Presbyterian Support Central
(Operating as Kandahar Home)

Registered Nurse A

A Report by the

Deputy Health and Disability Commissioner

(Case 12HDC01403)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In February 2012, Kandahar Home began accepting terminally ill patients into its care, with specialist nursing and medical support for residents and relevant palliative care education being provided by the District Health Board (the DHB) through the palliative care service.

2. Mrs C was admitted to Kandahar Home for palliative care in Month1[1] 2012. She had multiple co-morbidities and elected to remain under the care of her existing general practitioner (GP), Dr D. Mrs C's daughter, Ms B, held an enduring power of attorney (EPOA) as to her mother's care and welfare, which had not been activated. Registered nurse (RN) A was a senior registered nurse at Kandahar Home.

3. Mrs C's charted medication included PRN (as required) morphine. Despite input from the palliative care service, there was confusion amongst Kandahar Home staff as to the administration of Mrs C's PRN morphine.

4. From 26 Month2, Mrs C was increasingly unable to communicate her pain levels. She was put on a continuous syringe driver that delivered morphine, haloperidol and midazolam subcutaneously. PRN morphine, midazolam and Buscopan were to be provided every two to four hours for breakthrough pain.

5. RN A provided care to Mrs C on 27, 28 and 29 Month2. During this time, Ms B requested pain relief on a number of occasions for her mother, who she believed was in pain. On 27 and 28 Month2, RN A provided PRN morphine and midazolam at Ms B's request.

6. On 29 Month2, RN A refused to dispense PRN morphine and midazolam to Mrs C at Ms B's request because she assessed Mrs C's respiratory rate to be below 12 breaths per minute, and because she did not consider that Mrs C was in pain. RN A provided non-pharmacological comfort cares.

7. On 29 Month2, RN A administered Buscopan to Mrs C at Ms B's request. Ms B recalls that RN A then told her that Dr D had advised that Mrs C was not to have any additional PRN morphine or midazolam that night. Ms B then exchanged a series of text messages with Dr D, who advised that Mrs C was to receive her PRN morphine and midazolam as usual.

8. On 30 Month2, Mrs C passed away. Ms B is concerned that her mother endured significant and unnecessary pain as a result of RN A's refusal to administer PRN morphine and midazolam.

Findings

9. RN A failed to provide services to Mrs C with reasonable care and skill in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the

[1] The months of Mrs C's admission are referred to as Month1 and Month2 to protect privacy.

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Code), in that she failed to assess and manage Mrs C's pain levels adequately. Adverse comment is also made about RN A's communication with the family.

10. Presbyterian Support Central (operating as Kandahar Home) failed to provide services to Mrs C with reasonable care and skill in breach of Right 4(1) of the Code, in that it failed to ensure that its staff were adequately trained and supervised, failed to retain sufficient records, and did not keep clear and accurate records of medication administration.

Complaint and investigation

11. The Health and Disability Commissioner received a complaint from Ms B about the services provided to her mother, Mrs C, by RN A at Kandahar Home in 2012.

12. An investigation was commenced on 29 August 2013. The following issues were identified for investigation:

- *Whether Presbyterian Support Central (operating as Kandahar Home) provided adequate and appropriate care to Mrs C between Month1 and 30 Month2 2012.*
- *Whether registered nurse RN A provided adequate and appropriate care to Mrs C between Month1 and 30 Month2 2012.*

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

14. The parties directly involved in the investigation were:

RN A	Registered nurse
Ms B	Complainant/Consumer's daughter
Kandahar Home	Provider

Also mentioned in this report:

Dr D	General practitioner
RN E	Care manager
RN F	Registered nurse
RN G	Registered nurse
RN H	Palliative care CNS
RN I	Palliative care CNS
RN J	Registered nurse
RN K	Registered nurse

15. Information was received from the above parties, the DHB, and Dr D.

16. Independent expert advice was obtained from RN Dawn Carey (**Appendix A**).

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Information gathered during investigation

Background

Mrs C

17. Mrs C had multiple co-morbidities including lung cancer, advanced chronic obstructive pulmonary disease (COPD),[2] emphysema,[3] asthma, depression, anxiety, and panic attacks. On 1 Month1 she was referred to a public hospital by her general practitioner (GP), Dr D, for a review of her complex medication regimen and multiple clinical and psychiatric presentations.

18. On 14 Month1, Mrs C was discharged to Kandahar Home for palliative care.

Mrs C's status

19. Kandahar Home provided HDC with a copy of an enduring power of attorney (EPOA) for property and for personal care and welfare, dated 3 Month1, which appointed Ms B as EPOA. However, there is no evidence that Mrs C's competence was assessed. Kandahar Home stated: "[T]here was no activation of the Personal Care Welfare EPOA as it was to take immediate effect ie, no mental capacity clause."

20. On admission, RN noted in the progress forms that Mrs C was cooperative and cheerful. It was also noted that Mrs C had a "[s]ocial phobia".

21. Mrs C's progress forms indicate that she was independent with her cares until 27 Month2, when it is documented that her level of consciousness had reduced.

Kandahar Home

22. Kandahar Home is owned and operated by Presbyterian Support Central as part of its aged care service. Kandahar Home is funded by a combination of DHB, Ministry of Health, and private funding.

23. In February 2012, Presbyterian Support Central started providing palliative care pursuant to a Memorandum of Understanding with the DHB. Kandahar Home then began accepting terminal patients into its care, with the DHB providing specialist nursing and medical support for palliative care residents, along with relevant palliative care education for Kandahar Home's staff through the palliative care service.

24. At the time of Mrs C's stay at Kandahar Home, four of the five enrolled nurses (ENs) and four of the seven RNs were undergoing the palliative care training "Fundamentals of Palliative Care", which involved sessions over four full days.

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[2] Chronic obstructive pulmonary disease (COPD) is a lung disease characterised by chronically poor airflow, which typically worsens over time. The main symptoms include shortness of breath, cough, and sputum production.

[3] Emphysema occurs when the air sacs in the lungs are gradually destroyed, making the person progressively more short of breath.

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RN A

25. At the time of Mrs C's residency at Kandahar Home, RN A was a senior registered nurse. Kandahar Home told HDC that, at that time, RN A had yet to attend palliative care training, except syringe driver training, which all registered nurses had completed. Kandahar Home stated that RN A had been scheduled to attend palliative care training at Presbyterian Support Central Head Office, but had resigned from her position in 2012 before attending the training.

26. In contrast, RN A stated that she attended the following palliative care training prior to and during Mrs C's residency at Kandahar Home:

- A two-hour workshop through the palliative care service in 2012 (prior to Mrs C's admission).[4]
- "Palliative 2" on 23 Month1 (although RN A stated that she never received her certificate for this training).[5]

27. In response, Kandahar Home stated that the two-hour workshop that RN A attended prior to Mrs C's admission was an in-service presentation for all staff, which provided an introduction to the training that was to be delivered over the coming months. It was not training specific to registered nurses.

28. Kandahar Home further advised that RN A attended an acute care study day on 23 Month1 in her own time, following which she worked an afternoon shift beginning at 3pm.[6] Kandahar Home advised that it is not clear what was studied at that session, but "it does not appear to be palliative training".

Dr D

29. Prior to her admission to Kandahar Home, Mrs C was under the care of GP Dr D. Mrs C decided that Dr D would continue to be her GP during her time at Kandahar Home, rather than changing to the Kandahar Home GP.

30. The Care Manager at Kandahar Home, RN E, told HDC that there were difficulties from the outset regarding access to medical care from Dr D, who worked at a medical centre some distance away from Kandahar Home. RN E stated, "[Ms B] was adamant she wanted [Dr D] to remain [Mrs C's] GP, even after meeting our facility [GP]." RN E said that Dr D was ill during the week of Mrs C's admission to Kandahar Home, and away on leave during the last week of Mrs C's life, "which added to the issues that were faced during her stay with us".

31. RN E told HDC that Ms B had direct contact with Dr D, and was very reliant on her for ongoing support. RN E believes the contact "was not conducive to the management of her [Mrs C's] care. This [made] the management of [Mrs C's] needs

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[4] RN A provided HDC with a certificate of attendance for this workshop.
[5] RN A told HDC that she had also been scheduled to attend "Palliative 1" in 2012, but that the course was cancelled. Kandahar Home told HDC that there were no courses cancelled in 2012.
[6] Kandahar Home provided HDC with a roster and timesheet for this day.

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very difficult for staff as information from [Dr D] was at times relayed to staff via [Ms B].”

Records

32. Kandahar Home provided HDC with a series of progress forms, interdisciplinary progress notes, integrated clinical notes and GP progress notes, in which Mrs C’s progress was recorded during her admission.

33. RN F told HDC that Mrs C and her daughter, Ms B, asked RN F if she would be the key worker for Mrs C. RN F said that she accepted that role and formed a good rapport with both Mrs C and Ms B. RN F told HDC that with the help of RN E (as Care Manager) she organised a meeting with Mrs C and Ms B, and that together they completed a plan of care for Mrs C stating her abilities and also areas where she required more assistance.

34. HDC requested a copy of all care plans prepared for Mrs C. Kandahar Home supplied a copy of a short-term care plan, which included entries dated 15, 17 and 28 Month2, and a support plan, which is undated and unsigned. Kandahar Home advised that the support plan was completed in conjunction with Mrs C and her daughter, but it was not signed because it was not completed until Mrs C’s last days.

35. HDC also requested all incident forms completed during Mrs C’s time at Kandahar Home, noting that the progress notes for 24 and 27 Month1, and 27 Month2 refer to incident forms having been completed. Kandahar Home advised that when a form was completed it was reviewed by the Care Manager, Quality Co-ordinator and Facility Manager, and then put into a tray for filing into the resident’s file. Kandahar Home stated: “[I]t would appear that these three forms did not get back to the resident’s file and we [have] searched in all other potential locations but have been unable to find them.”[7]

36. Similarly, when HDC requested the “pain management diary” referred to in Mrs C’s progress notes on 24 Month2, Kandahar Home was unable to supply it. Kandahar Home advised that the pain management diary was kept in Mrs C’s room, and stated: “[W]e can only assume that her daughter has inadvertently collected this up as part of her personal effects after her mother passed away.”

