Registered Nurse, Ms B

A District Health Board

A Report by the

Deputy Health and Disability Commissioner

Rae Lamb

(Case 06HDC06218)

Parties involved

Ms A	Consumer
Ms B	Provider/Registered nurse
Ms C	Unit manager
Ms D	Clinical supervisor
Mr E	Registered nurse

Complaint

On 4 May 2006, the Commissioner received a complaint from a District Health Board about the services provided by registered nurse Ms B to Ms A. The complaint had been sent to the Nursing Council of New Zealand, and it was forwarded to the Commissioner in accordance with section 64(1) of the Health Practitioners Competence Assurance Act 2003.

The following issue was identified for investigation:

- *The appropriateness of registered nurse Ms B's relationship with Ms A, a client of an alcohol and drug service, a District Health Board.*

An investigation was commenced on 15 May 2006.

Information reviewed

Information from:
- Ms A
- Ms B
- Ms C
- Ms D
- Mr E
- A District Health Board
- New Zealand Nurses Organisation

Independent expert nursing advice was obtained from Ms Clarissa Broderick.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Overview

On 14 December 2005, Ms A contacted the manager of an alcohol and drug service (the service), at a District Health Board (the DHB), to allege that she had been having a relationship with a registered nurse at the service. An internal investigation was commenced into the relationship between Ms A and Ms B, a registered nurse at the service.

The internal investigation concluded that there had been inappropriate conduct on behalf of Ms B that breached professional boundaries, and her employment was terminated.

Ms A stated that she does not support the complaint, and that "nothing sexual happened" between her and Ms B.

Information gathered during investigation

Background

Inpatient detoxification service
The inpatient detoxification service is part of the District Health Board's alcohol and drug service. It is staffed by multidisciplinary health professionals, including registered nurses and medical officers. The daily clinical service delivery is co-ordinated by the clinical nurse leader, who reports to the Service Manager, Ms C. Clinical supervision for registered nursing staff is provided by Ms D, who is a level 4 registered nurse.

Ms A
The DHB advised that Ms A had ongoing contact with the service from 1999 to 2006. During 2005, she was admitted three times to the inpatient unit for medical alcohol detoxification. Ms A had also been diagnosed with Borderline Personality Disorder.

Ms B
Ms B described her role as a registered nurse in the inpatient unit:

> "[T]he primary focus of the team and the nurses is to meet the clients' needs for a medically safe alcohol (or other drug) withdrawal. A bio/psycho/social nursing approach is taken in assessment, intervention and evaluation. However due to the medical risk involved (especially in alcohol withdrawal), a definite focus is given to physiological needs in withdrawal."

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Ms B described her training and experience:

> "I graduated as Registered Comprehensive Nurse in 1995 with a Diploma in Nursing. I have not received any particular training on professional boundary issues during my initial training as a nurse or since. The New Zealand Nurses Code of Conduct at that time does not mention boundary issues. I was not aware of any changes made to the Code until I checked the Nursing Code of Conduct on the Nursing Council website in December 2005.
>
> I completed three additional nursing papers, finishing in 1999, to gain [further qualifications at a University].
>
> I have worked in surgical, medical; child health, older adult and mental health nursing mostly all for [the DHB]. I have never been offered or had access to any training with [the DHB], on boundary issues.
>
> In 2001 I completed a mental health postgraduate programme, sponsored by [the DHB], involving two mental health practicums and two papers at [a University]. Again there was no specific education on boundary issues (in particular, no training on friendships or contact with clients or ex-clients). There was a focus on issues such as de-stigmatisation; empowerment of consumers and client strengths based models and reducing some of the formality of contact between clients and nurses.
>
> Since completing this postgraduate programme I worked in mental health nursing for two and a half years. I have worked in acute and long term (residential and outpatient services) mainly working with clients with axis 1 disorders.
>
> [The DHB] code of conduct (guidelines for accepted behaviours), regarding contact with clients/ex-clients, states: 'staff may not have sexual relationships with any client in the service'. It also says positive action; feedback, negotiation and training should be provided in relation to these guidelines. (This did not occur.)
>
> …
>
> As a result of this incident I am now more fully aware of how underlying mental health issues, particularly on axis 2 diagnosis of borderline personality disorder, can make clients particularly vulnerable to misinterpreting relationships and making impulsive attempts to avoid rejection. It is unfortunate that I had not received training or guidance to enable me to have avoided my good intentions resulting in the situation in the first place."

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Inpatient unit admissions — March to September 2005

22 to 29 March
Ms A was admitted to the inpatient unit at 9pm on 22 March, having been referred for alcohol detoxification. The admission summary was completed by a registered nurse. He recorded:

> "[Ms A] is a 39yr old female referred … for alcohol detox. [Ms A]… relapsed into heavy drinking 3 weeks ago however states on and off all the time.
>
> [Alcohol and drug history]
> Alcohol binge drinking from teens. Heavy drinking from her 20s, unsure why her alcohol use escalated then. Used psycho stimulants in her 20s … Speed, [ecstasy] cocaine took these substances for a few years[,] stopped in 1999.
>
> Current use
> Currently drinking 3 bottles of wine daily, last drink 12.30pm today. [Ms A's] mother came around to her flat and removed what alcohol was left over after 12.00pm.
>
> Admission to Detox/Rehab programme
> [Ms A] has had various admissions to [inpatient unit] 2 x admissions in 2005. Also admitted to [a rehabilitation unit] in 2000 and also previous admissions to [a second rehabilitation unit].
>
> …
>
> Mental Health
> Has not had admissions to Psych units however has been seen as an outpatient [at two community mental health centres]. Mood is sometimes elevated … prescribed Lithium Carbonate 1½ years ago. Elevated mood affects sleep pattern. [Ms A] drinks to bring mood down. [Doctor] has initiated [Sodium] Valproate for mood stabilising effect. Denies any suicidal thoughts or suicidal plan [at] present. Past [history] of self harm. Cut wrists twice last year."

