HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Management of vulnerable resident at care home

Complaint background

1. This Office received a complaint from Mr A about the care provided to his father, Mr B, at Experion Care New Zealand Limited (trading as Wensley House), located in Richmond, Tasman region. The complaint concerns the lack of timely escalation of Mr B's care and a lack of communication with his family. Mr A requested an investigation into the care provided to his father in the days before his father's death.

2. I express my sympathy and heartfelt condolences to the family and friends of Mr B for their loss. I hope this report brings some closure for Mr B's family.

Background

3. Mr B, aged 84 years at the time, was a resident at Wensley House from January 2018 until January 2022. He had multiple comorbidities, including congestive heart failure,[1] arthritis,[2] and an anxiety disorder. Mr B was on long-term regular and PRN (as required) pain relief to manage his arthritic pain, as well as long-term and PRN anti-anxiety medication. His medications included controlled[3] and other high-risk medications that require careful monitoring.

4. Clinical records show that, from January 2022, Mr B was deteriorating. On day1 January 2022, Mr A was advised by Wensley House that Mr B had been complaining about increasing pain in his arms, legs and side, and Wensley House asked what Mr A would like to do about this. The conversation was not documented. Wensley House confirmed that a staff member did ring Mr A but said that the discussion was about Mr B's arthritis, which was becoming problematic. In response to the provisional decision, Mr A told HDC that his family were not informed that Mr B had been deteriorating.

5. On day2 January 2022, Mr B had reduced fluid intake and increased lethargy, confusion, and pain. He became increasingly unwell, and on day3 January 2022, the Facility Manager of Wensley House contacted Mr B's general practitioner (GP), Dr D (based at the local general practitioner's) to review him. Antibiotics were prescribed for Mr B to treat a suspected urinary tract infection (UTI) while awaiting the results of his urine test. Mr B's sister was present during the GP review, but there is no documentation of the discussion that occurred between the GP and Mr B's sister. In response to the provisional decision, Mr A told HDC that a GP appointment had

[1] A chronic condition in which the heart does not pump blood as well as it should.
[2] Inflammation of one or more joints, causing pain and stiffness.
[3] Controlled medications relate to class A, B or C drugs as defined in the schedules of the Misuse of Drugs Act 1975. They have strict regulations because of their potential for misuse, dependence, or harm.

already been arranged for day3 January 2022 by the family, and his aunty rang Mr B to inform him of this on the evening of day2 January 2022.

6. On day4 January 2022, Mr B was delirious and continued to decline, despite a review by Dr D the previous day. Mr B's sisters visited him and were concerned about how unwell he looked and informed Mr A, who visited his father immediately. Mr A was also very concerned about his father's deteriorating condition and asked Wensley House 'what was happening and what they planned to do for [Mr B]'. Mr A told HDC that, in response, staff advised that '[Mr B] was fine'. However, Mr A said that it was clear that there was no treatment plan, and he had to insist that an ambulance was called. In response to the provisional decision, Mr A told HDC that his aunty had called Wensley House to check on Mr B's condition on day2 January 2022 and was told that he had improved and that he was going to get up for a shower. Mr A stated that his aunty 'felt the need to visit' Mr B that morning.

7. Mr B was transferred to hospital, where he was found to have had an opioid overdose and was given naloxone to reverse his narcosis.[4] In addition, he was diagnosed with *Staphylococcus aureus* bacteraemia[5] (the source was uncertain, possibly the left hip), an acute kidney injury, and respiratory depression associated with the drug toxicity. Mr B was given treatment in the hospital, but he had a poor response and was placed on a palliative pathway. Sadly, in mid-February 2022, Mr B passed away.

8. Wensley House's Medicines Management policy (undated) states that it is the 'R[egistered] N[urse's] responsibility to regularly check and monitor PRN usage and to ensure that staff are competent in relation to PRN administration'. Medication records show that in the nine days leading up to day4 January 2022, Mr B was administered PRN medications (lorazepam,[6] morphine,[7] midazolam,[8] quetiapine[9]) 19 times by caregivers. Although the medications administered were in line with the GP's instructions/prescription, oversight by a registered nurse was provided for only two of the 19 events. Mr B's care plan instructed that staff were 'to always report any change in mood or behaviour. Administer [medication] reporting their effect.' Mr B's PRN medication records show that the effectiveness of the medication was recorded. In response to the provisional decision, Mr A questioned the impact of so many unsupervised doses of medications administered PRN on his father's condition.