Pain assessment and relief

Pain management policy

37. Kandahar Home’s Pain Management Policy provided for three pain assessment tools (Numerical, Wong-Baker and Painaid). The policy records that the most appropriate pain assessment tool is to be used according to the communication abilities of the resident being assessed. In particular:

- The Numerical Pain Scale allows the resident to describe the intensity of his or her discomfort in numbers ranging from zero to ten.

[7] Kandahar Home provided extracts from its Health and Safety Report, which records a summary of these incidents.

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- The Wong-Baker Faces Pain Rating Scale is useful for residents who may be cognitively impaired, and offers a visual description for those who do not have the verbal skills to explain their level of discomfort.
- The Painaid Scale is a specific tool for residents who are unable to vocalise or point out the location, type or severity of their pain. This tool sets out a series of observations relating to breathing, vocalisation, facial expression, body language and consolability to enable staff to assess the severity of the pain.

38. RN A told HDC that during Mrs C's residency at Kandahar Home, her pain level was regularly assessed using the Numerical Pain Scale and the Wong-Baker Scale when she was able to convey her needs, and later using the Painaid Scale when she was unable to do so. RN A stated that, "on reflection, this was not always well documented in the clinical notes". She told HDC:

> "[I]n [my] experience [Mrs C] had difficulty analysing and scoring her pain but expressed pain individually by her sad facial expressions and [I] used open ended questions to enquire. When [Mrs C] was able to verbalise her pain to me, I always acted on what she told me. In the absence of [Mrs C] verbalising clearly, I attempted to use the Numerical scale to ascertain her level of pain. She often replied "Worst" (constant high level of pain)."

Pain relief

39. Mrs C had a complex medication regimen. With regard to pain relief, Mrs C's charted medication as at the time of her admission to Kandahar Home (14 Month1) included regular doses of slow-release morphine (M-Eslon),[8] and additional morphine elixir PRN (as required).

40. The administration of Mrs C's PRN pain relief was recorded in various forms. Between 14 Month1 and 24 Month2, PRN morphine was recorded on a PRN medication administration signing sheet (MASS). Between 20 and 26 Month2, PRN morphine was also recorded in a separate PRN administration record. From 26 to 30 Month2, PRN morphine was recorded in a different PRN MASS.

41. On 24 Month1, a healthcare assistant recorded in the progress forms that at 4.10am Mrs C rang the bell and requested pain relief but "didn't say what for". RN G was informed and "was concerned about time frame". It was also recorded that Mrs C "appeared unhappy for not getting it [pain relief] straight away". A further entry from RN G states: "[Mrs C] appears not in pain … given as she's persistent to have it."

42. On 24 Month1, the DHB Palliative Care Clinical Nurse Specialist (CNS) RN I recorded in the interdisciplinary progress notes that she had advised Kandahar Home that the administration of morphine elixir to Mrs C three to four times per 24 hours was not extreme, and that Mrs C should be given the PRN medication when required. The notes state that RN E said that she understood that information and would pass it on to the other registered nurses.

[8] Morphine tablets.

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43. On 25 Month1 an enrolled nurse recorded in the progress forms at 9.29pm that Mrs C "remain[ed] in pain". There is no entry reporting PRN pain relief being administered from 6.00pm on 25 Month1 until 5.40am on 26 Month1.

Ms B's concerns

44. On 20 Month2, Ms B wrote to Kandahar Home expressing concern about eight incidents regarding the dispensing of Mrs C's medication.

45. In her letter, Ms B recorded that in late Month1 her mother's M-Eslon dose was increased.[9] As Dr D was away, another GP at the medical centre completed the script to increase the dose, but mistakenly reduced the morphine elixir to 5ml when it had previously been charted at 5–10ml.

46. Ms B stated that the result was confusion as to whether the morphine elixir was to be given at 5ml, 5–10ml or 10ml, and there were a number of incidents when the night nurses would give only 5ml of the elixir, resulting in unnecessary pain and distress to Mrs C. The night staff had told Mrs C that, as she was having her M-Eslon at 6am, they could not give her any morphine elixir before then.

47. Between 24 Month1 and 26 Month1 Mrs C was administered 5ml (instead of 10ml) morphine elixir doses.[10] It is recorded in Mrs C's interdisciplinary progress notes that there was a discrepancy between the information on the morphine elixir bottle and the charted dose, in that the "charted dose state[d] 10mg, bottle state[d] 5mg". On 26 Month1, the prescription was clarified.

48. Ms B also complained that her mother's antibiotics were not given on two consecutive evenings, and said that, as Mrs C had had difficulty swallowing tablets, it had been agreed that she would have liquid paracetamol instead of tablets. Ms B stated that whether Mrs C received liquid or tablets was dependent on the person dispensing on that particular day, which Ms B felt was an example of information not being consistently handed over or notes not being read.

49. In her letter, Ms B noted that on 17 Month2 Dr D increased the M-Eslon by 10mg. On 18 Month2 Kandahar Home staff told Mrs C that the increase would not be given until 20 Month2 because of delays in the delivery of the drug by the pharmacy. Ms B expressed concern about Kandahar Home's ability to dispense medication, particularly with regard to morphine, which is a controlled drug.

50. Ms B stated that she was concerned that her mother had to experience unnecessary pain and distress, and stated that the issues with PRN morphine made Mrs C feel as though the nurses thought she was a "drug seeker" and, as a result, she had waited in pain until the day shift began before asking for morphine.

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[9] Medication Administration Signing Sheets indicate that Mrs C's M-Eslon was increased by a doctor on 24 Month1.

[10] Medication Administration Signing Sheets indicate that Mrs C was administered 5ml morphine elixir on four occasions on 24 Month1, and on two occasions on 26 Month1.

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51. Kandahar Home put in place improved procedures as a result of Ms B's concerns. It did not formally respond to the complaint until January 2013. However, Ms B told HDC that she feels that her concerns were taken seriously by Kandahar Home.

Palliative care visit

52. On 21 Month2, DHB Palliative Care CNS RN H visited Kandahar Home and met with RN E and nursing staff to discuss Ms B's concerns and Mrs C's pain and symptom management. RN H suggested a palliative review to reassess Mrs C's pain issues. An attempt was made to contact Dr D. However, she was away until the following Monday, and a message was left for her.

ED visit

53. On 22 Month2 at 6.00am, Mrs C was administered 10ml morphine elixir. At 9am RN A recorded in the interdisciplinary progress notes: "Pain in back — worst pain and pain to breath[e]. Very swollen ankles." RN A recorded that she had asked Dr D to review the charted pain relief, and that further PRN morphine elixir was not due until midday. RN A recorded: "[Dr D] phoned to request morph Elix[i]r within the hour? … Nil body language pain nil grimace, nil writhing, resting [and] reclining on bed." The next recorded administration of PRN morphine elixir was at 4.58pm.

54. On Sunday 23 Month2 at 8.45am, RN A recorded in the interdisciplinary progress notes that Mrs C was requesting a transfer to hospital because her pain was uncontrolled. RN A noted that she had administered 10ml morphine elixir.[11] RN A recorded that she had advised Mrs C to allow the pain relief time to work, and had contacted Dr D asking that she visit or telephone as soon as possible.

55. At 8.50am, Ms B visited the staff room and informed the staff that she was transporting her mother to the public hospital's Accident and Emergency Department (ED) because of Mrs C's back pain.

56. At the ED, Mrs C was prescribed anti-inflammatory medications (Voltaren PR (per rectum) and Diclax BD (twice daily) for 10 days), and her morphine elixir was increased to four hourly PRN until she could be reviewed by her own GP. Mrs C was discharged back to Kandahar Home that day.

57. On 24 Month2, Palliative Care CNS RN I provided Kandahar Home with a pain diary for Mrs C. RN I recorded in Mrs C's progress forms that the "pain level is what [Mrs C] says it is", and should be treated as such. RN I also arranged for a palliative consultant to review Mrs C the following day, which was agreed to by both Dr D and the family.

58. On 24 Month2, RN E recorded that she and RN F met with Mrs C and Ms B to work on Mrs C's care plan. RN E noted that both Mrs C and Ms B appeared exhausted, and that Mrs C was "in pain ++ flushed and [short of breath]". It was decided that they would reschedule the meeting.

[11] At 8.30am, RN A recorded in the PRN MASS and PRN administration record that 10ml PRN morphine elixir had been given.

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59. The notes also record that Ms B was very upset that Mrs C had received an accidental double dose of paracetamol that morning, when she was given both paracetamol liquid and tablets. RN E recorded that she had spoken with the staff concerned, and that RN J had administered liquid paracetamol that morning while they were waiting for the pharmacy to send new blister packs. When the packs arrived, RN J was busy, and RN A administered the morning blister pack. The records state: "[I]ncident form to be completed."[12]

60. In her response to my provisional opinion, RN A stated that RN J completed an incident form, and that she (RN A) also recorded in that form that the administration of Mrs C's morning medication had not been documented or verbally handed over to her. RN A recalls "politely interrupt[ing]" RN J to offer to administer Mrs C's morning medication, and being told by RN J that Mrs C had not yet been given that medication. RN A stated that she checked Mrs C's medication charts, and that there were no PRN paracetamol or morning medications recorded. RN A then administered the paracetamol.

61. On four occasions on 22, 23 and 24 Month2, the administration of Mrs C's PRN morphine was duplicated between the PRN MASS and the PRN administration record.

Palliative care review

62. On 25 Month2, a consultant palliative physician visited Mrs C. Her pain was reviewed and her medications altered. At 3.20pm, morphine elixir 30ml was given as per the new script. Mrs C's pain at that time was recorded in her progress form as nine out of ten.

Mrs C's condition deteriorates

26 Month2

63. On 26 Month2 at approximately 5.45am, Mrs C collapsed in the bathroom. At 7.20am, morphine elixir was administered. Ms B thought her mother was still in pain and, at 11.10am, further morphine elixir was administered. The interdisciplinary progress notes state: "[Mrs C] continues to twitch and has fidgety feet/legs."

64. At 11.30am, DHB Palliative Care CNS RN H visited Mrs C and recorded in the interdisciplinary progress notes that Mrs C was unresponsive to voice and touch but that staff reported intermittent periods of wakefulness. Concerns were expressed by the registered nurse that Mrs C was drowsy and unable to swallow tablets safely. CNS RN H advised the staff to contact Dr D regarding the possibility of a subcutaneous infusion.

