Registered Nurse, Ms E

Registered Nurse, Ms F

General Practitioner, Dr J

Medical Practitioner, Dr I

A Rest Home

A Report by the

Deputy Health and Disability Commissioner

(Case 06HDC19526)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer (deceased)
Mrs B	Consumer's daughter
Mr C	Consumer's grandson/complainant
Ms D	Consumer's granddaughter
Ms E	Registered nurse/Rest home manager/ Provider
Ms F	Registered nurse/Hospital manager/ Provider
Ms G	Registered nurse
Ms H	Registered nurse
Dr I	The rest home company manager/Provider
Dr J	General practitioner/Provider
Dr K	Emergency department doctor
A rest home company	Rest home company
The rest home	Rest home
The hospital	Hospital
The public hospital	Public hospital
Hospital 2	Another rest home/hospital

Complaint

On 21 December 2006 the Commissioner received a complaint from Mr C about the services provided to his grandmother, Mrs A, by a rest home/hospital company (the Rest Home). The following issues were identified for investigation:

- *The appropriateness of the care the Rest Home manager, registered nurse Ms E, provided to Mrs A between 20 June 2006 and 28 July 2006.*

- *The appropriateness of the care the Hospital manager, registered nurse Ms F, provided to Mrs A between 29 July 2006 and 4 August 2006.*

- *The appropriateness of the care general practitioner Dr J provided to Mrs A between 20 June 2006 and 4 August 2006.*

- *The appropriateness of the care the Manager Dr I provided to Mrs A between 20 June 2006 and 4 August 2006.*

- *The appropriateness of the care the Rest Home provided to Mrs A between 20 June 2006 and 4 August 2006.*

An investigation was commenced on 9 February 2007.

Information reviewed

Information was received from:

- Mr C
- Ms E
- Ms F
- Ms H, registered nurse
- Dr I
- Dr J
- Manager of Hospital 2

Mrs A's Rest Home and Hospital 2 medical records, and the relevant Rest Home policies and procedures were reviewed.

Independent expert advice was obtained from general practitioner Dr Tessa Turnbull and a registered nurse specialising in aged care, Ms Jan Featherston. Additional advice was provided by the Commissioner's clinical advisor, Dr Stuart Tiller, a general practitioner.

Information gathered during investigation

The Rest Home/Hospital
The Rest Home/Hospital comprises the Rest Home, which accommodates 103 frail elderly residents, and the Hospital, which provides hospital level care for 54 patients. The Hospital also has a number of independent living units. The Hospital manager is Dr I, a registered medical practitioner. The rest home and the hospital each have a nurse manager. At the time of the events complained about, Ms F was the Hospital's nurse manager, and Ms E was the Rest Home's nurse manager. Ms F has since left the Hospital, and Ms E has been appointed the nurse manager of the Hospital.

Dr I advised that the Hospital was purchased in 2006 by a syndicate. Dr I is a part owner of the facility and responsible for the overall operational management of the business. She said that the regulations require a re-accreditation within six months of purchase by new owners. The Hospital passed the audit later that year and achieved the maximum accreditation period of one year (following purchase). The Hospital has subsequently been accredited for two years.

Dr I stated that as a general practitioner she is qualified to manage care facilities. However, at the Hospital, direct clinical oversight is the primary responsibility of the nurse managers and the general practitioner assigned to the residents. Dr I undertakes specific clinical oversight only on an "as required" basis when there is an issue of attendance by the general practitioner. This action is taken with the GP's consent.

Dr J stated that she became the "house doctor" at the Hospital in September 2003. She visited twice a week and was available at other times, by request. Patients unable to continue with their previous GP were offered the option of having her take over their care.

Mrs A

On 22 January 2004, Mrs A, aged 92 years, was assessed by the District Health Board Needs Coordinator. At this time Mrs A was living in one of the Hospital's independent living units. The assessment was carried out in response to a formal request, dated 23 September 2003, from an enrolled nurse in the Hospital, who was concerned about Mrs A's ability to continue to care for herself. The Needs Coordinator found Mrs A to be Support Needs Level (SNL) 4, requiring rest home level care for assistance with daily living needs such as showering, toileting, dressing and medication supervision. She was suffering from severe short-term memory loss and confusion and was exhibiting signs of "sundowner syndrome". This syndrome is characterised by increased agitation and confusion in the late afternoon and evening. In addition, Mrs A suffered from the eye conditions of glaucoma and macular degeneration, congestive heart failure with associated swelling of her legs, moderate hearing loss, urinary incontinence and skin lesions.

The Needs Coordinator arranged for a community nursing service to provide Mrs A with five hours per week of personal care. The Rest Home was asked to conduct a continence assessment and to have Mrs A's hearing reassessed. The rest home was also asked to provide her with assistance with meals, household tasks and medication supervision. The plan was to reassess Mrs A in January 2005, or sooner if it was thought that additional support was required.

On 10 August 2004 the Hospital medical officer was asked to review Mrs A because she had a urinary tract infection and her dementia had increased. He met Mrs A's daughter, Mrs B, to discuss reassessing her mother with a view to moving her to a rest home. Mrs B expressed concern about moving her mother to unfamiliar surroundings. However, on 28 August 2004 Mrs A was transferred from her independent living unit to the Rest Home. Dr J, general practitioner, took over responsibility for Mrs A's care in February 2006.

Care planning and documentation

Multi-disciplinary meetings were held at the Rest Home regarding Mrs A's care — the first was on 30 September 2003 when Mrs A was still in the independent unit and her care requirements were minimal.

A long-term care plan recorded for Mrs A on 26 March 2004 covered such matters as showering and eye drops, and her nutritional, physiotherapy and diversional therapy requirements. The documentation for that plan reflects the information recorded at a multi-disciplinary meeting on that day. Mrs A still required minimal support care at that time.

Dr I said that the function of the multi-disciplinary meetings was to review the care plans. There were only two further meetings (interdisciplinary review meetings) relating to Mrs A's care — on 17 October 2005 and 13 April 2006. The information recorded at the last meeting on 13 April 2006 was scant. It does not show who was present at the meeting and, apart from recording that Mrs A was on the diuretic frusemide, provides no information about her condition or management. The meeting records headed, "Current Care Plan", note:

> "Medical ankles swollen sometimes — on frusemide regularly — legs put on chair. Seen Dr 3/12, 12 Oct 05.
>
> Relsenjoys rels [relatives] coming in, copes only with 1 person
>
> Cognitive."

A short-term care plan was documented on 21 March 2006 to address the management of a urinary tract infection. There is no recorded outcome to indicate whether the treatment plan was effective.

A routine weekly record was kept of the number of times Mrs A's bowels opened. There were also a number of forms recording injury/wound management.

It appears that the daily progress notes were used to instruct staff on care. For example, on 15 May the enrolled nurse recorded, "To try Codeine Phos. 15mg i mane [one in morning] to see if this helps with the pain. … [C]heck that [Mrs A's] bowels are moving regularly and mobilise as able." On 25 May 2006 a note states, "S/B [seen by] Dr J — Trial over the next week regular Codeine 15mg. Break lunch, tea, bed & document any change in [Mrs A's] pain." There was no chart to document or monitor Mrs A's pain.

June 2006

On 20 June 2006, Mrs B and her son, Mr C, a registered nurse, met with the Rest Home nurse manager, Ms E. Mr and Mrs B had been concerned for some weeks that Mrs A's condition was deteriorating and they asked for the meeting to discuss whether the level of care that was being provided by the Rest Home was appropriate to her needs. Of particular concern to Mr C was the management of his grandmother's bowels. Constipation was a significant problem for Mrs A at this time. Mrs B had been present when a manual evacuation of Mrs A's bowel had been conducted. The procedure was painful and distressing for Mrs A.

Mr C and his mother were concerned that Ms E appeared to be new to the position of nurse manager, was not familiar with Mrs A's management issues, and was unprepared for the meeting.

Ms E graduated as a registered nurse in 2004. She was employed by the Hospital on 19 August 2005 and appointed Nurse Manager of the Rest Home on 27 April 2006.

Ms E informed the family that Mrs A did not need two staff to provide her care and therefore did not require hospital level care. She stated that there would be little point in a reassessment at that time.

Ms E undertook to discuss the issues raised at the meeting — the management of Mrs A's constipation, pain and incontinence — with the rest home medical officer, Dr J, when she was next at the home. Ms E informed Mr and Mrs B that she would also develop a care plan for Mrs A, to address these matters.

Ms E stated:

> "As a newly appointed manager to the rest home, I was still unfamiliar with all of the residents and was therefore unable to answer all questions about the individual care of [Mrs A].
>
> I did obtain the resident file and attempt to give feedback according to these in response to the questions and concerns they raised. As I did not have the medication chart at hand I said I would review this with [Dr J] on her next visit. Unfortunately I did not document the details of the conversation. …
>
> [Mr C] and his mother [Mrs B] raised concerns around [Mrs A's] confusion, her decreasing eyesight, her constipation and her increase in care needs. I discussed that due to the confusion secondary to severe dementia that there may come a time where she may be assessed for dementia care but this was not something we felt was needed at this time as her safety in the facility was not undermined.
>
> I do not recall discussing bladder continence during this meeting. However, it was my understanding that [Mrs A] was and had been using incontinence products for some time. … I followed up on [their] concerns with [Dr J] on her next visit, advising [Dr J] of the concerns both [Mr C] and [Mrs B] had mentioned to me, these being her continuing constipation, her increased confusion and the possibility of her being referred to an eye clinic for reassessment of her vision.
>
> I also went over the scripting of both pain medication and constipation interventions, and noted that [Mrs A] was on regular QID [four times daily] Panadol and both Codeine and Laxsol had been scripted PRN [as required] since May 06. This discussion resulted in an increased dose [sic] of PRN Codeine to allow for better management of [Mrs A's] pain and regular Laxsol administration.
>
> I did not adjust the care plan specifically to these but did ensure that staff [were] aware of the need to utilise the PRN medication as scripted, and maintain regular checks of bowel cares. I also encouraged fluid intake."

There is no documentation by Ms E in the clinical records regarding these matters.

Mr C stated that Ms E "undertook to get back to [Mrs B] with an overview of the proposed plan. This did not happen."

Dr I stated that during the period from late June to mid-July 2006, the Hospital experienced an outbreak of Norovirus. The outbreak progressed over three weeks and affected staff and residents in all areas of the facility. In total, 23 staff and 79 residents suffered vomiting and diarrhoea. Dr I stated that staffing levels were stretched during this time for the following reasons:

> "The number of residents requiring high level care levels and in particular treatment for dehydration (most treated with oral fluids (gastrolyte)).
>
> Bureau agencies refused to provide carers due to the risk of transmitting the virus to other facilities.
>
> Both Nurse Managers succumbed to the virus making the care planning difficult.
>
> [The] Public Hospital refused to accept some residents due to the risk of outbreak and expected these residents to be managed in our setting."

Ms E advised that due to the outbreak of the Norovirus, which she contracted herself, she failed to provide feedback to Mrs B about her discussion with Dr J and the staff.

As a result of the discussions between Mr and Mrs B and Ms E, Dr J visited Mrs A on 22 June 2006. The focus of the consultation was Mrs A's pain and constipation. Dr J noted that the Codeine was constipating Mrs A and, despite taking Laxsol regularly for two weeks, there was "VERY LITTLE recorded in the bowel book". There were entries in the progress notes from enrolled nurses instructing staff to "check that [Mrs A's] bowels are moving regularly" and "encourage a high fibre diet, try giving Kiwifruit".

Mrs A informed Dr J that she had no complaints and her legs were "fine at the moment". She also informed Dr J that her bowels were "pretty good". Dr J noted, "Probably doesn't go every day." Dr J recorded that Mrs A had skin lesions on her left lower leg and that she would refer her to the Plastics Clinic for assessment of the lesions. Dr J also asked the nursing staff to continue to give codeine to Mrs A.

