Manis Aged Care Limited

(trading as Cameron Courts Rest Home)

A Report by the

Deputy Health and Disability Commissioner

(Case 12HDC01420)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Background

1. In 2012, Mr A, 96 years old at the time of these events, was admitted to Cameron Courts Rest Home (Cameron Courts), which is owned by Manis Aged Care Limited (Manis). An outbreak of influenza at Cameron Courts affected both staff and residents. On Wednesday, Mr A's general practitioner (GP), Dr F,[1] assessed Mr A and diagnosed him with influenza. At Mr A's request, Dr F prescribed oral amoxicillin[2] for seven days.

2. On Thursday, the Clinical Manager (CM), CM D, was on sick leave with influenza. She did not return to Cameron Courts until after Monday. As CM D was the only registered nurse on staff at Cameron Courts at this time, while she was on sick leave there were no registered nurses on site at Cameron Courts. However, CM D remained available by telephone contact, and continued to provide clinical advice to the Operations Manager (OM), OM E.

3. On Friday, Mr A's condition deteriorated. At 12.15pm, Dr F visited Mr A. Dr F "did not consider [Mr A] to be terminally ill at that stage". Antibiotics were continued for Mr A.

4. At 11.00am on Saturday, OM E contacted the weekend duty doctor, Dr G,[3] regarding Mr A. OM E advised Dr G that Mr A was receiving "end of life care", was in pain and agitated and needed medication, and that he was having trouble swallowing tablets. Dr G advised OM E over the telephone to administer Mr A 5ml of liquid morphine every four hours to decrease his discomfort. Dr G and OM E agreed that morphine elixir left over from another patient could be administered to Mr A.

5. On Saturday, Mr A was administered morphine on at least three occasions. However, this was not always documented appropriately. Manis staff did not administer Mr A any further amoxicillin, despite his prescription being for another three days. At approximately 8.25pm, Dr G visited Cameron Courts to assess Mr A, and documented his prescription for morphine on the doctor's prescribed medication chart.

6. On Sunday, Mr A was administered morphine on at least six occasions. Mr A's family visited Mr A and expressed concern that they had not been informed that he was receiving morphine prior to its administration. They asked to speak to Dr G. At around 9.25pm, Dr G visited Mr A. At this time, Mr A was unresponsive.

7. Mr A's family expressed concerns to Dr G that they were unaware that Mr A was receiving end-of-life care. Dr G checked Mr A's notes and found that there was no record of a decision to commence end-of-life care for Mr A. Dr G decided to continue administering morphine to Mr A every six hours to assist with his comfort.

8. Mr A's condition continued to deteriorate, and he died in the early hours of Monday.

[1] Dr F is vocationally registered in general practice.
[2] Used to treat bacterial infection.
[3] Dr G is not vocationally registered in general practice.

Findings

Manis Aged Care Limited

9. Manis did not have in place appropriate systems to ensure that adequate cover would be available in the event that the only registered nurse on staff was unavailable. This failure led to poor communication between providers caring for Mr A and decisions being made about his care and treatment, without him being clinically assessed appropriately. Accordingly, Manis failed to ensure that Mr A was provided continuity of services, in breach of Right 4(5)[4] of the Code.

10. Manis staff failed to ensure that Mr A received relevant information regarding his condition, as well as the withdrawal of amoxicillin and the commencement of morphine, and failed to obtain Mr A's informed consent to the commencement of morphine and withdrawal of amoxicillin. Accordingly, Manis breached Rights 6(1)[5] and 7(1)[6] of the Code.

11. Adverse comment is made about Manis with regard to the following matters:

a) The failure to record the administration of morphine adequately, in accordance with controlled drugs regulations.
b) Its Medication Administration Policy not being in line with Ministry of Health (MOH) Guidelines with regard to requiring a registered nurse to be available to assess and monitor a patient who is administered a controlled drug for the first time.
c) The administration to Mr A of morphine that was not prescribed for him.
d) The lack of comprehensive documentation of discussions between CM D and Manis staff.

OM E

Adverse comment is made about OM E regarding her advice to Dr G that Mr A was on end-of-life care. Mr A had not been assessed as clinically appropriate for end-of-life care, and no discussion had taken place between him and/or his family with regard to end-of-life care. OM E's communication with Dr G in this respect was inappropriate, and affected the quality and continuity of Mr A's care.

CM D

12. Adverse comment is made about CM D regarding having placed herself in an inappropriate position of retaining responsibility for patients while she was on sick leave.

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[4] Right 4(5) states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."
[5] Right 6(1) states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including — a) an explanation of his or her condition; and b) an explanation of the options available …"
[6] Right 7(1) states: "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."

Complaint and investigation

13. The Commissioner received a complaint from Ms B and Ms C regarding the care provided to their late father, Mr A, by Manis Aged Care Limited (trading as Cameron Courts Rest Home). The following issue was identified for investigation:

- *Whether Manis Aged Care Limited (trading as Cameron Courts Rest Home) provided an appropriate standard of care to Mr A over the period of a week in 2012.*

14. This report is the opinion of Ms Theo Baker, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

15. The parties directly involved in the investigation were:

Ms B	Complainant
Ms C	Complainant
Manis Aged Care Limited	Provider
CM D	Clinical Manager and registered nurse
OM E	Operations Manager

16. Information was also reviewed from:

Dr F	General practitioner
Dr G	Doctor

Also mentioned in this report:

FM H	Facility Manager

17. Independent expert advice was obtained from a registered nurse, Rosemary Minto (**Appendix A**).

Information gathered during investigation

Background

18. Mr A, 96 years old at the time of these events, was admitted to Cameron Courts Rest Home (Cameron Courts) in 2012.[7] At that time he was independent with most daily activities except showering. He was unsteady on his feet and used a walking stick, and required a walking frame for longer distances. Mr A was otherwise in good health.

19. In 2012, Mr A was diagnosed with influenza. Subsequently he was commenced on end-of-life care and died. This report relates to the care provided to Mr A at this time.

[7] On admission to Cameron Courts Mr A signed an Advance Directive, which stated: "I do not wish to be resuscitated. Medical assessment will identify that I will have no reasonable expectation of recovery or chance of regaining meaningful life."

Cameron Courts Rest Home

20. Cameron Courts is owned by Manis Aged Care Limited (Manis).

Management staff

FM H

21. FM H was the Facility Manager at Cameron Courts.[8] FM H was on leave overseas at the time of these events, but kept in frequent contact with the Operations Manager, OM E.

OM E

22. At the time of these events, OM E had been working in elder care for 15 years, primarily as a senior caregiver. OM E does not hold a nursing qualification, but was assessed by Manis as competent to administer medication. According to her job description, OM E was responsible for ensuring appropriate staff cover on all shifts. She was also responsible for ensuring open communication with residents and their family, ensuring that changes in residents' conditions were documented appropriately, and keeping in contact with the Facility Manager regarding any adverse events.[9]

CM D

23. CM D, a registered nurse (RN), was the Clinical Manager at Cameron Courts. At the time of these events, CM D was the only registered nurse employed at Cameron Courts. CM D normally worked Monday to Friday and was on call to provide assistance over the weekends. According to her job description, CM D was responsible for ensuring appropriate staff cover on all shifts, and overseeing clinical care provided to residents. CM D was also responsible for ensuring that changes in residents' condition were identified and documented.[10]

[8] FM H is also one of two directors of Manis Aged Care Limited.

