Presbyterian Support Services (Central) Limited

A Report by the
Deputy Health and Disability Commissioner

(Case 17HDC02135)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report primarily concerns the end-of-life care provided to an elderly woman while she was a resident at a rest home in 2016. The report also concerns the preparation of the woman's care plan at the time of her admission in 2013, and the administration of the antibiotic Augmentin, to which she had a suspected intolerance.

2. The report highlights the importance of adequate end-of-life care, including ensuring that a resident is comfortable, medicines are administered appropriately, the resident's pain is managed appropriately, and an appropriate short-term care plan is prepared in the event of a significant change in the resident's status. The report also highlights the importance of adequate documentation, and of keeping family informed of a resident's status.

Findings summary

3. The Deputy Commissioner found the rest home in breach of Right 4(1) of the Code, as it failed to provide appropriate care and services to the woman in 2016. The rest home did not prepare a short-term care plan in response to the woman's change in status, did not treat or assess her vulvar pain adequately, did not inform the woman's GP of her urinary test result, and did not administer a nebuliser as required. In respect of the end-of-life care, the Deputy Commissioner found a lack of planning and a delay in starting syringe-driver medications. In addition, the overall documentation by staff for this period was found to be poor.

4. The Deputy Commissioner was also critical that the rest home did not keep the family updated and fully informed of the woman's deteriorating condition, and that the care plan was not updated adequately when she was admitted to the rest home. It was found that the administration of Augmentin was appropriate despite her suspected intolerance.

Recommendations

5. It was recommended that the rest home apologise to the family for its breach of the Code, conduct an audit on its Death, Dying and Bereavement policy, Pain Management policy, End of Service Planning policy, and Medicine Management policy, and use this report as a basis for staff training.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided by Presbyterian Support Services (Central) Limited to her deceased mother, Mrs A. The following issues were identified for investigation:

- *Whether Presbyterian Support Central[1] provided Mrs A (deceased) with an appropriate standard of care between Month1[2] and Month2 2016.*
- *The adequacy of the documentation regarding the diagnosis of multiple myeloma in 2013 and the administration of the antibiotic Augmentin in 2015.*

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

8. The parties directly involved in the investigation were:

Ms B	Complainant
Presbyterian Support Services (Central) Limited	Provider

9. Further information was received from:

Dr C	General practitioner (GP)
A pharmacy	

Also mentioned in this report:

RN D	Care Manager
RN E	Registered nurse
RN F	Registered nurse

10. Independent expert advice was obtained from Registered Nurse (RN) Rachel Parmee, and is included as Appendix A. In-house clinical advice was obtained from GP Dr David Maplesden, and is included as Appendix B.

[1] Also known as Enliven.
[2] Relevant months are referred to as Months 1-2 to protect privacy.

Information gathered during investigation

Introduction

11. In 2013, Mrs A, aged 84 years, became a resident of a rest home[3] following her admission to a public hospital for a fractured neck of femur (broken hip). Previously she had been a resident of another facility, but because of a functional decline, she was unable to return and was admitted to the rest home for hospital-level care.

12. This investigation concerns the care Mrs A received at the rest home — in particular, the documentation of Mrs A's suspected multiple myeloma[4] at the time of her admission in 2013, documentation of the administration of Augmentin[5] in 2015, and the end-of-life care provided to Mrs A before she passed away in 2016.

Documentation of potential multiple myeloma

13. Prior to being admitted to the rest home, Mrs A was diagnosed with suspected multiple myeloma. The public hospital's medical record of Mrs A stated: "[S]uspected multiple myeloma … Conclusion: Appearances are consistent with possible myeloma of the thoracolumbar spine and skull."

14. Ms B told HDC that Mrs A was seen by a consultant haematologist. The public hospital's medical record noted: "The patient was reviewed during the admission by the haematology team who suggested that MGUS[6] was the most likely diagnosis though multiple myeloma was also a possibility." A copy of the public hospital's medical record was provided to the rest home when Mrs A was admitted.

15. The public hospital sent the rest home a copy of the Care Plan Report for Mrs A's admission. The report stated:

> "Presenting situation
>
> [2013]
>
> [Amend] previous careplan — NO DIAGNOSIS OF MULTIPLE MYELOMA AS PER HAEMATOLOGIST [2013]."

16. Three weeks later, RN D, the Care Manager of the rest home (at the time of the incident),[7] prepared the Residential Support Plan and assessment plan (the Care Plan) for Mrs A. The Care Plan stated:

[3] The rest home is owned and operated by Presbyterian Support Central (also known as Enliven).
[4] Cancer of plasma cells, which usually arises in the bone marrow.
[5] An antibiotic that can cause side effects of diarrhoea, skin rash, vaginitis, and vomiting.
[6] Monoclonal gammopathy of uncertain significance — a condition that causes the body to create an abnormal protein.
[7] RN D is now retired.

> "B. Intake and initial history …
>
> [Mrs A] needs a higher level of care than provided at [the previous rest home] — likely to deterio[ra]te from now on due to Multiple Myeloma diagnosis as well."

17. The Care Plan did not record the new information regarding the possibility of Mrs A having MGUS instead of multiple myeloma. In 2015, the Care Plan was updated by RN D, but the information about no diagnosis of multiple myeloma was still not recorded in the updated plan.

18. RN D told the rest home:

> "Re Myeloma Diagnosis … [the previous] Rest Home gave me a personal handover the day prior [to Mrs A's] admission to Hospital Level of Care at [the rest home]. The [DHB Haematologist had obviously discussed this Myeloma Diagnosis with [Mrs A] and sent the report to [the previous] Rest Home … Hence the Diagnosis appeared on my documentation … [A] week after [Mrs A's] Admission to [the rest home] the int[erRAI] report came through and obviously the Diagnosis had been changed … but not personally stated that there was a change of Diagnosis."

19. In relation to the updated review, RN D said:

> "[U]nfortunately the Myeloma Diagnosis was not changed. With my pending retirement, I was endeavouring to complete [interRAI], do follow ups [a]nd review as I was concerned by the workload on the remaining Registered Nurses."

Administration of Augmentin

20. Mrs A's public hospital Care Plan report stated: "[1998] — Warning — ALLERGY TO AUGMENTIN." The rest home's Risk Summary dated 2013 recorded: "Augmentin — Allergy & Sensitivity". The form was signed by RN D and Mrs A. Mrs A's Medication Chart (last reviewed on 11 Month1 2016) also stated: "Allergies ... Suspected: Augmentin … Intolerance and Adverse Drug Reactions … Suspected … Augmentin."

21. Augmentin was prescribed for Mrs A by her GP, Dr C, who was also the rest home's contracted GP. The rest home told HDC that according to the clinical records, Mrs A was given Augmentin on four occasions. Dr C prescribed Augmentin again following her examination of Mrs A in 2015.

22. Dr C told HDC that she prescribed Augmentin for Mrs A's urinary tract infection (UTI), as another antibiotic had already been given to Mrs A, but despite this she still had a UTI. Dr C stated:

> "I have reviewed [Mrs A's] notes and see that I prescribed Augmentin on 4 occasions in 2015 … it is always a juggle of risks and benefits when prescribing it. I believed that in [Mrs A's] case benefits of Augmentin outweighed its risks [and] hence, decide[d] to prescribe it."

23. The rest home told HDC:

> "[D]espite Augmentin allergy being mentioned on the Risk summary page, interRAi assessment, the pre-admission care plan report from NASC and the medication chart … neither the pharmacy, GP and [the rest home] RNs noticed the Alert. Hence [Mrs A] was administered Augmentin on several occasions."

24. The rest home stated: "[T]here was noted failure to take into account the documented allergies …"

25. RN D told the rest home:

> "Augmentin prescribed by House Doctor for U[rinary] T[ract] I[nfection] … GP's surgery had the same alerts as our hospital medication so they obviously felt safe about prescribing … Augmentin cured the problem and there was no rash or allergic reaction to the drug. [Mrs A] was monitored for this …"

26. Augmentin was dispensed by a pharmacy, which confirmed that it dispensed Augmentin for Mrs A on four occasions in 2015. The pharmacy said: "[I]f a patient reports an adverse effect we record it in the patient's notes. No adverse effects were reported to us regarding the dispensing in question."

