HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Inadequate clinical management at end of life

1. This Office received a complaint from Ms B about the end-of-life care provided to her father, Mr A, by The Ultimate Care Group Limited (trading as Alden Manurewa (Alden)), located in Manurewa, Auckland region. This investigation has focused on the standard of care provided to Mr A in the period leading up to his death. In particular, the investigation examined the adequacy of pain assessment and management, the support provided to Mr A and his family during the dying process, the management and administration of medications, and the effectiveness of Alden's internal processes relevant to end-of-life care.

2. I wish to express my heartfelt condolences to Mr A's family for their loss.

Background

3. Mr A, aged 82 years at the time of the events, was admitted into Alden on 1 July 2022 and transitioned to rest home-level care from 5 August 2022 after an assessment of his care needs. Mr A had various comorbidities, including end-stage chronic obstructive pulmonary disease (COPD), heart failure, shortness of breath, an abdominal hernia, diverticulitis, chronic kidney disease, and a history of urinary retention managed with an indwelling urinary catheter.

4. Through October 2022, Mr A appeared to deteriorate, experiencing loss of appetite, multiple falls, and a low mood. Ms B was updated about Mr A's health decline, and she advised care staff that he was not for hospitalisation. Hospice services (who were known to Mr A and his family due to his end-stage COPD and heart failure) were contacted and advised Alden staff to continue the current management and that Mr A's family could contact them with any concerns. There were no further discussions about an appropriate end-of-life care plan for Mr A. Ms B stated that Mr A did deteriorate during October 2022 and that he had made it 'very clear' to her that he did not want to return to hospital under any circumstance. Ms B also added that their family were not asked to participate in any further end-of-life planning and were reassured that the staff would closely monitor Mr A and respond appropriately to his needs.

5. On day2 October 2022, Mr A's medications were reviewed by Hospice, and he was commenced on subcutaneous medications via a syringe driver as he had difficulty swallowing. He was also then reviewed by the General Practitioner (GP), who noted his increased pain, adjusted the dose of his medications via the syringe driver, and encouraged Alden staff to use PRN (as required) pain relief medications when needed.

6. Syringe driver medication is designed to be given continuously to ensure the patient is kept comfortable. Unfortunately, there was a two-and-a-half-hour gap in the administration of Mr A's continuous pain medication via the syringe driver, and it was unclear what plan was in place to support Mr A's comfort over this time. Ms B expressed her concerns about the gap in medication infusion and requested that Mr A be transferred to hospice, which did not

happen. Ms B added that Hospice advised they had no available room for him to be transferred to.

7. On day4 October 2022 during the night shift, no registered nurses (RNs) were onsite, so care staff administered Mr A subcutaneous medications (oxycodone, midazolam, and haloperidol). At 1.43am, Mr A's daughter contacted the ambulance service for assistance with pain relief management. Mr A's daughters were distressed that their father was still in pain and told ambulance staff that his medication was not given to him in a timely manner. The ambulance staff administered fentanyl (a strong pain relief) subcutaneously to Mr A. Ms B told the Health and Disability Commissioner (HDC) that, after they had raised concerns about the staffing levels, they were both reassured that the staff on duty would be adequately trained to care for Mr A and that there would be an RN onsite.

8. Later that morning, Hospice contacted Alden staff to advise that they identified a medication documentation error, meaning that the wrong dose of PRN oxycodone and midazolam had been given to Mr A. The Clinical Services Manager, RN C, noted that the dose was signed in milligrams (mg) but given in millilitres (please see appendix A). RN C also noted that oxycodone was administered by the care staff but not signed out of the Controlled drugs[1] register.

9. Sadly, later that day, Mr A passed away with his family in attendance.

Ambulance care summary

10. As mentioned in paragraph 7, the ambulance service attended Mr A after receiving a call from his daughter, who reported that he was 'restless and appear[ed] to be in pain.' The ambulance care summary records that Mr A's daughter expressed concerns about the care provided to their father, noting that they had to make multiple requests for PRN medications to be administered. They also reported that there was no RN onsite and no on-call doctor available at the time.