Ms A was commenced on an alcohol withdrawal programme.

Ms A was discharged on 29 March, with the clinical notes recording that she had "Completed her alcohol detox safely". The clinical record shows that Ms B wrote notes on Ms A's care on all four shifts when Ms B was at work during this admission — 23, 25, 26 and 28 March.

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28 June to 5 July
Ms A was readmitted on 28 June. The medical officer of the unit, recorded:

> "39yr old [woman] with Borderline Personality Disorder presents for medically managed alcohol withdrawal."

Ms A was discharged on 5 July. The clinical record shows that Ms B wrote notes on Ms A's care on two of the three full shifts Ms B worked during this admission. On 29 June, Ms B recorded that Ms A wanted outpatient treatment. On 3 July, Ms B recorded the care that Ms A had received during the afternoon and evening.

14 to 21 September
At 2.30pm on 14 September, Ms A was admitted to the inpatient unit. A medical officer at the detoxification unit described Ms A's condition:

> "[Ms A] turned up late and very drunk. Breathing alcohol level was 1400 on admission. She is agitated, sweared [at] staff and clients, not [cooperating]. … Unable to take history or perform [examination] as she is not [cooperating]."

The medical officer set Ms A's management plan to include hourly clinical observations ("make sure she is breathing, not in … coma"), and a temporary alcohol treatment plan until Ms A became sober.

Ms A was discharged on 21 September. The clinical record shows that Ms B wrote notes on Ms A's care for both shifts she worked during this admission — 17 and 18 September.

Contact outside work
Ms B stated that after Ms A's discharge from the inpatient unit on 21 September, Ms A telephoned the unit and spoke to her. Ms B said:

> "[Ms A] phoned and I was the person that answered the phone, and it didn't come across that she particularly wanted to speak with me, but she wanted to talk with someone and she seemed a little bit anxious, but she said things were going well and she just wanted to let us know, or let me know, let us know — that was the impression I got, that she was doing ok. And I felt she was just making a bit of contact wanting a bit of encouragement, which wasn't unusual, it wasn't particularly unusual, although quite often clients could phone in because maybe they weren't doing so well or they were doing well."

Ms B further stated:

> "After [Ms A's] discharge I spoke to her two or three times on the telephone over the following month. That was in my nursing capacity at Medical Detox when she rang the ward telling me of her current progress.
>
> …

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> Approximately … a month after discharge … [Ms A] rang again to detox and spoke to me briefly. On this occasion she asked me if I would go for a coffee with her to celebrate her month of abstinence. I initially declined but when she phoned again asking me, I agreed to meet her."

Ms B was interviewed as part of my investigation. Ms B said that she felt "pressured" by Ms A to go for coffee:

"[Ms B]:	And I felt kind of pressured I must admit, I felt pressured from her but I also thought well in my head things happened quite quickly but I sort of thought, about the pros and cons and I thought there was a risk in terms of how it could be perceived but I knew that I was just wanting to basically extend a bit of friendship to her.
HDC Interviewer:	You say friendship?
[Ms B]:	Well yes, support, friendship, I'm not really sure, I wasn't really sure at that stage I just sort of thought I was just more responding to her request and yes I don't know I can't really explain it more than that.
HDC Interviewer:	Did you raise this with any of your colleagues at the time, as you describe it now you seemed a bit unsure, did you talk to anybody at the time about this?
[Ms B]:	No, I didn't talk to anyone at the time, I don't think …"

Ms B acknowledged that she had a shared culture with Ms A due to their sexual orientation:

> "Well, I guess … meaning gay, lesbian, bi-sexual community, like in terms of resources. … She was openly gay … and I talked to her about resources within that community that I knew some things about, and that I was able to say to her in terms of her general wellness when she left, 'Have you thought about going to lesbian functions?' or utilising and giving her a little bit of information on things I had access to — resources that might support her. So yes, there was some rapport around that because I had done that, extended myself in that way, because I was in touch with some of those resources."

Ms B agreed to meet for a coffee. She said:

> "I was conflicted even at that stage as to whether I was doing the right thing, I wasn't thinking about the risks to myself [and] I wasn't thinking about the risks to the organisation."

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Ms B stated that she believed that Ms A was an ex-client, who was mentally well. Ms B added:

> "However in hindsight agreeing to meet [Ms A] was an error of judgement on my part. It was overstepping of the professional boundaries. It was not part of any planned treatment and I should have discussed this issue with my supervisor or line manager at this point.

Ms B confirmed that she met Ms A at a café. She stated that subsequently:

> "[Ms A] phoned me again at work and said she enjoyed meeting up and would I like to visit her at home and see her cat, she talked about her cat quite a bit — some special kind of cat you know Persian cat, and to her it was the most amazing cat, and so I like cats … so anyway I sort of um'd and ah'd and kind of agreed eventually."

