# Bupa Care Services NZ Limited

# Clinical Manager, CM D

# Registered Nurse, RN C

## A Report by the

## Deputy Health and Disability Commissioner

## (Case 13HDC01254)

Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

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## Executive summary

1. Mr A (aged 74 years) had terminal prostate cancer and bowel cancer with associated metastases.[1] He was on medication for pain management, required assistance with showering and dressing, and used a walking frame.

2. In 2013, Mr A was admitted to a private hospital (the hospital), which is owned and operated by Bupa Care Services NZ Limited (Bupa), for pain management and palliative care. Mr A remained at the hospital until Day 23[2]. His medications at admission included the controlled drugs OxyContin[3] (80mg, once daily) and methadone[4] (40mg, once daily), and also haloperidol[5] (0.5mg twice daily).

3. At that time, Registered Nurse (RN) CM D was the Clinical Manager (CM) at the hospital, and RN C was the Unit Coordinator.

4. During Mr A's admission there were a number of errors made regarding his medication, including a failure to administer methadone in accordance with his prescription, for six days, and the administration of oral haloperidol for five days despite the prescription having been discontinued. On multiple occasions staff also failed to record the administration of his medications correctly.

5. Mr A was not informed about the medication errors, and there was a 10-day delay in notifying his family of the haloperidol errors.

6. On Day 23, Mr A was transferred to another hospital where, sadly, a short time later, he died.

### Findings

*Bupa Care Services NZ Limited*

7. It was found that the hospital's staff consistently failed to adhere to relevant policies, and to manage Mr A's pain and medication adequately. As a result, staff made multiple errors in relation to the ordering, storage and administration of Mr A's medication, in particular his methadone and haloperidol. Despite Mr A experiencing high levels of pain, there were multiple occasions on which his pain assessment and management were suboptimal. Furthermore, once the medication errors were identified, staff failed to respond appropriately in documenting and notifying Mr A of the errors.

[1] The development of secondary malignant growths at a distance from the primary site of cancer.
[2] Dates are referred to as Days 1-23 to protect privacy.
[3] OxyContin is the brand name for a timed-release formula of oxycodone, a narcotic analgesic.
[4] An opioid medication, used for the relief of moderate to severe pain.
[5] An antipsychotic medication. Also used in the treatment of nausea, vomiting and delirium.

8. Bupa failed to ensure that Mr A received care that was of an appropriate standard and complied with the Code and, accordingly, breached Right 4(1)[6] of the Code of Health and Disability Services Consumers' Rights (the Code).

*CM D*

9. CM D failed to ensure that the hospital staff complied with relevant policies and procedures, particularly in relation to pain and medication management; she did not follow up to ensure that corrective actions had been carried out following the identification of the medication errors; she failed to inform Mr A's family of the errors in a timely manner; and she did not act in a timely manner in administering OxyNorm to Mr A on Day 8. In conclusion, it was found that CM D failed to provide services to Mr A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

*RN C*

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

**Recommendations**

11. It was recommended that Bupa Care Services NZ Limited provide ongoing training to all registered nurses with regard to its policies and procedures, communication with residents and their families, medication management, and professional standards regarding documentation; conduct an audit at the hospital with regard to the corrective action plan; and disseminate the learnings from this investigation to all Bupa facilities nationwide. Bupa has provided a written apology to Mr A's family.

12. It was recommended that the Nursing Council of New Zealand consider competence reviews of both CM D and RN C, and that both CM D and RN C provide written apologies to Mr A's family for the breaches of the Code.

## Complaint and investigation

13. The Commissioner received a complaint from Ms B about the services provided to her father, Mr A, by the hospital. The following issues were identified for investigation:

- *Whether Bupa Care Services NZ Limited provided an appropriate standard of care to Mr A between Day 1 and Day 23 2013.*
- *Whether Clinical Manager and Registered Nurse CM D provided an appropriate standard of care to Mr A between Day 1 and Day 23 2013.*

[6] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

- *Whether Unit Coordinator and Registered Nurse RN C provided an appropriate standard of care to Mr A between Day 1 and Day 23 2013*

14. The parties directly involved in the investigation were:

| | |
|---|---|
| Ms B | Complainant/consumer's daughter |
| Bupa Care Services NZ Limited | Provider |
| RN C | Registered nurse/Unit Coordinator |
| CM D | Registered nurse/Clinical Manager |

15. Information has also been reviewed from:

| | |
|---|---|
| Mrs A | Consumer's wife |
| Ms E | Consumer's daughter |
| Dr F | General practitioner/provider |
| Dr G | Palliative care consultant/provider |
| RN H | Registered nurse/provider |
| RN I | Registered nurse/provider |
| RN J | Registered nurse/provider |
| RN K | Registered nurse/provider |
| Ms L | Facility Manager/provider |

Also mentioned in this report:

| | |
|---|---|
| RN M | Palliative care nurse |
| Ms N | Pharmacy technician team leader |
| RN O | Registered nurse |

16. This report is the opinion of Deputy Commissioner Rose Wall, and is made in accordance with the powers delegated to her by the Commissioner.

17. In-house clinical advice was obtained from registered nurse Dawn Carey (**Appendix A**).

## Information gathered during investigation

### Introduction

18. At the time of these events, Mr A was 74 years old and had terminal prostate cancer and bowel cancer with associated metastases.[7] He was on medication for pain management, required assistance with showering and dressing, and used a walking frame.

19. Mr A was experiencing pain all over his body, which affected his sleep. He was admitted to the hospital for pain management and palliative care. He was accompanied to the hospital by his wife, Mrs A, and daughters Ms B and Ms E.

[7] The development of secondary malignant growths at a distance from the primary site of cancer.

20. This report considers Mr A's care while at the hospital between Day 1 and Day 23, particularly his medication and pain management. During this time there were a number of errors made regarding Mr A's medication, including (but not limited to) a failure to administer methadone in accordance with his prescription over six days, and the administration of oral haloperidol over five days, despite his prescription having been discontinued.

## The hospital

21. The hospital is owned and operated by Bupa and is contracted by a district health board to provide hospital, dementia and palliative care. Mr A resided in the hospital-level care ward.

*Staff at the hospital*

Clinical Manager CM D

22. Registered Nurse (RN) CM D was the Clinical Manager (CM) at the hospital at the time of these events. CM D was responsible for the care provided by 24 registered nurses and their support staff to between 110 and 120 hospital-level care residents at the hospital.[8]

23. CM D's job description stated that her role included providing high-level clinical leadership and support to clinical and care staff, monitoring the provision of clinical care to residents to ensure that the highest standards were achieved and maintained, ensuring systems were in place to keep family and significant others fully informed of any issues relating to clinical care, coordinating the provision and use of clinical supplies within the facility, providing oversight of all resident clinical records and recordings to ensure that they met organisational and legislative requirements, and ensuring that clinical staff adhered to safe work practices.

24. With regard to medication, Bupa's Medication Management policy at the relevant time provided that Clinical Managers were responsible for "[a]ssisting with the provision of safe medication systems within the facility, [and] [m]onitoring staff practice and compliance with [the] policy".

25. CM D's role also included following up medication incidents at the hospital and developing corrective action plans following such incidents. She also undertook two facility-wide medication management audits in the six months leading up to this incident, which she discussed with the staff at the hospital.

Unit Coordinator RN C

26. RN C was the Unit Coordinator on the ward at the time of these events, and had worked at the hospital for some time.

27. RN C's job description stated that her role included providing effective day-to-day coordination and supervision of the clinical aspects of the care provided to residents, participating in the delivery of care to residents, applying principles of clinical best

[8] At this time the Unit Coordinator for two other wards was on leave. CM D was also covering the coordination of both of those wards during that period.

practice and leading by example, liaising with families and health professionals, maximising the safety of residents within the unit by regularly reviewing their safety needs and ensuring all interventions were utilised, ensuring staff practised safe work methods and adhered to safety policies and procedures, assisting with orientating new staff to the unit, and supporting and assisting the Clinical Manager in order to implement excellent and safe nursing practices.

28. RN C began working in the ward about two months prior to Mr A's admission, having previously worked in the dementia wards. According to RN C, her role as Unit Coordinator was to lead and coordinate a team of registered and enrolled nurses, caregivers and others involved in the care of the residents.

29. RN C told HDC that usually she checked on priority patients, such as Mr A, at the beginning of every shift.

30. RN C said that having only recently begun working on the hospital wards, she was not familiar with processes such as ordering controlled drugs. RN C told HDC that her orientation to the ward consisted of being "buddied" with a Unit Coordinator from another ward for "a few hours". She stated that she spent time within her first few months familiarising herself with the procedures in the hospital wards with which she was unfamiliar.

Dr F

31. Community-based general practitioner (GP) Dr F[9] was contracted to the hospital to provide care for many of its residents, including Mr A. Dr F told HDC that typically he visited the hospital for two hours on Mondays and Fridays, and at other times was available by cell phone. Dr F regularly gave advice or visited the hospital outside of his scheduled ward rounds.

*Hospice*

32. While Mr A was a resident at the hospital, staff were able to contact staff at a hospice for further review or assistance with Mr A's pain management and palliative care. Previously Mr A had been a resident at the hospice, and his most recent discharge had been about two weeks prior to his admission to the hospital. Providers from the hospice involved in Mr A's care during his stay at the hospital were a palliative care physician, palliative care consultant Dr G, and palliative care nurse RN M.

*Medication management at the hospital*

33. With regard to recording the prescribing and administration of medications, the hospital used the following processes and forms of documentation.

Ordering medication

34. The hospital received medication for its patients from a pharmacy. Bupa told HDC that the usual process for requesting medication from the pharmacy for new admissions involved staff sending to the pharmacy a copy of a recent discharge summary (for example, from a hospital or hospice), listing the patient's currently

[9] Dr F is vocationally registered in general practice.

prescribed medications. This information had to be sent to the pharmacy prior to 3pm Monday to Friday, in order for the pharmacy to arrange for delivery of the medication that day.

35. On receipt of the medication, the receiving registered nurse was expected to check the first 24 hours of the medication provided against the discharge summary or the prescription the doctor had recorded on the prescribed medication chart (see below).

36. Frequently, medication was dispensed from the pharmacy packed in a robotic roll (packed medication).[10] However, controlled drugs and PRN (as required) medications were not included in robotic rolls and were dispensed separately.

37. The hospital's process when requesting controlled drugs was to send a Controlled Drug Bulk Supply Order Form[11] (Controlled Drug form) to the pharmacy, requesting the drug.

38. With regard to its normal processes for dispensing controlled drugs to facilities such as the hospital, the pharmacy told HDC:

> "[The facility] fax[es] us a Bulk Supply Order Form with the requested controlled drug written on it for supply. This form is processed in the computer on the day it is received. The controlled drugs are delivered the next day unless facility staff ring to request same-day delivery. It is assumed that if a bulk supply order is not sent to the pharmacy that the facility has adequate levels of that particular drug."

Medication administration record

39. The administration of packed medication was recorded on a medication administration record (MAR). Staff members signed the MAR on a space under each day for breakfast, lunch and dinnertime doses of medication.

Non-packed or PRN administration record

40. Administration of non-packed or PRN medication was recorded on the non-packed medication administration record (NMAR), on which the administration of each medication was assigned a separate column under which staff recorded the date, dose and time the medication was given, and then signed next to each record.

Red non-packed medication administration record for controlled drugs

41. A red non-packed medication administration record (red NMAR) was used to record the administration of controlled drugs, in order to differentiate between controlled drugs and other medications.

[10] Medication is dispensed at the pharmacy by an automatic "robot", which seals medication into individual packages (ie, medication to be taken in one sitting: am/pm doses) joined together in a roll or strip.

[11] The Controlled Drug Bulk Supply Order Form is a quadruplicate form issued by the Ministry of Health. The first three copies are sent to the pharmacy, while the fourth copy is retained by the hospital.

42. On the red NMAR, the administration of each medication was assigned a separate column under which staff recorded the date, dose and time the medication was given, and signed next to each record.

Controlled Drugs Register

43. The Misuse of Drugs Regulations 1977 (the Regulations) place restrictions on the prescribing, supply and custody of controlled drugs. The Regulations require persons authorised to administer controlled drugs to maintain a Controlled Drugs Register (CD Register) in relation to all controlled drugs administered, possessed or dispensed by the authorised person (a person with the required competencies), for each individual consumer. The regulations require that each controlled drug be recorded on a separate page in the CD Register.

**Care provided to Mr A from Day 1 to Day 13**

44. At the time of Mr A's admission to the hospital, Mr A brought his medication with him in two blister packs. Mr A had enough medication with him to last until the end of Day 5.

*Nursing assessment*

45. Mr A's initial nursing assessments were undertaken by RN I, who was new to the hospital at the time of Mr A's admission. The nursing assessments included an Admission Assessment and a Falls Risk Assessment.[12]

*Medical assessment*

46. Dr F advised HDC that on Day 1, he reviewed Mr A's discharge letter from the hospice. The discharge letter set out a list of medications that Mr A had been taking, including haloperidol[13] (0.5mg twice daily), OxyContin[14] (60mg twice daily), methadone[15] (40mg every night) and OxyNorm[16] (30mg PRN).

47. Dr F assessed Mr A and filled out the prescribed medication chart[17] in accordance with the medications and dosages provided in the discharge summary. However, the dosage of OxyContin that Dr F recorded in the prescribed medication chart differed from Mr A's blister pack medication, because his dose had been increased from 60mg to 80mg twice daily since he had been discharged from the hospice.