9. Wensley House acknowledged that there was no in-depth review of the medications (including the benzodiazepines, opioids, and antipsychotic medications) that were administered by caregivers in the nine days prior to Mr B's transfer to hospital.

10. HDC sought copies of Wensley House's policies and procedures that were available to guide staff at the time of the events. Wensley House provided the Medicines

[4] A state of stupor, drowsiness, or unconsciousness produced by drugs.
[5] A serious bloodstream infection that can lead to severe complications, including death.
[6] A benzodiazepine medication used to treat anxiety.
[7] An opioid medication used to treat severe pain.
[8] A benzodiazepine medication used to help with relaxation and sleep.
[9] An antipsychotic medication used to treat depression.

Management policy, Infection Control policy, Wound Care policies, and the Communication with Relatives policy. As many of the policies supplied were not dated and did not have a review date, it is not known whether the policy contained up-to-date information to inform best practice.[10] The Infection Control policy did not include consideration of asymptomatic bacteriuria,[11] which can affect older adults. In addition, while it is recorded that a team meeting in April 2022 discussed best practice guidelines for managing UTIs, this information was not included in the policy provided.

11. Mr A raised several concerns about the communication from Wensley House. These include a lack of appropriate explanation around Mr B's deteriorating condition and treatment plan on day4 January 2022, a lack of timely notification to family around Mr B's deterioration, conflicting information around the medications given to Mr B, and failure to provide Mr B's medical records despite Mr A 's brother (Mr B's executor of his estate) requesting this information from Wensley House staff.

12. In response to the above concerns, Wensley House told HDC that Mr A was not Mr B's Enduring Power of Attorney (EPOA), and so communication occurred only with Mr B's sister, Mrs C, and not with his sons. The Communication with Relatives policy (undated) states that any contact with relatives should be documented in the progress notes. While there is a mention of Mr B's sister visiting on day4 January 2022, there is no documentation of the content of discussions in the clinical notes. Wensley House acknowledged the lack of documentation regarding this discussion. In response to the provisional opinion, Mr A told HDC that he didn't understand why there were 'so many key clinical conversations' not recorded and said that this 'appears to lean towards a disregard for transparency with [the] patient's family.'

In-house clinical advice

13. In-house clinical advice was sought from Nurse Practitioner (NP) Isabella Wright (Appendix A), who identified the following departures from the accepted standards of care:

- Standard of nursing assessment, oversight, and management of Mr B in the days preceding his admission to hospital, including the lack of oversight provided to caregivers in relation to PRN medication administration — **moderate to severe departure.**
- Standard of policies and procedures available to nursing staff — **moderate departure**.
- Standard of communication with Mr B's family — **mild departure**.

[10] In response to the provisional report, Experion Care New Zealand Limited told HDC that, though the policies were not dated at that time '[i]t does not completely invalidate that there were policies' or that these were not followed.

[11] The presence of bacteria in the urine without any accompanying symptoms of a UTI.

Responses to provisional decision

Experion Care New Zealand Limited

14. Experion Care New Zealand Limited was given a copy of the provisional report and given the opportunity to respond. Experion Care New Zealand Limited stated that, following further investigation, it was found that the nurse manager had not followed policies and procedures and is currently not practicing as a nurse in New Zealand.

Mr A

15. Mr A was given the opportunity to respond to the provisional decision, including the proposed findings and recommendations. His responses have been incorporated where relevant in the report. Mr A told HDC 'Dad's condition deteriorated when he was in hospital, and he died in a very confused condition, not in a dignified manner that he deserved. I am sure this was at least partly caused by the care, or lack of, delivered by Wensley House …'

Decision — breach

16. The key consideration is whether Experion Care New Zealand Limited (trading as Wensley House) provided Mr B with an appropriate standard of care during January and February 2022. NP Wright identified issues with the oversight provided by a registered nurse for the administration of PRN medication, the adequacy of Wensley House's policies, and the adequacy of communication in relation to Mr B's care. NP Wright advised that, in these areas, the care provided by Wensley House fell below the accepted standard of care. I accept this advice.

17. It is concerning to note that, of the 19 times Mr B was administered his PRN medication by carers in the nine days leading up to day4 January 2022, oversight by a registered nurse is documented only twice. Mr B was on strong pain relief, including morphine, which needs to be given safely with oversight, as per Wensley House's Medicines Management policy, as there is a risk of overdosing. Oversight by a registered nurse provides a safety net for the resident, as the nurse can monitor for any side effects and take immediate action if required.