As she felt some disquiet about meeting again, and wanted to know what her "ethical or legal standing was", she contacted the New Zealand Nurses Organisation (NZNO). Ms B described her call to NZNO:

> "I rang and I spoke to [a NZNO representative], and I told her what had happened and I asked her whether that was ok or not, to have contact with an ex client like that, and she says 'it sounds ok to me, but I will talk to another professional advisor and I will get back to you if there is any concern', so when she said that, I sort of thought, well I have asked somebody … from a nursing organisation point of view and I felt kind of more at ease in a way after that so that's when I probably didn't hesitate as much and went for the second coffee."

The minutes of a meeting on 20 January 2006, held as part of the internal investigation, record that Ms B stated that the NZNO representative told her "she was not doing anything wrong".

The NZNO representative told the internal investigation:[1]

> "[Ms B] contacted NZNO on 14 October 2005 to seek advice on her situation. She described that she had met a client while working in detox and [after] the client's discharge had formed a friendship. She was concerned [about] the implications of this. At the time she phoned I was with someone and not able to speak fully to [Ms B]. I indicated that a friendship wouldn't probably be a problem but that I would speak to our legal advisor or PNA [Professional Nursing Advisor] and get back to [Ms B]. I phoned [Ms B] the following week and left a message for her to ring me — unfortunately we kept missing each other and I did not speak to [Ms B] until 15 December."

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[1] Email to the DHB on 24 January 2006.

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The NZNO representative stated that the advice that would have been given was for Ms B to get in contact again to discuss the matter in more depth, so that NZNO could advise her.

Ms B got a message on her phone "probably like a week or two later", but she did not call the NZNO representative back as she had decided to discuss the matter with her clinical supervisor, Ms D.

The second time Ms B and Ms A met was at Ms A's house, where Ms B went to see Ms A's cat. Ms B stated:

> "I went to her house, had a coffee, saw the cat, had a chat, and left again."

Ms B gave Ms A her mobile phone number "after that second meeting". Ms B said that Ms A called her on her mobile phone "a couple of weeks" after the second meeting, suggesting that she come round to Ms B's house. On this occasion, Ms B stated, "We had something to eat … and a drink, and then [Ms A] left." Ms B added: "On that occasion we hugged and kissed as she was leaving. It was a friendly not a romantic incident."

"[Ms B]:	Again it was just superficial kind of chatting and then when she left we had a hug and felt that when she was hugging me she was kind of holding on a little bit and so I just kind of moved away and I felt slightly uncomfortable.
HDC Interviewer:	Was there any other physical contact that went with the hug prior to or after or at the same time?
[Ms B]:	Yes, [I] kissed her on the cheek, she kissed me. I can't remember, you know just a friendly kind of goodbye kiss.
HDC Interviewer:	So that was an awkward moment … ?
[Ms B]:	It was slightly awkward for me and I did talk to [Mr E][2] about that and that's when he gave his statement, that's what I was referring to when I talked to him about, we had a hug and a kiss.
HDC Interviewer:	So would it be a fair comment to say at that, at that point you suspected that [Ms A] may have been attracted to you?
[Ms B]:	I did wonder but it wasn't clear to me."

[2] Mr E was a registered nurse colleague of Ms B.

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Ms B told the internal investigation that she had felt uncomfortable on this occasion, as "[Ms A] had made it clear 'she wanted more'", which Ms B took to be a reference to a more physically intimate relationship with her. [3]

Ms B also stated:

> "I realised that I had an ethical dilemma regarding the contact with [Ms A] and whether it was appropriate to develop a potential friendship and ongoing contact with an ex client. I decided to discuss this with my supervisor, [Ms D].
>
> …
>
> I remember I discussed with [Ms D] the fact that I had had contact with [Ms A] since her discharge in September 2005 and that we had met a few times over the previous few weeks. That I had enjoyed her company but that I now had ethical concerns that I needed to discuss and take some guidance from her in regard to appropriateness of ongoing contact with [Ms A].
>
> I believed [Ms A] to be an ex-client and [Ms D] also discussed her as an ex-client. In the session she guided me to reflect on the pros and cons of continuing to have contact with [Ms A]. [Ms D] also talked about counsellors' codes of ethics and gave me an article on this. I asked her for information on the New Zealand Nurses code of conduct but she said she did not have a copy or access to it.
>
> However during the session I came to the decision it was not appropriate to continue contact and potentially develop a friendship with [Ms A] because she was a recent client. I decided I would not continue the contact but rather encourage her to approach [the service] again to discuss her relapse prevention needs. [Ms D] was supportive of this decision."

Ms D recalled her supervision meeting with Ms B on 25 October 2005:[4]

> "[Ms B] told [Ms D] that she had spent time with a client whilst she had been receiving treatment on the detox unit and that they had become attracted to each other. They wanted to have a 'relationship'. … [Ms D] stated that she had told [Ms B] that any type of relationship with an ex-client was not appropriate and asked her to examine her feelings around the matter hoping to get her to understand the situation more clearly. [Ms B] said that her 'head' told her that forming a relationship was wrong, but that her 'heart' was very attracted to the woman in question. [Ms D] then addressed the issues around power and control and the fact that a relationship would compromise the safety of the client and the

[3] Internal investigation — minutes of meeting dated 7 February 2006.

