St Andrew's Village

A Report by the
Deputy Health and Disability Commissioner

Case 09HDC01783

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of contents

Executive summary

Background

1. Mr A (aged 85 years) was diagnosed with bladder cancer and secondary testicular cancer. He developed bony metastases, and sustained a pathological fracture of his right fibula[1] in mid 2009. Three months later, he was admitted to House 4 St Andrew's Village (SAV) in Auckland, for hospital level care. Although Mr A was not admitted to the designated palliative care unit within SAV, he and his family understood that his care was to be palliative.

2. The following day, SAV confirmed a suspected norovirus outbreak, and the facility went into voluntary "lockdown". Four areas, including House 4, were closed to visitors. Over the following nine days, family members attempted to maintain contact with Mr A from outside his bedroom window, by writing notes and using a cell phone. They were concerned about his apparent distress and confusion, and about the management of his pain. The following day, arrangements were made for family members to have limited contact with Mr A. Three houses, including House 4, reopened for visitors six days later. During this period, Mr A's mobility had deteriorated and he had developed pressure areas on his back and sacrum.

3. Several days later, Mr A's right lower leg was observed to be bruised and swollen, and his foot appeared to have dropped down. He was admitted to the public hospital later that day, and X-rays confirmed a fracture of the tibia and fibula. His leg was stabilised, and issues with dehydration, hypoxia,[2] an impacted bowel, and medication were addressed. However, Mr A's condition continued to deteriorate, and he died a short time later.

Summary of findings

4. I consider that there was a lack of reasonable care and skill in the services provided to Mr A by SAV, and that services were not provided in a manner that optimised his quality of life. Accordingly, I find that SAV breached Rights 4(1)[3] and 4(4)[4] of the Code of Health and Disability Services Consumers' Rights.

[1] One of the two long bones between the knee and the ankle.
[2] A deficiency of oxygen in the tissue.
[3] Right 4(1) — Every consumer has the right to have services provided with reasonable care and skill.
[4] Right 4(4) — Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

Investigation process

5. On 21 September 2009 the Commissioner received a complaint from Mr A's son and daughter-in-law, Mr and Mrs B, and his daughter, Ms C, about care provided to Mr A at St Andrew's Village. Their concerns relate in particular to the provision of effective analgesia, the standard of nursing care, the adequacy of the GP's clinical review, and the management of the lockdown during the norovirus outbreak.

6. After preliminary assessment, an investigation was commenced on 23 February 2010. The following issues were identified for investigation:

- *Whether St Andrew's Village provided appropriate care to Mr A over a period of 28 days in 2009.*
- *Whether St Andrew's Village communicated effectively with Mr A over a period of 28 days in 2009.*
- *Whether St Andrew's Village provided adequate information to Mr A over a period of 28 days in 2009.*

7. The parties directly involved in the investigation were:

Mr A (deceased)	Consumer
Mrs A	Consumer's wife
Mr B	Son/complainant
Mrs B	Daughter-in-law/complainant
Ms C	Daughter/complainant
Ms D	Care manager, St Andrew's Village
Dr E	General Practitioner
Dr F	General Practitioner
Ms G	Clinical support registered nurse
Ms H	Clinical support registered nurse

Also mentioned in this report:

Dr I	General practitioner
Ms J	Palliative care nurse
Dr K	Palliative care specialist
Ms L	Acting Admissions Co-ordinator
Ms M	Registered nurse
Ms N	Health care assistant
Ms O	Registered nurse
Ms P	Registered nurse
Ms Q	Community palliative care nurse
Ms R	Health care assistant
Ms S	Health care assistant
Ms T	Health care assistant
Ms U	Health care assistant

8. Information was reviewed from: Mr A's family, St Andrew's Village, Dr E, Dr F, Dr I, and the District Health Board including the Regional Public Health Service (the RPHS).

9. Independent expert advice was obtained from registered nurse Margaret O'Connor (**Appendix 1**). Advice was obtained from HDC's clinical advisor, Dr David Maplesden, to assist with assessing the complaint, prior to the start of the formal investigation.

10. In assessing this complaint, my Office reviewed the general practitioner care provided to Mr A. We did not identify issues that would warrant formal investigation. Nonetheless, I consider that some aspects of the medical care and associated documentation departed from accepted standards to a mild degree. This has been brought to the attention of the doctors.

11. This report is the opinion of Tania Thomas, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

Information gathered during investigation

Background

12. Mr A lived at home with his wife, Mrs A. In 2008 he was diagnosed with bladder cancer, and in 2009 with secondary testicular cancer. The cancer spread to his bones, and he sustained a pathological fracture of his right fibula. This was treated conservatively with a partial plaster cast, and Mr A was provided with a moon boot.

13. The following month Mr A was assessed by the community palliative care service as needing residential care. Palliative care nurse Ms J noted that Mr A needed one person to assist when mobilising, that he had memory loss, and that he was "occasionally confused but mostly coherent, alert and clear".[5] Palliative care specialist Dr K confirmed that Mr A needed hospital level care, noting: "Metastatic cancer of bladder. Deterioration overall condition, low back pain ? spinal metastases. Mostly bed bound." Dr K indicated that Mr A did not meet the criteria for palliative care funding.[6]

Admission to St Andrew's Village — Day 1

14. St Andrew's Village (SAV) is a retirement village offering rest home care, dementia care and hospital level care for 180 residents, and other accommodation for more independent residents. There are three areas, or "houses", providing hospital level care. At this time, SAV employed two Clinical Support Registered Nurses who were each responsible for overseeing the nursing care provided in three areas of 30

[5] Mr A's family note that he was very deaf without his hearing aids and that this may have contributed to others thinking he was confused. They note also that he was frustrated by the effect of too much morphine, and that without morphine he was "perfectly lucid".

[6] This covers the cost of residential care for people who are terminally ill and who are not expected to live more than six weeks. People who do not qualify for this apply for a Residential Care Subsidy through WINZ, or pay privately for their care.

residents (ie, one Clinical Support Registered Nurse for 90 residents). Within one house, there is a three-bed "Palliative Care Unit", which is contracted out to a hospice.

15. Mr A was admitted to House 4 at SAV on Day 1. An "Admission Agreement" and an "Informed Consent Agreement" were signed by Mr A. The latter indicated that Mr A consented to family being involved in his care and to information being shared with them except in the case of impaired decision-making, in which case permission should be sought from his enduring power of attorney (EPOA). Mr A had appointed his daughter, Ms C, as his EPOA in relation to care and welfare, but there was nothing to indicate that this had been invoked. SAV was provided with copies of Mr A's EPOA documents. Mr A's daughter-in-law, Mrs B, had completed other admission documentation a few days earlier.

16. Ms L was acting Admissions Co-ordinator at the time of Mr A's admission. She recalled that his family had requested a bed in the Palliative Care Unit. Ms L confirmed that Mr A had not been assessed for palliative care funding, and was advised by the manager of the hospice that it had not received a referral for Mr A. In addition, the three beds in that unit were occupied. Family recall that Ms L reassured them that Mr A would receive the same care in the hospital wing. Ms L's recollection is that she explained that he would receive the same meals and personal care, and be looked after by an RN who was also responsible for those in the hospice beds, but also that the health care assistant (HCA) staffing ratio was different, with one HCA to five residents in the hospital and one to three in the hospice.

17. An initial nursing assessment was completed by RN Ms M. She noted that Mr A used a walking frame and needed the assistance of two people when mobilising. He needed regular pain relief for lower back pain, including prior to receiving personal care. He also required laxatives twice daily and regular review in relation to bowel function.

18. Mr A's family state that prior to his admission, Mr A was being showered every day, he was toileting in the bathroom, and spending part of each day in the sitting room. They state that they "knew to give pain relief prior to such activities, to talk him through what was going to happen in order to gain his trust, and to listen to him; this did mean his care took considerable time and patience".

19. Mr A's previous GP was unable to provide a service to Mr A following his admission to SAV, so arrangements were made for GP services to be provided by SAV's contracted provider.[7] As neither of the doctors from the service was immediately available when Mr A was admitted, another doctor, Dr I, was asked to chart his medications. Mr A's family had provided SAV with a written summary of Mr A's medication regime **(Appendix 2)**. This included the pain relief medication oxycodone, in its controlled release form (Oxycontin) and its rapid release form (Oxynorm). Mr A had been receiving at least 75 mgs of oxycodone daily (20mg

[7] This service contracts two doctors, Dr E and Dr F, to provide GP services to SAV. Between them they visit five days a week and after-hours as required. Dr E is also a shareholder and co-director of the service.

Oxycontin twice a day and 5mgs Oxynorm 7 times a day), with additional Oxynorm for breakthrough pain. He was also taking paracetamol four times a day.

20. Dr I charted regular analgesia as 20mg Oxycontin twice a day and paracetamol four times a day, with 5mg Oxynorm as required up to two-hourly. Dr I subsequently explained:

> "When charting [Mr A's] medication I was presented with an unconventional regimen of opioid medication in that short acting oxycodone was being used on a regular and frequent basis, rather than only as required, which is the accepted way for it to be used.
>
> At the time I thought that the best way to assess his requirements was to chart a regimen that both covered his pre-admission regimen and allowed for additional doses as required. Assuming careful and full assessment of his pain by the nursing staff, Oxynorm two hourly as needed achieved this. I did not assume that he was overmedicated, (although this was a possibility), only that an unconventional regimen of oxycodone administration had arisen. By using the medication I charted, potentially he could have received more oxycodone than he had been receiving prior to admission and subsequently it would have been converted to twice daily Oxycontin.
>
> I emphasize that this was an interim measure, which I knew would be re-evaluated when he was formally admitted within 24 hours of my charting his medication."

21. After his arrival at SAV, Mr A was given a total of 45 mgs of oxycodone.

Norovirus outbreak

22. The following day, Clinical Support RN (CSRN) Ms H, who had responsibility for infection control at SAV, notified Regional Public Health Service (RPHS) of a suspected norovirus outbreak. At this time there were seven residents and two staff members with diarrhoea and vomiting.[8]

23. The Ministry of Health "Guidelines for the Management of Norovirus Outbreaks in Hospital and Elderly Care Institutions" (MOH Guidelines) state that noroviruses are highly infectious and cause significant morbidity in New Zealand.[9] Outbreaks are common and, although illness is usually of a short duration, protracted outbreaks have been reported in elderly care settings, with hospital patients and nursing home residents representing high-risk populations. Hand hygiene has been identified as the most important hygienic measure for preventing the spread of infection.