[9] OM E's job description states that she was required to: "Ensure staff roster gaps are filled to ensure appropriate cover on all shifts to meet resident needs … Ensure Code of Rights is upheld by all staff at all times … Encourage residents, their family/whanau to be involved in care planning process and seek information where appropriate to ensure safe, appropriate care provision in consultation with RN … Ensure staff are familiar with current policies and procedures and work in accordance with their content. Ensure lines of communication between visitors, staff and health professionals are appropriate. Ensure verbal and written communication is maintained between self and management in relation to residents and operational (including staffing) issues … Ensure changes in residents conditions are identified, documented and other health professional advice sought as deemed necessary to promote optimum health in consultation with RN … Advise the Facility Manager of adverse issues as they arise … Uphold and comply with the organisational policies and procedures …"

[10] CM D's job description states under "Key responsibilities" that CM D was responsible for: "Staff supervision: Ensure staff roster gaps are filled to ensure appropriate cover on all shifts to meet resident needs … Ensure Code of Rights is upheld by all staff at all times. Communication: Encourage residents, their family/whanau to be involved in care planning process and seek information where appropriate to ensure safe, appropriate care provision. Ensure verbal and written communication is maintained between self and management in relation to residents and operational (including staffing) issues. Clinical: Oversee all components of clinical care to residents … Ensure medication requirements are documented appropriately by Medical personnel and the administration is recorded in accordance with policy and procedures …"

Influenza outbreak at Cameron Courts

24. An outbreak of influenza at Cameron Courts affected both staff and residents. Manis advised HDC that this resulted in approximately half of Manis' staff being unable to attend work owing to illness, and limits were being placed on visitors. However, at this time, Cameron Courts maintained the usual number of staff on shift.

25. On Tuesday Mr A became unwell with a fever and cough.

Mr A diagnosed with influenza — Wednesday

26. The following day, Wednesday, CM D contacted Mr A's general practitioner, Dr F, and requested that he assess Mr A. Dr F attended Cameron Courts and recorded in the medical notes:

> "Probable influenza but now [secondary] infection chest. [Mr A] requesting antibiotics. 0: febrile. Rattley [sic] chest. D: Viral influenza?/+[secondary] bronchitis. Rx Reg Paracetamol/fluids."

27. Dr F told HDC that he recalls discussing with Mr A that his infection appeared to be viral, and that antibiotics would not be effective against a viral infection. However, Mr A requested antibiotics, so Dr F prescribed oral amoxicillin[11] 500mg to be administered three times daily for seven days.

Deterioration of Mr A's condition — Thursday and Friday

28. CM D and Manis advised HDC that from Thursday afternoon, CM D was on sick leave with influenza, and did not return to Cameron Courts until after Monday. As CM D was the only registered nurse on staff at Cameron Courts at this time, no registered nurse was on site at Cameron Courts while she was on sick leave. However, CM D remained in telephone contact, and told OM E that she could come in if necessary. CM D told HDC:

> "I took phone calls two and three times a day from [OM E] — Operations Manager — to update me on [Mr A] and other residents and ensure she was instigating the correct procedures."

29. On Thursday evening, Mr A had trouble swallowing food and liquids.

30. On Friday, CM D was still on sick leave and remained available by telephone. At 8.00am on Friday, at the beginning of her shift, OM E contacted CM D to inform her that Mr A's condition had deteriorated overnight and he was unable to swallow his antibiotics. OM E and CM D decided to contact Dr F to request that he visit Mr A before the weekend. Dr F's notes record that CM D communicated to him that Mr A had deteriorated, had problems breathing, and was wheezy and a "little incoherent". CM D also contacted Mr A's daughter, Ms C, to inform her that Mr A had deteriorated overnight and that Dr F had been informed.

[11] An antibiotic.

31. At 12.15pm, Dr F visited Mr A and noted in the medical records that he was "[v]ery rattley [sic] and wheezy, awake but not talking … no signif[icant] temperature". Following his assessment of Mr A, Dr F noted:

> "[C]ontinue current management trial salbutamol[12] nebuliser[13] if you wish, no other treatment options at this stage …"

32. Dr F told HDC that his note "continue current management" was in reference to Mr A's general care, including offering fluids and paracetamol. Dr F stated that he "did not consider [Mr A] to be terminally ill at that stage", and he did not feel that there was a need to set in place any special measures for Mr A's management over the weekend. Antibiotics were continued for Mr A.

33. At 5.25pm on Friday, a health care assistant (HCA) administered 500mg amoxicillin for Mr A as prescribed.[14] This was the last time amoxicillin was administered to Mr A, despite his prescription being for three times daily for another five days.

34. At 5.50pm on Friday, it is recorded in the clinical notes that an HCA gave Mr A oxygen to assist him with his breathing. It is recorded:

> "In bed. Oxygen given 5.50pm, 6.30pm O_2 80 — Pulse 84 — Temp 36.9. 9pm O_2 81 Temp 37.1 Pulse 76. [OM E] rung and notified. Trying to keep [Mr A] comfortable. Checked regularly."

35. In her report written retrospectively,[15] OM E recorded that night staff "checked [Mr A] hourly over night very unsettled tried to give fluids and oxygen but refused".

Commencement of end-of-life care — Saturday

36. On Saturday, CM D remained on sick leave and available by telephone. By the morning of Saturday, Mr A had deteriorated further. OM E recorded in the clinical notes regarding contacting Mr A's family:

> "Rang [Ms C] to let her know that [Mr A] had deteriorated over night and we were continuing to care for him and would ring if he deteriorated."

37. At approximately 11am, OM E contacted the weekend duty doctor, Dr G, about Mr A, as Dr F did not work weekends.

38. Dr G told HDC that he recalls that a staff member at Cameron Courts contacted him and advised him that Mr A was receiving "end of life care", was in pain and agitated and needed medication, and that he was having trouble swallowing tablets. Dr G advised HDC: "Naturally I would have assumed that such a decision [that Mr A was on

[12] Used in asthma, bronchitis, bronchospasm, and treatment of reversible airways obstruction.
[13] A drug delivery device used to administer medication in the form of a mist inhaled into the lungs.
[14] Staff administering medication to Mr A between Thursday and Monday had the appropriate medication administration competencies at Cameron Courts, including for controlled drugs.
[15] "A report by [OM E]/Operations Manager into the death of [Mr A]" (undated).

'end of life' care] would have been made after full discussion with him and his family if possible."

39. In her report written retrospectively, OM E recorded that she informed Dr G that Mr A had deteriorated and become "very very restless over the previous few hours", and that she described to Dr G the care that she and the health care assistants had given to Mr A that day. She recorded: "Doctor advises that to make [Mr A] more comfortable would it be possible for us to administer liquid morphine to decrease his discomfort. This was discussed at length with the doctor." OM E advised HDC that she does not recall discussing end-of-life care with either CM D or Dr G, and stated: "I do not believe this was mentioned and at the time the Doctor prescribed morphine [Mr A] was not on end of life care." She told HDC that she did not make any decisions herself about Mr A's care.

40. Dr G advised OM E over the telephone to administer Mr A with 5ml of liquid morphine every four hours to decrease his discomfort. Dr G told HDC that he was told that there was "morphine elixir available left over from another patient that could be used as the pharmacy was closed". Both the morphine prescribed to Mr A, and the available morphine that had been prescribed to another patient, were 1mg/ml strength.

41. At 12.15pm on Saturday, OM E recorded in Mr A's progress notes:

> "Family again has been contacted as [Mr A] has deteriorated overnight and during the day today, generally incontinent, restless, unresponsive verbally. End of life care has been started, duty doctor has been rung and morphine has been charted to make [Mr A] more comfortable. Friend rung & is sitting with him."

42. In response to the provisional opinion, OM E told HDC that she attempted to contact Mr A's family to advise them that Dr G had prescribed morphine. She stated that unfortunately at that time the family were "in transit" on their way to Cameron Courts and did not answer her telephone calls.

43. The administration of morphine for Mr A was recorded (on most occasions) on both his Medication Administration Signing Sheet (MASS), and on the Controlled Drug Register (CDR) (both discussed further below).

44. In response to the provisional opinion, OM E told HDC that prior to administering morphine to Mr A on Saturday, she contacted CM D, who "confirmed that she considered it was appropriate to administer the prescribed morphine". This is not documented.

45. It is recorded on the CDR that at 1.50pm OM E administered Mr A 5ml of morphine. During the investigation, OM E told HDC that she did not have a conversation with Mr A at this time with regard to the administration of morphine, because he was "unable to hold a conversation".

46. In response to the provisional opinion, OM E told HDC: "Before administering the morphine [I] explained exactly what was happening to [Mr A] …"; however, this is not

documented. OM E also told HDC in response to the provisional opinion that she explained "exactly what was happening" to Mr A's friend, who was sitting with him at the time.

47. During the course of the investigation, a friend of Mr A told HDC that she was advised that Mr A "was given oral morphine after consultation with a Dr".