11. The ambulance staff documented that, on arrival to Alden, they observed staff 'looking at us through the window' but not opening the door until they knocked repeatedly. The ambulance staff further noted that the care home staff 'only called the [on-call] RN when we arrived.'

12. The ambulance staff supervised staff drawing up medications, during which one Alden staff member attempted to use the previous unlabelled syringes. Ambulance staff advised that syringes should be appropriately labelled or new syringes used each time. The ambulance staff noted that Mr A's daughters were 'frustrated' that their father was not receiving the treatment required to keep him comfortable and expressed concerns that care home staff were 'uncomfortable' or lacked the capability to provide this level of care.

[1] Controlled medications relate to class A, B, or C drugs, as defined in the schedules of the Misuse of Drugs Act 1975. They have strict regulations because of their potential for misuse, dependence, or harm.

Pain management

13. Hospice New Zealand defines palliative care as an approach that 'improves the quality of life of patients and whānau who are facing problems associated with a terminal illness.[2] It prevents and relieves suffering through early identification, correct assessment, and management of pain and other symptoms, whether physical, psychological or spiritual.' As Mr A had end-stage COPD and heart failure, he was under Hospice care but residing at Alden.

14. The Ultimate Care Group's Pain Management Policy (2017) has a stated purpose to 'promote resident comfort, well-being and quality of life.' The policy requires that an RN complete a pain assessment for any resident presenting with acute or new pain. Although a pain assessment was completed on 8 September 2022, it appears that Mr A's pain was not assessed again in response to his health decline in October 2022.

15. According to this policy, PRN analgesia medication and its effect on the resident's pain level is to be recorded on the resident's electronic medication chart (MediMap) and noted in their progress notes. However, a review of the documentation shows that Mr A's pain level was not consistently recorded in MediMap or the progress notes. This was also in contravention of the policy, where it directs that residents who are approaching their end of life will have their pain levels reviewed each shift by the senior staff member on site. Mr A's pain levels were not consistently recorded each shift.

16. The GP instructed that a pain monitoring form be commenced, with Mr A's pain to be assessed every four hours from day1 October 2022 to day4 October 2022. However, a review of the documentation shows that Mr A's pain level was assessed on only five occasions during the 72-hour period.

17. This policy provides that a resident's pain is initially managed through the development of a short-term care plan, with ongoing or persistent pain subsequently incorporated into the resident's long-term care plan. On review of the documentation, an initial pain care plan was completed on 8 September 2022. However, there is no evidence that this care plan was reviewed or updated in October 2022 when his condition deteriorated or that a short-term care plan was developed to guide staff in the management of his pain as he approached the end of his life.

18. In terms of managing a resident's pain, this policy provides that, where a resident is unable to swallow medications, they may be given their medications via a syringe driver, which is used to continuously deliver pain relief and other medications subcutaneously.

Support for the dying person and their family

19. The Care Plan Policy (2017) directs that residents on end-of-life/palliative care should be on the Te Ara Whakapiri pathway. Te Ara Whakapiri is a 'set of principles and guidance for end-of-life care in New Zealand, aimed at ensuring consistent and quality care for adults at the end of life.' It includes resources such as the 'Recognising the Dying Person flow chart,'

[2] A health condition that cannot be cured and is likely to result in death.

symptom management flow charts, ongoing plans of care for the dying person, and information for families about death and dying.

20. The Health Quality & Safety Commission Te Tāhū Hauora Frailty Care Guides support healthcare professionals in the care of older people with frailty, particularly in residential care, and are intended to facilitate communication and care planning with the older person, their family, and the healthcare team. The Frailty Care Guides outline the need for an Advance care plan and an end-of-life care pathway to support both the resident and their family during the last days of life.

21. However, contrary to the Care Plan Policy and the Frailty Care Guides, Ultimate Care Group advised that no specific end-of-life care plans had been developed for Mr A.