24. SAV residents and their families, including Mrs A, were informed of the outbreak and that SAV was in "lockdown". This meant that visitors were not allowed entry to Houses 1, 2, 3 and 4. Other measures included restrictions on staff moving between

[8] Twelve specimens were sent for laboratory testing. The first results were received the following day, confirming norovirus.
[9] http://www.moh.govt.nz/moh.nsf/pagesmh/8727/$File/guidelines-management-norovirus.pdf

the houses, the use of designated staff to care for symptomatic residents, and the closure of all communal areas. SAV subsequently advised that it liaised with the RPHS on a daily basis during the outbreak, and that it acted under its instructions.

25. SAV's "Outbreak Management Policy" sets out the actions to be taken in the event of an outbreak of influenza or other infectious disease. It states that the primary goal of outbreak management is to "control and prevent further disease and to identify factors that contribute to the outbreak in order to develop and implement measures to prevent similar outbreaks in the future". CSRN Ms H subsequently stated that the policy had been reviewed following a norovirus outbreak in 2008.

26. SAV's policy includes the following:

> "Isolation for gastrointestinal illness must remain in force until the resident has been symptom free for at least 48 hours.
>
> …
>
> Restriction of allied health personnel and visitors entering the ward/unit may be necessary to confine and contain the outbreak.
>
> …
>
> Where closures and isolation restrictions are implemented residents, relatives and staff must be informed of reasons and procedures for isolation."

27. In relation to closing facilities to residents and admissions, the MOH Guidelines state:

> "In certain circumstances, such as where outbreak control is difficult and significant ongoing risk of norovirus infection exists, closure of hospital wards or elderly care facilities to new admissions or residents may need to be considered. In general, criteria for considering closure will include both of the following.
>
> - There are ongoing cases despite full implementation of outbreak control measures.
> - There is a high level of debility among new arrivals. For example, an elderly care hospital or hospice constitutes a considerable risk of severe disease."[10]

28. And in relation to the management of visitors:

> "Visits to symptomatic cases should be minimised. Visitors of a suspected case should be prevented from visiting other patients/residents. Visitors must comply with all isolation procedures and should be supervised when putting on and removing gown and gloves to ensure hand hygiene is thorough. Visitors should be

[10] http://www.moh.govt.nz/moh.nsf/pagesmh/8727/$File/guidelines-management-norovirus.pdf p.10.

> told not to visit patients or residents in other institutions for at least three days if they visit suspected cases of norovirus infection."[11]

29. During the outbreak at SAV, there were 31 confirmed cases of norovirus, with the onset of illness in the first case four days prior to Mr A's admission, and in the last case 17 days after his admission. Most of the cases (20) were in House 2, which is next to House 4. There were four cases in House 4, with no symptoms in any House 4 residents after Day 8 of Mr A's admission. Houses 1, 3 and 4 were reopened to visitors nine days later, and House 2 reopened six days after that.

30. Over the days that followed the start of the lockdown, Mr A's family continued to visit, attempting to communicate with him through the window. They had some telephone contact, but this was difficult as Mr A's hearing was impaired, and he was confused and distressed. He did not yet have a landline in his room, and cell phone coverage was not good. They used barbecue tongs to pass notes through the window.

31. Mr A's family stated:

> "We were unfamiliar with routines at the hospital and so we watched carefully during the next days. We talked to the family of other residents, outside in the cold. We saw some residents with visitors, others without. We were confused, distraught, guilt-ridden and very frightened for Dad — we felt we had unwittingly betrayed him."

Continuing care, Days 2-8

32. On Day 2 of Mr A's admission, HCA Ms N recorded in the progress notes that Mr A refused a shower, that he had been unable pass a bowel motion, and that he complained of lower back pain at times of transfer but was very happy after his morning care.

33. That day, Dr E completed Mr A's initial medical assessment. He noted:

> "Patient under hospice with bladder Ca [cancer] and apparently bony mets [metastases]. Bedridden. Mentally intact. Chronic lumbar pain. Respirations 12 BS [breath sounds] vesicular Abdo [Abdomen] NAD [No abnormality detected]."

34. Dr E subsequently advised that he conducted an examination of Mr A's chest and abdomen. He noted that Mr A found movement painful at that stage, and was careful to disturb him no more than necessary. Mr A was particularly troubled by lumbar spine pain, but seemed quite comfortable when lying still.

35. Dr E stated further:

> "A patient presenting for palliative management in the last few weeks of his life needs active management of his pain and associated symptoms, such as nausea. In my view, such a person does not require an extensive work up with multiple and

[11] http://www.moh.govt.nz/moh.nsf/pagesmh/8727/$File/guidelines-management-norovirus.pdf p.12.

> potentially distressing examination procedures, blood tests, and everything a patient with a recent acute presentation would receive. At the time of his admission to St Andrew's, [Mr A's] condition had been thoroughly investigated, and major treatment options had either been tried or deemed unsuitable. In such circumstances I consider my role to be to reassure, explain, and address the symptoms vital to a well-managed death."

36. Dr E recalled speaking at some length with Mr and Mrs A, and discussing Mr A with the CSRN for House 4, Ms G. This conversation was not documented. Mrs A recalled that she went to SAV that morning to take a newspaper for her husband, and that she saw him through the window. She does not recall speaking with Dr E. Mr and Mrs B consider that had she done so, she would have discussed it with the family and recorded it in her diary.

37. That night, RN Ms O noted that Mr A had had a settled evening. She stated that Mr A's daughter-in-law had phoned, with concerns from Mrs A that her husband had not been getting pain relief since being admitted to SAV. RN Ms O said she explained the pain relief that had been administered, and that "[Mr A] has not been complaining of pain since he came to our care".

38. The medication record that day shows that Mr A had his Oxycontin and paracetamol as prescribed, and one dose of Oxynorm at 5pm. His total oxycodone that day was therefore 45mgs.

39. On Day 3, RN Ms O completed Mr A's care plan. There were three entries in his progress notes, with no reference to Mr A being in pain. That day, Mr A was given a total of 65mgs of oxycodone.

40. The following day, HCA Ms N noted that Mr A was "[s]till complaining of pain in lower back at all times". That day, he was given a total of 55mgs of oxycodone.

41. On Day 5, CSRN Ms G asked Dr F to increase Mr A's Oxycontin, as he had required Oxynorm several times a day in the preceding four days. Dr F increased the Oxycontin from 20mgs twice a day to 30mgs twice a day. Dr F subsequently stated that:

> "Oxynorm ought to be used for breakthrough pain, and when a patient requires it regularly as [Mr A] appeared to, it indicates the dose of his long-acting pain relief should be increased; I understand the intention was to monitor how much [Mr A] needed and adjust his regimen accordingly. [Mr A's] pain relief requirements were being monitored by [Ms G], the Clinical Nurse Manager responsible for him."

42. On that day, Mr A was given 50mgs of oxycodone.

43. RN Ms P recorded in the progress notes that they had been advised by the public hospital that Mr A had an appointment at the radiation oncology clinic the following Monday. RN Ms P spoke with Mrs A about transport to the appointment.

44. Mr A's family recalled that later that day, Mrs A received another telephone call from a staff member to say that Mr A could not leave SAV, followed by a later call to say that he could. They queried this, aware that it meant taking a resident from an apparently norovirus-infected area, directly to a public hospital. They recall being told that this was all right as there was no norovirus in House 4.

45. SAV subsequently advised that the information provided to Mr A's family changed that day when it was confirmed at lunch time that norovirus was present in House 4. CSRN Ms G also recalled speaking with Mrs B about this, and that she explained it was only after norovirus had been confirmed that House 4 was put into isolation. However, it is noted in SAV's "Summary of Norovirus Outbreak [Day 2] 09" that [Day 2] was the first day of isolation, and in the "Outbreak Report" that symptoms of norovirus were first observed in House 4 the same day. Mr A's family stated that the appointment was eventually cancelled for other reasons; it was decided that he did not need the trauma of another hospital visit.

46. On Day 6, a health care assistant noted that Mr A was in pain. That day he was given a total of 60mgs of oxycodone. The following day, RN Ms P noted that Oxynorm was not indicated.

47. On Day 8, an RN completed assessments of Mr A's continence, mobility, and a pressure area risk assessment, which confirmed that he was at high risk of developing pressure areas. The RN noted that an oncology nurse had phoned to ask about Mr A's condition as Mrs A was worried about him, and that she reassured them. That day, Dr F prescribed lorazepam. Nothing was documented in the clinical notes, but it was noted on the "Medication Chart" that this was to be given up to three times a day as required, for anxiety. SAV subsequently advised that this was prescribed in response to family concerns about Mr A phoning at night in an anxious state.

Days 9-16

48. On Day 9, Mrs B emailed Ms H, outlining the family's concerns. These included Mr A's distress, the impact this was having on Mrs A, and their confusion around the measures in place to manage the norovirus outbreak. She noted that the Department of Health (RPHS) had told them that a facility can reopen once it has been clear for two days, but they had been told that SAV's policy was seven days. Mrs B noted that CSRN Ms G had been "incredibly helpful reassuring us about [Mr A's] pain relief etc and the care we have witnessed [his] receiving, whilst standing in the freezing cold outside his window, has been very good". She stated further:

> "None of us wants to catch Norovirus but we feel that if we could follow strict clinical procedures to minimise the risk of becoming infected then it would be hugely beneficial to [Mr A] and his wife. In 58 years of marriage they have never spent so long apart. Many years ago I was a nurse and so I do understand that you are trying to contain a highly infectious illness but if staff can come and go from the building could one of us not put on gown and gloves for one visit to talk to [Mr A]?"

49. Ms H responded promptly, saying she would reply in full the following day after speaking further with staff. She said that reopening the facility would depend on when the last symptoms had occurred and when they were given clearance by RPHS. She stated further that they could not allow visitors as this stage, and that the only visitors allowed were to a dying patient.

50. Mr and Mrs B have no recollection or record of further contact from Ms H the following day. However, Mrs B recalls that on Day 10, she spoke with CSRN Ms G about seeing Mr A, and "met the usual opposition". She states that at the end of the conversation she told CSRN Ms G that she was "done", and that she would not ring SAV or the Department of Health anymore. Within half an hour CSRN Ms G telephoned, suggesting that they could meet with Mr A outside the building the following day.

51. That day, RN Ms O noted that family were concerned that Mr A had had a stroke, and she explained that he was just very sleepy. She noted that Mr A was well settled, that he appeared comfortable, and that his food and fluid intake were satisfactory.

