Inadequate pain management in residential aged care facilities

General Practitioners (GPs) are often working closely with Residential Aged Care Facilities (RACFs) to ensure their patients receive appropriate medical intervention and seamless care. It is important that GPs are alert to potential issues that can arise in the provision of care in RACFs. The following article notes pain management as being one of the more common complaints HDC receives about RACFs, and provides an example of where a service can fail a consumer in this area.

In September 2016, the Health and Disability Commissioner (HDC) published an in-depth analysis of HDC's complaint data about residential Aged Care over the five year period from 1 July 2010 to 30 June 2014. The report analysed the issues raised in complaints made to HDC about RACFs and examined in detail the trends in complaints. This analysis identified pain management, including the effective assessment and management of pain, as being one of the more common issues raised in complaints HDC received about RACFs, with it being at issue in 15% of cases.

Further analysis of this data showed that inadequate pain management was at issue in 63% of cases relating to the provision of end-of-life care within RACFs. My recent decision, published in March 2017, is one such case (13HDC01254). In this instance, the RACF and several of its staff failed to ensure that the consumer's pain was appropriately managed and as such he did not receive care that was of an appropriate standard, in breach of the Code.

The consumer, an elderly man, had terminal prostate cancer and bowel cancer with associated metastases. He was admitted to the private hospital for pain management and palliative care, and remained there for 23 days. During the man's admission there were a number of errors made regarding his medication, including a failure to administer methadone in accordance with his prescription, for a number of days, and the administration of oral haloperidol for five days despite the prescription having been discontinued. On multiple occasions staff also failed to record the administration of his medications correctly. The man was not informed about the medication errors, and there was a 10-day delay in notifying his family of the haloperidol errors. The man was transferred to another hospital where he died a short time later.

In my view, the deficiencies in the care provided were not the result of isolated incidents involving one or two staff. They were numerous and widespread, involving a number of staff members.

I found that staff consistently failed to adhere to relevant policies, and to manage the man's pain and medication adequately. As a result, they made multiple errors in relation to the ordering, storage and administration of the man's medication, in particular his methadone and haloperidol. Despite the man experiencing high levels of pain, there were multiple occasions on which his pain assessment and management were suboptimal. Furthermore, once the medication errors were identified, staff failed to respond appropriately in documenting and notifying the man of the errors. In conclusion, I found that the operator of the private hospital failed to provide services to the man with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

The clinical manager failed to ensure that staff complied with relevant policies and procedures, particularly in relation to pain and medication management; she did not follow up to ensure that corrective actions had been carried out following the identification of the medication errors; she

failed to inform the man's family of the errors in a timely manner; and she did not act in a timely manner in administering OxyNorm to the man. I concluded that the clinical manager failed to provide services to the man with reasonable care and skill and, accordingly, breached Right 4(1).

A registered nurse failed to ensure that adequate clinical nursing assessments were undertaken when the man had high levels of pain, and she did not supervise the actions of staff in relation to medication management and clinical documentation. In conclusion, I found that the RN failed to provide services to the man with reasonable care and skill and, accordingly, breached Right 4(1).

In response to these failures, I recommended that the hospital management provide ongoing training to all its registered nurses with regard to its policies and procedures, communication with residents and their families, medication management, and professional standards regarding documentation. I also recommended the RACF conduct an audit as a follow up to the corrective action plan it had implemented, and disseminate the learnings from this investigation to all its facilities nationwide. I further recommended that the Nursing Council of New Zealand consider competence reviews of both the clinical manager and the registered nurse.

The private hospital, clinical manager and the registered nurse have all since provided a written apology to the man's family.

In conclusion, it is never acceptable for a vulnerable consumer to endure inadequately treated pain. This case is an important example of the factors that can lead to inadequate pain management – one of the most common areas of concern to HDC in relation into RACFs. As such, GPs are encouraged to be proactive in considering the pain management of their patients, particularly during end-of-life care, and not rely solely on the RACF staff raising concerns.

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