Pain assessment and management of palliative care patient (12HDC01403, 27 June 2014)

Rest home ~ Registered nurse ~ Palliative care ~ Morphine ~ PRN pain relief ~ Pain assessment tools ~ Respiratory rate ~ Staff training and education ~ Record-keeping ~ Communication with family ~ Right 4(1)

A 62-year-old woman was admitted to a rest home for palliative care. The rest home had only recently begun accepting terminally ill patients into its care, with the District Health Board (DHB) providing specialist nursing and medical support for residents and relevant palliative care education for staff. The woman's daughter held an enduring power of attorney (EPOA) as to her mother's care and welfare which had not been activated. Her daughter complained about the failure by a registered nurse to administer PRN pain relief. The RN in question was a senior RN who had not completed full palliative care training.

Despite input from the DHB, there was confusion amongst rest home staff as to the administration of the woman's PRN morphine. The woman became increasingly unable to communicate her pain levels. She was put on a continuous syringe driver which delivered morphine, haloperidol and midazolam subcutaneously, with PRN morphine, midazolam and Buscopan to be provided every two to four hours for break-through pain.

The daughter requested pain relief on a number of occasions for her mother, who she believed was in pain. On one occasion the RN refused to dispense PRN morphine and midazolam because she assessed the woman's respiratory rate to be below 12 breaths per minute and because she did not consider that the woman was in pain. The RN then told the daughter that the woman's general practitioner (GP) had advised that the woman was not to have any additional PRN morphine or midazolam that night. The daughter then exchanged a series of text messages with the GP, who advised that the woman was to receive her PRN morphine and midazolam as usual. The daughter believes that the RN intentionally lied to her.

The following day, the woman passed away. The daughter believes that her mother endured significant and unnecessary pain as a result of the RN's refusal to administer PRN pain relief.

It was held that the RN breached Right 4(1), as she failed to adequately assess and manage the woman's pain levels. Adverse comment is also made about the RN's communication with the woman's family.

It was also held that the rest home breached Right 4(1), in that it failed to ensure that its staff were adequately trained and supervised, failed to retain sufficient records and did not keep clear and accurate records of medication administration.