52. On Day 11, arrangements were made for Mr A's family to see Mr A at the door of House 4. When they arrived, they were allowed into the building and asked to put on plastic aprons and to wash their hands as they left. They found Mr A uncommunicative and in pain, and within a few minutes he asked to be returned to his room.

53. The following day, Mr A's family were given aprons and overshoes when they visited, but were not asked to wash their hands when they left.

54. SAV subsequently advised HDC that:

- Rigorous handwashing protocols were in place during the outbreak, with bright yellow signs posted on the entry doors to all wards.
- Hand sanitising gels were placed on tables at all ward entry and exit points with gowns, gloves, masks and bootee covers.
- All visitors were expected to comply with signage, even if they were unsupervised.
- There was a large whiteboard in reception to warn visitors and give updates. There was hand sanitising gel there also, with directions to use this before and after visits.

55. On Day 15, Mr B emailed Ms H to ask about the possibility of Mr A moving to a brighter room, which they had seen was vacant. Mr B noted that Telecom was due that day to connect Mr A's landline and, if the room change was possible, asked that the landline be connected in the new room. Ms H replied, explaining that she had forwarded the room request to the Admissions Co-ordinator, but that Telecom would not be able to visit that day as the facility was still closed to outside visitors. It was suggested that Telecom should be postponed for a few days, by which time they expected the lockdown to be lifted. It was Mr B's understanding that the engineer did

not need to go into his father's room, only to a room near the front office.[12] Later that day, Mr A moved to another room in accordance with the family's request.

56. That day, SAV care manager Ms D sent letters to residents' family members/advocates, thanking them for their support during the outbreak and for complying with the "no visitor" policy (**Appendix 3**).

57. On Day 16, RN Ms O noted that there were broken pressure areas on Mr A's back and sacrum. She cleaned and dressed the areas, and noted that Mr A needed side-to-side nursing.[13] RN Ms O completed an initial wound assessment and plan, stating that dressings were to be changed every two to three days, but did not complete an "Incident/Accident Form". As a result, the CSRN was not alerted to this development.

58. Throughout these first two weeks at SAV, Mr A was given Laxsol twice daily as prescribed, and Lactulose once or twice daily. A "Bowel Book" shows that Mr A had a bowel movement at least every other day.

Days 17-27

59. Houses 1, 3 and 4 were reopened for visitors 15 days after the lock-down began. By this time, Mr A wanted to stay on his bed.

60. On Day 18, RN Ms P noted that Mr A complained of pain in his back when being moved, and that he was having difficulty moving his bowels. She noted that the family had requested a doctor's visit.

61. Dr E reviewed Mr A that day, noting that he spoke with Mr and Mrs A about the diagnosis and analgesia. Dr E increased Mr A's regular Oxycontin by a further 20mgs per day, and increased the dosage of Oxynorm available as required from 5mgs to 10mgs. Mrs A noted that her husband was not physically examined.

62. On Day 22, Mr A's family recalled meeting with community palliative care nurse (PCN) Ms Q. SAV explained in its response to HDC that PCN Ms Q's role included supporting the provision of palliative care in aged care facilities, but that she was not directly responsible for the care of individual patients.

63. That day, HCA Ms R noted that Mr A was uncomfortable because of his sore back, and that she had reported the broken areas on his back and buttock area. She stated that she had informed the RN, and subsequently advised that this was RN Ms M. The following day, HCA Ms R again noted that Mr A had a sore back and buttock area, and that she had asked RN Ms M to attend to his dressings.

64. RN Ms M recalled changing the wound dressings on Days 22 and 23, but did not document this in the progress notes or the wound management plan. She later stated that she was not aware that a wound management plan had been started.

[12] SAV subsequently informed HDC that this was not correct and the engineer did need access to the room.
[13] The person is turned at regular intervals.

65. On Day 24, HCA Ms R noted that Mr A was not comfortable when being moved, and that he was reluctant to stay on his side. An overhead bar was put in place to assist Mr A to adjust his position. Later that day, HCA Ms N noted that Mr A was still in pain when he was moved, and that she informed the RN on duty that he had requested more pain relief. RN Ms O noted that Mr A had been in pain for most of the shift, and that he was given two doses of Oxynorm in addition to his regular pain relief. She redressed his wound areas, recording this in the progress notes and on the wound management plan.

66. On Day 25, it was noted that family had requested a review of Mr A's pain relief. CSRN Ms G consulted PCN Ms Q about Mr A's continuing pain, noting that the pain he described was indicative of neuropathic pain. RN Ms G spoke with Dr E about trying Mr A on amitriptyline. This was charted the same day, although the first dose was not administered until Day 28.

67. That day, the SAV Chief Executive wrote to the families of residents in the houses that had been closed during the norovirus outbreak, explaining why they had taken the actions they did (**Appendix 4**).

68. On Day 26, CSRN Ms G was asked to review Mr A's pressure areas after RN Ms P noted necrotic areas in the wound. CSRN Ms G cleaned and redressed the wound area, and updated the wound care plan. She recorded in the progress notes that she had spoken with Mr A's family about the amitriptyline, and about trialling an air mattress, in an effort to make Mr A more comfortable. SAV subsequently advised HDC that Mr A had tried an air mattress at the start of his admission, but he found it uncomfortable and it was removed two days later.[14]

69. That afternoon, RN Ms O noted that Mr A needed to be turned regularly and that a "Turning Chart" had been started.

70. The following day, it was noted that Mr A had refused a shower, that he had pain in his lower back, and that he had reported feeling very constipated. Over the previous ten days, Mr A had been given Laxsol twice daily with the exception of Day 19 when he had only one dose, and Lactulose once or twice daily, with the exception of Day 20 when he had none. The "Bowel Book" indicated that Mr A had had regular but small bowel motions throughout this period.

Day 28

71. HCA Ms S stated that on Day 28, Mr A did not want a shower so she washed him in bed, and changed his pyjamas and the bed linen.

72. That morning, the residents were weighed as is usual at the end of the month. This was done by HCAs Ms S, Ms T, and Ms U. They later explained that Mr A was assisted to the edge of his bed and then into a weighing chair. He was returned to bed, and as HCA Ms T straightened his pyjamas, she noticed that Mr A's right shin was

[14] There is no record of this in the progress notes. The care plan completed on Day 3 indicates no special mattress was being used.

swollen and his foot appeared to have dropped down. She recalls asking the other HCAs to support his foot with a pillow, while she informed RN Ms P.

73. HCAs Ms S, Ms T, and Ms U provided HDC with detailed accounts of their contact with Mr A at this time. It is noted that in describing what happened, they each referred to Mr A "often" and/or "usually" complaining of pain when he was moved.

74. RN Ms P was dispensing controlled drugs at the time. HCA Ms T recalls that RN Ms P said she would go and see Mr A when she had finished. RN Ms P states that she was on her way to see Mr A when the family arrived.

75. RN Ms P subsequently recalled that the bone of Mr A's lower right leg was protruding, and that family confirmed this was in the same place as his previous fracture. She also noted that family had explained that following this fracture, Mr A wore a moonboot but that he stopped wearing this prior to his admission to SAV.

76. Mr and Mrs B recall these events somewhat differently. They state that when they arrived there was a terrible smell in the room, and Mr A appeared unwashed. Mr A complained about the weight of the sheet on his right leg. They saw that his leg was blue and swollen and that the angle of his foot was distorted. Mr A wanted to be moved, so Mrs B went to the nurses' station and asked for some pain relief, which she gave to Mr A. They waited about 20 minutes for this to take effect before turning him. As they did so, his "right foot 'fell' through 120 degrees onto the bed". Mrs B returned to the nursing station and informed the RN that Mr A's leg was broken.

77. Mrs B requested that Mr A be admitted to the public hospital. RN Ms P contacted the duty manager that day, Ms H, and was advised to contact the Emergency Department (ED) at the public hospital to arrange admission. At 12.30pm, RN Ms P noted that they had tried several times to contact the ED but could not get through. At 1.15pm, she spoke with an orthopaedic registrar and was advised to transfer Mr A to ED immediately. Mr A was given another 10mgs of Oxynorm at 1.45pm, and the ambulance arrived just after 2pm.

78. RN Ms P later recalled that when Mr A left SAV he was washed, in clean pyjamas and wearing a clean continence pad. Ms H said that although her shift did not start until 3pm, when she was informed of what had happened she went in early to assist nursing staff. She found that several family members were present, Mr A was settled, and staff were attentive. She recalled that Mr A was clean and cared for, and that he was complaining of his ongoing back pain but not about pain in his leg.

79. Mr A's family also state that while they were with Mr A that day they saw ants crawling up his leg.

80. The medication chart shows that Mr A was given Oxynorm at 11.30am, 1.40pm and 3.30pm on this day, although the ambulance record shows that the ambulance left SAV at 2.38pm. Mr A's family subsequently noted that the 3.30pm entry could probably be explained by the fact that they returned to SAV following Mr A's transfer and asked for his next medications, fearing that he might have a long wait before

being seen at the public hospital. They note that he was triaged on arrival and these medications were never used.

Admission to the public hospital

81. Mr A was assessed and treated in ED. Records show he was triaged at 3.10pm. An X-ray confirmed fractures of the right tibia and fibula. A back-slab was applied to stabilise his leg, and he was given fluids, pain relief and medication for nausea. Mr A was drowsy and confused. Later that night, he was admitted to an orthopaedic ward.

82. Mr B was present when Mr A was washed the next morning, and was alerted by a nurse to old faecal matter on his father's inner thighs. Mr B said that it was very clear from the effort required by the nurse to remove the staining that it had been present for some time.

83. The following day, Mr A was referred to the Palliative Care team. After discussion between the Palliative Care, Older People's Health and Orthopaedic teams, and Mr A's family, it was decided that further investigations were not appropriate and that a palliative approach should be taken.

84. Mr A's condition deteriorated, and he died a short time later.

Further information from SAV

Staff statements

85. On receipt of this complaint, SAV arranged for statements from the staff involved in Mr A's care throughout this period. Specific details have been incorporated above, but the following general points are also noted:

- It was often difficult to move Mr A because of his stiffness and/or back pain.
- Mr A was reluctant to stay on his side, and often moved the pillows that had been positioned to keep him off his back.
- He became increasingly reluctant to have a shower, but on the days that he was not showered he was given a bed bath. He was quite strong and often grabbed at staff when they were assisting with his care.
- Mr A was sometimes confused and agitated, and called out. He sometimes had difficulty using the phone. One staff member recalled that he inadvertently phoned 111 while trying to phone his family, while another noted that he appeared to be trying to contact the Police as he thought he was being detained against his will.
- Family provided Mr A with bottled water, fruit, sweets and snacks, which he ate between meals.
- Staff saw no sign of ants in Mr A's room.
- Staff were aware that Mr A's family were anxious about him, and endeavoured to keep them informed and to assist with contact during the lockdown period.