48. The administration of morphine to Mr A is recorded in the CDR, but there is a space on the CDR for the name of the controlled drug, which is left blank. The entries in the CDR match those in Mr A's MASS for morphine.[16]

49. Despite limits being imposed for visitors due to the influenza outbreak, Mr A's family were given permission to visit him. Mr A's family arrived at Cameron Courts around mid-afternoon. OM E stated in her report written retrospectively that, at that time, the family were advised that the doctor had charted morphine elixir, staff were doing what they could to keep Mr A comfortable, and the doctor would attend as soon as possible.

50. In response to the "Information gathered" section of the provisional opinion, Ms B advised that when she and her sister arrived at Cameron Courts that afternoon, Mr A was incoherent and not responsive to them.

51. At 5.11pm, OM E sent a fax to Dr G stating:

> "As per our telephone conversation via 0800 nursing number to duty doctor being yourself, can you please confirm instructions to administer morphine HCL LI 1mg/ML … that we currently have here belonging to [another patient] who has passed away yesterday and has not yet been delivered back to [the Pharmacy]. [Mr A] is currently receiving end of life care and has become very restless, unresponsive verbally."

52. On Saturday evening, an HCA administered Mr A 5ml of morphine on two occasions.[17] The HCA told HDC that on Saturday, Mr A was unable to swallow solids and was "very distressed".

53. At approximately 8.25pm, Dr G visited Cameron Courts and assessed Mr A. Dr G recorded in the medical notes: "Called to see. Seem to be in more pain this evening [illegible] Plan: Start on morphine elixir." Dr G documented Mr A's prescription for 5ml of morphine elixir every four hours on the doctor's prescribed medication chart (PMC, discussed further below).

Mr A continues to deteriorate — Saturday and Sunday

54. It is recorded in the clinical records for the night shift on Saturday to Sunday:

[16] Except for three entries that are missing from the Medication Administration Signing Sheet on the evening of Sunday at 6.40pm, 10.00pm and 11.30pm, as it was not signed by the HCA (discussed below).
[17] At 6.00pm and 10.00pm.

> "11pm–7am Not feeling well. Slept for only 2 hours and rest of the night was awake. Tried to give oxygen but refused to have it — checked every 1 hour."[18]

55. At 2.00am and again at 6.00am on Sunday, an HCA administered Mr A 5ml of morphine. The HCA recorded this in both the CDR and the MASS.

56. On Sunday, CM D was still sick, but remained available by telephone. At 10.40am, an HCA administered Mr A 5ml of morphine. This was recorded in both the CDR and the MASS.

57. At 12.15pm, OM E recorded in the clinical notes regarding contacting Mr A's family: "Rang as [Mr A] had deteriorated over the morning advised that may be good that family came down." When [Mr A's] family arrived at Cameron Courts, [OM E] met with them. She recorded:

> "Family expressed concern and that they were not informed about morphine prior to administration and had doctors questions also about where the RN was. Advised that I would ring the doctor and ask him to visit also offered for the RN to attend this offer was declined. I did tell the family it was general practice for the doctor to prescribe morphine to make patient more comfortable as he was very agitated."

58. Following her conversation with Mr A's family, OM E contacted Dr G on the family's behalf and requested that he attend Cameron Courts. At 2.40pm, an HCA administered Mr A 5ml of morphine and recorded this on both the CDR and the MASS. At 6.40pm, an HCA administered Mr A 5ml of morphine and recorded this on the CDR but failed to record it on the MASS.

59. At around 9.25pm, in response to OM E's request, Dr G visited Mr A. Mr A's family was still at Cameron Courts at this time. Dr G told HDC that he recalls that Mr A was in a "pre-terminal state and unresponsive".

60. Mr A's family expressed concerns to Dr G that they were unaware that Mr A was receiving end-of-life care. At this point, Dr G checked Mr A's notes and found that there was no record of a decision to commence end-of-life care for Mr A. Dr G discussed Mr A's condition with his family, and decided to continue administering morphine to Mr A every six hours to assist with his comfort. Dr G told HDC that he advised Mr A's family that, in his opinion, there was no chance of Mr A recovering, and that he should receive whatever care was necessary to maintain comfort and minimise suffering. At 9.50pm, Dr G recorded in the medical notes:

> "Asked to visit by patient's family. Concerned that his medication sp:[19] antibiotics were stopped. Told family I had been told that [Mr A] was for palliative care. Told by family they were unaware that this decision had been made.

[18] In response to the "Information gathered" section of the provisional opinion, Ms B said that either she or her sister were with Mr A throughout Saturday and Sunday nights, and they never saw him refuse oxygen.
[19] Sp stands for "status post" referring to the patient's previous status.

> [On examination] [Mr A] lying supine in bed. Responds to being moved with opening his eyes but not really aware. Temp 38.5[20] BP 128/78[21] P 120[22] resp PR 50.[23] Very noisy breathing …
>
> Plan: After discussion with family morphine 5ml to be given 6/hrly regularly because of difficulty breathing …"

61. Dr G updated Mr A's prescription on the PMC for morphine to be given every six hours. It is recorded in the CDR that at 11.30pm an HCA administered Mr A a further 5ml of morphine. The HCA recorded the administration of morphine to Mr A in the MASS.

62. Mr A's condition continued to deteriorate, and he died in the early hours of Monday.

Relevant Manis policies and procedures

Documentation of medication prescribing/administration policies

63. With regard to recording the prescribing and administration of medications, Manis uses the following forms of documentation:

Doctor's Prescribed Medication Chart

64. The PMC is the form on which doctors record prescriptions. The doctor records the date of the prescription as well as the name of the medication, route, times at which the medication should be administered (ie, breakfast, lunch, dinner, bedtime) and the date the prescription is to be discontinued. The doctor is required to sign each prescription.

Medication administration signing sheet

65. The medication administration signing sheet (MASS) is used for recording the administration of medications. The administration of each medication is assigned a separate column, under which staff record the date, dose and time the medication was given, and then sign next to each record.

66. Mr A's MASS was used to record the administration of amoxicillin and morphine.

Controlled Drugs Register

67. The Misuse of Drugs Regulations 1977 (the regulations) place restrictions on the prescribing, supply and custody of controlled drugs. The regulations require persons authorised to deal in controlled drugs to maintain a Controlled Drugs Register (CDR) in relation to all controlled drugs dealt in, possessed or dispensed by the authorised person (a person with the required competencies), for each individual consumer. The regulations require that each controlled drug be recorded on a separate page in the CDR (it states on the CDR: "1 kind and 1 strength only to each page").

68. The CDR was used to record the administration of morphine to Mr A.

[20] Normal body temperature for an adult is around 37–38°C.
[21] Normal blood pressure for an adult is between 90–120/60–80mmHg.
[22] Normal pulse rate for an adult is between 60–100 beats per minute.
[23] Normal respiratory rate for adults over 80 years old is between 10–30 breaths per minute.

Administration of Medication Policy

69. The Manis Administration of Medication Policy relevant in 2012 states:

> "Each individual administration of a controlled drug must be signed out of the Controlled Drug book by two staff who verify the correct balance of the particular drug book.
>
> …
>
> Staff responsibilities:
>
> The Registered Nurse in charge of clinical management is responsible for over-seeing all aspects of medication management within the facility …
>
> Controlled Drugs:
>
> …
>
> Each individual administration of a controlled drug must be signed out of the Controlled Drug book by two staff who verify the correct balance of the particular drug book. Both staff who have signed the controlled drugs book must witness the administration of the medication and both will then also sign the medication order signing sheet.
>
> …
>
> Staff signing the Controlled Drug Register, must observe the resident during administration of that medication."

70. On the standard form used for "Administration of Medication Competency Assessment" at Cameron Courts it is noted under "Controlled Drugs": "*Where able*, one of the two staff signing out should be a Registered Nurse" (emphasis added). On OM E's medication competency assessment there is an annotation that states: "RN not always available. 8hrs a day. 5 days a week," as CM D did not work weekends but remained on call. Similar annotations are written on other staff medication competency assessments.