18. I am critical that the policies were not dated. In my view, policies provide the backbone of good nursing and support care, as they guide good consistent practice. Without up-to-date policies in place, the accuracy and currency of the information is unclear, and therefore residents may not receive the most appropriate, research-based care. As NP Wright noted, the Infection Control policy did not include consideration of asymptomatic bacteriuria in older adults, which, had it been included, may have provided a different outcome for Mr B.

19. Wensley House told HDC that there were difficult family dynamics and no EPOA, and therefore communication occurred only with Mr B's sister. Whilst I acknowledge that there may have been family issues, there is no documentation in Mr B's progress notes regarding the content of communication with family. I am critical that Mr B's care was not escalated to the GP earlier than day3 January 2022. Had this occurred, the GP may

have instigated interventions to treat Mr B, which may have avoided his hospital admission on day4 January 2022.

20. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[12] requires that services are provided with reasonable care and skill. In the circumstances, having reviewed all the information available, I consider that Experion Care New Zealand Limited (trading as Wensley House) did not provide services to Mr B with reasonable care and skill and breached Right 4(1) of the Code.

Changes made since events

21. Experion Care told HDC that it 'wish[ed] to apologise for any feelings of distress the family of Mr B may have experienced, regarding the care of Mr B at Wensley House'.

22. Experion Care said that it made the following changes:

- It established and filled the role of Experion Care Clinical Governance Advisor (a registered nurse) in 2024. The advisor is available to all managers and clinical leads by phone for any emergency, at any time, to provide clinical support.
- It now has a monthly managers report template that is preloaded with the previous month's incident data, which is then presented to the monthly managers meeting chaired by the Clinical Governance Advisor. Experion Care noted that '[t]his level of reporting throughout Experion Care ensures ongoing clinical oversight and identification of potential issues … and trends'.
- Wensley House now has a village manager and a clinical manager, who work together to manage Wensley House.
- All policies now have review dates.
- Documentation of communication with the GP and family is now mandatory in the electronic health record.
- A weekly review of rest-home residents is now conducted by the registered nurses.

Recommendations

23. I recommend that Experion Care New Zealand Limited (trading as Wensley House):

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

b) Arrange for its facility manager and clinical manager to receive regular mentoring from an aged-care expert over a six-month period. The mentoring should cover clinical oversight, medication management, and recognising and managing clinical

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

decline. Evidence of these mentoring sessions is to be provided to HDC within 12 months of the date of this report.

c) Undertake an audit of the Medicines Management policy, the Infection Control policy, the Communication with Relatives policy and the Wound Care policies, to determine whether they are based on best practice and are dated with a review period noted. A summary of the findings and a copy of these policies are to be provided to HDC within six months of the date of this report.

d) Undertake an audit of 10 resident clinical notes to determine whether there has been an adequate standard of documentation with respect to communication with families. A summary of the findings with corrective actions to be implemented is to be provided to HDC within six months of the date of this report.

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

f) Following completion of recommendation (d), undertake an audit of 10 residents who receive PRN controlled medications to determine whether there has been adequate oversight by a registered nurse. A summary of the findings with corrective actions to be implemented is to be provided to HDC within 12 months of the date of this report.

Follow-up actions

24. A copy of this report with details identifying the parties removed, except the clinical advisor on this case and Experion Care New Zealand Limited (trading as Wensley House), will be sent to HealthCERT and Health New Zealand | Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Rose Wall
Deputy Health and Disability Commissioner

Appendix A: In-house clinical advice to Commissioner

The following in-house aged-care advice was obtained from NP Isabella Wright:

'**1. Complaint**

Family of late [Mr B] have submitted a complaint against Wensley Care Home on the grounds of failing to escalate his unwellness in a timely manner, and that a lack of consistent communication occurred between the facility staff and the family on the day of hospitalisation. They have also expressed frustration at not being provided copies of the notes when requested on multiple occasions.

Complaint was reviewed by aged care navigator, […] on 2/3/23 and updated on 22/3/23 and 2/8/23.

Medical advice was provided by Dr [E] on 14/8/23.

2. Review of clinical records

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

3. Clinical advice

Background (as per Navigator's report):

This complaint related to an elderly gentleman, the late Mr [B], who was resident at Wensley Care Home from […] January 2018 to [day4] January 2022 [until] when he passed away in hospital. At the time, he was 84 years of age.