65. Dr D followed up with the consultant palliative physician and commenced Mrs C on a syringe driver of morphine tartrate 1.25ml, haloperidol 0.5ml to 1ml, and midazolam 3ml over a 24-hour period. PRN medication included morphine sulphate 1ml, midazolam 0.5ml to 1ml, and Buscopan 1ml every two to four hours by subcutaneous injection when required.

[12] As stated, no incident forms were supplied by Kandahar Home.

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27 Month2

66. On 27 Month2, it was recorded in the interdisciplinary progress notes that Mrs C was very restless and "quite cyanosed".[13] That afternoon, Mrs C slipped off her bed and onto the floor. An EN noted in the progress form that an incident form had been completed.[14]

67. At 4pm, RN A noted in the progress forms that Mrs C was unresponsive, agitated, unsettled and restless. At 4.15pm, morphine sulphate 10mg (1ml) and midazolam 2.5mg (0.5ml) were given. However, Mrs C remained unsettled and, at 4.40pm, midazolam 2.5mg (0.5ml) was added to settle her, with effect.

68. At 5.15pm, RN A recorded in the progress form that Dr D had visited and increased Mrs C's syringe driver medications. At 6.30pm, RN A recorded in the interdisciplinary progress notes that Mrs C was unsettled and that Ms B had requested more midazolam. At 7.00pm, Mrs C was given midazolam 2.5mg (0.5ml).

69. RN A recorded in the interdisciplinary progress notes that, at 9.40pm, Mrs C was "unsettled, restless, throwing arms & legs/flaying. Daughter upset & tearful as Midazolam 5mg given. Daughter insisted & demanded morphine 10mg be given. Agreed to give on return. [Mrs C] settled & asleep & nil restlessness, nil agitation."

70. In her complaint to HDC, Ms B stated that she asked RN A for PRN morphine as Mrs C was in pain, but that RN A did not want to give Mrs C the morphine. Ms B told HDC that it was difficult to get RN A to give her mother PRN morphine, as she appeared to have an aversion to dispensing it. In her response to my provisional opinion, RN A stated that she did not have an aversion to dispensing morphine, and that "where appropriate morphine is definitely the most effective drug".

71. In her complaint, Ms B stated that she asked RN A "who decides whether to dispense PRN medication, the patient, or you as the nurse?" and RN A replied, "the patient". Ms B said that she told RN A that she had enduring power of attorney over Mrs C's care and welfare, and that she wanted her mother to have the morphine.[15]

72. At 10pm, morphine sulphate 10mg (1ml) was given. Ms B told HDC that RN A said at this point, "I hope this is the outcome you are looking for [Ms B], I truly do."

73. Ms B provided HDC with copies of electronic notes taken by her on her cellphone recording details of this exchange with RN A. Her notes were electronically dated 27 Month2, 11.57pm.[16]

74. Ms B told HDC that she believed that RN A meant that there was a possibility that the additional morphine could cause her mother to die, and that she ([Ms B]) had forced RN A to give Mrs C the morphine. Ms B said that she spent the next hour mentally begging her mother to keep breathing, even though she knew it was extremely

[13] Bluish discolouration of the skin.
[14] As stated, no incident form was supplied by Kandahar Home.
[15] As noted, there is no evidence that Mrs C's competence was assessed in relation to the EPOA.
[16] In her complaint, Ms B incorrectly stated that this exchange occurred on the evening of 28 Month2.

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unlikely that a morphine overdose would occur, given the dose and Mrs C's existing morphine regimen.

75. In her response to my provisional opinion, RN A stated that Ms B had misinterpreted her comment. RN A explained, "When I made the remark I intended it was to make [Mrs C] more comfortable, not to hasten her death. It would not have occurred to me that [Mrs C] may/would die because of the [morphine] dose just given."

76. RN A recorded in the interdisciplinary progress notes at the end of her shift: "Every attempt to ensure [Mrs C] is comfortable and pain free, all requests by [Ms B] have been acted on promptly. Comfort cares continue."

77. RN A told HDC:

> "Using my experience and clinical judgment and the validated pain assessment tools, I believe my assessment of [Mrs C's] pain levels were able to be relied upon. However there were times when [Ms B] requested additional morphine for [Mrs C] when in my professional opinion she was comfortable and pain free. I endeavoured to explain to [Ms B] that the assessments we had made indicated that [Mrs C] was currently pain free; unfortunately she did not always concur with the decision and insisted her mother was in pain. I also explained that restlessness does not always indicate pain and that Midazolam may be a more appropriate medication to use."

78. RN A explained that she was aware of the need to weigh up the risks and benefits when administering opiate medications. RN A stated:

> "Non-pharma[co]logical interventions complement drug therapy and ensure a holistic approach to delivering comfort cares. These interventions may include sponging the febrile or restless patient, putting on fresh nightwear, changing linen, repositioning the patient, massage of feet and hands, gentle conversations, music."

28 Month2

79. On 28 Month2 at 3.30pm, RN A recorded in the interdisciplinary progress notes that Mrs C was asleep, unresponsive, and unconscious, and appeared comfortable. At 7.30pm, RN A recorded that Mrs C was settled with some restlessness. At 8pm, RN A dispensed morphine sulphate 10mg (1ml) and midazolam 2.5mg. At 11pm, RN A dispensed Buscopan 20mg after Dr D texted Ms B to request it be given to help with Mrs C's stomach cramps.

29 Month2

80. In her complaint, Ms B stated that when RN A came on duty on the evening of 29 Month2, Ms B asked for more PRN morphine for Mrs C, and that RN A refused because she did not think Mrs C was in pain. Ms B stated that she had been sitting with her mother and knew she was in pain but, as her slow-release morphine had just been increased, she decided not to "push the matter". PRN medication records indicate that Mrs C had been given midazolam at 6am and morphine at 11am that day.

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81. RN A recorded in the interdisciplinary progress notes that Mrs C remained unconscious and unresponsive, but appeared to be comfortable. RN A told HDC that she does not believe that Mrs C was in any pain on the evening of 29 Month2 and, if she had been, she (RN A) would have telephoned the GP or the duty doctor on call and requested an order for administration of breakthrough pain relief.

82. RN A stated that she assessed that Mrs C was not in pain because there were no alterations in her facial expression, grimacing, flinching or agitation. RN A said that there was no moaning, groaning, sighing, verbalising of any noise, or Cheyne-Stokes respirations. There was also no restlessness, rigidity, knee or body movement, clenched fists, elevated pulse or respirations, and no frowning, which Ms B had told her was a key indicator of pain for her mother.

83. RN K was also on duty on the evening of 29 Month2. She stated that Mrs C appeared comfortable and was not restless, but she was not responsive to verbal or physical stimuli as they delivered her cares. RN K recalls that Ms B asked RN A about the need for more PRN pain relief, and that RN A stated that Mrs C did not appear distressed or in pain, but RN A said she would check with Dr D. Ms B told HDC that her mother's breathing was becoming very laboured, so she again requested morphine for her mother. Ms B said that RN A entered the room with RN K, who said one word: "ten". RN A then told Ms B that under their guidelines they were not able to dispense PRN morphine if Mrs C's breaths per minute (bpm) were less than 12.

84. Ms B told HDC that once RNs A and K had left the room, she checked her mother's breathing, and counted 14bpm. She repeated the process and again counted 14bpm. She stated that a few hours later, the night nurse counted 19bpm. Ms B said that RN E subsequently told her that the Palliative Care team had said that the minimum requirement of 12bpm before morphine could be administered did not apply in palliative care cases.

85. RN A stated that she had learned from her palliative care nursing education sessions,[17] and from available literature, that morphine should not be given for breakthrough pain if the respiratory rate is 12bpm or under. RN A told HDC that her understanding is that respiratory depression can be an indication of morphine overdose or toxicity. She stated:

> "I did not want to risk further and unnecessary Respiratory depression or suppress the Respiratory system that may have hastened [Mrs C's] death. I realise that in my duty to care I must not hasten anybody's death. In my opinion that is known as Euthanasia. But, if there had been pain, let me state emphatically, that I would have phoned the Dr for a verbal Directive Order for low respiratory rate and administration of break through Morphine dose".

[17] As stated, RN A attended an introductory workshop. Kandahar Home advised that RN A had not attended any palliative care nursing education sessions at Kandahar Home, other than syringe driver training, at the time of Mrs C's residency.

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86. Ms B told HDC that later that evening she rang the bell, and RN K came in. Ms B asked whether her mother could have some Buscopan, which was prescribed PRN for secretions, as she knew it could also be used for stomach cramps. Her mother had severe stomach cramps and also was beginning to have secretions when she exhaled.

87. Ms B stated that RN K said that she could not hear any secretions, so she told RN K to call Dr D, who was willing to receive telephone calls about Mrs C's care at any time. RN A came into the room and said that there was no need to call Dr D, and that she would give the Buscopan because it was charted. At 6.30pm, RN A recorded in the interdisciplinary progress notes: "Buscopan given — secretions and loose chest with effect."[18] It is noted that Mrs C appeared settled and comfortable, with a respiratory rate of 10bpm, and that Ms B was not present.

88. At 6.52pm, Ms B sent a text message to a family member stating that she had asked for Buscopan, which was a "major drama again", and that she had left the room when RN A came in.[19] Ms B told HDC that when she returned some 20 minutes later she could hear RNs A and K talking loudly as she walked down the hall (but could not hear what was said).[20] Ms B stated that she believes that this was inappropriate in a palliative care situation when the patient is in a semi-coma and cannot respond, and showed no respect for Mrs C.

89. In contrast, RN A stated, "[W]e provided a calm, harmonious, ambience/aura and worked together to give the best of care treating [Mrs C] with dignity and respect."

90. Ms B stated that shortly after RN A dispensed the Buscopan, she (RN A) came back into the room and stated that she had spoken to Dr D, and that Mrs C was not to have any more morphine or midazolam that night. Ms B recalls that RN A stated that Dr D would visit in the morning to chart permanent Buscopan via the syringe driver.

91. In her response to my provisional opinion, RN A stated, "When I spoke to [Dr D] I discussed secretions and a new regime for the syringe driver the next day and everything prn [to] continue the same tonight."