Medication management

22. The Medication Management Policy (2021) states that '[a]ll residents receive the right medication, **in the right dose**, at the right time and by the right route and in a timely manner [emphasis added].' The policy notes that health care assistants can administer PRN (as required) medications under [an on-call RN] and, in urgent circumstances, administer subcutaneous medications and manage syringe drivers under the **direct supervision** of [an on-call RN]. The policy is silent on whether PRN medications include controlled drugs (such as oxycodone) and does not define 'direct supervision.'

23. The policy directs that when a PRN medication is administered, its effect is to be recorded in the resident's progress notes. As noted earlier in this report, the effects of PRN medications on Mr A's pain levels were inconsistently documented in his records.

Internal processes at Ultimate Care Group

24. The On-Call Management Policy (2020) states that a Clinical Services Manager or Senior RN must be available to attend onsite when required. The policy further clarifies that on-call support is intended to provide directions by telephone only and that any advice given is to be reviewed by the Facility Manager or Clinical Services Manager on the next business day. Ultimate Care Group advised that limited registered nurse availability meant that duty teams received clinical guidance from an on-call RN to support Mr A's care during the afternoon shifts on day1 and day2 October and the night shift on day3 October 2022.

25. The Open Disclosure Policy (2016) defines an open disclosure as '[c]ommunication of an event causing unintended harm to a resident … Errors and near misses may also require open disclosure.' The policy requires that families be notified of an event within 24 hours of its occurrence and that all relevant parties participate in a full investigation. The Clinical Services Manager, RN C, informed Ms B of the medication error (in which Mr A received an incorrect dose of oxycodone and midazolam) and advised that the matter would be investigated, and corrective action taken. However, on review of the documentation, there is no evidence that a full investigation was undertaken following the medication error.

Response from The Ultimate Care Group Limited

26. In its response to HDC, The Ultimate Care Group noted that there was an opportunity for improved communication and shared planning between Ultimate Care, the family, and external palliative and primary care support.

27. The Ultimate Care Group told HDC that, in the absence of an RN onsite, a senior caregiver acts as shift lead who can escalate concerns to the on-call RN for a site visit, phone call, or video conference; however, the shift lead did not ensure that staff administered Mr A's subcutaneous medications (which also included controlled drugs) under the guidance of the on-call RN.

28. The Ultimate Care Group acknowledged that 'in the last few days of Mr A's life, this care relationship could have benefited from more proactive planning, communication and support … where a resident's health is deteriorating … We are sorry for the undue stress and concern to Ms B and [are] committed to using her complaint as the basis for improvement.'

In-house clinical advice

29. In-house aged care advice was sought from RN Jane Ferreira (Appendix B), who identified the following deviations from the accepted standard of care:

- **Moderate to serious deviations** in relation to clinical leadership and oversight of a vulnerable resident, nursing assessments and care planning, medication management, pain management, incident management, communication and documentation standards.

Response to provisional opinion

Ultimate Care Group Limited

30. Ultimate Care Group was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations, and it has accepted the decision.

Ms B

31. Ms B was given the opportunity to respond to the 'background' part of the provisional opinion, and her responses have been incorporated into the report where appropriate.

32. Ms B told HDC:

> "[Mr A] was a much-loved father and grandfather, and while we understood that he was nearing the end of his life, we had reassured him that we would do everything possible to keep him comfortable and pain free … Dad had a long-standing reliance on tramadol, something he had used for many years. He was very fearful of experiencing pain, and it was important to him – and to us – that this was managed with care and understanding."

33. Ms B added:

> "[T]he failures in his care were particularly distressing and entirely avoidable. It also left our family feeling that his end-of-life care was not being managed with the level of competence and preparedness we had been led to expect. The absence of trained staff, combined with the lack of any contingency plan, meant that [Dad] was left without the timely pain relief he urgently needed."

Decision — breach

34. The key issue here is whether The Ultimate Care Group (trading as Alden Manurewa) provided Mr A with an appropriate standard of care at the end of his life. RN Ferreira identified multiple issues, as noted in paragraph 29 and advised that, in these areas, the care provided by Alden Manurewa fell below the accepted standard of care. I accept this advice.

