Counties Manukau District Health Board

A Report by the

Mental Health Commissioner

(Case 14HDC01390)

Table of contents

Executive summary....1

Complaint and investigation....3

Information gathered during investigation....4

Opinion: Preliminary comment....21

Opinion: Counties Manukau District Health Board — breach....21

Recommendations....26

Follow-up actions....27

Appendix A: Independent psychiatrist advice to the Commissioner....28

Appendix B: Independent nursing advice to the Commissioner....37

Executive summary

1. In 2014 (Day 1[1]), Police found Mr A (then aged in his fifties) wandering outside an airport. Mr A appeared dazed and confused. He was taken to the police station, where he was seen by a consultant psychiatrist, Dr I, and a Duly Authorised Officer and social worker, Ms J.

2. Dr I recorded her impression as: "Psychosis NOS [not otherwise specified] — possibly associated with mood disorder, possibly drug induced. History of polysubstance abuse." The plan was to admit Mr A to a psychiatric inpatient unit after he had been cleared medically.

3. Mr A was admitted directly to the psychiatric inpatient unit, and placed on observations every 15 minutes. Psychiatrist Dr K completed the certificate of preliminary assessment and a clinical report for the Director of Area Mental Health Services. Dr K recorded that he believed that Mr A was mentally disordered. Mr A was given notice of a period of compulsory assessment and treatment under section 11 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA).

4. At 2pm, Mr A was reviewed by consultant psychiatrist Dr D, who decided on a plan that included further assessment and monitoring for signs of withdrawal. She recorded a request that Mr A be reviewed by a registrar the following day (Saturday) and on Sunday if necessary. However, Mr A was not reviewed again by a psychiatrist during his admission.

5. At 5.02pm, a house officer, Dr F, conducted Mr A's admission physical examination. Dr F recorded a history of substance abuse, chronic pain, and anxiety. There is no record of a risk assessment.

6. On Saturday Day 2 Mr A's mood appeared low, and he was subdued and kept to himself, but approached staff to have his needs met. He is recorded as showing no signs or symptoms of withdrawal. Dr F reviewed him again, but did not request a review by the on-call psychiatrist or do a risk assessment.

7. In the afternoon of Day 3 Mr A was visited by two friends, who remained in his room for more than an hour and then left the ward. The ward clerk, Ms L, said that Mr A's friends spoke to her after their visit with him and told her that he had said that he was not going to come out of there alive. They said that they had attempted to cheer him up and they were concerned that he was going to try to kill himself. Ms L telephoned RN G, Mr A's allocated nurse for the day, and relayed the friends' concerns. RN G came from the ward and spoke to them.

8. The friends told RN G that they thought Mr A was "low and distressed as he was expressing thoughts of wanting to make a will as he believed that he would not be able to make [it] out of the hospital". She said she asked whether the friends knew whether Mr A had any suicidal intention or plans. They were unable to identify any, but were able to identify that he was dissatisfied with his recent trip. The friends said

[1] Relevant dates are referred to as Days 1-4 to protect privacy.

HDC

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that Mr A had had a previous psychiatric admission two years ago, had been using LSD for the previous two weeks, and had begun to identify himself as the "Messiah". RN G mentioned the conversation to another nurse and recorded it in the progress notes, but did not seek a medical review.

9. At around 5.30am on Day 4 a psychiatric assistant saw Mr A standing by his open door, "fiddling around by the door hinges". Mr A started talking quickly and stuttering, and said, "[H]ey please I just want to do something quick please." Mr A returned to his room and sat on his bed.

10. At around 8am, two nursing students found Mr A unconscious in his room. Staff commenced CPR compressions, but, sadly, Mr A could not be resuscitated.

Findings

11. Counties Manukau District Health Board (CMDHB) did not provide services to Mr A with reasonable care and skill as follows:

- Staff failed to arrange a psychiatric review of Mr A on Day 2 or Day 3.
- Mr A's risk was not assessed sufficiently following his admission.
- Staff failed to respond adequately to his changing presentation.
- Staff failed to monitor him for signs of withdrawal after Day 2, as required by the plan made by Dr D.
- Staff failed to respond adequately to the concerns expressed by Mr A's friends and the information that he was talking about making a will.

12. Accordingly, CMDHB breached Right 4(1)[2] of the Code of Health and Disability Services Consumers' Rights (the Code).

13. Comment is made about CMDHB's inability to provide HDC with a copy of the 15-minute observation checklists for Days 2 and 3.

Recommendations

14. It is recommended that CMDHB :

a) Report back to HDC on the implementation of the recommendations of the Serious Incident Review Triage Team, including:

- Findings from the follow-up reviews recommended by the team;
- A report on the implementation of any subsequent recommendations arising from the follow-up reviews; and
- Copies of any new processes, policies, and procedures.

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

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b) Conduct audits of the new standard operating processes and policies and procedures, and provide HDC with the results of the audits and any service improvements that will be taken as a result of the audits.

c) Provide HDC with evidence of further training completed by clinical staff involved in Counties Manukau Mental Health and Addiction Services regarding patient risk assessment, and the clinical documentation of patient presentation.

d) Audit the use of risk assessment documentation for patients presenting with possible substance withdrawal, significant risks, or suicidal ideation, or who are receiving compulsory care under the MHA, to ensure that the documentation meets professional standards.

e) Consider whether a registrar or consultant should attend the inpatient unit each day over the weekend and on public holidays, and advise HDC of the outcome and information about what medical cover is now provided.

15. It is further recommended that at the next meeting of the Mental Health Clinical Directors of the DHBs to be attended by a CMDHB representative, the representative arrange for the agenda to include a discussion of psychiatrist input into inpatients at weekends, and report back to this Office on the outcome from the discussion.

Complaint and investigation

16. The Commissioner received a complaint from Ms B about the services provided to Mr A byCMDHB.

17. The following issue was identified for investigation:

The appropriateness of the care provided by Counties Manukau District Health Board to Mr A in 2014.

18. This report is the opinion of Kevin Allan, Mental Health Commissioner, and is made in accordance with the power delegated to him by the Commissioner.

19. The key parties referred to in the report are:

Ms B	Complainant
Ms C	Sister of consumer
Counties Manukau District Health Board	Provider
Dr D	Psychiatrist
RN E	Registered nurse
Dr F	House officer
RN G	Registered nurse
RN H	Registered nurse

Also mentioned in this report:

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Dr I	Consultant psychiatrist
Ms J	Social worker
Dr K	Psychiatrist
Ms L	Ward clerk
RN N	Registered nurse
RN M	Registered nurse
RN O	Registered nurse
RN P	Registered nurse
RN Q	Registered nurse
PA R	Psychiatric assistant
PA S	Psychiatric assistant
Dr T	Clinical director

20. Independent expert advice was obtained from a psychiatrist, Dr Rosemary Edwards, (**Appendix A**) and a registered nurse, Dr Tony Farrow (**Appendix B**).

Information gathered during investigation

Background

21. Mr A was in his fifties. His older sister, Ms C, said that he had been addicted to drugs for many years. She said that he had stopped using methadone a few years previous, and began to recover slowly; however, he had pancreatitis, diabetes, and "significant difficulties with anxiety and major gaps in everyday coping capacities. He lived a lot in his head." Mr A lived alone with support from friends and neighbours.

22. Ms C stated that her brother suddenly decided to go overseas; however, he had minimal travel skills. She said that on the return trip he missed three flights. She said: "We had frantic calls and texts" from him. Mr A's youngest sister said that she was involved in getting her brother back to New Zealand once he had missed his flights and his mental state became delicate.

Day 1

23. Around 8.30am on Friday, Day 1, the Police found Mr A wandering around the airport in a confused and disoriented state after having flown home. He was taken to the police station.

24. At 10.45am a consultant psychiatrist, Dr I, and a DAO (Duly Authorised Officer)/social worker, Ms J, reviewed Mr A at the police station. Ms J recorded that she had telephoned a friend of Mr A to obtain further information about Mr A's condition.

25. Ms J recorded in the clinical notes:

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"[The friend] explained that [Mr A] went [overseas] a month ago and that he was to […] … he possibly has used some illegal drugs and this has unsettled him.

[The friend] stated that [Mr A] would normally have a fractured mind and that he has not been this bad for a very long time. He has scared people [while away] in how he has been presenting and that he would not stay at the accommodation and they could not arrange some medical support for [Mr A] [while there]."

26. Ms J recorded the outcome of the assessment as:

"[Mr A] is presenting as confused/delusion and possible manic. … [Mr A] seems to be a risk to himself by not being able to maintain his own health and that he will meet the criteria of the Mental Health Act at this time."

27. Dr I recorded her impression as: "Psychosis NOS [not otherwise specified] — possibly associated with mood disorder, possibly drug induced. History of polysubstance abuse. Plan: Admit [to the inpatient unit][3] after medical clearance at ED [Emergency Department]."

28. Ms J completed an MHA section 8A application for assessment, and Dr I completed the section 8B supporting medical certificate. Ms J recorded that the section 10 (Certificate of Preliminary Assessment) and section 11 compulsory assessment would be completed by psychiatrist Dr K at the inpatient unit.

29. Ms J recorded in the clinical notes under the heading "Plan":

"[Dr K] to complete second assessment at the inpatient unit.

…

Care Plan Assessment & Risk Assessment started."

30. Ms J recorded that the inpatient unit house officer would review Mr A medically, rather than the review being conducted via the ED. The CMDHB Serious and Sentinel Event (SSE) review report notes that Dr I stated that subsequently she discussed the medical review with the intake and assessment clinician, and it was decided that evaluation by the house officer would be an appropriate alternative to a review in the ED.

31. Dr I told the Police that she and Ms J asked Mr A to accompany them from the cell to an interview room, where they completed a comprehensive mental health assessment form. Under "Part G: level of motivational change of substance use", it is recorded: "[Mr A] reported no thoughts of harm to self or others." Under "Part B: risk to self" it is recorded: "Currently unable to care for himself. Very confused and perplexed, appears not to be eating or bathing." The clinical record under the next heading — "Summarise risk issues as a risk statement" — is: "as above". Dr I told the Police that Mr A denied thoughts of harming himself or other people, and "he seemed motivated

[3] This is a residential unit that supports people with mental health problems during a crisis.

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to get back on his medications and to get help". She said she thought Mr A was psychotic and unable to take care of himself.