48. Bupa advised HDC:

[12] Mr A was assessed as having a "high" falls risk. The Admission Assessment and Falls Risk Assessments are to be completed within 12 hours of a resident's admission, as are the Braden Scale Pressure Risk assessment (BSPR) and the Skin Assessment (the latter two assessments were completed the following day).
[13] An antipsychotic medication, also used in the treatment of nausea, vomiting and delirium.
[14] OxyContin is the brand name for a timed-release formula of oxycodone, a narcotic analgesic. It is a controlled drug.
[15] An opioid medication used for the relief of moderate to severe pain. It is a controlled drug.
[16] Immediate release formula of oxycodone, a narcotic analgesic. It is a controlled drug.
[17] This chart records the date of the prescription, name of the medication, route for administration, times at which the medication should be administered (ie, breakfast, lunch, dinner, bedtime), and the date on which the prescription is to be discontinued. The doctor is required to sign each prescription.

> "[P]rior to the administration of OxyContin, [RN H] noted that an insufficient prescription had been recorded by [Dr F] … The RN contacted [Dr F] by telephone and a verbal order was given to increase the dose to 80mgs. This dosage was administered and signed for, however the RN did not follow policy regarding documenting the altered dose as charted by verbal order at that time and the doctor documented the correct prescription of 80mgs on the following day."

**Methadone administration error**

49. As noted previously, when he was admitted to the hospital, Mr A brought his medications with him, including sufficient methadone to last him until Day 5. While the hospital had OxyContin and OxyNorm in stock, it did not have methadone at the time of Mr A's admission, and was required to order it from the pharmacy.

50. On the afternoon of Day 1, RN C called the pharmacy and spoke with pharmacy technician team leader Ms N about Mr A's prescriptions. RN C advised Ms N that the hospital had enough of Mr A's blister pack medication to last the weekend.

51. According to RN C, Ms N informed her that the pharmacy was currently "out of stock" of methadone. The pharmacy advised HDC that its staff have no recollection of this advice. Bupa has provided no documentation of the conversation.

52. The pharmacy told HDC that its "understanding with facilities that dispense their [controlled drugs] out of facility controlled ward stock (such as the hospital) is that they fax [the pharmacy] a Bulk Supply Order Form with the requested [controlled drug] written on it for supply".

53. RN C stated that following her conversation with the pharmacy, she faxed Mr A's discharge summary from the hospice to the pharmacy, but did not include a controlled drug form for methadone. RN C told HDC that she was not aware of the requirement for a controlled drug form, and the pharmacy did not advise her of this when she faxed the discharge summary.

54. The medication for Mr A (excluding methadone) was dispensed at the pharmacy in robotic roll packaging the same day, to be delivered to the hospital that evening. The pharmacy told HDC that, as no controlled drug form was received, no methadone was sent.

55. CM D advised HDC that there was no follow-up with the pharmacy on Day 2 regarding Mr A's methadone supply.

56. Methadone was administered to Mr A in line with his prescription from Day 1–Day 4. Over the following six days, staff administered Mr A's medication directly from the robotic packs supplied from the pharmacy, as well as controlled drugs from the hospital's supply cupboard. However, the hospital staff did not check the medication in Mr A's robotic packs against the prescribed medication chart when administering the medication, and did not realise that Mr A should also have been administered methadone from Day 5 until Day 11.

57. At 8.30pm on Day 5, RN I administered Mr A's OxyContin from the hospital's supply.[18] However, she failed to administer Mr A's methadone (which was available in his blister packed medication from home). RN I told HDC that she believed that Mr A's methadone was in his packed medication, which she had administered to him during the day.

58. RN I told Bupa that this was her first shift since Day 2, and the morning staff handed over that Mr A had no changes to his medications. She stated that she was not told that Mr A still had his blister pack from home containing OxyContin and methadone. She said she did not know that methadone is a controlled drug.

59. As stated above, RN I was new to the hospital at the time of Mr A's admission. She told HDC that she was still supposed to be under the supervision of another qualified staff member. However, she said that she was the only qualified staff member on duty during her shifts "for several days" after Day 5.

60. On Day 5, RN K sent a controlled drug form to the pharmacy as part of the weekly ordering procedure, requesting controlled drugs for the hospital's supply, including one bottle of 40mg methadone tablets. Bupa stated that RN C telephoned Ms N, who said that they did not have the methadone tablets in stock and would not be able to supply the tablets until the following week.

61. On the morning of Day 6, the pharmacy received the controlled drug form sent from the hospital the previous day, requesting the supply of methadone. RN O told the hospital that she received a telephone call from Ms N advising that they could provide methadone in liquid form, rather than tablet form. The pharmacy stated that Ms N has no recollection of any conversations with staff from the hospital, but agrees that a conversation must have occurred given that the request form has been changed from methadone in a tablet form to a liquid form.[19]

62. According to RN O, she discussed this conversation with RN C, who agreed to the supply of liquid methadone. The controlled drug form was amended to state "10mg/ml liquid" methadone, and re-sent to the pharmacy.

63. The pharmacy told HDC that it requested liquid methadone from its supplier that afternoon, and the methadone was sent to the pharmacy on Day 7.

64. On the afternoon of Day 7, the pharmacy delivered liquid methadone to the hospital. RN I and another RN entered the methadone into the CD Register and put it in the controlled drugs cupboard. RN I told HDC that as the methadone was not labelled for Mr A, she believed it was for the hospital's supply.

65. At 8.30pm RN I failed to administer methadone to Mr A despite it being available in the controlled drugs cupboard. She said she still thought that Mr A's methadone tablets were included in his packed medication.

[18] Recorded accurately in the red NMAR and CD Register. Also signed by an enrolled nurse.
[19] According to the pharmacy, methadone is available in either liquid or tablet form.

66. RN I was on duty on the evening of Day 8, and again failed to administer methadone to Mr A.

67. At 8.30pm on Day 9, RN H failed to administer Mr A's methadone. RN H told HDC that she checked the prescribed medication chart and noted that methadone had been prescribed for Mr A, but failed to compare the prescribed medication chart with the packaged medication.

68. RN H was again on duty on the evenings of Day 10 and Day 11, and did not administer methadone to Mr A.

69. According to Bupa, at 8.30pm on Day 12, because of the discovery of the haloperidol errors (detailed below), RN I checked Mr A's methadone against his medication chart before administering it.

70. RN I discovered that Mr A had not been given methadone since Day 5. RN I administered Mr A's methadone, signed the red NMAR,[20] and recorded the administration in the CD Register. RN I recorded in the progress notes, "Bedtime methadone given", but she did not record that there had been methadone errors.

71. Ms B told HDC that when she visited her father on the morning of Day 13, he told her, "[T]hey gave me a different medicine last night, it was a liquid," but they would not tell him what it was. Bupa told HDC that they believe Mr A's statement that he was given a different medicine would have been in reference to the dose of liquid methadone that RN I administered at 8.30pm on the evening of Day 12.

72. Following Day 12, methadone continued to be administered to Mr A in accordance with his prescription until his discharge.

**Haloperidol administration error**

73. On admission to the hospital, Mr A was taking 0.5mg haloperidol twice a day. Haloperidol is not a controlled drug.

74. On Day 7, following a review in response to reports of increased breakthrough pain, Dr F opted to start a subcutaneous pump for some of the medications, as he "wondered how well [Mr A] was absorbing the medications via the oral route …".

75. Dr F decided to discontinue oral haloperidol and include haloperidol by subcutaneous pump (SC pump).

76. RN J recorded in the progress notes: "GP charted Oxynorm 70mg + Haloperidol 1mg via syringe pump, commenced. PRN Oxynorm 15mg SC[21] or 30mg oral for pain."

77. Ms B told HDC that when she visited her father that afternoon she was informed of the change regarding the administration of her father's haloperidol.

[20] Also signed by an enrolled nurse
[21] Subcutaneous (under the skin).

*Advice to the pharmacy*

78. RN C told HDC that usual practice was for the registered nurse who accompanied the GP on his round to document the details of the GP visit, including any changes to medication, and to fax the changes to the pharmacy. The pharmacy would then send the replacement robotic packs to the hospital.

79. RN C told HDC that before she left on her lunch break she made sure that RN J was aware of Dr F's instructions for changes to Mr A's medication. RN J recalls sending the amended prescribed medication chart to the pharmacy indicating the change to Mr A's prescription.

80. Bupa told HDC, however, that the hospital staff failed to communicate to the pharmacy the change to Mr A's prescription of haloperidol and, therefore, new robotic packs without haloperidol were not delivered.

81. The pharmacy told HDC that it "[suspected it was] only faxed the back chart of [Mr A's] medication on [Day 7] and dispensed this as is", noting that the front page of the chart is where regular packed medication is written.

82. The pharmacy also told HDC:

> "It is common practice for doctors at the hospital to chart drugs in a syringe pump without stopping oral medications, ensuring that facility staff have a supply of subcutaneous medication, in case patients deteriorate over the weekend and require such medication immediately."

83. Over the next four days, from Day 8 until Day 11, staff continued to administer Mr A's medication from the robotic packs containing oral haloperidol, and he also received haloperidol by way of the SC pump in accordance with his prescription.[22]

84. RN H administered Mr A his packed medication on Day 9, and told HDC: "I noted … that his haloperidol had been discontinued on the drug chart and I removed it from his medication pack before giving his regular medications to him." However, this is not documented, and RN H did not inform anyone at that time that haloperidol remained in Mr A's packed medication.

85. The pharmacy told HDC that, on Monday Day 12, it received the front page of Mr A's medication chart showing that his prescription for oral haloperidol had been stopped. There is no record at the hospital of this being sent. The pharmacy advised HDC that this is the first time it became aware of the change in Mr A's prescription.

86. Ms N called the hospital and spoke with RN J. Ms N informed RN J that the pharmacy had just noticed that Mr A's oral haloperidol had been discontinued on Day 7, and that the change in medication had not been communicated to the pharmacy previously. Accordingly, the pharmacy had continued to provide oral haloperidol in Mr A's packed medication.

[22] The following registered nurses were on duty and directly involved: Day 8, RNs K and I; Day 9, RN K; 11 and Day 11, RNs K and H.

87. That afternoon, the pharmacy supplied new packed medication for Mr A, excluding oral haloperidol.

**Pain assessment and management**

88. Dr F advised HDC:

> "On admission, Mr [A] appeared quiet, subdued and was a man of few words. Then, and only rarely during our time together, did he discuss much concerning his illness or pain, and he seemed to relay most of his information via his daughter [Ms B]. During my rounds throughout his hospitalisation he rarely seemed in pain and most of his pain was reported to occur at night."

89. Dr F's notes from Mr A's admission indicate the need for Mr A's pain to be monitored.

*Pain Assessment Tools*

90. On Day 2, as part of the initial nursing assessment, RN J undertook a pressure risk assessment, skin assessment and pain assessment for Mr A.

91. The Summary of Assessment Tools (Summary) included in the assessment paperwork states that a pain assessment tool should be completed within one week of admission and repeated at least six monthly. It goes on to state:

> "If pain is identified at any time during this period, complete a full pain assessment and commence regular monitoring, and update care plan."

92. The Summary references two different pain assessment tools, the Iowa Pain Assessment Tool[23] (verbal) and the Abbey Pain Assessment Tool[24] (non-verbal), with instruction that the most appropriate one for the resident is to be chosen.

93. Mr A's admission assessment records that he experienced pain "all over [his] body". His detailed Pain Assessment Chart, completed as part of the Iowa Pain Assessment Tool, records that on Day 2 his pain score was 5 out of 6, experienced as intermittent stabbing pain in his back that was made worse with movement. Pain was recorded as relieved with OxyNorm.

94. The Iowa Pain Assessment Tool was used again on Day 4 (1350) when Mr A reported pain of 4/6; and on Day 6 (1235) when he reported pain of 4/6.

95. The Iowa Pain Assessment Tool was used three times on Day 7 (0730, 1230, 1430), with Mr A reporting pain of 5/6, 6/6 and 3/6 respectively.

[23] The IOWA Pain Assessment Tool is designed for use with patients who are able to communicate and rate their pain experience clearly. It uses a scale of pain between 0 (no pain) and 6 (severe pain).
[24] The Modified Abbey Pain Assessment Tool is used for patients whose cognitive deficits are assessed as moderate to severe, or who have difficulty communicating verbally. The scale measures pain as being 0–2 no pain, 3–7 mild pain, 8–13 moderate pain, and 14+ severe pain.

96. From 8.45pm on Day 7, and in the early morning on Day 8, the hospital staff used the Modified Abbey Pain Assessment tool to assess Mr A's pain rather than the Iowa Pain Assessment tool because Mr A was showing signs of confusion and anxiety and was vague in his response regarding his pain score. At that time, the staff believed that the Iowa tool was no longer applicable.

97. Staff reverted to using the Iowa Pain Assessment Tool from 8am on Day 8.

*Other records of pain Day 2–Day 7*

98. According to nursing progress notes, between his admission and Day 7, Mr A was provided with PRN OxyNorm on a number of occasions. However, there are no corresponding records of the assessment of his pain levels and administration of the PRN pain medication.

99. Nursing progress notes recorded the following incidents of pain and use of PRN medication:

> **Day 2**: Mr A received 30mg OxyNorm at 4am and "settled back in bed after[wards]";
>
> **Day 3**: Requested pain relief at 4.30am and "settled and slept well after[wards]";
>
> **Day 4**: Asked for pain relief for back pain at 2.30am, which was "given with good effect";
>
> **Day 5**: Given 20mg OxyNorm at 10.40pm and "settled in bed";
>
> **Day 7**: Asked for pain relief at 2.30am, at which time he was given 20mg Oxynorm. At 4.30am Mr A requested more pain relief and was given an additional 10mg OxyNorm. He was given 20mg OxyNorm at 12.35pm after Ms B told nurses that her father was in pain.