35. In my view, there were significant and multiple deficiencies in the care provide to Mr A. In particular, the approach to pain management was inadequate. Despite a clear deterioration in Mr A's condition in October 2022, no further pain assessment was completed. As a result, there was no updated baseline to determine the severity of his pain, no documented plan for how his pain would be assessed or communicated should he lose the ability to do so verbally, and no clear record of recommended pain relief interventions, including the use of oxycodone via a syringe driver. I am critical that, despite the GP's direction that Mr A's pain be assessed and recorded every four hours over a three-day period, this was completed on only five occasions. This level of monitoring was insufficient and resulted in an incomplete and unreliable picture of Mr A's pain experience. I am further concerned that no short-term care plan was developed to guide staff in the management of his pain during this period.

36. In relation to the management of Mr A's end-of-life needs, I am critical that no end-of-life care plan was developed or Te Ara Whakapiri resources utilised. As a result, opportunities to provide structured guidance, support, and information to Mr A and his family, were missed.

37. In relation to medication management, I am very concerned about the ability of care staff to safely administer subcutaneous medications. Whether this reflected a lack of competence or a lack of confidence, the absence of staff appropriately skilled in this area posed a significant risk to Mr A's care. I am highly critical that incorrect medication dosages were administered, particularly in relation to the use of oxycodone, a potent controlled drug. This error had the potential to result in serious harm: overdosing could have caused significant adverse effects, and underdosing would have left Mr A in unnecessary pain. Despite the seriousness of this medication error, there is no evidence that a full and robust investigation was undertaken in response to the incident.

38. In summary, the breach finding reflects a combination of clinical and systemic deficiencies. There was a failure to undertake adequate and regular pain assessments, including a failure to follow GP instructions regarding monitoring frequency. There was an absence of a structured end-of-life care plan, resulting in limited guidance for staff and insufficient support for Mr A and his family. Additionally, medication management practices were unsafe, including incorrect dosing and the administration of subcutaneous medications by staff who did not appear competent in this area. These deficiencies were compounded by

inadequate oversight and a failure to undertake a robust internal investigation after a serious medication error. Taken together, these factors reflect a pattern of care that fell well below the expected standard.

39. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) states, 'Every consumer has the right to have services provided with reasonable care and skill.' In the circumstances, having reviewed all the information available, I consider that The Ultimate Care Group Limited (trading as Alden Manurewa) did not provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

Changes made since events

40. The Ultimate Care Group has made the following changes:

- Provided training in escalation and communication
- Provided contingency planning when short staffed
- Provided training in communication with family
- Staff now utilise Te Ara Whakapiri resources

Recommendations

41. I recommend that The Ultimate Care Group Limited (trading as Alden Manurewa):

a) Provide a formal written apology to Mr A's family for the breach of the Code identified in this report. The apology is to be sent to HDC, for forwarding to the family, within three weeks of the date of this report.

b) Undertake further staff training on pain management and the importance of completing associated documentation (such as pain assessments and pain levels). Evidence of staff training by way of staff attendance records and an outline of the training session is to be provided to HDC within six months of the date of this report.

c) Undertake further staff training on developing short-term care plans and end-of-life plans. Evidence of staff training by way of staff attendance records, an outline of the training session, and a copy of four end-of-life plans (with identifying data redacted) is to be provided to HDC within six months of the date of this report.

d) Undertake staff training on the responsibilities associated with controlled drugs, including when registered nurse oversight is needed for caregivers administering such medications. Evidence of staff training by way of staff attendance records is to be provided to HDC within six months of the date of this report.

e) Review its on-call and after-hours clinical support arrangements to ensure timely access to a registered nurse with the appropriate skills to support pain and end-of-life care, including syringe driver management. Evidence of the revised processes is to be provided to HDC within six months of the date of this report.

f) Review and revise as necessary its medication management policy to explicitly define the scope of practice for caregivers in administering subcutaneous medications, including controlled drugs, and clearly specify what constitutes 'direct supervision' by a registered nurse. This revised policy is to be provided to HDC within six months of the date of this report.

g) Implement a formal competency assessment process for all staff involved in the administration of subcutaneous medications, including controlled drugs. This should include a documented initial competency assessment, ongoing reassessment, and clear escalation requirements when appropriately competent staff are not available. Evidence in the form of the revised training is to be provided to HDC within six months of the date of this report.

h) Review and strengthen its incident management processes to ensure medication errors, particularly those involving high-risk medicines, are subject to timely, documented, and robust investigations. The revised processes and examples of completed investigations are to be provided to HDC within six months of the date of this report.