Complaint response

86. In its initial response to this complaint, SAV expressed its regret for the distress caused to Mr A's family. It acknowledged that there was a failure on the part of some staff to take appropriate action in relation to pressure area/wound management and apologised for this. It acknowledged that the lockdown was distressing for residents and families, but noted that the norovirus outbreak was beyond staff control and that its response was in accordance with public health advice. SAV considers it "went to great lengths to relieve the family's obvious stress and anxiety, and special arrangements were made for this family to visit".

87. SAV noted the significant differences between hospice and private hospital staffing levels, with one registered nurse to two patients in the hospice setting, compared to one registered nurse to 30 patients at SAV. In a subsequent response, it noted that SAV is a generalist hospital and cannot offer hospice level care, although patients with terminal conditions including bony metastases are often managed in facilities such as SAV.

88. SAV's initial response to the complaint included a statement from Dr E and CSRN Ms G, in which they state that they were responsible for the management of Mr A's pain symptoms while he was at SAV. They considered the amount of opiate pain relief charted for Mr A was sufficient for his needs at all times.

89. They state further:

> "It must be remembered that opiates cannot be given in sufficient quantities to block all symptoms of pain. Opiates may cause drowsiness and confusion, and deprive a dying person of their remaining few days of lucid interaction with their families. They may also suppress respiration, and cause death prematurely. A degree of pain from time to time is an unavoidable part of trying to find the right balance between these competing objectives.
>
> We also note that a major aspect of the family's complaint about [Mr A's] management is the confusion and distress he exhibited. Confusion and distress can be expected when a person is in the last stages of dying from a disseminated malignancy, and is being managed by powerful drugs. It is inevitably upsetting for the family to see a loved one deteriorate this way, but it does not reflect any lack of good nursing or medical management."

90. CSRN Ms G subsequently explained that during the lockdown the CSRNs did not go onto the wards unless absolutely essential. They received verbal reports from the RNs at the door of the wards. She states that she asked the RNs about Mr A's breakthrough pain the previous day. She considered that one or two episodes of breakthrough pain were acceptable, and noted that when she was advised on Day 4 that relief for breakthrough pain had been administered five times the previous day and three times that day, she requested a GP review with a view to adjusting the long-acting pain relief. RN Ms G agreed that if Mr A was not in pain when lying still, but was in pain on movement, this should have counted as breakthrough pain. She stated that he

should have been given medication prior to being moved if it was anticipated that movement would be painful.

91. With regard to documentation, SAV noted that at the time of these events, there was a requirement for an entry in the progress notes every 24 hours, and that these were completed mainly by HCAs. RNs were required to write in the notes twice a week and "by exception".

92. SAV advised that following the norovirus outbreak, RN Ms H contacted the RPHS in relation to feedback SAV was receiving about its management of the outbreak. In an email from RPHS staff on Day 29 it was stated:

> "Please be assured that our office strongly supported your isolation procedures and advised family members of this. We did receive a number of calls from family members concerned about the closure and explained to them the necessity of 'infection control procedures' & informed them that closure is a 'Public Health' recommendation."

93. An "Outbreak Report" completed by the RPHS concluded:

> "Overall, St Andrew's rest home has very good infection control procedures in place, which contributed to the virus being controlled. [The] RPHS provided ongoing support to the rest home throughout the course of the outbreak. Four of the affected houses were shut down and remained in lock down until all residents and staff were symptom free for 48 hours, strict hand hygiene and disinfection procedures were in place throughout the outbreak.

94. In response to this investigation, SAV also sought advice from "Bug Control", an infection control advisory service. The Managing Director noted that in her experience in Australia and New Zealand it is usually the district health board or public health unit that is responsible for placing facilities in full lockdown, in which visitors are prevented from entering. She wrote: "This is usually done when a Norovirus outbreak is persistent and normal outbreak control measures have not limited the spread of infection." The Managing Director noted the relevant sections of the MOH Guidelines in relation to facility closure and visitor management. She stated that while SAV's approach may have been overzealous, it may also have been "instrumental in confining and containing the outbreak in a shorter period of time and thus protecting the largest number of susceptible persons".

95. In response to the provisional findings, SAV noted that it had had a norovirus outbreak the previous year, which was effectively contained to one area but during which two residents passed away. SAV states that this gave it even more reason to maintain its zealous approach, particularly as this second outbreak was spread over four areas. It was particularly concerned that the outbreak did not spread to the dementia unit, where patient compliance with containment instructions would have been problematic.

96. CSRN Ms G also noted that she and Ms H were "continuously in contact with Mr A's family", in person or by email, and both were contactable at any time during the day by phone. Accordingly, she considers that they were supportive of Mr A's family.

Action taken and changes made

97. SAV outlined action taken and changes that have been made since and/or in response to this complaint and investigation. These include:

- the appointment of another Clinical Support RN, so that each of the three nurses is responsible for two areas of 30 beds;
- changes made to documentation requirements to improve communication between staff (eg, introduction of a "Communication Log" and changes made to CSRN Handover Sheet);
- changes made to arrangements for meetings between senior staff to improve communication (eg, early morning meetings initiated between the CSRNs, the Care Manager and the Human Resources Manager to ensure regular updates on new or outstanding issues, and Continuous Quality Improvement meetings are now weekly instead of fortnightly);
- introduction of a new bucketless cleaning system using microfibre and colour-coded mops, to minimise the risk of infection transmission;
- a review of the Pain Management policy and the introduction of more comprehensive pain assessment protocols;
- full implementation of the Liverpool Care Pathway, a model of care for people in the last hours or days of their life;
- a requirement for the RN on duty in the morning to write in patients' notes on a daily basis;
- random auditing of wound care plans;
- disciplinary action taken against several staff members who failed to take appropriate action in relation to the management of Mr A's pressure areas.

Further changes were outlined in response to HDC's provisional report:

- additional in-service education sessions on pain and palliative care;
- a review of the Bowel Management policy, with further in-service education scheduled;
- a review of the Outbreak Management Policy. Visitors will now be allowed in to visit once they have complied with SAV's infection control procedures;
- distribution of another DHB's RN Care Guides for residential aged care to HCAs and RNs for use as a learning tool and resource;
- changes to improve the pre-admission information for new residents.

98. On 15 March 2010, the Chief Executive wrote to Mr and Mrs B, apologising for deficiencies in the care provided to Mr A.

Opinion: Breach — St Andrew's Village

99. Mr A was admitted to St Andrew's Village for end-of-life care. He and his family had reluctantly acknowledged that he could no longer be cared for at home, but they took some comfort from the belief that at SAV he would receive good care and treatment during the last stage of his life.

100. Mr A was admitted to part of the facility providing hospital level care. He was assessed as not eligible for care in the specialist Palliative Care Unit and, in any event, there were no vacancies in this unit at the time. It is accepted that there are important differences between a hospice and a private hospital. A hospice is a specialist facility, set up and staffed specifically for the care of terminally ill patients. Nevertheless, private hospitals such as SAV offer and regularly provide care to people with terminal conditions. As such, Mr A and his family had every reason to consider that he would be provided with services of an appropriate standard in the last weeks of his life.

101. The day after Mr A's admission, SAV informed the RPHS of a suspected norovirus outbreak and implemented a lockdown. This undoubtedly impacted on the provision of care, as well as on Mr A's experience at SAV and that of his family. Nevertheless, I do not consider that it explains or excuses deficiencies in the care provided to Mr A by SAV, as detailed below.

Pain management

102. The New Zealand Palliative Care Strategy refers to palliative care as "the total care of people who are dying from active, progressive diseases or other conditions when curative or disease-modifying treatment has come to an end".[15] A key aim is to provide relief from distressing symptoms.

103. Effective pain control is an integral part of palliative care, irrespective of where and by whom the care is being provided. It is acknowledged that achieving this is not always straightforward, as treatment to relieve pain may create or exacerbate other problems. This is all the more reason for health professionals to make good use of their skills and relevant tools. I do not consider that SAV nursing staff did enough to assess and monitor Mr A's pain levels.

104. When Mr A was admitted to SAV, staff were provided with a clear summary setting out the medication regime he had been on prior to admission. Dr I states that the medication regime was unconventional, but that he charted medication which would cover Mr A's preadmission regimen and allow for additional doses if required. Dr I states further: "Assuming careful and full assessment of his pain by the nursing staff, Oxynorm two hourly as needed achieved this." In my view, it was this careful and full assessment by nursing staff that was lacking.

[15] http://www.moh.govt.nz/moh.nsf/0/65C53A08E9801444CC256E62000AAD80/$File/palliativecare strategy.pdf, p 10.

105. The initial nursing assessment, completed on the day of admission, refers to Mr A needing regular pain relief for lower back pain. The pain management section of his care plan was completed two days later. However, as my nursing expert Ms O'Connor notes, there was no evidence of an in-depth pain assessment being completed on admission or at any other time.

106. In addition, Ms O'Connor notes that although the initial nursing assessment stated that Mr A should have Oxynorm prior to personal care, he was given this between 6am and 9am on only five occasions.

107. During the first few days of his admission, Mr A was administered less Oxynorm than he had been having prior to admission. If the intention was to assess more accurately Mr A's actual pain relief requirements, this needed to be undertaken in a more formal and structured way.

108. It is accepted that achieving an optimum level of pain relief needs to be balanced against other objectives, including control of nausea and anxiety, maintenance of respiratory function, and avoiding over-sedation. However, there are multiple references in the progress notes to Mr A being in pain, from the day after his admission. Clearly this was also a concern for Mr A's family.

109. Ms O'Connor commented that throughout the progress notes there are multiple reports of pain with movement, suggesting that Mr A's pain was not well controlled. Ms O'Connor explains further that:

> "[i]ndeed the assessment and planning around this man's pain and administration of analgesia and evaluation of its effectiveness is sadly lacking by SAV staff. Registered staff seemed to be relying on HCA reports and it appears that these may not have been responded to effectively by further assessment of pain and intervention and evaluation. Having any resident in pain is unacceptable with the resources available in the health service."