100. According to the medication charts, Mr A was given PRN OxyNorm on other occasions between Day 1 and Day 7.[25] No corresponding record was made in the progress notes on these occasions.

101. On Day 5, Dr F reviewed Mr A during his scheduled ward round. Dr F told HDC that he discussed with staff the use of PRN medication for Mr A's breakthrough pain and nausea.

*Further reports of pain*

102. Ms B advised HDC that from Day 6, her father experienced a "rapid deterioration". Ms B stated:

> "My father became withdrawn, pale, sweating profusely and refused to get out of bed or shower. He was able to eat small amounts of food but seemed to have

[25] 1.50pm on Day 4; 1am on Day 5.

become overwhelmed by pain. He knew something had changed but didn't know if he was starting to die or something was amiss."

103. RN J recorded in the progress notes that Mr A and his daughter[26] had requested an increase in Mr A's morning doses of OxyContin and OxyNorm because of his increased pain, and that she had discussed Mr A's condition with Dr F.

104. Dr F assessed Mr A on Day 7, accompanied by RN J and RN C. As mentioned above, Dr F decided to discontinue the oral haloperidol and include it by subcutaneous pump. Dr F told HDC:

> "[On assessing Mr A] it was apparent that since my visit 2 days prior he had some increase in breakthrough pain reported via [Ms B], again this was mostly at night … I opted to start a subcutaneous pump. At this stage I wondered how well he was absorbing the medications via the oral route …"

105. RN J recorded in the progress notes: "GP charted Oxynorm 70mg + Haloperidol 1mg via syringe pump, commenced. PRN Oxynorm 15mg [subcutaneous pump] or 30mg oral for pain."

106. Ms B told HDC that when she visited her father that afternoon she was informed of the change regarding the administration of her father's haloperidol.

107. Ms B advised HDC that on Day 8 she visited her father at the hospital and that he "looked dreadful". She stated:

> "Due to intolerable pain he was still unable to have a shower and was sweating profusely which required changing his top regularly. He still would not get out of bed. He reported to me that he rang the bell last night and screamed out 'I demand pain relief'. He said the nurse mumbled some reply he could not understand and left the room. This was very distressing to hear …"

108. Ms B said that after seeing her father, she telephoned his palliative care nurse at the hospice, RN M, to explain her concerns regarding her father's pain relief. RN M said that she would visit Mr A the following morning.

109. At 8.15am on Day 8, CM D recorded in Mr A's family/whānau contact record: "[S]poke with [Ms B] — very upset because father in pain ++ Reassured I will follow up, see progress notes …" At 8.30am CM D recorded in the progress notes:

> "Spoke with daughter [Ms B], [Mr A] continues to have severe pain even with the increased amount of PRN Oxynorm overnight. [Discussed with] Dr F — to have [subcutaneous][27] oxynorm 20mg STAT (immediately). Also [subcutaneous] Oxynorm dose increaseed to 100mg in 24 hrs via syringe driver pump. Clonazepam has been added. [Dr F] will review at lunchtime."

[26] It is not recorded to which daughter this refers.
[27] Under the skin, via injection.

110. CM D told HDC that this was the first time she had met Ms B and become directly involved in Mr A's care, although previously she had been aware of him as a resident. At 10.30am CM D recorded in the progress notes that RN K had given Mr A OxyNorm at 10.00am, and that by 10.30am Mr A's pain was minimal. There is no recorded reason for the delay between 8.30am (when CM D spoke to Dr F) and 10.00am, when the OxyNorm was administered.

111. Dr F recorded in the clinical notes: "[P]ain overnight, use PRN if needed. Pump Oxynorm 100mg, Haloperidol 1mg, Clonazepam 2mg, use PRN if needed."

112. Mr A's pain was assessed every two hours between 8.00am and 10.00pm on Day 8 and recorded as decreasing from 5/6 to 0/6 by 4.00pm.

*Supply cupboard locked*

113. Bupa advised HDC that on Day 9 staff could not get into the supply cupboard in Mr A's unit for 11.5 hours, because the key for the supply cupboard was missing. Bupa advised HDC that during this time staff sourced drugs from another unit and, therefore, this incident did not have any direct impact on the care provided to Mr A. There is no documentation regarding this incident, and Bupa advised HDC that although this was a reportable event, no incident report was completed.

114. Bupa told HDC that in order to prevent this from happening again, the key entry locks to the treatment rooms are being replaced with a pin code keypad lock system.

*Palliative care and medical assessment*

115. At 11.00am on Day 9, RN M visited Mr A while Ms B was present. Ms B told HDC that at this time her father was comfortable, as he often was at that time of the day. Shortly after RN M's visit, Dr F visited Mr A.

116. Dr F recorded in Mr A's clinical notes: "Pain seems well controlled on 100mg Oxycodone and prn meds same sedation ≤ clorazepam 2mg."

117. Dr F told HDC that he discussed Mr A's condition with the hospital staff, who were satisfied with the medication charted. Dr F said that he considered it appropriate to leave Mr A on the current medication regimen, and did not consider it necessary to involve a community palliative care physician, as Mr A's pain "appeared to be under control".

118. At 2.00pm, CM D recorded in the family/whānau contact record: "[S]poke with [Ms B] again. Family are very happy with the care given in the past 24 hrs. [Mr A's] pain much improved. New mattress in place. Visit from [CNS] and [Dr F]."

*Day 11–Day 12*

119. At 9am on Day 11, Mr A was noted to be experiencing 3/6 "stabbing" and "constant" pain. Mr A was noted to be on an OxyNorm pump, and no further pain relief was administered at that time. At 11.30am, Mr A's pain score was noted to have increased to 5/6 "stabbing" and "constant". At that time, Mr A was given additional PRN OxyNorm medication.

120. At 8am on Day 12, Mr A was noted to be experiencing 3/6 "sharp" and "constant" pain. At that time, Mr A was noted to be on an OxyNorm pump, and no further pain medication was given.

121. Ms B told HDC that on the morning of Day 12 she visited her father because of her "mounting concerns" about his pain. She said that when she saw her father he was "grimacing and grey with discomfort", and she went to find a nurse immediately.

122. Ms B said that she found a nurse in the corridor doing the medication round. Ms B explained that she was "really angry", and said: "Dad is in 6 out of 6 pain." The nurse replied: "We are going to give pain relief after the medication round." Ms B told HDC that she waited with her father and did not feel that there was any urgency by staff to relieve his pain.

123. At 9.30am a pain assessment was carried out, and Mr A was noted to have 4/6 "constant" pain, but he was not given PRN OxyNorm until 10am.

124. In response to Ms B's concerns regarding the nurse's responsiveness, Bupa told HDC:

> "We agree that it would have been more appropriate for the nurse to have prioritised the management of [Mr A's] pain over the routine medication round."

125. Dr F told HDC that, on the afternoon of Day 12, he visited Mr A during his regular ward round. Dr F stated:

> "Although settled at the time of the ward round it did appear that he had not had a good weekend. In response, I initiated an increase in the pump medications from 100mg to 120mg Oxycodone and changed the Clonazepam to Midazolam[28] 2.5mg as this could be markedly increased if needed."

126. Dr F contacted the palliative care physician at the hospice, who advised him to arrange for Dr G to visit Mr A. Dr F contacted Dr G and arranged for him to visit Mr A the following day.

127. On Day 12 at 3pm, Ms B returned to the hospital and found that her father was again in pain and distressed. Ms B said that when she spoke with RN C:

> "I became really upset this time and openly wept when I raised my serious concerns with [Dad's] pain and asked [RN C] why dad was suffering so much …"

128. Ms B said she requested that RN C ask CM D to contact Dr G. According to Ms B, RN C "appeared to understand" how severe Ms B believed her father's pain to be, and said that she would talk to CM D.

129. RN C recorded in the family/whānau contact notes:

[28] Used for sedation or to assist with sleeping.

> "D/W [Ms B] re pain mgt. Reassured will reassess [Mr A] tomorrow + phone [Dr F] if pain is still uncontrolled."

130. RN C passed on Ms B's concerns to CM D, who told HDC that, as she did not know who Dr G was, she contacted Dr F and discussed seeking input from the palliative care team. CM D stated that Dr F told her that he had already contacted Dr G and arranged a review for the following day.

131. At 6pm Mr A was noted to be in 3/6 constant pain. However, no pain medication was administered at that time. At 8pm, Mr A was noted to have 6/6 pain that was "constant" and "sharp". At that time, OxyNorm was administered.

*Day 13*

132. CM D told HDC that when she arrived on shift on Day 13, she noticed that during the previous 24 hours Mr A had required more doses of PRN pain relief than usual. At 8.15am CM D contacted Dr F regarding Mr A's ongoing pain relief issues.

133. At 10.15am Mr A had a fall. RN C recorded in Mr A's progress notes that she carried out a physical assessment of him, commenced neurological observations, and informed Dr F. At 12.30pm RN C contacted Ms B and informed her about Mr A's fall and his condition.

*Dr G's assessment of Mr A*

134. Dr G attended the hospital, assessed Mr A, and recorded the following information in the clinical notes:

> "[Complained of] 'severe' pain. R axilla[29] across to L axilla + L forearm 'aching' deep, constant pain …
>
> [F]ell getting up to toilet this AM → upper back pain — Pt a bit vague, but appears pain described above is related to the fall + not the source of pain past — wk … "

135. Dr G recommended splitting Mr A's dose of methadone into 15mg twice a day and 30mg at bedtime, rather than a single dose, and updated his prescription accordingly. It is recorded in Mr A's clinical notes that the hospital staff discussed Dr G's management plan with Dr F. Neither Dr G nor Dr F were aware of the methadone error (detailed below) at that time.

136. Following his review of Mr A, Dr G telephoned Ms B and informed her that her father had suffered a fall that morning, but had no injuries. He also explained that he had changed Mr A's methadone dose to three times a day.

[29] Underarm/armpit.

**Responses to medication errors**

*Methadone error*

137. According to RN I, she contacted RN H on Day 12 to advise her of the error regarding the failure to administer methadone. RN I said that RN H told her that there was "nothing she could do about" the methadone errors. RN I said she did not alert a doctor or discuss the errors with Mr A or his family at that time because of RN H's advice. RN I did not inform the hospital management of the methadone errors until the following day.

138. RN H told HDC that she does not recall the detail of her conversation with RN I, but remembers that it was her day off, and she had been asleep when she received RN I's telephone call. RN H told HDC that she was "very stressed and shocked that there had been an error".

139. There is no record in the progress notes on Day 12 regarding the failures to administer methadone.

140. RN I told HDC that, on Day 13, she informed RN C of the methadone administration errors, and RN C then told CM D. RN I told HDC that she was not aware of any other steps that she was required to take.

141. However, in contrast to RN I's recollection, RN C told HDC that following Dr G's review on Day 13, she and RN K administered Mr A's increased dose of methadone as prescribed by Dr G. RN C stated that at that time they discovered that their entry into the controlled drug chart for methadone was only the second entry since Day 4, the first being RN I's entry the previous evening. RN C told HDC that she reported the methadone errors to CM D, who told her that she would discuss the errors with Mr A's family.

142. CM D told HDC that as Ms B visited her father each evening, she planned to tell her about the methadone errors that evening. However, Ms B did not visit on the evening of Day 13, so CM D planned to speak with her when she visited the following day.

143. At 3.00pm on Day 13, CM D filled out an Incident Form with regard to the methadone errors, which included the following:

> "During the period of [Day 6-Day 12] [Mr A] required increased amounts of PRN Oxycodone for severe breakthrough pain and three medical reviews for syringe driver and PRN Medication adjustment. Registered Nurse not checking the medication pack against the prescription chart …"

144. That afternoon, CM D advised Dr F, Dr G, and the hospital's Facility Manager, Ms L, of the methadone errors.

145. Dr F visited Mr A to assess him around midday on Day 14, having been advised about the methadone administration errors the previous evening. He recorded in the clinical notes: "Pain relief excellent over last 24hrs. Some issues w[ith] methadone doses."

146. Bupa advised HDC that, at approximately 1pm on Day 14, Mrs A arrived to visit her husband, and CM D told her about the methadone administration errors. Mrs A had left the facility when Ms B arrived approximately 45 minutes later. CM D also informed Ms B of the methadone administration errors. There is no record that Mr A was advised of the errors.

147. Ms B said that when she visited her father, CM D told her that her father had not received methadone for six days, in error. Ms B said she asked what Dr F thought, and CM D responded that "he wasn't happy". At 2.30pm CM D recorded in the family/whānau contact records:

> "Spoke to [Mrs A] and [Ms B] following GP visit at lunch time. Advised of medication incident and formal investigation. Both relieved that [Mr A] is now comfortable and more settled."

148. On the afternoon of Day 16, Ms B contacted Ms L to request a meeting about the methadone errors. A meeting was scheduled for later that morning, and Ms B attended with her sister, Ms E.

149. At the meeting, Ms L provided Ms B with a letter that confirmed the methadone administration errors and stated that Bupa was undertaking an internal investigation. Ms L told Ms B that they were still unsure how the errors had occurred, but that they would talk to the pharmacy staff and Dr F. Ms L told Ms B that they would like to meet with the family again following Bupa's investigation. Ms L did not tell Ms B about the haloperidol errors at the meeting, as she was not yet aware of them herself.

150. CM D told HDC that following the discovery of the methadone incidents, the registered nurses involved remained working on the ward. CM D stated that she was "disappointed with this decision", and said she felt that a "period of clinical supervision was warranted for such a serious incident and this would have been better carried out in a different unit/environment …".