Annual Leave and Rostering Policy

71. The Manis Annual Leave and Rostering Policy relevant in 2012 states:

> "Staffing levels and routine rostering will be determined by the Facility Manager in consultation with the RN taking into consideration the assessed needs (acuity) of residents, and associated roles, responsibilities and levels of experience of staff.
>
> …
>
> The senior person on-duty will arrange staffing cover for those staff calling in sick at late notice (this practice is unacceptable however it is acknowledged that at times emergencies occur which can't be pre-empted). If cover attempts have been made and the roster gap has not been filled, contact the facility manager for advice.
>
> …

> The Facility Manager or Registered Nurse when on duty is responsible for over-seeing each shift and approving any changes to the roster on a shift by shift basis to cover short notice absenteeism eg; sickness, bereavement leave etc
>
> Ring the Facility Manager to authorise an Agency caregiver.
>
> …
>
> Any concerns regarding staffing cover call the Facility Manager for clarification."

Further information

Contact with Facility Manager

72. As stated above, FM H was overseas at the time of these events. FM H advised HDC that OM E was in telephone contact (by text message) with her, and reassured her that appropriate care was still being provided to residents, that extra staff were working, and that there was no need to call agency staff. Manis further advised HDC that there was a shortage of agency staff at that time owing to the influenza outbreak. However, there is no evidence that OM E or Manis attempted to contact agency staff to obtain registered nurse cover.

73. In her report written retrospectively, OM E noted that between 1.30–1.40pm on Saturday, she sent three text messages to FM H "to inform as to the current situation within the facility". With regard to Sunday, OM E noted: "Facility Manager contacted via txt to inform about facility and [Mr A] conditions 3 times during day." There is no other record of these text messages including the content of the messages. FM H told HDC that she "does not recall the content of the text messages that OM E claims were sent to [her] on Saturday …".[24]

74. OM E also told HDC that at all times there was an "adequate amount of staff (normal amount as usual)" on shift, and that CM D was available by telephone contact.

Decision to commence end-of-life care

75. With regard to the decision to commence end-of-life care for Mr A, Manis advised HDC: "It would also not be expected that the operations manager would make a decision like this. Her role was primarily non-clinical …"

76. OM E told HDC:

> "[T]here was a misunderstanding in regard to the end of life care and if [Mr A] was or was not on end of life care. I'm not sure how this occurred. If it was a lack of correct communication by me to the doctor I'm not sure and I'm still not sure how the doctor came to the conclusion that [Mr A] was on end of life care as I do not recall this being discussed.
>
> …

[24] FM H told HDC that she was not able to provide evidence of any such text messages, as she has changed her phone since then.

> I personally would not want any family to feel the way [the family] do [and] I apologise to them if it was my interaction with the family that partially led to them feeling this way."

77. OM E further stated: "I was not responsible for the clinical care or decision making regarding clinical care … I was not making decisions about [Mr A's] care, that was not my role." She said:

> "During the period in question [CM D] the Clinical Manager was on call and I spoke to her several times by telephone. On each occasion I spoke to her she would convey her instructions to me about care and I would pass on any instructions to [Dr G]."

78. CM D informed HDC that she did not provide any advice to Cameron Courts' staff specifically regarding end-of-life care issues.

79. Manis advised HDC that, since these events, Manis has had a registered nurse working every day including weekends. Manis has also ensured that a registered nurse is on call, 24 hours a day.

Responses to the provisional opinion

80. The relevant parties were given an opportunity to respond to the provisional opinion. Where relevant these responses have been incorporated into the opinion. Further responses are outlined below:

OM E

81. OM E told HDC that CM D was not on sick leave from Thursday, but that she was "on call". With regard to her conversation with Dr G on Saturday, OM E told HDC:

> "One of the major concerns during this period was that [Mr A] was unable to take in fluids. The staff began using a mouth care sponge to attempt to get fluids into [Mr A]. Mouth care sponges are part of end of life type care. Similarly, the staff began pressure cares which is also used for end of life care. These care procedures are not used exclusively for patients who are receiving 'end of life care' but are also used for other patients like [Mr A] to alleviate their distress.
>
> …
>
> What [I] was trying to communicate to [Dr G] was that [Mr A] was receiving end of life 'type' care (being mouth sponges and pressure care) not 'end of life care' [I accept] that [my] choice of words and [my] fax to [Dr G] were poorly worded and [I] regret not being clearer with [Dr G] in that respect …"

CM D

82. CM D stated: "Due to staffing levels at the time I felt I had no choice but to be available over the phone to support the staff for the residents."

83. CM D also told HDC that since these events a specific form has been made available for Cameron Courts staff to record conversations with the registered nurse on call, and

that ongoing education has been offered to staff on medication management and documentation.

Preliminary matters

84. For the avoidance of doubt, I note that my role does not extend to determining the cause of death of Mr A. This is the role of the Coroner. My role is to assess the quality of care provided to Mr A, in light of the information that was known at the time that care was provided. Accordingly, my opinion should not be interpreted as having any implication as to the cause of Mr A's death.

85. My main concern is that there appears to have been inadequate communication, and an assumption by staff involved in Mr A's care, that someone had made a decision to commence end-of-life care for Mr A.

Opinion: Manis Aged Care Limited — Breach

Introduction

86. Following Mr A's diagnosis with influenza, failures at Manis led to decisions being made about his care and treatment without him being clinically assessed appropriately, and in the absence of discussions with him. The individual health professionals who provided care to Mr A do hold a degree of responsibility for the failures that occurred, and I have commented below on the care provided by individuals. However, I am of the view that those failures were largely a result of service-level failures at Cameron Courts, for which Manis holds responsibility. As this Office has noted in a previous opinion:[25]

> "That responsibility comes from the organisational duty on rest home owner/operators to provide a safe healthcare environment for residents. That duty includes … any deviations from good care are identified and responded to. It also includes responsibility for the actions of its staff."

87. One of the issues in this case is whether a decision had been made to cease active treatment of Mr A, and to provide only end-of-life care. A provider may decide that non-treatment or withdrawal of treatment is clinically appropriate, for example, if treatment is futile or is causing suffering. If the withdrawal of life-prolonging treatment is clinically appropriate, the providers responsible have a lawful excuse for not providing the treatment. However, consumers have a right to information, including an explanation as to their condition and options available to them.[26]

[25] See Opinion 10HDC01286 (18 November 2013), available at www.hdc.org.nz.
[26] Right 6 of the Code states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including — a) an explanation of his or her condition; and b) an explanation of the options available …"

88. In this case, there is no evidence that a provider made a decision that it was clinically appropriate to cease active treatment and commence Mr A on end-of-life care (discussed further below). Furthermore, Mr A had clearly indicated that he wished to be provided with antibiotic treatment. Accordingly, a clinical decision to cease active treatment and provide end-of-life care had not been made, and therefore any care and treatment decisions should not have been made without Mr A's informed consent (discussed further below).

Staffing and continuity of care — Breach

89. I am concerned that Manis did not have systems in place to ensure that adequate cover would be available in the event that the only registered nurse on staff was on sick leave. I consider that this failure led to inadequate communication between providers caring for Mr A, and inadequate communication with Mr A.

Failure to have systems in place to ensure adequate registered nurse cover

90. The outbreak of influenza affected staff and residents at Cameron Courts. At the time, CM D was the only registered nurse employed by Manis at Cameron Courts. CM D worked Monday to Friday, and remained on call over the weekends. From Thursday, CM D was on sick leave with influenza, meaning that there was no registered nurse on site at Cameron Courts from Thursday until after Mr A died on Monday. However, CM D remained available by telephone while she was sick.

91. The Manis "Annual Leave and Rostering Policy" states: "The senior person on-duty will arrange staffing cover for those staff calling in sick at late notice …" As the Operations Manager, and senior person on duty, OM E was responsible, in accordance with her job description, for ensuring that "staff gaps [were] filled to ensure appropriate cover on all shifts to meet residents' needs". OM E told HDC that at all times there was an "adequate amount of staff (normal amount as usual)" on shift, and that CM D was available by telephone contact. OM E kept in frequent contact with her manager, and with CM D. I also note that it was normal practice on weekends for CM D to be available by telephone, and Cameron Courts operated without an on-site registered nurse during those times.

92. However, my expert nursing advisor, RN Rosemary Minto, advised: "I do not consider expecting an RN who has gone off duty due to sickness to continue to be involved in the care of residents to be best or even good practice." RN Minto further stated: "It is clear to me that an RN should have been on site during an influenza outbreak. It shows poor management by the facility that this … was allowed to occur."