July 2006
Dr J saw Mrs A again on 11 and 21 July to check her bowel management and a report of a sore throat.

On the morning of 27 July, Dr J was asked to review Mrs A because of concern about an increase in her agitation and a reluctance to eat. Dr J noted that Mrs A had lost 4kg since the last time she was weighed on 4 June 2006. Her blood pressure was low at 90/60 and her ankles were oedematous (swollen). Dr J stated that as a result of this

examination she decided that Mrs A needed more intensive care than could be provided in the rest home environment, and referred her for a reassessment.

Dr J's referral letter to the DHB health service for elderly people, dated 27 July, provided a brief outline of Mrs A's condition, which included progressive dementia, treated glaucoma, heart murmur and oedema of her feet. Dr J noted that Mrs A had been commenced on the anti-psychotic quetiapine in March 2006 by a geriatrician, which was "some help", but her condition had deteriorated and it was felt that she "now needs hospital level care".

At about 5.15pm on 28 July 2006, Mrs B was advised that her mother was being transferred to the public hospital by ambulance because of concerns about her food and fluid intake over the preceding week. Mr and Mrs B drove to the rest home so that Mrs B could accompany her mother in the ambulance. Mr C was concerned that no details of his grandmother's medical history or the reason for her transfer were communicated to public hospital staff.

Dr J said that Dr I telephoned her towards the end of her afternoon surgery session on 28 July, to ask her to visit Mrs A. Dr J was unable to recall the exact time of this call. She received a second call shortly after this advising that Mrs A was about to be transferred to the public hospital.

Dr I stated that the nursing staff asked her to review Mrs A at around 5.30pm that day because they were concerned about Mrs A's condition and Dr J was unavailable. Dr I examined Mrs A and referred her to hospital for investigation of possible bowel obstruction and treatment of dehydration. Dr I stated:

> "I note that [Mr C] … suggests that no note of transfer was written. It is my practice to always complete a note for the referral. In the particular case I completed a detailed hand written note for the emergency department and spoke to the registrar over the telephone prior to [Mrs A] being transferred. I gave the note to the carer responsible for her care, to transport with the resident. It is unclear to me why this was not received by the hospital. To my knowledge it is not common practice to retain copies of referral notes."

The Public Hospital

Mrs A was admitted to the public hospital Emergency Department at 6.51pm and examined by Dr K. Dr K found that she had a distended and tender abdomen and signs of dehydration. An abdominal X-ray revealed faecal loading throughout the large intestine and a calcified abdominal aortic aneurysm.

Mr C stated that Dr K was of the opinion that Mrs A could be managed adequately by the Rest Home staff and Dr J, and that her admission to hospital was "not feasible or required in the circumstances".

Dr K telephoned the Rest Home to advise the staff of his decision to discharge Mrs A back to the Hospital, and of his treatment plan for her. He wrote a discharge summary advising that Mrs A had a lower bowel impaction. The discharge summary also noted the results of the abdominal X-ray and that Mrs A needed rehydration. Dr K recorded, "IV line left in for you", and recommended that Mrs A be given enemas until her bowel was clear and "perhaps" a manual disimpaction. He suggested that Mrs A be given codeine 60mg before the manual disimpaction, and that this should be undertaken the following morning with GP supervision. Dr K stated that Mrs A had been given two Fleet enemas and glycerol suppositories at the public hospital, and it had been noted that she had anal fissures. He recommended that the Hospital staff consider applying Xylocaine gel prior to any further bowel treatments.

The Hospital
Mrs A returned to the Hospital and was admitted at 12.30am on 29 July by registered nurse Ms G. Mr C stated that Ms G did not appear to be familiar with the process of administering intravenous fluids.

Ms G initially questioned Mr C about continuation of the intravenous fluids, as she assumed that the fluids would have been given at the hospital. Mr C confirmed that no treatment had been provided to his grandmother at the public hospital.

Dr I stated that it was unusual for the public hospital not to undertake Mrs A's rehydration. She understood that at the time of Mrs A's admission, the public hospital was "gridlocked". Dr I stated that it is not standard practice for intravenous fluids to be provided in the aged care situation.

Ms G reviewed the discharge notes to identify the type of fluid and treatment regime, but found that Dr K's letter was not clear about the quantity and rate of fluids required to rehydrate Mrs A. She inspected the intravenous site and advised Mr C that she was not familiar with the type of luer bung inserted by the public hospital staff. Ms G obtained two 500ml bags of normal saline. As Mr C was familiar with the luer he assisted in connecting the intravenous line to a 500ml bag of saline and provided some information to Ms G about intravenous fluids.

The nursing notes record the commencement of the intravenous fluids and that Mrs A was to have two litres of normal saline, one litre to run over eight hours at 42 drops per minute. Ms G instructed the nursing staff to follow the treatment plan in Dr K's letter, and said that she had given Mrs A an enema at 1.20am to soften the faecal impaction. Ms G noted that Mrs A required a further softening enema in the morning prior to the manual evacuation, and that Dr J was to be informed of events and the treatment plan.

The nursing notes for 29 July record that as per Dr K's instructions, Mrs A was given the prescribed pain relief, codeine, prior to a manual removal being performed. The procedure was distressing for Mrs A but it appeared to clear her rectum of impacted faeces.

Fluid replacement

Mr C complained that his grandmother "went without IV or Subcut fluid for at least 24 hours because the hospital did not have the stocks of IV fluids or IV tubing and could not obtain them".

At 10am on 30 July, Mrs A's intravenous line site "tissued".[1] Dr J was notified and ordered that the line be discontinued and subcutaneous administration commenced. Registered nurse Ms H stated that as she was not certificated to perform intravenous therapy, one of the other registered nurses on duty removed the line and introduced a subcutaneous giving set. Ms H stated that it took some time to locate additional intravenous fluids, and these were located only after she called the on-call manager three times.

It appears from the nursing notes that Mrs A's subcutaneous fluids finished some time during the night of 1 to 2 August and were not recommenced until 9.50pm on 2 August.

The Hospital manager, registered nurse Ms F, stated that the fluids were in a locked cupboard in her office. The registered nurses did not have access to the cupboard. She said:

> "There are emergency fluids located in the downstairs part [of the Hospital] which were used. This was then changed after this particular event. The RNs now have a key to my office so can access any fluids/dressings/extra requirements after hours, or whenever they are required."

Dr I stated that there were no suitably trained staff on duty at the Hospital when Mrs A's intravenous line "tissued". Therefore it was necessary for the staff to obtain permission from Dr J for the method of administering the replacement fluids to be changed to subcutaneous.

Dr I advised that the Hospital undertakes a monthly stocktake of all medical supplies with orders placed at the beginning of the month depending on use. The Hospital's nurse manager is responsible for ordering and monitoring the medical supplies for general and emergency consumption. The stocktake and order form for July 2006 indicate that 10 bags of normal saline 500ml were ordered at the beginning of July. Dr I stated that as a result of the Norovirus outbreak, a number of the patients and residents at the Hospital had required fluid replacement therapy, with the result that most of the normal saline that had been ordered for July 2006 had been used.

[1] When the fluid being administered leaks from the vein into the surrounding tissues.

Pressure area care
Mr C stated that despite Mrs A being at high risk of developing pressure sores, she was frequently not turned two-hourly and, on one occasion, went for eight hours without being turned.

The nursing notes for 29 July record that Mrs A was turned at "regular intervals". However, the Hospital did not provide any documentation that showed that Mrs A's risk of developing pressure areas had been assessed, or a care plan that instructed staff to turn her two-hourly, or a chart that recorded the number of times she was turned.

Quality of care
On 31 July Mr and Mrs B met with Ms F to express their concerns about the quality of care being provided to Mrs A by the Hospital staff. They discussed their concerns about the lack of intravenous equipment, and the training of one of the staff in relation to intravenous fluid management and other staff in relation to pressure area prevention. Mr C discussed his primary concerns — Mrs A's comfort and hydration and her bowel management. He provided research papers to assist the nursing staff in his grandmother's bowel management and clearly communicated his opinions about Mrs A's care requirements.

Despite this discussion, Mr C believed the quality of the care did not improve. He stated:

> "[Mrs A] continued to be in considerable pain and became quite anxious, she was particularly distressed screaming out when being turned. … There continued to be problems with inadequate subcutaneous hydration and family members often had to request that [Mrs A] be turned."

Ms H stated that the analgesic prescribed for Mrs A, codeine phosphate 30mg, was charted per oral route. However, Mrs A was unable to take her medications orally, even when crushed and added to yoghurt or thickened fluids. Ms H stated that after a number of failed attempts to administer the pain relief to Mrs A she telephoned Dr J for advice. Dr J instructed Ms H to contact the after-hours medical service. Ms H contacted the after-hours medical clinic and a doctor visited at 4.45pm. He prescribed morphine sulphate 10mg twice daily and morphine elixir 5mg in one millilitre PRN. A further Microlax enema was given with no result.

The following day the staff continued with the morphine and intravenous fluids. Dr J visited to assess Mrs A, and ordered antibiotics and Buscopan (an antispasmodic) to be administered subcutaneously. The Buscopan appeared to provide relief to Mrs A until 1pm, when she became agitated and pulled out the subcutaneous line. Dr J advised that she would visit Mrs A again the next day.

On 1 August, Mr C contacted a palliative care educator to discuss arranging a transfer to palliative care for his grandmother. She advised that a referral from a general practitioner was required.

On the morning of 2 August the nursing notes indicate that Mrs A was continuing to have difficulty in swallowing her medications. The nurses were reluctant to push her to take her medication, mindful that her painful throat was making swallowing difficult. Mrs A was able to take the morphine elixir.

Ms F stated that she discussed with Dr J the possibility of starting Mrs A on a morphine infusion via a Graseby pump. Ms F believed that this would be the best way of managing Mrs A's pain and anxiety. Dr J did not agree with Ms F's suggestion.

Mr C stated that while he was sitting with his grandmother at the Hospital, he observed a pulsation on the right side of her abdomen. He felt her abdomen and believed that the aortic aneurysm identified on the abdominal X-ray taken at the public hospital on 28 July was dissecting. Mr C informed the registered nurse on duty and alerted his family so that they could come in to be with Mrs A.

On 2 August, Mr C spoke with Dr J about his concerns. Dr J was of the opinion that Mrs A did not require palliative care at that time. Dr J advised Mr C that it was common to feel a pulsating abdominal aorta in thin elderly patients, and she did not consider that Mrs A's condition was terminal. Mr C contacted the community gerontology assessment team to ask how quickly Mrs A could be reassessed so that she could be transferred. An appointment was made for a registered nurse from the assessment team to assess Mrs A at 11.30am on 4 August.

Dr J stated:

> "When I saw [Mrs A] on 3.8.06 she was more alert, but not keen on drinking. She continued to be able to take oral medication. Her grandson, [Mr C], a tutor in nursing at [a tertiary institution], indicated her pulsatile aorta which was visible on observation of her abdomen. …
>
> [Mr C] also enquired about her prognosis. I indicated that her condition required day to day assessment; that her outcome was uncertain, but it had not yet 'declared itself' as being terminal.
>
> I believed there was a significant chance that [Mrs A] may recover from this condition, and indicated this, and that she should be treated expectantly. She had not reached a condition where 'death appeared inevitable'.
>
> I indicated that if she progressed to a stage where she could not take oral medication, that we would substitute medication via subcutaneous pump; should that situation occur, she would have entered an irreversible phase of her condition.
>
> I planned to visit her and reassess her condition on 4.8.06."

When the registered nurse from the assessment team saw Mrs A on 4 August, she advised Mr C that she would facilitate a transfer for his grandmother. Mr and Mrs B

had already chosen Hospital 2 as the facility they wished Mrs A to be transferred to. Mrs A was transferred there by ambulance later that day.