151. Ms B said that, following the meeting, she tried to have her father transferred to another facility, but there were no beds available. Ms B said she reassured herself that the staff would not make the same errors again.

*Response to haloperidol errors*

152. RN J informed RN C of the haloperidol errors on Day 12. RN J and RN C then reviewed the MAR and found that Mr A's oral haloperidol had been administered to him from his packed medication for five days since Day 7, despite it having been discontinued. RN I told HDC that she checked Mr A for any reaction to the medication errors, including his vital signs.[30]

153. RN C said that she immediately informed CM D of the errors, asked her for guidance, and advised her that she (RN C) was comfortable informing Mr A's family of the

[30] There is no contemporaneous record of this telephone conversation or follow-up actions in Mr A's progress notes. However, the fact that the telephone conversation occurred is recorded in an incident form (discussed below).

errors. According to RN C, CM D advised her not to tell Mr A's family at that stage, and said that she would "take care of it" herself the following day, as she had a "good relationship" with Ms B.

154. RN C then spoke to RN J and RN I, who were on duty, and reminded them of the correct practice regarding checking medication against the prescribed medication chart prior to administration. According to RN C, she told RN J that she did not need to inform the family about the errors because CM D said that she would do it.

155. In contrast to RN C's recollection, CM D told HDC that she recalls telling RN C to follow the Accident/Incident policy process, and believed that, as well as speaking to the nurses on duty, RN C would inform Dr F and Mr A's family about the errors that day.

156. Neither Dr F, Mr A, nor Mr A's family was informed about the errors on Day 12.

157. According to RN C, after discussing the errors with the nurses on duty, she returned to CM D's office and asked whether she needed to do anything else and, at that time, CM D asked whether RN J had completed an incident form. RN C realised that RN J had not, so she (RN C) went back to the ward to ask her to do so. RN J had left for the evening, so RN C telephoned her at home and arranged to take a blank incident form to RN J's house that evening.

158. RN J completed the incident form that evening, setting out the following:

> "[Ms N] from [the pharmacy] rang to clarify about the haloperidol tablet for [Mr A]. I double checked the medication chart & [blister pack] & found that it was stopped since [Day 7] but it was still in the breakfast & bedtime packs.
> …
> Checked [Mr A] for any bad reaction from the medication error. Escalated the incident to the unit coordinator."

159. RN C told HDC that at 10am the following morning she gave RN J's completed incident form to CM D.

160. CM D told HDC that following discovery of the haloperidol errors on Day 12, RN C worked closely alongside her unit staff, "monitoring, coaching and supporting safe practice".

161. In respect of her actions taken in response to the discovery of the haloperidol errors, RN J told HDC:

> "My first reaction was to immediately inform my unit coordinator. I admit that I did not have much information on the protocol for medication errors such as this, except to write an incident report which I did. However, I should have also contacted the doctor as soon as I discovered the mistake to ensure that there were no ill effects from the extra dose and should have done more assessment to the said patient."

162. Ms L advised HDC that, on Day 21, CM D informed her about the haloperidol medication administration errors. Ms L told HDC that she was very concerned that she had not been informed about the medication errors until then, and that she would have expected to be informed immediately after they were discovered. Ms L asked CM D why there had been a delay in informing her. According to Ms L, CM D explained that she had "only just discussed gaps in the incident form with [RN C]" that day. CM D told Ms L that RN C had discussed the errors with the four nurses involved, and was monitoring their medication competencies.

163. Ms L asked CM D whether Mr A's family had been informed of the errors. According to Ms L, CM D told her that she was waiting to discuss the errors with Dr F before telling Mr A's family. Ms L told HDC that CM D wanted to discuss the errors with the family herself, as she "had built up a close rapport with [Mr A's] daughter [Ms B]".

164. CM D advised HDC that she learnt from RN C that day that Dr F had still not been informed of the haloperidol errors. CM D tried unsuccessfully to contact Dr F that afternoon.

165. On the morning of Day 22, CM D contacted Dr F and informed him of the haloperidol errors relating to Mr A. Dr F suggested to CM D that she discuss with Ms B the possibility of transferring her father to a different facility.

166. CM D said she had been informed of the haloperidol errors on Day 12 and, at that stage, she thought that RN C had contacted Mr A's family. CM D does not recall how she found out that this had not occurred.

167. On Day 22, Ms B visited her father. She told HDC that CM D stopped her as she was leaving the hospital and advised her that there had been another drug error for "two to three days", which involved Mr A having been given extra haloperidol. CM D said that she relayed Dr F's comments to Ms B.

168. Ms B said that she asked CM D why she was only just being told of the errors. According to Ms B, CM D told her that she had only just learnt about the errors herself. CM D told Ms B that she would discuss the errors with Dr G and let her know whether any changes to Mr A's medication would be required.

169. There is no record of Mr A having been informed of the haloperidol errors.

170. That afternoon, CM D wrote on the incident form relating to the haloperidol errors:

> "… Medication incident policy not followed. G.P not contacted immediately. Family not informed in a timely manner.
>
> …
>
> Corrective action plan: All qualified staff to read and sign for medication management and medication incident policies by [date]. All staff involved with haloperidol medication error to complete a learning reflection by [date] …"[31]

[31] CM D subsequently noted on the incident form: "These have been completed on time."

171. With regard to communication with Mr A, Bupa told HDC:

> "Due to [Mr A's] ongoing pain management issues, the Clinical Manager believed that because of his deteriorating condition at that time, it was best to inform his family of the errors in the first instance. I understand that staff were also of the belief that family had a preference that these errors were not to be raised directly with [Mr A] we presume to spare him further anxiety therefore staff accommodated this.

172. Bupa told HDC that, "in hindsight":

> "[We acknowledge that] more frequent contact with [Mr A] and his family during the investigation would have given them more assurance that the incident was being taken very seriously and we sincerely apologise for not doing this at the time."

173. CM D said that she has reflected on the way in which she informed Mr A's family of the medication errors, and "sincerely apologised for not ringing family to arrange to talk with them earlier".

*Transfer to another facility*

174. Ms B told HDC that, having been informed of the haloperidol errors at the hospital, she organised for her father to be transferred to a different hospital immediately, but to remain under the care of Dr F.

175. Mr A was transferred to another hospital on Day 23. Ms B advised HDC that, during Mr A's time at the second hospital, he was cared for very well and his pain was well managed. He was able to sit comfortably in a chair and watch TV. Mr A died at the hospital a short time later.

**Administration of controlled drugs**

176. On Day 2, Day 4, and Day 5 Mr A was administered medication from the blister packed medication he had brought from home, rather than from the hospital's supply. Bupa told HDC that, with the exception of methadone, which was not in stock at the hospital, it is not clear why Mr A was not administered medication from the hospital's stock.

177. As detailed above, the administration of controlled drugs involves more detailed processes than are required for other drugs. Administration of controlled drugs should have been recorded in the red NMAR as well as the CD Register.

178. Mr A was prescribed three controlled drugs, methadone and OxyContin to be taken on a regular basis, and OxyNorm to be taken as required (PRN).

179. A review of the medication records showed that the requirements for the documentation of administration of each of these controlled drugs to Mr A were not met on a number of occasions, by a number of registered nurses, during Mr A's stay at the hospital. Summaries of these instances are set out below:

*Methadone*

- On Day 1 the administration of methadone was recorded on the NMAR, rather than the red NMAR.
- On Day 2 and Day 3 the administration of methadone was not recorded on the CD Register, and was recorded on the NMAR rather than the red NMAR.
- On Day 4 the administration of methadone was not recorded on the CD Register, and was recorded on the NMAR rather than the red NMAR. Methadone was not administered from Day 5–Day 11 (as outlined above).

*OxyContin*

- On Day 1 Mr A's OxyContin was administered without an entry being made on the CD Register.
- On Day 2 (morning), administration of OxyContin was not recorded on the CD Register, and was recorded on the NMAR rather than the red NMAR.
- On Day 3 (morning) OxyContin was not recorded on the CD Register, and was recorded on the NMAR rather than the red NMAR; in the evening the administration was entered on the red NMAR but not recorded on the CD Register.
- On Day 4 the OxyContin morning administration was recorded on the red NMAR but not recorded in the CD Register; the evening administration was also not recorded in the CD Register.
- On Day 5 the morning administration was not recorded on the CD Register.
- On Day 7 OxyContin was not recorded on the CD Register.

*OxyNorm (PRN)*

180. Administration of OxyNorm (PRN) should have been filled in on the CD Register and on the red NMAR. However, it was recorded on the red NMAR on only one occasion on each of the following dates:

Day 7 ; Day 9 ; Day 10 ; Day 11; Day 12 ; Day 13 ; Day 15 ; Day 16 ; Day 17 ; Day 21 .

**Bowel issues and delirium**

*Bowels*

181. Ms B expressed her concern to HDC that hospital staff did not always take appropriate action in response to her father's constipation. Hospital staff recorded Mr A's bowel movements daily in a Bowel Record,[32] and the following actions were taken by hospital staff.

182. On Day 1, Mr A did not open his bowels. Lactulose[33] was added to Mr A's regular packed medication, to be taken twice daily. On Day 2, it was recorded for the second day in a row that Mr A did not open his bowels. On Day 3, it is recorded that Mr A

[32] Mr A's bowel movements are recorded each day in his Bowel Record form. When it is recorded that Mr A had moved his bowels, the consistency and size of the stool is also documented on the Bowel Record form.
[33] Used to treat constipation.

moved his bowels that afternoon. On Day 4, it is recorded that he moved his bowels. On Day 5, Mr A did not move his bowels.

183. On Day 6, RN C recorded in the progress notes that Ms B was concerned that her father was in pain and was constipated. RN C recorded that Mr A declined an offer of "Kiwi Crush"[34] as he did not like the taste, and said that he did not normally move his bowels daily. She further noted: "[M]ay have lactulose if continues to be constipated or for GP referral to [prescribe] more laxatives." Mr A moved his bowels later that day.

184. Mr A next moved his bowels on the morning of Day 11. On Day 12, Mr A did not move his bowels, so Dr F prescribed further lactulose to be taken at breakfast and dinner time.

185. Ms B told HDC that on Day 15 her father told her that he felt constipated, so she asked a nurse to check his bowel record. According to Ms B, the nurse checked the book and stated that Mr A's last bowel motion had been on Day 11. Ms B told HDC that she was confused about why the hospital staff would leave this issue so long, and she asked the nurse to report it to RN C.

186. In light of the fact that Mr A had not had a bowel movement in four days, Dr G arranged for Mr A to be given lactulose, and prescribed Pinorax[35] 15ml every 72 hours and a Microlax enema.[36] However, Mr A's bowels did not open on Day 15.

187. On Day 16 at 7.40am Mr A was given lactulose and Pinorax, and at 11.30pm he was given a further dose of Pinorax. Mr A moved his bowels twice that day but did not do so on Day 17 and Day 18. On Day 18, he was given a Microlax enema, and on Day 19 he was given Pinorax. On Day 20 and Day 21 he opened his bowels.

*Delirium*

188. On the afternoon of Day 16, Dr F assessed Mr A and recorded that he was a "little confused". RN H recorded in the progress notes that at 5.20pm Mr A "appear[ed] confused and agitated … Daughter [Ms B] in for a visit also concerned about [Mr A's] confusion and thirst." Dr F advised RN H to give Mr A midazolam.[37] According to the progress notes, when Mr A later "seemed really confused and twitchy" RN H rang Dr F again and was advised not to give any more OxyNorm as "it may be the reason why he's twitching".

189. RN H noted that Mr A settled down after a few minutes. At 7.20pm RN H contacted Dr G and left a message to update him on Mr A's condition. Ms B was present at the hospital at the time, and RN H informed Ms B about her father's condition.

[34] A kiwifruit based drink designed to support and balance the digestive system.
[35] Most commonly used for the prevention and treatment of opioid-induced constipation. Used commonly in palliative care.
[36] Used to treat constipation.
[37] A short-acting drug in the benzodiazepine class.

190. RN H recorded in the clinical notes that, after Ms B returned home, she contacted the hospital and requested that if her father ever appeared to be deteriorating she wanted to be contacted.

191. At 1.20am, 2.50am and 3.30am on Day 17, an RN recorded that Mr A had woken up and was "confused".

192. Ms B said that she visited her father on Day 19. She told HDC:

> "Dad asked me not to leave him. He described his delirium [that he had experienced on [Day 17 and Day 18] as the worst thing that he had ever experienced. He said he [could] remember feeling confused and thought he had developed dementia …"

193. Ms B told HDC that she was concerned that it appeared that no one at the hospital had reassured her father when he was frightened.

194. That afternoon Dr F assessed Mr A and recorded in the clinical notes: "Seems to have settled well, especially at night. Pain under control but feels weak → continue [treatment] as prescribed."

**Bupa's internal review**

195. Bupa undertook an internal investigation into the medication administration errors in relation to Mr A. The findings from that investigation were as follows:

- Hospital staff failed to check the first 24 hours of packed medication against the prescription chart and failed to check the packed medication against the medication chart when administering the medication. Both were required by Bupa's medication management policy (outlined below).
- Owing to the "systemic nature" of the medication incidents, all qualified staff were required to redo their medication competency assessments.