93. I agree with RN Minto's advice in this respect. In my view, it is not appropriate to expect an unwell registered nurse to continue to provide advice while on sick leave. I also share RN Minto's concerns that there was no registered nurse on site during an influenza outbreak. I acknowledge Manis' statement that it was relying on advice from OM E that adequate staffing levels were in place, and that appropriate care was being provided to residents. However, after having spoken to OM E, Manis was aware that there was an influenza outbreak in the town, and that staff, including CM D, were on sick leave. Manis should have reasonably anticipated that there would be an increase in

the clinical needs of its residents, and that OM E would be stretched in terms of her responsibilities without registered nurse support in these circumstances.

94. In my view, it was Manis' responsibility to ensure that appropriate procedures were in place to ensure that registered nurse cover was arranged in the event that the only registered nurse on staff was unwell and unavailable.

95. I am also concerned that it was usual practice at Cameron Courts that CM D was expected to be available to be contacted seven days a week in order to provide advice on the clinical management of residents at Cameron Courts. I do not consider it appropriate in any circumstances for a staff member to be required to be on call constantly, as this places significant pressure on that staff member.

Poor communication between providers

96. I consider that Manis' failure to ensure that there was registered nurse cover available, in the event that its only registered nurse on staff was unwell, led to poor communication between providers caring for Mr A. The most senior staff member on duty after Thursday, and during an influenza outbreak, was OM E. Although OM E had no clinical qualifications, it was part of her role in these circumstances to provide information regarding Mr A to both CM D and Dr G, so that they could provide clinical advice on Mr A's care and treatment. As the on-call doctor over the weekend, having not had the opportunity to assess Mr A himself, Dr G was reliant on information given to him by OM E about Mr A's condition.

97. Dr G recalls being told by OM E that Mr A was on end-of-life care. In this respect, it was reasonable for Dr G to assume that Manis staff had had appropriate conversations with Mr A and his family about end-of-life care.

98. OM E recalls that she told Dr G that Mr A's condition had deteriorated and that he had become "very very restless". OM E initially told HDC that she does not recall discussing end-of-life care with either CM D or Dr G. However, in response to the provisional opinion, OM E told HDC that in her conversation with Dr G she was trying to convey that Mr A was on end of life "type" care.

99. I have considered OM E's response to the provisional opinion on this point and, having done so, and based on the information provided to HDC, I remain of the view that it is more likely than not that OM E told Dr G during her conversation with him at 11.00am on Saturday that Mr A was for end-of-life care. This is supported by OM E's documentation in the progress notes, and the fax she sent to Dr G later on Saturday. I am unable to make a finding that OM E made the decision to commence Mr A on end-of-life care, but rather that during her conversation with Dr G she conveyed this message to him. This was a clear error by OM E, as Mr A had not been assessed clinically, and no discussion had taken place between him and/or his family, with regard to end-of-life care. OM E's communication with Dr G in this respect was clearly inappropriate, and affected the quality and continuity of Mr A's care.

100. In my view, having a staff member on site with clinical qualifications and responsibilities may have contributed to improved and more accurate communication

between staff, including about issues relating to end-of-life care. In the circumstances, there was no person with appropriate clinical qualifications on site after Thursday who was responsible for overseeing Mr A's clinical care, including communicating with external providers.

Cessation of amoxicillin

101. At 5.50pm on Friday, Mr A was administered amoxicillin for the last time, despite his prescription being for three times a day for another five days. End-of-life care appears to have commenced for Mr A around the same time, or the following morning on Saturday (see discussion below).

102. There is no documentation regarding the decision to cease administering amoxicillin to Mr A. However, the decision to cease administration of amoxicillin for Mr A appears to have been linked to, or based upon, the same assumption that led to the commencement of end-of-life care for Mr A, in addition to the fact that Mr A was having trouble swallowing tablets. Regardless of why Manis staff failed to continue to administer amoxicillin to Mr A in accordance with his prescription, I am concerned that Manis staff ceased administration of Mr A's medication without ensuring that this was appropriately authorised by a GP.

Informed consent

103. On Wednesday, Dr F assessed Mr A and diagnosed him with influenza. Mr A requested antibiotics, so Dr F prescribed oral amoxicillin. On Friday, Mr A was administered amoxicillin for the last time, and the following day, he was commenced on morphine.

104. There is no evidence that Mr A was reviewed clinically and/or a decision made that it was clinically appropriate to cease active treatment and to commence Mr A on end-of-life care. Likewise, there is no evidence that Mr A's condition was discussed with Mr A himself, before his amoxicillin was withdrawn, or before he was commenced on morphine. As Mr A was not assessed as being incompetent, he is presumed to have been competent for the purposes of the Code.[27] Accordingly, Mr A should have been consulted regarding the cessation of amoxicillin and commencement of morphine, and his consent obtained to that treatment plan.[28] There is no evidence that this occurred.

105. No registered nurse was on site, and the most senior staff member was OM E, who was not clinically trained. OM E administered the first dose of morphine at 1.50pm. OM E initially told HDC that she did not have any discussions with Mr A regarding the administration of morphine at that time. In response to the provisional opinion, OM E told HDC that before administering the morphine she "explained exactly what was happening to Mr A …". However, this is not documented.

[27] Right 7(2) states: "Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent."
[28] If Mr A was not competent at that time, he should have been certified as not competent and such consent obtained from someone legally entitled to consent on his behalf (Mr A's daughter, Ms B, held enduring power of attorney for Mr A, but there is no evidence that this was activated at any time).

106. Given OM E's initial response to HDC that Mr A was "unable to hold a conversation" at this time, and taking into account that there is no documentation of such a conversation with Mr A, I remain concerned that relevant information regarding Mr A's condition, the withdrawal of amoxicillin and the commencement of morphine, was not provided to Mr A prior to him being placed on end-of-life care. In my view, this is information that a reasonable consumer, in Mr A's circumstances, would expect to receive. As no one was available to assume responsibility for informing Mr A about his condition and obtaining his consent, Manis must take responsibility for this failure owing to inadequate staffing.

Conclusion

107. I do not consider that Manis had appropriate systems in place to ensure that adequate clinical cover would be available in the event that the only registered nurse on staff was unavailable. This failure led to poor communication between providers caring for Mr A, and decisions being made about his care and treatment without him being clinically assessed appropriately. Accordingly, Manis failed to ensure that Mr A received continuity of services, in breach of Right 4(5) of the Code.

108. Manis' failure to ensure that adequate clinical cover was available also led to poor communication with Mr A about his condition. Mr A was not provided with information that a reasonable consumer would expect to receive. Accordingly, I find Manis in breach of Right 6(1) of the Code. Without this information, Mr A was not in a position to provide his informed consent to the treatment plan, including the withdrawal of amoxicillin and the commencement of morphine. Consequently, Manis also breached Mr A's right to give informed consent under Right 7(1) of the Code.

Controlled drugs — Adverse comment

Documentation of controlled drug

109. Between Saturday and Monday, Mr A was administered morphine on a number of occasions. The administration of morphine for Mr A was not always documented adequately.

110. In accordance with Schedule 2 of the Misuse of Drugs Act 1975, morphine is a class B controlled drug. As outlined above, the regulations require providers to maintain a CDR in relation to controlled drugs, for each individual consumer. The regulations require that each controlled drug be recorded on a separate page in the CDR.

111. During the course of this investigation, instances of inaccurate or suboptimal documentation with regard to controlled drugs have come to my attention. First, there is a space at the top of each page of the CDR for the name of the controlled drug being administered to be recorded. However, with regard to Mr A, this space has been left blank, so that it is not immediately apparent that the records relating to the administration of a controlled drug for Mr A relate to morphine.

112. While the name of the controlled drug administered to Mr A (morphine) is not recorded at the top of each individual page of the CDR, it is evident that the CDR relates to morphine, because the entries on the CDR (for the most part) match those in the MASS for morphine.

113. In addition, at 6.40pm and 11.30pm on Sunday, Manis staff recorded on the CDR that Mr A was administered morphine, but failed to sign the MASS.