110. It certainly appears that the number of times Mr A was actually given medication for breakthrough pain is not an accurate reflection of the pain relief he required. As CSRN Ms G acknowledges, Mr A should have been given pain-relief prior to being moved and given cares if it was anticipated that movement would be painful.

111. Ms O'Connor also noted in her advice that if staff had used a pain assessment tool, more regular GP reviews may have been prompted. I agree that this would have been a useful tool for staff to have employed at the time.

112. As it was, I note that medical reviews were sought on three occasions after the first week, all in response to concerns by the family or at their explicit request. I consider it unacceptable to have to wait until family or friends voice their concerns about inadequate pain relief. This should be a proactive process undertaken by staff.

113. In its response to the provisional report, SAV drew attention to Mrs B's email and her comments regarding the reassurances they had had from CSRN Ms G about Mr A's

pain relief, and the care they had witnessed. I do not doubt that staff reassured Mr A's family that his pain was under control; my concern is the basis on which they gave this reassurance. I note also that this email was only one week into Mr A's stay at SAV.

114. I also note the delay following the prescribing of amitriptyline on Day 25. It would appear that in fact Mr A never received amitriptyline. Records show that the first dose of this was administered at dinnertime on Day 28, several hours after Mr A's transfer to hospital. It may have been included with the medication Mr A's family returned to collect, although this is not evident from the records.

115. This was always going to be an extremely difficult and distressing time for Mr A and for his family. If his family were not going to be allowed to visit — and I will address this further below — they needed to have confidence that Mr A was being kept as comfortable as possible. I am not surprised that they questioned whether this was occurring.

116. In my view, the management of Mr A's pain by SAV staff was not adequate, and there is sufficient reason to consider that this impacted adversely on his quality of life. It is appropriate that SAV has introduced a more comprehensive pain assessment protocol, and undertaken further staff education in relation to pain management.

Wound care

117. SAV has acknowledged that there were deficiencies in relation to the management of Mr A's pressure areas. I agree.

118. The pressure area risk assessment was completed six days after Mr A's admission, although SAV's own policy states that this should have been completed on the day of admission. The assessment identified Mr A as being at high risk of developing pressure areas. He was apparently provided with an alternating pressure mattress on admission but this was removed two days later as he found it uncomfortable. I accept that this was probably the case, although there was no contemporaneous record.

119. On Day 16, RN Ms O noted that there was a broken area on Mr A's sacrum and a reddened area on his back. The areas were cleaned and dressed, and a wound management plan was completed. This specified that the dressings should be changed in two to three days' time. An "Incident/Accident Report", which would have alerted the CSRN, was not completed.

120. There is nothing documented in relation to wound care for the next five days. On Days 22 and 23, HCA Ms R noted that pressure areas had been reported to the RN. RN Ms M later recalled that she cleaned and dressed the wounds, but this was not recorded in the progress notes or in the wound care chart.

121. On Day 24, RN Ms O cleaned and redressed the wound area and documented this in the wound management plan and the progress notes. CSRN Ms G was not informed of the pressure areas until Day 26. She then reviewed the wound care plan, and spoke with Mr A's family.

122. As SAV has acknowledged, there were deficiencies in the wound care provided by several staff members. SAV needs to ensure that it has robust processes in place to support staff to make appropriate use of their nursing skills, and to ensure that they comply with its policies and protocols. I note that SAV has introduced random audits of wound care plans.

Documentation

123. Good residential care requires the clear and accurate documentation of a resident's condition and of the care provided. This ensures that relevant information is shared between those involved, in a timely manner.

124. There were entries in the progress notes in relation to Mr A's care and condition most days. These were made by HCAs and RNs, with two entries by CSRN Ms G. SAV's policy at the time was that an entry should be made in the progress notes at least once every 24 hours. Entries were to be made by an RN twice a week and if change occurred, in reply to doctors' instructions, and "by exception". I note that there is now a requirement for daily entries in the progress notes by the RN on morning duty, and by the RNs on the afternoon and night shifts by exception.

125. Ms O'Connor notes deficiencies in relation to Mr A's care planning and the documentation of this. The initial care plan did not include a plan for bowel management, when this was clearly an area of potential concern. There was no documented plan for managing Mr A's anxiety. There is no evidence that Mr A's care plan was reviewed and updated during his admission, even though his condition was clearly deteriorating. As Ms O'Connor explains, care plans guide the delivery of care. They should be current, relevant and accurate.

126. I consider that there is room for improvement in relation to documentation, and SAV needs to ensure that its RNs and CSRNs are meeting their responsibilities in this regard.

Bowel care

127. Nursing staff needed to ensure that Mr A maintained regular bowel function. He was at risk of becoming constipated for several reasons, including immobility and opioid medication. Although there was no care plan for bowel management, a bowel chart was completed daily. Mr A was reported as feeling very constipated on Day 27, the day before his admission to the public hospital. As Ms O'Connor notes, it would have been appropriate to follow up on this and assess the need for increased medication (which had been charted for use as required).

Care provided on Day 28

128. Mr A's family outline several concerns in relation to hygiene on the day of Mr A's admission to the public hospital, including the smell in his room, ants, and the fact that he appeared to be unwashed. They also report old faecal matter being found on his inner thighs when he was first washed at the public hospital the following morning. SAV staff maintain that Mr A had a bed bath that morning, and that they did not see any ants. They state also that he was clean and cared for when he left in the

ambulance later that day. I do not think it is possible to comment definitively on these matters.

129. It is also not possible to determine how or when Mr A sustained the fracture to his leg. There were three HCAs present when Mr A was weighed, none of whom report anything untoward until Mr A was back on his bed, when the bruising and swelling was observed. The HCAs informed the RN on duty. There are discrepancies between the accounts of staff and Mr A's family in relation to the course of events at this time that cannot be fully reconciled. The RN later notes that the family had requested a medical review; I note that this should have been sought even if the family had not been present to request this.

Norovirus outbreak management

130. SAV notified the RPHS of a suspected norovirus outbreak on Day 2. It then initiated a range of measures aimed at limiting the spread of infection, in accordance with its own "Outbreak Management Policy" and MOH Guidelines.

131. SAV's policy states that it may be necessary to restrict visitors from entering a ward/unit. The MOH Guidelines identify the need to minimise visits to symptomatic patients, prevent visitors of suspected cases from visiting other patients or residents, and for visitors to comply with isolation procedures. There is no specific recommendation to prevent visitors from seeing non-symptomatic residents. Nevertheless, on the day that SAV notified the RPHS of the suspected outbreak, the decision was made to close Houses 1, 2, 3 and 4 to visitors. Although the closure appears to go beyond required outbreak measures, it is clear from the information provided to HDC that SAV was in regular communication with the RPHS throughout this period, and that the RPHS supported the decision to close the facility to external visitors.

132. Norovirus is highly infectious and frail elderly people living in residential care facilities are particularly vulnerable. SAV clearly recognised this and took decisive action to prevent the infection from spreading. It is accepted that the closure of the facility to external visitors may indeed have helped to limit the spread of infection within the facility and in the community.

133. I also accept that SAV was mindful of its previous experience of norovirus, and acknowledge that outbreak measures meant significant disruptions to the facility's normal functioning. There were, for example, restrictions on staff moving between areas, cleaning requirements over and above usual routines, and symptomatic residents required extra nursing care.

134. However, SAV staff still needed to attend to residents' other nursing and care needs, and, in my view, there were deficiencies in the way in which SAV managed Mr A's situation. If there really was no scope for more flexibility in relation to family visits, the reasons needed to be better communicated.

135. Mr A required a high level of care, and his condition was deteriorating. He was a very recent admission — he did not know the staff and they did not know him.

Communication was affected by his hearing loss. At times he was confused, anxious, and in pain. His family were, understandably, extremely concerned and also anxious. While Mr A was not expected to deteriorate as quickly as he did, he and his family knew that he was at the end of his life.

136. I remain unclear as to why Mrs A was initially told on Day 5 that her husband could attend his public hospital appointment the following week. Although the laboratory results confirming norovirus were not received until lunchtime on Day 5, there had been two symptomatic residents in House 4 since Day 2, and most of the facility, including House 4, had been in lockdown since then. While I understand that confirmation of norovirus was significant, the fact is SAV had been in isolation for three days. It is entirely understandable that Mr A's family questioned the logic of it apparently being all right for Mr A go to his appointment at a public hospital but not possible for them to visit him.

137. Houses 1, 3, and 4 were reopened for visitors on Day 17. Although the majority of affected residents were in House 2 and this was next to House 4, SAV identified that it could open House 4 ahead of House 2, ie, the two houses were able to be separated. There were no symptoms in any residents in Houses 1, 3, or 4 after Day 8, so it is not clear why they remained closed for a further nine days. As Ms O'Connor states, this seems excessive.

138. A member of Mr A's family with nursing experience agreed to wear gown and gloves and sign a disclaimer in order to visit. I agree with my expert that not allowing even this person to visit seemed extreme. Ms O'Connor states that in her opinion:

> "… given that family members were fully aware of the risks, were prepared to comply with infection control measures and there were other physical entrances that could be used it would have been feasible to allow them to visit".

139. I agree. However, if SAV — in consultation with the RPHS — considered that there were sound reasons for a more restrictive response to the outbreak than that required by its policy and MOH Guidelines, the rationale for this should have been clearly explained to residents and their families at the time, rather than when the outbreak was over. Mr A's family clearly communicated their understanding of the problem and the risks posed by norovirus, as well as their willingness to comply with the measures SAV put in place. In return, they should have been provided with a reasonable explanation as to why a more flexible response was not possible, particularly in relation to visiting a non-symptomatic, terminally ill resident. There was a lack of clarity and consistency in the information provided, which added unnecessarily to the concerns of Mr A's family and contributed to a loss of confidence and trust.

Other matters — placement assessment and palliative care funding

140. At the end of her advice, my nursing expert, Ms O'Connor, raises a concern about adequacy of the pre-admission information shared with SAV, and whether a more extensive assessment would have resulted in Mr A qualifying for palliative care funding.

141. The DHB's Needs Assessment and Service Co-ordination service (NASC) has confirmed that where a person has been assessed by the Palliative Care service as needing residential care, it considers whether there is anything to be gained from a further assessment by the NASC team — given that this is often occurring at a time when the person is very unwell. If NASC considers it has sufficient information, placement will be authorised on the basis of the assessment completed by the Palliative Care service. Eligibility for palliative care funding is determined by a clinician, as was the case for Mr A.