Ms F contacted Dr J to tell her that Mrs A was transferring.

Dr J stated:

> "I am devastated that [Mrs A's] family regarded the care I provided so poorly and have tried to provide as high a level of care as possible to all of my patients."

Ms F
Ms F stated:

> "[Mrs A's] situation was very difficult to manage from my perspective. When I met [Mr C] at [the Hospital], he was already very upset and rightly so. I feel [I] did my best to give [Mrs A] the best for her — although her outcome/prognosis was not good. I aim in every resident's case to be the patient/resident's advocate — and I did try to do this for [Mrs A].
>
> Changes were made as a result of the incidents set out to do with [the Hospital], directly due to [Mrs A] and the handling of this situation. The changes that were made were in place until I left my manager's position, Oct 2006. …
>
> I would like to offer a personal apology to [Mr C] and his family if they feel [s]he was failed by us."

Ms E
Ms E stated:

> "I do believe I failed to feedback to [Mrs B] of my discussion with the doctor and staff of their concerns. As I did not treat this as a formal complaint and document the process, I did not respond in writing to either [Mr or Mrs B]. I do believe that the staff did the best to their ability during this stressful time."

Hospital 2
Mrs A's condition was assessed on admission to Hospital 2. The treatment plan was to provide her with comfort care. The rehydration fluids were continued and she was prescribed morphine elixir 2.5 to 5ml PRN to four-hourly.

On 6 August Mrs A was reviewed and started on morphine 20mg with haloperidol 1mg (to control agitation) over 24 hours via a Graseby pump. Mrs A died a short time later.

Other issues

Lack of respect
Mr C complained that on one occasion when he and his family were waiting outside Mrs A's room for staff to complete her cares, a nurse entered the room and was overheard laughing and joking that Mrs A's screams could be heard at the other end of the ward. He said that the family were distressed by this nurse's response to Mrs A's pain.

Ms F stated that throughout the time Mrs A was at the Hospital, staff worked hard to build up communication and a rapport with Mrs A and her family. She stated that this proved difficult.

Dr I stated:

> "We believe that [Mr C], being a registered nurse himself, may have had unreasonably high expectations given the setting of care and common practice for the industry. … Other than the informal meeting with [Ms E], we do not believe we were given adequate opportunity to address any concerns raised by [Mr C] at the time and had he come forth we may have been able to resolve these issues."

Face masks
Mr C also complained about the unavailability of face masks at the Hospital. When one of Mrs A's granddaughters, visited her grandmother at the Hospital she asked for a face mask because she had a respiratory infection and did not want to infect Mrs A. Ms C was told that there were no face masks available.

Ms H stated:

> "I checked the usual places [for face masks], and asked the carers if they had any knowledge of where the face masks were. I checked downstairs in two wings and could not find any face masks. I went upstairs and told [Mr C] and other visitors I could not find any."

Ms H thought that the reason she was unable to locate any face masks may have been that they had run out as a result of the Norovirus outbreak.

Additional information

A number of policies relating to documentation were created in 2006 and are relevant to the period covered by the complaint.

The Hospital policies — admission policy
The Admission Policy dated 17 March 2006 stated that when admitting a resident/patient the nurse manager or registered or enrolled nurse must:

> "Fully complete the Admission check list (this must be completed within 72 hours of admission with the exception of the Long Term Care plan, which must be completed within three weeks)."

Resident record management
In March 2006 the Hospital created a policy regarding resident record management. The purpose of the policy was to promote an "efficient and effective delivery of treatment" to residents via an "accurate and confidential record". The policy stated:

> "Progress notes must be written at least once per 24 hours (once a day). In addition the following entries must be made:
>
> — Whenever the resident's condition changes (and if so what action has been taken i.e., medical services called, requests for assessment etc)
> — When there is any incident or accident
> — When family speak specifically to staff
> — Any concern, or any other interaction of note
> — Medication changes
> — Allied health professional discussions."

Multi-disciplinary meetings policy
A policy relating to the management of multi-disciplinary meetings was issued on July 2006. The policy stated:

> "[The Hospital] ensures review and evaluations of each resident's plan of care is completed at least 6 monthly, this process is carried out through multi-disciplinary meetings.
>
> Minutes of these meetings are documented and held in the resident's care plan.
>
> Changes in a resident's health status, as a result of the multi-disciplinary meeting, will be implemented on the resident's care plan by the RN/EN and appropriate staff notified of the changes.
>
> **Procedures**
> 1. A multi-disciplinary meeting will be held for every resident at least 6 monthly, more frequent reviews and evaluations will be carried out by the Registered Nurse/Enrolled Nurse as changes to resident's needs dictate."

Pain management
In May 2003, the Hospital issued a policy on pain management. The policy stated that a multi-disciplinary consultative approach to pain management "shall be taken", which may include the family. Pain was described as "Acute pain (transient) … an alarm for immediate attention, eg after a fracture" or "Chronic Pain (persistent) … usually poorly localised and leads to changes in lifestyle, depression, weight loss/gain, fatigue, inability to manage activities of daily living".

The policy stated that an assessment of the pain should be conducted, taking into consideration factors such as disease process and anxiety. The assessment was to be documented in the initial health assessment, the care plan and the medical and nursing notes. The policy stated that a pain assessment chart recording the sites of individual pain(s) and severity "is a useful means of analysing pain because it is visual". The policy outlined the processes for evaluation, observation, and management of pain, including the role of medication in pain control, stating:

> "The analgesic ladder provides a logical sequence for the use of analgesics and adjunctive therapies beginning with the non-opioid analgesics and moving in a stepwise fashion as disease progresses. If analgesia fails to relieve pain when other factors have been dealt with eg, anxiety, it is important to go to the next step on the ladder."

Continence management policy
In May 2005 the Hospital issued a policy on the management of continence. The policy covered constipation as well as urinary incontinence and diarrhoea, and instructed staff on the management of constipation as follows:

> "Signs and symptoms of constipation may include:
> - Lack of bowel movements — refer to documented bowel output but no movement for four days requires monitoring and assessment
> - Abdominal bloating and discomfort
> - Frequent small bowel motions and faecal leaking
> - Hard faeces
>
> Things we can do to prevent constipation include:
> - Encourage residents to exercise daily
> - Maintain or increase fluid intake
> - Maintain or increase fruit and vegetables and high fibre diet
> - Work with natural remedies eg. prunes, bran but if not successful use laxatives which promote natural bowel function eg. lactulose
> - Allow sufficient time for bowel to empty when on the toilet
> - Plan toileting regimes around resident's usual routine ie: allowing time on the toilet after breakfast
> - Ensure correct positioning on the toilet to facilitate passing of bowel motion."

Job descriptions
The Hospital's job description for the rest home nurse manager states:

> "**Position Purpose**
> To provide motivated leadership to ensure competent and consistent delivery of resident care and services.
>
> **Main Objectives**
> To ensure resident care is maintained at optimal levels that promote the resident's rights and quality of life. …
>
> **Key Tasks/Accountabilities/Performance Indicators**
> *Clinical Oversight* Is responsible for maintaining high quality care in areas.
> *Documentatio*n Ensures all documentation required for resident care is complete and updated at all times to a standard that will meet audit requirements."

The job description for the hospital nurse manager states:

> "**Position Purpose**
> To provide motivated leadership to ensure competent and consistent delivery of resident care and services.
>
> **Main Objectives**
> - To ensure resident care is maintained at optimal levels that promotes the resident's rights and quality of life. …
> - To ensure standards of care and documentation comply with accreditation standards and the mission statement of [the Hospital]."
>
> **Key Tasks/Accountabilities/Performance Indicators**
> *Clinical Oversight* Is responsible for maintaining high quality care in areas.
> *Documentatio*n Ensures all documentation required for resident care is complete and updated at all times to a standard that will meet audit requirements."

Independent expert advice

Dr Tessa Turnbull's advice is attached as **Appendix 1** and Ms Jan Featherston's advice is attached as **Appendix 2**.

Responses to Provisional Opinion

Ms F
Ms F stated that the provisional report was "comprehensive and covered well the issues as they happened". She said that the "lack of support" was one of the factors in her resignation in October 2006. Ms F advised that she has reviewed her practice in light of this report. She is now part of a supportive team of nurses at the public hospital. Ms F provided a written apology to Mrs A's family.

Ms E
Ms E advised that she accepts the provisional opinion, and she outlined the corrective actions she has taken in response to the recommendations made in this report. She stated:

> "I personally have undergone training in both clinical and management areas. A list of these can be provided if needed.
>
> In summary, I have taken this complaint very seriously and believe that the training I have received along with the experience and changes that have taken place here at [the Hospital] over the past year, will all alleviate the chance of such incidents occurring again in future."

Ms E provided a written apology to Mrs A's family.

The Hospital
Dr I stated that the Hospital accepts the findings of the provisional opinion. She advised that currently, the Hospital's "organizational framework is fully implemented and that we provide high quality care to residents". Dr I stated that the Hospital has taken corrective actions as a result of this complaint. The corrective actions taken are:

- The Continence Policy and Bowel Chart have been refocused on proactive management of constipation. Individual bowel charts are signed off weekly by the charge nurse for each area, who address any issues identified.

- Staff training has been introduced for staff in relation to the monitoring and management of independently toileting residents with significant dementia.

- Menus are being reviewed. A dietician provides 18-monthly advice on the Hospital menu and supplement requirements. Any resident experiencing a greater than 2.5kg weight change in a month now has a medical review.

- Additional IV fluids are held onsite to cover emergencies.

- Charge nurses and registered nurses have been reminded of the [Hospital] policy to notify families of changes in a resident's condition and to include families in the regular care plan review meetings.

- An End of Life Care Plan has been designed to trigger greater staff awareness when residents are reaching the terminal phase.

- All unwell residents are discussed at the weekly charge nurse meetings with a view to assessment issues and care planning.

- The Graseby Policy has been updated and two of the current charge nurses are IV certificated. Training is to be introduced for staff in the management and oversight of IV fluids.

- A new policy has been written for subcutaneous fluid administration, and draft policies for oral hydration are underway.

- The pain management, palliative care, infection control and continence policies have been reviewed.

Dr I stated: "[The Hospital] has taken this complaint very seriously and I believe that these changes have mitigated the chance of such incidents occurring again in future."

Mr C
Mr C stated:

> "Overall I accept and support your opinions, proposed recommendations and proposed follow-up actions as stated in your provisional report. Your opinions, recommendations and follow-up actions go a long way to addressing my original reasons for, and expectations of, referring this complaint to the Health and Disability Commissioner. …
>
> The one significant area of your provisional opinion that does not meet my expectations relates to the recommendations to [Dr J]. It is my opinion that a recommendation relating to undertaking further education in palliative care, the management and evaluation of pain, constipation and heart failure is warranted and desirable to help prevent similar situations arising for other residents and patients. …
>
> The Medical Council's 'Good medical practice — A guide for doctors' requires 'an adequate assessment of the patient's condition based on the history

> and clinical signs and an appropriate examination' (p.3). There are a number of areas where in my opinion [Dr J's] assessment was less than adequate. Furthermore, although the Medical Council's 'Good medical practice — A guide for doctors' does not state anything about evaluating treatments, the Nursing Council competencies for nurse practitioners seeking prescribing rights expects nurse practitioners to evaluate the effectiveness of the client's response to prescribed medications and monitor decisions about prescribing, take remedial action and or refer accordingly. It is hard to believe the Medical Council does not similarly expect doctors to assess and evaluate the intended effects and side effects of medications they prescribe.
>
> While [Dr J's] prescription of Frusemide (a diuretic) might have been fine, her evaluation of its effect and side effect could have been improved. Side effects of Frusemide include dehydration and hypotension (low blood pressure) both of which [Mrs A] had when she was transferred to [the public hospital] on 28 July 2006. In addition it should be noted that dehydration can lead to constipation which was the reason for [Mrs A's] admission to [the public hospital] on 28 July 2006. There is no evidence that [Dr J] monitored [Mrs A's] blood pressure between 25/04/06 when she increased the dose of Frusemide to 120mg and the 28 July 2006 when [Mrs A] was admitted to [the public hospital] with dehydration and hypotension. The desired effect of Frusemide is to relieve symptoms of heart failure such as peripheral oedema by reducing fluid overload. The reduction in fluid is best measured by monitoring the patient's weight. … There is no evidence [Mrs A's] weight was monitored by [Dr J] as [Mrs A's] weight was not recorded at all in May or June."