114. Regardless of the fact that a staff member failed to sign the MASS, it is evident that Mr A was administered morphine, and by whom, on the two occasions on Sunday, because of the records in the CDR.

115. This Office has frequently emphasised the importance of record-keeping, which is particularly important with regard to the administration of controlled drugs. This is supported by the regulations (outlined above). As stated in a previous opinion,[29] "the failure to record medications given is poor practice, affects continuity of care, and puts patients at real risk of harm". In my opinion, the incomplete documentation of Mr A's medication administration was poor.

Administration of a controlled drug

116. At 1.50pm on Saturday, Mr A was commenced on morphine and, at 6.00pm that evening, he was administered morphine for a second time. No registered nurse was on site during this time. RN Minto advised that when administering a controlled drug for the first time, "good or best practice would have been that an RN would have been on site and assessing the response to the drug". The Medicines Care Guides[30] state:

> "For those residents who have recently started a controlled drug, skilled assessment of treatment efficacy is required and should be carried out by a health professional whose scope of practice includes clinical assessment (eg, a registered nurse)."

117. As there was no registered nurse on site at Cameron Courts on Saturday and Sunday, the administration of morphine to Mr A (and the checking of that administration) on those days was undertaken without the direct input of a registered nurse. The Cameron Courts Medication Administration Policy does not require that a registered nurse is on site when a controlled drug is administered. The policy states:

> "Each individual administration of a controlled drug must be signed out of the Controlled Drug book by two staff who verify the correct balance of the particular drug book."

118. Furthermore, on the standard form used for "Administration of Medication Competency Assessment" at Cameron Courts it is noted under "Controlled Drugs": "*Where able*, one of the two staff signing out should be a Registered Nurse" (emphasis added). On OM E's medication competency assessment there is an annotation that states: "RN not always available. 8hrs a day. 5 days a week", as CM D did not work weekends (but remained on call). Similar annotations are written on other staff medication competency assessments.

119. RN Minto advised that "while the facility is legally able to have enrolled nurses and health care assistants administering medications, including controlled drugs, it is their

[29] See Opinion 08HDC10236, available at www.hdc.org.nz.
[30] Ministry of Health (2011). Medicines Care Guides for Residential Aged Care.

responsibility to ensure the staff involved are adequately trained … if so, then the administration of a controlled drug by staff would be acceptable".

120. I accept that the staff involved in the administration of drugs to Mr A at Cameron Courts held the required medication competencies, including for controlled drugs, and that morphine was administered to Mr A in accordance with Manis policy. However, I am concerned that Manis' Medication Administration Policy is not in line with Ministry of Health (MOH) Guidelines. I recommend that Manis consider re-evaluating its Medication Administration Policy to bring it in line with the MOH Guidelines, which would require a registered nurse to be available to assess and monitor a patient who is administered a controlled drug for the first time.

Administration of a controlled drug, previously prescribed to another consumer[31]

121. Dr G told HDC with regard to his conversation with OM E on Saturday that there was "morphine elixir available left over from another patient that could be used as the pharmacy was closed". Both the morphine prescribed to Mr A, and the available morphine that had been prescribed to another patient, were 1mg/ml strength. At 5.11pm, OM E sent a fax to Dr G requesting confirmation of instructions to administer morphine for Mr A that was being held at Cameron Courts, "belonging to [another patient]". The morphine administered to Mr A on Saturday had been prescribed for another patient, who no longer required it.

122. The Medicines Care Guides[32] outline that medicine should not be administered to a person other than to whom it has been prescribed. RN Minto advised HDC that in situations where medication cannot otherwise be obtained in a timely manner, "[a]s long as the medication is the correct strength, dose and preparation, and is tracked adequately via the documentation … to avoid 'lost' medication, then the use of another patient's unused prescription might be tolerable in such a situation. It should not, however, be routine practice."

123. I consider that the staff responsible for administering morphine to Mr A had a responsibility to consider whether it was appropriate to administer medication that had been prescribed for another patient. The administration to Mr A of morphine that had not been prescribed for him was contrary to the Medicines Care Guides as outlined above and, accordingly, was not good practice. I accept my expert's advice that it was "tolerable" in the specific circumstances of this case, but emphasise that this is not the standard to which facilities such as Manis should aspire.

Documentation — Adverse comment

124. While CM D was on sick leave and available by telephone between Thursday and Monday, she provided advice to Manis staff over the telephone with regard to Mr A's care and treatment.

125. I am critical that there is no documentation regarding telephone conversations that CM D had with Manis staff, or advice that she gave regarding Mr A's care while she was

[31] HDC has dealt with issues relating to controlled drugs regarding Dr G separately.
[32] Ministry of Health (2011). Medicines Care Guides for Residential Aged Care.

on sick leave. Consequently, it is not clear what advice CM D provided to Manis staff while she was on sick leave, or what information she was provided about Mr A's condition. In normal circumstances where CM D provides advice while on call, I consider that both CM D and staff with whom she had conversations would have a responsibility to keep accurate records of those discussions. However, in the circumstances of this case, where CM D was on sick leave, I do not consider it appropriate to expect CM D to be providing advice to Manis staff. For this reason, it would not be reasonable to expect her to keep records of the discussions that she had with Manis staff.

126. The lack of comprehensive documentation in this respect has affected my ability to obtain a complete understanding of the decisions made and care provided to Mr A. Substandard documentation is poor practice, and I am critical that Manis did not ensure that higher standards of documentation were maintained at Cameron Courts.

127. I acknowledge that since these events, Manis has implemented the use of a specific form for Cameron Courts' staff to record conversations with the registered nurse on call.

Opinion: OM E — Adverse comment

Communication regarding commencement of end-of-life care

128. Dr F told HDC that when he saw Mr A at 12.15pm on Friday, he did not consider him to be terminally ill. Having assessed Mr A, he noted: "[C]ontinue current management … no other treatment options at this stage." I accept that the reference to current management included the administration of antibiotics.

129. The following day, at 11.00am, Dr G received a telephone call from OM E. Dr G recalls being informed by OM E that Mr A was receiving "end of life care", was in pain and agitated, and needed medication. Dr G told HDC that he recommended administering 5ml of oral liquid morphine to Mr A, four times a day. OM E advised that she did not recall discussing end-of-life care with either CM D or Dr G, and stated: "I do not believe this was mentioned and at the time the Doctor prescribed morphine [Mr A] was not on end of life care." However, in response to the provisional opinion, OM E told HDC that in her conversation with Dr G she was trying to communicate to him that Mr A was receiving end-of-life "type" care.

130. Nevertheless, later that day (Saturday) OM E sent a fax to Dr G that stated:

> "As per our telephone conversation … can you please confirm instructions to administer morphine … [Mr A] is currently receiving end of life care and has become very restless and unresponsive verbally."

131. There is also a statement in the nursing progress notes dated Saturday at 12.15pm, signed by OM E, stating: "[E]nd of life care has been started."

132. There are no records that Mr A was assessed by a registered nurse or a doctor between 12.15pm on Friday, when Dr F assessed Mr A and determined that he was not terminally ill, and 11.00am on Saturday, when OM E contacted Dr G. There is also no documentation at that time relating to end-of-life care for Mr A. This means that at some point between Dr F's final assessment of Mr A on Friday, and OM E's telephone call to Dr G, miscommunication or assumption led to Mr A being commenced on end-of-life care. During the investigation, OM E told HDC: "[T]here was a misunderstanding in regard to the end of life care and if [Mr A] was or was not on end of life care. I'm not sure how this occurred."

133. I have considered OM E's response to the provisional opinion on this point and, based on the information provided to HDC, I remain of the view that it is more likely than not that OM E told Dr G during her conversation with him at 11.00am on Saturday that Mr A was for end-of-life care. This was a clear error by OM E, as Mr A had not first been clinically assessed, and no discussion had taken place between him and/or his family with regard to end-of-life care. OM E's communication with Dr G in this respect was clearly inappropriate, and affected the quality and continuity of Mr A's care.

134. Dr G was the on-call doctor on the weekend. In my view, in the circumstances of this case, it was reasonable for Dr G to rely on information given to him on the telephone by OM E that Mr A had been started on end-of-life care, and reasonable for Dr G to assume that the appropriate discussions had been had with Mr A and/or his family about end-of-life care.