92. At 7.20pm, Dr D sent a text message to Ms B noting that she had "[j]ust had a chat with RN she is going to give buscopan prn until tomorrow […] advised from tomorrow will do 80mg via syringe driver".[21] There is no reference to other PRN medications in the text message.

93. RN A did not document her telephone call with Dr D or her subsequent conversation with Ms B. RN A told HDC:

> "Towards the end of the shift I took [Ms B] a tray of tea and biscuits and informed her that I had phoned [Mrs C's] GP to update her on [Mrs C's] health status […] I

[18] The dispensing of this medication was not documented in Mrs C's PRN administration record.
[19] In her complaint, Ms B stated that she left the room at around 8.00pm.
[20] Ms B's text message of 6.52pm records that she had overheard the nurses "gossiping" about her.
[21] Ms B provided HDC with a copy of this text message.

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explained the GP had instructed me to 'continue with the PRN medications as charted, and she would review the drug chart in the morning'."

94. PRN medication records indicate that Mrs C was not administered either PRN morphine or midazolam during RN A's shift. At around 10.00pm, RN A recorded in Mrs C's notes that Buscopan 1ml had been given[22] and, "[m]orphine declined @ [respirations] 10bpm (req. 12 — legally)".

95. Ms B stated that after RN A had finished her shift, Dr D text messaged her to ask how her mother was doing and about her symptoms. After Dr D read Ms B's reply, Dr D text messaged "PRN Morphine please". Ms B told HDC that she was confused by this message in light of what RN A had told her earlier. Ms B replied, "Did you tell the nurse no more PRN? She told me that's what you said." Dr D replied, "No, I said PRN Buscopan until tomorrow then put Buscopan 80mg/24hr into new Syringe Driver!!! I did NOT say no more PRN!! PRN as USUAL please."

96. Ms B believes RN A intentionally lied to her when she said that Dr D had instructed no more morphine or midazolam that night.

97. In her response to my provisional opinion, RN A stated, "I interpreted [Dr D's] instructions as being open to my professional judgment and I did not feel the [patient] was in pain. I did not lie, I interpreted the doctor's instructions." RN A recalls that Mrs C was "settled, appeared comfortable" and that she told Ms B, "I'm not legally allowed to give [morphine] for no reason/no pain," which was her "professional opinion at that time".

98. At approximately 11.50pm, Ms B sent a text message to Dr D advising that a "lovely new nurse" was now on duty. PRN medication records indicate that at 1.30am on 30 Month2 Mrs C was administered morphine 10mg, midazolam 5mg, and Buscopan 20mg.

30 Month2

99. On 30 Month2 at 8.30am, Mrs C died.

100. Ms B stated that she believes her mother endured significant and unnecessary pain and suffering in the last two days of her life as a direct result of RN A's refusal to dispense morphine and midazolam.

Further information

Kandahar Home

101. Kandahar Home stated that it supports the view that RN A may not have provided optimal communication and care in relation to the administration of pain relief to Mrs C.

102. Kandahar Home agreed that there was confusion about the respiratory rate and administration of morphine in a terminal scenario. Kandahar Home stated that the

[22] The dispensing of this medication was not documented in Mrs C's PRN administration record.

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registered nurse has the choice of which pain assessment tool is the most appropriate in the circumstances in order to reach a conclusion about the subsequent nursing intervention. However, Kandahar Home agreed that the communication and decision-making about the assessment and provision of pain relief was the key issue in Mrs C's case.

103. Since Mrs C's death, the following changes have been implemented at Kandahar Home:

- Five Kandahar staff have attended palliative care training.
- Two Kandahar care managers have completed postgraduate certificates.
- A new medicine management policy has been introduced.
- The quality management programme has been reviewed to include more targeted internal audits and, in March 2013, the audit "Pain: Assessment and Support Planning" was conducted.
- A second CNS role has been created.
- A quality project is in progress.
- From 2014 an additional professional day will be included in the core programme cycle for registered nurses and enrolled nurses, to allow the inclusion of the quality improvement process and tools.
- From 2014 an additional clinical day will be included in the core programme cycle for registered nurses and enrolled nurses to allow more time to focus on each of the clinical topics, in particular end stage care. The programme will be worded to make the end of life/palliative aspect more evident.
- The core professional and core clinical days will be provided multiple times during the year at three different venues to facilitate ease of releasing staff to attend.

RN A

104. RN A stated that she believes that none of the alleged medication errors were made by her. She stated, "I feel I am being made a 'scapegoat' for Kandahar problems" and said that she endeavours to continue safe medication administration practices.

105. RN A told HDC that after Mrs C died, the palliative nursing team stated that they do not recognise the respiration rate in palliative cases. In her response to my provisional opinion, RN A told HDC:

> "In hindsight I agree respiration rate is not important in palliative care when administering morphine which I have acknowledged and have actively amended my nursing practice since. I would now not focus on [respiration rate] as an indicator but would continue to use subjective data balanced with objective data to attain a robust assessment."

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106. RN A told HDC that she remains of the view that, where there is no indication of pain, the overuse of morphine "would simply have the possible effect of accelerating the death of the patient, which would be both ethically and legally unacceptable. The purpose is not to hasten the Pt's death but to relieve intractable symptoms."

107. RN A said that she continually strives to make accurate and appropriate pain assessments and always administers pain relief when pain is present.

Ms B

108. Ms B told HDC that she does not wish to receive an apology or any other correspondence from RN A, either directly or indirectly.

Responses to provisional opinion

109. The following responses were received to my provisional opinion, in addition to the responses incorporated into the "information gathered" section above.

Kandahar Home

110. Kandahar Home accepted the findings set out in my provisional opinion without further comment, and advised that its focus has been, and will continue to be, on ensuring that the opportunities for improvement highlighted in the complaint are addressed. Presbyterian Support Central further advised that it intends to share the information contained in this report across its aged care service, so as to maximise the learning opportunities.

RN A

111. In her response to my provisional opinion, RN A stated that she does not recall ever refusing to administer morphine elixir. She stated that she has reflected on "the way I view the needs of palliative care patients and meeting their needs", and agrees that further training and education will enhance and improve her nursing practice and care of palliative patients. RN A stated:

> "I believed I provided care that was appropriate but on reflection I would attempt to communicate and seek therapeutic relationships with family and also use palliative care service and resources more, hence [I] will become more familiar with legislation and standards around the dying patient."

Opinion: Introduction

112. Ms B demonstrated considerable concern for her mother's welfare in the last months of her mother's life. A month after Mrs C was admitted to Kandahar Home, Ms B raised a number of concerns regarding the administration of her mother's medication, and Kandahar Home took steps to remedy these issues.

113. Ms B spent extensive time with her mother during the last months of her mother's life, and was familiar with the signals that her mother exhibited when she was in pain. It is clear from the clinical record that while Mrs C was still able to communicate, she frequently said she was in pain. In my view, it was entirely reasonable for Ms B to wish to be assured that her mother, who was terminally ill, would be as comfortable and free of pain as practicably possible. I accept that Ms B did not want her mother's life to be shortened, but did want to be confident that her mother was not suffering unnecessary pain.

Opinion: RN A

114. During Mrs C's residency at Kandahar Home, she and her daughter frequently told RN A that she (Mrs C) was in pain. I have concerns with the manner in which RN A assessed Mrs C's pain (both while Mrs C was able to express her pain levels and after she became unable to communicate), the delays in providing pain relief to Mrs C, and RN A's failure to communicate effectively with Mrs C and her daughter.

Management and assessment of Mrs C's pain levels — Breach

115. My in-house nursing advisor, RN Dawn Carey, advised me that the pain assessment form used by Kandahar Home was appropriate, as it uses three scales — self-reporting Numerical Pain Scale, the Wong-Baker Pain Scale, and the Painaid Scale. Ms Carey advised that the use of an objective pain scale acknowledges the research findings that pain is usually under-recognised and under-treated by health practitioners. Ms Carey advised that the self-reporting Numerical Pain Scale was appropriate to use while Mrs C was able to report her pain, and that the other scales were appropriate once she lacked the ability to communicate her pain verbally.

Response to Mrs C's request for pain relief

116. On 24 Month1, Palliative Care CNS RN I advised Kandahar Home that the administration of morphine elixir to Mrs C three to four times per 24 hours was not extreme, and that she should be given the PRN medication. The notes state that RN E understood the advice and said she would pass it on to the registered nurses.

117. On 22 Month2 at 6.00am, Mrs C was administered 10ml morphine elixir. At 9am, RN A recorded in the interdisciplinary progress notes: "Pain in back — worst pain and pain to breath[e]. Very swollen ankles." RN A recorded that she had asked Dr D to review the charted pain relief, and that further PRN morphine elixir was not due until midday. RN A recorded: "[Dr D] phoned to request morph Elix[i]r within the hour? […] Nil body language pain nil grimace, nil writhing, resting [and] reclining on bed." Despite RN A's statement that she has no recollection of refusing to administer morphine elixir, the next recorded administration of PRN morphine elixir was not until 4.58pm.

118. Ms Carey stated, "[I]n my opinion, using one scale to 'overrule' [Mrs C's] pain score demonstrates a lack of understanding about pain assessment tools, [and] a lack of

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empathy for [Mrs C's] experience and her reason for admission to [Kandahar Home]." I agree.

119. Ms Carey advised that established knowledge concerning pain assessment, end-of-life care, pain experiences and opioid management is that a patient's self-reporting of his or her pain is recognised as the gold standard measurement of pain. Similarly, on 24 Month2, when Mrs C was still able to vocalise the extent of her pain, CNS RN I advised staff that Mrs C's pain should be treated as being what she said it was.

120. Ms Carey stated that prescribing PRN medication to manage the symptoms of pain is recommended, and anticipatory prescribing is advocated. She advised that progression of the disease is considered the most likely cause of an increasing need for pain relief, and that it is rare for patients to develop an opioid tolerance and/or respiratory depression. While Mrs C was still able to vocalise the extent of her pain, it was not appropriate for RN A to refuse to administer pain relief on the grounds that her assessment of Mrs C's pain (by applying the Painaid Scale) was different from Mrs C's self-reporting of her pain. In my view, RN A's responses to Mrs C's requests for pain relief were suboptimal.