196. Following these events, Bupa developed and began to implement a "Corrective Action Plan". The plan includes the following:

- The Clinical Manager met with the GP regarding the medication charts and requested more effort be made to keep these clearer for staff. (Completed)
- The process of ordering bulk supply medications, and the responsibilities of the registered nurse when ordering and receiving controlled drugs, have been reviewed. It was the pharmacy's expectation that the prescription charts were to be sent with the bulk supply medication orders, but this was not routinely happening. This requirement has been reinforced with staff. (Completed)
- Dr G provided a compulsory palliative care education session at the hospital, which was attended by all qualified staff. (Completed)
- Study days have been implemented for registered nurses with regard to the introduction of the New Zealand Nursing Council's Code of Conduct. (Completed)

- The hospital undertook a review of all methods of communication used in each wing of the facility. (Completed)
- A review of staff responsibilities with regard to new admissions was carried out and discussed with staff. There was also a discussion about the actions that should be taken when the Unit Coordinator is on leave: The Clinical Manager should be the contact person responsible for following up clinical issues.
- All registered nurses have been reminded about the use of the Facility Manager's report for new admissions and any follow-up required. (The Facility Manager's report is completed over a 24-hour period and signals to the Facility Manager and Clinical Manager any issues that have arisen during that time period.) (Completed.)
- All qualified staff were required to review the medication management policy, including management and storage of controlled drugs. (Completed)
- All qualified staff have repeated medication administration competencies. (Completed)
- The learnings from the incidents regarding Mr A are being used in a debrief/case review type education session with all qualified staff. Key areas included: Pain assessment; evaluation of effectiveness; review of prescribed vs administered medications; management of controlled drugs; reconciliation; documentation and storage; and accident and incident reporting. This is on-going with meetings every two weeks.
- Registered nurses have been informed of the action they should take when the pharmacy communicates that it is unable to supply medications in a timely manner.
- Registered nurses will spend half a day at the hospice as part of their orientation.
- An email was sent to all clinical managers and facility managers of Bupa care homes asking that they check that all medication competent staff are following the correct procedure and checking medications against the medication chart.

**Training and orientation**

197. Since the hospital has employed a staff educator, who is responsible for coordinating and implementing staff orientation and ongoing training.

198. RN C told HDC that prior to the medication errors involving Mr A, registered nurses were trained and had completed medication competencies before being allowed to work on a ward. Once on the ward, registered nurses were "buddied" by senior registered nurses for two weeks. Senior registered nurses showed new staff around the ward, including where medication and ordering forms were kept, and went over medication procedures with them.

199. RN C told HDC that prior to the incidents involving Mr A, she had noticed that some registered nurses had failed to follow the correct procedure in the administration of medication. She said that on those occasions she had reminded the staff member about the correct procedure and had continued to observe the staff member until she was satisfied that there was no continuing concern.

200. Bupa advised HDC that both medication competency training and medication policy training are now done on the ward, at which time the staff members are shown where medication and ordering forms are kept. Medication competency training is now the responsibility of the Unit Coordinator.

201. RN C told HDC that following the medication errors involving Mr A, she asked the hospital management whether the current training was sufficient, and was told that it was. RN C said that she was responsible for staff orientation, and she ensured that new staff were buddied with "competent and experienced staff", and she reviewed new staff after six weeks on the ward.

202. In relation to her personal development, RN C told HDC that following the incidents relating to Mr A, she attended staff training on pain management, arranged by the hospital, and spent four hours at the hospice in order to become familiar with their practices and establish relationships with hospice staff. She stated that her knowledge and experience of palliative care and pain management has increased substantially since her involvement with Mr A.

**Bupa's relevant policies**

203. Bupa's Medication Management policy relevant at the time of these events stated:

> "…
>
> **2. Delivery and Receipt**
> The Facility Manager will ensure appropriate systems are in place that:
>
> a) Allocates responsibility for checking delivered medications (an RN).
> b) Ensures an accurate signing system that evidences the check has been done and by whom.
> c) Regular monitoring to ensure the required checks are being completed.
>
> …
>
> **Before the new packs are released** (emphasis in original) for use by staff a physical check is done of each resident's roll (or medication cassette) — checking the first 24 hour medications against the medication chart.
>
> The check must be carried out by a Registered Nurse and documented.
> …
>
> **5. Medication reconciliation**
> This is the process of comparing the resident's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions.
>
> It should be done at every transition of care in which new medications are ordered or existing orders are rewritten. Transitions in care include changes in setting, service, practitioner, or level of care.

…

**8. Responsibilities**
Facility Managers are responsible for:

— Ensuring safe medication systems within their facilities;
— Medication systems cover:
  - Prescribing
  - Delivery
  - Storage and disposal
  - Administration
  - Reconciliation
  - Competencies
  - Education

Clinical managers are responsible for:

— Assisting with the provision of safe medication systems within the facility;
— Monitoring staff practice and compliance with policy.

…

**9. Medication administration — rules**
Bupa Care Services promotes the use of the 5 R's in medication administration

— Right resident
— Right medication
— Right dose
— Right time
— Right route

…

**11. PRN doses**
PRN doses are prepacked in separate packs/supplies to the resident's/clients regular medications. They are charted on medication chart and must clearly state what the PRN medication can be used for, for that particular resident (eg 'for pain').

Whenever staff administer a PRN medication they are required to:

a) Sign the medication chart.
b) Document in the progress notes that the prn medication was given.
c) State what the clinical indication for its use was.
d) What outcome was achieved.

…

**12. Changes to medications**
Where changes are required to a resident's medications mid cycle:

a) the pharmacy is informed of the required change via fax.
b) the entire current roll or cassette for the resident is returned to the pharmacy.

c) a check is done of the first 24 hours of the replacement roll/cassette against the medication chart.

…

**15. Missed dose**

A missed dose is when medication has not been given within 2 hours of the prescribed time. If this occurs it is a medication incident and will be reported as such.

Caregivers and Enrolled Nurses must seek advice from an RN on how to manage a missed dose. Advice can be gained from the pharmacy or websites such as www.medsafe.govt.nz or www.medicines.org.uk.

Most missed doses can be omitted and the medication given at the next prescribed time except [in some circumstances] …

**16. Medication Incidents** — See 'Medication Incident' policy [below].

…

**20. Medication Administration**

…

- Residents are identified by a photo on the medication chart …
- Read the medication chart and check when the medication was last given.
- Select the named pack for the resident — expel the medications due — check against medication chart.
- Administer the medication to the resident, **staying with them until medication is swallowed** (emphasis in original)**.**

…

**21. Controlled drugs**

…

- Controlled drugs are kept in a locked metal cabinet secured to the wall held within a locked cupboard.
- All controlled drugs are monitored via a Controlled Drug Register and physical stock counts are to be done **weekly** (emphasis in original) by nursing staff.

…

**Procedure for administering controlled drugs**

- 2 nursing staff to check medication — one must be Registered, the other can be a caregiver who has completed competency assessment.
- In Rest homes it can be two caregivers — both have to have had competencyassessment completed.

…

- Remove the complete stock of the prescribed medication from the cupboard.

…

- Remove appropriate dose from stock.

- Recheck the prescription bottle and amount required against the medication chart.
- Enter the correct details in the register, both staff sign and enter designation then lock and secure the cupboard.
- Both staff members go to the resident — identify (by use of photo or wrist band) and administer — both waiting with resident until administration complete and the staff member signs the medication chart.
- Administration of the controlled drug will be documented in the resident's daily progress notes if it is prescribed PRN."

204. Bupa's Medication Incident policy valid in stated:

> "Staff are required to complete an incident form in the event of any [of the following] occurring …
>
> **Administration error:**
> Wrong med given
> Wrong dose
> Wrong time
>
> …
>
> Medication not given.
>
> **Administration error — Action**
> Ensure clinical needs are met in the event of an acute adverse reaction.
>
> Notify the GP (on call if after hours) and follow directions (record these on the incident form) — this may include notifying pharmacy to determine any likely complications.
>
> Care givers doing medications — notify RN on duty (on call if after hours) and seek advice.
>
> Incident form to be written up by the staff member involved …
>
> Facility/Clinical manager to determine if Category One incident and follow up accordingly.
>
> …
>
> **Medication not given/Missed Dose**
> Definition: Missed dose is when medication has not been given within 2 hours of prescribed time. If this occurs an incident form needs to be completed.
>
> …
>
> **Informing residents**
> 'Competent' residents must be informed of medication incidents when they occur and informed of the corrective actions taken — this is done by the RN on duty.

> Residents who are 'Incompetent' — resident's family must be informed of medication incidents and the corrective actions taken — this is done by the RN on duty."

205. Bupa's Medication Management policy has been updated following an internal review of these events. The updated Medication Management policy includes a review against the Medicines Care Guides for Residential Aged Care, and was re-released to Bupa Care Homes on 17 April 2014.

206. Bupa has also provided HDC with a copy of the Category One Incident policy in place at the time of these events.

207. Relevantly, a "Significant medication incident" is defined as a category one incident, and includes:

a) situations in which a resident has over and above the dose prescribed for the resident;

b) situations in which a resident has a serious reaction to a drug;

c) controlled drug discrepancies; and

d) any other significant incident involving medication use/misuse or theft.

208. In the event of a category one incident:

a) The senior nurse on duty must inform the Facility Manager or senior person on call as soon as reasonably possible — including after hours.

b) The Facility Manager or senior person on call will then decide whether the incident needs to be escalated to the Health Operations Manager or other senior corporate staff.

c) The category one incident will be recorded on a standard accident/incident form. The form must provide:

i. a clear account of the incident
ii. what actions were taken in response
iii. who and when people were informed
iv. any detail that will assist in determining how the incident occurred
v. what actions were taken/are required to prevent recurrence.

d) The completed form is forwarded to Care Services (Quality Management Coordinator) as soon as possible and definitely within 24 hours of the event (even if the investigation is ongoing).

**Audit**

209. The hospital underwent a full certification audit against the Health and Disability sector standards, following which they were awarded four years' certification.

210. The hospital was found to have two areas of partial attainment — one of these related to staff documentation of a controlled drug administered to a resident who had been prescribed 2–5mg of morphine elixir.

## Response to provisional opinion

211. Ms B, Bupa and the individuals involved in Mr A's care were given the opportunity to comment on relevant sections of my provisional opinion.

212. CM D did not wish to comment further.

213. In response to my provisional opinion, RN C stated that she had been in the position of Unit Coordinator for only six weeks at the time of Mr A's admission. She said that the position had been vacant for three months prior to her arrival, leading to a backlog of work that had not been attended to. RN C further noted that the training and orientation of staff employed in the ward was completed before her commencement there, and that at the time she was caring for Mr A she had limited experience in caring for patients receiving palliative care. RN C stated that staff had not received palliative care training prior to Mr A's admission.

214. RN C is of the view that her ability to oversee and monitor the care afforded to Mr A was compromised as a result of the factors noted above. She accepts, however, that she was insufficiently aware of some processes and policies, but stated that she took steps to seek advice.

215. Despite this, RN C accepts the analysis of the care provided to Mr A, and her responsibility for the failings in the care identified in my provisional opinion. RN C apologised for her role in the care provided to Mr A. She told HDC that her own practice and knowledge base has developed considerably since the time of these events, as has her ability to ensure that her staff provide good quality care to their patients.

216. In response to my provisional opinion, Bupa acknowledged the seriousness of the breaches in the standard of care, and stated that it deeply regrets the pain and distress Mr A suffered, and the grief that was experienced by his family.

217. In relation to the experience RN C brought to her role as Unit Coordinator, Bupa stated that she had been employed at the hospital for several years, and that prior to taking up the Unit Coordinator role she was a senior registered nurse on the dementia ward of the hospital. Bupa noted that controlled drugs are prescribed, ordered and dispensed on the dementia ward. Bupa further noted that RN I had completed orientation on medication policies and competences.

218. In relation to medication competencies, Bupa acknowledged that registered nurses were allowed to work on the ward while undertaking these competencies under the supervision of a senior competent registered nurse.

219. Bupa has accepted all the recommendations contained in the provisional opinion, and will report to HDC on implementation.

## Opinion: Bupa Care Services NZ Limited — Breach

### Introduction

220. In accordance with the Code, Bupa has a responsibility to operate the hospital in a manner that provides its residents with services of an appropriate standard. The New Zealand Health and Disability Sector Standards (NZHDSS) also require that rest homes ensure that the operation of their services is managed in an efficient and effective manner, which ensures the provision of timely and safe services to consumers.[38]

221. This case is another example of poor end-of-life care being provided by a residential aged care facility.[39] Consumers in such circumstances require holistic care, including, but not confined to, the provision of adequate pain relief. Furthermore, staff need to be trained appropriately in palliative care, and to be alert to the changing requirements of consumers. In my view, the hospital failed woefully in its duty of care to Mr A and his family at a critical time in his life.

222. With regard to the organisational responsibilities of residential aged care facilities, previously this Office has noted:[40]

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

223. Mr A was admitted to the hospital for pain management and palliative care. He remained there until Day 23.

224. During his time at the hospital there were repeated failures by multiple staff members to provide services to Mr A with reasonable care and skill, particularly in relation to his medication management, and the assessment and management of his pain. I consider that Bupa must take responsibility for the extent of such failings.

[38] New Zealand Health and Disability Sector (Core) Standards (NZS8134.1.12:2008, Standard 2.2).
[39] See also 13HDC00196 (11 June 2015) and 13HDC00405 (26 June 2015).
[40] See Opinion 12HDC01286 (18 November 2013), available at www.hdc.org.nz.

**Medication management**

225. When Mr A was admitted to the hospital he was on multiple medications, including methadone and haloperidol.

226. During his stay, nursing staff made multiple errors relating to the documentation of medication dispensing, and dispensing the correct medications at the correct dosage, particularly in relation to methadone and haloperidol. As a result of these errors Mr A suffered unnecessary pain.