Care from Month1 to Month2

Vulvar pain and UTI

27. The progress notes record that on eight days in Month1, Mrs A complained of a burning sensation in her vulvar[8] area, and the following treatment was provided:

- On 9 Month1, non-ionic cream[9] was applied to her vulvar region;
- On 13 Month1, she declined Micreme[10] and was given a Ural sachet[11];
- On 15 Month1, she declined Micreme;
- On 17 Month1, cream was applied twice to her vulvar region, at 1pm and 11pm;
- On 19 Month1, a Ural sachet was given;
- On 21 Month1, she refused to have any cream applied.

28. Ms B told HDC that her mother "did state to [her] once that she was certain the staff had applied the wrong cream to her vulvar area as it burnt her, causing extreme pain".

29. No short-term care plan was initiated by the rest home for Mrs A's vulvar pain, and staff did not enquire or investigate why Mrs A refused to have Micreme applied.

[8] The outer part of the female genitals.
[9] A moisturiser used to treat dry skin conditions.
[10] A cream used to treat inflamed skin.
[11] An alkaline drink used to relieve the symptoms of UTI.

30. On 12 Month1, the progress notes record that a urine sample was collected and sent to the laboratory, but the result was negative for UTI. On 15 Month1, the progress notes record that a further attempt was made to collect a urine sample, but this was unsuccessful.

31. At 11.50am on 19 Month1, Dr C assessed Mrs A and noted UTI symptoms, and asked for a urine and a faeces sample to be sent to the laboratory for testing. The progress notes at 3.30pm record the result of the urine test as follows: "[Leucocytes[12]], nitrate positive, protein, [and] large blood." However, Dr C was not informed of this result.

End-of-life care provided to Mrs A

30 Month1

32. The progress notes record that on the morning of 30 Month1, Mrs A "was coughing a lot" and was feeling nauseated. At 7.55am, RN E administered Metamide[13] 10mg and noted that there was "minimal effect".

33. RN E recorded in the progress notes at 2.40pm:

> "[Mrs A] had Gees Linctus[14] at 8.30 am and again at [1pm] at her request for cough. Her temperature was recorded to be at 36.9 [degrees Celsius] and she was still feeling nauseated at lunch time. Further dose of 10 mg metamide was given at [1.55pm]. Visited by family who were updated and will come back later."

34. RN F noted in the progress notes that Mrs A was still feeling nauseated at 6pm and was given Metamide 10mg. She still had a sore throat, and RN F gave her Gees Linctus 5ml at 6.10pm. It was recorded at 11pm that "[Mrs A was] visited by family and daughter [and] would like [Mrs A] to be reviewed by GP … [and] would like to be rung if [Mrs A's] condition deteriorate[d] day or night".

35. RN F made additional notes in the progress notes that at 9.15pm Mrs A looked slightly flushed. Her observations were recorded as: "Temp[erature] 38.4, BP [Blood Pressure] 153/65, P[ulse] 83, R[espirations] 24, Spo2 [oxygen saturations] 95%." Mrs A was given a tepid sponge and the fan was turned on. She was administered Pamol[15] 20ml and repositioned. It was noted that Mrs A was feeling lethargic,[16] and RN F asked staff to observe her.

31 Month1

36. At 4am, a nurse recorded in the progress notes: "[Mrs A] was settled overnight. Temp[erature] 37c at 3 am and nil complaints voiced — checked regularly [and] turned."

[12] White blood cells that help the body to fight infection. A high number of leucocytes in the urine may indicate a UTI.
[13] Medication used to treat nausea and vomiting.
[14] A cough mixture.
[15] A medication used to relieve pain.
[16] Weary.

37. At 7.50am, RN E administered Mrs A metoclopramide,[17] and recorded her observations as: "T[emperature] 36.6, BP 109/57, P[ulse] 75, R[espirations] 16, O2 [oxygen saturation] 96%." RN E noted that the Care Manager was notified regarding Mrs A's condition, that Mrs A was to be reviewed by her GP in two days' time, and that her family was to be kept updated. At 10.20am, RN E noted that Mrs A remained lethargic and nauseated.

38. At 1.30pm, RN E recorded in the progress notes:

> "Family visited today and were updated. Linctus Gee given at [1pm]. Temp[erature] 37.2 c when re-checked. [Dr C] notified by care manager. [Mrs A] has asked to see [the Chaplain]."

39. Dr C said that she was telephoned by the Care Manager on the afternoon of 31 Month1. Unfortunately, she was unable to see Mrs A, but she suggested that staff contact her delegated after-hours provider. The after-hours provider was not contacted by the rest home.

40. At 11pm on 31 Month1, RN F recorded the following:

> "[Mrs A] was feeling miserable with nausea at [4.30pm] — give[n] metamide 10 mgs … taking regular pamol and given linctus gee 5mls ... [at 9pm] but [Mrs A] having difficulties in swallowing medications and feels like she is choking. Looking flushed at [9pm]. Temp 38 c. Cooling measure commenced. Taking small sips of lemonade regularly."

1 Month2

41. On 1 Month2, Mrs A was reviewed by Dr C, who noted:

> "[Mrs A] is in bed, weak, pale (as per her usual) T[emperature] 37.3 (was 38 in the early hours of the morning … Assessment: bronchitis[18] likely and given development of fever … Plan: antibiotics, comfort cares, push fluids,[19] nebulisers[20] prn[21] to relieve coughing …"

42. At 2.30pm, a nurse noted that Dr C had reviewed Mrs A and had prescribed nebulisers as necessary to relieve her coughing.

43. The rest home said that "no RN entries [are] evident from 1 [Month2] at [2.30pm] to 4.15 am of 2 [Month2]". There is no record that any nebulisers were administered to Mrs A after they were prescribed. The rest home told HDC that nebulisers were available and should have been administered to Mrs A.

[17] Generic name for Metamide.
[18] Inflammation of the lungs.
[19] Ensure that plenty of fluid is given.
[20] Medication administered as a fine mist to treat lung conditions.
[21] "Pro re nata" — "as needed".

2 Month2

44. At 4.15am, the progress notes state: "[Mrs A] had a really large loose [bowel movement]. Washed and changed … feeling clammy and hot …"

45. Dr C reviewed Mrs A later in the morning and recorded: "Deteriorated further — not eating and drinking this morning and complained of pain … D[iscussed] w[ith] Family — for comfort cares. Plan: stop oral agents and for palliative meds." Dr C prescribed midazolam,[22] Nozinan,[23] and hyoscine hydrobromide[24] to be administered via a syringe driver.[25] No end-of-life care plan was prepared following this diagnosis. The rest home told HDC that an end-of-life care plan should have been prepared immediately once Dr C had prescribed the end-of-life medications.

46. At 12.25pm, the progress notes record Dr C's plan to use a syringe driver for the prescribed medications, and note that Mrs A's temperature was 40.4°C, and that her enduring power of attorney had been notified of her deteriorating condition. The syringe driver medication prescription was faxed to the pharmacy.

47. Ms B told HDC that the family was not informed of Mrs A's deteriorating condition until after Dr C's review on 1 Month2. Ms B stated: "[T]his delay in informing family meant that some family who live further away, and wished to be with her could not get to [her] prior to her death."

48. The rest home's Syringe Driver Checking Sheet records the starting time of the syringe driver as 2.40pm.

49. Nothing is recorded in the progress notes from 12.25pm to 5pm.

50. At 5pm, the progress notes record that Mrs A was in pain and had discomfort when breathing. At 5.10pm, the progress notes record that oxycodone[26] 2.5mg and midazolam 2.5mg were administered for pain and agitation. The level of Mrs A's pain and discomfort was not documented.

51. The progress notes record that Mrs A passed away peacefully at 5.40pm, with one of her daughters present. At 7pm, Dr C reviewed Mrs A and recorded that the main cause of death was septicaemia.[27]

[22] A sedative medication used to treat anxiety and agitation.
[23] Medication used to relieve anxiety and distress associated with severe pain.
[24] Medication used to prevent nausea and vomiting.
[25] A pump that delivers medication from a syringe at a constant rate.
[26] An opioid medication used to treat moderate to severe pain.
[27] Blood poisoning.
[28] *Te Ara Whakapiri: Principles and guidance for the last days of life* — a Ministry of Health document that outlines the essential components and considerations required to promote quality of care at the end of life for all adults in New Zealand.