Follow-up actions

42. A copy of this report with details identifying the parties removed, except the aged care advisor on this case and The Ultimate Care Group Limited (trading as Alden Manurewa), will be sent to HealthCERT and Health New Zealand | Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Rose Wall
Deputy Health and Disability Commissioner

Appendix A: Midazolam and Oxycodone administration records

Administration of Midazolam on [day4] October 2022

Instructions by GP "for use at half hourly intervals as needed" for agitation or shortness of breath.

Time given	Dose as prescribed by GP	Dose given	Administered by
2.13am	Between **2.5mg** and **5mg**	0.25mg	Caregiver
3.34am	Between **2.5mg** and **5mg**	1mg	Caregiver
4.14am	Between **2.5mg** and **5mg**	0.5mg	Caregiver
5.35am	Between **2.5mg** and **5mg**	0.5mg	Caregiver
6.05am	Between **2.5mg** and **5mg**	0.5mg	Caregiver
6.37am	Between **2.5mg** and **5mg**	0.5mg	Caregiver

Administration of Oxycodone on [day4] October 2022

Instructions by GP "for use at hourly intervals as needed" for pain or shortness of breath

Time given	Dose as prescribed by GP	Dose given	Administered by
1.08am	Between **2.5mg** and **5mg**	0.25mg	Caregiver
2.12am	Between **2.5mg** and **5mg**	0.5mg	Caregiver
3.33am	Between **2.5mg** and **5mg**	0.5mg	Caregiver
4.32am	Between **2.5mg** and **5mg**	0.25mg	Caregiver
5.36am	Between **2.5mg** and **5mg**	0.25mg	Caregiver
6.37am	Between **2.5mg** and **5mg**	0.25mg	Caregiver

Appendix B: In-house clinical advice to the Commissioner

The following in-house aged-care advice was obtained from RN Jane Ferreira:

CONSUMER : Mr [A]

PROVIDER : Ultimate Care Manurewa

FILE NUMBER : C22HDC02665

---

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

2. **Documents reviewed**

- Complaint received [day2] October 2022
- Provider responses dated 22 December 2022, 13 October 2023, 1 October 2024
- Clinical records, including nursing assessments, progress notes, monitoring records, medication records, health information
- Organisational policies, including Assessment and Care Planning, Falls Management, Medication Management, Open Disclosure, Oxygen Management, Pain Management, related resources, education and competency records

3. **Complaint**

Mr [A]'s family/whānau have expressed concern regarding the care provided to him while resident at the care home. Their concerns relate to medication management, pain management, care and communication.

Background

[Mr A] was admitted to the care home on 1 July 2022 at rest home-level care. His medical history included heart failure, COPD, chronic kidney disease with urinary retention, ulcerative colitis, diverticulosis, abdominal hernia, leg pain (multifactorial) prediabetes, peripheral oedema, and memory impairment. File information indicated that [Mr A] required moderate carer assistance to meet all activities of daily living. He mobilised with the assistance of a walking frame and preferred to rest in an armchair rather than his bed due to breathing and sleep difficulties. [Mr A]'s health declined during his admission, requiring palliative care, and he passed away [at the end of] October 2022. I extend my sincere condolences to [Mr A]'s family/whānau at this time.

4. **Review of clinical records**

For each question, I am asked to advise on what is the standard of care and/or accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? How would it be viewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future.

In particular, comment on:

a) Did [Mr A]'s end-of-life pain assessment and pain management meet acceptable standards of practice and guidelines?