Pain assessment and consideration of respiratory rate

121. From 26 Month2, Mrs C was increasingly unable to communicate her pain levels. She was on a continuous syringe driver, which delivered morphine, haloperidol and midazolam subcutaneously. Additional PRN pain relief was to be provided for breakthrough pain.

122. It is evident from the notes that while Mrs C was still able to communicate, she said she was experiencing frequent breakthrough pain. There is no reason to assume that she would not continue to experience such pain after she lost the capacity to verbalise the extent of her pain.

123. RN A frequently recorded that Mrs C was unsettled and restless. RN A stated that restlessness does not always indicate pain, and said she provided comfort cares to Mrs C. Ms Carey advised:

> "Whilst I agree that non-pharmacological interventions have a definite place in providing comfort measures to a patient and facilitate the effectiveness of administered analgesia, I disagree that [Mrs C's] observed restlessness was not a sign of discomfort/pain. In my opinion, [Mrs C's] signs of restlessness or agitation should have been managed by administration of her PRN medications in addition to the other measures employed to promote her comfort."

124. RN A told HDC that there were times when Ms B requested additional morphine for Mrs C when in RN A's professional opinion Mrs C was comfortable and pain free. Ms B told HDC that it was difficult to get RN A to give her mother morphine, as RN A appeared to have an aversion to dispensing it. RN A denied having any such aversion, stating that "where appropriate morphine is definitely the most effective drug".

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125. In particular, Ms B told HDC that when RN A came on duty on the evening of 29 Month2, she asked RN A for PRN morphine for Mrs C, and RN A refused because she did not think that Mrs C was in pain. Ms B told HDC that she decided not to “push the matter”.

126. RN A told HDC that she does not believe that Mrs C was in any pain on the evening of 29 Month2. RN A stated that she assessed Mrs C using the Painaid Scale and concluded that Mrs C was not in pain, as there were no alterations to her facial expression (frowning, grimacing), no verbalising (moaning, groaning, sighing), no restlessness, rigidity or body movement (flinching, agitation, clenched fists) and no elevated pulse or respirations.

127. Ms B told HDC that her mother’s breathing became laboured. She therefore requested PRN morphine again. RN A acknowledged that she refused to administer PRN morphine to Mrs C on 29 Month2, and recorded in the notes: “Morphine declined @ [respirations] 10bpm (req. 12 — legally).” RN A said she was concerned that an additional dose of morphine would further depress Mrs C’s respiration rate.

128. RN A stated that respiratory depression can be an indication of morphine overdose or toxicity, and added, “I did not want to risk further and unnecessary Respiratory depression or suppress Respiratory system that may have hastened [Mrs C’s] death. I realise that in my duty to care I must not hasten anybody’s death. In my opinion that is known as Euthanasia.”

129. RN A added that where there is no indication of pain, the overuse of morphine would “simply have the possible affect of accelerating the death of the patient, which would be both ethically and legally unacceptable. The purpose is not to hasten the Pt’s death but to relieve intractable symptoms.”

130. Ms Carey advised that focusing on Mrs C’s respiratory function in determining whether to administer additional opioid, based on her respiratory rate:

> “demonstrates confusion about what competencies, legislation and standards guide an RN during end of life care; about what the goal is during provision of palliative care, and denies a dying person access to adequate pain relief when they are at their most vulnerable.”

131. I agree with Ms Carey that it is disappointing that, despite Kandahar Home working closely with the palliative care service, such fundamental confusion continued. Ms Carey advised that RN A’s failure to administer Mrs C’s prescribed PRN medications on the evening of 29 Month2 demonstrates a departure from the expected standards of nursing care.

132. I agree with Ms Carey’s concerns. As stated, I consider that it was entirely reasonable for Ms B to wish to be assured that her mother, who was terminally ill, would be as comfortable and free of pain as practicably possible. I accept that Ms B did not want her mother’s life to be shortened, but did want to be confident that her mother was not suffering unnecessary pain.

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133. I am concerned that, following these events, RN A maintained her view that, even in palliative care, morphine should not be administered if respiration rates are below a set number. As Ms Carey advised me:

> "I admit to being disappointed by [RN A's] continued fixation with the need for a patient to have respirations of X before they can be administered prescribed opiate medication. She persists with this even after clarifying it with the palliative care nurses at [the palliative care service] following [Mrs C's] death; and being told … *they do not recognise the respiration rate …*"

134. I note Ms Carey's advice that she considers that RN A should not participate in end-of-life/palliative care nursing until she undergoes further clinical education from an appropriate specialist such as palliative care or hospice registered nurses, and is willing to amend her nursing practice to take such knowledge on board. I also note RN A's comments in response to my provisional opinion, in which she accepts that, in hindsight, "respiration rate is not important in palliative care when administering morphine", and that she "would not now focus on [respiration rate]". RN A also agrees that further training and education will improve her nursing practice and care of patients requiring palliative care.

Conclusions

135. In my view, RN A failed to provide services to Mrs C with reasonable care and skill, in breach of Right 4(1) of the Code, in that she failed to assess and manage Mrs C's pain levels adequately. In particular:

- RN A failed to respond appropriately to Mrs C's request for pain relief on 22 Month2, in that she effectively "over-ruled" Mrs C's reported pain level and failed to administer prescribed PRN medication.

- RN A failed to assess appropriately and alleviate Mrs C's pain on 29 Month2, in that RN A inappropriately focused on Mrs C's respiratory rate in determining whether to administer prescribed PRN medication.

Communication with family — Adverse comment

136. As stated, Ms B demonstrated considerable concern for her mother's welfare, and spent extensive time with her during the last months of her life. It is also evident that RN A and Ms B had a difficult relationship, and I am concerned by a number of aspects of RN A's dealings with Ms B, the details of which are set out below.

Response to Ms B's request for PRN morphine

137. At 9.50pm on 27 Month2, RN A noted that Mrs C was "unsettled, restless, throwing arms & legs/flaying. Daughter upset & tearful as Midazolam 5mg given. Daughter insisted & demanded morphine 10mg be given. Agreed to give on return. [Mrs C] settled & asleep & nil restlessness, nil agitation." In her complaint to HDC, Ms B stated that she asked RN A for PRN morphine as Mrs C was in pain, but that RN A did not want to give Mrs C the morphine. Ms B recalls that she asked RN A "who decides whether to dispense PRN medication, the patient, or you as the nurse?", and

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RN A replied, "the patient". Ms B said that she told RN A that she wanted her mother to have the morphine.

138. At 10pm, morphine sulphate 10mg (1ml) was given to Mrs C. Ms B told HDC that RN A said at this point, "I hope this is the outcome you are looking for [Ms B], I truly do." Ms B provided HDC with notes taken by her, which set out the details of this exchange as described in her complaint. It appears that these notes were taken contemporaneously (being electronically dated as 11.57pm on 27 Month2), which, in my view, lends credibility to Ms B's account. In her response to my provisional decision, RN A submitted that Ms B had misinterpreted her remark. In any event, I remain of the view that this exchange was unfortunate, unprofessional and unkind.

139. Ms B was understandably distressed by the exchange that took place with RN A. Ms B told HDC that she believed that RN A meant that there was a possibility that the additional morphine could cause her mother to die, and that she (Ms B) had forced RN A to give the morphine. Ms B said that she spent the next hour mentally begging her mother to keep breathing, even though she knew it was extremely unlikely that a morphine overdose would occur, given the dose and Mrs C's existing morphine regimen.

Information from GP

140. Ms B recalls that on the evening of 29 Month2, RN A told her that she had spoken to Dr D, who had told her (RN A) that Mrs C was not to have any more morphine or midazolam that night, and that Dr D would visit Kandahar Home in the morning to chart permanent Buscopan to be administered via the syringe driver. However, later that night, Dr D sent a text message to Ms B stating, "No, I said PRN Buscopan until tomorrow then put Buscopan 80mg/24hour into new Syringe Driver!!! I did NOT say no prn!! PRN as USUAL please." Ms B believes RN A intentionally lied to her about Dr D's instructions on the night of 29 Month2.

141. In contrast, RN A told HDC that she explained that Dr D had instructed her to "continue with the PRN medications as charted, and she would review the drug chart in the morning". However, RN A did not document her conversations with either Dr D or Ms B, and medication records indicate that Mrs C was not administered either PRN morphine or midazolam during RN A's shift.

142. Ms B provided HDC with a text message she received from Dr D at 7.20pm, which recorded that Dr D had "[j]ust had a chat with RN she is going to give buscopan prn until tomorrow […] advised from tomorrow will do 80mg via syringe driver".[23] There is no reference to other PRN medications in the text message. In my view, this casts further doubt over RN A's version of events.

143. In her response to my provisional opinion, RN A stated that she had interpreted Dr D's instructions as being open to her professional judgement, and that she did not assess Mrs C as being in pain. RN A recalls advising Ms B that she was not "legally allowed to give [morphine] for no reason/no pain".

[23] Ms B provided HDC with a copy of this text message.

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144. I do not consider that currently I have, or can obtain, sufficient information to determine precisely what communications took place between RN A, Dr D and Ms B on 29 Month2 with regard to Mrs C's PRN pain relief, nor whether RN A deliberately provided false information to Ms B in this regard. This does not mean that I have preferred one account over the other. It simply means that I do not have sufficient evidence to resolve these factual discrepancies. That said, it appears that there was a serious miscommunication with regard to this issue, and it is understandable that Ms B was distressed and frustrated by her dealings with RN A on this occasion.

Manner

145. At 6.52pm on 29 Month2, Ms B sent a text message to a family member stating that she had asked for Buscopan, which was a "major drama again", and that she had left the room when RN A came in. Ms B told HDC that when she returned some 20 minutes later, she could hear RNs A and K talking loudly as she walked down the hall. In a text message to a family member, Ms B stated that the registered nurses had been "gossiping" about her.

146. Ms B stated that she believes that this was inappropriate in a palliative care situation when the patient is in a semi-coma and cannot respond, and that it showed no respect for Mrs C. In contrast, RN A stated, "[W]e provided a calm, harmonious, ambience/aura and worked together to give the best of care treating [Mrs C] with dignity and respect."