227. My expert nursing advisor, Dawn Carey, stated: "[Mr A] was subject to a sustained level of suboptimal care in relation to medication management." This is unacceptable.

*Storing and administering controlled drugs*

228. When Mr A was admitted to the hospital he brought with him his medication from home in two blister packs. One of the blister packs contained his controlled drugs, including OxyContin and methadone. The second blister pack contained Mr A's other medications.

229. Bupa had in place a Medication Management policy, which detailed how controlled drugs should be stored, and the steps to be taken when administering medication.

230. The policy required that controlled drugs be kept in a locked cabinet secured within a locked cupboard. All controlled drugs were to be administered from Bupa's stock and recorded in the CD Register and on the resident's medication chart. The red NMAR was to be used to record the administration of controlled drugs, in order to differentiate between controlled drugs and other medications.

231. The Regulations require persons authorised to administer controlled drugs to maintain a CD Register in relation to all controlled drugs administered, possessed or dispensed by the authorised person for each individual consumer. The Regulations require that each controlled drug be recorded on a separate page in the CD register (it states on the CD Register: "1 kind and 1 strength only to each page").

232. Despite this policy, Mr A's records show multiple instances of staff having failed to record the administration of Mr A's medication appropriately and in accordance with the Regulations. The controlled drugs that Mr A brought with him were not entered into the CD Register, and sometimes staff administered controlled drugs from Mr A's blister pack, and at other times from the hospital's stock. The administration of controlled drugs was at times not recorded in the red NMAR and CD Register. In my view, it was Bupa's responsibility to ensure that its staff were aware of, and complied with, its policy and the legal requirements when dealing with Mr A's controlled drugs. However, the hospital staff repeatedly failed to comply with the policy and the Regulations. I am left with the impression that staff were ill-informed about the legislative requirements, lacked knowledge of the correct processes, and were poorly supervised.

*Methadone*

233. On Day 1, RN C contacted the pharmacy, which arranged to supply Mr A's medication the following day in robotic roll packaging. RN C faxed to the pharmacy Mr A's discharge summary from the hospice, which listed his current medications, but she did not include a controlled drugs form because she was not aware that a form was required. When the robotic rolls arrived, no one carried out a medication reconciliation, as was required by the Medication Management policy. Methadone was not ordered from the pharmacy until Day 5, when RN K ordered it as part of the weekly ordering procedure.

234. When administering robotic rolls, staff were required by the Medication Management policy to read the medication chart, check when the medication was last given, select the named pack for the resident, and check the pack against the medication chart. When administering controlled drugs, the Medication Management policy required that the staff member administering the controlled drug check the prescription bottle and amount required against the medication chart, and sign the medication chart.

235. Staff did not check the medication administered to Mr A against the prescribed medication chart as required by the Medication Management policy. As a consequence, Mr A did not receive his prescribed oral methadone from Day 5–Day 11 inclusive, which equated to seven separate occasions on which the methadone was not administered. Ms Carey advised that it is an expectation that "prior to administering a medication, checks such as time of last administration and dose of medication are noted". If staff had done so, the error would have been apparent. Ms Carey advised that, in her opinion, omitting to administer prescribed medications is a "severe departure from expected standards". Ms Carey also advised that she is "critical of the delay in realising this error". I accept this advice.

*Haloperidol*

236. By Day 7, Mr A and his family had become concerned about his worsening pain, and they requested that his morning doses of OxyContin and OxyNorm be increased. Dr F reviewed Mr A and decided to start a subcutaneous pump because he was concerned that Mr A might not have been absorbing the medications via the oral route. Dr F then discontinued Mr A's oral haloperidol and charted subcutaneous OxyNorm 70mg and haloperidol 1mg.

237. RN J recalls sending the amended prescribed medication chart to the pharmacy indicating the change to Mr A's prescription. However, the pharmacy believes it was faxed only the back page of the chart, which did not show the change to the packed medication, ie, the discontinuation of the oral haloperidol. The pharmacy said that it was common practice for doctors at the hospital to chart drugs in a subcutaneous pump without stopping oral medications.

238. As a consequence, replacement robotic packs without haloperidol were not delivered. Again, staff failed to carry out a medication reconciliation and check Mr A's administered medication against his prescribed medication chart, and continued using Mr A's existing robotic packs, which contained oral haloperidol. The pharmacy told HDC that on Day 12 it received the front page of Mr A's medication chart showing

that his prescription for oral haloperidol had been stopped. The pharmacy notified the hospital that it had just noticed that the oral haloperidol had been stopped and sent a new supply of packed medications excluding the oral haloperidol. While it remains unclear exactly when or how this error occurred, I note that Bupa has accepted that the hospital staff failed to communicate to the pharmacy the change to Mr A's prescription of haloperidol.

239. As a result of the error, Mr A received both the oral haloperidol and the newly charted subcutaneous haloperidol, for the next four days, from Day 8–Day 11. Again this demonstrates that staff were consistently failing to check Mr A's administered medication against his prescribed medication chart. I accept the advice of Ms Carey that continuing to administer a discontinued medication was a severe departure from expected standards.

**Pain management**

240. At the time of his admission, Mr A's main problem was pain all over his body, which affected the quality of his sleep. The following day, a pain assessment chart was completed, which recorded Mr A's pain score as 5/6. A pain assessment chart was used on Day 4, when Mr A reported pain of 4/6, and on Day 6, when he reported pain of 4/6. On Day 7 a pain assessment chart was used on three occasions, with a reported pain score of 5/6, 6/6 and 3/6. During this time there were also multiple occasions on which Mr A was noted to be experiencing high levels of pain but no pain assessment chart was used. On each of these occasions Mr A was administered OxyNorm with good effect.

241. Ms Carey advised that once pain had been identified as an issue, regular monitoring and care planning should have commenced. She stated:

> "Unfortunately, there is little evidence of nursing staff regularly assessing or monitoring [Mr A] for pain/effectiveness of analgesia prior to [Day 7]."

242. Furthermore, Ms Carey stated:

> "In my opinion, nursing staff should have undertaken formal pain assessments through the use of an objective pain assessment scale at regular intervals (one to two hourly when [Mr A] was awake) and certainly whenever [Mr A] indicated that he was in pain. I consider regular formal assessment to be necessary in order to establish the extent/pattern of a resident's pain experience and to capture the effectiveness of the prescribed analgesia."

243. I accept this advice and am concerned that, even after a short-term pain management care plan was commenced on Day 7, there were numerous delays in Mr A being provided with appropriate medication.

244. On Day 8, at 8.30am, CM D recorded that she had discussed Mr A's severe pain with Dr F, who had directed that Mr A was to have OxyNorm 20mg immediately. However, Mr A did not receive the OxyNorm until 10am. No reason for the delay is documented in the clinical records.

245. I am critical that Mr A remained in pain and did not receive his medication until one and a half hours after the verbal order. As advised by Ms Carey:

> "[Mr A] should have received this stat dose more promptly and any circumstances causing delays should be recorded in the [progress notes]."

246. Ms B said that she visited her father on Day 8, and again he reported intolerable pain and told her that when he requested pain relief from a nurse she "mumbled some reply … and left the room". Ms B was so concerned about her father's pain relief that she contacted his palliative care nurse at the hospice.

247. Ms Carey identified three further incidences[41] on which Mr A was reporting 3/6 constant pain but PRN medication was not given. In each of these incidences, Mr A's pain then increased over the following hours until his pain was reported to be 4–6/6 and severe or extreme.

248. In another incidence, on the morning of Day 12, Ms B visited her father and found him "grimacing and grey with discomfort". Ms B found a nurse who was doing the medication round, and explained that her father was experiencing pain at a level of 6/6. The nurse replied that Mr A would be provided with pain relief after the completion of the medication round.

249. I also note that initiatives to review Mr A's pain, such as contacting Dr F or Dr G, were mainly in response to Ms B's concerns about her father's pain.

250. As noted in another HDC opinion:[42]

> "While it is appropriate to work together with patients and their families when providing care, it is not a patient's and/or his or her family's responsibility to ensure that appropriate care is provided."

251. Mr A suffered avoidable pain while at the hospital, which I consider to be unacceptable. In my view, his pain assessment, particularly prior to Day 7, and his overall care planning and pain management were seriously suboptimal. I note Ms Carey's opinion that the care provided to Mr A prior to Day 7 demonstrates a mild to moderate departure from accepted standards.

**Responses to medication errors**

252. On Day 12, the errors involving both the haloperidol and methadone were discovered. The haloperidol error was discovered after the pharmacy received the front page of Mr A's prescribed medication chart showing that his prescription for oral haloperidol had been stopped. The pharmacy notified RN J of the error.

[41] On Day 11 at 9am, and Day 12 at 8am and 6pm.
[42] See Opinion 13HDC00196.

253. RN J told RN C about the haloperidol administration error and they then reviewed the MAR and found that Mr A's oral haloperidol had been administered to him from his packed medication for five days, despite it having been discontinued.

254. RN C said she then told CM D about the error and asked for guidance, and that CM D agreed to tell Mr A's family about the errors. In contrast, CM D recalls telling RN C to follow the accident/incident policy process. CM D said she thought that RN C would inform Dr F and Mr A's family about the errors that day. However, Dr F, Mr A and Mr A's family were not informed about the errors on Day 12.

255. There was some discussion between staff about the errors, and RN C arranged for RN J to complete an incident form (after being asked by CM D about this). RN J said that she was not aware of the protocol for medication errors apart from the need to write an incident report.

256. Bupa told HDC that because of the discovery of the haloperidol errors, Mr A's methadone was also checked against his chart prior to it being administered. At that time, RN I discovered that Mr A had not been given methadone since Day 5. RN I did not record that there had been previous medication errors with Mr A's methadone. RN I said that she contacted RN H, who told her that there was nothing she could do about the errors, so she (RN I) did not alert a doctor or discuss the errors with Mr A or his family. She did not tell the hospital management about the methadone errors until the following day (when she advised RN C), and said that she was not aware of any other steps she was required to take.

257. While there are conflicting accounts as to how CM D became aware of the methadone error, it is clear that CM D was aware of both medication errors on Day 13.

258. On Day 14, CM D told Mrs A and Ms B about the methadone administration errors, but did not inform them of the haloperidol errors. CM D said she thought that RN C had contacted Mr A's family about the haloperidol errors, but subsequently discovered that that was not the case. On Day 21, CM D decided to tell the family about the haloperidol errors. However, she did not tell Dr F about the errors until the morning of Day 22.

259. Ms B said that, on Day 22, CM D told her that there had been another drug error involving her father, and he had been given extra haloperidol for two to three days, and that she (CM D) had only just learnt about the errors herself.

260. According to the Bupa medication incident policy, both these incidents were classified as a "category one" incident. The category one incident policy requires that once the error is identified, the "senior nurse on duty must inform the Facility Manager or Senior person on call as soon as possible", who will then decide whether the incident needs to be escalated to the Health Operations Manager or other senior corporate staff. The incident must also be recorded on an incident form. In accordance with the Medication Management policy, following any administration error, actions

include informing the patient's GP, and informing "competent" residents. The policy states that this should be done by the registered nurse on duty.

261. It is clear from the clinical records that Mr A was competent, but as Bupa has acknowledged, Mr A was not informed about the medication errors. Bupa said that this was because CM D believed that "because of his deteriorating condition at that time, it was best to inform his family of the errors in the first instant", and because the family preferred that errors not be raised directly with Mr A to spare him further anxiety. However, the family was not informed about the haloperidol errors for 10 days.

262. I accept the following advice from Ms Carey:

> "I disagree strongly with the ten day delay in notifying [Mr A's] family of the haloperidol errors. In my opinion, the communication with [the family] demonstrates a departure from the expected standards of communication following a clinical error."

263. I am strongly critical that Bupa staff (either the registered nurses on duty or senior staff who were aware of the errors) did not inform Mr A of the medication errors as required by the Medication Management policy. While it is unclear exactly what occurred after the discovery of the errors (and I do not consider that I need to make a finding in that regard), it is obvious that several staff were confused or unaware of the policy requirements. As mentioned above, there was also a lengthy delay in informing Mr A's family of one of the errors. In my view, these issues raise serious concerns about the culture at the hospital in relation to the reporting, disclosure and learning from incidents. I note that Ms Carey views these failings as a significant departure from accepted standards. I agree.

**Conclusions**

264. Overall, I consider that the care Mr A received at the hospital was very poor. In particular, the hospital staff consistently failed to adhere to the relevant policies, and to manage Mr A's pain and medication adequately. As a result of these failures, the hospital staff made multiple errors in relation to the ordering, storage, and administration of Mr A's medication, in particular his methadone and haloperidol. Despite Mr A experiencing high levels of pain, there are multiple occasions on which his pain assessment and management were suboptimal. Furthermore, after the medication errors were identified, staff failed to respond appropriately, particularly in notifying Mr A of the errors.

265. The deficiencies in the care provided to Mr A were not the result of isolated incidents involving one or two staff. They were numerous and widespread, involving several staff involved in Mr A's care.

266. Bupa had the responsibility to operate the hospital in a manner that provided Mr A with services of an appropriate standard, and ultimately is responsible for such widespread failings of its staff. As previously stated by this Office:[43]

> "The inaction and failure of multiple staff to adhere to policies and procedures points towards an environment that did not sufficiently support and assist staff to do what was required of them. [The rest home] as an organisation must bear overall responsibility for this."

