers are legally responsible for the prescriptions they sign."

In my opinion, in signing the prescriptions for Mrs B without close scrutiny, Dr E failed to comply with his professional and legal responsibilities, and breached Right 4(2) of the Code.

Opinion: No breach – Dr E

Assessment and monitoring of Mrs B
Dr E had been Mrs B's general practitioner for seven years before she was admitted to the rest home in 1998. Mrs B's neighbours, district nurse and daughter were all concerned about her ability to cope alone in her own home. When these issues were brought to Dr E's attention he arranged for Mrs B to be assessed with a view to admission to a rest home. She was subsequently classified as a Support Needs Level (SNL) 4 resident and transferred to rest home care at the rest home.

Mrs B's classification was "level 4", which requires a routine GP visit every three months and urgent visits as requested. Dr E's notes demonstrate that he provided this level of care and was available for telephone and other consultations on request. It was the responsibility of the rest home to notify Dr E of any change in her health status and request his attendance outside of these times. Unless notified otherwise, it was reasonable for Dr E to assume that Mrs B was well, or had not deteriorated from when he last saw her.

Dr E's notes record three-monthly visits and changes in Mrs B's health status. There is evidence of telephone consultations and appropriate medications being prescribed. When telephoned on 22 August 2000 and asked to visit Mrs B to investigate her complaint of pain in her left hip, Dr E attended promptly and diagnosed a possible hip fracture. He arranged for Mrs B to be transferred to hospital for further assessment and treatment. My general practitioner advisor, Dr Turnbull, commented that once notified of the problem, Dr E acted promptly and appropriately. Dr Turnbull commented that "[Dr E's] management of [Mrs B's] medical condition seems entirely appropriate".

On the basis of all the evidence and my expert medical advice, I am satisfied that Dr E assessed and treated Mrs B appropriately, and did not breach the Code.

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Other comment

Documentation
The nursing records exhibit subjective language on a number of occasions when referring to Mrs B. There is no evidence that Mrs C or Mrs D instructed staff about the use of appropriate language when reporting clinical observations. There appears to have been a disturbing tolerance of demeaning language. Mrs B was an elderly woman who was entitled to be treated with respect and dignity.

I am advised by my nursing advisor that Mrs B's nursing notes were lacking in detail and planning. The notes indicate that Mrs B had a large unexplained weight loss and was suffering from dehydration. Contemporary practice should have included a meal chart and a fluid balance chart, and an evaluation of the information gathered, with a view to formulating an appropriate management plan.

Actions taken

Dr E accepts that in failing to closely scrutinise the prescription forms sent to him for signing by the pharmacy, his practice was unsatisfactory. He has now adopted a "best practice" system for signing prescriptions. He has spoken with the pharmacy to ensure that it will only dispense medications from drug sheets signed by him and according to his written instructions. He now signs prescriptions only when accompanied by a photocopy of the original drug sheet. He has also instructed the pharmacy to refer any queries about prescriptions to him personally.

Actions

I recommend that the following actions be taken:

- The rest home arrange for a pharmacist to provide training to relevant staff on the legal requirements relating to the prescription, administration and management of medication.
- The rest home conduct staff training for all staff in the management of residents presenting with difficult behaviour.

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Further actions

- This matter will be referred to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of this report will also be forwarded to the Nursing Council, the Medical Council, and the Ministry of Health Licensing Office.

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

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

Appendix – Job Description for Registered Nurse [working in the rest home]

[The rest home] - **JOB DESCRIPTION**

Position: Registered Nurse

Responsible to: Manager / Licensee

Directly Supervising: All other staff

Primary Objectives: To provide a safe, secure and homelike environment for the residents under care.

To provide optimum physical and psychosocial care for the residents following a nursing care plan written by a registered nurse.

To co-ordinate staff to ensure resident care is completed safely.

To respect the rights and wishes of the resident/relatives.

To be responsible and accountable to the Manager/Licensee for the efficient, effective care given to the residents of [the rest home]

Key Tasks:

1) Nursing Expectations:

1. Develop and maintain a nursing service which respects and values the individuality of each resident.
2. Develop care plans for all residents obtaining detailed assessment data.
3. To be an advocate for the resident and to voice the residents needs to doctors and staff.
4. To liaise with relatives on matters relating to the health of the resident.

2) Education Expectations:

1. To plan with Manager/Licensee on orientation programme to meet the needs of the staff.
2. To facilitate the inservice training programme at [the rest home]
3. To update own nursing knowledge by attending courses appropriate to the care of the elderly.

3) Safe Drug Practice Expectations:

1. To ensure the home has safe practice 37(2)(d)(e) of the Old Peoples Home Regulations 1987 and Standards of Care for Old Peoples Homes.
2. To ensure administration records are kept for each resident.
3. To ensure each resident's medication profile is charted/signed by the GP.
4. To educate staff in the safe administration of drugs and drug side effects.
5. To safely dispose of old stocks.

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Addendum

The Director of Proceedings laid before the Nursing Council of New Zealand a charge alleging professional misconduct. The charges in relation to incorrect administration of Imovane; alteration of the administration directions when drafting the prescription, without consultation with the prescriber; and failure to assess, monitor, evaluate and respond to the patient's weight loss and falls were upheld by the Council on 23 December 2004. It imposed a penalty of censure and payment of $15,400 (30% of the costs of the hearing). The Council ordered that for a period of twelve months Mrs D practise under conditions, including preparation and completion of a professional development programme approved by a nominated mentor and the Council. The Council also ruled that its orders in respect of Mrs D be published in the *New Zealand Gazette*, *Kai Tiaki: Nursing New Zealand* and the *Nursing Council Newsletter*.

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