Dr Turnbull

Dr Turnbull was asked to review her advice in light of Mr C's above comments. Dr Turnbull stated:

> "Thanks for the copy of the provisional report which I think is extremely fair and reflects very adequately the complaint and the resolution.
>
> [Mr C] makes some comments regarding [Dr J].
>
> The [Deputy] Commissioner has asked [Dr J] to review her practice in the light of the report. [Mr C] mentions further education specifically in palliative care, constipation, pain management and heart failure as these were highlighted in the case. Care of the elderly involves many more areas than this and I would expect [Dr J] to wisely reflect on the Commissioner's directive and seek out professional development activities to complement her care of the elderly in rest homes and private hospitals.
>
> [Mr C] comments that the Medical Council do not specify that Drs need to assess and evaluate the intended effects and side effects of medication. This is

the heart of what we do every day and does not need to be specified [a]s it is inherent in our daily work."

Dr Tiller

In light of Mr C's questions in response to the provisional opinion, the Commissioner's clinical general practice advisor, Dr Stuart Tiller, was asked to review the file, Dr J's clinical records and Mr C's response to the provisional opinion. On 18 October 2007, Dr Tiller advised the following:

"On 27/7/06 [Dr J] noted a further 4kgs weight loss in the three months since April. There was by this time documented loss of 7kgs over the preceding 6 months. I would deduce that [Mrs A] was now approximately 51kg in weight. She would have looked wasted and thin. …

[Dr J] did examine the heart and chest, pulse and blood pressure. She did not examine the abdomen for signs of a mass to suggest a bowel or other cancer to explain the weight loss. She did not obtain a dietary history from the nursing staff or suggest a dietician's assessment of the nutritional intake of [Mrs A].

On 27/7/06 the only documented examination was of the pulse, blood pressure and ankles for oedema.

It is my view that blood tests should have been ordered on both occasions to investigate for weight loss and peripheral oedema of uncertain origin.

No blood tests were ordered or faecal occult blood tests.

… Throughout the period between February and August 2006 [Dr J] has only documented chest examination on the two consecutive days of 27 and 28/7/06. And yet throughout this time frusemide for fluid excretion was increased from 40mg daily to 120mg daily. This could not only lower blood pressure, which was low already on 40mg of frusemide daily, but also create dehydration and impairment of renal function.

… It is my view that mandatory monitoring of renal function and blood pressure should have been ordered by [Dr J] after she increased the frusemide dose to 120mg. Further, it is my view, that [Dr J] was treating the ankle oedema symptomatically and did not make a diagnosis as to the cause of the oedema.

… On 27/7/06 when [Mrs A] was 'struggling to eat' and had been placed on a puréed food diet, another opportunity for rectal examination was present but not taken by [Dr J]. [Dr J] has said that [Mrs A] refused to lie on her bed that day. On 28/7/06 when the situation was deteriorating and the abdomen was tense and firm and generally tender, a rectal examination should have been undertaken. …

In summary, Dr Tiller advised:

> "It is my view that the care provided by [Dr J] would be viewed by peers as moderately below an acceptable standard for a doctor working in primary care and in a rest home setting."

Dr J
Dr J did not respond to the provisional opinion. On 18 October 2007, she was provided with a copy of Dr Tiller's advice and was invited to respond. Despite repeated follow-up, Dr J has not responded to the provisional opinion or Dr Tiller's advice.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

RIGHT 5
Right to Effective Communication

…

(2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

Other Relevant Standards

The Medical Council of New Zealand's "Good medical practice — A guide for doctors" (2004) states:

> "**Medical care**
>
> Good clinical care
>
> 2. Good clinical care must include:
>
> …
>
> Taking suitable and prompt action when necessary."

The Nursing Council of New Zealand's "Competencies for registered nurse scope of practice", approved by the Nursing Council of New Zealand in February 2002 (and renamed in September 2004) states:

> "**4.01 Management of Nursing Care**
>
> The applicant manages nursing care in a manner that is responsive to the client's needs, and which is supported by nursing knowledge, research and reflective practice.
>
> **Generic Performance Criteria**
>
> The applicant:
>
> 2.1 Uses an appropriate nursing framework to assess and determine client health status and the outcomes of nursing intervention.
>
> …
>
> 4.4. Assesses and provides individualised nursing care based on appropriate knowledge, research and reflective practice. …
>
> 4.6. Prioritises nursing actions to ensure effective and safe nursing care."

The New Zealand Health & Disability Sector Standards (NZS 8134: 2001) published by the Ministry of Health state:

> "Part 2 Organisational Management …
>
> Quality and Risk Management Systems …
>
> Standard 2.7 Consumers/kiritaki receive timely, appropriate and safe service from suitably qualified/skilled and/or experienced service providers.

…

C2.7.3 This may be achieved by but not limited to:

Ensuring appropriately qualified/skilled service providers are available to provide the service where professional expertise is required;

a) Ensuring service provision reflects an appropriate skill mix combining both knowledge and experience;
b) Ensuring adequate and appropriate supervision/support is provide when required;
c) Ensuring suitably experienced service providers are available to provide the service."

Opinion

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

Overview
Mr C and his mother believe that Mrs A did not receive an appropriate standard of care from Dr J, the Rest Home and the Hospital between 20 June and 4 August 2006, and that Mrs A's right to effective communication was breached.

Mrs A was entitled to have services provided with reasonable care and skill, and that complied with relevant standards. The advice I have received from independent experts in aged care services, Dr Tessa Turnbull and registered nurse Jan Featherston, and from Dr Tiller, supports Mr and Mrs B's complaint that this was not always the case. I agree with this view.

The Hospital and Dr J missed a significant opportunity to deliver quality care. Mrs A's family were well informed. They had clear and not unreasonable views about how her care should be managed. They discussed their requests with senior staff and they were willing to assist. Sadly, their requests were overlooked or overruled.

Breach — Ms E

Ms E was the registered nurse manager at the Rest Home at the time of the events complained about. She had overall responsibility for the care provided to Mrs A. According to her job description the main objective of her role was "To ensure resident care is maintained at optimal levels that promotes the residents' rights and quality of life". Furthermore, the registered nurse competencies promulgated by the Nursing Council of New Zealand state that registered nurses should direct, monitor and evaluate the nursing care provided, and document and communicate relevant client information.

Care Planning
Mrs A was a 92-year-old woman who suffered multiple medical problems, including increasing confusion, oedema of the legs, and constipation. She required well-planned care. As my expert, Ms Featherston, explained, a care plan is an important part of any rest home resident's care. It means that residents are assessed and their ability to carry out activities is documented, problems are identified, and objectives are set for their care. Long-term objectives are used for such things as hygiene, mobility and elimination needs, while short-term objectives may include problems like wound care

or urinary tract infections, which can be addressed more quickly. Care plans need to be reviewed and updated as residents' needs change. A medical order is not needed for nurses to identify care issues and amend care plans.

There are records for four multi-disciplinary meetings for Mrs A (the first was on 30 September 2003) where the various management issues were discussed. Mrs A had one long-term care plan documented on 26 March 2004, when she required minimal intervention. It reflects the information recorded at a multi-disciplinary meeting on that day. No other care plans were documented apart from a short-term care plan, dated 21 March 2006, for the management of a urinary tract infection. Dr I said that the multi-disciplinary meeting records indicate that Mrs A's care plan was reviewed. However, there were only two further multi-disciplinary review meetings recorded — on 17 October 2005 and 13 April 2006. The information recorded at the last review meeting on 13 April 2006 was scant. It does not record who was present at the meeting and, apart from recording that Mrs A was on the diuretic frusemide, it provides no information about her condition or management.

Ms Featherston remarked that the overall assessment and care planning for Mrs A was "very poor", with little documentation in relation to Mrs A's four major problems in the last year of care: her constipation, pain, oedema in her legs, and increasing frailness.

Mr and Mrs B complained that when they met with Ms E on 20 June 2006 to discuss their concerns about the care being provided to Mrs A, Ms E appeared to be unfamiliar with Mrs A's case and notes. Ms E had been appointed to the position of nurse manager on 27 April 2006 and she was still unfamiliar with all of the residents. However, given that this was the case, it would have been prudent to have taken to the meeting one of the other registered nurses who were more familiar with Mrs A's problems. Ms E said that she obtained Mrs A's file and attempted to give feedback on the concerns but was unable to answer all the questions.

Ms Featherston commented that when a family raises concerns about care, whether at a formal meeting or an informal discussion, their concerns should be documented in the resident's clinical records. This was not done. There was no care plan documenting the family's concerns. Ms Featherston advised, "Certainly one would expect a care plan to be developed following family concerns in relation to such issues as pain and constipation."

She advised that Mrs A physically and cognitively deteriorated during 2006 and it would have been appropriate to have reassessed her some months before she was admitted to the Hospital.

Pain management

The nursing and medical notes indicate that Mrs A had suffered pain for a number of months prior to 20 June 2006. Ms Featherston advised that pain in the elderly can present in a number of ways and increasing confusion can inhibit a resident from saying

that he or she is in pain, or from identifying the source and the severity of the pain. Research shows that pain is seriously under-treated in the elderly and more so when the resident has a degree of confusion. Mrs A was often tearful and cried out a lot, which happened frequently when she passed a bowel motion. Also her hip, knee and back pain was restricting her mobility as indicated in the nursing notes for 7, 9 and 13 May 2006.

On 15 May Dr J prescribed Mrs A the analgesic codeine phosphate 15mgs, as required, up to three times daily. She was given one tablet that morning. The nursing note was, "[S]ee if this helps with the pain." The caregivers continued to report their concerns about Mrs A's pain, and the records show that she was regularly given 15mgs of codeine phosphate in the morning.

Ms Featherston advised that there is limited evidence in the clinical notes that an evaluation of Mrs A's pain was undertaken. There is no pain chart and also no evidence that an assessment was undertaken by a registered nurse. Although there was an attempt to increase Mrs A's pain medication from paracetamol to codeine, she continued to suffer pain on a regular basis, and her pain levels were not adequately assessed after the codeine was commenced.

Ms E stated that following the 20 June meeting with the family, she ensured that staff were aware of the need to provide Mrs A with her PRN pain relief, but she did not document this in the clinical records or a care plan. The Hospital pain management policy clearly outlines the steps to be taken to assess a patient in acute or chronic pain — that an assessment of the patient is to be conducted to determine the cause of the pain, the assessment is recorded in the care plan and clinical notes, and a pain assessment chart is commenced to monitor the site and severity of the pain. There is no record of these assessments being performed.

Bowel management

At the 20 June meeting, Mr C expressed his concern about the management of Mrs A's bowels. His mother had witnessed Mrs A's distress during a manual evacuation of her bowel. Ms E undertook to discuss Mr C's concerns with the Rest Home medical officer, Dr J, when she next called at the home. Ms E did not adjust the care plan regarding Mrs A's constipation, but stated that she ensured that staff were aware of the need to maintain regular bowel checks. Although there were comments in the progress notes by enrolled nurses regarding the need to monitor Mrs A's bowels and suggesting that she be given a high fibre diet and kiwifruit, there is no written instruction from Ms E.