142. In response to HDC's provisional findings, SAV followed up the question of pre-admission information with Dr K. Dr K noted that the forms he and RN Ms J completed which were provided to SAV were NASC forms relating to eligibility for care and funding, and are not designed for transferring detailed handover information. Dr K states that this information would usually be provided from the person's GP record and/or the Hospice's community patient file, and notes his regret that this information was not available at the time of Mr A's transfer.

Summary

143. As outlined above, I consider that aspects of the care provided to Mr A while he was at SAV were inadequate.

144. I am particularly concerned about the way in which his pain levels were assessed and monitored. I accept that it may not have been possible to keep him completely free of pain at all times, but in my view, the way in which staff dealt with this aspect of his care increased the risk of Mr A suffering unnecessarily. Similarly, while the development of pressure areas does not in itself indicate inadequate care, the management of his wounds increased the risk of the problem worsening and causing further discomfort. There were shortcomings in planning and reviewing Mr A's care, and in the documentation of this.

145. SAV acknowledged that some staff failed to take appropriate action in relation to wound care, and apologised for this. However, when this is taken together with the deficiencies in relation to pain management, care planning and documentation — also involving several staff members — I find it difficult to conclude that these were simply isolated failings by individuals. As I noted in a previous investigation in relation to another provider, the inaction and failure of multiple staff to adhere to policies and procedures points toward an environment that does not sufficiently support and assist staff to do what is required of them.[16] SAV as an organisation must bear overall responsibility for this.

146. Notwithstanding the support SAV received from the RPHS in relation to its management of the norovirus outbreak, I am inclined to think that there was scope for a more compassionate response, without unreasonably compromising efforts to contain and control the spread of infection. If a less rigid approach to visiting was not possible sooner, a clearer explanation was needed.

[16] Opinion 07HDC16959, p 18.

147. On this basis, I find that there was a lack of reasonable care and skill in the services provided to Mr A by SAV. Services were not provided in a manner that optimised his quality of life. In my view there is sufficient reason to consider that some of the distress and discomfort Mr A experienced in his final weeks was avoidable. Accordingly, I find that SAV breached Rights 4(1) and 4(4) of the Code of Health and Disability Services Consumers' Rights.[17]

Other matters — Naming

148. I have discretion to name group providers in any breach reports that are published on the HDC website and sent to relevant agencies. Each case is considered on its own merits. In this case, SAV submitted that its name should not be published in this report. It considers that in light of difficulties with the recruitment and retention of staff in the aged care sector, the circumstances of the complaint, the exceptional circumstances of the norovirus outbreak, its constructive response to the complaint, and the changes it has made, naming is not warranted. I have carefully considered this issue and decided that, on balance, the public interest favours publication. The public has a clear interest in knowing that services are provided to particularly vulnerable groups of consumers in a manner that meets their requirements and respects their rights. Accordingly, St Andrew's Village will be named in the report published on the HDC website and sent to relevant agencies.

Recommendations

149. SAV is to be commended on the changes it has implemented in response to this complaint and investigation.

I recommend that SAV provide HDC with a copy of its revised "Outbreak Management Policy" by **30 April 2011**.

Follow-up actions

150. A copy of this report, identifying St Andrew's Village and the expert who advised in this case, will be sent to the Ministry of Health (HealthCert), the District Health Board, and the New Zealand Aged Care Association, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[17] See footnotes 3 and 4.

Appendix 1 — Independent expert advice

I have been asked to provide a nursing opinion regarding the standard of care that [Mr A] received by St Andrew's Village (SAV) for the period [Days 1-28]. I have read the Commissioner's guidelines for independent advisors and agree to follow them to the best of my ability.

Professional profile

Since registering as a Comprehensive Nurse in 1989 I have completed a Bachelor of Nursing (2001), Graduate Certificate in Hospice Palliative Care (2002) and a Masters of Nursing with a clinical pathway (2008). My initial nursing experience was as a Public Health Nurse after which I moved to the hospital setting first in orthopedic nursing then acute/general medical in a rural hospital. Following this I embarked on an overseas trip where I worked firstly as an agency nurse in various hospital wards then in the community setting as a district nurse in London. Also in London, I worked for 9 months in a Nursing Home for older people before returning to New Zealand and commencing nearly 5 years in Assessment, Treatment and Rehabilitation. In this setting, I coordinated a 12 bed unit and completed needs assessments for older people in a large geographical area. For the past nearly 12 years I have been working for a non-profit charitable organization managing various aged care facilities. My current facility is a retirement village of 60 beds, residential, hospital and dementia levels, and 21 cottages. I am current chair of the facility's Quality team and the organization's Clinical Practice Group. I have managed my facility through many changes in care provision and enjoyed successful audits. I am a member of the New Zealand College of Nurses and enjoy providing education and insight into care of the older person for various groups in my region.

Expert Advice required

1. Please comment on the standard of care provided to [Mr A] by SAV including

    a) Whether [Mr A's] pain levels were monitored adequately by nursing staff

    b) Wound care management

    c) Whether the care provided was consistent with the standards expected of a private hospital providing palliative care

    d) The standard of documentation by nursing and care staff

    e) The standard of communication between staff and with medical staff, in relation to [Mr A's] condition and care

2. Were there any systemic factors impacting on the ability of nursing and care staff to provide appropriate care?

3. Please comment on the standard of communication with [Mr A] and family.

4. Please comment on the response by SAV to the Norovirus outbreak. If possible please include comment on the appropriateness of the care provided to [Mr A] in the context of the lockdown.

5. Please comment on the changes outlined by SAV in response to the concerns arising from this complaint.

6. If applicable, please outline any recommendations you may have to address the concerns arising from these events.

7. Are there any aspects of the care provided by SAV that you consider warrant additional comment?

If, in answering any of the above questions you believe that SAV did not provide an appropriate standard of care, please indicate the severity of the departure from that standard.

Supporting Information

I have been provided with the following supporting information [page numbers deleted]

1. Letter of complaint dated 17 September 2009
2. Notification letters
3. Response from SAV, with appendices as referred to in response
4. Additional information from SAV
    a) Extracts from further response dated 15 March 2010
    b) Pain management policy, evaluation and teaching plan
    c) Health records policy
    d) Minutes
    e) Infection Control RN position description and statement
    f) Norovirus staff memo and email advice
    g) Doctor's protocol
    h) Position descriptions Clinical Support RN, RN, Clinical Co-coordinator
    i) Wound care policy
    j) Incident and accident reporting
    k) Changes made
5. Responses from [Dr E] and [Dr F]
6. Information from [the] regional Public Health Services in relation to Norovirus
7. Google map of the facility

Background

[Summary of events omitted for brevity.]

Standard of care

Pain management

In her referral, RN [Ms J] from [the] Hospice stated that [Mr A] was known to be stoic and [Dr K], also from [the] Hospice, states that [Mr A] had low back pain. On admission [Mr A] was receiving, according to his family's information:

- Long acting morphine, Oxycontin 20mg twice daily
- Paracetamol 1 gram four times daily

- At least seven doses of short acting morphine, Oxynorm 5mg daily.

No initial pain assessment was completed by SAV staff even though there was a diagnosis of terminal cancer and [Mr A] came requiring at least 75mg of morphine a day already.

The regime his family supplied on admission was not followed by staff of SAV. The administration of his as required (prn) medication by staff was very limited in the first five days as the following table shows:

Date	Number of doses of 5mg Oxynorm used
[Day 1]	1
[Day 2]	1
[Day 3]	5
[Day 4]	3
[Day 5]	2

The importance of this is that [Mr A] was being given less morphine that what he had previously been having and there were still reports of pain from his family and Health Care Workers (HCA).

RN Ms O recorded a conversation on [Day 2] with [Mr A's] daughter in law regarding [Mrs A's] concern that her husband had any pain relief since admission. She told her that he was having his usual regular medications and prn Oxynorm. However in reviewing his signing sheet he only received 1 prn dose on [Day 1] at 2000hrs until l700hrs on the [Day 2] in conjunction with his regular 20mg Oxycontin twice daily.

The admitting nurse recorded in his progress notes on [Day 1] that he needed "regular Oxynorm prior to cares" however according to the signing sheets it was only given on [Days 3, 5, 12, 16 and 27] between 0600and 0900 hours despite [Ms D's] statement [in SAV's initial response to the complaint] that "it was given prior to morning cares". This perhaps highlights a lack of understanding around the use of long acting and short acting morphine for preventative or breakthrough pain.

Nursing assessment on admission documents that [Mr A] was on regular/continuous pain relief. The care plan for pain management completed on [Day 3] indicates that [Mr A] requires

- Breakthrough pain management
- Review as needed
- Administer as prescribed

However, there is no evidence an in depth pain assessment was completed on admission or at any other time. Ongoing care planning for pain relief is not evident in the progress notes although there is an entry on [Day 24] where a RN asks staff to "observe and offer prn Oxynorm when needed". There is no evaluation of the effectiveness of medication administered either.

CSRN [Ms G] states that she requested a medication review following admission. Dr F reviewed his medications on [Day 5] which resulted in an increase in his twice daily dose for long acting morphine to 30mg twice daily. He continued to be administered Oxynorm at 1–2 doses per day, only on [Day 18] and [Day 28] did he receive 3 doses. The CSRN states that the family discussed with her [Mr A's] increasing anxiety especially at night; however, there is no record of this conversation in the progress notes, only in her post complaint statement. According to policy this should have occurred. She spoke to [Dr F] who prescribed Lorazepam 1 mg three times daily prn on [Day 8]. It is indicative of the care that this man received that no one actually questioned why this man had become anxious at night time. He was reported in his pre-admission residential care level assessment, completed [pre-admission], as being only "occasionally confused but mostly coherent/alert and clear". There would have been an opportunity to further assess this presentation and provide intervention other than this medication to assist [Mr A].

[Mr A's] analgesia was reviewed again on [Day 18] in consultation with the family at his request. Dr E increased the Oxynorm dose to 10mg and added a regular Oxycontin 20mg in middle of day. Family requested a Doctor review on Thursday [Day 25] which resulted in consultation with the hospice nurse and prescribing of Amitriptyline 50mg. I note that the first dose of this medication was signed as administered on [Day 28], 3 days after it was prescribed.

Throughout the progress notes there are multiple reports of pain with movement that suggest that [Mr A's] pain wasn't well controlled. Indeed the assessment and planning around this man's pain and administration of analgesia and evaluation of its effectiveness is sadly lacking by SAV staff. Registered staff seemed to be relying on HCA reports and it appears that these may not have been responded to effectively by further assessment of pain and intervention and evaluation. Having any resident in pain is unacceptable with the resources available in the health service.