147. I am unable to make a finding as to which account of events is correct. However, it is clear that Ms B and RN A had a difficult relationship. This was an emotional and stressful time for Mrs C's family and, in my view, RN A should reflect on the need to treat family members with sensitivity and compassion at all times. I am concerned that Ms B felt sufficiently uncomfortable around RN A that she left her mother's room. This indicates that there was a serious breakdown in the relationship between RN A and Mrs C's family.

Opinion: Breach — Presbyterian Support Central (operating as Kandahar Home)

148. Mrs C was a complex patient with multiple co-morbidities. She entered Kandahar Home in early Month1 for palliative care.

149. In February 2012, Presbyterian Support Central started providing palliative care at Kandahar Home pursuant to a Memorandum of Understanding with the DHB. Kandahar Home then began accepting terminally ill patients into its care, with the DHB providing specialist nursing and medical support for palliative care residents, along with relevant palliative care education for Kandahar Home's staff through the palliative care service.

HDC

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150. I have concerns with the standard of care provided to Mrs C at Kandahar Home, particularly in relation to the assessment of her status and the management and documentation of her pain relief regimen.

Status

151. On 3 Month1, Mrs C signed a document appointing Ms B as her EPOA both in relation to personal care and welfare, and property. Both Kandahar Home and Ms B believed that Ms B became Mrs C's EPOA in relation to personal care and welfare from that day on.

152. However, as provided in section 98(3)(a) of the Protection of Personal Property Rights Act 1988, an attorney must not act in respect of a significant matter relating to the donor's personal care and welfare unless a relevant health practitioner has certified that the donor is mentally incapable. A significant matter means a matter that is likely to have a significant affect on the health, well-being or enjoyment of life of the donor.[24] There is no evidence that Mrs C was certified as being incompetent. Accordingly, the EPOA was never activated.

153. Given that the EPOA was never activated, the correct legal position, once Mrs C was no longer able to make or express her informed choices, was that the people providing her care were able to provide services that were in Mrs C's best interests and in accord with the choice Mrs C would have made if she were competent. If those views were not known, the views of other suitable persons who were interested in Mrs C's welfare and available to advise the providers (such as Ms B) would be taken into account.[25]

154. In this case, it is clear that, when competent, Mrs C wanted to have treatment provided to alleviate her pain, and it was in her best interests to be provided with pain relief.

155. Kandahar Home stated: "[T]here was no activation of the Personal Care Welfare EPOA as it was to take immediate effect ie, no mental capacity clause." It is concerning that Kandahar Home is providing care for patients requiring palliative care, but lacks knowledge of the legal framework for decision-making with regard to incompetent persons.

156. It was Kandahar Home's responsibility to be clear about Mrs C's legal status. As this Office has stated previously, all health and disability service providers have a responsibility to verify a consumer's legal status, and be clear about the legal basis on which to provide services.[26]

Staff understanding of palliative care

157. Ms Carey noted the need for Kandahar Home to continue its collaborative relationship with the palliative care service, and to develop the knowledge, skills and

[24] Section 98(6).
[25] Right 7(4) of the Code.
[26] Opinion 08HDC20957, available at www.hdc.org.nz.

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competencies of its staff team in the delivery of palliative care. Kandahar Home has agreed that there was confusion about the significance of the respiratory rate and morphine administration for terminally ill patients.

158. I have some concern as to the level of staff understanding of palliative care at the time of Mrs C's admission. I note that the CNS nurses, RNs H and I, had on several occasions indicated that Mrs C's statements about the extent of her pain should be accepted, and that she should receive the prescribed PRN morphine when she requested it. In my view, there were occasions where Kandahar Home staff failed to apply this advice properly. For example, on 24 Month1, RN G was advised that Mrs C had requested pain relief, but "didn't say what for". It was noted that RN G was "concerned about time frame", but that the pain relief was "given as she's [Mrs C] persistent to have it". Later that day, RN I advised RN E that the administration of morphine elixir three to four times per 24 hours was not extreme. However, on 25 Month1 it was noted at 9.29pm that Mrs C "remain[ed] in pain", with no recorded administration of PRN pain relief until 5.40am the following morning.

159. Ms Carey advised that established knowledge concerning pain assessment, end-of-life care, pain experiences and opioid management is that a patient's self-reporting of his or her pain is recognised as the gold standard measurement, and that pain, excessive secretions, restlessness, dyspnoea and nausea and vomiting are the most commonly reported symptoms. Ms Carey stated that prescribing PRN medication to manage these symptoms is recommended, and that anticipatory prescribing is advocated.

160. I also have some concern regarding the level of RN A's training at the time of Mrs C's stay at Kandahar Home. It appears from the documentation provided to HDC that RN A attended a two-hour palliative care workshop (prior to Mrs C's admission). I note Kandahar Home's comment that this was an in-service presentation for all staff, as opposed to palliative care training specific to registered nurses. RN A stated that she then attended "Palliative 2" on 23 Month1 but never received her certificate.[27] Kandahar Home told HDC that RN A attended an acute care study day on 23 Month1 in her own time, following which she worked an afternoon shift starting at 3pm. Kandahar Home advised that it is not clear what was studied at that session, but "it does not appear to be palliative training". Kandahar Home stated that RN A had been scheduled to attend palliative care training but resigned from her position before attending that training.

161. I am unable to make a factual finding on the available evidence as to whether RN A attended palliative care training in Month1. In any event, it appears to me that RN A had not completed full palliative care training at the time of Mrs C's admission. It is concerning that despite this, RN A was put in a position to make decisions about Mrs C's pain relief.

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[27] As stated, RN A told HDC that she had also been scheduled to attend "Palliative 1" in 2012, but that the course was cancelled. Kandahar Home told HDC that there were no course cancellations in 2012.

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Records

162. This Office has frequently emphasised the importance of good record-keeping. HDC requested a copy of all care plans prepared for Mrs C. Kandahar Home supplied only a short-term care plan with entries dated 15, 17 and 28 Month2, and a support plan that is undated and unsigned. Kandahar Home advised that the support plan was completed in conjunction with Mrs C and her daughter Ms B, but it was not signed because it was not completed until Mrs C's last days.

163. HDC also requested all incident forms completed during Mrs C's time at Kandahar Home, noting that the progress notes for 24 and 27 Month1, and 27 Month2 refer to incident forms having been completed. Kandahar Home advised that "it would appear that these three forms did not get back to the resident's file and we had searched in all other potential locations but have been unable to find them".

164. Similarly, when HDC requested the "pain management diary" referred to in Mrs C's progress notes on 24 Month2, Kandahar Home was unable to supply it. Kandahar Home advised that the pain management diary was kept in Mrs C's room, and stated: "[W]e can only assume that her daughter has inadvertently collected this up as part of her personal effects after her mother passed away."

165. As this Office has stated previously, the importance of good record-keeping cannot be overstated.[28] Accurate documentation is the basis for delivering continuous and appropriate care. In my view, Kandahar Home's record-keeping was suboptimal.

Medication administration

166. It is evident that there were a number of issues with the administration of Mrs C's medication during her residency at Kandahar Home. On 20 Month2, Ms B wrote to Kandahar Home expressing concern about eight incidents regarding the dispensing of Mrs C's medication. Her letter referred to confusion as to the appropriate dose of Mrs C's PRN morphine; Mrs C's antibiotics not being given on two occasions; paracetamol being given in tablet rather than liquid form; and delays in obtaining Mrs C's prescription from the pharmacy.

167. I note that Ms B feels that her complaint of 20 Month2 was taken seriously by Kandahar Home, and that steps were taken by Kandahar Home to remedy its processes. Nonetheless, I am concerned about the medication administration practices at Kandahar Home. In particular, I am concerned that despite Ms B raising these concerns with Kandahar Home, issues with the administration of Mrs C's medication continued throughout her residency there.

168. For example, on 24 Month2 Mrs C received a double dose of paracetamol, when she was given both paracetamol liquid and tablets. RN J had administered liquid paracetamol while they were waiting for the pharmacy to send new blister packs. When the packs arrived, RN J was busy, and RN A offered to administer the morning blister pack. RN A recalls being told by RN J that Mrs C had not yet been given her morning medication. RN A stated that she also checked Mrs C's medication charts

[28] See Opinion 11HDC00423, available at www.hdc.org.nz

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before administering the paracetamol, and there were no PRN paracetamol or morning medications recorded. Further, the administration of Mrs C's PRN morphine was recorded in various forms. Between 14 Month1 and 24 Month2, PRN morphine was recorded on a PRN medication administration signing sheet (MASS). Between 20 and 26 Month2, PRN morphine was also recorded in a separate PRN administration record. From 26 to 30 Month2, PRN morphine was recorded in a different PRN MASS. On four occasions on 22, 23 and 24 Month2, the administration of Mrs C's PRN morphine was duplicated between the PRN MASS and the PRN administration record.

169. Ms Carey advised that this indicates that Kandahar Home's staff did not fully appreciate the documentation requirements for administration of controlled medications. In my view, the failure to record medications accurately is poor practice, and affects continuity of care and puts patients at real risk of harm. In the absence of good documentation, Mrs C was at risk of both an overdose, and of receiving no medicine at all from those responsible for her care.

170. However, I note Ms Carey's advice that Kandahar Home's medication manual is clinically robust and has the correct requirements specified for the administration of controlled drugs.

Conclusions

171. Presbyterian Support Central (operating as Kandahar Home) failed to ensure that its staff were adequately trained and supervised, failed to retain sufficient records, and did not manage medication administration effectively. In my view, Presbyterian Support Central did not provide appropriate care to Mrs C, particularly with regard to its assessment of her status and the management of her pain relief regimen. I consider that Presbyterian Support Central failed to provide services to Mrs C with reasonable care and skill, in breach of Right 4(1) of the Code.

Recommendations

RN A

172. In my provisional opinion, I recommended that RN A provide a written apology to the family. In response, RN A provided an apology letter. However, Ms B subsequently advised that she does not wish to receive an apology or other correspondence from RN A. I have therefore removed this recommendation from my report.

173. I recommend that the Nursing Council of New Zealand conduct a review of RN A's competence.

Kandahar Home

174. Presbyterian Support Central (operating as Kandahar Home) provided HDC with a written apology to the family, which has been forwarded to Ms B.