The organisation's Pain Management policy outlines their expectations for the assessment, management and evaluation of resident pain, and related care responsibilities. The policy states pain interventions will be documented in a resident care plan and regularly reviewed. A record of resident pain will be written in the resident progress notes, noting location, type of pain and assessed severity.

Pain assessment scores will be reported in MediMap (an electronic medication management system) with evaluation of treatment effectiveness documented.

File documentation showed that [Mr A]'s health was declining in October 2022.

A weekly progress note review completed by a registered nurse (RN) on 4 October 2022 stated that he was receiving palliative care. The entry provided a summary of [Mr A]'s health status and preferences at the time. The provider has stated that a care plan was in place to guide his care requirements; however, there is no evidence of any nursing care plans in the submitted evidence to inform further comment. Records show that clinical oversight was provided by his general practitioner (GP), in partnership with hospice services.

The Pain Management policy states that residents who are approaching end of life will have their pain levels reviewed each shift by the senior staff member on site, noting GP/NP and specialist service involvement where indicated. A pain assessment completed 8 September 2022 stated that [Mr A] experienced intermittent pain all over his body, mostly on his legs, lower back and right shoulder, reporting that it was most severe during activity and impacted his mobility. Strategies stated to ensure that pharmacological interventions were reviewed. It is unclear if the pain assessment tool was repeated given the medication changes made in response to [Mr A]'s health decline in October 2022.

As outlined in the Health Quality & Safety Commission's Frailty Care Guides, pain is often undertreated than overtreated in older people, particularly for those living with cognitive impairment. Nurses have a role in assessing signs of pain using appropriate pain assessment tools, offering non-pharmacological interventions, administering prescribed analgesic medicines, monitoring and recording of treatment effectiveness (HQSC, 2019; HQSC, 2023).

File information shows that a pain monitoring form was commenced on [day1] October 2022 with instructions to assess [Mr A]'s pain four-hourly until [day4] October 2022. Records show that his pain was assessed overnight twice on [day1] October (2.05am, 5.45am) and three times on [day2] October (12.30am, 3.30am and 6.30am). No pain scores are reported, although entries indicate that [Mr A] was experiencing moderate pain at times. The monitoring tool suggests that further assessment and review of [Mr A]'s pain did not occur, with no further entries recorded across other shifts during the requested timeframe, which is concerning.

Medication administration records show that [Mr A] received multiple doses of medication for pain and agitation during the timeframe in question. The Pain Assessment policy states that "*all PRN and Standing Order medication administered will have a follow-up within 45-60 minutes to assess the effect. This will be recorded in MediMap and noting in progress notes."* Administration records and progress note entries do not consistently discuss pain assessment processes, such as an assessed score before and after administration of prescribed as-required (PRN) medications, with limited evidence of escalation for clinical guidance based on the continued reported distress. Comments and Outcome statements refer to communication and handover information, but supporting records were not provided to inform further comment regarding clinical leadership, senior nurse oversight and care continuity.

Progress note entries on […] October discuss PRN administration of anti-anxiety medications, with concern expressed by family/whānau regarding palliative care medications to support comfort. Records on [day1] October 2022 discuss care delivery, noting that [Mr A] appeared frail and required increased assistance. Progress notes refer to communication and interaction with Hospice services regarding [Mr A]'s care on [day1] and [day2] October 2022; however, there is no indication that an agreed plan of care was commenced to guide [Mr A]'s care during his last days of life, as stated in the Care Plan policy. An end-of-life care policy was not submitted to inform further comment at this time.

End-of-life care planning is considered a responsibility of the clinical team and an important part of the therapeutic relationship. The Health Quality & Safety Commission (HQSC) Frailty Care Guides provide guidance about accepted practice standards to support clinical judgement and inform staff practice (HQSC, 2019; HQSC, 2023). Having an Advance Care Plan and an End-of-life care pathway, such as "*Te Ara Whakapiri*," are considered recommended approaches to support the resident and whānau during the last days of life (HQSC, 2019; MoH, 2017). The provider has acknowledged this is a development area within a corrective action plan.