Ms Featherston advised that Mrs A's bowels were very poorly managed. The management was reactive using such interventions as the laxative Laxsol and frequent manual removals. An enrolled nurse had noted that when the codeine phosphate was started that staff should "keep a check that [Mrs A's] bowels are moving regularly". As Mr C has also highlighted, codeine is recognised as causing constipation. The progress notes recorded advice to staff to encourage Mrs A with a high fibre diet, but

there was no proactive management such as a documented plan to show that other bowel management alternatives had been considered or that a dietician had been consulted.

Manual evacuations of the bowel are painful and distressing. Mrs A had a bowel motion on average once a week, and staff usually responded to her constipation problem only when she complained. Ms Featherston advised that correct management would have been a plan to review Mrs A's bowels on a daily basis and to have interventions ready before manual removal was necessary. If staff at the facility felt they were not able to manage Mrs A's bowels, they should have sought advice from specialist nurses employed by the District Health Board. There was no evidence that independent advice was sought.

Communication with the family
Mr and Mrs B complained that following the 20 June meeting, Ms E undertook to report on her proposed plan regarding the management of the issues discussed at the meeting — Mrs A's constipation, pain and incontinence. This did not happen.

Ms Featherston advised that communication is vital in the care of the older adult, benefiting the resident and their family, and also staff. In this case, Mrs A's family included health professionals with an informed understanding of Mrs A's needs. Effective communication did not occur. They were given an assurance that plans would be put in place to address their concerns, when in fact no such plans were documented.

Ms E failed to report back to Mr and Mrs B the action she took regarding the family's concerns. She stated that this was because there was an outbreak of Norovirus at the Hospital involving a large number of patients and staff, and that this had a considerable impact on the delivery of care. She was also unwell.

However, Mrs A's family were frequently at the rest home during the weeks following the meeting. In particular, they were called in on 28 July when Mrs A was transferred to the public hospital. I do not accept that there was no opportunity for Ms E to communicate with Mr and Mrs B.

Furthermore, I note that the Hospital's pain management policy clearly states that the family should be included in the planning of care. In my view, this means that Ms E had a clear obligation to report back to the family.

Summary
Ms E was the nurse manager responsible for ensuring that resident care was maintained at the optimal level and that documentation met the standards. There is evidence that the policies and procedures relating to Mrs A's pain and bowel management were not followed. There was a lack of planning of care and documentation. Mrs A's bowel and pain issues were managed in a reactive way, which led to unnecessary suffering. Ms Featherston stated that the care delivered to Mrs A at the Rest Home, as directed by

Ms E, was poor and that this would be viewed by her peers as a moderate departure from the standards. I accept that the Norovirus outbreak had an impact on the delivery of care, but the sad result of Ms E's failure to communicate with Mr and Mrs B emphasises the importance of open and honest communication with a resident's family. By not providing adequate supervision, direction and support of the clinical team and the opportunity for effective communication, Ms E did not ensure that Mrs A received services of an appropriate standard. Accordingly, in my opinion, Ms E breached Rights 4(1), 4(2) and 5(2) of the Code of Health and Disability Services Consumers' Rights (the Code).

Breach — Ms F

At 6.15pm on 28 July 2006, Mrs A was transferred to the public hospital for assessment and treatment of a suspected bowel obstruction and dehydration. The public hospital was "gridlocked" that day. As a result, Mrs A was discharged back to the Hospital later that night after an assessment and abdominal X-ray, with a detailed treatment plan. The treatment plan included intravenous fluids, and bowel preparation to free the identified lower bowel impaction. Mrs A was admitted to the Hospital at 12.30am on 29 July.

Mrs A's family complained that her pain was not adequately controlled following her discharge from the public hospital. They also expressed their concern about the general standard of care provided to Mrs A by the Hospital from 30 July to 4 August 2006.

Ms F was the nurse manager of the Hospital. Her job description states that the "main purpose" of this position is to "provide motivated leadership to ensure competent and consistent delivery of resident care and services". One of the objectives for her role as nurse manager was to "ensure standards of care and documentation comply with accreditation standards and the mission statement of [the Hospital]".

Ms Featherston advised that the care given to Mrs A in the Hospital was adequate with the exception of her pain management and documentation in relation to her care plan.

Pain management
On 30 July 2006, Mrs A's family expressed concern that her pain was not being adequately controlled by the codeine phosphate. The registered nurse on duty, Ms H, contacted the Hospital medical officer, Dr J, who advised her to contact the after-hours medical service. The doctor from the after-hours service visited, reviewed Mrs A and ordered morphine sulphate 10 mgs (to be given rectally twice daily) and morphine elixir 5mg as required.

Dr J visited the following day and ordered subcutaneous Buscopan to control Mrs A's colonic spasm. Ms F discussed with Dr J the possibility of starting Mrs A on a morphine infusion via a Graseby pump. She considered that this would be the best way

of controlling Mrs A's pain and anxiety, but Dr J did not consider this intervention necessary. (This issue is discussed below.) Ms Featherston supported Ms F's decision to ask Dr J to have Mrs A's pain managed via a Graseby pump. This method gives a better level of pain relief and allows for other drugs to be added to the pump as required.

I accept that the primary responsibility for the prescription of appropriate pain relief is that of the medical practitioner. However, Ms F, as the nurse manager, had an important role of ensuring that the site and severity of Mrs A's pain was adequately assessed, documented, and monitored, and that this information was passed on to the doctor so that the adequacy of the pain relief could be re-evaluated.

As previously mentioned, the Hospital had a pain management policy designed to evaluate, monitor, and document a patient's pain levels. The policy also stated that the family should be involved in the planning. Although Mr C was a registered nurse and had expressed his concern about this aspect of his grandmother's care, he was not involved in the decisions regarding her pain control.

Ms F failed to comply with the policy. She did not record in the clinical notes her conversation with Dr J about the use of a Graseby pump, or ensure that there was appropriate documentation regarding Mrs A's pain.

Documentation
When Mrs A arrived back at the Hospital she was dehydrated, constipated, in chronic pain, and unable to swallow and to take her medications without high risk of aspiration. She was eating very little. She also had a urinary tract infection and oral thrush.

The public hospital discharge letter recorded specific instructions regarding Mrs A's care. However, the Hospital staff did not update her care plan to reflect these instructions. There should have been a plan outlining the immediate areas of concern. The rationale for the care and evaluations should have been documented. Ms Featherston commented that although staff might use the progress notes to plan and evaluate the care, when writing the progress notes they usually do not go back and review the old notes. She stated:

> "What might have been acceptable would have been a short term care plan but that does not appear to have been documented. I am of the opinion that the clinical notes do not reflect what care was given. I am also of the opinion that the care planning was poor."

Summary
Although Ms F, as the nurse manager, relied on her registered nurses to appropriately document and evaluate care, she was responsible for ensuring that the care and documentation met the standards. In relation to Mrs A's pain management and the planning and documentation of her care, Ms F did not comply with the standards

required by the Hospital. Accordingly, in my opinion, Ms F breached Right 4(2) of the Code of Health and Disability Services Consumer's Rights.

Breach — Dr J

Dr J was contracted to provide medical care to the residents and patients at the Hospital. She took over the care of Mrs A in February 2006. At that time Mrs A was aged 94 years. Mrs A had been progressively developing memory loss and confusion. She was incontinent and had glaucoma, arthritis in her knees and oedema of her legs. My independent general practice expert, Dr Tessa Turnbull, stated that Dr J was a competent practitioner who assessed Mrs A regularly after she took over her care. Dr Turnbull noted that Mrs A was treated with minimal medication, which was appropriate for her age and general health. She said that antipsychotic mediation was prescribed with input from the appropriate specialists and, although there are other ways to treat heart failure, Dr J's prescription of frusemide was "fine".

My clinical advisor, Dr Tiller, went further. He noted that frusemide could affect blood pressure, cause dehydration, and impair renal function. He advised that Mrs A's renal function and blood pressure should have been monitored once the frusemide was increased to 120mg, and this should have been ordered by Dr J.

July to August 2006
In July 2006, Dr J reviewed Mrs A and recorded her concern about Mrs A's poor appetite and weight loss. Dr J examined Mrs A's heart and chest, and checked her pulse and blood pressure. However, it appears that Dr J did not examine Mrs A's abdomen to look for a mass that might suggest a bowel or other cancer to explain the weight loss. She did not ask the nursing staff about dietary history or suggest a dietician's assessment. Dr Tiller noted that these actions were not taken and advised that a blood test and a rectal examination should have been done by Dr J at least by 28 July.

At this time, Mrs A was also exhibiting increased agitation and progressive dementia, and Dr J requested a reassessment of Mrs A's support need level as she believed that she required hospital level care. Before this could take place, Mrs A was admitted to public hospital on 28 July for assessment and treatment of a suspected bowel obstruction.

Within 12 hours, Mrs A was transferred back to the Hospital from the public hospital. The hospital's instructions were to rehydrate Mrs A with intravenous fluids and progressively soften her impacted bowel with enemas, with the option of progressing to a manual disimpaction if the enemas did not clear the bowel. When the intravenous line site "tissued", Dr J was contacted and she ordered the nursing staff to start a subcutaneous line to maintain Mrs A's fluid intake.

Mrs A continued to deteriorate and her family expressed their dissatisfaction with the care provided to her.

Dr Turnbull advised that laboratory tests for a blood count, and electrolyte and creatinine measurements would have been useful at this time, as they might have indicated a pre-existing condition that could be rectified.

On 30 July an after-hours doctor was called in to see Mrs A because of her increased pain levels. She was prescribed morphine suppositories and elixir.

Dr J visited Mrs A on 1 August and prescribed subcutaneous Buscopan to treat her increasing abdominal discomfort. The nurse manager suggested to Dr J that Mrs A be started on a Graseby syringe driver/pump to administer her medication. Dr J disagreed, and the medications were continued rectally and orally.

Dr Turnbull stated that initially Mrs A's pain was managed according to the Hospital pain management policy, but from 1 August the management was "suboptimal". She said that a Graseby pump, as suggested by Ms F on 1 August, would have enabled good pain relief, and nausea and agitation control for Mrs A, and should have been used. Dr Turnbull also noted that the pain management policy indicated that the family should be involved in the planning of care.

Dr Turnbull stated:

> "[Mr C] could have been better utilised had there been more effective and ongoing communication between the three parties, ie, family, staff and [Dr J]."

Mrs A's family believed that Mrs A was dying. They wanted her last days to be as comfortable as possible. Dr J was of the opinion that Mrs A's condition was not at the stage where "death appeared inevitable". She stated that the outcome at that time was not certain, there was a significant chance that Mrs A might recover, and her condition required "day to day assessment". Dr J informed the family that it was her opinion that Mrs A should be treated "expectantly" and that palliative care was not appropriate.

Dr Turnbull said that Dr J's judgement in this matter was based on her experience, her knowledge of Mrs A, and the clinical picture presenting at that time. Dr Turnbull commented that although Dr J and the family disagreed about how Mrs A should be managed, she was "on a journey towards death" and the progress of that process "is never set in stone". However, Mr C was an experienced health practitioner and his requests regarding his grandmother's care were the wishes of her family and not unreasonable.

Dr Turnbull stated that overall Dr J's care of Mrs A was adequate, but there were areas where the care could have been improved and managed proactively — her constipation, pain, and laboratory testing. Dr Turnbull noted that there were communication difficulties, and she suggested that these difficulties may have been

averted if Dr J had accepted the family's view on 2 August and supported their request for palliative care.

Dr Tiller also advised that some aspects of Dr J's care could have been better. He said that peers would regard her care as moderately below the acceptable standard.