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175. I recommend that Presbyterian Support Central (operating as Kandahar Home):

- Review its policies and procedures with regard to the provision of palliative care, and report the findings to this Office.
- Review and amend its medication manual to reflect end-of-life medication administration issues, or develop a new end-of-life care policy.
- Audit the training of all staff providing palliative care, with particular focus on pain relief, and report the findings to this Office.
- Ensure that all Kandahar Home registered nurses and enrolled nurses involved in the provision of palliative care receive palliative care training.
- Provide HDC with an update as to the implementation of an additional professional and clinical day in the core programme cycle for registered nurses and enrolled nurses.

These recommendations are to be completed within three months of this report being issued.

Follow-up actions

176.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Presbyterian Support Central (operating as Kandahar Home), will be sent to the Nursing Council of New Zealand and the College of Nurses, and they will be advised of RN A's name. As noted above, I have recommended that the Nursing Council of New Zealand carry out an assessment of RN A's competence.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Presbyterian Support Central (operating as Kandahar Home), will be sent to the District Health Board, and it will be advised of RN A's name.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Presbyterian Support Central (operating as Kandahar Home), will be sent to Hospice New Zealand and the Ministry of Health.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Presbyterian Support Central (operating as Kandahar Home), will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A — Independent expert advice to the Commissioner

The following expert advice was obtained from RN Dawn Carey:

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms B] about the care provided to her late mother whilst she was resident at Kandahar Rest Home by [RN A]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the documentation submitted; complaint from [Ms B]; response from [RN A] including letters of reference, performance appraisal, Curriculum Vitae, pain assessment tool; KRH clinical file for [Mrs C].

3. [Ms B] has complained that in the two days prior to her mother's death, [RN A]
   - (i) Refused to dispense PRN (as required) morphine elixir and midazolam without adequate explanation
   - (ii) Spoke loudly and negatively about [Ms B] in her mother's presence whilst [Ms B] was out of the room
   - (iii) Lied to [Ms B] about [Dr D's] advice concerning pain management regime for [Mrs C] on 29 [Month2]

   As a RN peer I have asked to provide advice about the standard of care provided to [Mrs C] by [RN A] between 28 and 30 [Month2]. As [RN A] is no longer employed by Kandahar Rest Home (KRH) I have been asked to answer whether referring [RN A] to Nursing Council of New Zealand (NCNZ) would be appropriate. [Ms B] also forwarded this complaint direct to NCNZ and KRH.

4. [RN A] reports an awareness of her professional responsibilities as a RN and striving to deliver a high standard of nursing care. She reports that the Wong-Baker or Pain Aid pain scale was used to assess [Mrs C's] pain score and that her assessments of [Mrs C's] pain were reliable. She acknowledges that there were occasions when she disagreed with [Ms B's] assessment that her mother was experiencing pain. [RN A] reports that she believes that she always acted appropriately and consulted with [Mrs C] and her daughter when PRN analgesia was requested. She refers to occasions when she administered PRN morphine as requested, as indicating that she was responsive to [Mrs C's] pain experience. [RN A] reports her awareness of the risk versus benefit that needs to be weighed up when administering opioid analgesia.

   [RN A] reports that from 26 [Month2] until her death on 30 [Month2], [Mrs C] was on a continuous syringe driver which delivered morphine, haloperidol and midazolam subcutaneously. On 29 [Month2] at approximately 4pm, she and another RN reviewed [Mrs C]. This review was in response to [Ms B] reporting that her mother's breathing was laboured and that she was frowning. [RN A] assessed [Mrs C] with the Painaid Scale and found her

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comfortable and settled. She reports that [Mrs C's] syringe driver medication doses had been increased that morning and that her respiration rate was now below 12 per minute. She reports being concerned that an additional dose of morphine would further depress [Mrs C's] respirations and discussed this with [Ms B].

Later on 29 [Month2], [RN A] reports that she and another RN spent considerable time making [Mrs C] more comfortable through sponging and moisturising her skin and repositioning her. She reports both registered nurses speaking quietly and respectfully to [Mrs C], who was in a comatose state. Again [Mrs C] was assessed for signs of pain and deemed comfortable. Later in response to [Ms B] reporting her mother had severe stomach cramps and chest secretions on the exhale, Buscopan was administered. [RN A] later updated [Ms B] that she had phoned [Mrs C's] GP to update her and request an alternative medication to assist with [Mrs C's] increased secretions. [RN A] reports that she explained that the GP had instructed her to continue with the PRN medications as charted and that she would review the medication chart the next day. [RN A] reports that [Mrs C] was calm, peaceful and free of pain when her shift ended on 29 [Month2].

5. **Review of clinical notes and comments**

[Mrs C] was admitted to KRH for palliative care in [Month1]. From the outset she was prescribed opioid analgesia to manage her level of pain. In [Month1] the Clinical Nurse Specialist (CNS) from [palliative care services] faxed KRH and advocated that the KRH nurses administer the PRN analgesia (morphine elixir) when [Mrs C] reported pain. The CNS liaised directly with KRH Nurse Manager via telephone, followed this up with a fax and also offered to communicate directly with the KRH nursing team if necessary. It is reported by KRH that all registered nurses received this advice.

I note that [RN A] reports using the Wong-Baker Faces Pain Rating Scale (WBFPRS) to assess [Mrs C's] level of pain. The submitted Pain Assessment Form (PAF) is good as it uses three scales — self reporting numerical pain scale (NPS), WBFPS and Painaid Scale (PS) — that can be used to assess pain. The use of an objective pain scale acknowledges the research literature findings that pain is usually under-recognised and under-treated by health practitioners. The NPS is valid for use with a resident that can report their subjective pain experience whilst the WBFPRS and Painaid Scale are valid for those who lack the verbal ability to communicate their pain experience. When [Mrs C] could verbalise her pain and did so, stating a score, the incorporation of the WBFPRS was unnecessary and inappropriate. I recognise that this occurred prior to the tight timeframe — two days — that are specified within the complaint. I draw attention to this, as I consider it as fundamentally damaging to the relationships between the [family] and [RN A]. In my opinion, using one scale to 'over rule' [Mrs C's] pain score demonstrates a lack of understanding about pain assessment tools, a lack of empathy for [Mrs C's] experience and her reason for admission to KRH.

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Upon review of the progress notes (PN) dated 28–30 [Month2], there are regular reports entered by [RN A] that [Mrs C] was *unsettled and restless.* At this stage [Mrs C] was on a continuous syringe driver pump with additional opioid analgesia, antispasmodic and benzodiazepine prescribed for administration as required. I note that [RN A] makes the point that *restlessness does not always indicate pain*. Whilst I agree that non-pharmacological interventions have a definite place in providing comfort measures to a patient and facilitate the effectiveness of administered analgesia, I disagree that [Mrs C's] observed restlessness was not a sign of discomfort/pain. In my opinion, [Mrs C's] signs of restlessness or agitation should have been managed by administration of her PRN medications in addition to the other measures employed to promote her comfort.

[RN A] acknowledges that she did refuse to administer PRN morphine to [Mrs C] on 29 [Month2], *morphine declined as R10 (req 12 legally) …*

Throughout the [progress notes] [RN A] regularly reports [Mrs C's] respiration rate. In my opinion, focussing on [Mrs C's] respiratory function and determining whether to administer additional opioid based her rate demonstrates confusion about what competencies, legislation and standards guide a RN during end of life care; about what the goal is during provision of palliative care, and denies a dying person access to adequate pain relief when they are at their most vulnerable. It is disappointing that despite the KRH collaborating with [the palliative care service] closely that such fundamental confusion continued. In my opinion, [RN A's] failure to administer [Mrs C's] prescribed PRN medications demonstrate a mild–moderate departure from the expected standards of nursing care.

Following a review of the submitted clinical file I am unable to resolve the other aspects of [Ms B's] complaint:

(ii) Spoke loudly and negatively about [Ms B] in her mother's presence whilst [Ms B] was out of the room

(iii) Lied to [Ms B] about [Dr D's] advice concerning pain management regime for [Mrs C] on 29 [Month2]

6. **Comments**

In my opinion, [RN A's] response, appraisal and colleague's references reflect a RN who does strive to deliver a high standard of nursing care. Unfortunately I do consider that in relation to pain management, the standard of nursing care that she delivered to [Mrs C] departed from [the] standard expected. I am of the opinion that the departures were grounded in a lack of knowledge about end of life care rather than in any wish to deliver suboptimal care. As a RN peer I consider it extremely sad that an individual received poorer access to their prescribed pain relief because they chose to die in the care of health professionals rather than in their own home.

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If the Commissioner is agreeable I would recommend that my advice — or selected parts — are forwarded to KRH. In my opinion [RN A] was not the only KRH employee who acted as a 'gate keeper' when [Mrs C] complained of pain or showed signs of discomfort. I would urge KRH to continue their collaborative relationship with [palliative care services] and to develop the knowledge, skills and competencies of their staff team in the delivery of palliative care.

7. **Clinical advice**
As a RN peer I have been asked to consider whether [RN A] provided care to the expected standards in relation to [Mrs C] between 28–30 [Month2]. In my opinion, there is evidence that [RN A] refused to dispense PRN medications during palliative care provision to [Mrs C] despite the same being prescribed. In my opinion this was a departure from the expected standard of nursing care. I am of the opinion that within this clinical file there is evidence of a lack of competency with regard to objective pain assessment and goals of palliative care. As [RN A] is no longer employed by KRH I would recommend that [RN A] be referred back to NZNC.

Dawn Carey (RN PG Dip)
Nursing Advisor
Health and Disability Commissioner
Auckland."

Further advice

Further expert advice was obtained from RN Carey as follows:

"1. Thank you for the request that I provide further clinical advice in relation to the complaint from [Ms B] about the care provided to her late mother, [Mrs C]. 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. This advice is to be read in conjunction with my previous brief clinical advice.
2. I have been asked to review the additional information provided and advise whether the responses cause me to confirm, amend, add to, qualify or depart from my opinion as expressed in my previous brief clinical advice.
3. In my previous advice, I expressed the opinion that:

- In relation to pain management, the nursing care provided by [RN A] to [Mrs C] demonstrated mild–moderate departures from the expected standards of nursing care.
- The departures were grounded in a lack of knowledge about end of life care rather than resulting from any desire to deliver suboptimal nursing care.