135. As a non-clinically qualified staff member, OM E should have been especially careful to ensure that she provided clinical staff with accurate information and, if necessary, sought clinical review in order to make decisions such as the commencement of end-of-life care. I am critical that this did not occur.

Opinion: CM D — Adverse comment

Clinical care

136. With regard to remaining available to provide advice by telephone while being on sick leave between Thursday and Monday, CM D told HDC:

> "I took phone calls two and three times a day from [OM E] — Operations Manager — to update me on [Mr A] and other residents and ensure she was instigating the correct procedures."

137. It is not clear what information or advice was provided by CM D over the telephone. However, there is evidence that CM D was providing some level of support via telephone, to staff members caring for Mr A over Friday–Monday.

138. RN Minto advised that "the absence of an RN on duty on the days in question, [Saturday and Sunday] when the controlled drug was administered is of concern". She

stated that best practice is that a registered nurse is available to "assess and monitor for effect and reaction". She further stated: "As the RN had delegated this duty to the staff on duty, it is her responsibility to be directly involved with the patient when their condition is changing … it is clear that there was no assessment of the patient by an RN during the days in question." RN Minto advised that CM D remained involved in Mr A's care, "thus remaining responsible".

139. I agree with my expert that CM D placed herself in an unacceptable position of retaining responsibility for patients while she was on sick leave. However, RN Minto also advised: "I do not consider expecting an RN who has gone off duty due to sickness to continue to be involved in the care of residents as best or even good practice." RN Minto confirms that this is "not satisfactory provision of care in the context of an unwell patient …". I acknowledge CM D's submission in response to the provisional opinion that she felt that she had no choice but to be available over the telephone owing to staffing levels at that time. However, I accept my expert's advice, and consider that CM D should take some responsibility for the shortcomings in the care provided to Mr A. However, as discussed above, I do not consider that Manis had appropriate systems in place to ensure that adequate cover would be provided when the only registered nurse on staff was unavailable.

Documentation

140. I am critical that there is no documentation regarding telephone conversations that CM D had with Manis staff, or advice that she gave regarding Mr A's care while she was on sick leave. Consequently, it is not clear what advice CM D provided to Manis staff while she was on sick leave, or what information she was provided about Mr A's condition. In normal circumstances where CM D provides advice while on call, I consider that both CM D and the staff with whom she had conversations would have a responsibility to keep accurate records of those discussions. However, in the circumstances of this case, where CM D was on sick leave, I do not consider it appropriate to have expected CM D to provide advice to Manis staff. For this reason, it would not be reasonable to expect her to have kept records of the discussions that she had with Manis staff.

Recommendations

141. I recommend that Manis Aged Care Limited:

a) Implement appropriate procedures/policies to ensure that adequate cover will be available when registered nurses on staff are unavailable (ie, through annual/sick leave), and report to HDC **within three months** of the date of this opinion regarding its implementation at Cameron Courts.

b) Provide training to staff about the importance of accurate documentation regarding the administration of medication, particularly with regard to requirements regarding controlled drugs, and provide evidence of that training **within three months** of the date of this opinion.

c) Consider re-evaluating its Medication Administration Policy to bring it in line with the MOH guidelines, which would require a registered nurse to be available to assess and monitor a patient who is administered a controlled drug for the first time, and report to HDC within **one month** of the date of this opinion.

d) Provide a written apology to Mr A's family for its breaches of the Code. The apology is to be sent to HDC for forwarding **within one month** of the date of this opinion.

Follow-up actions

142. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Manis Aged Care Limited (trading as Cameron Courts Rest Home), will be sent to the District Health Board and HealthCERT (Ministry of Health).

143. A copy of this report will be sent to the Coroner.

144. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Manis Aged Care Limited (trading as Cameron Courts Rest Home), will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent nursing advice to the Commissioner

The following expert advice was obtained from registered nurse Ms Rosemary Minto:

"My instructions from the Investigator are to provide preliminary expert advice in relation to concerns raised by the complainant about aspects of care provided to Mr A between [Friday and Monday].

Specific issues include:

1. The overall facility management and clinical supervision when faced by an absence of RN staff — in particular, commencement and ongoing administration of controlled drugs in the absence of RN staff input into the management of an unstable deteriorating patient.

2. Should agency staff have been made available?

3. The general standard of care documentation

4. The standard of medication management

5. The standard of nursing clinical supervision with respect to communication with RN staff, family and [Dr G] around the decision to initiate end-of life care for [Mr A]

6. Comment on any other nursing issues identified.

I base my advice on the information provided and the assumptions that:

- As a Registered Nurse (RN), the RN in question is aware of her requirements to meet Nursing Council of NZ Competencies for RNs and the Health Practitioners Competence Assurance Act 2003, including her responsibility for direction and delegation.
- That the facility manager in question is cognizant of her legal responsibilities as set out in her job description, and the legal responsibilities of the facility in terms of the safe staffing levels required to provide adequate and safe care to residents.

1. The overall facility management and clinical supervision when faced by an absence of RN staff — in particular, commencement and ongoing administration of controlled drugs in the absence of RN staff input into the management of an unstable deteriorating patient.

The Ministry of Health set out clear guidelines[1] for the management and administration of controlled drugs. This includes:

- having staff who are trained in the administration of medications and who have ongoing competency assessments by an RN; and

[1] Ministry of Health (2011). *Medicines Care Guides for Residential Aged Care* Wellington: Ministry of Health.

- having an RN who is able to provide oversight during the direction and delegation[2] aspects of her duties.

The Nursing Council of NZ (NCNZ) direction and delegation guidelines specifically state that:

> The decision to delegate is a professional judgment made by a registered nurse and should take into account:
>
> (a) the health status of the health consumer;
> (b) the complexity of the nursing intervention required;
> (c) the context of care; and
> (d) the level of knowledge, skill and experience of the enrolled nurse/health care assistant.

a. Whilst the facility is legally able to have enrolled nurses and health care assistants administering medications, including controlled drugs, it is their responsibility to ensure the staff involved are adequately trained and that they have had a competency review completed by an appropriately trained RN.

— Is there clear documentation that staff have regular training and competency review in the administering of medication, including controlled drugs?

If so then the administration of a controlled drug by staff would be acceptable.[3]

b. It is not clear from the documentation supplied if the staff checking and administering the controlled drug are enrolled nurses (ENs) or health care assistants (HCAs). An EN may have the skills and knowledge to perform an assessment if they have adequate training. I do note that on one occasion the facility manager did sign as checking the balance, which would be acceptable if she has had the appropriate medication management training. The absence of an RN on site on the days in question — [Saturday and Sunday] when the controlled drug was administered is of concern. Best practice is that an RN is available to 'assess and monitor for effect and reaction'.

As the RN had delegated this duty to the staff on site, it is her responsibility to be directly involved with the patient when their condition is changing as detailed in NCNZ Competency 1.3.[4] From the documentation available it is clear that there was no assessment of the patient by an RN during the days in question.

This is not satisfactory provision of care in the context of an unwell and deteriorating patient to a severe degree.

[2] Nursing Council of New Zealand. (2011). Guideline for the direction and delegation of care to Enrolled Nurses.
[3] Ministry of Health (2011). Medicines Care Guides for Residential Aged Care Wellington: Ministry of Health.
[4] Ministry of Health (2011). Medicines Care Guides for Residential Aged Care Wellington: Ministry of Health.

c. The operations manager's job description provided in the documentation states that they must ensure safe appropriate care provision in consultation with the RN.

The manager must also ensure that staff roster gaps are filled to ensure appropriate cover on all shifts to meet residents' needs. If in fact there was an 'influenza outbreak' occurring at the time of [Mr A's] death as stated by the managing director, it is difficult to understand why agency staff had not been called in, given the number of residents affected.

I consider this a failure on the part of the manager not to have provided adequate RN cover to a severe degree. I do not consider expecting an RN who has gone off duty due to sickness to continue to be involved in the care of residents as best or even good practice.

Is there adequate agency staff available to provide cover in the event of an outbreak of this kind?