[4] Internal investigation — minutes of meeting dated 22 December 2006. Ms D stated that the notes she took during the supervision meeting on 25 October 2005 have subsequently been mislaid.

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importance of boundaries when dealing with clients clinically and non-clinically. It was clear to [Ms D] that [Ms B] understood the concerns and they discussed the New Zealand Association of Counsellors code of ethics and NZ Nursing Council requirements at length. [Ms B] was clear that she could lose her annual practicing certificate and jeopardise her career if she embarked on a relationship with an ex-client.

…

[Ms B] told [Ms D] that she had planned to meet with the client the next day for a coffee and to discuss whether they should have a relationship. … [At] the end of the supervision meeting … [Ms B] had undertaken that she would ring the client and cancel the coffee date and tell her that there could be no further contact as [Ms B] did not want to compromise the client or put herself in professional danger."

Ms B disagreed that she had discussed with Ms D that there was a mutual attraction between herself and Ms A, and also denied that she wanted advice regarding starting an intimate relationship with Ms A.

During the District Health Board internal investigation Ms B stated that "she had taken [Ms D's] advice and had not met with [Ms A after 25 October]." [5]

Ms B later told my Office:

"I spoke with [Ms A] in late October and explained that a friendship was not possible due to my ethical responsibilities as a nurse at [the detox unit]. I suggested she contact [the service] for more support. She seemed to accept this, although she did say she had trouble accessing [the service] (but gave no further detail). She phoned me again a few times in November wanting to discuss her progress. I kept these conversations brief and encouraged her to persist with trying to access [the service]."

In her letter, dated 20 January 2006, to the DHB, Ms B said that she informed Ms A in "early November" that she could have no more contact with her but:

"[Ms A] didn't seem to be able to accept this and over the following weeks began harassing me, demanding to see me and started ringing up intoxicated. I encouraged her to seek further professional help through [the service]."

The clinical record dated 21 November 2005 notes a psychiatric registrar review. The record states:

"Arrived on time.

[5] Internal investigation — minutes of meeting dated 7 February 2006.

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> Hasn't had any [alcohol] in [three months].
>
> …
>
> [Ms A] feels all she needs is a [three-month course of treatment]. Doesn't feel she needs a full [six-month] course, especially as so far it's going very well."

Ms B stated that in early December, Ms A telephoned her "several times intoxicated", telling Ms B that she had relapsed and also asked to see her. Ms B said that she again told Ms A that meeting was not possible.

Ms B agreed that, with hindsight, she could have contacted the alcohol and drug service team herself with the information about Ms A's relapse.

14 December 2005

Ms A telephoned the inpatient unit at 12.40pm, speaking to a senior physiotherapist. The physiotherapist was unaware that it was Ms A to whom she was speaking. The physiotherapist sent an email to Ms C the following day, describing the call:

> "I received the call about 12.40hrs as [Ms D] and I were ending our lunch break. At my request [Ms D] remained in the room during the call both for support and as a witness.
>
> The lady stated she wanted to talk to someone about a staff member she was concerned about. … The conversation continued for about 30 mins as I attempted to de-escalate the lady's agitation and end the call.
>
> The lady said she had recently been an inpatient in the Unit and was currently in a relationship with this staff member. She stated several times that she was concerned about the staff member because the staff member was so distressed when she left to go to work and talked about her worry about losing her job if she was found out. The lady said she was ringing because she wanted the staff member be given help, she did not want her to lose her job."

Ms A also left a telephone message on Ms C's phone. Ms C returned the call at 4pm. She completed a Complaint/Incident Review Report which states:

> "[Ms A] stated that she was having a relationship with a Detox staff member, she did not state with whom but stated that 'surely I knew about it and who it was'. … [Ms A] disclosed significant detail about the staff member. Towards the end of the conversation I asked [Ms A] if she was talking about [Ms B], she said she was.
>
> …
>
> [Ms A] stated the purpose of her phoning was to 'get back at that staff member as she had gone away for two days and had not been in contact'. However, towards

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> the end of the conversation [Ms A] expressed ambivalence about phoning me as she didn't want [Ms B] to get into trouble or lose her job.
>
> …
>
> [Ms A] disclosed significant detail about [Ms B] (e.g. she knew she was applying for the Group Coordinator role), the Inpatient Team (she knew where and when the staff Christmas party was being held) for me to believe there may be validity to the allegations and to investigate the matter further.
>
> Note: [Ms A] sounded coherent during our conversation and there were no obvious signs/sounds of intoxication."[6]

Ms A then called Ms B to tell her that she had spoken to Ms C.

Ms A confirmed that she often called to try and persuade Ms B to have a relationship. Ms A stated, "I was very full on." She recalls Ms B saying that it was "wrong, wrong, wrong" to have a relationship, and this was soon before Ms A's telephone call on 14 December to Ms C.

Ms B was asked if she made any clinical record of her contacts with Ms A. Ms B stated:

> "No, I didn't see it as a clinical contact, I saw it in my mind at the time, I saw [Ms A] as an ex-client and I was not going on a professional visit ... it was just a personal kind of response."