The Ngā Paerewa Health and Disability Service Standards (HDSS) and Age-Related Residential Care (ARRC) Services Agreement require service providers to have systems, policies and processes in place for the safe and appropriate management of medications, in line with legislative requirements and practice standards. This includes a responsibility to ensure that prescribed medications are safely administered by trained, medication-competent nurses and carers. File information showed that [Mr A]'s

oral medications were discontinued on [day2] October 2022 and he was commenced on a syringe driver for subcutaneous administration of prescribed medications.

The provider has discussed workforce challenges in place at the time of [Mr A]'s admission and shared their On-Call Management policy, which outlines steps to support clinical and operational cover. Policy expectations include provision of phone advice to give direction, with onsite attendance if required, noting that actions will be reviewed by senior leaders on the next business day. There does not appear to be a requirement for the on-call RN to document clinical interactions regarding resident care in the care record or on a reporting tool. It would be recommended that an RN record the clinical guidance provided with rationale to support resident care and safety, in line with professional practice responsibilities.

The provider has advised that due to a lack of RN availability, duty teams received clinical support from an on-call RN to guide [Mr A]'s care during afternoon shifts on [day1] and [day2] October and the night shift on [day3] October 2022. There is no evidence provided to indicate that a specific plan of care had been implemented by the clinical manager or RN team to guide [Mr A]'s care needs and medication requirements given the absence of an RN. While it appears that [Mr A] was well known to the care team, he had a complex health history with rapidly changing needs. It would therefore be considered accepted practice to ensure that a comprehensive nursing plan was in place which included prompts for clinical escalation.

File records indicate that [Mr A] was experiencing increased pain during this time, with evidence that concerns were escalated to the on-call GP for support. Due to swallowing concerns, oral medications were discontinued and a syringe driver commenced on [day2] October 2022. Records show that PRN medications were available for use as needed to support comfort.

Prn Medications

Date Started & Prescriber	Medication	Dose	Route	Freq	Instructions
[illegible]2022	LEVOMEPROMAZINE HYDROCHLORIDE 25 MG/ML INJECTION, AMPOULE (Edited: 28-10-2022 01:01)	6.25 mg	(SC) Subcut	Q2H	2nd line for restlessness, terminal agitation
[illegible]-2022	SERENACE - HALOPERIDOL 5 MG/ML INJECTION (Edited: 28-10-2022 00:50)	0.5 mg	(SC) Subcut	Q3H	nausea, restlessness Comments: Max 2.5mg/24hrs (of PRN)
[illegible]-2022	MIDAZOLAM 15 MG/3 ML INJECTION (Edited: 28-10-2022 00:52)	2.5 - 5 mg	(SC) Subcut	Half Hourly	agitation or shortness of breath
[illegible]-2022	OXYCODONE HYDROCHLORIDE 10 MG/ML INJECTION (Edited: 28-10-2022 00:38)	2.5 - 5 mg	(SC) Subcut	Hourly	pain or shortness of breath

Records show that [Mr A] was seen by his GP on [day3] October 2022, who commented on the "*minimal use of PRN meds"* with instructions to "*please use more PRN palliative meds."* While progress notes reflect the health visit, there is no evidence of any updates made to nursing documentation at this time nor communication provided to incoming teams by clinical leaders about [Mr A]'s plan of care to ensure his needs were prioritised.

The organisation's Medication Management policy states that "*health care assistants/caregivers can administer PRN medications under the guidance and supervision of 504 (*On Call RN*) and in urgent circumstances administer sub cut fluids and medications and manage syringe drivers under the direct supervision of UCG's 504 RN On Call via Telehealth."*

PRN medication administration records on [day3] and [day4] October 2022 show that [Mr A] received varying doses of prescribed medications, which is concerning. Records indicate that he presented with signs of restlessness and agitation, but it is unclear whether pain assessments were completed to inform nursing actions.

As show above, an anti-anxiety medication (Midazolam) was prescribed for use at half hourly intervals as needed, with a dose range of (2.5mg–5mg). Administration records show that [Mr A] received medication as follows on [day4] October 2022:

- 2.13am (0.25mg)
- 3.34am (1mg)
- 4.14am (0.5mg)
- 5.35am (0.5mg)
- 6.05am (0.5mg)
- 6.37am (0.5mg)

The Medication Management policy discusses competency criteria and responsibilities for controlled drug administration and syringe driver use. The policy states that "*controlled drugs to be delivered through the syringe driver will be signed out, prepared and administered by two medication competent staff, and at least one staff member holding a syringe driver competency".*

Pain relief (Oxycodone, a controlled drug) was prescribed for use at three hourly intervals as needed, with a dose range of (2.5mg–5mg). Administration records show that [Mr A] received medication as follows on [day4] October 2022:

- 1.08am (0.25mg)
- 2.12am (0.5mg)
- 3.33am (0.5mg)
- 4.32am (0.25mg)
- 5.36am (0.25mg)
- 6.37am (0.25mg)

It is unclear what the rationale was for the reduced dosages, or if the volumes were incorrectly entered into MediMap administration records, with no evidence of pain scores noted to monitor medication effectiveness. There are no supporting notes supplied from the On-Call RN who was providing clinical cover in the absence of an RN on the night shift ([day3–day4] October), nor evidence of controlled drug book records to show stock balance, drug calculations and checking processes as discussed in the

policy. Progress notes show that the clinical manager sought support from Hospice services regarding [Mr A]'s level of comfort, who identified the medication discrepancies and provided clinical guidance.

The provider has discussed the suspected documentation error, although incident investigation and improvement processes are unclear. The provider stated that the shift lead did not ensure that staff administered medications under the guidance of the remote clinical team and acknowledged this was a departure from their expected practice. While clinical responsibilities for direction and delegation of nursing tasks were not discussed, I would consider the clinical manager as senior nurse to hold responsibility for the oversight, planning, implementation and evaluation of [Mr A]'s care across the shifts in question. There is no evidence to show that an agreed plan was in place to provide clinical guidance and reduce clinical risk in the circumstances.

Medication records show that [Mr A]'s syringe driver was commenced at 6.28pm on [day2] October and reached completion at 6.03pm on [day3] October 2022.

However, the next syringe driver was only commenced at 8.39pm on [day3] October, 2.5 hours later. Syringe drivers are used to deliver a continuous supply of medication over a prescribed time period to support resident comfort, in partnership with prescribed PRN medications. It is unclear what steps were put in place to maintain [Mr A]'s comfort given the reported delays. There is no evidence provided of syringe driver monitoring records to show that regular checks were completed across all shifts in line with medication care and safety.

Medication administration records on [day3] October show that he last received PRN medicines at 12.44pm, with late entries reporting additional doses given at 7.15pm, 8.20pm and 9.34pm, indicating apparent discomfort. It does not appear that a pain assessment was recorded during this time. The care record reflects that [Mr A]'s family/whānau were concerned about the management of [Mr A]'s care given the lack of RN oversight and observed distress and sought paramedic support. Event documentation is comprehensive and discussed a plan of care to support [Mr A] to remain safe and supported until he could be reviewed by Hospice teams and his GP.

From the evidence reviewed to respond to this question and raised discussion points, I consider there to be moderate to serious deviations in care delivery. Identified concerns relate to clinical leadership and oversight of a vulnerable resident, nursing assessment and care planning, medication management, pain management, incident management, communication and documentation standards, and this would be viewed similarly by my peers in the circumstances.

- Departure from accepted practice: Moderate to serious.

Jane Ferreira, RN, PGDipHC, MHlth

Nurse Advisor (Aged Care)
Health and Disability Commissioner

References

Health Quality & Safety Commission. (2021). Advance Care Planning. https://www.hqsc.govt.nz/our-work/advance-care-planning/acp-information-for-clinicians/

Health Quality & Safety Commission. (2019; 2023). Frailty Care Guides. http://www.hqsc.govt.nz/

Ministry of Health. (2017). Te Ara Whakapiri Toolkit: Care in the last days of life. https://www.health.govt.nz/publication/te-ara-whakapiri-principles-and-guidance-last-days-life