Pain management and palliative care
13HDC01254, 13 March 2017

Private hospital ~ Clinical manager ~ Registered nurse ~ Palliative care ~ Pain management ~ Incident reporting ~ Communication ~ Right 4(1)

A 74-year-old man had terminal prostate cancer and bowel cancer with associated metastases. He was on medication for pain management, required assistance with showering and dressing, and used a walking frame.

The man was admitted to a private hospital for pain management and palliative care, and remained there for 23 days. His medications at admission included the controlled drugs OxyContin, methadone and haloperidol.

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 six 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, sadly, he died a short time later.

It was held that the staff consistently failed to adhere to relevant policies, and to manage the man's pain and medication adequately. As a result, staff 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. The hospital failed to ensure that the man received care that was of an appropriate standard and complied with the Code and, accordingly, breached Right 4(1).

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. In conclusion, it was found 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, it was found that the RN failed to provide services to the man with reasonable care and skill and, accordingly, breached Right 4(1).

Recommendations

It was recommended that the hospital management provide ongoing training to all registered nurses with regard to its policies and procedures, communication with residents and their families, medication management, and professional standards regarding

documentation; conduct an audit with regard to the corrective action plan; and disseminate the learnings from this investigation to all its facilities nationwide. The hospital has provided a written apology to the man's family.

It was recommended that the Nursing Council of New Zealand consider competence reviews of both the clinical manager and the registered nurse, and that both provide written apologies to the man's family for the breaches of the Code.