52. Ms B stated:

> "It took more than 2 hours and 15 minutes before [rest home] staff got the syringe driver connected to [Mrs A]. My sister … had to ask the staff 3 times when they were coming to do that as [Mrs A] was exhibiting clear signs of pain and distress … [The staff] were too busy to provide humane care to a dying wom[a]n. If someone is terminal and in pain at the end of life they are a priority."

53. In relation to the care provided to Mrs A from 31 Month1 to 2 Month2, the rest home told HDC:

> "There were no documented assessments or S[hort] T[erm] C[are] P[lan]s noted on file to indicate that an assessment, management and evaluation process had been taken to promote [Mrs A's] comfort … Only on one occasion was there mention of 'cooling measures commenced' but no other mention of the ongoing implementation … There is no evidence on file to show that staff followed the Enliven policy and documentation standards to manage [Mrs A's] pain and promote comfort during this time … There was noted failure to take into account … the administration of prescribed nebulizers by staff."

Subsequent events

54. On 11 December 2017, Presbyterian Support sent an apology letter to Mrs A's family. The letter stated:

> "Please accept my letter as Enliven Presbyterian Support Central's sincere apology for the way in which your mother's care was managed at [the rest home] … Over that period there were significant issues at [the rest home] that impacted on the level of care [Mrs A] received."

55. The rest home told HDC:

> "In early [Month2], a visit by the General Manager identified a significant systems failure in the management and clinical practice at [the rest home]. [The] manager was immediately put on special leave and [did not return] … [A]s a result of reorganisation, five of the staff who looked after [Mrs A] at the time in question are no longer Enliven employees."

Changes made since incident

56. The rest home told HDC that as a result of this incident and the significant systems and clinical practice concerns, it addressed several issues and made several improvements over the year. The rest home advised that the following occurred:

a) External audit and certifications: There was a Ministry of Health Surveillance audit in 2015, a District Health Board issues-based audit in 2016, a Ministry of Health Surveillance audit in 2016, and a Ministry of Health Certification audit in 2017. The

rest home received sign-off from the Ministry of Health and District Health Board that systems were in place to meet the expected standards and contractual requirements.

b) Changes to the rest home Senior Team: the rest home employed a relieving manager, a new Home Manager, a new Clinical Nurse Manager, and two new Clinical Coordinators.

c) Staff training and development: The new senior clinical staff were supported into their role through a comprehensive orientation and induction programme. They also attended a three-day senior nurse orientation with the Clinical Director and a nurse consultant. Staff were provided with training on palliative care and *Te Ara Whakapiri*.[28]

d) Performance reviews: Managers assessed individual staff members' performance over the previous year against the agreed plans, goals, and standards included in the key expectations of their position descriptions.

e) Purchase of Lee-Care,[29] an electronic resident management system: This is to enable better streamlining of clinical records and to provide alerts and reminders for nurses around residential assessments, support plans, and evaluation of care delivery.

f) Review regarding end-of-life care: In 2018, the Clinical Director undertook case reviews with staff to look at the care delivery provided to residents with complex medical issues at the end of their life. The rest home said that the reviews provided a great opportunity for nurses to learn and reflect as peers on the delivery of care.

g) Introduction of Health Checks in 2017: Once a year, each home is peer reviewed by senior staff from other homes. The rest home said that this has enabled Enliven to make improvements at all homes.

h) Use of the GOSH[30] system: The GOSH system is used to record resident incidents, infections, complaints, and outbreaks. In 2016, an additional capability to the GOSH system was trialled to flag due dates of assessment and support plan reviews.

i) Audit training: In 2016, audit training was provided to the rest home staff by a full-time nurse consultant who had recently undertaken the Auditing in Healthcare Training Programme with Quality Plus.

57. The rest home completed an audit with HealthCERT in 2019. The audit report stated that the rest home fully attained all the required standards with no shortfalls or proposed changes identified.

[28] *Te Ara Whakapiri: Principles and guidance for the last days of life* — a Ministry of Health document that outlines the essential components and considerations required to promote quality of care at the end of life for all adults in New Zealand.
[29] Aged-care management software.
[30] On-line health and safety system.

Rest home policies

58. The rest home provided HDC with its "Assessment and Support Planning" policy, which states:

> "Short Term Care Plan — Permanent and Respite Residents
>
> A short term care plan is developed for short term problems such as infections or treatments. This is often put on red or yellow paper to draw attention to it."

59. The Pain Management policy states:

> "All residents have a pain assessment using one of the three pain assessment tools: upon admission, when acute pain occurs, when exacerbation of chronic pain occurs … The provision, timing and monitoring of an appropriate analgesic medicine, both PRN and regular as prescribed, is an important intervention. However, other comfort measures must be included in the short term and long term support plans … When acute pain occurs or there is [a]n exacerbation of chronic pain an Assessment and Short term Care Plan — Pain is commenced."

60. The Medicine Management policy states:

> "PRN medicines are used to treat specific symptoms when required … The administration of PRN medicine is to be by the RN after they have completed the assessment of the resident."

61. The Death, Dying and Bereavement policy states:

> "Every effort is made to maintain a resident's sense of wellbeing during the final stage of life, and to ensure family/whānau feel informed and involved in the knowledge that their relative is cared for with sensitivity, confidentiality and professional support."

62. Guidelines in the policy state:

> "
> - Staff identif[y] the particular needs of dying residents and their family/whānau and ensure an end of life plan is in place.
> - Family/whānau members are given adequate and clear information of the dying process. The Registered Nurse, in consultation with the GP, will give professional advice on care and management.
> - Full and open communication is maintained.
> - Adequate and appropriate symptom control, including pain relief, is available.
> - Medical and nursing attention is continued even though treatment goals may be changed to comfort goals."

63. The End of Service Planning policy states: "[D]eath, discharge and transfer are documented on the End of service checklist, which is retained in the resident's file. A copy is given to the Manager."

Responses to provisional opinion

Ms B

64. Ms B was provided with an opportunity to comment on the "information gathered" section of the provisional opinion. Ms B reiterated her concerns about the care provided to her mother, and stated:

> "My mother was a [health practitioner for many] years; and cared for human-kind greatly. She was a very generous person, and if her death has contributed to the Enliven Group improving their policies and procedures; then what an ultimate generous gift she has given."

Rest home

65. The rest home was provided with an opportunity to comment on the provisional opinion. It stated:

> "[W]e have had an opportunity to review the report and the proposals which we are mostly in agreement with … [W]e will follow-up the other recommendations you have outlined in the provisional report and keep you updated."

Relevant standards

66. The rest home utilises the Ministry of Health *Te Ara Whakapiri: Principles and guidance for the last days of life* (released in 2015 and updated in April 2017) (*Te Ara Whakapiri*). The rest home said that Enliven uses this resource as the core reference manual for end-of-life care. In 2015, the Clinical Director of Enliven included the following in an internal newsletter:

> "The Te Ara Whakapiri document takes a broader perspective and provides principles and guidance for the last days of life. It is to be used as a resource supporting clinical best practice and decision making. Decision making and communication around caring for a resident in their last days of life are to be documented on the resident support plan and in the Health Status Summary …"

67. The *Te Ara Whakapiri* guidelines state:

> "[H]ealth practitioners should conduct a baseline assessment to identify a person's priorities of care, symptom management needs and physical care needs … [T]he baseline assessment should include conversations with the person and their family/ whānau about factors contributing to the person's changing condition and options for

> an individual plan of care. Health practitioners should develop an individualised care plan for a person in their last days of life, in collaboration with the person and their family. Practitioners should clearly document the plan, and regularly review it and practitioners should undertake regular assessments of the person's condition, to ensure that they can address changes in a timely manner."

68. The *Te Ara Whakapiri* guidelines include a tool to identify the dying patient (Tool A). Tool A states:

> "[I]t is important that dying is identified as early as possible, as this can ensure that the appropriate care and communication needed by patients and families/whānau are anticipated and provided. It also allows the clinical team to prioritise the goals of comfort and support based on the patient's preferences."