267. Mr A was admitted to the hospital in order to manage his pain and, ultimately, to ensure his comfort in the final days of his life. In order to achieve this, Mr A needed to be provided with holistic care, where staff were attentive to all his needs and proactive in managing his pain. The failure to provide this level of care is a disappointment, and a concern for how end-of-life care patients are managed in this type of environment. While I have identified my concerns about the actions of CM D and RN C in relation to these clinical failures (see below), Bupa had the ultimate responsibility to ensure that Mr A received care that was of an appropriate standard and complied with the Code. In my view, for the reasons outlined above, Bupa failed in that responsibility and breached Right 4(1) of the Code.

## Opinion: CM D — Breach

### Standard of care

268. CM D was the Clinical Manager at the hospital and responsible for the care delivered by the registered nurses and support staff to the hospital-level-care residents. CM D's job description stated that her role included providing high-level clinical leadership and support to clinical and care staff, monitoring the provision of clinical care to residents to ensure that the highest standards are achieved and maintained, ensuring systems are in place to keep family and significant others fully informed of any issues relating to clinical care, providing oversight of all residents, all resident clinical records and recordings to ensure that they meet organisational and legislative requirements, and ensuring that clinical staff adhere to safe work practices. CM D's role included following up medication incidents and developing corrective action plans.

269. CM D was also required to comply with the Nursing Council of New Zealand (NCNZ) Competencies for Registered Nurses, which state that the standard expected of a registered nurse in management is to promote a quality practice environment that supports nurses' abilities to provide safe, effective and ethical nursing practice.[44]

270. There are a number of areas in which the care provided to Mr A by staff at the hospital fell below an acceptable standard, for which CM D, as Clinical Manager,

[43] 09HDC01783 and 11HDC00686.
[44] NCNZ "Competencies for Registered Nurses" (December 2007), Competencies for nurses involved in management.

must accept some responsibility, including pain assessment and management, medication management, and communication with Mr A and his family.

271. Mr A's primary concern at the time of his admission was pain. However, as noted by Ms Carey:

> "Unfortunately, there is little evidence of nursing staff regularly assessing or monitoring [Mr A] for pain/effectiveness of analgesia prior to [Day 7]."

272. Registered nurses are responsible for ensuring that all health services they provide are consistent with their education and assessed competence, meet legislative requirements, and are supported by appropriate standards. Ms Carey advised that safe medication administration is an indicator that sits within the standards set by the NCNZ.

273. Mr A did not receive his prescribed oral methadone on seven occasions between Day 5–Day 11. In addition, Mr A received oral haloperidol when this prescription had been discontinued. This error occurred from Day 7–Day 12 inclusive and resulted in Mr A being administered oral haloperidol in error on seven separate occasions, during which time he was also receiving haloperidol via a subcutaneous pump. In addition, Mr A's records show multiple instances of staff having failed to record the administration of Mr A's medication appropriately.

274. I agree with Ms Carey's advice that the methadone and haloperidol medication errors, which continued for an extended time, indicate that there was a lack of robustness in Bupa's systems. In particular, checks and monitoring were not in place to ensure that the correct processes were followed when receiving medications, administering medications, checking controlled medications, and recognising errors.

275. Following identification of the errors, CM D did not ensure that all the correct actions had been carried out by relevant staff, including notifying Mr A's GP and Mr A himself. Furthermore, CM D failed to inform Mr A's family of the errors in a timely manner.

276. As noted above, as the Clinical Manager, CM D was responsible for monitoring the provision of clinical care to residents to ensure that the highest standards were achieved and maintained. In accordance with this, CM D had a responsibility to oversee pain assessment and management and the medication management processes, and to remedy any failures to comply with the policies and regulations. Clearly she failed in these responsibilities. Furthermore, on Day 8 the care CM D provided directly to Mr A was suboptimal. That day she spoke to Dr F about the severe pain Mr A was suffering. Dr F directed that CM D administer 20mg of OxyNorm to Mr A immediately. However, the OxyNorm was not administered until 10am. There is no explanation in the clinical records for the delay of 1.5 hours in providing pain relief to Mr A. Ms Carey advised me that Mr A should have received this dose more promptly, and that any circumstances causing delay should have been recorded in the progress notes. I am critical that CM D failed to ensure that Dr F's instructions were complied with.

277. Overall, CM D failed to provide services to Mr A with reasonable care and skill by failing to:

a) Ensure that the hospital staff complied with relevant policies and procedures, particularly in relation to pain and medication management;

b) Follow up to ensure that all corrective actions had been carried out following the identification of the medication errors;

c) Inform Mr A's family of the errors in a timely manner; and

d) Act in a timely manner in administering OxyNorm to Mr A on Day 8.

278. Accordingly, I conclude that CM D breached Right 4(1) of the Code.

## Opinion: RN C — Breach

279. RN C was the Unit Coordinator at the hospital at the time of these events. Her job description included providing effective day-to-day coordination and supervision of clinical aspects of care provided to residents, participating in delivery of care to residents, applying principles of clinical best practice and leading by example, liaising with families and health professionals, maximising the safety of residents within the unit by regularly reviewing their safety needs and ensuring all interventions were utilised, assisting with orientating new staff to the unit, and supporting and assisting the clinical manager in order to implement excellent and safe nursing practice.

280. According to RN C, her role as Unit Coordinator was to lead and coordinate a team of registered and enrolled nurses and caregivers. RN C was also required to comply with the NCNZ Competencies for Registered Nurses, which state that the standard expected of a registered nurse in management is to promote a quality practice environment that supports nurses' abilities to provide safe, effective and ethical nursing practice.[45]

281. There are a number of areas in which the care provided to Mr A by staff at the hospital fell below an acceptable standard, and for which RN C, as Unit Coordinator, must accept some responsibility. Those areas include pain assessment and management, and medication management and documentation.

282. When Mr A was admitted, he had pain all over his body affecting his quality of sleep. The following day a pain assessment chart was completed, which recorded that Mr A's reported pain score was 5/6. Ms Carey advised that once pain was identified as an issue, regular monitoring and care planning needed to commence. She stated: "Unfortunately, there is little evidence of nursing staff regularly assessing or monitoring Mr A for pain/effectiveness of analgesia prior to [Day 7]." In my view, RN C should have overseen the care planning and monitoring of Mr A's pain.

[45] NCNZ "Competencies for Registered Nurses" (December 2007), Competencies for nurses involved in management.

283. As the Unit Coordinator, RN C was responsible for overseeing the medication management of the registered nurses and ensuring that she was fully aware of the requirements of the hospital's policies. From Day 5–Day 11, multiple hospital staff members failed to follow the hospital's processes for ordering controlled drugs and checking the medication in Mr A's robotic packs against the prescribed medication chart when administering his medication. In addition, Mr A's records show multiple instances of staff having failed to record the administration of Mr A's medication appropriately. On Day 7, when Dr F decided to discontinue oral haloperidol and administer haloperidol by way of a subcutaneous pump, RN C did not document the details of the GP visit and fax the changes to the pharmacy. She said that before she left on her lunch break she made sure that RN J was aware of Dr F's instructions, but she did not follow up to check that the appropriate processes had been followed.

284. I note RN C's response to my provisional opinion regarding her view of the limitations on her ability to perform her role and oversee and monitor the care provided to Mr A. I also note that she accepts responsibility for the failings identified in this opinion. Given her role at the hospital, I remain concerned that RN C was not familiar with the hospital's processes, such as ordering controlled drugs. Furthermore, her supervision of staff was inadequate in that regard. Despite the fact that Mr A was reporting increasing and distressing levels of pain, RN C did not review his medication records to ensure that he was receiving all the prescribed medications.

285. I agree with Ms Carey's advice that the methadone and haloperidol medication errors, which continued for an extended time, indicate that checks and monitoring were not in place to ensure that the correct processes were followed when receiving medications, administering medications, checking controlled medications, and recognising errors.

286. RN C's actions following the discovery of the medication errors suggest that she did not have an adequate understanding of Bupa's policies about medication incidents, which, as Unit Coordinator, is concerning.

287. Furthermore, the clinical documentation is incomplete. There are multiple incidents of inadequate recording of medication administration. In my view, there was insufficient oversight of staff compliance with documentation standards at the hospital and, as Unit Coordinator, RN C must take some responsibility for that.

288. Overall, I consider that RN C failed to provide services to Mr A with reasonable care and skill by failing to:

a) Ensure that adequate clinical nursing assessments were undertaken when both Mr A and Ms B reported that Mr A had high levels of pain; and
b) Supervise the actions of staff effectively in relation to medication management and clinical documentation.

289. Accordingly, I conclude that RN C breached Right 4(1) of the Code.

## Recommendations

290. I recommend that Bupa Care Services NZ Limited:
   a) Provide ongoing training to all registered nurses with regard to its policies and procedures, communication with residents and their families, medication management, and professional standards regarding documentation, within three months of the date of this report.
   b) Conduct an audit at the hospital with regard to the corrective action plan, and report to HDC on the outcome of the audit within six months of the date of this report.
   c) Disseminate the learnings from this investigation to all Bupa facilities nationwide.

291. In accordance with the proposed recommendation in my provisional opinion, Bupa has provided a written apology to Mr A's family, and this has been forwarded to the family.

292. I recommend that CM D provide a written apology to Mr A's family for her breaches of the Code. The apology is to be sent to HDC within one month of the date of this report, for forwarding.

293. In accordance with the proposed recommendation in my provisional opinion, RN C has provided a written apology to Mr A's family, and this has been forwarded to the family.

294. I recommend that the Nursing Council of New Zealand consider undertaking a competence review of CM D and RN C.

## Follow-up actions

295. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Bupa Care Services NZ Limited, will be sent to HealthCert (Ministry of Health) and the Health Quality and Safety Commission.

296. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Bupa Care Services NZ Limited, will be sent to the district health board and the Nursing Council of New Zealand, and they will be advised of the names of CM D and RN C.

297. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Bupa Care Services NZ Limited, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

## Appendix A: In-house clinical nursing advice

The following expert advice was obtained from in-house clinical nursing advisor Dawn Carey:

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms B] on behalf of [the family] about the care provided to her late father, [Mr A] whilst he was resident at [the hospital], Bupa Care Services. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the documentation on file: complaint and correspondence from [Ms B]; response from Bupa Care Services (BCS) including [Mr A's] clinical file.

3. The late [Mr A] was a [74-year-old man] who had metastatic adenocarcinoma of the colon to liver and metastatic prostate carcinoma. [Mr A] was admitted to [the hospital] on [Day 1] for palliative care. He transferred to a different facility on [Day 23]. His daughter, [Ms B] has complained about the standard of nursing care provided to her father at [the hospital] especially in relation to:

   - Medication management — Delay in administering prescribed analgesia; medication errors
   - Pain assessment
   - Communication — Delay in notifying family of the medication errors

4. BCS have provided a detailed response to the Commissioner. They report deep regret and sincere apologies for the distress caused by the medication errors. It was realised that [Mr A] had been subject to two errors — non administration of prescribed oral Methadone for 6 days and administration of oral Haloperidol (discontinued prescription) on 10 occasions — whilst he was resident at [the hospital]. Upon realising these errors BCS commenced an internal investigation. [Mr A] transferred to a different facility before the investigation was completed.

The investigation identified that the:

- Processes for checking received medications were not followed, which facilitated both errors and is contrary to BCS Medication Policy
- There was a lack of timeliness in notifying [the hospital] senior RN, [Mr A's] GP, and his family of the Methadone medication error
- There was a lack of timeliness in completing an incident form and in notifying [Mr A's] family of the Haloperidol medication error

BCS instituted a range of corrective actions (CA) to address the identified practice gaps and have provided the Commissioner with a copy of the completed CA plan. The actions included compulsory education sessions; changing the RN orientation

programme to include a day placement at a Hospice; review of relevant policies; liaising with GP and pharmacy service.

BCS also report:

- Administration of pain relief to [Mr A] was delayed on [Day 9] due to the controlled drug keys being inadvertently locked in a treatment room. Whilst the spare key was being sought, medication was sourced from another unit for [Mr A]. To prevent a reoccurrence, the key locks to the treatment rooms are being replaced with a pin code keypad lock system.
- Agreement that on the [Day 12] it would have been more appropriate for the RN to have prioritised administering 'as required' (PRN) analgesia to [Mr A] over completion of the medication round. This has been discussed with the individual involved and also at the wider RN meeting.

5. Review of clinical records and comments

**Medication management**

(i) [Day 1]: The reviewed Medication Signing Sheets (MSS) show that [Mr A] was administered OxyContin two 40mg tablets at 8.30pm, which is more than the prescribed dose of 60mgs. In my opinion, this is either a medication administration error or a documentation error and should have been realised when the next dose was administered on [Day 2].

(ii) As acknowledged by the Provider, [Mr A] did not receive his prescribed oral Methadone on [Day 5–Day 11] inclusive. This equates to 7 separate occasions of a prescribed controlled drug medication not being administered. I am critical of the delay in realising this error.

(iii) As acknowledged by the Provider, [Mr A] received oral Haloperidol when this prescription had been discontinued. This error occurred on [Day 7–Day 12] inclusive. Based on the MSS and drug charts (DC), it appears that [Mr A] was administered oral Haloperidol in error on 7 separate occasions. During this time [Mr A] was also receiving Haloperidol in a subcutaneous form via a twenty-four hour delivery pump system.

(iv) On [Day 19], [Mr A] did not receive a prescribed Methadone dose on one occasion. This is a medication error, which should have been realised when the next dose of Methadone was administered.

(v) The reviewed MSS have blank signing registers, which is a mild departure from the expected standards of clinical documentation for medication administration.

Comments: Registered nurses are accountable for ensuring that all health services that they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards[1].

[1] For example Health & Disability Services Standards (2008); The Health Practitioner's Competence Assurance Act (2003); The Medicines Act (1981) and associated regulations; The Misuse of Drugs Act (1975) and associated regulations.