The process involved with administering narcotic drugs, for at least two staff members in a residential facility, may have contributed to this situation especially with the extra workload involved in outbreak management. It would have been prudent for SAV to consider promoting the use of a syringe driver administered medication for better analgesic cover instead of having to administer multiple doses of a controlled drug when pain is already being felt. If the registered staff had been utilizing an ongoing pain assessment tool more regular GP reviews may have been prompted.

In my opinion the registered staff responsible for [Mr A's] care, particularly the CSRN who had overall responsibility for the follow up of "high needs" residents on a

daily basis, did not adequately assess the increasing need for analgesia and thus failed to plan for an appropriate level of analgesia to allow [Mr A] to be pain free. This would be viewed with moderate disapproval.

Wound management

The Waterlow pressure area risk assessment tool was completed for [Mr A] on [Day 8], 6 days after admission. According to the Nursing Staff Admission Checklist this should have been completed on the day of admission. This identified him as at high risk for developing pressure areas. His care plan for skin integrity was completed on [Day 3] and plans for [Mr A] to

- have regular pressure area care/repositioning while in bed
- any red/broken areas reported to EN/RN
- cleaning and moisturizing of skin on a daily basis
- encouragement of oral intake with nutritional supplements if necessary with monthly weight recording

According to RN Ms P's statement [Mr A] did initially trial an air alternating mattress but didn't like it and asked to have it removed. There is no evidence of this in his progress notes or care plan. No other kind of mattress was utilized such as a simple "Spenco" or mattress overlay despite his assessment result and obvious frailty at a weight of 50kg on day of admission. No turning chart or similar was implemented to ensure accountability for regular pressure area care while in bed. No further assessment was made of his skin integrity and planning despite the development of pressure areas first reported [Day 16] by RN [Ms O]. She noted [Mr A] had a broken area on his sacrum and also on back. In the progress notes she states she applied gauze and hyperfix for "protection" and planned for staff to do "side to side nursing". A wound care chart was commenced but there is no evidence of the wound being reported to either the CSRN nor an incident/accident form being filled out as per policy that might have alerted senior staff to the developing wounds. The wounds were further reported on [Day 22] by an HCA and no record of follow up is made for that day. The HCA on [Day 23] reports that she requested the RN to renew the dressing following a shower but there appears to be no record this was done. There is record in both the progress notes and the wound evaluation that RN [Ms O] completed dressings the following day, [Day 24]. There is a gap of eight days between these two recorded dressings despite the wound care plan specifying that the frequency of dressing was to be every 2–3 days. However, RN [Ms M] says she did attend the wounds on [Days 22 and 23] but did not record this on the wound evaluation as did not know there was one. The wounds are recorded as being reviewed by the CSRN on [Day 26] where she states she was asked to review the areas, dressed them as per the dressing plan and discussed trialling an air mattress on the bed with [Mr A] and family. A RN further entered that afternoon that [Mr A] was to be turned regularly and was on a turning chart which is not evidenced.

Overall I view the standard of care for [Mr A] developing pressure areas with mild disapproval. The poor standard of care may be due, in part, to the lack of initial reporting by RN [Ms O] and subsequent following of the wound care chart by all

registered staff involved in his care. The obvious lack of planning and ongoing assessment around prevention is also of concern.

Documentation

The RN's job description states that residents are to be appropriately monitored and clear concise records are to be kept and those findings are passed on appropriately to the clinical team. The CSRN job description states that the staff member is responsible for updating and keeping current care plans and care reviews.[18] Also to obtain reports from all areas at the start of the duty regarding residents' health status and follow up of "high needs" residents on a daily basis. Of concern is the lack of structured assessment, planning, intervention and evaluation for [Mr A] when he was obviously a high needs resident with a terminal diagnosis. A care plan was formulated but there had been no alterations or additions made within the month and there are obvious gaps in his care planning, for example bowel care. There is no evidence of regular CSRN review and reports to other clinical staff.

There is an entry in the House diary that asks that [Mr A] be "given Lorazepam at least B.D.". This instruction should have been included in a care plan that plans interventions for [Mr A's] anxiety. This is one indication that SAV registered staff perhaps need education around care planning.

The current Age Related Residential Care (ARRC) services agreement requires providers to contractually comply with the following in relation to care planning:

D 16.3

d. Each Subsidised Resident's Care Plan is reviewed by a Registered Nurse and amended where necessary to ensure it remains relevant to address the Subsidised Resident's current identified needs and health status;

h. The Care Plan addresses personal care needs, health care needs; rehabilitation/habilitation needs, maintenance or function needs and care of the dying;

j. Each care plan focuses on each Subsidised Resident and states actual or potential problems/deficits and sets goals for rectifying these and detail required interventions;

I. Care plans are available to all staff and that they use these care plans to guide the care delivery provided according to the relevant staff member's level of responsibility.

D 16. 4 Evaluation

[18] SAV stated in its response to the provisional report that this was an error in the job description, which has since been corrected. RNs are responsible for updating care plans and care reviews, while the CSRNs are responsible for ensuring the RNs are aware of their responsibilities in this regard.

a. You must ensure that each Subsidised Resident's Care Plan is evaluated, reviewed and amended either when clinically indicated by a change in the Subsidised Resident's condition or at least every six months, whichever is the earlier.

I find that these contractual obligations were not met due to:

- the care plan not being completed initially e.g. bowel management and care of the dying;
- registered staff not evaluating, reviewing and amending the care plan as necessary.

This deficiency in documentation indicates a deficiency in care delivery as the care to be provided to [Mr A] should have been dictated within this plan. Overall I view the standard of documentation with mild disapproval.

Bowel management
An initial bowel elimination assessment was completed which says that [Mr A] usually had a bowel movement every 2–3 days of small to medium amount and that he has been taking two Laxsol tablets twice daily for assistance. He was also prescribed Lactulose 20ml daily to twice daily which he was being given at least once a day and on occasion twice a day except for [Days 14, 15 and 20] where he got none. He was also prescribed Movicol daily on [Day 2] which it appears was never utilized.

The admitting nurse has recorded on [Day 1] that [Mr A] needed "regular bowel aperients as can get constipated". It appears that no care plan for [Mr A's] bowel management was completed at any time either by the admitting nurse or by the CSRN responsible for this area. This is a very important consideration for a resident who is having opiates as constipation is a very prominent side effect.

On [Day 27] at 1030hours a HCA reports that [Mr A] says he feels constipated. If the RN to whom this was reported had heeded [Mr A's] complaint of feeling constipated despite the level of laxatives being given and equating that with the ongoing use of opiates a red flag may have been raised. Indeed thorough study of the bowel charts shows that he had very small firm bowel motions for the past 9 days summarized as follows:

Date	Bowel movement recorded as
[Day 19]	Small
[Day 20]	Small
[Day 21]	Small
[Day 23]	Small
[Day 24]	Small x2
[Day 26]	Small

I have to question whether [Mr A] was receiving adequate assessment of his bowels especially when the family reported he was being treated for an impacted bowel in hospital. The lack of care planning around bowel management is a serious oversight and although bowel movements were well recorded in the bowel book trends was not assessed especially when [Mr A] said he felt constipated. This would be viewed with mild disapproval.

Fracture of right lower leg
HCA [Ms T], who initially reported to the RN, says in her statement that she reported the lower leg abnormality to the RN who was in the medication room checking out D.D.s and said she was checking out his pain relief and would be there shortly, the family members arrived shortly after.

The RN on duty says that HCA reported the fracture at 1030 hours; she completed the issuing of D.Ds and was on her way to assess [Mr A] when the family arrived.

The documentation does not indicate the periods of time between staff reporting the abnormalities in [Mr A's] leg to the RN on duty, to the family arriving and witnessing the injury, to the RN attending and making an assessment. Stabilization of the leg had been completed by the HCAs. I would hope a timely assessment by the RN was completed and I note that this RN gave [Mr A] analgesia (Oxynorm 10mg) at 1130 hours.

Of interest is the family providing information at that time that [Mr A] wore a "moon boot" at home prior to admission but stopped wearing it before he went to SAV. There is no evidence of this information being provided to SAV by either the family or referring agencies therefore I would have to assume that this information may not have been shared. The use of this boot during [Mr A's] time at SAV may have prevented this fracture reoccurring especially as he still had limited mobility upon admission.

Communication between staff and medical staff
It appears that there were no issues with communication between the medical and nursing staff. All resident/family requests for GP reviews were responded to and once with the family in attendance.

However there seems to be some discrepancies around communication between the registered staff and the CSRN especially regarding the wound and its management and prompting regular review of pain levels. There does appear to be some effective communication lines in place e.g. the communications diary and Duty manager's report.

There were some issues with the CSRN completing her responsibilities in overseeing this man's care and completing the necessary documentation to communicate his care needs to the staff. In supporting this comment I can find no evidence of regular planned reviews and certainly no updating nor indeed sign off of the care plan. I view this with moderate disapproval.

Communication with [Mr A] and family
The registered nurses' job description states that they must "liaise with families as required and is vigilant in keeping family members informed of resident's situation/condition".

[Mrs A] was notified in a timely manner of the lockdown. Emails regarding families' concerns during this time were responded to. The conflicting advice on duration of lockdown was perhaps compounded by other services. The confusion between staff and [Mr A's] family around the outpatients appointment is possibly due to the positive Norovirus result for House 4 that arrived after initial discussion with the family regarding the appointment. The request, by family, for a room change was conveyed and duly processed.

Perhaps it would have been more beneficial for the family to access one staff member for their information on [Mr A's] health status and their concerns during the lockdown period. Given that the CSRN's job description states that a key accountability is to provide support for family and whanau and she is the constant among the registered staff it could have been her priority.

Norovirus Outbreak management
SAV staff are to be commended for the virtual containment of the virus to House 2 with limited spread to houses 1, 3 and 4. Outbreak case logs show that

- House 1 first case presented [a few days prior to Mr A's admission] and last case [the day prior to his admission] with last symptoms stopped [Day 5]
- House 2 first case presented [the day prior to Mr A's admission] and last case [Day 18] with last symptoms stopped [Day 19]
- House 3 first case presented [the day prior to Mr A's admission] and last case [Day 7] with last symptoms stopped [Day 7]
- House 4 first case presented [Day 2] and last case [Day 6] with last symptoms stopped [Day 8].