69. Tool A provides examples of different modes of dying, which may involve a period of increasing weakness and tiredness, a period of withdrawal, and difficulties in swallowing, etc. Tool A states:

> "[T]here are five symptoms specifically associated with the dying process … Not every dying patient experiences these symptoms, but some may experience all five. The five symptoms associated with dying are a) pain, b) nausea and vomiting, c) agitation and distress, d) respiratory tract secretions, and e) breathlessness."

70. Tool A concludes:

> "[T]he standard of end-of-life care by which we should judge the care that we deliver is whether we would be content if the same care was given to our own family/ whānau or to ourselves."

71. The Health and Disability Sector Standards NZS 8134.1.2:2008 (NZHDSS) state:[31]

> "Service Management Te Whakahaere Ratonga
>
> Standard 2.2 The organisation ensures day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.
>
> …
>
> Family/whānau participation Urunga Whānau
>
> Standard 2.6 Family/whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals."

[31] https://www.standards.govt.nz/assets/Publication-files/NZS8134.1-2008.pdf.

Opinion: Presbyterian Support Services (Central) Limited

72. The NZHDSS require that rest homes ensure that the operation of their services are managed in an efficient and effective manner, to provide timely, appropriate, and safe services to consumers.[32] The rest home had the ultimate responsibility to ensure that Mrs A received care that was of an appropriate standard and that complied with the NZHDSS and the Code of Health and Disability Services Consumers' Rights. It needed to have in place adequate systems, policies, and procedures, and then ensure compliance with those policies and procedures so that the care provided to Mrs A was appropriate and that any deviations from good care were identified and responded to.

73. Mrs A was let down by various aspects of the care provided to her by numerous staff at the rest home during her stay. Expert advice was obtained from RN Rachel Parmee, who stated:

> "I believe systematic failure, through poor staff skill mix, education and oversight of practice contributed to the individuals' ongoing sub-standard practice … I believe the overall departures are attributable to a systematic failure rather than attributable to a particular clinician."

74. I agree with RN Parmee's advice. I have carefully considered the extent to which the deficiencies in Mrs A's care occurred as a result of individual staff action or inaction, as opposed to systemic and organisational issues. The problems that arose with Mrs A's care were not the result of isolated incidents involving one or two staff members, but are attributable to several registered nurses, healthcare assistants, and clinicians who provided care to Mrs A during her stay at the rest home.

75. The rest home told HDC that in early Month2 a visit by the General Manager identified a significant systems failure in the management and clinical practice at the rest home, and that consequently the employment of several staff was terminated and there was a major change to the management team. As a result of the issues identified, the rest home underwent an additional audit by the Ministry of Health.

Standard of care from Month1 to Month2— breach

Failure to prepare short-term care plans

76. Between Month1 and Month2, several changes in Mrs A's condition should have prompted the commencement of a short-term care plan, including the following:

- Several documented complaints of a burning sensation around Mrs A's vulvar area in Month1;
- A high temperature (between 38 and 40°C) between 30 Month1 and 2 Month2;
- A suspected UTI in Month1; and

[32] NZS 8134.1:2008, Standard 2.2.

- The diagnosis of bronchitis and deterioration of Mrs A's respiratory condition in early Month2.

77. The rest home's Assessment and Support Planning policy states that a short-term care plan should be developed for short-term problems such as infections.

78. RN Parmee advised that it is expected that "a short term care plan (STCP) is documented and followed in the event of a significant change in patient status", and that "there has been a highly significant departure from accepted practice" and "the standards of care planning and intervention have not been met in this case".

79. I agree with RN Parmee. I am critical that the rest home did not commence any short-term care plans despite Mrs A's concerning symptoms and her overall deteriorating condition. It is clear that staff did not comply with the rest home's policies, and this was likely attributable to the systematic failure at the rest home. Preparation of short-term care plans by the nursing staff would have assisted in ensuring that there was planned follow-up, review, and appropriate investigation of Mrs A's symptoms.

Pain management of Mrs A's vulvar condition

80. In Month1, the progress notes recorded several complaints by Mrs A about the burning sensation in her vulvar area. The notes document that staff mainly applied Micreme or non-ionic cream to treat her vulvar pain. It was noted that on several occasions Mrs A refused to have the cream applied. No short-term care plan was prepared, and staff did not investigate why Mrs A refused the cream.

81. The Pain Management policy requires that when acute or chronic pain occurs, staff must undertake a pain assessment, prepare a short-term care plan, and provide any appropriate intervention.

82. RN Parmee advised:

> "Further investigations by the RN may have helped explain [Mrs A's] reluctance to have Micreme applied. There is no further documentation of assessment, treatment or evaluation of treatment to this pain and discomfort."

83. I accept RN Parmee's advice. I am critical that despite entries in the progress notes by numerous staff, there was no pain assessment of Mrs A's vulvar condition. As a result, no plan was prepared and appropriate treatment provided for Mrs A's vulvar pain. I am also critical that staff did not investigate why Mrs A refused to have the cream applied.

Failure to inform GP of UTI

84. On 19 Month1, Dr C assessed Mrs A and ordered urine and faecal samples to be sent to the laboratory. The progress notes record the result of the urine sample as positive for leucocytes, protein, and blood (indicating infection). However, Dr C was not informed of the test result.

85. RN Parmee advised:

> "[There were] clear signs of urinary tract infection … [T]here does not appear to be any subsequent recording of vital signs or reporting to the GP which would be accepted practice. These symptoms appear to be in conjunction with vulval pain and excoriation. Again [this was] a trigger for further assessment, intervention and a prescribed plan of care."

86. I agree with RN Parmee's advice. I am concerned that Dr C was not informed of the test result immediately, and that no further intervention was undertaken.

Failure to administer nebulisers for respiratory condition

87. On 1 Month2, Mrs A's condition deteriorated and she was seen by Dr C. Dr C diagnosed Mrs A with bronchitis and prescribed PRN nebulisers. However, the rest home staff did not administer any nebulisers to Mrs A despite these being available. The rest home accepted that this was an omission.

88. RN Parmee advised:

> "Given [Mrs A's] reported symptoms it would be expected practice for prescribed medications to be administered along with Gees Linctus and paracetamol … [T]here was a failure to administer prescribed nebulisers to [Mrs A] for her respiratory distress."

89. I agree with RN Parmee's advice and am critical that nebulisers were not administered. The rest home's Medicine Management policy states that PRN medicines are to be used to treat specific symptoms when required. The rest home accepted that nebulisers should have been administered to Mrs A.

End-of-life care planning

90. From 30 Month1, Mrs A continued to deteriorate. She was feeling nauseated and was coughing, and she had a high temperature and a sore throat. She remained nauseated with a high temperature on 31 Month1. It was also noted that she was having difficulty swallowing medications, and felt like choking. Mrs A asked to see the chaplain.

91. On 1 Month2, Mrs A was reviewed by Dr C, who noted that Mrs A was weak and pale, and advised that comfort cares were to be provided. Dr C reviewed Mrs A again on 2 Month2, and prescribed palliative medications.

92. The rest home's Death, Dying and Bereavement policy provides guidelines that require an End of Life Care plan to be prepared for the comfort of the patient, and for family members to be given clear information. An End of Service checklist is also to be prepared for the death of the patient. The policy incorporates *Te Ara Whakapiri* guidelines. Similarly, *Te Ara Whakapiri* requires that an individualised care plan be prepared in collaboration with the person and the person's family, and that this be documented clearly.

93. No End of Life care plan or any plan for palliative care for Mrs A was documented by the rest home. The rest home said that the End of Life care plan should have been prepared immediately once Dr C had prescribed the palliative medications. The rest home accepted that the end-of-life care provided to Mrs A was not adequate, and told HDC that there is no evidence on file to show that staff followed its policy. RN Parmee advised:

> "End of life or palliative care planning is based on the assessment of nursing staff rather than the prescription of medications by a GP. Palliative care planning should have been initiated as soon as there were signs that [Mrs A] was deteriorating. End of life medications are often prescribed as part of the process and towards the conclusion of end of life care, not as a signal that end of life care has begun."