In my view, Dr J should have listened to the wishes of Mrs A's family and to the nurse manager's suggestion regarding the Graseby pump. The Medical Council's "Good medical practice — A guide for doctors" states that good clinical care must include taking suitable and prompt action when necessary. Dr J's actions regarding Mrs A's care tended to be reactive rather than proactive. While her care may have been adequate, there were clearly areas where it could have been improved, and these have been highlighted by Dr Turnbull and Dr Tiller. Dr J's actions contributed to the distress of Mrs A and her family. Mr C felt strongly that his grandmother was not being cared for adequately. In my view it is regrettable that despite his requests, he had to look for outside assistance and facilitate her transfer to another care facility. In my opinion, Dr J did not provide Mrs A with a service with reasonable care and skill and that complied with professional standards. Accordingly, Dr J breached Rights 4(1) and 4(2) of the Code.

Opinion: Breach — Dr I and the Hospital

Standard of care
As previously discussed, there were issues relating to the planning and management of Mrs A's care at both the Rest Home and the Hospital.

The nurse managers were responsible for ensuring the delivery of an appropriate standard of care and that the staff complied with the standards promulgated by the Hospital. These responsibilities were clearly set out in the job descriptions. Dr I did not have any direct clinical responsibility for care, except in unusual circumstances such as occurred on 28 July 2006 when Dr J was not available to arrange an urgent transfer to the public hospital for Mrs A. However, as manager and part owner of the Hospital, Dr I was responsible for the overall operational management of the facility.

The Hospital had numerous written policies in place to guide staff in a variety of care issues applicable to this complaint. However, the information gathered in this investigation suggests that these policies were not always followed or monitored adequately by those responsible for managing the facility.

In March and May 2006, the Hospital created policies regarding resident/patient admissions and record management, which provided guidance on the required documentation. There was also a policy specifying that care plans were to be reviewed and evaluated at the six-monthly multi-disciplinary meetings. As already discussed

there were four multi-disciplinary meetings between September 2003 and 21 March 2006 regarding Mrs A's care. The recording of these meetings was scant and there was no corresponding review or evaluation of the care plan. For example, following the 13 April 2006 meeting where Mrs A's increasing leg oedema was discussed, there was a note to elevate her legs. However, there was no care plan to evaluate this problem. It appears that her risk of developing pressure areas had not been considered as there was no instruction to turn her two-hourly, or any chart to record the number of times she was turned.

Although by 2006 there appeared to be adequate policies in place to ensure appropriate care, there was a lack of clear clinical leadership, and the mechanisms for monitoring the clinical policies and procedures were missing. As a result, Mrs A was not provided with an adequate standard of care. Having policies in place is of little use if action is not taken to ensure that staff are aware of the policies and put them into practice.

Subcutaneous fluids

When Mrs A was discharged back to the Hospital from the public hospital she had an intravenous line in situ. I accept that it is not standard practice for intravenous fluids to be provided in a chronic care/private aged care situation. However, private hospitals should be able to provide fluid replacement therapy with no problems, and I would expect the Hospital to have suitably qualified, IV certificated registered nurses and the appropriate equipment available.

When registered nurse Ms G admitted Mrs A to the Hospital during the night of 29 July, she was unfamiliar with the IV luer placed by the public hospital. Fortunately, Mr C was able to help her change the IV fluids for Mrs A. At 10am on 30 July, the intravenous line "tissued". Dr J was contacted and ordered that the fluids be given subcutaneously. When the replacement line was sited, there was some difficulty in obtaining fluids. The necessary fluids were located only after a third call was made to the on-call manager. Later that night when the bag of fluid finished, the staff were unable to locate further fluids, as the general stocks had run out during the Norovirus outbreak. Although there were emergency stocks locked in the nurse manager's cupboard, the staff did not have the keys. As a result, Mrs A went 24 hours without replacement fluid.

Dr I advised that at the beginning of each month the Hospital undertakes a monthly stocktake and places orders for replacement medical supplies. I accept that the Norovirus outbreak in July 2006 would have placed extraordinary pressure on staff and equipment. However, emergency situations are likely to occur in all medical facilities and there should have been systems in place to ensure that the fluid stocks were monitored and replaced. It is also fairly fundamental to ensure that staff can actually access emergency stocks. Overall, the delivery of subcutaneous fluids to Mrs A from 29 July until 4 August was generally very poorly managed and highlighted systemic deficiencies in relation to monitoring and replacing fluid stocks.

Summary
Standard 2.7 of the New Zealand Health and Disability Sector Standards states that organisations must ensure that consumers receive safe, timely and appropriate services from suitably skilled service providers. In my view, by failing to provide appropriate clinical monitoring and supervision, the Hospital did not comply with this standard. The Hospital and Dr I, as operational manager, were both responsible for putting in place effective systems and monitoring them to ensure that Dr J, Ms E and Ms F provided a service with reasonable care and skill, complied with professional standards, and did not breach the Code. The care provided to Mrs A demonstrates that Dr I and the Hospital failed to discharge these responsibilities. In my opinion, the Hospital and Dr I did not provide services that comply with the relevant standards and thus breached Right 4(2) of the Code.

Other comment

Dignity and respect
Mr C stated that he and his family were upset on one occasion when they were waiting outside Mrs A's room at the Hospital and overheard a member of staff laughing about Mrs A's cries. The Hospital management did not comment on this issue, except to state that they were not given adequate opportunity (apart from the informal meeting with Ms E on 20 June) to address any concerns raised by Mr C. Dr I stated that if Mr C had complained at the time, the issues might have been resolved. It is extremely regrettable that a member of staff acted in such an inappropriate manner. I would expect that when an incident such as this is brought to the attention of the management, all staff are reminded of their patients' right to be treated with respect and dignity.

Facemasks
The lack of availability of face masks at the Hospital on one occasion was, like the issue of the intravenous fluids, linked to the outbreak of Norovirus. As previously mentioned, emergency situations occur in all health care facilities from time to time, and there should be adequate systems in place to ensure that essential medical supplies do not run out.

I suggest that the Hospital review its systems so that there are additional means of ascertaining stock levels during unusual circumstances.

Recommendations

I recommend that Dr J:

- apologise for her breach of the Code. The written apology should be sent to this Office for forwarding to Mrs A's family
- review her practice and report to me by **21 November 2007** on any actions taken to change her practice in light of this report.

Actions taken

In response to the recommendations made in the provisional opinion, Dr I provided a written apology to Mrs A's family and advised:

- There is now greater oversight of the documentation standards at the Hospital, with regular review and audit.
- Nursing and caregiver staff have completed two separate documentation training sessions this year.
- Compliance with Care Plan Review and doctor review schedules are now monitored weekly at the charge nurse meetings.
- Performance indicator targets have been set at 0% overdue.
- All managers have been given additional training in managing complaints, and systems are in place to monitor response times to complaints.
- Various other changes have been made to correct specific issues identified during this investigation.

Copies of the apology letters from Dr I, Ms F and Ms E have been sent to Mrs A's family.

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand, the Medical Council of New Zealand, the Ministry of Health, and the District Health Board. The Ministry of Health will be asked to consider an audit of the Hospital's policies and procedures.

- A copy of this report, with details identifying the parties removed, will be sent to HealthCare Providers New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix 1

The following expert advice was provided by independent general practitioner Dr Tessa Turnbull.

> "*To advise the Commissioner whether in your opinion, general practitioner [Dr J] and [the Hospital] provided [Mrs A] with services of an appropriate standard. In particular*:
>
> **Dr J**
> *Was the treatment and care [Dr J] provided to [Mrs A] appropriate?*
>
> [Dr J] appears to be a competent practitioner who assessed [Mrs A] regularly after she took over her medical care from [the Hospital medical officer] in February 2006.
>
> **Background**
> [Mrs A] was aged 84 when she was admitted to [the Hospital] into a studio unit in 1996. Medical notes at that time indicate the main background health problems to be oedema of her feet, glaucoma, and an arthritic knee.
>
> Between then and August 2004 [Mrs A] slowly but progressively developed signs of memory loss, confusion, faecal and urinary incontinence, poor vision and increasing leg oedema. In April 2004 [Mrs A] was assessed by a senior psychiatric registrar and risperidone .25mg was suggested at teatime to reduce the buildup of confusion at that time of the day.
>
> In August 2004, [Mrs A] was transferred to [the Rest Home] after a SNL4 assessment. [Mrs A's] general health problems continued to get worse with indications of fluctuating but increasing confusion, urinary infections, faecal and urinary incontinence, oedema and sores on her legs.
>
> In February 2006, [Dr J] took over [Mrs A's] care. At the initial consultation she noted her weight loss and increased memory loss and confusion, wondered about postural hypotension and asked for regular blood pressure recordings which were done.
>
> In March 2006 [Mrs A] was seen by [a geriatrician] and quetiapine was commenced to assist the reported agitation.
>
> Reports of tearfulness, constipation, leg pain and swollen ankles occur regularly in the progress notes after this time.
>
> [Dr J] reviewed [Mrs A] over this time and made adjustments to her medication. In particular, the dose of frusemide was varied, Codeine Phosphate 15 mg and laxsol was added on an as needed basis in addition to the regular paracetamol given on a four hourly basis.

On 20 June 2006, [Mrs B] and [Mr C] met with [the Rest Home] nurse manager [Ms E] to discuss [Mrs A's] care needs. They were concerned about her incontinence, constipation and pain management.

[Dr J] notes these concerns on 22 June and tables the conflict between prescribing regular Codeine Phosphate and the role of this drug in causing constipation. Again on 27 July 2006 [Dr J] was concerned about [Mrs A's] poor appetite and loss of weight. She notes increased agitation and the problems of progressive dementia. On this date she asked for a new SNPs assessment feeling that hospital level care was now required.

On 28 July [Mrs A] was transferred to [the public hospital] Emergency Department. [Dr I] had assessed [Mrs A] as being dehydrated and having abdominal pain. X-ray examination at ED revealed rectal impaction and faecal loading and a calcified abdominal aortic aneurysm. A treatment plan was developed and [Mrs A] categorised as requiring hospital level care and transferred back to [the Hospital] for intravenous fluids and management of her constipation and rectal impaction.

[Mrs A] arrived back at [the Hospital] in the early hours of 29th July 2006 with an IV cannula, and IV fluids were commenced at 1am, as per the instructions to give 2 litres over the next 16 hours. This IV line tissued during the morning and [Dr J] suggested moving to subcutaneous fluids.

However, [Mrs A] further deteriorated refusing or finding oral pain relief very difficult to manage and taking minimal fluids or food herself. An after hours doctor called at 1645 on 30th July and prescribed morphine 10mg B.D to be given rectally and morphine elixir together with Nilstat oral drops for thrush. In the following days subcutaneous fluids were continued but any oral intake of food, fluids and medication was very difficult or impossible.

At this point [Mrs A] had entered the terminal phase of her life. Her family were aware and accepting of this fact. [Dr J] visited [Mrs A] on August 1st and 3rd and her working diagnosis was subacute bowel obstruction secondary to constipation. She prescribed buscopan subcutaneously as needed for abdominal pain.

On 4 August [Mrs A] was transferred to [Hospital 2] where she died [a short time later].

Opinion

[Mrs A's] medical and nursing care seems reasonable until the 1st August 2006. Prior to August 2006 the combination of paracetamol and low dose Codeine follows accepted practice when regular pain relief is needed. I was unable to see the cause of the painful legs detailed but assume this was considered to be due to persistent leg oedema and an arthritic knee. The

nursing progress notes detail this as a persistent and distressing problem. The downside of the use of regular Codeine is the likelihood of constipation which needs to be managed proactively.

From the 1st August, I think that [Mrs A's] pain management was suboptimal. Oral medication, and indeed rectal medication, was very difficult or impossible to manage well as the notes indicate. A Graseby pump would have enabled good pain relief together with medication to control nausea and agitation.