In Ms H's outbreak management report she reports that the facility was totally "locked down" on [Day 2] with no visitors allowed. The voluntary lockdown occurred 6 days after the first case presented and the fourth house became infected. Houses 1, 3 and 4 were reopened on [Day 17] after discussion [the] DHB Public Health Service and House 2 reopened on [Day 23].

In reviewing the documentation it appears that SAV staff have responded according to "The guidelines for the management of Norovirus outbreaks in hospitals and elderly care institutions" (2008) to manage this outbreak except in the instance of excluding visitors or the voluntary lockdown. Although SAV's policy on the "Management of an outbreak of viral gastroenteritis" does give provision for facility closure where determined by the Care Manager or delegate, resident's Medical Officer and Public Health Service. The Managing Director (Bug Control) states in her email that "facilities may need to be in quarantine i.e. with no admissions or visitors — this is quite common but would usually be done with advice or as a request from DHB".

However given that this is the second outbreak of Norovirus this facility has experienced they could possibly be reacting to the potential level of infection they know can occur.

In hindsight the lockdown might appear overzealous in some ways. In regards to the management of visitors the guidelines state:

> *"Visits to symptomatic cases should be minimized. Visitors of a suspected case should be prevented from visiting other patients/residents. Visitors should comply with all isolation procedures and should be supervised when putting on and removing gown and gloves to ensure hand hygiene is thorough."*

There are no recommendations for implementing a complete lockdown to all visitors only to new admissions where there is "ongoing cases despite full implementation of outbreak control measures". Recommendations do say that visitors can visit with infection control instruction and it appears that there was a separate entrance/s that could have been used for entry and exit rather than pass through the main entrance and infected areas. According to the guidelines visitors have the choice to visit providing they comply with infection control measures. In not allowing even the family member with nursing experience to visit seemed a little extreme given the anxiety the family were conveying in phone calls and emails regarding [Mr A's] condition.

The guidelines also recommend that where exposure of residents to Norovirus is likely to have occurred, a temporary ban on transfers to other hospitals may need to be imposed. Therefore the caution SAV exercised in [Mr A] being transferred to [the public hospital] for an outpatient appointment was appropriate, however more effective communication with family members may have alleviated their confusion over this matter.

The other area of concern is the length of time SAV took in lifting the lockdown in Houses 1, 3 and 4 given the last symptoms stopped on [Day 8]. The houses were not reopened till [Day 17]. SAV policy gives no guidance as to when a voluntary shutdown should be lifted. Quite possibly, 48 [hours] after the last symptoms stopped and no new cases presented may have been feasible in which case the extra seven days these three houses were closed seems excessive. However, staff did respond to family requests for visiting during this time and CSRN gave permission for access at the side door on [Day 11].

I feel that staff failed to assess the family's anxiety over the changes they were seeing in [Mr A] since his admission. In my opinion, given that family members were fully aware of the risks, were prepared to comply with infection control measures and there were other physical entrances that could be used it would have been feasible to allow them to visit. Not making this exception in this example would be viewed with mild disapproval.

Recommendations

SAV needs to review policy on "Management of an outbreak of viral gastroenteritis" in accordance to the guidelines (2008) and the best practice implementation for SAV as a facility. They need to review the restriction of visitors in accordance with the guidelines and reconsider the need for lockdown as a method of containment. If SAV feel a complete lockdown is necessary for containment then a procedure for this needs to be included in the policy including considering the length of time a lockdown needs to occur, SAV needs to review the outbreak management flowchart, which appears to be created for an influenza outbreak, to be more generic or develop a specific Norovirus one.

Changes made post-complaint by SAV
St Andrews Village management are to be commended on their own investigation into this complaint and the steps they have taken to address the significant issues identified around

- Documentation in progress notes
- Doctors have requested a separate page for their notes
- Communication between ward RNs and senior clinical nursing staff
- Implementation of the Liverpool Care Pathway
- More comprehensive pain assessment protocols and education being provided
- Random check of wound care plans

SAV's policy "Information Management — Health records" that was revised in December 2009 states that all changes of condition must be reported to the CSRN overseeing the area at the time. I am unsure if this is a new addition or existing but should assist in the transfer of information between registered and senior staff. The changes made to the level of reporting in the progress notes is also recognised, however, given the importance of documentation and accountability I wonder if SAV should consider extending their requirements further to include:

- HCA on each shift to record the care provided and their observations at the end of their shift.
- Registered nurses to have their own evaluation page for entries that are made "by exception". This would give a clear concise "picture" of events for each individual resident without having to read through the daily entries.

This may be excessive of what SAV sees as industry standards but it will improve the level of their documentation and thus accountability for care provided or not.

Further Recommendations
I would further recommend that SAV provides education to all staff surrounding documentation and its importance. Registered nurses need to be updated on the use of the nursing process and care planning and in particular the contractual obligations that need to be met. Also included needs to be specific education around what documentation "by exception" means in SAV policy and the recording of advice, support and assistance by senior staff.

I would also recommend that SAV consider adopting the "RN care guides for aged residential care" developed by another DHB in conjunction with providers of this care. They are based on best practice and are an excellent clinical practice tool for registered nurses.[19]

Further recommendations I can make include

- Close monitoring of standards of care at this facility
- Monitoring and support of CSRN
- Regular review of documentation

Additional comment
An area of concern in this case was the insufficiency of the pre admission information shared with SAV through the one page "Residential Care Level Assessment" and to a lesser degree the "Residential Care Placement Referral". SAV's admission information gathering is sufficient but would have been assisted greatly if a more extensive assessment had been completed prior to admission and shared. My concern, without knowing this region's procedure, that perhaps this man's level of care was determined by this very basic assessment and that meant he was denied specialist palliative care funding and all that it entails. This would have made a very real difference to the expectations of the family in this instance.

SAV admission procedures should allow for reassessment if they felt [Mr A] did indeed meet the palliative funding criteria. In hindsight the Norovirus outbreak may have diverted the registered staff's attention away from [Mr A] and his high needs but SAV should still have been responsive to his increasing needs.

Margaret O'Connor, MN

Further advice

In response to HDC's provisional report, CSRN [Ms G] noted Ms O'Connor's comments regarding the prescribing of lorazepam for [Mr A's] anxiety, and commented that increased anxiety at night is not unusual in someone who is terminally ill. Ms O'Connor responded:

I have reviewed my comments as recorded in the latest report and feel that I have nothing more to add. My primary concern around this intervention, as I have reported, is not the intervention itself but the **lack of documentation** around

1. the assessment of [Mr A's] anxiety and its potential cause

[19] As noted on page 17, SAV informed HDC in its response to the provisional report that these guidelines had been disseminated to staff.

2. the conversations with family that are only recorded in CSRN [Ms G's] recollections
3. lack of Doctors recording in the progress notes
4. the lack of careplanning around his anxiety and its management

I am well aware that lorazepam is a useful drug for anxiety in older people but I am also aware that anxiety can be caused by many things including spiritual distress, hypoxia, a delirium from perhaps an acute infection and pain. Indeed the incident that CSRN [Ms G] reports where [Mr A] dialled 111 on [Day 24] it is reported in the progress notes that he appeared to be in pain at the time

Appendix 2 — Summary of pre-admission medication regime

Brought in by family

2009

Medication at time of Admission

MIDNIGHT
0100
0200 OXYNORM 5mg
0300
0400 OXYNORM 5mg
0500
0600 OXYNORM 5mg + PANADOL X2
0700
0800 OXCONTIN 20mg
0900
1000 OXYNORM 5mg + PANADOL X2
1100
1200
1300
1400 OXYNORM 5mg + PANADOL X2
1500
1600
1700
1800 OXYNORM 5mg +PANADOL X2
1900 OXYCONTIN 20mg
2000
2100
2200 OXYNORM 5mg
2300
PLUS MORE OXYNORM AS NECESSARY

Appendix 3 — Letter to families/advocates

ST ANDREW'S Village

Dear family member / advocate
We would like to thank you very much for the support you have given to St Andrew's Village during the recent Noro Virus outbreak. We appreciate how you have recognized the vulnerability of our residents by complying with our 'no visitor' policy during the outbreak, and your combined efforts in assisting us to prevent & contain the spread to people in the community.

Please pass on our grateful thanks to other members of your family.

Our sincerest thanks

Care Manager St Andrew's Village

Names have been removed (except St Andrew's Village and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix 4 — Letter to families

ST ANDREW'S *Village*

For all our families with relatives in Houses 1, 2, 3 and 4

As you will know recently we had an infectious outbreak of norovirus. This necessitated us closing Houses 1, 2, 3, and 4 in the Goodfellow Centre to visitors. All areas are now fully re-opened and back to normal.

To express our thanks to you for your patience and understanding during this trying time our Care Manager, recently wrote to you and as she has said, we certainly do appreciate your support in what was a difficult time for everyone.

We have found some people wondering why we had to remain closed for quite as long as we did so I am writing just to explain this for you. Norovirus is now wide spread in the community and unfortunately it is something we all have to deal with, now and into the future. For those unsure of what it is Wikipedia explains that it is a virus causing approximately 90% of epidemic non-bacterial outbreaks of gastroenteritis around the world. It is usually characterised by nausea, vomiting, diarrhoea and abdominal pain. There are cases of it affecting people in their own homes also and in the same period that St Andrew's was affected there were at least 5 other aged care providers in I that were closed for the same reason. It is in many other areas of the country too and only a few weeks ago Hospital was closed to all admissions due to an outbreak for example. With it being so prevalent in the community now Public Health authorities naturally do their best to at least contain it wherever it occurs. That is why we are told by Public Health to close down until we are clear of it and the same process of 'isolation' should be followed by anyone in their own home who contracts it.

To return to our own situation we appreciate that this was a trying time during which you were unable to visit your loved one here at St Andrew's. Equally we are sure that you understand the necessity for this in order that the infection can be stopped from spreading so it was in everyone's interest that this be done. Unfortunately because it is continually circulating within the wider community all hospitals and aged care facilities like St Andrew's, just like the rest of the community, have to face the fact that it is something that can occur every now and then. We are using strict infection control processes to prevent it re-occurring from within St Andrew's but we are less able to control it being reintroduced from outside.

We realise that the period of closure may have seemed long in the sense that even after the last person to suffer infection was clear we had to remain closed for another couple of days or so just to be absolutely sure that no new infections occurred. This is dictated by the Public Health authorities and is not in the control of St Andrew's although St Andrew's fully supports the view of Public Health that re-opening must be done at an appropriate time and not before. We hope that you understand this and again we thank you for being so patient.

Yours sincerely

Chief Executive

Names have been removed (except St Andrew's Village and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.