94. RN Parmee said that the "care plan should include the expected cares … such as turning, mouth cares, cooling cares, attention to family needs and checking of continence products". She noted that Mrs A deteriorated significantly from 30 Month1, and exhibited some of the symptoms specifically associated with dying — as described in Tool A of *Te Ara Whakapiri* — such as nausea, difficulty swallowing, and pain. In addition, on 31 Month1 Mrs A asked to see a chaplain. In my opinion, an End of Life Care plan should have been prepared on or around 30 Month1, and I am critical that this was not done.

End-of-life care provided on 2 Month2

95. In the morning of 2 Month2, Mrs A was prescribed palliative medications to be administered via a syringe driver. The rest home's progress notes record Dr C's instructions at 12.25pm. The prescription was faxed to the pharmacy, and the medications were first administered at 2.40pm. Mrs A passed away at 5.40pm.

96. Ms B told HDC that her sister asked staff several times to start the syringe medication immediately, and the family's impression was that "the staff were too busy to provide humane care to a dying wom[a]n".

97. RN Parmee identified the following concerns regarding the palliative care provided to Mrs A on 2 Month2:

- There was a significant delay in starting the syringe-driver medications. RN Parmee noted that "it would be expected that these medications would be on hand in the facility and commenced as soon as prescribed". She deemed the delay "unacceptable".
- There was no documentation of Mrs A's level of pain and discomfort in her last hours.

98. RN Parmee considered that the end-of-life care provided to Mrs A was not adequate. She said: "Consequently Mrs A received, what I consider to be, less than adequate end of life care … [T]his is a highly significant departure from accepted practice and care." As Tool A of *Te Ara Whakapiri* states, "The standard of end-of-life care by which we should judge the care that we deliver is whether we would be content if that same care was given to our own family/whānau or to ourselves."

99. I agree with RN Parmee's advice. I am critical of the delay in administering syringe-driver medications to Mrs A. Staff should have retrieved the syringe-driver medications from the pharmacy immediately following Dr C's prescription, to ensure that Mrs A's level of discomfort and pain was minimised.

Documentation overall

100. I am concerned by the level of documentation by rest home staff in the progress notes, and note the following deficiencies:

- From 2.30pm on 1 Month2 to 4.14am on 2 Month2, there were no entries by registered nurses.
- From 4.15am to 12.25pm and from 12.26pm to 5pm on 2 Month2, no entries were recorded.
- It was not noted which family member was notified of the change in Mrs A's status, or what information was provided.

101. RN Parmee advised that the "shortfalls are clearly related to poor documentation of observations, [and] lack of follow up in terms of reporting and interventions". She considered that it was "not adequate just to note that family were informed particularly when there are several next of kin".

102. From 4.15am on 1 Month2 to 5pm on 2 Month2, there were only two entries in the progress notes by the rest home's staff, and one entry recorded only the instructions from Dr C. There is no record of what was communicated to the family, and who had been communicated with. The *Te Ara Whakapiri* guidelines state that practitioners should clearly document a plan and undertake regular assessments of the person's condition. I am very critical of the quality of the documentation by the rest home during Mrs A's final days.

Conclusion

103. In summary, I find that the rest home did not provide appropriate care and services to Mrs A for the following reasons:

a) No short-term care plan was prepared in response to Mrs A's change in status.

b) Mrs A's vulvar pain was not assessed and treated adequately.

c) Dr C was not informed of the urinary test result.

d) Mrs A was not administered nebulisers.

e) Mrs A was not provided with adequate end-of-life care, including:

   (i) a delay in starting her syringe driver medications; and

   (ii) a lack of planning.

f) Documentation by staff was poor.

104. As a consequence, Mrs A's symptoms and pain were not assessed and responded to appropriately. Accordingly, I find that the rest home breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[33]

Communication with family — adverse comment

105. On 30 Month1, one of Mrs A's daughters visited her at the rest home and informed staff that she could be contacted "day or night" if Mrs A's condition deteriorated. This was recorded in the progress notes. On 1 Month2, Mrs A was reviewed by Dr C and diagnosed with bronchitis and fever. The family was not informed until 2 Month2, following a further review by Dr C.

106. Ms B told HDC that because of this delay, some of the family were unable to reach the rest home in time to visit Mrs A in her final hours. RN Parmee advised:

> "[F]amily also received inadequate care in terms of notification of [Mrs A's] status and presence of staff to provide reassurance and regular care during the last days of [Mrs A's] life."

107. *Te Ara Whakapiri* strongly emphasises the importance of clear communication to family, and the rest home's Death, Dying and Bereavement policy states that family members are to be given clear information, and that full and open communication is to be maintained. This did not occur. I am critical that the rest home did not keep the family updated and fully informed of Mrs A's deteriorating condition, and that there was no discussion with Mrs A's family about an End of Life care plan.

Documentation of potential multiple myeloma — adverse comment

108. Prior to being admitted to the rest home, Mrs A was advised by the public hospital that she might have multiple myeloma. Subsequently, she was advised by a haematologist that she had MGUS. The public hospital's medical record notes MGUS as a likely diagnosis, and also multiple myeloma as a possibility. A copy of the medical record was provided to the rest home when Mrs A was admitted. In 2013, the public hospital sent the rest home a copy of the public hospital's Care Plan report, which provided updated information that there was "no diagnosis of multiple myeloma" as previously advised.

109. The rest home prepared Mrs A's Care Plan, which noted that Mrs A was likely to deteriorate owing to her diagnosis of multiple myeloma. The Care Plan was updated the following month, but the information regarding multiple myeloma was not removed or amended. RN D said that the diagnosis of multiple myeloma was not changed when the Care Plan was updated because she had numerous other tasks and was concerned by the workload of the remaining registered nurses.

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

110. RN Parmee advised:

> "The standard of care is that all documentation be accurate. This includes the documentation of diagnoses present on admission … [T]he continuing belief that [Mrs A] had a terminal illness could possibly have affected ongoing decisions regarding her care."

111. A care plan is an essential tool for ensuring that a resident's care requirements are communicated to all staff involved in the resident's care. I am critical that the rest home did not update Mrs A's Care Plan following receipt of the information that she did not have multiple myeloma.

Administration of Augmentin — no breach

112. The DHB Care Plan report noted a warning of Mrs A's potential allergy to Augmentin. The suspected allergy was also noted in the rest home's Risk Summary and Mrs A's medication chart. Mrs A was administered Augmentin on four occasions.

113. Dr C told HDC that she was aware of Mrs A's potential allergy, but explained that in Mrs A's case the benefits of prescribing Augmentin outweighed its risks. RN D said that she considered that it should be safe to administer the Augmentin, as it had been prescribed by Dr C. Mrs A was monitored, and there was no allergic reaction to the Augmentin.

114. My in-house clinical advisor, GP Dr David Maplesden, advised:

> "I think [Dr C's] explanation regarding use of Augmentin and management of [Mrs A's] intermittent vulvitis … is satisfactory and there was no significant departure from accepted standards of care … [T]here is no evidence [Mrs A] was allergic to Augmentin or that there was any contraindication to its use."

115. I agree with Dr Maplesden that the administration of Augmentin to Mrs A was appropriate.

Recommendations

116. I note RN Parmee's statement that she is "satisfied that each of the issues raised in [her] initial report have been addressed and that robust processes and remedial actions have been put in place to ensure that there should not be a recurrence of these issues". I also note that in 2019, HealthCERT audited the rest home, and it fully attained all the required standards. Nevertheless, in light of this complaint and the findings made, I recommend that Presbyterian Support Central Limited:

a) Provide a written apology to Mrs A's family. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms B.

b) Conduct an audit of staff compliance with the following policies for the preceding four months from the date of this report:

   i. Death, Dying and Bereavement policy and *Te Ara Whakapiri* guidelines;

   ii. Pain Management policy;

   iii. End of Service Planning policy; and

   iv. Medicine Management policy, particularly the use of PRN medication by staff.

   The results of the audit are to be reported to HDC within six months of the date of this report.

c) Use this report as a basis for staff training at Presbyterian Support Services (Central) Limited, focusing particularly on the breaches of the Code identified, and provide HDC with evidence of the training having been completed, within six months of the date of this report.

Follow-up actions

117. A copy of this report with details identifying the parties removed, except the experts who advised on this case and Presbyterian Support Services (Central) Limited, will be sent to HealthCert (Ministry of Health), the DHB, and the New Zealand Aged Care Association, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was received from RN Rachel Parmee:

"1.Thank you for the request to provide clinical advice regarding the complaint from [Ms B] in relation to the care of her mother [Mrs A] at [the rest home] from [her admission in] 2013 to 2 [Month2] 2016.

