

**Palliative care provided in a rest home
(13HDC00405, 26 June 2015)**

Registered nurse ~ Clinical nurse leader ~ Rest home ~ Palliative care ~ Pain assessment ~ Documentation ~ Uncontrolled drugs ~ Legislative requirements ~ Clinical oversight ~ Policies ~ Rights 4(1), 4(2)

A 57-year-old woman with advanced pancreatic cancer was admitted to a rest home for palliative care.

Several times during her admission, the woman was noted by staff as being in pain on movement, and still in pain after pain relief was administered. On other occasions, the woman's daughter complained that her mother was in pain, but at these times the registered nurses' (RN) views were that she was not.

None of the RNs completed a Pain Evaluation/Assessment Chart in line with the rest home's Pain Management Policy. Also contrary to this policy, a pain scale was not used and vital signs were not taken. Therefore, no formal pain assessment was ever carried out when the woman was documented as being in pain, or when the woman's daughter thought that her mother was in pain. None of the RNs sought the advice of a senior staff member or contacted a GP or the hospice.

The woman's daughter brought a bottle of morphine elixir onto the premises from home. She told an RN that she would administer it to her mother herself if the RN would not. The RN did not inform any senior staff member, management, the hospice or a GP of this incident. Another RN later found the morphine elixir in the woman's bathroom, but did not take any further action.

One of the RN's was found to have failed to carry out a formal pain assessment of the woman when the woman's daughter raised concerns about her mother's pain. This RN also failed to seek advice or report the daughter's concerns about her mother's pain. Furthermore, when the daughter brought a controlled drug into the rest home and advised the RN that she would administer morphine to her mother, the RN did not take appropriate steps, in line with legislative requirements. It was held that she breached Right 4(2).

It was also found that another RN failed to carry out any formal pain assessments of the woman, and did not seek advice or report the woman's pain or the daughter's concerns about her mother's pain. This RN also failed to take any action when she was informed that the woman's daughter had brought morphine in to the rest home, or when she found morphine in the woman's bathroom. It was held that she breached Right 4(2).

The failure by a number of registered nurses to document adequately demonstrated a lack of clinical oversight or leadership by the Clinical Nurse Leader (CNL). Accordingly, the CNL breached Right 4(1).

The rest home had the ultimate responsibility to ensure that the woman received care that was of an appropriate standard by ensuring that its policies were adequate and followed appropriately by its staff. It failed in that responsibility and, accordingly, was found to have breached Right 4(1).

Staff consistently failed to document the woman's care and treatment adequately and appropriately, and failed to document family member concerns adequately. Very little was documented regarding discussions had with family and the hospice regarding the woman. Even when she was in pain, or her daughter's concerns as to pain were documented, there was no rationale provided in the notes to say why these issues were not escalated. In addition, the woman's National Health Index number or date of birth was often missing from her notes, and her name was not recorded consistently throughout her documentation. The rest home did not comply with standards in respect of documentation and, therefore, breached Right 4(2).