Safe medication administration is an indicator that sits within standards set by the Nursing Council (NCNZ)[2]. Within the relevant literature medication errors are unfortunately commonplace. Distraction, unfamiliarity with the medication and lack of concentrated focus are all known 'human factors' that are recognised contributory issues in medication errors. Within healthcare these factors can have devastating results and a phenomenal impact on the health of the patient and their trust in the system that is meant to care for them. However, despite the common nature of medication errors, they cannot ever be deemed an acceptable part of nursing practice.

Knowledge of pharmacology and safe medicine management is a core competency that all nurses are deemed to hold when they gain registration in New Zealand. This includes overseas trained nurses. Exempting situations where medication is withheld on the basis of a clinical assessment; to omit to administer prescribed medications is a severe departure from the expected standards of medication administration expected of a RN/EN. Similarly, to administer a discontinued medication is a severe departure from the expected standards of medication administration expected of a RN/EN.

The fact that the 'two' medication errors continued causes me to question the robustness of BCS systems in practice — checks/monitoring in place to ensure that the correct process is followed when receiving medications, administering medications, checking controlled medications, recognising errors etc — which were in place during [Mr A's] tenure at [the hospital]. I have noted either additional medication errors or documentation errors on [Mr A's] MSS. In my opinion, it is expected that prior to administering a medication, checks such as time of last administration and dose of medication are noted. I would view this as a necessary behaviour to demonstrate 'medication competency'. I am unaware whether the staff members involved in the administration of [Mr A's] medications are registered or non-registered health providers[3]. In my opinion, [Mr A's] increasing pain experience from [Day 7] should have meant that any delegated[4] authority to administer his analgesia medication was removed. During his short period of time at [the hospital], [Mr A] was subject to a sustained level of suboptimal medication management by BCS staff and I am critical of this.

**Pain assessment/management**

(i) The Admission Assessment (AA) completed on [Day] 1 identified pain *all over body* affecting quality of sleep, as a problem for [Mr A]. A Pain Assessment (PA) chart was completed the next day, which records 5/6 as [Mr A's] reported pain score. BCS requires that once pain is identified as an issue, regular monitoring and care planning needs to commence.

[2] Nursing Council of New Zealand (NCNZ), *Code of conduct* (Wellington: NCNZ, 2012).
[3] Health Practitioners Competence Assurance Act, 2003.
[4] Nursing Council of New Zealand (NCNZ), *Guideline: delegation of care by a registered nurse to a health care assistant* (Wellington: NCNZ, 2011).
Nursing Council of New Zealand (NCNZ), *Guideline: responsibilities for direction and delegation of care to enrolled nurses* (Wellington: NCNZ, 2011).

Unfortunately, there is little evidence of nursing staff regularly assessing or monitoring [Mr A] for pain/effectiveness of analgesia prior to [Day 7].

(ii) A short term Pain Management care plan (PM/STCP) was commenced on [Day 7]. This plan initially reported that the Modified Abbey Pain (MAP) Scale should be used to assess [Mr A's] pain experience.

(iii) [Day 8] 8.15am: The Family/whānau Contact Record (F/WCR) records [Ms B] being *very upset because father in pain*$^{++}$. This resulted in [Dr F] being contacted and the stat administration of subcutaneous Oxynorm being requested. The MSS and PN reports that [Mr A] received this medication 1.5 hours after the verbal order. In my opinion, [Mr A] should have received this stat dose more promptly and any circumstances causing delays should be recorded in the PN.

(iv) Day 9: An amendment was made to the PM/STCP changing the assessment tool to the Iowa Scale. I agree that this was appropriate.

(v) There are incidences when [the hospital] staff record persisting high pain scores for [Mr A] but do not administer PRN analgesia, which could have been given. I am critical of such incidences.

(vi) There is good evidence that [Dr F] (GP) was accessible and responsive to concerns when notified and was timely in reviewing [Mr A].

(vii) There is evidence that contact with [Dr F] was initiated at [Ms B's] or her father's insistence rather than based on clinical nursing assessment.

Comments: In my opinion, an objective pain assessment scale should always be used when assessing pain and evaluating administered analgesia, rather than subjective terms. The use of a pain scale tool, acknowledges literature findings concerning pain being usually under-recognised and under-treated by health practitioners. Stereotypically, in comparison to other adult patient population groups, the elderly often suffer pain in relative silence and benefit from encouragement to report pain/increasing pain promptly. I am critical of the lack of regular pain assessment/monitoring for [Mr A] prior to [Day 7].

Within the literature, measurement tools that support the patient to 'self report' their pain score are recognised as the gold standard. The Iowa pain scale is one such measurement tool. In my opinion this scale should have been consistently used for [Mr A] at [the hospital] as he was coherent and able to verbalise whilst he was resident there. I note that the completed compulsory education sessions as detailed in the CA plan, included pain assessment as a topic. I agree that this was an appropriate remedy action.

**Post error management**

Methadone:

(i) Error discovered on [Day 12] at approximately 8pm.

(ii) Reported to Clinical Manager (CM) and GP on [Day 13].

(iii) Reported to [Mr A's] family on [Day 14].

(iv) BCS CM reports reflecting on the initial management of this error and apologises for not ringing [Mr A's] family to arrange to talk with them earlier.

Haloperidol:

(i) Error discovered by Pharmacist on [Day 12] and discussed with duty RN.
(ii) Response reports the occurrence of the error being discussed with CM and Unit Co-ordinator. The date this occurred is not referred to specifically but it appears that it was [Day 12].
(iii) Reported to [Mr A's] family on [Day 22].
(iv) BCS acknowledges that [Mr A] and his family should have been notified immediately when the error was realised.

Comments: I have not received the BCS Medication Incident Policy (MIP) for review but I note the Provider reporting that it was not followed fully in either medication error. In a BCS response direct to [Ms B], the initial expected actions as per the MIP are detailed. I agree that the specified actions are in accordance with expected nursing practice.

There appears to be some confusion regarding Enduring Power of Attorney (EPA). [Mr A's] [hospital] admission information records that the EPA was *not activated*, which means that [Mr A] retained full autonomy and should have been communicated with as such. I have found no documentation reporting [the hospital] staff informing [Mr A] of the medication errors.

In my opinion to meet Principle 3 and 7[5] means that the RN acknowledges an error when it is realised or as soon as reasonably practical. I also consider this to be the requirement of meeting Health and Disability standards[6]. It appears that both medication errors were known about when Mrs A and [Ms B] were spoken to on [Day 14] by [the hospital] CM and therefore could have been acknowledged then. I disagree strongly with the ten day delay in notifying [Mr A's] family of the Haloperidol errors. In my opinion, the communication with [the family] demonstrates a departure from the expected standards of communication following a clinical error.

6. Additional Comments

(i) As the submitted Medication Management (MM) policy records the last review as 04/09 while the BCS response reports the policy being reviewed as part of the CA plan, I am unsure whether I have received the most up-to-date version. If not already done so I would recommend that BCS review the MM policy against the medication care guides[7] produced in 2011. The care guide recommends that a '5+3R and 3 checks' approach is followed. This is associated with a reduction in medication errors and acknowledges the responsibilities held by registered health providers. In my opinion, section 7 of the MM would also

[5] Nursing Council of New Zealand (2012), *Code of conduct for nurses* (Wellington: NCNZ, 2012).
[6] New Zealand Standards (NZS), *8134.1:2008 Health and disability services (core) standards* (Wellington: NZS, 2008).
[7] Ministry of Health (MoH), *Medicines Care Guides for Residential Aged Care* (Wellington: MoH, 2011).

benefit from review as the expectation is that any delegated authority to a non RN must be removed when a health consumer's health status is unstable[8].

(ii) Incident forms and error analysis have many benefits. They highlight the common circumstances that contribute to the likelihood of errors occurring, enable a systematic review of the error and the circumstances, and have opportunities for learning. The response reports that there were delays in completing the necessary incident forms, which affected the timeliness of notifying [Mr A's] family. I would encourage BCS to continue to work with their nursing and managerial team to support the development of a culture where errors are reported, acknowledged, apologised for, and analysed for learning routinely and promptly.

(iii) Clinical documentation standards require that entries include the date and time, ensuring that retrospective entries and additions are identified as such; the writer should sign, print their surname and include their designation. This is not consistently done within the submitted clinical file and a mild departure from the expected standards.

7. Clinical advice

- Medication management was suboptimal and a severe departure from the expected standards of safe medication administration. I am concerned about the processes that facilitated [Mr A] being subject to continuing medication errors over a sustained period of time and the delay in realising the errors.
- Pain assessment was not regularly done despite pain being identified as an issue for [Mr A] on [Day 1]. I am critical of this and consider it a mild–moderate departure from expected standards of assessment and monitoring.
- I disagree with the delays in communicating that [Mr A] had experienced medication errors at [the hospital]. To wait ten days before acknowledging/apologising for an error is a significant departure from the expected standards of communication."

**Further advice from Ms Carey**

"1. Thank you for the request that I provide additional clinical advice on this file. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following documents: previous clinical advice dated 30 March 2014; the hospital clinical notes of [Mr A]; further responses from Bupa Care Services dated 15 May 2014, 6 November 2014 and 20 April 2016 including policies.

3. Review of policies

[8] Nursing Council of New Zealand (NCNZ), *Guideline: delegation of care by a registered nurse to a health care assistant* (Wellington: NCNZ, 2011).
Nursing Council of New Zealand (NCNZ), *Guideline: responsibilities for direction and delegation of care to enrolled nurses* (Wellington: NCNZ, 2011).

i. Medication Incident Policy
In my opinion this policy is clinically sound and consistent with accepted standards. I acknowledge and agree with the response that nursing staff did not act in accordance with the policy expectations.

ii. Category One Incident Policy
In my opinion this policy is clinically sound and consistent with accepted standards. I acknowledge and agree with the response that nursing staff did not act in accordance with the policy expectations.

iii. Additional comments
I acknowledge that the Medication Management Policy has been updated and now incorporates the '3 checks' recommended in the Medicines Care Guides for Residential Aged Care. I consider this to be appropriate and have no further recommendations in relation to this policy. I also consider the changes made to the medication management audit tool to be appropriate.

4. Clinical advice
   i. **Medication management** — The response reports that on [Day 1] [Mr A] was administered Oxycontin 80mg based on a telephone order from [Dr F]. This order followed [Dr F] being informed that [Mr A's] prescription had been increased after his discharge from [the hospice]. The response acknowledges that the registered nurse did not follow policy expectations as in the verbal order was not documented. While I cannot verify whether this telephone order was given or not, I would agree with the response that such an instruction would mean that this was a documentation error rather than an administration error.

   The response also reports that entries in the controlled drug register confirm that [Mr A] was administered Methadone as prescribed on [Day 19]. The response acknowledges that there was a failure to sign the medication administration sheets. While a copy of the controlled drug register has not been provided, I would agree with the response that this would be a documentation error rather than a medication error.

   In my opinion, part of safe medication administration practice involves checking when the last dose was administered. This check is completed by reviewing the medication signing sheet. In my opinion, any questions that arise from this check are expected to be followed up as until this occurs it is not known whether the resident was subject to a medication error or not.

   I have reviewed the provided copy of the register of staff signatures and initials. I note that the response reports that this is used in lieu of the register on the medication administration sheets. I acknowledge that each of the staff members involved in administering medication to [Mr A] during the relevant time period is on this register.

Following a review of the additional information submitted I remain critical of the medication management of the nursing staff. I continue to hold the opinion that [Mr A] was subject to a sustained level of suboptimal care in regard to medication management.

ii. **Pain assessment** — Following a review of the additional information submitted I remain critical of the standard of pain assessment utilised prior to [Day 7]. In my **opinion**, nursing staff should have undertaken formal pain **assessment** through the use of an objective pain assessment scale at regular intervals (one to two hourly when [Mr A] was awake) and certainly whenever [Mr A] indicated that he was in pain. I consider regular formal assessment to be necessary in order to establish the extent/pattern of a resident's pain experience and to capture the effectiveness of the prescribed analgesia. It is accepted knowledge that as the disease (cancer) progresses the individual's experience of pain can also increase[9]. In my opinion, prompt identification of prescribed analgesia becoming less effective is dependent on nursing staff being committed to using an objective pain assessment scale and doing so regularly.

While formal pain assessments were undertaken from [Day 7], there are incidences when nursing staff record pain but did not respond by administering the prescribed 'when necessary' (PRN) analgesia. I am critical of these incidences:

| Date Time | Recorded pain score | Action taken | Could PRN analgesia be administered? | Next assessment of pain/ administration of analgesia |
|---|---|---|---|---|
| [Day 11] 9am | 3/6 constant (moderate) | Nil | yes | 11.30am pain score 5/6 (extreme), analgesia administered |
| [Day 12] 8am | 3/6 constant (moderate) | Nil | yes | 9.30am pain score 4/6 (severe) 10am analgesia administered |
| [Day 12] 6pm | 3/6 constant (moderate) | Nil | yes | 8pm pain score 6/6 (pain as bad as could be), analgesia administered |

Other than the occasions identified, I consider that [Mr A] was provided with appropriate care in relation to pain assessment and monitoring from [Day 7]. However, I continue to hold the opinion that the care provided to [Mr A] prior to [Day 7] demonstrates a mild–moderate departure from expected nursing standards.

[9] Ellershaw J, Wilkinson S. (2003) Care of the Dying: A pathway to excellence.

iii. **Communication post errors** — Following a review of the additional information I remain critical of the delay in apologising and acknowledging the medication errors and continue to view it as a significant departure from the expected standards of communication post error."