In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I registered as a nurse in 1985. Upon registration I worked as a RN in the Haematology ward at Christchurch Hospital. This included care of acutely ill elderly patients. In 1986 I engaged in study for a Diploma in Social Sciences (Nursing) and worked 2 nights a week in the Oncology Ward at Palmerston North Hospital. On return to Christchurch, I worked as a staff nurse in the Ear, Nose and Throat Ward and became Charge Nurse of that ward from 1987 through to 1992. I then moved to Dunedin and worked as a senior lecturer at Otago Polytechnic during the development of the Bachelor of Nursing programme. I completed my Master of Nursing at Victoria University in 1998. My thesis studied patient education and chronic illness. In 1999 I was appointed Charge Nurse of the Children's Unit at Dunedin Hospital. I returned to Otago Polytechnic in 2001 and was appointed Principal Lecturer and Programme Manager of the Postgraduate Programme in 2003. In 2005 through to 2006 I worked as a sole charge Practice Nurse in a local General Practice. In 2008–2010 I worked as Co-ordinator of Education Programmes for Southlink Health. In 2011 I moved to Christchurch where I worked as an RN in the Hospital wings of 2 large Residential Villages and a senior lecturer at Christchurch Polytechnic specialising in care of the elderly. In 2013, upon return to Dunedin, I worked as a Clinical Co-ordinator at Dunedin Hospital. In 2014, I worked as an Academic Advisor at Otago Polytechnic. In 2015 I worked as Nurse Manager at a local Rest Home. My current role is co-ordinating courses in the Enrolled Nurse programme at Otago Polytechnic. I am currently a member of the Nursing Council of New Zealand's Professional Conduct Committee.

3. The Commissioner has requested that I review the documentation provided and advise whether I consider the care provided to [Mrs A] by [the rest home] was reasonable in the circumstances and why.

With particular comment on:

1) Whether the actions taken by nursing staff in response to [Mrs A's] deterioration in [2016] were appropriate.
2) Whether [Mrs A] received appropriate palliative care prior to her death [in] 2016.
3) The administration of medication to [Mrs A] in [2016].

4) The overall nursing care provided to [Mrs A] in [2016].

5) Any other matters in this case that I consider amounts to a departure from accepted standards of care.

For each question I am asked to advise:

a. what is the standard of care/accepted practice?

b. if there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be?

c. how would it be viewed by peers?

d. recommendations for improvement that may help to prevent a similar occurrence in future.

4. In preparing this report I have reviewed the documentation on file:

1) Letter of complaint dated [2017]

2) [The rest home's] response dated [2017]; including an investigation, clinical review, apology from [Presbyterian Support], and audit reports.

3) [Rest home] policies on end of life care.

4) Clinical records from [the rest home] covering [the final few months of Mrs A's life].

5) Clinical records from [the medical centre] [covering the final few months of Mrs A's life].

5. Background

[Mrs A] was admitted to [the rest home] from [the public hospital] [in] 2013. She became unwell in [2016] and died in [the rest home] [a short time later]. The cause of death was recorded as septicaemia.

6. Were the actions taken by nursing staff in response to [Mrs A's] deterioration in [Month1]/[Month2] appropriate?

My response to this question is based on review of the progress notes and other documentation provided by [the rest home] along with the findings of the investigation carried out by [the Clinical Director] and the letter of apology sent to [Mrs A's] family by [Presbyterian Support].

a. What is the standard of care/accepted practice?

The accepted standard of care is that when there is a deterioration in client status all observations (both objective and subjective) and responses to these observations are recorded in client progress notes. It is also expected that a short term care plan (STCP) is documented and followed in the event of a significant change in patient status.

In this case significant change was exhibited by [Mrs A] in terms of:

(i) Pain

[Mrs A] was reported to be experiencing pain in her vulval region (3 [Month1], 7 [Month1], 9 [Month1], 13 [Month1]), shoulders, back and heels (24 [Month1]).

Interventions noted were ionic cream for vulval pain and excoriation on 09 [Month1] and on 13 [Month1] [Mrs A] refused Micreme. [Mrs A's daughter] notes that her mother had complained of extreme burning when a cream had been applied to her vulval area. [Ms B] contends that this may have been an anti-inflammatory cream applied in error and probably explains her mother's reluctance to have Micreme applied. Further investigation by the RN may have helped explain [Mrs A's] reluctance. There is no further documentation of assessment, treatment or evaluation of treatment to this pain and discomfort. Accepted practice would have been implementation of a short term care plan which documented assessment, treatment and evaluation. [Ms B] notes that the inflammation of [Mrs A's] vulval area was still present after her death on 02 [Month2].

(ii) Nausea

It was recorded that [Mrs A] was complaining of nausea for the previous 3 days on 28 [Month1], and again on 31 [Month1], 01 [Month2] and 02 [Month2]. On each occasion Metoclopramide was administered with varying degrees of effectiveness.

(iii) Fever

[Mrs A] was reported as having a temperature of 36 degrees Celsius and then 38.4 degrees on 30 [Month1], 38 degrees on 31 [Month1] and 40 degrees on 02 [Month2]. She was also reported as being 'clammy, hot and rattley' on 02 [Month2]. It was recorded that she was given cooling cares on 30 [Month1] only. A raised temperature is often absent or a late finding in the elderly experiencing fever. Therefore other indicators such as lethargy loss of appetite and urinary symptoms (all of which were experienced by [Mrs A]) needed to be responded to as signs of possible infection.

Again documentation was sporadic and no short term care plan was documented. This would be the expected standard of practice.

It is noted that regular paracetamol was administered. However, this should have been done in the context of a short term care plan.

(iv) Respiratory status

[Mrs A] reported a cough and was diagnosed by the GP as having bronchitis on 31 [Month1]. Nebulisers and antibiotics were prescribed but records show administration of one dose of antibiotics and no nebulisers. Given [Mrs A's] reported symptoms it would be expected practice for prescribed medications to be administered along with Gees Linctus and paracetamol. A short term care plan would also have been indicated.

(v) Change in level of responsiveness

[Mrs A] reported herself to be tired and not feeling well. This was reported but no assessment or interventions were noted as would be expected.

(vi) Change in nutritional status

Given [Mrs A's] reports of nausea and sudden decline in appetite beginning 26 [Month1] it would be expected that this would trigger a plan of care to ensure that her nutritional needs were met.

(vii) Urinary tract infection

[Mrs A] had urine samples collected on several occasions (13 [Month1], 14 [Month1], and 19 [Month1]) with the latter showing clear signs of urinary tract infection (positive leucocytes, protein and blood). She was also noted as being confused on 19 [Month1]. On each of these occasions there does not appear to be any subsequent recording of vital signs or reporting to the GP which would be accepted practice. These symptoms appear to be in conjunction with vulval pain and excoriation. Again a trigger for further assessment, intervention and a prescribed plan of care.

b. If there has been a departure from the standard of care or accepted practice, and how significant departure this is?

I consider there to have been a highly significant departure from accepted practice and therefore standard of care in each of these incidences. I have stated above my reasons for this finding.

c. How would it be viewed by your peers?

My peers in practice and education would agree that the standards for documentation, care planning and intervention have not been met in this case.

d. Recommendations for improvement that may help to prevent a similar occurrence in the future.

My recommendation is that there be ongoing staff education in terms of documentation and care planning with a particular focus on the need to report findings to the clinical manager and GP to ensure that appropriate advice is sought in regard to appropriate interventions.

7. Did [Mrs A] receive appropriate palliative care prior to her death on 2 [Month2]?

a. What is the standard of care/accepted practice?

There are very clear guidelines in the End of Life policy (Te Ara Whakapiri) which was introduced to the [the rest home] in [2015] — prior to [Mrs A's] decline and need for palliative care. This includes the need for an End of Life Care plan.

This care plan should include the expected cares noted by [Mrs A's] daughter [Ms B] such as turning, mouth cares, cooling cares, attention to family needs and checking of continence products.