[The Hospital] policy on pain management indicates that the facility and staff had knowledge about Graseby pumps or could obtain it easily. The pain management plan also indicates that family should be involved in the planning of care. [Mr C] could have been better utilised had there been more effective and ongoing communication between the three parties, ie, family, staff and [Dr J].

In particular:

1. Should [Dr J] have monitored [Mrs A's] serum electrolytes, creatinine, blood urea and CO levels in light of her prescribing of Frusemide to [Mrs A]?

There are no records of any blood tests in the notes provided. A blood count, electrolyte and creatinine measurements would have been useful in management. Bloods were taken at [the public hospital] but these are not included in the information provided. They might indicate if there was a pre-existing problem that should have been rectified.

2. Was [Dr J's] prescribing for [Mrs A] appropriate? For example the pain management and prescription of Frusemide.

On the whole [Mrs A] was treated with minimal medication which is appropriate for her age and general health. Anti-psychotic medication was prescribed with the input of the appropriate specialists.

The Frusemide prescription was fine. There are other ways to treat heart failure but this is a personal decision of the doctor concerned.

The pain management follows closely the recommended "ladder" in [the Hospital] policy on pain management up until the last few days at [the Hospital].

3. Was [Dr J] correct when she advised [Mrs A's] family, "it is often possible to feel a pulsating aorta on thin elderly patients." Was her assessment of [Mrs A] in relation to this condition appropriate?

Absolutely correct. [Mrs A] was thin and had lost weight so a pulsating aorta is a normal finding in this situation. There is no evidence that the aortic aneurysm had dissected or had anything to do with [Mrs A's] pain or eventual death.

Are there any other aspects of the care provided by [Dr J] that you consider warrants comment?

[Dr J] says that her working diagnosis of [Mrs A] was constipation causing a subacute bowel obstruction and an associated urinary tract infection in the days between 31/7/06 and 3/8/06. She indicated to [Mr C] that [Mrs A's] condition required "day to day assessment, that her outcome was uncertain, but that it had not yet declared itself as being terminal." [Dr J] felt that there was a significant chance that [Mrs A] might recover and that she should be treated expectantly.

I do not have a problem with this judgment which was a clinical one based on [Dr J's] experience, her knowledge of [Mrs A] and examination at the time. [Mrs A] was on a journey towards death and at what point the journey becomes "terminal" and requires "palliative care" is never set in stone. The feelings of [Dr J] and [the family] differed in this judgment.

I feel [Dr J's] care of [Mrs A] was adequate. However, the areas that the care might or could have been improved are:

- laboratory monitoring
- proactive management of the constipation
- perhaps other forms of pain management for the leg pain, eg, steroid into the arthritic knee
- direct and ongoing communication with the family
- acceptance that [Mrs A's] condition was terminal on 2nd August and that palliative care would have better supported [Mrs A] and her family
- use of a Graseby pump sometime after her return from [the public hospital]

[The Hospital]
Was the service [the Hospital] provided to [Mrs A] appropriate? In particular, what is the usual practice regarding the provision of subcutaneous fluids in private geriatric hospitals?

I feel [the Hospital's] care of [Mrs A] was mostly adequate. The Norovirus infection would have thrown enormous stress on the institution, the staff and the residents. The areas that the care could have been improved are:

- proactive management of the constipation
- dietitian input and food supplements
- 24 hr ready availability of subcutaneous fluids
- better communication with the family
- acceptance that [Mrs A's] condition was terminal on 2nd August and that palliative care would have better supported [Mrs A] and her family
- use of a Graseby pump sometime after her return from [the public hospital]

Intravenous fluids are almost never used in private geriatric hospitals. In contrast, subcutaneous fluids are widely used for short term fluid management. Certification of nurses is not required for this, although training is needed, in contrast to the administration and overseeing of intravenous fluids.

Appropriateness of [the Hospital] policies:

- Pain management — this is a good resource document
- Infection control — generally a good resource document
- Continence management — very adequate
- Constipation — mentioned in above but there is no policy to actively manage the problem
- I cannot find a fluid intake policy."

Appendix 2

The following advice was provided by an independent registered nurse specialist in aged care, Ms Jan Featherston. Ms Featherstone stated:

> "I have been asked to provide independent advice to the Health and Disability Commissioner.
>
> I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> **Supporting Information**
>
> - Letter of complaint to the Commissioner from [Mr C], dated 15 December 2006, marked with an 'A'. (Pages 1–9).
> - Letter of response from [Ms F], dated 14 March 2007, marked with a 'B'. (Pages 10–15).
> - Notes taken during a telephone call to [Ms F] on 19 March 2007, marked with a 'C'. (Page 16).
> - Response received from [the Hospital] on 16 March 2007, marked with a 'D'. (Pages 17–31).
> - [Mrs A's] [Hospital 2] clinical records provided to HDC on 26 April 2007, marked with an 'E'. (Pages 32–193).
> - Letter from [Mr C] dated 24 April 2007, marked with an 'F'. (Pages 194–202).
>
> **Rest Home**
>
> *Clinical care in relation to [Mrs A]*
> In reviewing care: clinical notes, doctor notes and care plan are reviewed along with supporting information. These give an outline of the care and services provided to [Mrs A].
>
> [Mrs A] was a rest home resident who suffered multi medical problems.
>
> The major nursing problems were:
> - Increasing confusion
> - Oedema of the legs
> - Pain
> - Constipation
>
> In reviewing care I have read the clinical notes which support the listed problems. The clinical notes show that pain was on ongoing problem for a number of months.

Pain in the frail elderly can present in a number of ways, increasing confusion can inhibit resident saying "I am in pain". The clinical notes indicate that [Mrs A] cried out a lot, she was often tearful — clinical notes indicate this would happen often while having a bowel motion.

In May 06 the notes indicate that the pain in her legs was inhibiting her mobility.

eg, 07.5.06 *complaining of chronic pain in legs*
09.5.06 *sore back and legs, says she is in pain and doesn't know what to do with herself*
13.5.06 *[Mrs A] in a lot of pain with hip and knee*

CodeinePhos. 15 mg was commenced on or about the 15th May. One tablet was given in the morning.

On the 25th May 06 Codeine was given TDS [three times daily] and staff were asked to document any change in [Mrs A's] pain.

There is limited evidence in the clinical notes that an evaluation of pain was undertaken. No pain chart was viewed and I did not view any evidence that an assessment was undertaken by a registered nurse.

The clinical notes throughout June and July indicated that pain was still very evident and was not well controlled

05.6.06 legs very sore
08.6.06 [Mrs A] still says she's in a lot of pain quite tearful
11.6.06 [Mrs A] in high level of pain
25.6.06 crying with pain
28.6.06 complaining of painful legs
29.6.06 complaining of very painful legs, unsteady on feet
02.7.06 complaining of pain in her knees
03.7.06 complaining of pain in neck

Bowel Management
Included in the documentation provided are bowel charts. …

These charts are read in conjunction with the clinical notes.

[Mrs A] was prone to constipation and the bowel charts show that she would have a bowel motion on average once a week, some weeks twice.

Clinical notes for this period also indicate that constipation was a major problem. Many times throughout this time a manual removal would be performed. Clinical notes indicate that this caused distress for [Mrs A]. They do

not show if a local anaesthetic agent was used when staff carried out the manual removal.

Medication was charted for [Mrs A] — (I found it difficult to comment on as limited drug charts were available.)

Laxsol two tablets at night was charted on the Prescribed Medication sheet.

PRN Drugs 16.5.06 Laxsol tabs two PRN daily for constipation.

It was charted on the 'Short Course Drug' Laxsol tabs for 2 wks dated 06.6.06.

It was then charted on the regular drug chart on the 22.6.06 Laxsol tabs pack separately two.

From the drug sheets that were supplied. Laxsol was given. …

24.7.06	two in AM and two PM
25.7.06	two AM and PM
26.7.06	two PM
27.7.06	two AM and PM 28th and two AM
29.7.06	two at 14.30 and two PM
30.7.06	two AM and PM

I could find no other evidence of this drug being given.

Care Planning

Care planning is an important part of resident's care and documentation. It dictates the care that is given and gives rationales for the reason for the care.

In simple terms residents are assessed for their ability to carry out activities of living. This assessment is documented and from this, problems are identified. Objectives are set and it is from this that care delivery is undertaken.

A good assessment means that all aspects of resident's problems should be identified.

Many facilities use long term objectives and short term objectives.

Long term objectives may be for such things as hygiene needs, elimination needs, mobility etc this is usually identified as Activities of Living.

Short term objectives include such things as urinary track infections, wound care, or any short term problem that either is able to be addressed in the short term, eg, weeks.

Short term problems may be written at any time when nursing staff identify residents who have problems which is not part of their normal care needs.

Nursing Care plans are written and directed by nursing staff. A medical order does not have to be given for nurses to amend and identify care issues.

I reviewed the Care Plan for [Mrs A].

This consisted of pages 00148–00154) (page 00192) and Wound Care (pages 000097–00091).

The nursing intervention plan was undertaken on the 26.3.04 and lists the problems as:

- Nursing
- Physiotherapy
- Divisional Therapy
- Nutritional
- Medical
- Mental Status
- Relatives NOK

The Implementation Plan/Goals are listed.

This assessment and plan was obviously undertaken when [Mrs A] was in a unit and reasonably independent.

I did not view any other care plan.

A short term care plan was documented on the 21.3.06. This lists the problem as 'UTI' and also lists the treatment as 'AB'S' [antibiotics] as charted 'Encourage fluids 2hrly'. No other short term care plan was documented.

Also included in the documentation was Multi Disciplinary Meeting forms. These are dated:

30.09.03
26.03.04
17.10.05
13.04.06

The first two dates give a brief statement of how [Mrs A] is managing. There is no signature on either of the forms.

The third is dated the 17.10.05 and shows that [Mrs A's] daughter was present. It states that the areas identified were nursing, DT [diversional therapy], physio and nutrition. This form is not signed, nor was it completed well to show what areas were discussed and what input from the family.

The final review which is dated on the 13.4.06, does not list who was present, and who contributed to the review. It lists the problems as 'Medical, Rels [relatives], and Cognitive'.

There are a number of injury wound management forms. These forms are designed to tick what staff find re wound and what type of dressing is used. The date is written at the top and there is a signature at the bottom. The majority are signed, although designation is not listed, so I am unable to say whether these are caregivers or registered staff who have undertaken the wound care.

Overall the assessment and care planning is in my opinion very poor. In reviewing the clinical notes [Mrs A] had four major problems in the last year of care; these would be:

- Constipation
- Pain
- Oedema in her legs
- General increasing frailness

I could not find anywhere where these issues have been identified and documented, apart from progress notes written by caregivers. The four areas of concern identified show a clear pattern in the clinical notes throughout this time.

Communication with family
As stated the only formal family review was listed as the 17.10.05. This review did not go into what the family contributed to that meeting or how they felt [Mrs A] was being cared for.

The family in their complaint to the HDC state that they had a meeting on the 20 June 06.

This meeting was not documented in the clinical notes nor was a family review form completed.

Clinical notes show that the family was present but do not elaborate on any aspect of communication with staff.

1. Was the treatment and care provided to [Mrs A] by [the Rest Home] appropriate?
2. If not, please comment on what else should have been done.
3. Did [Ms E], as manager of [the Rest Home], fulfil her responsibilities as detailed in [the Hospital] rest home nurse manager's job description? Please comment.
4. Were [Mrs A's] family concerns on 20 June 2006 appropriately managed? Please comment.

5. Was there an appropriate response to [Mrs A's] problems, such as her bowel management and pain? Please comment.
6. Did the documentation of the care provided to [Mrs A] reflect [the Hospital] policies and comply with the accepted standard. Please comment.

[Ms E] was Registered Nurse Manager in the Rest Home. Her job description is thorough and outlines the Key Tasks and Performance Indicators that are expected.