32. Ms J also completed an adult risk assessment and management plan. This consisted of a series of prompt questions about the background to the patient's illness or problems; a personal history; the level of motivational change away from substance abuse; the risk to self; and a summary of risk issues. Under the heading "Unintentional self harm, neglect", Ms J recorded: "Lack of self care and this is causing ongoing mental health issues, which seems to lead [Mr A] to [make] decisions about how to look after [himself]." The plan was not updated after Mr A's admission.

The psychiatric inpatient unit

33. Ms J told the Police that she stayed with Mr A and went with him to the inpatient unit, where she handed him over to the staff there. She said that she stayed with Mr A until he was assessed by Dr K in relation to the MHA (see below).

34. At 1pm Mr A was admitted directly to the psychiatric inpatient unit, and placed on observations every 15 minutes. Registered mental health nurse (RN) RN N (a charge nurse) told HDC that he thought that Mr A was not suitable for the psychiatric inpatient unit, "based on his vulnerability and disorganisation", but was told that the only beds available at the time of Mr A's admission were on the psychiatric inpatient unit.

35. RN N stated that because of Mr A's disorganisation, he was left "in the open low stimulus environment (LSE)" area, as was common practice with admissions to the psychiatric inpatient unit. RN N said that the "verbal plan" was to leave Mr A in the LSE area until staff were satisfied that it was safe to transition him to the main part of the ward.

36. A Psychiatric Assistant (PA) told HDC that while in the LSE area, Mr A "expressed concerns in regard to opiate addiction".

Observations

37. All service users in the psychiatric inpatient unit were on 15-minute general observations. These consisted of visual observations by a staff member (usually a PA), who signalled that the patient had been sighted by placing a tick in a generic observation form. The form does not give information on what the service user is doing, or which staff member carried out the check. However, the night form is completed with "S" if the patient is sleeping.

38. PAs support patients with activities of daily living, and strengthen patients' capacity for self care. PAs may provide direct patient care under the supervision of a registered nurse or an enrolled nurse, either as part of the plan of care or when care is delegated or directed.

Preliminary assessment

39. Dr K told HDC that Ms J asked him to complete the section 10 and 11 assessments, which he did after Mr A had been admitted to the psychiatric inpatient unit.

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40. Dr K completed the certificate of preliminary assessment (under section 10 of the MHA) but the certificate does not record whether Mr A was mentally disordered. Section (ii) of the certificate (reasonable grounds for believing proposed patient is mentally disordered) is not completed, nor are the tick-boxes to record that relevant third parties were informed, such as the proposed patient's family and medical practitioner.

41. Dr K also completed a clinical report for the Director of Area Mental Health Services. Dr K recorded that Mr A was found in a "confused and disorientated state in the airport", and that on assessment in the Police cell he was "disorganised, thought disordered and paranoid". Dr K documented that he believed that Mr A was mentally disordered. Mr A was given notice of a period of compulsory assessment and treatment under section 11 of the MHA. Dr K made no further clinical notes.

Psychiatric review

42. At 2pm, Mr A was reviewed by consultant psychiatrist Dr D. Dr D had been employed on a fixed-term contract with CMDHB since mid 2014.

43. Dr D recorded her discussion with Mr A about his activities over the past few days, the medications he was taking, and his presentation, affect, and general mood.

44. A letter from a general practitioner (GP), written for travel reasons, was found in Mr A's bag. This noted his medical history and medications as:

> "Medical history:
>
> Varicose veins of legs — with ulcer left ankle
> Non-[insulin-]dependent Diabetes Mellitus
> Current smoker
> Anxiety states
> Foot arthritis
> Hepatitis C
>
> Medications:
> Dihydrocodeine[4]
> Temazepam[5]
> Metformin[6]
> Gliclazide[7]
> Ibuprofen[8]
> Aspirin[9]"

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[4] For the management of moderate to moderately severe pain, as well as coughing and shortness of breath.
[5] Used to treat insomnia.
[6] Used to treat people with diabetes.
[7] Used for the control of blood glucose in people with type 2 diabetes.
[8] Used to reduce fever and treat pain or inflammation caused by conditions such as headache, toothache, back pain, arthritis, or minor injury.
[9] Used to treat pain, fever, and inflammation.

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45. The letter did not refer to Mr A having been prescribed oxazepam,[10] but empty dihydrocodeine and oxazepam bottles were found in Mr A's bag.

46. In a letter to the Coroner, Dr D said:

> "On my assessment, [Mr A] presented as restless, reasonably well kempt, with intermittent eye contact and rapport was superficial and brittle … He displayed some mild incoherence in his thought processes and presented as vague and evasive … my impression was that [Mr A] needed further assessment."

47. Dr D told the Coroner that her suspicion was that Mr A had a drug-induced psychosis/hypomania. She said she suspected that he had probably not been using his medication as prescribed. Dr D recorded in the clinical notes:

> "Risk: as per MHA assessment section 10/11 Mental Health Act. Impression: needs further assessment: …
>
> …
>
> Plan:
> 1. Assessment in a safe environment; consider transfer to the open ward/HCA after 18–24 hours if appropriate.
> 2. More information from [home town] has been requested.
> 3. PRN [as required] Olanzapine and Lor[a]zepam charted; also regular Temazepam 20mg/nocte [at night] as per [GP's] letter found on patient.
> 4. Please monitor for symptoms of withdrawal.
> 5. Please review by a registrar tomorrow (and on Sunday if necessary)."

48. Mr A was not reviewed again by a psychiatrist during his admission. CMDHB told HDC that no review occurred because of suboptimal clinical documentation practices related to the use of the clinical record system and Dr D's lack of familiarity with the protocol that such plans were communicated verbally to the on-call psychiatrist to follow up over the weekend.

Family contact and assessments

49. Ms C said that on Day 1 she called the inpatient unit at 2.04pm, to enquire about her brother, but was told that he had not arrived there. She said she was told by reception staff that her brother had not yet been entered into the system. Ms C said she later spoke to the nurse on the psychiatric inpatient unit, and gave the nurse her contact details and information about Mr A's last psychiatric admission (in 2011). Ms C said: "The nurse didn't ask questions or offer to put [Mr A] on the phone or find a doctor for me to speak to" and that the only information recorded was Ms C's telephone number.

50. At 2.44pm, RN E recorded in the clinical records further information about Mr A's background, general physical state, and thought content. Next to a heading "Behaviour/Appearance" she recorded: "Able to express his needs well." Under

[10] Oxazepam is a benzodiazepine used for the treatment of anxiety and insomnia, and in the control of symptoms of alcohol withdrawal.

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"Thought content/Process" she recorded: "[A]ppears confused and disorientated. Unable to make a decision and concentrate." Mr A's orientation and insight were recorded as "impaired". RN E recorded under the heading "Initial Treatment Plan 24–49 hours": "24 hour assessment in [unit] till reviewed again by on call [psychiatrist] tomorrow. To be possibly transferred back to [hospital in home town]." There is no risk assessment recorded.

51. Ms C said she called the inpatient unit again at 3.52pm after Mr A had been admitted to the ward, and spoke to a nurse, who said that Mr A had been in his room and was interacting with patients. Ms C said that the nurse gave no other information regarding her brother's condition or mental state. There is no record in the nursing notes of conversations with Ms C, and she said she was not contacted further.

52. At 5.02pm a house officer, Dr F, conducted Mr A's admission physical examination. Dr F recorded a history of substance abuse, chronic pain, and anxiety. He recorded a pulse rate of 90 beats per minute, that other vital signs were normal, and: "Currently feeling okay … Fast paced speech and very focused on getting codeine. Difficult to get straight answers from him. … Medically well. …" There is no record of a risk assessment. Dr F was not provided with the GP's note, which was not yet on the file.

53. At 10.19pm an RN recorded a brief background to Mr A's past few days, and noted that he had been making ritualistic gestures throughout the shift. She recorded: "When asked to have his pre-bed glucose levels he became irritable … Superficially euthymic[11] with underlying irritable edge, affect reactive." She also recorded that Mr A believed he had been admitted because he had a "gift" which, when shared, destroyed other people's gifts, and that he was saying things that were not appropriate to the content of the conversation.

Day 2

54. On Day 2 at 6.08am, an RN recorded Mr A's waking and sleep times overnight, and noted that he had been awake from 1.30am until around 4.00am.

55. At 11.54am Dr F saw Mr A for "admission bloods, ECG and Review". Dr F recorded that Mr A was afebrile and his vital signs were normal, and that he was "[a]nxious but no obvious tremor or shaking". Dr F recorded that there was obvious scarring of the ACF[12] veins. The plan recorded is: "1. Urine tox screen + MSU [mid-stream urine test] 2. Continue as per Psychiatric plan 3. Monitor for any symptoms of withdrawal." CMDHB told HDC that the "Psychiatric plan" consisted of the clinical notes rather than a separate document.

56. The Acting Clinical Nurse Manager, who was on duty during the morning shift, told HDC that during her shift Mr A was not raised as a patient of concern.

[11] Euthymia is a normal non-depressed, reasonably positive mood. It is distinguished from hyperthymia, which refers to an extremely happy mood, and dysthymia, which refers to a depressed mood.

[12] The triangular area on the anterior view of the elbow.

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57. At 3.37pm RN M recorded that Mr A's mood appeared low, and he was subdued and keeping to himself, but was approaching staff to have his needs met. RN M recorded: "Nil signs/symptoms of withdrawal", and that Mr A had said that his "field ha[d] collapsed", but would not clarify what he meant.

58. That afternoon, Mr A was visited by two friends.

59. An RN told HDC that Mr A's behaviour appeared disorganised, and she recalls seeing Mr A rummaging in his belongings for his passport. The RN said that she told Mr A that his passport was kept in the Acting Clinical Nurse Manager's safe, but he continued searching for it.

60. Around 10.40pm the first dynamic appraisal of situation assessment (DASA) form was completed. A DASA is designed to assess a patient's behaviour in the last 24 hours. By the time of the assessment, Mr A had been admitted for 33 hours.

61. The DASA form provides a score for the perceived level of patient risk (low — moderate — high) and personal factors such as irritability, unwillingness to follow directions, and negative attitudes. Mr A was scored at "0" for level of risk (low), and "0" for the personal factors assessment.