Subsequent events — 15 December onwards

Ms B met Ms A near her home to discuss her call to Ms C. Following the meeting, Ms B called Ms C and a meeting was arranged for 16 December.

Ms B stated that Ms A had been ringing her up to 10 times a day after she had met Ms A on 15 December, and that she had sent Ms A an email "telling her to stay away".[7] Ms B stated that she had given Ms A her personal email address around the time of their third meeting, and there had been some correspondence from her, including a picture of a flower. She did not recall if she had replied to Ms A's emails.

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[6] The DHB advised that Ms B was off sick on 13 and 14 December, the Christmas party was arranged two to three weeks prior to 16 December, and the Group Coordinator handed in her notice on 11 November 2005.

[7] Internal investigation — minutes of meeting dated 21 December 2005.

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Mr E said that Ms B had asked to talk with him at a mediation group on 18 December and she told him of Ms A's allegation. The minutes of a meeting on 23 December 2005, held as part of the DHB internal investigation, record that Mr E stated:

> "[Ms A] had asked [Ms B] to come for coffee with her a couple of times. [Ms B] had put her off a couple of times, but then had eventually arranged to meet her. [Ms B] told [Mr E] that she had subsequently had dinner with [Ms A] and had also gone to [Ms A's] flat a few times and had invited her to her own flat once. [Ms B] had stated [to Mr E] that she felt flattered by [Ms A's] attentions and understood that by being with her she was helping [Ms A] to remain sober. [Ms B] had noted [to Mr E] that she had 'kissed and cuddled' [Ms A] on one occasion but had become frightened and told Ms A to stop."

Ms B disagreed with Mr E's statement that she went to Ms A's flat "a few times", and said she went only once. She also stated that she could not recall telling Mr E that she felt flattered by Ms A's attentions.

In a subsequent statement (dated 14 February 2006) Mr E stated:

> "What was very clear to me from my discussion with [Ms B on 18 December 2005] was that an intimate relationship was not what her intention was with regard to [Ms A]. It was about supporting someone who had begged for help over a period of time."

On 22 December, Ms A met Ms C and her colleague. Ms A stated that she had been angry, concerned and distressed by what she perceived as Ms B "just going off and leaving her". The minutes of the meeting record that Ms A was angry as she had wanted to have a relationship with Ms B, but that Ms B had refused and this had upset and annoyed Ms A. She stated that Ms B had become her friend, and had helped her stay sober for three months. During this meeting Ms A withdrew her claim that she and Ms B had been in an intimate relationship.

Independent advice to Commissioner

The following expert advice was obtained from Ms Clarissa Broderick:

> "I have been asked to provide an opinion to the Commissioner on case number 06/06218.
>
> I have read and agree to follow the 'Guidelines for independent advisors'.
>
> My Qualifications are MSc Addictive behaviour (London University) PG Diploma Forensic Mental Health (London University) RMN (King's College London) I am registered with the Nursing Council of New Zealand as a Psychiatric Nurse. I have

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practiced in mental health for 25 years and have worked specifically in the Alcohol and Drug field since 1999, I currently work for a DHB and I am the team leader for the community alcohol and drug service which incorporates the dual diagnosis service, community detox service, methadone treatment service and generic alcohol and drug service.

My opinion has been based on the documents supplied by the Commissioner.

Additional documents used for reference:

1. Nursing Council of New Zealand's Competencies for the Registered Nurse scope of practice (September 2004)

2. Nursing Council New Zealand Code of Conduct (August 2005)

[At this point Ms Broderick describes the background to the complaint, the documents reviewed, the advice requested, and the issues notified for investigation. These have been omitted to prevent duplication.]

1. Comment generally on the standard of care provided by [Ms B] to [Ms A].

Nurses are in a privileged position with access to information and intimate details relating to their clients and this privilege carries responsibility.

The care provided to [Ms A] by [Ms B] fell below what would be considered acceptable. [Ms A] has a diagnosis of Alcohol dependence and Borderline Personality Disorder — both are clearly documented in her file notes. In terms of the nursing management of [Ms A's] managed withdrawal from alcohol, her treatment within the inpatient detox unit was appropriate. However the disregard for her diagnosis of borderline personality disorder is not acceptable. Characteristically, clients with borderline personality disorder have emotional instability, chronic feelings of emptiness, a liability to become involved in intense and unstable relationships, which often lead to emotional crisis and excessive attempts to avoid abandonment. These clients also have a propensity to threats and acts of self injurious behaviour.

2. What professional standards apply in this case?

3. Were these standards met?

There are a number of professional standards that apply in this case.

Nursing Council New Zealand Code of Conduct (August 2005)

<u>Principal 2: Acts ethically and maintains standards of practice.</u>

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2.4 Demonstrates expected competencies in the practice in which currently engaged.

[Ms B] failed to demonstrate the expected competencies for a nurse working in mental health. She should have had at least a basic understanding of her patients' diagnosis of borderline personality disorder.

2.7 Maintains and updates professional knowledge and skills in area of practice.

[Ms B] was actively involved in the inpatient care of [Ms A]. Having contributed to her care, [Ms B] would have been aware of [Ms A's] diagnosis of borderline personality disorder. It is not uncommon in nursing practice to come across areas within your field where you have limited knowledge. It then becomes the nurse's responsibility to address knowledge gaps and skills deficits through study and training (not necessarily in a formal setting). It is not possible to deliver quality treatment without an understanding of the client's presenting problems and/or diagnosis.