Mr [B]'s medical history included primary issues of arthritis, congestive heart failure, and a significant anxiety disorder.

In late January 2022, Mr [B] became increasingly unwell, and on [day3] January the Facility Manager (RN) arranged for his long-term GP, Dr [D], to conduct a home visit. He was suspected as having a urinary tract infection, and whilst results of a previous urine specimen were still in progress, antibiotics were prescribed due to his decline.

In addition, he was experiencing an exacerbation of his arthritic pain, regularly experiencing hip and shoulder pain, and was on long-term M-Eslon 10 mg BD, paracetamol 1 g QID, to manage baseline pain. PRN medications for pain included morphine elixir (oral 1mg/mL) 5mg twice daily.

In addition, he was on regular lorazepam TDS, quetiapine BD and zopiclone nocte and prescribed a combination of PRN lorazepam, zopiclone and quetiapine. Between [day1] and [day4] January, there were increased PRN administered, and on the [day4], Mr [B] was administered two separate doses of PRN morphine at 1222hrs and 1343 hrs.

As a result of his decline, the facility manager instructed an ambulance to be called, from where he was transferred to hospital, found to be narcotised (opioid overdose), given naloxone, to be later confirmed as having *staph aureus* bacteraemia, AKI [acute kidney injury], and drug toxicity with associated respiratory depression. Sadly, due to his poor response to antibiotics and intravenous fluids, from which he developed pulmonary oedema, the decision was made to treat palliatively. Sadly, Mr [B] passed away in the days following.

Medical history:
CVA (2018)

Hx ulcers on L toes

Smoker — 65 pk/year history

COPD

Pre-diabetes

Osteoarthritis of Left hip

R total hip joint replacement (1996)

Atrial fibrillation (on Rivaroxaban)

Anxiety & Depression

Abdominal hernia

Congestive heart failure (EF 18% in 2012)

Medications (regular):
doxazosin 2mg nocte

paracetamol 1g QID

omeprazole 20mg mane

Laxsol 2 nocte

frusemide 40mg mane

carvedilol 6.25mg mane

rivaroxaban 15mg daily

fluticasone nasal spray

lactulose syrup 15ml nocte

morphine 10mg SR BD

lorazepam 0.5mg TDS

quetiapine 25mg mane, 50mg nocte

venlafaxine 150 mg nocte

zopiclone 7.5mg nocte

PRN medications included:

- morphine 1mg/ml 5ml PO BD — *PRN dose for breakthrough pain relief. If needing regularly please let Dr know to convert to regular dose increase.*
- quetiapine 25mg daily od *in addition to regular.*
- lorazepam 1mg tab 0.5 tabs up to Q2hrly 2 *prn doses allowed each day in addition to regular doses — teatime and middle of the night good times*
- midazolam 5mg/5mL amp as nasal spray — 1 puff TDS *spray one spray intranasally as needed for anxiety. May* [use] *3 x a day*

Question:

Do you consider the nursing assessment, oversight, and management of Mr [B] in the days preceding his admission to hospital to be in line with expected nursing practice?

The review of clinical documentation from [the nine days before day4 January 2022] indicated that Mr [B] had a significant decline from [day2 January 2022] with reduced fluid intake, increased lethargy, and confusion, including increased pain. He was reviewed by GP on [day3 January 2022] and started on antibiotics for potential urinary tract infection. On [day4 January 2022], his general condition continued to decline (including delirium), and he was transferred to hospital and consequently passed away due to renal failure, bacteraemia (source not identified).

Upon review of PRN medication administration records from **[the nine days leading up to day4 January 2022]**, the following sedating medications were administered by care staff:

- Lorazepam (0.5 to 1mg) — **11 doses** (with good effect and mainly on resident's request)
- Morphine liquid (1mg/mL) — **5 doses** (without much effect)
- Midazolam 5mg/5mL (nasal spray) — **1 spray** (without effect)
- Quetiapine 25 mg — **2 doses** (with good effect)

PRN medications were administered in line with GP's instructions (see Dr [E]'s report for comments regarding prescribing of medications for older adults).

No documented evidence was found about oversight of RNs regarding the large number of PRN benzodiazepines, opioids and antipsychotic medications administered by caregivers in last nine days prior to his transfer to hospital. Only one documented event on [day4 January 2022] where two doses of PRN morphine were administered at 1230 hrs and 1335 hrs under RN instruction.

The Medicines Management policy states that it is 'RNs responsibility to regularly check and monitor PRN usage and to ensure that staff is competent'.

From the evidence reviewed to respond to this question, it appears that the nursing assessment, oversight, and management of Mr [B] in the days preceding his admission to hospital was not in line with expected nursing practice. Lack of appropriate oversight by RNs with administration of frequent doses of PRN medications (benzodiazepines, opioids and antipsychotics combined) would be viewed similarly by my peers. **Departure from accepted practice: Moderate/Severe.**

Question:

Do you consider the communication provided to both GP and the family is in line with expected nursing standards?

From the documentation reviewed, it was evident that there was a challenging family conflict situation. Resident register (31/8/2018) contains instructions "Do not contact sons — only sister", as Mr [B] did not have contact with his sons for 20 years.

A discussion is documented on 13/4/21 with his son [Mr A] that Mr [B] is to remain as a resident in Wensley care home.

The long-term care plan states that sisters visit occasionally, and son visits intermittently with update on care plan dating 24/11/21.

InterRAI assessment (1/11/21) indicates that Mr [B] is socially isolated and lonely. Experiences panic attacks. Has low family interaction.

Progress notes on [day3 January 2022] (during significant decline) indicate that Mr [B]'s sister and her husband were present during GP on-site consultation.

Statement from Wensley care home GM ([…]) on 4/4/22 indicates that there were frequent phone discussions with Mr [B]'s sister, which were not documented in the progress notes.

The Communication with Relatives policy states that any contact with relatives should be documented in the progress notes.

The GP was contacted due to significant decline and visited on [day3 January 2022]. As per previous response, if appropriate RN oversight occurred within nine days prior to Mr [B]'s admission to the hospital, it is likely that the GP visit would have been initiated earlier.

From the evidence reviewed to respond to this question, it appears that the communication provided to both the GP and the family was not in line with expected nursing standards and the care home's policies. Lack of appropriate documentation of family contact and oversight by RNs would be viewed similarly by my peers. **Departure from accepted practice: Mild.**

Question:

Do you consider the medication administration in the days preceding admission to hospital to have contributed to the overall decline of Mr [B]?

I agree with Dr [E]'s comment about this question:

"Medication is one potential cause of delirium, including sedatives, hypnotics, antipsychotics, and opioids. However, I am unable to state whether these medications might have contributed to Mr [B]'s decline, with infection/bacteraemia being, in hindsight, the most obvious cause of his deterioration. However, it is quite possible [that] the administration of morphine to Mr [B] on [day3] and [day4] January 2022, when he likely had undetected acute renal impairment, was responsible for the narcosis evident on admission to [the hospital]."

Question:

Do you consider the relevant policies; medication management, specifically PRN administration and infection control and prevention, to be sufficient to guide the safe delivery of nursing care?

The medication management and administration policies contain sufficient information for safe practice by caregivers and RNs. As mentioned earlier, these policies were not followed by staff.

Many of the provided policies were not dated and without a review date:

- Medications management policy (no date)
- Administration of medications policy (no date)
- Admittance checklist (no date)
- Pain management policy (no date)
- Medical services policy (no date)
- Wound management procedures (no date)
- Infection control policy (no date)
- Communication with relatives policy (no date)

The infection control policy reviewed is not considered to be in line with best practice for older adults. It provides information that a positive urine culture indicates infection and contains the use of urine dipstick. It does not include considerations of asymptomatic bacteriuria in older adults. However, the team meeting education record from April 2022 discusses best practice guidelines for management of UTIs in LTCFs, which need to be included in the infection control policy.

From the evidence reviewed to respond to this question, it appears that the relevant policies; medication management, specifically PRN administration are sufficient, but infection control and prevention policy is not sufficient to guide the

safe delivery of nursing care and would be viewed similarly by my peers. **Departure from accepted practice: Mild/Moderate.**

In addition to the provider's corrective actions, it is recommended that the care home update their policies and procedures to be in line with best practice guidelines, such as Frailty Guides 2023.[13]

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Nurse Advisor (Aged Care)
Health and Disability Commissioner'

[13] Urinary tract infections | Te pokenga pūaha mimi (Frailty care guides 2023) | Health Quality & Safety Commission (hqsc.govt.nz)