62. An RN recorded:

> "[Mr A] was with his friend at the start of duty sitting in his room. His friends verbalised that [Mr A] was dependent on Oxazepam[13] 10mg [four times daily] and Codeine 60mg [four times daily]. He was offered PRN (as required) Lorazepam but he refused it saying he will try to manage without it. He was given his nocte (night) Temazepam and he chewed it then spat it out. He blamed it for a terrible feeling last night and was not keen on taking it.
>
> Mental State: He has been reactive. … He appeared quite anxious and has been shaky. He appears to have lapses in memory and at times finds it hard to concentrate. Nil management issues.
>
> Plan: Continue with current care plan."

63. No medical advice was sought with regard to Mr A's refusal of medication.

Day 3

64. On Day 3 at 6.10am, RN O recorded that Mr A appeared to have slept intermittently overnight. At 2.49pm, RN P recorded that Mr A had accepted his morning medications, and that his mood was low and he had approached staff only "to have his needs met".

65. RN P told the Police that Mr A was dishevelled and superficially polite. She said that she gave him his charted medications and encouraged him to eat. RN P also recorded :

[13] Used in the treatment of anxiety, insomnia, and the control of symptoms of withdrawal.

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"Thought content/Process:

— … still remains indecisive when feeling anxious. Chose not to accept [afternoon medication] when offered, or use of the sensory room. The same [indecisive] when he wanted to make a phone call to his friends to say to them don't bother coming to visit him as he didn't want to be visited here in a mental health unit?

…

DASA: 0

Plan: … continue with current care."

66. RN G and RN H were rostered for the afternoon/evening shift. Mr A was visited again by the same two friends in the afternoon. The time of the visit is not recorded.

67. A PA told HDC that the visitors remained in Mr A's room for more than an hour, and then left the ward. The PA said that around that time Mr A was moved from his room to another room, because of a new admission. The new room had a "high level of visibility".

68. The ward clerk at the inpatient unit reception, Ms L, told HDC that Mr A's friends spoke to her after their visit with him. She stated:

> "[The friends] were very concerned and seemed distressed as he had told them he was not going to come out of here alive. They said they had attempted to cheer him up … and they were concerned that he was going to try to kill himself."

69. Ms L said that she telephoned RN G, Mr A's allocated nurse for the day, and relayed the friends' concerns, and RN G came from the ward and took Mr A's friends outside and spoke to them. In response to the provisional opinion, RN G said that all she was told by Ms L was that Mr A's friends were present and that they were "a bit concerned and would like to talk to the nurse".

70. RN G told HDC that the friends said to her that they thought Mr A was "low and distressed as he was expressing thoughts of wanting to make a will as he believed that he would not be able to make [it] out of the hospital". She said that she asked whether the friends knew whether Mr A had any suicidal intention or plans. They were "unable to identify any", but were able to identify that he was dissatisfied with his recent trip overseas. She said the friends told her that Mr A had had a previous psychiatric admission two years ago, had been using LSD[14] in the previous two weeks, and had begun to identify himself as the "Messiah".

71. RN G made a statement to the Police in which she said that she went back to the ward and "mentioned" the conversation to RN H. RN G said she told RN H that she would keep a regular check on Mr A. RN G told HDC that she discussed the information with RN H "to make her aware of the friends' concerns", and that RN H "agreed that

[14] Lysergic acid diethylamide is a psychedelic drug.

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maintaining the current observation level seemed appropriate at present with the need to observe [Mr A] over the shift and re-evaluate if further concerns were identified".

72. RN G also told HDC that raising her concerns with another staff member was "typical of what would happen on the ward when new information was received about a patient". She said that if a nurse received new information, it was shared with at least one other nurse, "so that a collective decision could be made on the appropriate response". RN G said she was aware that concerns could be escalated to more senior staff, but she spoke with RN H because the more senior member was busy with a patient. RN G stated that the consensus was to keep a closer eye on Mr A and, although he was already on 15-minute observations, she was working with a patient located near to Mr A's room, and so she could "see [Mr A] frequently".

73. In contrast, RN H told HDC that when RN G returned to the nurses' station, she (RN H) was working on the computer, and other staff were present, although she cannot be sure who was there. RN H said:

> "I recall that [RN G] stood at the door between the office and the ward, vaguely said something about the visitors and a will and then went straight back onto the ward. She did not provide any context to this and it was unclear to me exactly what the issue was with regard to the will."

74. RN H said that she did not get the impression that RN G's comments were directed at her personally, and that she "would not describe the interaction as a conversation". RN H said she did not respond to RN G, and her opinion was not requested. In particular, RN H stated that she "was not asked for and did not offer any input on observation levels or other aspects of [Mr A's] clinical management".

75. The Acting Clinical Nurse Manager told HDC that on Friday evening she introduced herself to Mr A, and he then got up and went to his room. She said that nursing staff made the comment: "[Mr A] isolates himself in his room and does not engage with staff."

76. RN G told HDC that Mr A took his diabetic medications but not his diazepam. When she offered the diazepam again, she was unsure whether Mr A had swallowed it, so she followed him to his room and found him standing "with his hand wide open" looking out of the window, and he said he did not need anything. RN G said she was unaware that Mr A had not had a psychiatric medical review over the weekend; therefore, she did not consider the need for a review during late afternoon/evening. She stated that "these reviews usually occur during the day shift".

77. A PA told HDC that, at approximately 9pm, he came across Mr A as he was leaving the toilets, and noted that Mr A smelt of tobacco. The PA said Mr A told him that he knew of the smoke-free policy but said he was "hanging out for one". The PA said that Mr A "spent the rest of the shift in his room looking out the window or sitting on his bed".

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78. RN G said she saw Mr A in bed, and he appeared to be sleeping in his clothes. At 11.43pm, at the end of her shift, RN G recorded the following:

> "… Phone call received from reception stating that [Mr A's] friends were concerned as [Mr A] had expressed his distress to them.
>
> When staff approached, friends stated that [Mr A] appeared to be low and distressed as he expressed wanting to make a will as he believed that he would not be able to make it out of the hospital. When asked if he had voiced any plans, they were unable to explain and went on to state that [Mr A] was expressing his unsatisfied trip , where plan didn't go as per his expectation. He expressed that he shouldn't [have] travelled without making a will.
>
> …
>
> Friends stated that [Mr A's] immediate family were in [another region] and that it would be more appropriate if he went back to them; one of them was willing to escort him back.
>
> …
>
> [Mr A] has been in his room for most of the shift. Came out only for meals and was approached for his nocte medication. Was co-operative with nursing intervention; however appeared to be vague whilst accepting his nocte medication. …
>
> DASA: 0"

79. Contact numbers were recorded for Mr A's friends, Ms C, and a neighbour.

Overnight 14/Day 4

80. On Day 3, RN Q and RN O worked the night shift, which started at 11pm. RN Q told HDC:

> "At handover we were informed … that two of the visitors [friends of Mr A] asked to speak with [Mr A's] nurse at reception following their visit. The visitors apparently had said that they were concerned about [Mr A] because he was talking about making a will and he was a bit agitated, he had mentioned that he wanted to give his house to his sister. … I did have some concerns when I was told about the [w]ill as it could be an indicator of suicidal ideation. … The afternoon staff said they … did not identify any change in his presentation that would have warranted increasing observation levels."

81. RN O told HDC that during her routine ward checks she observed Mr A sleeping. She told the Police that the first time she met Mr A was when she was in the communal area between 2.00am and 2.30am with the two other registered nurses, and Mr A came in and asked PA R to give him some blankets, which he did.

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82. PA S and PA R were on duty from 11pm to 7.30am, and conducted the 15-minute checks overnight. The night observation checklist shows that Mr A was asleep from 11.30pm until the check at 5.15am. PA R told the Police that when the checklist "is marked down as S, which means asleep, they aren't necessarily asleep. It is just our observation as we don't shine lights in their face or anything …" PA R said that he did not go into Mr A's room overnight.

83. PA S told HDC that at around 5.30am he saw Mr A standing by his open door, "fiddling around by the door hinges". PA S told the Police that Mr A started talking quickly and stuttering, and said: "[H]ey please I just want to do something quick please." PA S said that Mr A's hands were up by the top of the door near the top hinges, which were on the outside of the door, and it looked as though Mr A was trying to "break it or loosen the door hinge". PA S said that when he approached, Mr A quickly put his hands down by his sides. PA S said that Mr A "was acting differently than [he] had ever seen him before". PA S said that he marked on the check sheet that Mr A was awake, but did not mention the behaviour to a nurse, "because his behaviour was not unusual for the ward".

84. PA S told HDC that he told Mr A that he should stay in his room until 6am, when breakfast would be served. PA S said that Mr A then slammed the door, and he saw him sitting on his bed looking away, and then he started "pacing back and forth". PA S said:

> "I did not talk to [Mr A] at the time. I did not think his actions at this time were unusual enough to consider reporting to the Registered Nurse for further exploration."

85. PA S told the Police that when he checked at 5.45am he could not see Mr A in his bed. PA S said that he was then dealing with another patient, and PA R did the remainder of the checks, but he (PA S) forgot to give PA R the check sheet. PA S told HDC that he began breakfast preparations and did not conduct any further 15-minute observations.

86. PA R told the Police that Mr A asked him for two blankets at approximately 5.55am, and at about 6.10am to 6.15am he saw Mr A placing the blankets on his bed. PA R stated that at 7.15am, before finishing his duty, he checked Mr A, who was lying on his bed. PA R told the Police that he could not tell whether Mr A was asleep because he could not see his face.

87. The observation checklist for Mr A from 11.30pm on Day 3 to 5.30am on Day 4 has "S" (meaning "sleeping") recorded from 11.30pm to 5.00am. A dash is placed in the tick-boxes for 5.15am and 5.30am.

88. The checklist is not completed between 5.45am and 7.30am. PA R told the Police that they did carry out the checks but were distracted by undertaking other tasks, so they did not fill in the checklist.

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Morning Day 4

89. RN O stated to the Police that while handover was taking place she did a final check of the patients and, between 7.15am and 7.20am, she observed Mr A, who was on his bed and appeared to be sleeping.

90. A PA told the Police that he checked Mr A at around 7.30am, and he is "pretty certain" that Mr A was sitting on his bed. The PA said he also performed the checks at 7.45am and 8.00am. He told the Police that he believes Mr A was also sitting on his bed at 7.45am and 8.00am, but he cannot be sure. The PA said: "Nothing looked out of the ordinary when I checked though."

91. RN P told HDC that she was Mr A's assigned nurse for the morning shift. She said that handover did not finish until around 7.40am, following which she wrote draft plans for each of the patients assigned to her. She was attending to the needs of other patients and asked whether Mr A had been sighted eating his breakfast, and was told that he had not. RN P said that a student nurse offered to take Mr A's blood sugar levels, and RN P told her to take someone with her. RN P said that at around 8am, she saw the two nursing students walking towards Mr A's room with the blood sugar level kit. Shortly thereafter, she was alerted to an emergency via the pager she carried.

92. An RN stated that after handover she went about her normal duties, and about 8.00am she saw a student outside Mr A's room looking shocked, so she went to help. Mr A was unconscious in his room. The RN said that she commenced CPR compressions.

93. Unfortunately, Mr A could not be resuscitated, and his death was certified at 8.29am.

Subsequent events

94. CMDHB produced an internal report of the incident. This identified shortfalls in:

- Staff competency in the recognition, assessment, and treatment of acute opioid dependence detox;
- Clinical leadership and communication across the continuum of care with after-hours medical and nursing teams;
- Environmental risk factors within the inpatient unit; and
- Observation and monitoring practices within the inpatient unit.

95. In its root case analysis, the report identified that:

- There was a failure to organise a follow-up medical review, as requested by the admitting consultant;
- There was no screening tool available for staff to use for opiate withdrawal evaluation;
- Clinical notes were, at times, poor;
- The checklist for the generic 15-minute observations was completed inconsistently; and

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- The different on-call clinical leadership structure at weekends affected staff communication and collaboration.

96. CMDHB commissioned an external review of the incident, which was undertaken by a consultant psychiatrist from another district health board. The review concluded that the treatment provided to Mr A was not adequate. In summary, it found that:

- Information collected as part of Mr A's assessment was incomplete;
- There was no consultation with Mr A's family;
- Care was not co-ordinated between teams and clinicians; and
- Observations and support provided to Mr A were insufficient to keep him safe.

97. The external review stated that it would be reasonable to expect that a patient would be reviewed by a registrar and a psychiatrist over the weekend, and that it would not require the development of a standard operating procedure, but "rather it would be understood as good clinical practice". The review recommended that inpatient doctors have a minuted system of formal handover of their patients to the weekend on-call doctors, including written handover sheets.

CMDHB policies

98. CMDHB provided HDC with a copy of its therapeutic engagement and observation policy, which states that registered nurses are to determine the need for observations using "general clinical judgment". The policy also defines observation types and indicators. This includes intermittent 15-minute observations, which the policy states is appropriate where the patient is at "risk of self harm in [the] short term".

99. CMDHB also provided a copy of its draft clinical information policy for handing over patients in the in patient unit., along with a table of staff responsibilities for morning, afternoon, evening, and weekend shifts.

CMDHB — further information

100. CMDHB told HDC that Mr A was not reviewed again by a psychiatrist following Dr D's review at 2pm on Day 1. It said that the practice of the on-duty registrar and on-call psychiatrist was to respond to calls from staff within the unit if there were concerns about a service user. It was not usual practice for the on-duty registrar or on-call consultants to review all admissions within 24 hours of admission unless concerns were expressed by nursing staff, or there was a specific request from the responsible clinician to do so.

101. CMDHB told HDC that the on-call psychiatrist did not routinely attend the inpatient unit "after hours" (including weekends and public holidays), and usually attended only at the request of the registrar. When the regular inpatient psychiatrist had particular concerns about a patient, the usual practice was for the regular psychiatrist to contact the on-call psychiatrist on Friday to discuss the patient's weekend requirements. Typically this was followed up by an email, and usually the clinical head of department would be aware of this level of concern. CMDHB said that the

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practice of not regularly attending the inpatient unit out-of-hours was well established, and appeared to have developed over time, "notwithstanding the increased acuity and increased bed pressure within [the inpatient unit]". CMDHB did not provide any written policy regarding the expected practice.

102. CMDHB said that Dr D did not communicate the requirement for further assessment ("on Saturday, and Sunday (if necessary)", as recorded in the clinical notes) to the Charge Nurse or the Acting Clinical Nurse Manager, or call the consultant or on-call registrar. CMDHB said it did not know why Dr D did not contact the on-call psychiatrist to discuss Mr A's weekend requirements. It said that Dr D may not have been familiar with the practice noted above.

103. CMDHB told HDC that there was no change in Mr A's clinical presentation to alert staff that a medical review was necessary, and there was "no clear significant deterioration in his mood from being euthymic to low". It said that Mr A did not appear to be significantly different from how he was on admission.

104. CMDHB said that RN G did not document adequately the steps she took, or her clinical rationale following her conversation with Mr A's friends and her attempt to engage with him. It stated that she met with the Acting Clinical Nurse Director and that events around Mr A's care were discussed and RN G was "given the opportunity to reflect on her practice".

105. CMDHB stated that the clinical notes do not record or identify a clear deterioration in Mr A's mental state over the weekend, but the statements later made by staff do identify that there was a deterioration in his clinical presentation. CDHB said that, while staff did document changes in his mood, the changes were not at such a level that they felt concerned enough to seek input from the on-call doctors.

106. CMDHB said that the nursing handover between shifts is a team endeavour during which the nurse primarily allocated to the service user's care on the outgoing shift hands over the clinical information and plan to all of the staff on the incoming shift.

107. CMDHB acknowledged that the clinical nursing notes do not contain a documented management plan or updates of Mr A's risk status. It stated that staff found it challenging to engage with him effectively, and said:

> "In the restricted ward environment, and with [Mr A] not being identified as an immediate risk to himself, the staff felt that the risk management strategies implemented at that time did not require any change."

108. CMDHB stated that, once new information was obtained from Mr A's visitors, staff should have been prompted to review his medical plan, in which case they would have noticed that the planned medical review had not occurred. CMDHB said that none of the staff were sufficiently motivated to have a discussion about Mr A with the psychiatric registrar or consultant because they were "not unduly concerned about [Mr A]".

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109. CMDHB told HDC that, although documentation of communication with Mr A's family and friends "was less than satisfactory", reasonable attempts were made to contact the family.

110. CMDHB stated that items that might present personal risk are not routinely removed from service users on entry to the psychiatric inpatient unit. It stated: "This occurs only if the service user is identified as high risk. [Mr A] was not identified as high risk."

111. CMDHB provided HDC with the inpatient unit Multidisciplinary Team (MDT) Standard of Practice guidelines. These provide for how inpatient risk assessment, medical review of patient needs, and handover to weekend staff are performed. Each team within the inpatient unit must hold an MDT every week, attended by clinical staff and chaired by a consultant psychiatrist. Newly admitted patients are given top priority at MDT meetings. The guidelines state that an MDT review form is to be completed in the regional electronic clinical documentation system, and that risk issues are to be identified and recorded.

Changes following incident

112. The following changes have been made at CMDHB:

- It now has a MOSS[15] on duty in the Inpatient Unit every weekend and public holiday between 8.30am and 4.30pm, and outside of those hours an on-call registrar and psychiatrist are available. The MOSS has the assistance of a house officer, who attends the unit in the weekends. All new admissions are reviewed by a house officer, who will communicate to the registrar or MOSS any concerns about the service user's mental state.

- The on-call psychiatrist is expected to undertake a face-to-face clinical review of all new inpatient admissions within 24 hours of admission.

- A mental health services clinical information handover procedure policy has been drafted for the unit. The implementation was by way of a project management approach, which was expected to be completed in 2016.

- The Serious Incident Review Triage Team developed a corrective action plan containing 10 recommendations. The recommendations are:

  a) Ensure staff are able to provide appropriate assessment and treatment for clients experiencing significant alcohol and other drugs/detoxification issues within the inpatient unit.

  b) Develop a standard operating process that clearly identifies the after-hours clinical role and responsibilities, including tasks required.

[15] Medical Officer of Specialist Scale — a non-training position for a doctor who has not yet specialised or not yet gained a postgraduate qualification, or an international medical graduate who is not eligible for a consultant role.

HDC

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c) Enhance the clinical leadership to improve communication and enable the workforce to better provide highly effective therapeutic recovery-focussed care.

d) The new adult acute inpatient building design will be consistent with modern inpatient units in order to minimise risk.

e) CMDHB will develop a policy and procedure for care levels in the inpatient unit. This approach will be based on international evidence-based best practice.

f) Conduct a review of the quality of acute clinical assessment from intake to admission into the inpatient unit, and consider how continuity of care might be improved.

g) The Counties Manukau Director of Area Mental Health Services will review the approach to section 10 assessment under the MHA to ensure that these are of a standard that reflects the significant rights issues that accompany compulsory assessment and treatment.

h) Review practice with regard to consulting and liaising with family/whānau during acute assessment and throughout inpatient stays at the inpatient unit.

i) Gain clarity about access to the ED by the Intake and Acute Assessment Team for mental health patients with complex medical co-morbidities.

113. CMDHB stated that a Mental Health Division Mortality and Morbidity Review meeting on 5 October 2015 had concluded that the service failed to deliver adequate care to Mr A and, in doing so, did not keep him safe.

Job descriptions

114. CMDHB provided HDC with a copy of the job description for psychiatric assistants and registered mental health nurses. These documents state that psychiatric assistants must be:

> "Able to inform the RN or assigned [Enrolled Nurse] when [their] delegated activities are more complex or if they are uncertain of the requirements or the clients' response at any state of the activity. Able to verbally report and document accurately."

115. The duties of a registered mental health nurse include:

> "Undertake comprehensive and accurate nursing assessments and risk assessment of patients.
> Supports … physical health requirements with service user and their family/whānau.
> Ensures documentation is accurate and complete at all times …
> Ensures care provided is based on up to date knowledge.
> Provides planned nursing care to achieve identified outcomes in partnership with service users.
> …
> Promotes the concept of self care/self advocacy and the inclusion of families and significant others in the provision of care.

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> …
>
> Communicates clearly and effectively with service users and families developing a relationship with demonstrated sensitivity and empathy.
>
> Communicates effectively with colleagues, other members of the multi disciplinary team and external agencies to facilitate and co-ordinate care.
>
> …
>
> Identifies hazards within the clinical area and minimises the risk for self, service users, colleagues and the public.
>
> Ability to complete Comprehensive Assessment incorporating a risk assessment.
>
> Ability to formulate and develop a management plan in conjunction with the patient and members of the MDT."

116. Similarly, a registered nurse in the inpatient unit is required to "[u]ndertake comprehensive and accurate nursing assessment and risk assessment of patients".

117. CMDHB also provided HDC with a summary of the 10-day orientation programme given to nurses prior to the events in question. This included a "Risk Training" session held over one day.

Responses to provisional opinion

118. Responses were received from RN G, Mr A's sisters, and CMDHB. The responses have been incorporated into the "information gathered" section where appropriate. In addition, the following submissions were received.

Counties Manukau DHB

119. CMDHB accepted the finding that it had breached Right 4(1) of the Code.

120. CMDHB acknowledged that it was unable to locate Mr A's 15-minute observation sheets for Days 2 and 3, and said it was possible that the sheets were "misplaced or inadvertently discarded". However, its standard practice is to file the checklists as part of the service user's records, which are retained for a minimum of 20 years.

121. CMDHB formally apologised to Ms C in writing on 10 June 2015, and CMDHB staff also apologised in person at a meeting on 2 October 2015.

Ms C

122. Ms C said that the staff stated during a debrief that Mr A had said that he would like to call his sister, but he could not do so because he did not know the number, and his telephone was out of charge. Ms C stated that her number was in the clinical records, and that her brother was not offered a telephone to use.

123. Ms C said that she had no communication from the hospital between her call on Day 1 and the call from the hospital on Day 4 to inform her of her brother's death.

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Opinion: Preliminary comment

124. CMDHB has an organisational duty to ensure that patient care is provided with adequate care and skill. Individual clinical staff who provided care to Mr A hold a degree of responsibility for his suboptimal care at various times. However, as stated in previous opinions of this Office,[16] DHBs are responsible for the operation of the clinical services they provide, and can be held responsible for any service failures. I consider that in this case CMDHB failed in that duty.

125. For the avoidance of doubt, my role does not extend to determining the cause of Mr A's death. My role is to assess the quality of care provided to him in light of the information that was known at the time that care was provided. Accordingly, my opinion should not be interpreted as having any implication as to the cause of his death.

Opinion: Counties Manukau District Health Board — breach

Review by psychiatrist

126. On Day 1 Ms J and Dr I assessed Mr A at the police station. They recorded that he was unable to care for himself and was "very confused and perplexed". Dr I recorded that her impression was: "Psychosis NOS — possibly associated with mood disorder, possibly drug induced. History of polysubstance abuse." The plan formulated was to admit Mr A to the inpatient unit after he had been cleared medically at the ED.

127. However, Mr A was admitted directly to the inpatient unit, with the medical review to be conducted by the house officer. At 1pm Mr A was admitted to the psychiatric inpatient unit and placed on 15-minute observations. One hour later he was assessed further by psychiatrist Dr D. She recorded Mr A's medical history and an extensive list of prescription medications. Dr D told HDC that Mr A presented as restless, vague, and evasive, and displayed mild incoherence in his thought processes, and she believed he needed further assessment.

128. Dr D outlined a plan in the clinical notes, which included further assessment in a safe environment and review by a registrar "tomorrow (and on Sunday if necessary)". Beyond documenting the plan, Dr D took no steps to arrange for the review to take place.

129. Following Dr D's review, RN E recorded: "24 hour assessment in [Ward] [un]til reviewed again by on call [psychiatrist] tomorrow." Again, no further steps were taken by the nurses or the house officer (who saw him on Day 2) to facilitate the review. CMDHB stated that the Acting Clinical Nurse Manager did not advise the registrar or on-call psychiatrist that Mr A required review. Mr A had no further psychiatric review after Day 1, during his admission.

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[16] Opinion 14HDC00766, 10HDC00703 and 10HDC00419, available at www.hdc.org.nz.

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130. My expert advisor, psychiatrist Dr Rosemary Edwards, noted:

> "[Dr D] wrote please review by a registrar tomorrow (and Sunday if necessary). This says to me she expected a registrar review on Saturday as a minimum. It appears the plan from the admitting doctor was unknown, her written plan [was] not read, and therefore not followed. This falls below the expected standard of care to a moderate level."

131. CMDHB told HDC that the on-call psychiatrist did not routinely attend the inpatient unit after hours, and usually attended only at the request of the registrar. CMDHB said that if the regular inpatient psychiatrist had particular concerns about a patient, the usual practice was for the regular psychiatrist to contact the on-call psychiatrist on Friday to discuss the patient's weekend requirements. Typically this was followed up by an email, and usually the clinical head of department would be aware of this level of concern. CMDHB said that the practice of the psychiatrist not regularly attending the inpatient unit out-of-hours was well established, and appeared to have developed over time, "notwithstanding the increased acuity and increased bed pressure within [the inpatient unit]". I am concerned that there was no written policy setting out this process.

132. CMDHB said that Dr D did not communicate verbally to the on-call doctor, which was the expected protocol, albeit unknown to her. Dr Edwards stated:

> "This is part of a handover process in a busy acute unit that needs to be as simple and straightforward as possible with clear responsibility from the staff involved. With weekend (like every other day) morning attendance to the ward the on call psychiatrist should review the admitting doctor's plans, be informed of the patients they have responsibility for, listen to nursing observations and make any adjustments to the clinical plan."

133. Dr Edwards advised:

> "[A]ll patients admitted on a Friday afternoon/evening should be assessed the following day (Saturday) by a Psychiatric Registrar and possibly Consultant as part of a normal routine ward round. Especially those subject to the MHA. As this did not happen [Mr A] received no medical input for assessment of risk and consideration of care during the time he was an inpatient. In my view this is a moderate departure from accepted practice in the context of a culture at that time at Counties Manukau not to routinely provide medical reviews in the acute inpatient unit, including the newly admitted."

134. Dr Edwards noted that it is not best practice to admit an unwell person to hospital and have no psychiatric reassessment by medical staff for three days. Taking into account Dr Edward's comments, it is concerning that no review took place. In my view, a person who is low in mood should have a review of his or her mental state and risk by a consultant psychiatrist within 24 hours of admission. This is particularly so if the person is not known to the staff. Furthermore, Dr D should have been orientated adequately to make her aware of the expected practices. I am concerned that the

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entries in the clinical records, including Dr D's plan, were not read by clinical staff, or, if they were read, were not actioned.

135. In my view, each of the CMDHB clinical staff responsible for Mr A over the weekend should have perused his records, noted that the requested review had not occurred, and made the necessary arrangements to facilitate the review. The failure to do so meant that Mr A received no further psychiatric assessment, and his risk was not reviewed.

Risk assessment and care planning

136. On Day 2, house officer Dr F medically reviewed Mr A, recorded his physical observations, and noted: "Continue as per [p]sychiatric plan." This was the last time Mr A was seen by a doctor. Thereafter, nursing staff recorded: "[C]ontinue with current care plan."

137. The "psychiatric plan" made by Dr D consisted of:

"Plan:

1. Assessment in a safe environment; consider transfer to the open ward/HCA after 18–24 hours if appropriate.
2. More information from [home town] has been requested.
3. PRN [as required] Olanzapine and Lor[a]zepam charted; also regular Temazepam 20mg/nocte [at night] as per GP's letter found on patient.
4. Please monitor for symptoms of withdrawal.
5. Please review by a registrar tomorrow (and on Sunday if necessary)."

138. The only record of Mr A having been monitored for signs of withdrawal by nursing staff is on Day 2, when RN M recorded: "Nil signs/symptoms of withdrawal." CMDHB stated that although the clinical notes do not record or identify a clear deterioration in Mr A's mental state over the weekend, staff have since identified that there were concerns about his clinical presentation. I note that staff were aware of the information provided by Mr A's friends, and the information was recorded in the clinical records.

139. There were a number of instances where staff were aware of new information or behaviours, such as:

- At 10.19pm on Day 1 an RN recorded that Mr A had been making ritualistic gestures throughout the shift. "When asked to have his pre-bed glucose levels he became irritable" … "Superficially euthymic with underlying irritable edge, affect reactive." She also recorded that Mr A believed he had been admitted because he had a "gift" which, when shared, destroyed other people's gifts.
- On Day 2 RN M recorded that Mr A said that his "field ha[d] collapsed", but he would not clarify his meaning.
- On Day 2 an RN recorded that Mr A had refused medication and appeared to be quite anxious and shaky, seemed to have lapses in memory, and found it hard to concentrate at times.

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- On Day 3 RN P recorded that Mr A had accepted his morning medications, his mood was low, and he had approached staff only "to have his needs met". He refused his afternoon medication, or use of the sensory room. He was indecisive as to whether he wanted to make a telephone call to his friends.
- On Day 3 Mr A's friends told staff they were concerned about Mr A being low and distressed, and that he was talking about making a will.
- On Day 3 Mr A refused diazepam. When RN G offered the diazepam again, she was unsure whether Mr A had swallowed it, so she followed him to his room and found him standing looking out of the window "with his hand wide open".
- On Day 4, at around 5.30am, PA S saw Mr A standing by his open door, "fiddling around by the door hinges". Mr A started talking quickly and stuttering, and said: "[H]ey please I just want to do something quick please." Mr A's hands were near the top hinges of the door, and PA S thought it looked as though Mr A was trying to "break it or loosen the door hinge". Mr A was acting differently from how PA S had seen him act previously. Mr A then slammed the door and started pacing back and forth.

140. CMDHB said that, while staff did document changes in Mr A's mood, the changes were not at such a level that they felt concerned enough to seek input from the on-call doctors. Dr Edwards advised that the recordings of mood are observational rather than Mr A's feelings at the time, and so they are recordings of affect rather than mood. In particular, Dr Edwards noted that there was no risk assessment of Mr A following his admission, there is no mention of risk of harm to self, and there is no record of any specific conversation with Mr A to attempt to clarify whether there should be concern about his risk level.

141. My psychiatric nursing advisor, Dr Tony Farrow, also considered that the risk assessments were inadequate. He noted that there are no risk status updates in the nursing notes, and the initial risk assessment was not updated after Mr A's admission.

142. Dr Farrow advised that risk assessment and management plans (which are part of the assessments) must be written clearly and be up to date. He stated that the usual inpatient practice is to update the risk status at least once each shift, and focus on factors that place the consumer at risk at the time, or may be a perceived future risk. Dr Farrow stated that, in Mr A's case, there were known suicide risks that should have been considered at least once every shift (such as his psychosis and change in mood).

143. Dr Farrow said that although risk assessments are not solely a nursing role, it is usual practice for nurses (and other multi-disciplinary team members) to take responsibility for ensuring that risk assessments are made and updated, especially when new information comes to hand. Dr Farrow advised that nursing staff did not respond appropriately to Mr A's presentation, and that nursing risk assessments, management, and requests for medical assessment would have been the expected standard of care in this situation. Dr Farrow stated: "The absence of these is a severe departure from standards of practice and would be viewed very negatively by peers."

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144. In my view, the nursing staff did not respond appropriately to Mr A's changes in mood and behaviour. In particular I consider that the events on Day 3 should have caused staff to recognise the need to obtain a medical review. Given the differing accounts from RN G and RN H about whether there was a discussion between them about the friends' concerns and the appropriate response to those concerns and the lack of any clinical record of a discussion or plan about next steps, I am unable to make a finding as to what was discussed by RN G and RN H. Dr Farrow stated that the nursing staff should have requested an urgent risk assessment from a registrar or consultant when Mr A's friends communicated their concerns about his risk. However, none of the staff on that shift and the next shift took appropriate action, despite the account of the conversation in the records.

145. Registered nurses and registered mental health nurses are expected to "[u]ndertake comprehensive and accurate nursing assessments and risk assessment". The nursing staff did not complete a mental state assessment including mood, affect, psychosis, thought disorder and content, including thoughts/plans of harm to self and others. There is no recorded assessment or change in the management plan (such as changing levels of observation); nor was there a request for review by a psychiatric consultant or registrar. In my view, the level of nursing care was unacceptable.

Conclusions

146. A DHB is responsible for ensuring that it has robust systems in place to provide an appropriate standard of care to its patients. It is also responsible for taking reasonably practicable steps to ensure that its staff understand and are compliant with its policies, procedures, and guidelines. Taking into account that several staff were involved in Mr A's care, I consider that CMDHB holds primary responsibility for the deficiencies in the care provided.

147. CMDHB did not provide services to Mr A with reasonable care and skill as follows:

- Staff failed to arrange a psychiatric review of Mr A on Day 2 or Day 3.
- Mr A's risk was not assessed sufficiently following his admission.
- Staff failed to respond adequately to his changing presentation.
- Staff failed to monitor him for signs of withdrawal after Day 2, as required by the plan made by Dr D.
- Staff failed to respond adequately to the concerns expressed by Mr A's friends and the information that he was talking about making a will.

148. Accordingly, I find that Counties Manukau DHB breached Right 4(1) of the Code.

Other comment

149. CMDHB was unable to provide HDC with a copy of the 15-minute observation checklists for Days 2 and 3. CMDHB said that it no longer has the observation checklists for the entire period of Mr A's hospitalisation, and that the sheets for those days may have been misplaced or inadvertently discarded.

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150. The Health (Retention of Health Information) Regulations 1996 (the Regulations) impose an obligation on providers of health or disability services to retain, for a minimum period, health information relating to identifiable individuals. Under clause 6 of the Regulations, health information that relates to an identifiable individual must be retained for a minimum period of 10 years. Health information is defined under clause 2 as information about any services that are being provided, or have been provided, to an individual. In my view, the 15-minute observation checklist constitutes health information. I am concerned that CMDHB did not retain this information, as it is required to do.

Recommendations

151. I recommend that within three months from the date of this report, Counties Manukau District Health Board:

a) Report back to HDC on the implementation of recommendations of the Serious Incident Review Triage Team, including:

- Findings from the follow-up reviews recommended by that team;
- A report on the implementation of any subsequent recommendations arising from those follow-up reviews; and
- Copies of any new processes, policies, and procedures.

b) Conduct audits of the new standard operating processes and policies and procedures, and provide HDC with the results of the audits and any service improvements that will be taken as a result of the audits.

c) Provide HDC with evidence of further training completed by clinical staff involved in Counties Manukau Mental Health and Addiction Services regarding patient risk assessment, and the clinical documentation of patient presentation.

d) Audit the use of risk assessment documentation for patients presenting with possible substance withdrawal, significant risks, or suicidal ideation, or who are receiving compulsory care under the MHA, to ensure that the documentation meets professional standards.

e) Consider whether a registrar or consultant should attend the inpatient unit each day over the weekend and on public holidays, and advise HDC of the outcome and information about what medical cover is now provided.

152. In my provisional opinion, I recommended that Counties Manukau District Health Board provide HDC with a copy of the finalised Mental Health Services Clinical Information Handover Procedure policy. The DHB supplied the policy, which has

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been implemented, and stated that the procedure will be reviewed, as a minimum, every 12 months.

153. I recommend that at the next meeting of the Mental Health Clinical Directors of the DHBs to be attended by a Counties Manukau District Health Board representative, the representative arrange for the agenda to include a discussion of psychiatrist input into inpatient care and treatment at weekends, public holidays, and after hours, and report back to this Office on the outcome from the discussion.

Follow-up actions

154. A copy of this report will be sent to the Coroner.

155. A copy of this report with details identifying the parties removed, except the experts who advised on this case and Counties Manukau District Health Board, will be sent to the Director of Mental Health, the Ministry of Health, the Royal Australian and New Zealand College of Psychiatrists, and the Mental Health Foundation, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent psychiatrist advice to the Commissioner

The following expert advice was obtained from psychiatrist Dr Rosemary Edwards:

"At the request of the Commissioner I am providing expert advice in connection to a complaint about the care provided to [Mr A] (deceased) at [the inpatient unit] Counties Manukau DHB.

I am a consultant psychiatrist and Fellow of the Australian and New Zealand college of Psychiatrists. I work for Capital and Coast District Health Board as a consultant psychiatrist for the Regional Forensic and Rehabilitation Service. I have 6 years' experience as Clinical Leader for General Adult Services, including the Acute Inpatient ward.

[Mr A] had a history of mental illness with a previous diagnosis of substance abuse. On return from an overseas trip, he was assessed and placed under the MHA following assessment by [Dr I] with diagnoses of Psychosis NOS, poly substance abuse, opiate dependence, and major impairment with reality testing. There was contact with [a friend] who confirmed past periods of being unwell and regular codeine use up to 30mg daily, and that he was diabetic.

He was then assessed by [Dr D] who diagnosed '?drug induced psychosis/hypomania'. In MHA papers section 11 she opined he had an abnormal state of mind characterised by delusions and disorder of mood, possibly perception, volition and cognition and he posed a serious danger to the health of himself and others, and was diminished in his capacity of care to himself.

On Friday he was assessed by 3 psychiatrists due to the process of admission being inclusive of the MHA. He was not further assessed during the weekend by psychiatric doctors and [died] on Monday morning at 8.14am.

During the weekend he was visited by friends who raised concerns to staff. The letter of complaint from [Ms B] said they spoke with staff. The friends said [Mr A] expressed his distress to them. That he appeared low and discussed wanting to make a will, that his trip [overseas] had been unsatisfactory and not to his expectations. When asked by staff the friends said no plans (I presume of self-harm) were expressed. I am not clear from the documentation the time of the discussion with friends. I presume they visited during the day time on Sunday.

Following the conversation with his friends there was no change to the risk documentation or observations. There was documentation at 2344 hours of a conversation with [Mr A's] friends.

[Mr A] was assessed physically by a House Officer on Saturday.

If psychiatric on call staff attended the ward on the weekend to review recently admitted or unwell patients [Mr A] was not reviewed. [Dr T] wrote on 21 May

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2015 that medical reviews are not routine for inpatients on the acute ward over the weekend or on public holidays.

1. The adequacy of the risk assessment carried out and the care provided to [Mr A]

Admission risk was attended to as expected in response to available information at the time. There was no concern at that time of risk of self-harm. The risk information was not updated in the following two days in a risk document or specific assessment. There was additional information observed by friends of [Mr A] who visited and passed on their concerns to nursing staff. This information was discussed between nursing staff who took no further action. The risk register was not updated and there was no change to the care provided and it was not discussed with psychiatric registrar or consultant. The content of this discussion is not recorded or subsequent decisions and the reasons for the decisions.

There was regular risk response to: ARC Aggression Risk Checklist, VRC Vulnerability Risk Checklist and DASA Dynamic Appraisal of Situational Aggression. While these may be relevant to some patients it did not add materially to [Mr A's] care. There was reference to 'no observed symptoms of withdrawal'. There does not seem to be a section for suicide risk on the admission process form with the other risks.

There was no risk assessment carried out following admission. The documentation on [Day 1] by [Dr D] requests review by registrar the following day and Sunday if required. This is also in nursing notes on admission. This did not occur.

I believe there were two opportunities (at least) missed for an updated risk assessment. Firstly, all patients admitted on a Friday afternoon/evening should be assessed the following day (Saturday) by a Psychiatric Registrar and possibly Consultant as part of a normal routine ward round. Especially those subject to the MHA. As this did not happen [Mr A] received no medical input for assessment of risk and consideration of care during the time he was an inpatient. In my view this is a moderate departure from accepted practice in the context of a culture at that time at Counties Manukau not to routinely provide medical reviews in the acute inpatient unit, including the newly admitted. As acute psychiatric inpatient services throughout New Zealand have increased in acuity and demand for beds this historical culture is changing. It is not best practice to admit an unwell person to hospital and not reassess them by medical staff for three days. At other times in the year this practice could result in up to four full days where there is no medical input.

And second the information from friends to nursing staff was discussed with nursing staff only and a decision made to take no further action. The information received from his friends indicated thoughts of negative self-appraisal and some preparation for his death. In a man previously unknown to staff, unclear diagnosis, observed low mood, and no medical psychiatric assessment, to not document presumed discussion and consideration of risk by staff and update the risk

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documentation, in my opinion, is a departure from acceptable practice of a moderate degree. It is possible that the level of observations may not have changed however, with consideration to a suicide risk the procedures relevant to this risk could have been carried out as this was not done on admission. This procedure includes the removal of shoe laces, amongst other things.

The complainant commented 'that [the charge nurse] did not think [Mr A] was in the right unit, but did not act on these concerns'. Clarification in letter 21 May 2015 was that [the charge nurse] did not view [Mr A] at high risk for suicide. Is this what the complainant took from his comments? It is difficult to place this in context. [The charge nurse] spoke with family after [Mr A] had died. I can see no other entries in the clinical file from him so where did he gather the information to have this opinion? It is a very difficult conversation to have with family. It is important staff have the necessary education to support them.

2. <u>Whether staff responded appropriately to [Mr A's] deterioration in mood</u>

The clinical file records the staff observations of his change in mood. [Mr A's] presentation varied. On admission 'superficially euthymic with underlying irritable edge, affect reactive.' He was awake through the night from 0130–0400 hrs. On Saturday House Officer recorded he was 'feeling okay' but this may have meant physically. In the afternoon it was recorded his 'mood appeared low, subdued, affect restricted', 'indecisive' and some possibly psychotic content. While this is a reasonable mental state there is no impression made from it and he has not been asked about his mood or possible thoughts of self-harm. At 2248 hours it was recorded he spat out medication, 'appeared quite anxious and shaky. Appeared to have lapse in memory and at times finding it hard to concentrate'. On Sunday at 0613 hours it was recorded he 'appeared to have slept intermittently during the night'. 1503 it was recorded his 'behaviour has been anxious'. 'Mood low' 'still indecisive' 'impaired insight'. At 2344 recorded conversation with friends. No decision or conclusions recorded. Then noted [Mr A] had been 'in his room through most of the shift', was 'co-operative with nursing staff'. 'Vague when accepting medication, drinking 2 glasses of water but not the medication', 'then taking diabetic medication', and 'then Temazepam'. Unusual hand gestures noted. The recording document [Mr A's] mood on the ward was observed as low compared to euthymic on admission.

Despite these recordings/observations of mental state there is no mention of risk of harm to self. There is no record of a specific conversation with [Mr A] in attempts to clarify whether there should be concern about his risk level. The recordings of mood are observational rather than [Mr A's] feelings at the time (so are recordings of affect rather than mood). There is no documented consideration of [Mr A's] presentation or of any change to his care. It appears that at no time was there concern that he may be suicidal by the nursing staff. There was use of DASA but no prompts to consider suicide risk. Given recording of low mood, indecisiveness, unusual content (not explored), unusual hand gestures, and difficulty with concentration the response by nursing staff to his presenting behaviour was a departure from standard care. The level of departure will depend

HDC

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on expectation and level of triaging by the nursing staff at Counties Manukau. Either the nursing staff need to be more thorough in the mental state examination and consider and record impressions and plans for care that reflect this, or recognise that it needed to be done and a psychiatric doctor called. This could be done in the context of considering an increase in observations which can be initiated by nursing staff on the ward, and in doing this a registrar/SMO review would be requested. As this was not done it may be informative to explore the reasoning behind this and whether there is a culture of not calling on call psychiatrists for historical reasons. To have had no response is at least a moderate departure from an expected standard of care.

3. **<u>Other comments on care provided</u>**

The clinical notes are difficult to follow. It is not clear what aspects of the file are being added to and a lot of the information is repetitive. This is likely a function of the electronic system.

The observations were not recorded from 5.30am to 7.30am. A tick at 8am has no accompanying documentation. The person who completed this observation may be able to recall where [Mr A] was seen and what his behaviour was at the time. Fourteen minutes later he was unresponsive. This is possible within the time frame. A lack of completed documentation is a minor departure from expected practice, and in this case is unlikely to have made a difference in the care offered.

The level of observation was 15 minutes. The next level — in room in sight — can be experienced as invasive by the patient and would likely require additional staff. In practice utilising this level of care may be practically difficult and the additional expense questioned. Thus the threshold to invoke may be quite high. This is a common step wise progression in acute inpatient units in my experience. However, consideration of suicidal ideation can have other effects on the ward by raising awareness, placing person of concern in a visible bedroom and undertaking protective procedures hitherto not done.

[…].”

Further advice

The following further advice was obtained from Dr Edwards:

“… This request has asked to respond in respect to:

1. CMDHB told HDC that the on-call psychiatrist did not routinely attend the acute unit after hours. The practice of not attending … was well established.
2. CMDHB told HDC that there was no change in [Mr A’s] clinical presentation to alert staff … and “no deterioration in mood from euthymic to low.”
3. CMDHB did not know why [Dr D] did not contact the on call psychiatrist … and her requirement written in the clinical file was not communicated to anyone verbally.

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For each question to advise:

a) What is the standard of care/accepted practice?
b) If there has been a departure from the standard of care or accepted practices, how significant a departure do you consider it is?
c) How would it be viewed by your peers?

I was provided with the following additional documents:

- Letter from CMDHB dated 15 December 2015 containing documents listed in that letter.
- Statements from [RN H] x2
- DHB response dated 7 Sept 2015
- Staff roster
- Statements from relevant RN, PA and HO.
- Recommendations and Corrective Action Plan.
- Letter from CMDHB dated 13 October 2015 containing documents listed in that letter.

1. CMDHB told HDC that the on-call psychiatrist did not routinely attend the acute unit after hours. The practice of not attending … was well established.

I note the statement about the usual practice of no routine medical attendance on the unit outside 8.30 to 4.30 Monday to Friday at CMDHB. In contrary to the comment by [Dr T] in his letter dated 7 September 2015 this is not common practice for at least 2 of the larger DHBs in New Zealand. There has been a change in the practice that continues at CMDHB and previously occurred at other DHBs. At least one DHB changed in response to a critical incident. The trend is for the weekend consultant to attend the acute unit on both days of the weekend and discuss clinical information with the Charge Nurse of the unit. And usually to review new admissions.

At the smaller DHBs there appears to be an expectation that the on call psychiatrist will visit the ward at some stage each day of the weekend and that there would be communication with the Nurse in Charge to discuss patients.

I note that among the changes made at CMDHB there is now an expectation of a House Officer (HO) to attend the acute unit in the weekend. Given the acuity of such units I do not believe that a HO has the necessary expertise and a consultant psychiatrist should provide this supported by the psychiatric registrar. The skill that is required is that of assessment, in particular for a mental state examination associated with a risk assessment. This was not completed by the staff on the acute ward on [Mr A] and a HO usually does not have the knowledge or experience. The HO who attended [Mr A] attended to his physical health only.

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My opinion is unchanged although with the acknowledgement that the practice was well established at CMDHB. It is interesting that despite changes in practice, some driven by incident experiences, that [Dr T] as Clinical Director had not been privy to this information. The Mental Health Clinical Directors of the DHBs meet. I do not know what they discuss. There does need to be a venue or way for changes in practice to be communicated.

While I understand the practice of no consultant reviews in the weekend has been a long standing practice it is a practice that is changing through the country. CMDHB appears unaware of this. I believe a person admitted on a Friday, and in particular unknown to the staff, low in mood requires a review of mental state and risk by a consultant psychiatrist within 24 hours of admission. To not do this falls below the expected standard of care, to at least a mild level.

Interestingly the inpatient unit Staff Structure diagram dated [2014] (and the other 2 structural diagrams which only include the Clinical Director) does not contain doctors at all, at any level. I presume they are considered part of the clinical team.

2. CMDHB told HDC that there was no change in [Mr A's] clinical presentation to alert staff … and 'no deterioration in mood from euthymic to low.'

I am struggling to find in the clinical file or statements where [Mr A] was described as euthymic — not depressed/'normal' affect as observed by the staff and in contrast to mood which is subjectively described by the patient.

Many of the Staff in their statements noted a change in [Mr A] over the weekend in their observations and noted in statements. The communication of these changes was not documented by those staff not responsible for [Mr A] at the time of their observations. It sounds as though handover of the RN staff between shifts occurs on a one to one basis so there is no forum for all staff to listen, agree, disagree or add to the assigned nurses' observations.

[Dr I] completed MHA section 8 as the psychiatrist who first assessed [Mr A]. Her clinical note says Psychosis, possibly associated with mood disorder, possibly drug induced. States [Mr A] reported no thoughts of harm to self or others. Risk assessment not completed. No care/management to his plan other than for in-patient doctor review. In clinical file as [Dr I's first name] rather than by [Dr I's surname].

The MHA paperwork is incomplete and difficult to follow as some boxes are ticked, and some with bold X's and smaller x's. ? marks, some with empty boxes and some not. The doctor involved in section 10 said he completed the paperwork only and did not have a role in the care/management of [Mr A] as he had been seen by the In-patient doctor [Dr D]. In [Dr K's] statement he stated he (the patient) 'was disorganised, thought disordered and paranoid' and he 'had no doubt [Mr A] needed to remain in hospital for his own safety'. The MHA section 11

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paperwork ticked disorder of mood. So from this I conclude that [Mr A] was not considered euthymic at that time.

Admitted to the ward by [Dr D]. In her statement she remarked 'he seemed somewhat down'. Difficult to get information from and was unclear and contradictory in his statements. Despite [Mr A] describing his mood as 'fine', [Dr D] assessed his affect as irritable and restricted and mood-congruent. She considered drug induced psychosis and hypomania.

The Serious Incident Review Panel (SIRP)/complex case review, authors not identified, states Intake assessment — Psychosis of unknown cause (NOS) and possible mood disorder. In-patient consultant's impression was drug induced psychosis/hypomania. On Sunday mood was low (I presume they mean affect) and he had limited interactions.

The SIRP acknowledges [Mr A] was noted (observed rather than assessed) as anxious, had poor sleep, mood low, limited interactions with others. His friends were concerned enough to seek and wait to see the assigned RN. The SIRP review is dated later than the letter where [Dr T] states 'the comprehensive review … did not identify deterioration in [Mr A's] mood'. The clinical file records observations as mood subdued, low, keeping to self, affect restricted. Quite anxious and shaky. Mood low indecisive.

He was noted to be acting strangely on occasion and possibly responding to hallucinations (strange hand movements).

15 minute documented observations — he was not seen at 0615 and an assumption made of his whereabouts (? toilet). It seems the PA observations are made by whoever is available and changes between people dependant on their other duties. Also they must not carry a chart with them if it is not marked off when they see someone. Given the busyness described in the ward, change of staff and duties this likely explains the reason the chart is occasionally not completed. It also could raise the possibility of inaccurate marking of the chart if memory over time is required.

Regarding risk assessments. [Dr T] in his response of 7 September 2015 he stated no risk of self harm was identified during [Mr A's] admission. That he was assessed by three psychiatrists who did not identify risk of self harm. Dr K 'had no doubt [Mr A] needed to remain in hospital for his own safety'. The MHA section 11 paperwork ticked disorder of mood. He made no direct comment of risk to suicide. The only comment I can see regarding assessment of self harm is with [Dr I] who stated [Mr A] reported no thoughts of harm to self or others.

[Dr T] further states 'Nursing staff did not identify a risk of self-harm and there was no change in [Mr A's] presentation to alert staff a medical review was necessary.' The nursing staff in their statements noticed many changes in [Mr A's] presentation over the weekend and between the two days. How this was communicated at the time is unclear and incomplete.

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The nursing staff did not complete a mental state, a formal assessment including mood, affect, psychosis, thought disorder, content, including thoughts/plans of harm to self and others. And to consider risk and treatment and level of ongoing formal observations.

The process following the information from friends is difficult to follow clearly. The DHB has provided coaching to the inexperienced [RN G] who was recipient of the information.

[Mr A] was not known to the staff. They did not have access to [previous] notes. The nursing staff made observations but did not undertake a mental state examination and it seems when they did converse with him he was difficult to understand. He was not asked about suicidal ideation or plans. The style of handover meant there was no comprehensive discussion about his presentation or observations made by a variety of staff, RN and PA. Inexperience influenced a response to information from friends. The admitting directions for care by the admitting psychiatrist were either not read, or read and not followed. It is difficult to know how much difference this could have made. There was no plan regarding his medication requirements and how to manage refusal of medications and this was not brought to the attention of psychiatric doctors. He was not observed at 6.30am and no observations noted following that. He was found out of sight behind his door when a determined effort was made to find him by a student nurse. There have been a number of these processes identified and plans made to improve them.

[Mr A's] care was below that expected in this type of ward as he was not assessed after Friday afternoon and due to his quiet demeanour did not disturb the management of the busy ward, and despite observations noted and some recorded during handover overall the reporting by nursing and PA staff was fragmented and incomplete. He was clearly not euthymic and less well on Sunday with his friends expressing concern. Had all the information and observations been available to one experienced nurse on Sunday would this information have reached a threshold to motivate a discussion with a psychiatric registrar or consultant? An experienced psychiatric Nurse is best placed to answer this question.

3. CMDHB did not know why [Dr D] did not contact the on call psychiatrist … and her requirement written in the clinical file was not communicated to anyone verbally.

[Dr D] wrote clearly in the clinical file for the registrar to review [Mr A] Saturday (and Sunday if necessary). Did anyone read the notes? Should they have been read by the assigned RN, admitting RN, daily charge RN or all of them? Should it have been in the nursing hand over? Reason for admission was for further assessment.

The SIRP wrote this as — Review by Registrar Saturday or Sunday if necessary. [Dr D] wrote please review by a registrar tomorrow (and Sunday if necessary). This says to me she expected a registrar review on Saturday as a minimum.

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It appears the plan from the admitting doctor was unknown, her written plan not read, and therefore not followed. This falls below the expected standard of care to a moderate level.

[Dr T] says [Dr D] did not communicate verbally to the on call doctor and this was the expected protocol, albeit unknown to her. This is part of a handover process in a busy acute unit that needs to be as simple and straightforward as possible with clear responsibility from the staff involved. With weekend (like every other day) morning attendance to the ward the on call psychiatrist should review the admitting doctor's plans, be informed of the patients they have responsibility for, listen to nursing observations and make any adjustments to the clinical plan.

The review of nursing handover does not include a psychiatrist. It may be worth considering psychiatrist inclusion in this process."

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Appendix B: Independent nursing advice to the Commissioner

The following expert advice was obtained from registered nurse Dr Tony Farrow:

"I have been asked to provide an opinion to the Commissioner on case number C14HDC01390. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Independent Advisor qualifications, training and experience

I am a Registered Nurse with 24 years of experience in mental health clinical practice, education, workforce development and research, and have had various practice, leadership and management roles in mental health/mental health nursing.

I have a good understanding of contemporary national and international mental health nursing practice (including inpatient nursing). I have held a national workforce development role with Te Pou, which enabled me to work with and visit most New Zealand mental health inpatient units. My doctoral research examined the construction of inpatient nursing work with suicidal consumers.

I currently teach a number of courses to mental health clinicians within Canterbury District Health Board Specialist Mental Health Services. These courses include one on risk assessment and management in inpatient and community settings.

I have obtained the degrees of Bachelor of Nursing, Master of Health Science (First Class Honours) and Doctor of Philosophy (Nursing). I also have a post-graduate Diploma in Mental Health Nursing.

Referral instructions

I have been asked to review documents relating to case C14HDC01390 and provide my opinion on the nursing care provided to [Mr A], in particular the following issues:

1. The adequacy of the risk assessments carried out by nursing staff and the overall care they provided to [Mr A]
2. Whether nursing staff responded appropriately to [Mr A's] deterioration in mood
3. Whether clinical documentation was adequate
4. Based on the clinical records during the period of [Mr A's] admission, at what stage would it have been appropriate for nursing staff to discuss ongoing care with a psychiatric registrar or consultant
5. Had all the clinical information and observation been available to one experienced nurse on [Day 3], would this information have reached a threshold to motivate a discussion with a psychiatric registrar or consultant?
6. Any other comments on the care provided

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In addition, for each question I have been asked to advise:

a) What was the standard of care/accepted practice?
b) If there has been a departure from the standard of care or accepted practice, how significant a departure I consider it is (mild, moderate or severe)?
c) How would the departure (if any) be viewed by my peers?

Sources of information reviewed

I have reviewed the following documents supplied by the Commissioner:

- Copy of [Ms B's] complaint [date]
- Copy of Counties Manukau District Health Board (CMDHB)'s response dated [2014], including a report to the Coroner from [Dr D]
- Copy of [Mr A's] clinical records from CMDHB dated [Days 1- 4]
- Letter from CMDHB dated 21 May 2015 enclosing further responses
- CMDHB Review report dated [2014]
- CMDHB Review report dated 20 April 2015
- Letter from CMDHB dated 15 December 2015 containing the documents listed in that letter
- Statements from [RN H] dated 4 September 2015 and 13 December 2015
- CMDHB response dated 7 September 2015
- Staff rosters
- Staff statements
- MHSmart sheet
- Guideline: the inpatient unit Multidisciplinary Team Standard of Practice
- Recommendations and Corrective Action Plan
- Letter from CMDHB dated 13 October 2015 containing the documents listed in that letter. This includes a response from [Dr T] dated 12 October 2015

Factual Summary

[Mr A] was admitted, under mental health legislation ('the Mental Health Act'), to the intensive care unit of the inpatient unit, CMDHB's mental health intensive care unit, on [Day 1]. He had presented in a psychotic state on arrival (in transit to his [home city]) at [the] airport after a one month trip [overseas].

[Mr A] was not known to CMDHB mental health services, but had been known to [DHB services in his home town] since the early 1990s.

[Mr A] was under the care of the inpatient unit for a period of further assessment and treatment. He was found in his room on the morning of [Day 4].

The Commissioner has asked me to provide my opinion on nursing care to [Mr A], guided by the questions previously noted.

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My opinion on nursing care

The adequacy of the risk assessments carried out by nursing staff and the overall care they provided to [Mr A]
The risk assessments were inadequate. Risk status updates are absent in the nursing notes, and the initial risk assessment had not been updated since admission.

Risk assessment and management plans (which are part of the assessments) must be clearly written and up to date (Ministry of Health, 1998). Usual inpatient practices are that risk status be updated at least once each shift. Although absences of risk do not need to be repeated in every clinical note, usual practice is that attention is placed on factors that place a consumer at risk at the time, or may be a perceived future risk. In [Mr A's] case there were known suicide risks that should have been considered (such as his psychosis and change in mood).

It is vital that risk assessments are recorded on consumer files, updated, and be used as a basis for updating management plans. While risk assessments are not solely a nursing role, it is usual practice that nurses (and other multi-disciplinary team members) take responsibility for ensuring the presence of risk assessments and updating these, especially when new information comes to hand.

The absence of documented risk assessments and a management plan stemming from these is a severe departure from standards of practice and would be viewed very negatively by peers.

The absence of consultation with [Mr A's] family is also a deviation of an expected standard of care. This is important in both a general humanistic sense, and for the important information (including risk information) that they may have been able to provide. This is a moderate departure from standards, and would be viewed negatively by peers.

Whether nursing staff responded appropriately to [Mr A's] deterioration in mood
Nursing staff did not respond appropriately to [Mr A's] deterioration in mood. There is no recorded assessment or change in management plan (such as changing levels of observation); nor is there any note of ensuring that psychiatric or registrar review was requested.

Nursing risk assessment, management, and requests for medical assessment would have been the expected standard of care in this situation. The absence of these is a severe departure from standards of practice and would be viewed very negatively by peers.

Whether clinical documentation was adequate
Nursing notes often record [Mr A's] mental status, which is appropriate. However there are many nursing notes that do not record this. Usual inpatient practice is these would be summarised at least once a shift. A written mental status examination is considered to be vital in any on-going nursing care (Office of the Director of Mental Health/New Zealand College of Mental Health Nurses, 2012).

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The absence of this assessment would be viewed negatively by peers and is a severe departure from normal practice.

I have already commented on the absences of risk assessment, formulation and management.

Based on the clinical records during the period of [Mr A's] admission, at what stage would it have been appropriate for nursing staff to discuss ongoing care with a psychiatric registrar or consultant?
Nursing staff should have requested an urgent risk assessment from a registrar or consultant when [Mr A's] friends communicated their concerns about his risk, and when [Mr A's] mood was observed to have lowered.

The absence of such requests is a severe departure from standards, and would be viewed negatively by peers.

Had all the clinical information and observation been available to one experienced nurse on [Day 3], would this information have reached a threshold to motivate a discussion with a psychiatric registrar or consultant?
It is very likely that an experienced nurse with a reasonable level of competency would have considered that the threshold for discussion with a registrar or consultant had been reached.

References

Ministry of Health (1998). *Guidelines for Clinical Risk Assessment and Management in Mental health.* MoH. Wellington

New Zealand Nursing Council (2007). *Competencies for Registered Nurses.* NZNC. Wellington

Office of the Director of Mental Health/New Zealand College of Mental Health Nurses (2012). *Guidelines for Mental Health Nursing Assessment and Reports.* Office of the Director of Mental Health/New Zealand College of Mental Health Nurses. Wellington

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Names have been removed (except Counties Manukau DHB and the experts 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.