Principal 4: The nurse justifies public trust and confidence

4.4 Reports to an appropriate person or authority any limitations in professional expertise or personal health status or circumstances which could jeopardize patient/client safety.

[Ms B] either failed to identify the gaps in her knowledge or was remiss in addressing them; it is the individual nurse's responsibility to bring to the attention of a more senior colleague the knowledge gaps. It would also be the actions of a responsible nurse to report the nature of any contact with a former client to a manager, and document any contact in the client file. [Ms B's] lack of knowledge of borderline personality disorder and her failure to disclose her 'relationship' with [Ms A] would appear in this case to have led to a significant breach of boundaries that impacted on the client's wellbeing.

[Ms B] has stated that:

> 'as a result of this incident I am now more fully aware of how underlying mental health issues, particularly an axis two diagnosis of borderline personality disorder, can make clients vulnerable to misinterpreting relationships and making impulsive attempts to avoid rejection. It is unfortunate that I had not received training or guidance to enable me to have avoided my good intentions resulting in the situation in the first place.'

Nurses have a responsibility to identify their own training needs, and failure to do this subsequently led to her 'friendship' outside of the treatment setting. This amounts to suboptimal care.

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In terms of the Nursing Council New Zealand Code of Conduct (August 2005), the conduct in question would be:

- Lack of professional knowledge/judgment.
- Entering into a sexual or inappropriate intimate relationship with a client or ex-client.

5. Whether [Ms B] maintained appropriate professional boundaries with [Ms A].

Very poor judgment was exercised by [Ms B] when she agreed to meet for coffee with [Ms A]. The fact that she stated she had concerns, and thought 'am I doing the right thing' should have been enough to make her seek immediate advice from her manager, supervisor or a senior colleague. This meeting was the catalyst for the development of an inappropriate intimate relationship; [Ms B] does not view her relationship with [Ms A] as intimate. By definition, to invite and accept invitations to someone's home, particularly if you are the only guest, implies intimacy. Therefore it is reasonable to deduce that the relationship was an inappropriate intimate relationship.

Nursing Council of New Zealand's Competencies for the Registered Nurse scope of practice (September 2004)

Performance criteria 1.6:

> 'Practices nursing in a manner that respects the boundaries of a professional relationship with the client.'

Implicit in Mental Health Nursing is the need to appreciate the boundaries of the nurse client relationship. It is usual for nurses to 'like' their clients within the context of the professional relationship. However the nurse has the responsibility to recognize the significant power imbalance that exists within the therapeutic relationship. The dynamics of a relationship that involve disclosure on the client's part, and empathy and understanding from the nurse, can arouse strong emotions for the client and feelings of dependence. To take advantage of these emotions, to form a 'friendship', intentionally or not, is unethical and exploitative.

[Ms B] did not maintain appropriate professional boundaries with [Ms A].

6. The registered nurse's responsibility to be aware of the Code of Ethics for the profession.

All nurses have access to the Nursing Council of New Zealand code of conduct for nurses. The annual practicing certificate states that:

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> 'At the date of issue the person met the council's required standard of competence and fitness to practice and is entitled to practice nursing in New Zealand.'

The practicing certificate also contains details of the Nursing Council's web site. Nurses also have access to the Nursing Council of New Zealand competencies for the registered nurse scope of practice, via the Nursing Council web site. The Nursing Council also regularly publishes a news update; these are posted to the nurse's home address. This contains details of its web site and any new developments which alert the nurse to new legislation, professional standards and requirements. The web site is comprehensive, easy to navigate, and all publications that regulate practice are available to download or purchase. It is entirely the individual nurse's responsibility to be familiar with the code of conduct and competencies for the registered nurse scope of practice.

7. The appropriateness of [the DHB] policies and guidelines to guide staff in the maintenance of professional boundaries.

[The DHB] code of conduct [for staff] directs staff to their professional code of conduct by stating 'you must not breach any professional/clinical code of practice and/or code of ethics that govern your professional practice'.

Professional behaviour and code of ethics for [the service], direct staff to:

> 'Accord priority to alcohol and other drug counselling aspects of their relationship and should not participate in roles incompatible with treatment except where there is compelling justification for doing so.'
>
> 'Staff do not enter into sexual or inappropriate relationships with a client in the service.'

[The DHB] orientation book is an example of best practice, it is directive and ensures staff are equipped to practice in their specialist area with confidence. The orientation provides mentorship, and is a supportive and collaborative introduction for a new staff member.

[The DHB] policy and guidelines are appropriate for guiding staff in the maintenance of professional boundaries, however in light of this case it may be prudent to add 'ex-clients' to the statement about inappropriate relationships. This will make the document explicit and avoid a debate about semantics. However as the guidelines for [staff] directs them to their own professional code this is sufficient to guide staff on boundary issues in mental health nursing.

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8. Additional comment

[Ms B] did not provide the appropriate standard of care, the departure from professional boundaries is significant, pivotal to this case is that [Ms B] describes an initial reluctance to meet with [Ms A], and this should have been an indicator to seek advice from a senior colleague, it is not acceptable to ignore feelings of discomfort that relate to your practice, it is appropriate to seek advice and support from a more senior colleague.