Accepted practice would include the timely administration of prescribed end of life medication, including palliation of pain, restlessness, anxiety and other symptoms.

It would be expected that these medications would be on hand in the facility and commenced as soon as prescribed. In this case the syringe pump was not started for some 2 hours and 15 minutes following prescription. In any circumstances I would deem this unacceptable.

There was no documentation of [Mrs A's] level of pain and discomfort during her last hours. It was not noted which family members were notified of her status. It is not adequate just to note that family were informed particularly when there are several next of kin.

b. If there has been a departure from the standard of care or accepted practice, and how significant a departure this is?

I consider each of these findings to be a highly significant departure from accepted practice and standard of care. Consequently [Mrs A] received, what I consider to be, less than adequate end of life care.

c. How would it be viewed by your peers?

My peers would agree that this is a highly significant departure from accepted practice and care.

d. Recommendations for improvement that may help to prevent a similar occurrence in the future.

I recommend that all staff be expected to observe the guidelines and principles of Te Ara Whakapiri (including an accurately documented and monitored End of Life Care plan) as a condition of their employment.

8. The administration of medication to [Mrs A] in [Month1]/[Month2]

What is the standard of care/accepted practice?

In this case the most significant aspect of accepted practice is noting and appropriately responding to a documented drug allergy. As reported by [the Clinical Director] in reference to [Mrs A's] allergy to Augmentin it was:

> 'Noted on Risk summary page Inter Rai assessment, pre admission care plan report from NASC and medication chart neither the Pharmacy, GP or [the rest home] RNs noticed and acted on the alert.'

Augmentin was administered on 3 occasions in 2015 for urinary tract infections. As [Ms B] notes [Mrs A] developed vaginal thrush in response to Augmentin. The administration of Augmentin could reasonably be linked to [Mrs A's] ongoing issues with vulval irritation and the unnecessary discomfort she experienced from this.

As previously noted there was a failure to administer prescribed nebulisers to [Mrs A] for her respiratory distress. While it may be argued that she was unable to take further doses of the oral antibiotic due to swallowing difficulties, this cannot be argued for failure to administer nebulisers.

b. If there has been a departure from the standard of care or accepted practice, and how significant a departure this is?

Failure to note and act on a documented allergy is a highly significant departure from practice.

In this case there were several points where this was missed (GP, pharmacist and Registered Nurses). The Registered Nurses should be held accountable for not checking this information prior to administration and not holding the GP and pharmacy accountable.

Failure to administer prescribed nebulisers is also a highly significant departure from accepted practice. This could well have added to the discomfort experienced in her last days.

c. How would it be viewed by your peers?

My peers in practice and education would agree that this is a highly significant departure from accepted practice and care.

d. Recommendations for improvement that may help to prevent a similar occurrence in the future.

Further education on the importance of performing all required checks prior to administering medication including checking for documented allergies and all prescribed medications.

9. The overall nursing care provided to [Mrs A] in [Month1]/[Month2]

a. What is the standard of care/accepted practice?

My discussion above outlines the areas where I consider [Mrs A's] overall care was below accepted standard and practice. Shortfalls are clearly related to poor documentation of observations, lack of follow up in terms of reporting and interventions and the absence of appropriate care planning to guide all staff involved in [Mrs A's] care.

From [Ms B's] report it appears that her mother and family also received inadequate care in terms of notification of [Mrs A's] status and presence of staff to provide reassurance and regular care during the last days of [Mrs A's] life.

b. If there has been a departure from the standard of care or accepted practice, and how significant a departure this is?

This is a highly significant departure from the standard of care a family can expect during the final stages of the life of a family member.

c. How would it be viewed by your peers?

My peers in practice and education would agree that this is a highly significant departure from accepted practice and care.

d. Recommendations for improvement that may help to prevent a similar occurrence in the future.

My recommendation would be a robust procedure ensuring that appropriately qualified staff are employed to care for residents with ongoing training in policy and procedures for day to day and end of life care.

10. Any other matters considered to amount to a departure from accepted standards of care

A further matter for concern is the admission documentation for [Mrs A] which failed to recognise the change in her diagnosis of multiple myeloma.

a. What is the standard of care/accepted practice?

The standard of care is that all documentation be accurate. This includes the documentation of diagnoses present on admission. As [Ms B] states the initial diagnosis of Multiple Myeloma indicated that [Mrs A] had a terminal illness with a very short life expectancy. This was subsequently changed and documented in her notes from [the] Hospital. The continuing belief that [Mrs A] had a terminal illness could possibly have affected ongoing decisions regarding her care.

b. If there has been a departure from the standard of care or accepted practice, and how significant a departure this is.

This is a highly significant departure from accepted practice.

c. How would it be viewed by your peers?

My peers in practice and education would agree that this is a highly significant departure from accepted practice and care.

d. Recommendations for improvement that may help to prevent a similar occurrence in the future.

I recommend regular audits by nursing managers of nursing documentation for accuracy of admission and assessment data.

Conclusion

Although my brief is to comment on events leading up to [Mrs A's] death I note that significant change has taken place in the management staffing, education and procedures at [the rest home] which I believe would go a long way to meeting the recommendations I have made.

Rachel Parmee"

The following further expert advice was obtained from RN Parmee:

"Thank you for the opportunity to review further responses in relation to case C17HDC02135 for which I provided a report on 28th May 2018.

I have been provided the following information to review:

1. Response from [the rest home]
2. Response from [the Manager]
3. Response from HEALTH CERT
4. Previous advice provided by me.

In particular I am asked to advise:

a) Whether the information changes my view on the departures or the severity of the departures.

In my initial report I discussed:

1. Whether the actions taken by nursing staff in response to [Mrs A's] deterioration in [Month1]/[Month2] were appropriate.
2. Whether [Mrs A] received appropriate palliative care prior to her death on 2 [Month2].
3. The administration of medication to [Mrs A] in [Month1]/[Month2].
4. The overall nursing care provided to [Mrs A] in [Month1]/[Month2].
5. Any other matters in this case that I consider amount to a departure from accepted standards of care.

For each of these areas I found there to be highly significant departures from the standards of accepted practice. There is nothing in the information provided which

changes my view on the significance of the departures during the time that [Mrs A] was in the care of [the rest home].

However [the] PSC Enliven Clinical Director provides extensive evidence that a thorough and appropriate investigation has taken place into all aspects of management and care provided at [the rest home] in the light of [Mrs A's] situation.

The process reported includes:

- Identification of significant systems failure in the management and clinical practice at [the rest home] in early [Month2].
- Two issues based audits undertaken by the DHB in response to complaints in [2016].
- Two staff members reported to the Nursing Council of New Zealand.
- Clinical director file review which effectively supported the findings in my initial report.

The reported outcomes of this process include:

- Successful external audits and certifications
- Changes in senior staff to ensure competent RNs are in senior roles with appropriate professional development support
- Staff training particularly in relation to end of life care and clearly documented training for clinical nurse managers, registered nurses, enrolled nurses and health care assistants.

The report also includes Enliven policies related to the areas of concern in my initial report including:

1. Assessment and support planning
2. Pain management and STCP
3. Advance care planning and resuscitation
4. Death, dying and bereavement management
5. Medication management

b) Whether the overall departures from the standard of care in [Mrs A's] case are attributable to a particular clinician or a systemic failure.

I have reviewed the extensive documentation concerning the practice of the clinicians caring for [Mrs A].

I am aware that review processes were in place for particular clinicians and that their practice was well below accepted standards. I note that the Nursing Council decided

to take no further action in the case of [one of the nurses] in the light of the remedial processes which had been put in place.

However I believe systemic failure, through poor staff skill mix, education and oversight of practice contributed to the individuals' ongoing sub-standard practice. I believe that the orientation, education, support and supervision processes now in place at [the rest home] make it highly unlikely that the circumstances which influenced the poor standard of [Mrs A's] care would prevail in future.

I believe the overall departures are attributable to a systemic failure rather than attributable to a particular clinician.

In conclusion I am satisfied that each of the issues raised in my initial report have been addressed and that robust processes and remedial actions have been put in place to ensure that there should not be a recurrence of these issues.