I also expressed the opinion that [RN A] was not the only KRH employee who acted as a 'gate keeper' and asked could my advice be forwarded to KRH. I based my opinion on the documentary evidence that other KRH staff

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also had 'expectations' about the behaviours/lack of them [that] should accompany [Mrs C's] reportage of pain.

4. I have read and reviewed the KRH clinical file of [Mrs C], submitted responses and supportive documents and statements from Presbyterian Support Central (operating as Kandahar Home); response and supportive documents from [RN A].

   I note that KRH reports being unable to locate [Mrs C's] pain management diary and incident forms.

5. **Presbyterian Support Central (PSC) responses**
   PSC have provided a response in two parts; a specific response to my previous advice and supportive documentation and staff statements. The staff statements report:

   - That KRH obtained a contract to provide care and end stage support to palliative patients in early 2012.
   - The palliative care contract was accompanied by support from [the] Palliative Care team and the ability to contact them for advice; and a 24 hour ability to contact a GP for medical advice.
   - The difficulties in trying to access medical care from [Dr D] due to geographical distance and booked annual leave.
   - All ENs and RNs had an up to date medication competency at the time of [Mrs C's] stay.
   - That eight nurses from the EN/RN staff team were undergoing palliative care training during [Mrs C's] stay at KRH. Also that this training had commenced prior to [Mrs C's] admission to KRH.
   - With the benefit of hindsight, it has been recognised that [Mrs C] would have benefited from an earlier involvement of a palliative care medical specialist.

In response to a copy of my previous advice, PSC states that:

At a high level, I support the advice that [RN A] <u>may not have</u> provided <u>optimal</u> communication and care in relation to the administration of analgesia to [Mrs C].

The response also reports:

(i) Agreement that there was evidence of RN confusion about respiratory rate and Morphine administration in a terminal scenario but does not support the opinion that the departures were grounded in a lack of knowledge about end-of-life care.

(ii) A wish for the legislation that guides a RN during end of life care to be specified.

(iii) That the opinion reporting other RNs acting as 'gate keepers' needs to be supported with evidence and the staff identified or the opinion amended.

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These three points will be addressed in section 7.

6. **[RN A's] response plus comments**

[RN A's] response reports:

- A good understanding of the different pain assessment tools available.
- A sensitive understanding of the need for non-pharmacological interventions in end-of-life care and how to incorporate them into care.
- That she attended a two hour palliative care training workshop on syringe drivers in 2012.

[RN A] also reports:

- *When [Mrs C] was able to verbalise her pain to me, I always acted on what she told me …*

Comment: 22 [Month2] Health Status Summary (HSS): [RN A's] entry — *"Pain in back — worst pain …" nil body language pain, nil grimace, nil writhing, resting in reclining on bed …*

- *… In my palliative care nursing education sessions and available literature it has never been stated to give break through morphine if RR is 12 or under …*

Comment: Counter to this argument, I doubt that palliative care education would state **not** to give morphine if the respirations were less than 12. I am also of the opinion that such a requirement would not be found in the relevant peer reviewed nursing literature. In my opinion, a requirement that the patient's respiration rate is greater than X per minute before the administration of an opiate, is not a legislative requirement. I do accept that safe medication administration — monitoring and assessment would come into this — requires knowledge of known side effects etc. In practice this would mean that the RN assesses the patient's sedation level and respiration rate prior to administering such medications. However, I feel strongly that such requirements relate to non-palliative care patients.

7. **My secondary advice and response to PSC**

(i) This opinion is based on:

- The World Health Organisation (2008) defines palliative care/end of life care as an approach that improves the quality of life of patients and their families facing the problems associated with life limiting illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.
- [Mrs C's] reason for admission to KRH was to receive palliative nursing care.

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- [Mrs C's] prescribed medications; the GP's communication with KRH staff; and the consistent advice from the Palliative Clinical Nurse Specialist (CNS) team, which supports that [Mrs C] receives the PRN analgesia that she is prescribed and that ... *Pain level is what [Mrs C] says it is ...*
- [RN A's] medication administration to [Mrs C] on 24 [Month1].
- [RN A's] acknowledgement that she did refuse PRN morphine to [Mrs C] on 29 [Month2].
- [RN A's] acknowledgement that she used [Mrs C's] respiration rate to determine whether to administer the prescribed PRN opioid analgesia or not.
- Established knowledge concerning pain assessment, end-of-life care, pain experiences and opioid management: Patient's self-reporting of their pain recognised as the gold standard measurement; pain, excessive secretions, restlessness, dyspnoea, and nausea and vomiting are the most commonly reported symptoms; prescribing PRN medications to manage these symptoms is recommended; management of these symptoms is advocated by 'anticipatory' prescribing; as the pain experience is an 'antidote' respiratory depression is rarely seen [in the non-opioid naive]; tolerance to opioid effect is rare and progression of the disease is considered the most likely cause of increasing need of analgesics[1].

(ii) Health Practitioner's Competence Assurance Act (2003); Health and Disability Services (Safety) Act (2001); Medicines Act (1981); Misuse of Drugs Act (1975).

The enactment of HPCA Act (2003) requires the Nursing Council of New Zealand (NCNZ) to ensure that nurses are clinically competent and can demonstrate continuing competent practice. As such the NCNZ sets the standards that demonstrate the required clinical and cultural competence, and ethical conduct. Whilst NCNZ produces codes/guidelines/standards, the expectation is that nurses will adhere to the requirements as espoused in theses documents.

(iii) This opinion is based on:

- 24 [Month1] Progress Form (PF): HCA entry — … *at 04.10 she rung bell and requested her pain relief ... RN informed about this and was concerned about time frame, [Mrs C] didn't appear or say she was in pain, around 05.25 [Mrs C] followed up ...*

[1] Ellershaw J, Wilkinson S. (2003) Care of the Dying: A pathway to excellence. Melzack, R., Katz, J. (1994) Pain measurement in persons in pain. In Wall, P.D., Melzack, R. *Textbook of pain.* London: Churchill Livingstone. Watt-Watson, J.B et al (2001). Relationship between nurses' knowledge and pain management outcomes for their post operative cardiac patients. *Journal of Advanced Nursing; 16 (6), 1012–1020.*

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- 24 [Month1] PF: RN entry — … *[Mrs C] appears not in pain … given as she's persistent to have it.*
  Comment: I do not understand the 'time frame' concern. Over five hours had passed since [Mrs C] had received a PRN Morphine dose — Morphine Elixir was prescribed PRN four hourly according to printed notes from [the] Medical Centre, entry by IMA. [Mrs C] next received a PRN Morphine dose at 5.40am.
- 24 [Month1] Integrated Clinical Notes (ICP) from Palliative Clinical Nurse Specialist (CNS) … *concerns [Mrs C] asking for elixir a lot, 3–4 times per 24 hrs. I said I didn't feel this was extreme as charted (after a lot of assessments with meds) PRN [Mrs C] should be given it. [RN E] understood what I was discussing and will pass it onto RNs …*
- 25 [Month1] PF: EN entry (9.49pm) — *remains in pain …*
  Comment: There is no entry reporting PRN analgesia being administered from 6pm (25 [Month1]) to 5.40am.
- MASS reports incidences 24–26 [Month1] where [Mrs C] was administered 5ml (5mg) Morphine doses.
  Comment: It is reported in subsequent entries that there was a discrepancy between information on the Morphine Elixir bottle and on the prescription. Before 26 [Month1], there is no evidence of RN seeking to clarify the discrepancy with GP, seeking support from Palliative nursing team, completing an incident form.
- 23 [Month2] HSS: RN entry — *[Mrs C] does not appear to be in severe pain …*
- 24 [Month2] PF: entry completed by Palliative CNS … *Pain level is what [Mrs C] says it is …*
- Statements from KRH EN/RN colleagues sent by [RN A] as supportive documentation. For example
  RN 'A' … *[Mrs C's] respirations would be low below 12 respirations per minute, and one contraindication of Morphine administration is acute respiratory depression ….*

8. **Additional comments — KRH**
   When reviewing [Mrs C's] administered medications I noted that the administration of [Mrs C's] Morphine elixir is recorded on two different pages — MASS (M-Eslon on front) and on a PRN Administration Record (Midazolam and Buscopan on front, Morphine elixir, Lorazepam, Pamol on reverse). On four occasions during [Month2], the documentation for the administration record is duplicated:

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DATE	MASS	PRN Admin Record
22 Month2	16.48	16.00
23 Month2	08.30	08.30
23 Month2	14.30	14.30
24 Month2	18.50	18.50

To avail of the full learning available in this complaint I would recommend that KRH discuss the documentation requirements for medication administration, controlled medications with their RN and EN staff team. I note that the submitted Medication Manual is a clinically robust policy manual, which has the correct requirements specified for the 'administration of controlled drugs'.

I would also recommend that either the Medication Manual is extended to reflect end-of-life medication administration issues or that a new end-of-life care policy is developed.

I would also like to acknowledge that there is evidence of empathetic nursing care being regularly administered to [Mrs C] during her stay at KRH.

9. **Additional advice — [RN A]**
As a RN peer, I would suggest that [RN A] considers not participating in end-of-life/palliative nursing until she undergoes further clinical education from appropriate specialists — Palliative Care or Hospice RNs — and is willing to amend her nursing practice to take such knowledge on board. I make this point as there is good evidence of consistent and clear information being verbalised and documented by [the palliative care service] and of KRH communicating this information, during [Mrs C's] residency at KRH.

I admit to being disappointed by [RN A's] continued fixation with the need for a patient to have respirations of X before they can be administered prescribed opiate medication. She persists with this even after clarifying it with the Palliative Care nurses at [the palliative care service] following [Mrs C's] death; and being told ... *they do not recognise the respiration rate ...*

10. **Clinical advice**
Following a review of the additional responses and supportive documentation I remain of the opinion that [RN A's] failure to administer [Mrs C's] prescribed PRN medications demonstrates a mild–moderate departure from the expected standards of nursing care.

Dawn Carey (RN PG Dip)
Nursing Advisor
Health and Disability Commissioner, Auckland."

Names have been removed (except Presbyterian Support Central/Kandahar Home and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.