2. The general standard of care documentation

(a) As far as I can ascertain there is no documentation about when and how the decision to manage [Mr A] as terminal was made, other than the statement noted in the nursing progress notes by the operations manager that 'end of life care has been started'. There is also no documentation available from the RN, who remained involved in the care of residents whilst off sick, thus remaining responsible and required to document any care or advice she offered. Without documentation it is unclear who made the decision to transition [Mr A] to terminal cares and if that person had the clinical skills and knowledge to do so. Obviously the family were not included in the decision which is a direct contravention of the code of Health and Disability Consumers Rights 4, 5, 6 and 7, and the Nursing Code of Conduct Principles 1, 3, and 4.[5]

The lack of accurate documentation indicates a moderate failure of duty on the part of the facility staff.

(b) I agree with [Dr F's] statement (p2) that the lack of an onsite RN has contributed significantly to the family's dissatisfaction with the care provided to [Mr A] during his final days. I would go further to state that this also contributed to the lack of adequate documentation around the clinical issues of the decisions made to stop the antibiotic and commencing end of life care. The lack of any report from the RN in question, who was available by telephone, makes it difficult to further assess the veracity of information provided.

3. The standard of medication management

I have addressed this issue in 1(a) and (b). I consider it an oversight by [Dr G] that the antibiotic was not documented as stopped as this would be an expected action, when a patient has transitioned to end of life cares.

[5] Nursing Council of New Zealand Code of Conduct 2012.

4. The standard of nursing clinical supervision with respect to communication with RN staff, family and [Dr G] around the decision to initiate end-of-life care for [Mr A].

(a) This issue is at the crux of this complaint. The presence of a trained RN with the skills and knowledge to make the decision to transition [Mr A] to terminal cares, in collaboration with the family and the treating physician should have been standard care. This is made clear in the well known RN Residential Aged Care RN Care Guides — 'End of Life Care'. In continuing to maintain communication via telephone with the facility the RN has placed herself in an unenviable position of being responsible for residents without being able to fully complete her responsibilities as an RN, thus failing to meet NCNZ Competencies 1.1, 1.4, 2.4 and 2.6.[6]

It is clear to me that an RN should have been on site during an influenza outbreak. It shows poor management by the facility that this event was allowed to occur. However without any documented evidence or statement from the RN in question, it is difficult for me to make a full conclusive statement on the issue of RN clinical supervision.

Rosemary Minto."

Subsequent expert advice obtained from RN Minto on 2 December 2014

"… Previously I have been asked to provide an opinion on the following:

1. The overall facility management and clinical supervision when faced by an absence of RN staff — in particular, commencement and ongoing administration of controlled drugs in the absence of RN staff input into the management of an unstable deteriorating patient.

1. Should agency staff have been made available?
2. The general standard of care documentation.
3. The standard of medication management
4. The standard of nursing clinical supervision with respect to communication with RN staff, family and [Dr G] around the decision to initiate end-of-life care for [Mr A].
5. Comment on any other nursing issues identified.

My instructions from the Investigator for this report are to:

1. Reconsider my previous opinion in light of new evidence offered to me.

This new evidence includes:
— Responses from relevant staff.
— Controlled drug register for [Mr A].

[6] Nursing Council of New Zealand Competencies for Registered Nurses (2007), pg 9.

— Manis' response dated 8 August 2013.
— Annual Leave and Rostering Policy.
— Administration of medication Policy.

In addition I have been asked to offer my opinion on the following questions:

2. Whether the apparent administration of a controlled drug (morphine) by Operations Manager [OM E] at 1.50pm on Saturday was appropriate.

3. Whether the apparent checking by Operations Manager [OM E] of the administration of a controlled drug (morphine) by a Health Care assistant at 10.40am on Sunday was appropriate.

Opinion
1a. In my deliberations of this issue I have sought peer opinion of accepted practice and best and safe practice regarding the administration of controlled drugs in residential aged care facilities, and utilized the following resources:

Ministry of Health (2011). Medicines Care Guides for Residential Aged Care Wellington: Ministry of Health.

Nursing Council of New Zealand. (2011). Guideline for the direction and delegation of care to Enrolled Nurses.

New Zealand Nurses Organisation. (2012). Guidelines for nurses on the administration of medicines. Wellington: New Zealand Nurses Organisation. Wellington, New Zealand.

1b. From the evidence provided I accept that the staff at Cameron Courts Rest Home have the required training to safely administer medications. This includes controlled drugs.

1c. I acknowledge that there is no legislative requirement in New Zealand to have an RN as one of the two staff checking and/or administering controlled drugs.

1d. I acknowledge that there is no legislative requirement to have an RN on duty physically on the premises at all times.

1e. I acknowledge that in rural New Zealand access to appropriately trained nursing staff (e.g., RNs) is problematic for residential aged care facilities.

1f. In [Mr A's] case the administered drug in question is a controlled drug, having been newly prescribed and being given to a patient who is unwell — therefore clinically 'unstable'.

In this instance good or best practice would have been that an RN would have been on site and assessing the response to the drug as recommended in the Medicines Care

Guides[7]. The paragraph in particular is 'For those residents who have recently started a controlled drug, skilled assessment of treatment efficacy is required and should be carried out by a health professional whose scope of practice includes clinical assessment (eg, a registered nurse).'

So whilst there is no legislative regulation requiring an RN to be one of two administrating controlled drugs, and it may be accepted practice in smaller rest homes who do not have an RN on site at all times, current best practice guidelines[8][9] do recommend that for an unstable patient an RN is available to assess and monitor the effects of that drug.

1f. In summary I stand by my previous opinion, including that there should have been an RN on duty as the patient in question was unstable and requiring regular clinical assessment by a trained health professional.

For the following questions:

2. Whether the apparent administration of a controlled drug (morphine) by Operations Manager [OM E] at 1.50pm on Saturday was appropriate.

3. Whether the apparent checking by Operations Manager [OM E] of the administration of a controlled drug (morphine) by a Health Care assistant at 10.40am on Sunday was appropriate.

Whilst the administration and checking of controlled drugs by health care assistants may be appropriate in usual circumstances, my opinion is again that although there is no regulation requiring an RN to be present, best practice would be that because the patient is clinically unstable and the drug is newly prescribed that an RN should have been available to provide on site oversight. It is impossible to complete a clinical assessment over the telephone."

Subsequent expert advice obtained from RN Minto on 23 February 2015

"My instructions from the Investigator are to provide advice regarding:

1) The appropriateness of the administration of morphine on two occasions to [Mr A] after receiving a verbal order over the telephone from a GP, but before receiving a written prescription for morphine.

2) The appropriateness of the administration of morphine that was originally prescribed and dispensed for another patient, who no longer required it. I note that the administration of morphine in this context was based on advice from the GP.

[7] Ministry of Health (2011). Medicines Care Guides for Residential Aged Care. Wellington: Ministry of Health.
[8] Ministry of Health (2011). Medicines Care Guides for Residential Aged Care. Wellington: Ministry of Health.
[9] New Zealand Nurses Organisation. (2012). Guidelines for nurses on the administration of medicines. Wellington: New Zealand Nurses Organisation.

1) In my experience common practice is for the prescriber to fax through a written prescription on the medication chart utilized by the residential care facility — ie one that they have faxed to the prescriber to complete. If a telephone verbal request is done first, then ideally two nurses will take that request, one after the other or over speaker phone to verify the order, and signed by both on the order.

The medication may then be administered, and the prescriber is required to document the medication chart at the facility within the next 2 days.

This is covered in the Medicine Care Guides which I have referenced in my previous report.

The Residential care facility should have a policy covering this eventuality.

So given this process is common practice it would have been appropriate for the medication to have been to the patient [Mr A].

2). All controlled drugs require documentation of return or how the drug was wasted, ie broken ampoules, etc., as the potential for drug abuse is high if there is no clear tracking of usage and disposal. This is recommended for all patients. The Care Guides suggest that 'Never give medicine to anyone other than the person for whom it is labeled'. Unfortunately, the reality is that pharmacies are not often open when the patient is requiring newly prescribed medication and the patient is in pain or distress. As long as the medication is the correct strength, dose and preparation, and is tracked adequately via the documentation as above to avoid 'lost' medication, then the use of another patient's unused prescription might be tolerable in such a situation. It should not, however, be routine practice.

Rosemary Minto,RN,NP"