The main objectives are documented and this includes:

- To ensure resident care is maintained at optimal levels that promote the resident's rights and quality of life.

This job description is typical of what is found in aged care.

In my opinion the care provided while [Mrs A] was in the rest home was adequate to meet her basic daily needs such as essential cares, bathing, dressing etc. The care in the rest home did not in my opinion extend far enough to care for [Mrs A's] acute ongoing problems such as pain, bowel management and decreasing mobility.

Pain: Although an attempt was made to increase [Mrs A's] pain medication from Panadol to Codeinephos. no accurate pain assessment was undertaken nor was there an adequate assessment of her pain levels done once she had been commenced on Codeine.

Throughout the clinical notes it shows that [Mrs A] still suffered from pain on a regular basis.

All research shows that pain is very under-treated in the elderly and more so when residents have a degree of confusion.

Bowels: It is my opinion that [Mrs A's] bowels were managed very poorly. The bowel chart shows that [Mrs A] would have a bowel motion on average once a week and many of those times a manual removal would have to be undertaken. This procedure is very painful as well as distressing for any resident.

There is evidence in the Prescribed Medication Chart that drugs such as Laxsol were used. It is my opinion that this was managed on a reactive basis and not proactively.

It appeared that staff would pay attention to [Mrs A's] bowels when she complained about her bowels.

There was no plan documented to show that other alternatives such as a high fibre diet had been tried.

What would be expected would be a plan to review [Mrs A's] bowels on a daily basis and have interventions ready before it got to the stage of manual removal. If staff at the facility felt they could not manage [Mrs A's] bowel problems then they could have sought advice from specialist nurses in the community or through the local DHB. There was no evidence that independent advice was sought.

Communication with family: I am of the opinion from the documentation presented that [Mrs A's] family did raise concerns about her care on the 20th July 2006. I can only form an opinion following a review of documentation which was written post the meeting.

I am of the opinion that any family who raises concern, whether it is at a formal meeting, such as a multi-disciplinary meeting or at an informal discussion, should have their concerns documented in the resident's clinical notes.

This was not done. Hence there was no documented action plan to the concerns the family raised. Certainly one would expect a care plan to be developed following family concerns in relation to such issues as pain and constipation.

Policies: The policies that were presented by [the Hospital] were very typical of what is found in aged care. The policies would in my opinion meet an acceptable standard.

I do not believe that the policies in relation to bowel management were followed and certainly not the policies in relation to pain.

The pain management policy includes the use of a pain management chart and lists the evaluation of pain. I can find no evidence that this was undertaken in the care of [Mrs A].

Other aspects: I acknowledge that Nurse [Ms E] was new to her job having commenced this position on the 27th April 2006, and that she may not have fully reviewed all of the residents.

If, when taking over her position, the majority of care plans were as poorly documented as [Mrs A's] then it would have been a huge undertaking to ensure all the care plans were relevant and identified important clinical issues.

Certainly if she had only gone by the nursing care plan which was poor then she may have thought that [Mrs A] was stable. If she had reviewed the clinical notes then she would have identified that [Mrs A] had acute problems.

I did not view any documentation written by Nurse [Ms E] in [Mrs A's] clinical notes.

Communication: Communication is vital in care of the older adult. Often residents will behave or have problems that families cannot cope with. Communicating with family is two fold.

It allows staff to communicate how they feel the residents are doing both for general care and for acute problems. It also gives staff a chance to communicate to families if they are no longer able to provide the level of care to a resident either due to work load, which may have been the case due to the Noravirus, or due to the increased dependence of the resident.

[Mrs A's] family were health professionals and it appears from the documentation, from the family, that they were given an assurance that plans would be put in place to address their concerns when in fact no such plans were documented.

I am of the opinion that communication with the family was poor.

Overall
I am of the opinion that the care given in [the Rest Home] directed by Nurse [Ms E], nurse manager, was poor. There is evidence when reviewing the policies and procedures that these were not followed. The areas I have identified are Pain Management and Bowel Control.

As stated, [the Rest Home] had an outbreak of the Noravirus which can disrupt both routine and staffing. In this respect communication would have been vitally important with the resident's family.

Taking all factors into consideration I am of the view that [Ms E's] care would be viewed as moderate by her peers.

[Ms F]
[Mrs A] was admitted from [the Rest Home] into the Emergency Department of [the public hospital] on the 28th July 2006.

Emergency notes list [Mrs A's] problems as abdominal pain (page 00104).

[Mrs A] was readmitted to [the Hospital] at 0030 on the 29th July where she stayed until transferred to [Hospital 2] on the 4th August 2006.

The clinical progress notes in my opinion indicate that [Mrs A] was palliative. This opinion is reached by reviewing the progress notes and observing the general deterioration of [Mrs A] in the last 4 weeks. On arrival back to [the Hospital] she was dehydrated, constipated, in chronic pain, unable to swallow

and not able to take medications orally without high risk of aspiration, eating very little. She also appears to have had a UTI and oral thrush.

The clinical progress notes give a good indication as to the care that was given from a nursing staff. Staff administered the medications that were charted.

In [Ms F's] statement … she states that she discussed with [Dr J] about using a morphine pump as she believed this was the most appropriate way to manage [Mrs A's] pain. She goes on to say that [Dr J] did not agree. This discussion is not documented in the clinical progress notes.

I would support the RN decision to ask the medical officer to have [Mrs A's] pain managed by a Graseby pump. By having pain relief dispensed this way gives a much better level of pain relief. Also other drugs are able to be added to the pump should they be required.

The orders for IV fluids were documented. Once the IV line had 'tissued', Sub. Cut. fluids were commenced. I support [Mr C's] evaluation … of the SC fluids that were given to [Mrs A].

There does appear to have been a delay in acquiring the required solution.

1. Was the treatment and care provided to [Mrs A] by [the Hospital] appropriate?
2. If not, please comment on what else should have been done?
3. Was there an appropriate response to [Mrs A's] problems such as her bowel management and pain? Please comment.
4. Was the management of [Mrs A's] hydration issues, in particular the subcutaneous fluid administration, appropriate? Please comment.
5. Did the documentation of the care provided to [Mrs A] reflect [the Hospital] policies and comply with the acceptable standard.

I am of the opinion that the care given to [Mrs A] in [the Hospital] was adequate with the exception of:

Documentation in relation to the care plan: There was not an updated care plan viewed with the documentation supplied. It does not appear that a care plan was written when [Mrs A] arrived back into the hospital wing from [the public hospital]. One would expect to see a plan which outlined the immediate areas of concern. Rationales for care should have been written and evaluations undertaken. Staff may say that the clinical notes are used for this but traditionally staff do not go back and review old notes hence it is important to have a plan of care which covers the immediate concerns. What might have been acceptable would have been a short term plan but that does not appear to have been documented.

I am of the opinion that the clinical notes do reflect what care was given. I am also of the opinion that the care planning was very poor. There did not appear to be a care plan written for [Mrs A].

Pain Management: As stated nurse [Ms F] requested that [Dr J] review the use of a Graseby Pump which would have given a more adequate level of pain relief. She stated that the doctor did not think this was appropriate. This conversation is not documented in the resident's clinical notes. It appears the doctor advised to continue giving pain relief as charted.

It appears from the drug sheets that this was done.

Bowel Management: [Mrs A's] bowel chart is not available for the hospital so one has to assume that the clinical progress notes are accurate and a manual evacuation was done on the morning of the 29th July. The notes at the end of that shift indicate that the "rectum is quite clean of faeces now".

Suppositories were given on the 30th July and the notes indicate that a small and fairly hard result was obtained.

Following a doctor's visit on the 30th July the notes indicate that stat Microlax enemas were ordered.

Bowels did not open on the 1st August.

There is nothing again in the notes until the 3rd August when they say, 'Microlax enemas given 1430 hrs … result.' The notes do not show whether [Mrs A] had a bowel motion or not.

Following her admission to hospital with constipation it is my opinion that a more accurate record of her bowels should have been kept. Certainly a short term care plan should have been written.

Medication was charted for [Mrs A]. This consisted of Codalax 5mls which was given 4 times from the 1.8.06–3.8.06. I did not view this charted in the Prescribed Medication Sheet. Nor did I view this in the medical notes.

It is my opinion that bowel care and management was poorly managed.

Hydration: in viewing the clinical notes and medical orders, IV and Sub Cut fluids were not maintained as per instructions. I am of the opinion that staff attempted to do their best in relation to this.

[The Hospital]

Subcutaneous Fluids are a safe and effective way to hydrate patients in aged care. They are easy to administer by nursing staff and the side effects such as

overload are far less than if a patient has an IV line in. It is my opinion that most private hospitals are, and should be able to carry out the care with no problems. SC fluids are not as accurate to administer as IV fluids, it is also my experience that a person's hydration level will dictate how fast SC fluids will be absorbed. Staff need to be aware that the same principals of any IV apply e.g. infection control etc.

Each hospital is responsible for planning and certifying staff to carry out this task. Some hospitals will send staff off to study days at teaching institutions and others will plan and run study days in house. I do not have a preference for either but what is important is the content and the nurse's ability to understand the process and procedures for any IV, Sub cut, Graseby pumps etc.

Summary in relation to care

I am of the opinion that the care in the rest home was not adequate to meet [Mrs A's] needs.

I am of the opinion that the care in the hospital was adequate except for what I have stated.

It was obvious that she had deteriorated both in relation to her medical problems and her cognitive state. I believe from the information I reviewed that it would have been appropriate to have had [Mrs A] re assessed some months before her admission to hospital. I also am of the opinion that if the rest home felt they could not cope or have the skill to treat [Mrs A's] problems then they should have sought guidance from outside health professionals, such as the district nursing service. They would have been able to advise on pain management and bowel cares as required.

The nursing response to the Commissioner is that they did the best they could and their responses have added things that they did for [Mrs A], but my view is based on what was presented in the documentation and care plans.

Appropriateness of Policies

Management of pain
The policy on pain management was issued on May 03. The rationale is documented as:

'*The identification and management of pain is vital to well being and quality of life of our residents.*'

It states that there will be a multidisciplinary approach to pain, and lists staff and services involved in pain management.

The policy goes through:

- Identification of Pain
- Types of Pain
- Assessment
- Evaluation
- Observation
- Management
- Medication in Pain Control
- Adjunctive Therapies
- Prescriptions of Analgesics
- Alternative Therapies
- Procedure for Graseby Syringe Driver

Comment

This policy is very typical of what is found in aged care settings.

It is noted that [the Hospital] uses as a reference the 'Guide to Palliative Care in New Zealand.' This reference is appropriate in aged care settings.

It is good to see that under the heading 'Management', that family/whanau is included in the planning of care.

What this policy lacks is a copy of the pain chart that is used in the day to day management of resident's pain.

I would also expect to see a folder which would include journal articles, research articles and general resource material (the facility may have this on site).

It is my opinion that this policy is appropriate in this setting.

Fluid intake Management
There was not a specific policy supplied for this area of care.

Fluid intake was noted in the Continence Management Policy under the strategies to prevent UTIs.

It would be appropriate in aged care to have a policy which identifies several issues. These include:
- Residents at risk of poor fluid intake — dehydration
- Swallowing issues
- Use of thickened fluids
- Use of documentation in relation to fluid intake — Fluid Balance Charts
- Alternatives to increasing fluid intake
- Medical assessment

Continence Management Policy
This policy was issued on the 5th May 2005.

The policy includes:
- Purpose
- Scope
- Associated documents
- Policy
- Procedures
- Care of residents with catheters

Constipation is included in the policy although this section is brief. It lists the signs and symptoms of constipation and the things that can prevent constipation.

It is typical of policies found in aged care. It is my opinion that this policy should be expanded to include a more thorough section on constipation — the causes and strategies to deal with ongoing constipation."