Nursing Council of New Zealand's Competencies for the Registered Nurse scope of practice (September 2004).

7.0 Ethical accountability:

> 'The applicant practices nursing in accord with values and moral principles which promote client interest and acknowledges the client individuality, abilities, culture and choice.'

Mental health performance criteria:

- Recognises ethical dilemmas and problems arising in a mental health nursing context.
- Consults with experienced mental health nurses when confronted with an ethical dilemma.
- Practices within recognised codes of ethics and codes of conduct.

[The DHB] code of conduct states:

> 'If you are in any doubt about how to handle a situation, speak to your team coordinator and/or manager in the first instance.'

[Ms B] has sought to justify her actions by comparing her relationship with [Ms A] to colleagues who have relationships with clients outside of work, in the context of AA and NA meetings. The relationships are not comparable; NA and AA are group meetings to assist and maintain recovery. [Ms B's] meetings with [Ms A] were covert, and did cause [Ms A] harm. Consistent [with Ms A's] diagnosis, she became involved in a relationship that she wanted to take further. The termination of that relationship caused emotional crisis for [Ms A] and relapse into alcohol abuse.

A nurse with ten years' post registration experience, and having studied mental health at postgraduate level would be expected to have a good understanding of boundaries. Nurses know it is not acceptable to accept invitations to meet socially with clients or ex clients, nor is it acceptable to exchange phone numbers. It is a breach of the Nursing Council of New Zealand's Code of Conduct, and a significant departure from what would be considered acceptable.

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[Ms B] sought advice on 14 October 2005 from [NZNO]; the advice was not conclusive and [Ms B] was advised that legal advice, or advice from the professional nurse advisor would be sought, and that they would get back to her. [NZNO] phoned [Ms B] the following week and left a message for [Ms B] to phone her. [Ms B] had a professional responsibility to be proactive in gaining a definitive response from the NZNO.

[Ms B] did seek the opinion of her clinical supervisor on 25 October 2005, a significant period of time had elapsed since her first meeting with [Ms A], the breach had already occurred, and [Ms B] was advised that the relationship with [Ms A] was not appropriate. At this point [Ms B], knowing that she had breached ethical codes should have reported it to her manager.

It seems improbable that [Ms B] would not have been aware of the codes that govern nursing practice. [Ms B] was aware of the professional behaviour and code of ethics for [the service and the DHB code of conduct for staff] and did not comply with [the DHB] policy and guidelines.

It is noteworthy that since this incident [Ms B] has acknowledged that she should not have met with [Ms A] and regrets any harm she may have caused her. She has sought supervision to assist in addressing her skills deficits.

I think it is important to ensure that if [Ms B] continues to practice as a mental health nurse she has appropriate mentorship, clinical supervision, and training to ensure she is able to meet the competencies for the registered nurse scope of practice. [Ms B] also needs to develop an understanding of the governance role of the Nursing Council and be compliant with the expected standards."

Response to provisional opinion

Ms B stated:

"I do accept that I unintentionally overstepped the professional boundaries when I had social contact with [Ms A]. However I did not say, nor did I imply, that professional standards do not apply because she was not a current client of [the DHB]. What I meant was, was that when I had social contact with [Ms A] I knew her to no longer be a client of [the DHB], because she told me this several times and I was not involved in any therapeutic relationship with her nor were any of my colleagues. With hindsight I should have checked her records but this did not occur to me, as I was not involved in her care in any way once she was discharged from the inpatient detoxification unit in September 2005. If I had known that she was a continuing [the DHB outpatient] I would not have had any form of social contact with her. I do accept that professional standards apply and this is not misunderstood by me in any way.

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I agree with your view that it would have been improper for me to have an intimate relationship with a client or former client. As you are aware [Ms A] was in an intoxicated state when she made her initial phone call to [the DHB], as she stated in her interview in December that she had drunk a bottle of wine before making the call. It appears she initially alleged she had an intimate relationship with me and she subsequently retracted this. The reason is that it did not happen. We were acquaintances and she did come around to my place for a coffee on one occasion. There was nothing intimate about this nor was there going to be. My flatmates came and went during her visit to the house and [Ms A] stayed for dinner, as I was about to cook dinner for myself. Ms Broderick has expressed her opinion that this event shows that there was an intimate relationship and I do not agree with that. I am aware of my responsibilities and unequivocally respond that I did not breach this fundamental professional obligation.

In regard to the standard of care provided to [Ms A], and particularly why I did not refer [Ms A] to [the service] once I was aware she had relapsed. In fact I asked my Line Manager, [Ms C] for advice regarding this, at the meeting on the 21st of December.[8] I asked her for clinical and professional advice regarding [Ms A's] relapse, informing her that [Ms A] was ringing me incessantly whilst intoxicated and acting inappropriately. Her advice was that there was nothing much I could do and that I didn't need to refer [Ms A] to [the service outpatients department] because she could refer herself, [Ms C] said 'she knows what to do' (regarding self-referral). Whilst it was not properly recorded in the minutes I have a very clear recollection that this was my manager's advice, which I took.

Regarding clinical documentation. It was usual practice to inform other colleagues on shift if a former client phoned and to document if any action was required. However often it was not possible to document in the clinical files as the files were promptly removed on discharge, and this was the case regarding [Ms A's] file.

Also in regard to standard of care, I did not disregard [Ms A's] diagnosis of borderline personality disorder. I have a clinical knowledge and understanding of this disorder. What I did say is that I did not have *extensive* experience working with people with this disorder. When I told [Ms A] I could not continue the social contact I was acting on my supervisor's advice. I was mindful of her vulnerabilities; I was professionally supportive and encouraged her to refer herself back to Alcohol and Drug or other mental health services, as I was concerned about her potential vulnerability. However I was not aware of her full history which included information regarding a history of stalking and very inappropriate behaviour toward other mental health service providers. This is because I only had

[8] Meeting held as part of the internal investigation involving Ms C, Ms B and her representative, and another colleague of Ms C.

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need to see her current notes on file which did not include any current symptoms of this disorder.

I did disclose the social contact I had with [Ms A] promptly to my supervisor and then I ceased my contact with [Ms A], to the best of my abilities. I went to see my Supervisor, [Ms D] on the 25th of October 2005 and asked for professional advice. My Supervisor did not tell me emphatically that a friendship was *not appropriate* but she did support me to reflect on the situation, I then decided it was not in the client's or my professional best interests to have a friendship with [Ms A]. [Ms D] supported this decision. The consequence of that was that the contact with [Ms A] was then effectively terminated. I did say to [Ms D] that there was a 'conflict between my head and my heart', but this was meant in terms of wanting to be a supportive contact for her and definitely not in terms of [pursuing] any kind of intimate relationship. For the avoidance of any confusion over this matter, it was me and only me that made the decision to terminate our contact.

Having sought clarification from NZNO and my Nursing Supervisor I acted accordingly. This shows that I was aware of my professional responsibilities. The complaint from [Ms A] came as a consequence of my ceasing contact and acting responsibly toward her.

Summary

1. I do accept, and have always accepted, that by having a social relationship with [Ms A] it was an overstepping of the boundaries which I very much regret. However I did so with the clear understanding that she was not [a DHB] client and at all times that social contact was not of an intimate nature and it was not going to be nor intended to be.

2. I promptly sought professional advice from the appropriate persons — NZNO, and my Nurse Supervisor. Having reflected on the boundary issues and gaining advice and which I followed, this led directly to [Ms A's] complaint.

3. This indicates that I was aware of my responsibilities and have always been aware of my responsibilities. It indicates also that I am aware of the professional boundaries and that knowledge has been updated regularly.

Regarding your other matters findings. On page 26 there is a finding that *'[Ms B] did not cease contact with [Ms A] until after the 21st of November 2005'*. That is in fact correct, and it was some weeks after I sought advice from NZNO and my Supervisor, but the fact is that [Ms A] started stalking me and ringing me incessantly and I was trying to encourage her to stop ringing me. I was always civil to [Ms A] despite clearly telling her to stop calling me and that she should refer herself back to [the service], as I was advised by my line manager, [Ms C]. I may well have discussed with her very briefly the staff Xmas party plans in a limited and courteous way. I did not make inconsistent or contrary statements about this or mislead anyone and there is no reasonable or factual basis to conclude this.

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I deeply regret getting into the situation and for agreeing to have social contact with [Ms A] and this kind of situation will never happen again. I do accept I made an error of judgement and should have sought advice prior to agreeing to meet [Ms A].

For over a year now I have been under investigation, which has precluded me from even applying for any other DHB positions. After having my contract terminated by [the DHB], where I had worked for approximately seven years, I was unemployed for six weeks. I now work in a nursing position for half the wages I previously earned. After [the DHB] withdrew my fortnightly supervision in December 05 I began paying for monthly external supervision and have continued this as well as receiving supervision from the agency I now work for, to ensure I remain a safe professional practitioner.

I have and continue to reflect upon this incident and update my understanding and practice regarding professional boundaries and mental health nursing. I continue to study in the Masters in nursing programme, to be completed by 2008. I am now in my third year working in the Alcohol and Drug treatment area as a Registered Nurse. My current employer is aware of the current investigation. Despite the ongoing stress of investigation and its impact on my health, I remain committed to my nursing career and to learning from this situation."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

Right 4
Right to Services of an Appropriate Standard

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

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Other relevant standards

Nursing Council of New Zealand Code of Conduct for Nurses and Midwives (2004):

"**PRINCIPLE 2**

The nurse or midwife acts ethically and maintains standards of practice.

Criteria

The nurse or midwife:

…

2.4 demonstrates expected competencies in the practice in which currently engaged;

…

2.7 maintains and updates professional knowledge and skills in area of practice …

PRINCIPLE 4

The nurse or midwife justifies public trust and confidence.

Criteria

The nurse or midwife:

…

4.3 Obtains, documents and communicates relevant client information.

4.4 Reports to an appropriate person or authority any limitations in professional expertise or personal health status or circumstances which could jeopardize patient/client safety …

Nursing Council of New Zealand's Competencies for the Registered Nurse scope of practice (September 2004):

1.6: Practices nursing in a manner that respects the boundaries of a professional relationship with the client.

…

7.0 Ethical accountability:

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> The applicant practices nursing in accord with values and moral principles which promote client interest and acknowledge the client's individuality, abilities, culture and choice.

Mental health performance criteria

The applicant:

…

- Recognises ethical dilemmas and problems arising in a mental health nursing context.

…

- