Oceania Care Company Limited

A Report by the
Deputy Health and Disability Commissioner

(Case 18HDC00155)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided by a rest home to a woman in her late eighties in 2016, in particular the rest home's response to her mental and physical deterioration during that time. The woman was transferred to hospital owing to a significant decline in her health, and she passed away the next day.

2. The report highlights the importance of appropriate care planning, medication management, staff training, and timely escalation of care. The Deputy Commissioner considered that the rest home failed to escalate the woman's care sooner once the extent of her deterioration was clear, and that staff did not put sufficient interventions in place to manage her poor food intake. There was also an inexplicable delay of several days in obtaining blood tests, which affected the timeliness of escalation. In addition, the Deputy Commissioner was critical that the rest home did not start a short-term care plan for the management of a pelvic fracture and associated pain, and that the healthcare assistants who assessed her pain were not trained in pain assessment.

3. The Deputy Commissioner noted that a further highly concerning issue in this case is that a registered nurse signed a medication chart to say that he had administered clozapine, when he had not done so, and another nurse who had concerns about the medication given that day did not document her concerns at the time. The Deputy Commissioner was critical that the rest home failed to provide the nurse with adequate training in medication management before he started unsupervised medication rounds.

Findings

4. The Deputy Commissioner found that the rest home breached Right 4(1) of the Code. The rest home failed to provide an adequate standard of care in relation to the management of the woman's medication, pelvic fracture and pain, and care plan documentation. As a consequence, her deterioration and pain were not identified in a timely manner, or addressed adequately. The Deputy Commissioner was also critical of the nurses for their failure to follow medication procedures.

Recommendations

5. The Deputy Commissioner recommended that the rest home's owner, Oceania Care Company Limited, provide a written apology to the family, and review the effectiveness of service changes it has implemented since these events, and the timeliness and effectiveness of its staff induction training.

6. The Deputy Commissioner further requested an update in relation to the roll-out of a new resident information system across all Oceania Care Company Limited facilities, and recommended an audit at the rest home to ensure that all monitoring charts have been completed and followed up as needed, and that all resident documentation has been updated to show family preferences for ongoing care should their family member's condition deteriorate significantly.

7. It was also recommended that the Nursing Council of New Zealand consider whether a review of the nurse's competence in the area of medication administration is warranted.

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided to Mrs B by the rest home. The following issue was identified for investigation:

- *Whether Oceania Care Company Limited provided Mrs B with an appropriate standard of care in Month1 and Month2 2016.*

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

10. The parties directly involved in the investigation were:

Ms A	Consumer's niece/complainant
Oceania Care Company Limited	Rest home provider
RN C	Registered nurse/Clinical Manager
RN D	Registered nurse
RN E	Registered nurse
Dr F	General practitioner

11. Also mentioned in this report:

Ms G	Business and Care Manager

12. Further information was received from:

Office of the Coroner
District health board (DHB)
Ministry of Health

13. Independent expert advice was obtained from in-house aged-care advisor Registered Nurse (RN) Hilda Johnson-Bogaerts, and is included as Appendix A.

Information gathered during investigation

Introduction

Mrs B

14. Mrs B, aged in her late eighties at the time of events, had a long history of mental illness, and a diagnosis of schizoaffective disorder. She had received regular follow-up by a public health service and, since 2014, a DHB's mental health service. Mrs B was admitted to the rest home for hospital-level care in 2015. A consultant psychiatrist noted Mrs B's "general frailty" and recommended that her care be continued at the rest home unless "risks within the private hospital setting escalate e.g. repeated attempts to abscond or seriously inadequate fluid intake", at which point hospital admission would need to be considered.

15. Mrs B took clozapine[1] daily to manage her schizoaffective symptoms, which presented as paranoid delusions and low mood. In 2015, the psychiatrist increased Mrs B's clozapine dose owing to deterioration with presenting psychotic features. Around this time, the rest home assessed Mrs B as being at high risk of falls, and documented preventative measures included keeping Mrs B's walker and call bell within reach at all times. Mrs B received regular visits from a dietician because of weight loss, and at the last review in 2016 she was noted to have a low BMI[2] of 17.1.

16. Mrs B resided at the rest home until 5 Month2, when she was transferred by ambulance to a public hospital owing to a significant decline in her health. She passed away the following day owing to rhabdomyolysis[3] secondary to a fall with pelvic fracture.

Rest home

17. The rest home is contracted by the DHB to provide hospital-level and rest-home level care. The rest home received a three-year certification from the Ministry of Health in 2014.

18. RN C was the rest home's Clinical Manager at the time of these events, and had overall responsibility for Mrs B's care at the rest home. In response to my provisional opinion, RN C noted that at the time of the events in this report, she had been working at the rest home for only about six weeks.

19. This report discusses the rest home's management and response relating to the mental and physical deterioration of Mrs B while a resident at the rest home in Month1 and Month2, and the care provided to her during this time — in particular, issues relating to the escalation of Mrs B's care in her final two weeks at the rest home, the management of a pelvic fracture following a fall, and the management and documentation of her medication administration.

[1] Clozapine is used to treat schizophrenia, a mental disorder that distorts a person's behaviour, ideas, and moods.

[2] Body mass index: a ratio of a person's weight in kilograms to height in metres. A person with a BMI score of 17.1 is classified as being underweight.

[3] The degeneration of muscle tissue accompanied by the release of breakdown products into the bloodstream.

Medical and mental health service reviews

20. Dr F was the visiting doctor at the rest home, and had been Mrs B's regular GP since 2014. Dr F reviewed Mrs B three times in Month1 and Month2. Rest home staff contacted the mental health service on 23, 26, and 29 Month1 regarding concerns about Mrs B's condition, and the mental health service staff reviewed Mrs B on 28 Month1. It appears that the mental health service may also have attended on 29 Month1, but there is no documented evidence of that visit, only a noted plan for the review to occur, and mention in Dr F's notes for that day that the mental health service had attended.

Deterioration — 23 Month1 to 5 Month2

21. From 23 Month1, nursing observations noted that Mrs B's mood had altered and she had started to show increased signs of paranoia. That day, a nurse telephoned the mental health service about Mrs B's sudden change in mood and behaviour, and recorded that the mental health service advised the rest home to contact it again if Mrs B demonstrated further changes in her behaviour.

22. Observation charts and progress notes record that from 23 Month1, Mrs B also started to refuse food and fluids intermittently.

23. On 25 Month1, Mrs B had an unwitnessed fall, and staff completed an incident form. Mrs B's observations were taken and no injury was noted. RN C stated that Mrs B's mental health deterioration was a contributing factor to this fall.

24. On 26 Month1, Mrs B attempted to leave the rest home. An incident form documented that Mrs B was found by another resident with her luggage, saying that she would like to leave. RN D documented that the mental health service was informed about this, and that a plan was agreed for the mental health service to review Mrs B the following Monday, two days later.

25. On 28 Month1 at 1.55pm, Mrs B was seen acutely by a community mental health nurse to assess the deterioration in Mrs B's mental health. The nurse documented that Mrs B had missed two doses of clozapine (this is discussed further below), that she had tried to leave the facility, and that during the review, Mrs B accepted 400ml of fluid. Mrs B was not considered to require hospitalisation or changes to her psychiatric medication. The nurse recorded the following plan: "[C]heck bowels, request GP check dehydration, delirium screen[4] tomorrow. (form left) I will [follow up] tomorrow."

26. Later that day at 9.30pm it was documented that Mrs B tried again to leave the facility, and that staff took her back to her room.

27. On 29 Month1 at 5.15am, RN E found Mrs B standing on the sensor mat in her room. Mrs B told RN E that she had fallen on the floor but had managed to get herself up. RN E

[4] Assessment for delirium (disturbance in mental abilities that results in confused thinking and reduced awareness of the environment) and identification of possible contributing factors. Examination may include mental status assessment, physical and neurological assessment, and other tests, including blood and urine tests.

completed an incident report form and documented that her post-fall assessment found no head or body injuries other than a skin tear on Mrs B's left lower leg. RN E took further observations and noted that Mrs B had pain in her left groin but refused paracetamol for pain relief. Intentional hourly rounding [5] was commenced to monitor Mrs B as management for falls prevention, which included a visual check, asking about pain, comfort and toileting needs, and offering fluids. RN E also documented the plan to administer pain relief as needed, and for Dr F and the mental health service to review Mrs B later that day.

28. The rest home stated that healthcare assistants carried out the intentional rounding every hour from 29 Month1 to 5 Month2, and that during these rounds they would ask Mrs B if she had pain and consider her comfort levels. Staff documented that there was only one time when Mrs B experienced pain, and that the rest of the time she had no pain. It appears that only four of the seven healthcare assistants who carried out pain assessments during this time had received training in pain management prior to these events.

29. Later on 29 Month1, Dr F reviewed Mrs B and noted that she was "acting suspiciously, paranoid". Dr F's examination found that Mrs B had pain in the left hip region. He ordered an X-ray as he suspected a pelvic fracture. He further noted that the mental health service had also seen Mrs B earlier.

30. On 30 Month1, Mrs B had a pelvic X-ray. On 1 Month2, Dr F reviewed her again with the X-ray results, which documented that Mrs B had a fracture of the left superior pubic ramus.[6] Dr F told HDC that after consultation with the orthopaedic registrar at the public hospital, the plan was to manage Mrs B conservatively, and for her to remain at the rest home and "mobilise as her pain tolerated". Dr F told HDC that it is his "experience that this is normal management for pubic rami fractures". The rest home agreed that pelvic fractures are normally treated conservatively.

31. There is no evidence to show that staff created a short-term care plan to support the management of Mrs B's pelvic fracture at the rest home, and there is no reference to the fracture in Mrs B's person-centred care plan.

32. Food monitoring charts document that from 1 Month2 Mrs B refused all food offered to her. Fluid monitoring charts also record a similar significant reduction in fluid intake. On 30 Month1, Mrs B consumed 1000ml, and on each subsequent day after that the clinical notes record that she drank 450ml, 150ml, 400ml, and 50ml on 4 Month2. There is no evidence that this decline was escalated for appropriate and timely intervention.

[5] This involves staff carrying out regular checks on individual patients every hour to assess and manage their fundamental care needs and to monitor for falls prevention.

[6] This is a stable minor fracture of part of the pelvis, which is usually managed conservatively with pain relief and early mobilisation as tolerated. Hereafter in this report, Mrs B's fracture to the left superior pubic ramus will be referred to as a "pelvic fracture".

33. On 2 Month2, Mrs B had her bloods taken, further to the community mental health nurse's plan from four days earlier (28 Month1) for Mrs B to have a delirium blood screen. The rest home told HDC that it was unable to explain why there was a delay in the blood test being done, and stated that such a delay was unacceptable. RN C said that when she left work on Friday 2 Month2 her assessment was that Mrs B was "in a fragile condition but was reasonably stable". She remained on call over the weekend for any urgent issues.

34. The rest home did not receive the results of Mrs B's blood test until 5 Month2, by which point her health had deteriorated further.

35. On 3 Month2, a healthcare assistant documented that Mrs B was "not responsive, not communicating, monitored and checked". The rest home stated that it is uncertain whether this was reported to the registered nurse on duty, as there is no evidence of follow-up by a nurse.

36. On 4 Month2 at 7.40pm, Mrs B had a further unwitnessed fall. An incident report documented that another resident had found Mrs B on the floor. A nurse attended and noted that Mrs B reported not having any pain, and the only injury was a small abrasion on Mrs B's left knee, and her range of movement was normal.

37. RN C stated that she was not made aware of any issues by staff while she was on call over the weekend, and when she reviewed Mrs B again following handover (around 12.40pm) on 5 Month2, she noticed a significant deterioration, as Mrs B was "sprawled on a chair" and appeared semi-conscious. An ambulance was called, and at 1.10pm Mrs B was transferred to hospital.

38. Later that day, the rest home received the results of Mrs B's blood test taken three days earlier. RN C stated that the results provided clinical evidence of dehydration.[7]

39. Mrs B died on 6 Month2 at 10am. The cause of death was determined as rhabdomyolysis owing to a fall with pelvic fracture.

40. In response to my provisional opinion, Dr F stated:

> "[Mrs B] was a frail elderly lady (supported by the evidence of her low BMI) and with a deteriorating mental state (compounded by medication administrative errors) leading to dehydration. These factors both made her susceptible to sepsis and multiple organ failure of which she did not survive. The superior ramus fracture would have been a contributing factor in her death but not the leading one."

Medication management — clozapine

41. On one or more occasions in Month1, staff failed to administer Mrs B's clozapine.

[7] However, see also the advice to the Coroner noted at paragraph 63 that notwithstanding the delay in obtaining the blood test results that arrived on 5 Month2, the daily fluid chart should have been sufficient warning that Mrs B was becoming dehydrated.

42. Normally, registered nurses at the rest home administered clozapine to Mrs B at 9pm every day, and documented on a medication signing sheet when this had been done. The signing sheet also included sections for Mrs B's other daily medications.

43. Between 22 and 26 Month1, RN D was the afternoon nurse on duty responsible for administering Mrs B's clozapine. At the time of these events, RN D had been employed at the rest home for less than a month.

44. On 23 Month1, a nurse noted that Mrs B had had a sudden change of behaviour and mood, and documented: "[Mrs B] has been withdrawn and suspicious today. She's displaying paranoid behaviour … She didn't eat lunch and had overall minimal oral intake."

45. RN D told HDC that he administered Mrs B's clozapine on the first four days of his duty, but that he omitted to administer it on 26 Month1. However, on 26 Month1, RN D's signature is on the medication chart recording that he had given Mrs B's clozapine, and in the care progress notes for that day he documented: "All meds taken."

46. RN D stated:

> "I did not administer the Clozapine Medication to [Mrs B] because I was not able to find [it] in the treatment room … [It] was not in the Fridge and not in the medication trolley, even other places as well. Thus, I notified [the night duty nurse RN E] about it when I gave a hand-over. … I asked her to show me where medication is … [She] took the Clozapine medication out from the deep back corner behind other medications as soon as she opened the fridge. … I said 'I am going to administer the Clozapine medication to [Mrs B] now before I leave', but [RN E] said 'leave it, I will do' … I left, but I was not able to check whether [RN E] administered the Clozapine Medication to [Mrs B] after I left."

47. RN E stated that her recollection of the handover with RN D on 26 Month1 is that he told her that he had not administered Mrs B's clozapine as he could not find it, but that when she reviewed the medication chart it showed that RN D had signed for the 9pm medication round. She said that she tried to call RN D to confirm whether he had given Mrs B the clozapine dose, but there was no answer. RN E stated that she decided not to give Mrs B clozapine in order to avoid the possibility of administering a double dose, as RN D had signed that clozapine had already been given.

48. RN D originally told HDC: "I left to go home knowing that I did not administer the medication and … I know that it is not the right thing to sign the medication chart if I did not administer a medication to a resident." In response to my provisional opinion, RN D stated that he was not aware of any missed calls from RN E on the night of 26 Month1.

49. RN E told HDC that she did not complete an incident report on 26 Month1 regarding the possible missed clozapine dose because RN D had signed to confirm the clozapine administration for that night. There is no evidence that RN E reported this to the rest home management, Dr F, or the mental health service.

50. On 8 Month2,[8] RN E documented in an incident report that Mrs B's clozapine dose had been missed. RN E noted that RN D had documented that he had given Mrs B all prescribed medication at 9pm between 22 and 26 Month1, and that there was no documentation showing how many days Mrs B had missed her clozapine dose. RN E further noted in the report that she had asked the pharmacy for a separate new signing sheet for clozapine, and recorded the expected completion date for this action as 27 Month1.

51. RN E told HDC that she cannot recall why she completed the incident report 12 days after the incident in question.

52. Two nurses signed on Mrs B's original clozapine signing sheet that she had been given clozapine on 27 and 28 Month1. On 28 Month1, a nurse also signed the new, separate signing sheet for clozapine only.

Other information

53. The rest home stated that it has no evidence of any training or competency assessments undertaken by RN D at the rest home in relation to medication management and administration prior to these events.

54. The rest home told HDC that it is unable to clarify how many clozapine doses were missed, and is unable to determine whether the medication records were falsified.

55. The rest home commenced a sentinel event[9] investigation into Mrs B's care after her death. In relation to the matter of possible missed clozapine doses, the sentinel event report stated:

> "[RN D] admitted that he had not given the Clozapine as charted [on 25 and 26 Month1] and the reason was given that he couldn't find the medicine. He didn't seek assistance from other staff and did not notify senior staff or the on call RN or the GP. There was no documentation in the progress notes. … Because Clozapine was being signed for with the other regular packed medications on the signing sheet it is uncertain how many days were actually missed."

56. In response to my provisional opinion, RN D originally stated that he strongly disputes the above statement from the rest home. RN D told HDC:

> "I did not admit that I had not given the clozapine on 25th [Month1]. I know for a fact that I did administer the clozapine on the 25th [Month1], and I did not administer it on the 26th [Month1] as I could not find it … I did seek assistance from other staff that were working in the other wing but was still not able to find the medication. I did notify and advise the night duty [RN E] …"

[8] Two days after Mrs B's death.
[9] An event that is life-threatening or has led to major loss of function or an unanticipated death.

57. Ms G told HDC that she believes that clozapine doses were missed on 25 and 26 Month1. However, she noted that RN C thought that perhaps five doses were not administered from 22–26 Month1. RN C stated: "It did not make sense to me that [RN D] would miss only 2 out of 5 doses, given this reason for omission, but he did not admit to missing all 5." The rest home told HDC that there is no evidence that RN D was involved in the sentinel event investigation "besides [RN C's] email on 19.02.2018 of a conversation she had with [RN D]".[10]

58. In her report to the Coroner, RN C stated:

> "[Mrs B] had been stable on Clozapine for several months. … On the 26 [Month2] [RN D] admitted to omitting the clozapine dose … RN observation noted that from 23rd [Month1] [Mrs B's] mood had altered and she was showing signs of increased paranoia & delusions. The Community Mental Health Team was alerted to this on 26 [Month1] & the Community Mental Health Nurse visited 28 [Month1], as previously noted. The GP was also aware that this had happened."

59. In response to my provisional opinion, RN D originally reiterated that he did not admit to RN C that he missed two doses, and that he did ask other staff for assistance with finding the clozapine.

60. There is no documented evidence that the rest home notified the mental health service team or Dr F that RN D may have missed some of Mrs B's clozapine doses. However, it appears from the community mental health nurse's documented review of Mrs B on 28 Month1 that the mental health service was aware of this issue at that time.[11]

Further information

61. In her report to the Coroner, RN C stated:

> "From reading the notes and talking to staff, I noted a pattern of paranoid behavior with food & fluid refusal that settled with appropriate medication. … When I left work on Friday 2 [Month2], my assessment was that [Mrs B] was in a fragile condition but was reasonably stable. She had restarted her Clozapine, & I hoped that she would recommence eating & thus avoid a distressing hospital admission."

62. The rest home further told HDC:

> "[RN C's] report to the coroner indicated that there was usually a link between a decline in mental health stability and reduced food and fluid intake. Her thoughts were that this would improve with the re-introduction of [clozapine]."

[10] In this email, RN C stated: "[RN D] was on PM duty 22–26 [Month1]. He admitted the following week that he did not give 2 doses as he did not know where it was kept. … He had not asked anyone and as can be seen signed for the Clozapine as given. My recollection is that either I or [another member of staff] asked [RN D] about the Clozapine as part of investigating the acute deterioration in [Mrs B's] mental state. It did not make sense to me that he would miss only 2 out of 5 doses, given his reason for omission, but he did not admit to missing all 5."

[11] See paragraph 25 of this report.

63. It is noted that a pathologist[12] reported to the Coroner that notwithstanding the delay in obtaining blood test results, which arrived on 5 Month2, the daily fluid chart should have been sufficient warning that Mrs B was becoming dehydrated.

64. The rest home told HDC that it is unclear why the nurses responsible for Mrs B's care did not escalate her deterioration to either the GP (Dr F), the Clinical Manager (RN C), or the Business and Care Manager, as Mrs B continued to decline over the weekend of 2–5 Month2. The rest home stated that the registered nurses should have sought medical review when it was clear that Mrs B's fluid intake was inadequate over a 24-hour period.

65. The rest home stated that although the healthcare assistants reported Mrs B's reduced oral intake to the registered nurses, there was a lack of follow-up, and no evidence that staff escalated Mrs B's care or commenced new interventions in response to her refusal of food and fluids.

66. In relation to whether any measures were put in place to prevent Mrs B leaving the facility, the rest home told HDC that there is no evidence in her person-centred care plan that this occurred "besides the visual checks that were occurring".

67. The rest home's internal review of Mrs B's care revealed the following:

- Her fluid balance charts were incomplete, and frequently there was no documentation for entire shifts.
- Intentional rounding charts showed her ongoing lack of fluid intake, but there is no evidence that this was reported to a registered nurse.
- There is no evidence that nursing staff reviewed Mrs B's monitoring charts, or that interventions were added in response to her ongoing refusal of food and fluid.
- There is no evidence of nursing review of Mrs B's deterioration.

68. The "Medication Management Policy" in place at the time included the following sections:

> "• Accuracy of medication charts is vital and where staff have any concerns or identify any errors they must follow this up with the prescribing Doctor Immediately.
>
> …
>
> • Before giving medicines, all staff must demonstrate that they have knowledge, understanding and practical abilities to be considered as competent. Skill and Knowledge will be assessed by a Registered Nurse who has demonstrated competency.
>
> …

[12] The pathologist provided this advice on Mrs B's care upon request from the Coroner's office.

- Medications may only be administered by a suitably competent person. 'Suitably competent' is defined by the following factors:
  - The staff member has undertaken comprehensive education on the safe administration of medications.

  …

  - The staff member has successfully completed the Oceania Care Company Medication Competency (this will demonstrate application of the knowledge they have learned in relation to medications).

  …

- Clinical Managers/Leaders are responsible for: … Monitoring staff practice and compliance with policy.

- All Doctors, Registered Nurses, Enrolled Nurses and Health Care Assistants are accountable for … [f]ailing to take appropriate actions in the safe administration of medication … [f]ailing to question or seek clarification where a medication chart is not clear or appropriate with Oceania Care Company policy … [r]eporting any medication incidents as per Incident/Accident policy."

69. The Pain Management Policy in place at the time of these events stated: "A resident with pain who is able to participate in the process is assessed by a Registered Nurse using the Oceania approved tools."

Changes made as a result of these events

70. The rest home stated that in light of the failures identified in Mrs B's care, the following corrective actions were put in place:

- The Clinical Manager receives email handovers from registered nurses.
- Annual study days for registered nurses have been commenced, and include education on pain management, the aging process, falls prevention and management, behaviours that challenge, person-centred care planning, and documentation.
- A training session for staff regarding assessment and interventions for frail older adults was conducted by a gerontology nurse specialist.
- The Medimap medication management system has been introduced.
- ECase, a resident information system, is currently being rolled out throughout Oceania Care Company Limited. Oceania Care Company Limited told HDC: "[Staff] will commence training for this system [in] [2020] with a go live date of [2020]. The system includes electronic care planning and auto generated short term care plans in addition to generated work logs. These are visible to staff and management, even remotely, thereby increasing accountability and reducing the risk of omissions in care delivery."
- There is weekly oversight of all monitoring charts by the registered nurse responsible, to ensure that they are completed and followed up.

- All resident documentation has been updated to clarify whether a resident's family would prefer hospital admission or comfort care and symptom control at the rest home if an incident of this nature occurs again.

71. Oceania Care Company Limited told HDC:

> "There has been an increased focus on induction and orientation of new staff, particularly that of Registered Nurses. All facilities have implemented a process whereby a Registered Nurse is unable to be rostered onto a shift until the required medication training and competency has been successfully completed."

72. RN D told HDC:

> "Since this incident I have been working in the acute settings with my current employer which has provided me with training on medication administration and management, ongoing updates and support. I also have not had any medication incidents. I am happy to provide evidence of this."

Responses to provisional opinion

73. Ms A, Oceania Care Company Limited, Ms G, RN E, Dr F, RN C, and RN D were given the opportunity to respond to relevant sections of my provisional opinion.

74. In response to my provisional opinion, Ms A stated:

> "I had numerous times told staff on duty that [Mrs B] needed to be watched more carefully as she had become so fragile and weak. On the day she was admitted to hospital, I called the rest home in the morning to see how she was. I did speak to the Manager who said she was in the same condition and that there wasn't really anything which they could do. I requested she go to hospital; it was not [the rest home] who made the decision. I also had observed that there seem to be two or three new staff members. The issue I have is they were not able to find her [medication] and as a result this started her paranoia again and refusing foods and liquids."

75. Oceania Care Company Limited accepted the provisional opinion, and stated:

> "Oceania deeply regrets the events outlined in your report and acknowledges the impact of [Mrs B's] death upon her family. We extend our sincere apologies that [Mrs B] did not receive the standard of care one would normally expect in an Oceania facility."

76. It further stated:

> "In November 2019 a clinical governance review was commenced with an independent review team. This team's term of reference covers all areas of clinical and care for Oceania … The review team is presenting its report at the end of January 2020 through to the CEO and the Board. Your report findings will not only be considered in response to the above independent review report but also by our

> Clinical Governance Committee. This new committee has oversight of all clinical and care activities within Oceania …"

77. Ms G and RN E were in agreement with the report and recommendations. They made no further comment.

78. Dr F, RN C, and RN D all responded to my provisional opinion, and their comments have been noted in the report where relevant.

79. Most importantly, on being shown a copy of the medication chart for 26 Month1, RN D told HDC: "[F]rom looking at it now, it seems like my signature. However my recollection and belief was that i didn't sign it. I sincerely apologize for the process and for all this."

Opinion: Oceania Care Company Limited — breach

Introduction

80. Oceania Care Company Limited was responsible for providing services to Mrs B with reasonable care and skill. This included the administration of prescribed medication, coordination of care with other health services, escalation of significant concerns, documentation of care and health concerns, and appropriate pain management. It is apparent that from 23 Month1 to 5 Month2, Mrs B's condition deteriorated to the point where, evidently, she was unable to recover. Owing to the uncertainty around the days on which Mrs B missed her clozapine dose, it is not clear whether her deterioration was linked to, or largely the result of, the omission of her medication. Notwithstanding the disputed facts of that particular matter, it is clear that overall, the rest home's inadequate management of Mrs B's medication, pelvic fracture, and dehydration significantly contributed to her deterioration and eventual demise.

Deterioration between 29 Month1 and 5 Month2

Escalation of care

81. Staff noticed a sudden change in Mrs B's mood and behaviour from 23 Month1, when she also started to refuse food and fluids intermittently. Mrs B made two attempts to leave the rest home in subsequent days. On 29 Month1, Mrs B had a fall (her second in five days), which resulted in a pelvic fracture. Intentional hourly rounding was commenced to monitor her, but no care plan was created to support the management of the fracture. Healthcare assistants recorded in the hourly rounds chart that Mrs B almost always had no pain, but it appears that they had not all received training in pain assessment at that time. From 1 Month2, Mrs B refused nearly all food and fluids, but staff did not escalate her care or commence new interventions in response to her poor intake and declining condition. On 3 Month2, a healthcare assistant found Mrs B unresponsive and uncommunicative, but did not escalate this to nursing staff, and again there was no nursing follow-up.

82. There was a significant delay in taking the blood tests planned for 29 Month1, and the results were available only on 5 Month2, after Mrs B's admission to hospital. I note that the pathologist reported to the Coroner that even without the results of this blood test, Mrs B's fluid balance charts were evidence enough that she had become dehydrated.

83. My in-house aged-care advisor, RN Hilda Johnson-Bogaerts, said that it is clear that Mrs B was deteriorating following her fall on 29 Month1 when she sustained the pelvic fracture. RN Johnson-Bogaerts advised that there was a lack of documentation to show escalation of staff interventions regarding Mrs B's continued refusal of food and fluids, and that Mrs B's care plan did not include interventions for her episodes of mental relapse when she refused drinks and meals.

84. RN Johnson-Bogaerts considered it to be a mild departure from the accepted standard of care that the rest home nurses did not refer Mrs B to the GP or mental health team when necessary for a medical assessment of her competency and ability to decide to continue to refuse fluids. RN Johnson-Bogaerts advised that this issue should have been escalated earlier.

85. I accept this advice and am critical that staff failed to escalate Mrs B's care sooner once the extent of her deterioration was clear, and that staff did not put sufficient interventions in place to manage Mrs B's much reduced oral intake. I am critical that Mrs B's poor fluid intake, particularly from 1 Month2 — and most notably the 50ml intake on 4 Month2 — was not escalated for appropriate intervention, and that her noted unresponsiveness on 3 Month2 was not reported to, or acted on by, nursing staff. I am further critical that the delay in obtaining Mrs B's blood test — the results of which showed clinical evidence of dehydration — also affected the timeliness of escalation. Regardless of the failure to obtain timely blood testing, I note that a number of the staff involved in Mrs B's care already had ample warning from her charts that she was dehydrated, and I am critical that they did not intervene sooner.

Management of pelvic fracture and pain

86. In relation to the management of Mrs B's pelvic fracture, RN Johnson-Bogaerts advised that it is common practice to manage a pelvic fracture conservatively and in a care home, provided that the pain is manageable and clear care instructions are documented in a short-term care plan. She was critical that no such plan was put in place, and that no input was sought from a physiotherapist in developing a plan. RN Johnson-Bogaerts advised that the documented intervention to manage Mrs B's condition seems to have been limited to the intentional hourly rounds, but that the documented instructions for the rounds contain no mention of the pelvic fracture or specific care instructions. RN Johnson-Bogaerts further noted that whilst it is accepted practice for healthcare assistants to undertake pain assessments as part of hourly rounding, it is important for them to have received training in pain assessment prior to undertaking such rounds.

87. RN Johnson-Bogaerts further advised that in light of the likelihood of pain or tenderness accompanying a pelvic fracture, it seems unlikely that Mrs B never experienced any pain, as documented by care staff. RN Johnson-Bogaerts said that any pain assessment may

have been complicated by Mrs B's mental state and dementia. RN Johnson-Bogaerts advised that owing to the above issues, the rest home's management of Mrs B's pelvic fracture and related pain departed moderately from accepted standards.

88. I am highly critical that the rest home did not commence a short-term care plan for the management of Mrs B's pelvic fracture and associated pain, and that it appears that some of the healthcare assistants who assessed Mrs B's pain from 29 Month1 had not been provided with training in pain assessment prior to undertaking the rounds. I also agree with my expert that it is of concern that pain assessments conducted following Mrs B's fracture indicated that she did not experience pain. In the circumstances, that would seem unlikely to have been the case.

Medication management

89. Mrs B had a long history of mental illness, and took clozapine to treat her symptoms. Although RN D's belief and recollection throughout this investigation was that he had not signed the medication chart on 26 Month1 to show that he had given Mrs B clozapine on this date, I note that he acknowledged in response to the provisional opinion that the signature appears to be his. Accordingly, I find that on at least 26 Month1, RN D omitted to give Mrs B her clozapine dose but signed in the medication chart that he did. RN E had been uncertain as to whether clozapine had been given on that day, but did not document this at the time. RN E completed an incident report regarding this matter 12 days after the event.

90. Although RN D had been at the rest home for just under a month, it is noted that contrary to the rest home's policy on medication management, RN D had not been provided with any training in relation to medication management and administration.

91. RN Johnson-Bogaerts advised that although there are different versions of events surrounding the medication administration of clozapine between 22 and 26 Month1, it is clear that both RN D and RN E did not follow the rest home's medication management procedures. RN Johnson-Bogaerts stated:

> "When as a nurse you sign the medication record you sign for having given the medication and have assured that it has been administered safely and according to the prescription — any exceptions to this need to be noted on the record."

92. RN Johnson-Bogaerts advised that it is accepted good practice to assess and document each new employee's medication management and administration competency before he or she commences medication rounds alone. She noted that the rest home's policies show that training in this area is mandatory, but that its response confirmed that there is no evidence of any training or competency assessment for RN D at the rest home in relation to medication management.

93. Overall, on the matter of Mrs B's medication management, RN Johnson-Bogaerts advised that the rest home departed significantly from accepted practice as a result of the above omissions and failures. She further advised:

> "The element that stood out most as part of the overall departure in medication management is the element where management failed to assure that suitable trained and competent staff were available to provide safe medicine management …"

94. I am highly critical that the rest home failed to provide RN D with adequate training on medication management.

95. I am also highly critical of the following:

1. RN D signed the chart to say that he had administered clozapine when he had not done so;
2. RN E did not document her concerns regarding the missed clozapine dose; and
3. RN D and RN E failed to follow the rest home's medication procedures.

96. It is also unusual that RN E completed an incident report 12 days after the event being reported. It appears that this may have been done in response to the rest home's sentinel event investigation following Mrs B's death on 6 Month2, in order to assist with its review of care. I am critical that despite RN E's apparent concerns about clozapine omission — as shown by her incident report — she did not record this at the time.

97. Owing to the number of concerning omissions by staff in the management, administration, and documentation of medication to the expected standard, which contributed to the overall service failure, I find that the shortcomings in the care provided by RN D and RN E are part of a wider pattern of failures, for which ultimately the rest home is responsible.

Conclusion

98. I note that RN Johnson-Bogaerts advised that the measures taken by the rest home to improve medication management competencies and ensure that nurses identify inadequate food and fluid intake of residents at an earlier stage are adequate. However, overall I find that the rest home failed to provide Mrs B with an adequate standard of care in relation to the management of her medication, pelvic fracture and pain, and care plan documentation. As a consequence, Mrs B's deterioration and pain were not identified in a timely manner, or addressed adequately. Accordingly, I find that the rest home failed to provide Mrs B with an appropriate standard of care, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[13]

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

Recommendations

99. I recommend that Oceania Care Company Limited:

a) Provide a written apology to Mrs B's family. The apology is to be sent to HDC within one month of the date of this report.

b) Conduct a review of the effectiveness of the service changes implemented since these events, as noted at paragraph 70, and report to HDC within three months of the date of this report. In particular, the review should include:

i. Email handovers by registered nurses to the Clinical Manager.

ii. The introduction of the Medimap medication management system.

c) Conduct a review of staff induction training, and its timeliness and effectiveness, with particular regard to medication management, and report back to HDC within three months of the date of this report in relation to the outcome of the review.

d) Provide an update on the roll-out of the resident information system ECase in the rest home and throughout Oceania Care Company Limited, within three months of the date of this report.

e) Conduct an audit of 20 residents over a period of one month, to ensure that all monitoring charts have been completed and followed up as needed, and report to HDC on the outcome of the audit within three months of the date of this report.

f) Conduct an audit of 20 residents to ensure that all resident documentation has been updated to show whether residents' families would prefer hospital admission or on-site comfort care for their family member should significant deterioration occur, and report to HDC on the outcome of the review within three months of the date of this report.

100. I recommend that the Nursing Council of New Zealand consider whether a review of RN D's competence in the area of medication administration is warranted, and report back to HDC on its decision in relation to this.

Follow-up actions

101. A copy of this report will be sent to the Coroner.

102. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Oceania Care Company Limited, will be sent to HealthCERT (Ministry of Health), the DHB, and the Health Quality & Safety Commission.

103. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Oceania Care Company Limited, will be sent to the Nursing Council of New Zealand, and it will be advised of RN D's name.

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

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Hilda Johnson-Bogaerts:

"CLINICAL ADVICE — AGED CARE

CONSUMER: [Mrs B]

PROVIDER: [Rest home]

FILE NUMBER: C18HDC00155

DATE: 14 January 2019

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1. Thank you for the request that I provide clinical advice in relation to the complaint from the Coroner's office about the care provided by [the rest home] to [Mrs B]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have been asked to comment on the following aspects of [Mrs B's] care:

   i. The monitoring of [Mrs B's] condition between 23 [Month1] and 6 [Month2] and actions taken in response to [Mrs B's] deterioration between 23 [Month1] and 5 [Month2]

   ii. The management of her pelvic fracture

   iii. The overall standard of nursing care provided to her in [Month1] and [Month2]

   iv. The adequacy of the remedial measures in place at [the rest home] in response to their investigation of this complaint

   v. Any other matters in this case that could be considered to amount to a departure from accepted practice

3. Documents reviewed

In preparing for this advice the following documentation was reviewed:

1. Email referral from [Coroner]
2. Responses from [the rest home] dated 2 March and 5 March 2018.
3. Clinical records from [the rest home].
4. Response from [RN D] dated 11 March 2018.
5. Clinical records from the DHB for the period 28 [Month1] to 6 [Month2].

4. Background

[Mrs B] was an [elderly] resident at [the rest home] until her death [in hospital] on 6 [Month2], where she was admitted the previous day with severe shock, dehydration and multi-organ failure. She had sustained a pelvic fracture on 29 [Month1] which had been conservatively managed at [the rest home]. The cause of her death was noted as

'complications of the pelvic fracture'. Sepsis and dehydration were also found to have contributed to her death following a coroner's investigation.

[Mrs B] had a long history of severe mental illness (Schizophrenic disorder and Senile Dementia) and was sometimes non-compliant with medications, especially when becoming unwell. She was prescribed Clozapine which was reported to help. She was subject to recurrent urinary tract infections and chest infections that were managed by her GP. She also suffered from Ischaemic Heart Disease.

5. Review of clinical records

From 23 [Month1] nursing observations noted that [Mrs B's] mood had altered and she showed increased signs of paranoia and delusions. She started to refuse care, attempted to leave twice (26 and 28 [Month1]), sometimes refused food and fluids which was reported as her normal pattern when mentally unwell.

The Mental Health Team was contacted on 23 [Month1] and an update on the sudden change in behaviour provided. Staff were advised to monitor and contact the Mental Health Team again 'if [Mrs B] demonstrates further changes in her behaviour'. During this time care staff continued offering food and fluids.

[Mrs B] received regular visits from a Dietitian because of her continued significant weight loss and low BMI (17.1). She received a high energy and high protein diet with staff offering her extra food on those days that she was 'in a good mood'.

Food monitoring charts and fluid balance charts were completed on a daily basis during this period. These records show that she started refusing food on 23 [Month1] which improved slightly on 29 and 30 [Month1] to deteriorate again after this; she refused all food 1 [Month2] onwards. Fluid balance charts show the same trend regarding her fluid intake with an inadequate fluid intake from 1 [Month2] onwards. Care staff continued to offer food and fluids as documented on the monitoring charts.

On 25 [Month1] and on 29 [Month1] [Mrs B] had a fall which resulted in a pelvic fracture; she fell again on 4 [Month2]. She was identified as being at 'High risk of falls'. Care planning included preventative interventions as 'to keep her room clutter free, remind [Mrs B] to walk slowly with her walker'. On 29 [Month1] after her second fall the following was added, 'Started on intentional hourly rounding as falls prevention'. A falls analysis chart was commenced on 1 [Month2] showing patterns of late night and early morning falls.

On 26 [Month1] [RN D] admitted that he had omitted to give [Mrs B] the Clozapine dose on at least two occasions because he could not find any. He had been on duty on the evenings between 22 [Month1] and 26 [Month1]. While not administering the medication he had signed the medication administration sheets and when confronted he stated he could not exactly remember which ones he did not give, so it is not certain how many doses were missed. Reports are contradicting. The Mental Health Team and GP were alerted to the missed medication and the changes in [Mrs B's] mental health.

On 28 [Month1] [Mrs B] was seen by the Community Mental Health Nurse in relation to her mental health decline. It was decided that she did not need hospitalisation or changes to her medication. The plan was to check bowels, request GP check for dehydration.

Subsequently on 1 [Month2] the mental health nurse telephoned with advice that a delirium blood and urine screen be done to rule out any physical illness that could be contributing to [Mrs B's] behaviour. The blood tests were done on 2 [Month2]. Results were received on 5 [Month2] after [Mrs B] was taken to hospital already. The results showed indications of dehydration.

On 29 [Month1] after 5.00am [Mrs B's] sensor mat alarm was activated, and when the Clinical Manager responded she found [Mrs B] standing on her sensor mat holding her walker, and blood dripped from a wound on her left lower leg. [Mrs B] said that she fell and got up immediately. The nurse did a physical examination and did not find any other visual injury. [Mrs B] said that she had '*pain in her left groin*' and was observed to be *'wobbly when walking*'. The following observations were noted: Blood pressure: 120/70, Pulse 62, Respiration 22. The intervention plan include neurological observations, hourly checks, wound care, pain relief, to be seen by the GP, to inform next of kin and a review by medical health.

A mobile X-ray was taken on 30 [Month1] and the report of a fractured pelvis was received 3 [Month2]. The GP decided in consultation with the registrar at [the public hospital] for her to remain at [the rest home] as she could mobilise and seemed to respond to analgesia.

On 4 [Month2], [Mrs B] had again an unwitnessed fall. She was found by one of the residents. The attending registered nurse physical assessment did not find any '*apparent major injury*' and '*no complaint of pain on mobilising and transfer*'. The following observations were noted post fall: Blood pressure 90/40, Pulse 95, Respiration 32, temp 26.4°C. Neuro observations were taken showing that she was confused but followed instructions.

On the morning of 5 [Month2] nurses continued their close observations. [Mrs B] was found to be increasingly unresponsive. Blood pressure at 9am was 90/60. Normal Saline sub cut fluids administration was started as charted. Her next of kin was informed who advised the nurses 'to send her to hospital for further treatment'. An ambulance was organised and [Mrs B] was transferred to hospital.

6. Comments and clinical advice

i. The monitoring of [Mrs B's] condition between 23 [Month1] and 6 [Month2] and actions taken in response to [Mrs B's] deterioration between 23 [Month1] and 5 [Month2]

Reviewing the documentation, it is unclear what triggered the change in behaviour of [Mrs B] on 23 [Month1]. Was it the omission of Clozapine or other physical contributing factors? The RN responsible for the administration of Clozapine provided contradicting information regarding the number of days he omitted to give the

medication to [Mrs B]. Timely specialist referral was done by [the rest home] nursing which included the involvement of her GP, the mental health team and the dietician. [Mrs B] had a history of refusing food and fluids when mentally unwell. GP notes on 29 [Month1] include '*no signs of UTI*'. There was a significant delay in taking blood tests (2 [Month2]) with results made available on 5 [Month2].

[Mrs B's] clinical file includes comprehensive nursing assessments including the interRAI assessments and relevant long term care plans addressing the risks identified by the assessments. Care staff completed monitoring charts for the high risk items as per the care plan. This provides evidence of appropriate ongoing monitoring and interventions and shows that nursing interventions escalated appropriately when after her second fall on 29 [Month1] intentional hourly rounding was commenced.

On the other hand, I did not find documentation of a similar escalation of interventions regarding her continued refusal of food and fluids during this period. The care plan includes interventions to keep her weight up 'on good days', however does not include interventions for the episodes of mental relapse when she refuses food and fluids. From the clinical notes it is clear that [Mrs B] was deteriorating following her fall on 29 [Month1] when she sustained a pelvic fracture. It is my opinion a new escalation to the GP or mental health team by the nurses for a medical review and assessment of [Mrs B's] competency and ability to decide to continue refusing fluids was indicated. It is only at a very late stage, when [Mrs B] became unresponsive on 5 [Month2], that the issue was escalated and sub-cut fluids were commenced.

Overall [Mrs B's] condition was monitored well during this period and appropriate actions were taken. It is my opinion that her deterioration after 1 [Month2] should have been picked up at an earlier stage and that her ability to decide to continue to further refuse food and fluids should have been escalated earlier.

Departure from accepted practice — minimum

ii. The management of her pelvic fracture

The documentation includes that the GP consulted with the hospital's registrar before deciding to manage the fracture conservatively and for [Mrs B] to be able to remain in her familiar environment. This was 2 days after the fall when the X-ray results were received on 1 [Month2]. [Mrs B] could mobilise with her walker, use the commode toilet and seemed to respond to the pain relief. It is common practice to manage a pelvic fracture conservatively and in a care home provided that the pain is manageable and clear care instructions are in place for the nurses. Typically these care instructions are documented in a 'short term' or 'acute' care plan developed by the registered nurse with input from the GP, a physiotherapist and the health consumer.

I am concerned that the clinical documentation did not include the initiation of such a short term/acute care plan. [Mrs B's] long term care plan regarding her mobility was last updated on 29 [Month1] with: 'Started on intentional hourly rounding as falls prevention'. I did not find any mention of the pelvic fracture or any specific care instructions.

The 'hourly rounding' by nurses was documented well and included an hourly pain assessment. These were without exception always marked as 'No Pain'. Medication records show that Paracetamol was prescribed on an as required basis. The medication signing sheets show that Paracetamol was administered only once i.e. on 29 [Month1]. In light of the likelihood of pain or tenderness accompanying the pelvic fracture it seems unlikely that [Mrs B] in her condition never experienced any pain or tenderness which raises the question if appropriate pain assessment was completed by the nurses. Expressing pain and assessment of pain can be complicated by high age, mental illness and dementia.

Departure from accepted practice — medium

iii. The overall standard of nursing care provided to her in [Month1] and [Month2]

Overall the nursing care provided to [Mrs B] was adequate. Falls risk was identified and appropriate fall prevention interventions were implemented. Long term care issues were identified using best practice methods (interRAI and other assessment tools), an appropriate (long term) life style care plan was developed with input from the EPOA and the multidisciplinary team. The acute situation post falls was managed well with appropriate escalation and implementation of measures to prevent further falls.

I am critical however that no 'short term' care plan was developed following the decision to manage the pelvic fracture conservatively at [the rest home]. No input was sought from a physiotherapist. The documented intervention to manage the situation seemed to be limited to the 'Intentional hourly rounds'. The instruction written by the nurse on the hourly rounds chart was: *'Hourly checking and write intervention'*. There is no mention of the pelvic fracture or specific care instructions. The chart includes an hourly pain assessment which without any exception was always completed as NO pain. Seeing her pelvic fracture it is unlikely that [Mrs B] never experienced any pain which makes me question the pain assessment skill of the nurses which may have been complicated due to her mental state and dementia.

Departure from accepted practice — medium

I am questioning why registered nurses did not question [Mrs B's] decision making capacity to refuse food and fluids at an earlier stage and escalate this situation to her GP at an earlier time.

Departure from accepted practice — minimum.

Although the documentation and statements by different people surrounding the medication administration of Clozapine between 22 and 26 [Month1] differ in terms of how many days [Mrs B] was not given her dose it is clear that [RN D] did not follow the organisation's medication management procedure when he signed the medication administration record as if he had given [Mrs B's] medication. This is in breach with the registered nurse's code of conduct.

Departure from accepted practice — significant.

iv. The adequacy of the remedial measures in place at [the rest home] in response to their investigation of this complaint

The measures taken by [the rest home] to improve medication management competencies and the new measures to ensure that nurses pick up at an earlier stage the inadequate food and fluid intake of their residents seem adequate. It is my recommendation that in addition staff education is provided on pain assessments especially when complicated by high age, mental illness and dementia.

It is my recommendation that in addition to these measures the absence of a documented acute/short term care plan is addressed.

It is not clear from the documentation if the nursing council was notified of [RN D's] conduct.

Hilda Johnson-Bogaerts, RN MHSc PGDipBus
Aged Care Advisor
Health and Disability Commissioner"

RN Johnson-Bogaerts provided the following further expert advice on 19 May 2019:

"I have reread some of the documentation — I have not found the hard copy file I reviewed.

It would seem that [RN D] signed for the medication however did not give it himself but let the night RN administer the medication. Misunderstandings occurred.

In that case both persons did not follow the organisation's medication management procedures — When as a nurse you sign the medication record you sign for having given the medication and have assured that it has been administered safely and according to the prescription — any exceptions to this need to be noted on the record.

The above situation would still be a significant departure from accepted practice — see appendix I of the

Medicines Management Guide for Community Residential and Facility-based Services — Disability, Mental Health and Addiction 2013
https://www.health.govt.nz/publication/medicines-management-guide-community-residential-and-facility-based-services-disability-mental

I wonder if the nurses involved had regular in-service training on the organisation's medication management procedures and whether their competency was assessed. This is required by the above mentioned Medicine Management Guide.

What was the corrective action the nurse manager took after this issue had come to light?

Hilda Johnson-Bogaerts
Clinical Advisor — Aged Care
Office of the Health and Disability Commissioner"

RN Johnson-Bogaerts provided the following further expert advice on 4 September 2019:

> "I reviewed the response and here are amendments I would make having reviewed the additional information from the provider.
>
> The Pain Management Policy was provided and I am happy to change my recommendation that additional staff education be provided regarding pain assessment when complicated by high age, mental illness and dementia. I note that the provider's policy is comprehensive and based on good practice including assessing pain of residents who have sensory and cognitive impairment. With the provided additional information I am satisfied that adequate systems for pain assessment and management were in place.
>
> I note from the response from [Ms G] that 'there is no evidence on file of any training or competency assessment by [RN D] at [the rest home] in relation to medication management and administration'. It is accepted good practice to assess and document each new employee's medication management and administration competency before they commence doing medication rounds by themselves. The provided documentation shows that medication management is part of the mandatory training.
>
> A new question comes to mind here — Had the nurses who administered medication and were part of the mistakes in terms of signing where medication was not given all been assessed as competent to administer medication and follow the organisation's policy/procedures. In our conversation we were most concerned with the fact that medication was signed for as given when it was not etc. That there might be a systemic/staff culture issue.
>
> Hilda Johnson-Bogaerts
> **Clinical Advisor — Aged Care**
> **Office of the Health and Disability Commissioner**"

RN Johnson-Bogaerts provided the following further expert advice on 14 October 2019:

> "It is accepted practice that the care givers would do a pain assessment as part of the hourly rounding. As long as they escalate their findings to the registered nurse when pain is present.
>
> In [Mrs B's] case pain assessment would be complicated by her mental illness (Schizophrenic disorder and Senile Dementia) therefore it is good to see that caregivers looked at her comfort level as well as asking. Persons with advanced dementia experience and express pain differently and often by demonstrating behaviour that challenges and/or by increased confusion and/or restlessness.
>
> In addition it is good practice for care homes to use a standardised pain assessment tool adjusted for use with persons living with dementia (as for example the PAINAD tool) by which pain is scored as part of the regular nursing assessments, providing information for the completion of interRAI assessments and as a basis for care planning. Ongoing on the job training would include pain assessment as part of

nursing observation skills training and instructions on the use of the care home's standardised pain assessment tool/process.

This also leaves the question if the caregivers who performed the pain assessments as part of the regular rounding received pain assessment training.

Kind regards

Hilda Johnson-Bogaerts
Clinical Advisor — Aged Care
Office of the Health and Disability Commissioner"

RN Johnson-Bogaerts provided the following further expert advice on 27 November 2019:

"1. Thank you for the request that I provide additional clinical advice in relation to the complaint about the care provided by [the rest home]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have been asked to advise whether the significance of [RN D's] individual departure stood out from the other elements of the overall departure in medication management.

3. In conclusion and after reviewing the provider responses the element that stood out most as part of the overall departure in medication management is the element where management failed to assure that suitable trained and competent staff were available to provide safe medicine management as is a requirement by the Medicines Management Guide for Community Residential and Facility based services (MoH, 2013).

The registered nurses involved in the medication error were not assessed and signed off by the provider as being competent to administer medication and follow the organisation's Medication Management Procedure before giving medicines without supervision.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Aged Care Advisor
Health and Disability Commissioner"