Rachel Parmee"

Appendix B: Expert advice to the Commissioner

The following expert advice was obtained from HDC's in-house clinical advisor, vocationally registered general practitioner Dr David Maplesden:

> "1. Thank you for providing this file for advice. To the best of my knowledge I have no conflict of interest in providing this advice. I have reviewed the available information: complaint from [Ms B]; response from [the rest home]; [the rest home] clinical notes; response from [Dr C]; GP notes per [the medical centre].
>
> 2. [Ms B] complains about the management of her mother ([Ms B] (dec)) in [the rest home]. [Mrs A] had been admitted to [the rest home] (hospital level care) from [the public hospital] [in 2013] after receiving treatment at [the public hospital] for a fractured neck of femur. She had experienced significant functional decline following her injury and could not return to her previous rest home. While in [the public hospital], [Mrs A] was diagnosed initially with multiple myeloma (MM) and told she may only live for six months. However, on the day prior to discharge she was reviewed by a haematologist who diagnosed monoclonal gammopathy of uncertain significance (MGUS) which did not have the same poor prognosis as MM. [Mrs A] became unwell [in 2015] [with a] fever and cough and died in [the rest home] on 2 [Month2]. Cause of death was recorded as septicaemia. [Ms B] has identified several issues with her mother's care including:
>
> (i) use of Augmentin on several occasions when this was known to cause [Mrs A] vaginal thrush
>
> (ii) failure to seek alternative medical review on 31 [Month1] when [Mrs A] was unwell and her usual GP ([Dr C]) was unavailable
>
> (iii) failure to notify family of [Mrs A's] deterioration on 1 [Month2] or prior to [Dr C's] assessment on 2 [Month2]
>
> (iv) failure to organise hospital admission for [Mrs A] on 2 [Month2] despite further deterioration in her condition and end of life care plan indicating a desire for intervention
>
> (v) failure to administer prescribed medications from 1 [Month2]
>
> (vi) failure to undertake adequate observations of [Mrs A] in the hours before her death on 2 [Month2]
>
> (vii) delays in initiating end of life medications and failure to provide adequate comfort cares to [Mrs A] on 2 [Month2].
>
> 3. Most of the issues raised by [Ms B] appear to relate to her mother's nursing care and I understand nursing advice is being sought. With respect to [Dr C's] management, her response does not specifically address the issue of prescribing of Augmentin and its relationship to possible recurrent thrush (see below). With respect to [Dr C's] management of [Mrs A] on 1 and 2 [Month2], I believe the management as

documented was clinically sound and consistent with expected standards of care. Given [Mrs A's] age, co-morbidities and deterioration despite use of a broad spectrum antibiotic, I think the option of comfort cares only was entirely appropriate and [Dr C] has documented discussing this option with family members who were apparently in agreement with the approach. The 'end of life' prescribing was consistent with expected practice[1] and [Dr C] had no control over [Mrs A's] subsequent nursing management in this regard.

4. [Mrs A's] hand written drug chart dated [2015] includes a 'sensitivity' yellow sticker warning with the only listed allergy being tetracycline. The computer generated (pharmacy) drug chart dated 19 [Month1] lists, under the categories 'suspected Allergies' and 'suspected Intolerance and Adverse Drug Reactions' the following medications: Augmentin, Metronidazole, Diclofenac, Tramadol, tetracyclines. The [public hospital] discharge summary dated [2013] includes reference to Augmentin as: *(Product Intolerance) — 'thrush' (pp medical records 2011).* The [rest home's] response notes: *Despite Augmentin allergy being mentioned on the Risk summary page, InterRAI assessment, the pre-admission care plan report from NASC and the medications chart (Toniq, one chart) neither the pharmacy, GP and [rest home] RNs noticed the Alert. Hence [Mrs A] was administered Augmentin on several occasions.*

5. The [rest home's] response and notes indicate [Mrs A] was prescribed the following antibiotics for symptomatic urinary tract infections [over a period of 11 months]:

Date	**Antibiotic**
[2016]	Norfloxacillin
[2015]	Augmentin
[2015]	Norfloxacillin
[2015]	Augmentin
[2015]	Augmentin
[2015]	Norfloxacillin
[2015]	Nitrofurantoin (prophylactic)
[2015]	Norfloxacillin
[2015]	Augmentin
[2015]	Norfloxacillin

6. Results provided: MSU results [2015] showed UTI with organism sensitive to Augmentin, cefaclor and norfloxacin. Result from [2015] showed pyuria but negative antibacterial activity. Vulval swab dated [2015] was negative for thrush. Based on the clinical notes, there are likely to be other results which have not been provided. There are several references in the clinical notes to [Mrs A] experiencing vulvovaginal rashes, discharge and irritation and I note anti-thrush treatment was provided on several

[1] MacLeod R, Macleod S, Vella-Brincat J. The Palliative Care Handbook — guidelines for clinical management and symptom control. 6th Edition. 2016. Hospice NZ. ISBN: 978-0-473-36095-5

occasions although I am unable to see any microbiological confirmation of thrush being the cause of [Mrs A's] symptoms.

7. Clinical notes suggest the diagnosis of UTI was generally based on [Mrs A's] symptoms together with positive dipstick urinalysis and positive MSU results (when MSUs were obtained). The choice of antibiotic appears to have been based on current or historical sensitivity results. Diagnosis and management of UTI in elderly institutionalised patients is complex but, based on the clinical notes and limited laboratory results available to me, I feel the management of [Mrs A's] recurrent UTI did not depart from accepted standards of care[2] with respect to the general principles involved. The use of Augmentin when [Mrs A] had an issue with a known common side effect of the medication (thrush) probably requires further comment from [Dr C]. Recurrent thrush is not a contraindication to use of Augmentin, and if the antibiotic is clinically indicated, the side effect can generally be managed effectively through either prophylactic or reactive use of antifungal agents. What might be concerning is the apparent failure of the prescribing alert system, particularly at the dispensing phase. [Dr C] and [rest home] nursing staff were likely to be aware of the nature of [Mrs A's] reaction to Augmentin which did not preclude use of the drug. The dispensing pharmacist might have been aware also, but if not then the prescribing of a drug listed in the Toniq software as an allergy should have generated enquiry from the pharmacist before the drug was dispensed.

8. I recommend the following information be obtained:

(i) Comment from [Dr C] in relation to [Ms B's] complaint: prescribing of Augmentin for [Mrs A] when the drug was listed under 'allergies', and whether it was apparent [Mrs A] was experiencing recurrent thrush as a result of this prescribing rather than recurrent UTIs

(ii) Comment from the dispensing pharmacist regarding the actions taken when [Mrs A] was prescribed Augmentin, noting this was listed on the Toniq database under the categories of suspected allergy or adverse reaction, and standard operating procedure when confronted with this situation."

The following further expert advice was obtained from Dr Maplesden:

"1. I have reviewed the response and clinical notes provided by [Dr C]. The response is consistent with the contemporaneous clinical documentation. I think [Dr C's] explanation regarding use of Augmentin and management of [Mrs A's] intermittent vulvitis (not proven to be related to persistent thrush) is satisfactory and there was no significant departure from accepted standards of care. While [Mrs A] might have been prone to a common side effect of antibiotic use (vaginal thrush) there is no evidence she was allergic to Augmentin or that there was any contraindication to its use. While Augmentin has very few indications as first-line treatment for infections (mammalian

[2] Rowe T et Juthani-Mehta M. Urinary tract infection in older adults. Aging health. 2013 Oct; 9(5): 10.2217

animal bites, diabetic foot ulcers, mastitis in males and non-lactating females)[3], [Dr C] appears to have quite reasonably based her use of the medication on current and historical sensitivity data.

2. I have reviewed the correspondence on file regarding integration issues between [the rest home] and pharmacy prescribing/dispensing systems. I am pleased to see the comment from 1CHART [project manager] that integration issues have been acknowledged and solutions are currently being developed. The point at which pharmacy dispensing occurs is an important 'back stop' to reduce the potential impact of prescribing errors. I recommend [the rest home] review current prescribing and medication management processes and policies (with involvement of relevant GPs) to ensure any significant medication allergy records are available to the dispenser until such time that a reliable automatic two-way transfer of such information between the 1CHART and Toniq (or other pharmacy dispensing software) systems is guaranteed."

[3] https://bpac.org.nz/antibiotics/guide.aspx Accessed 13 June 2018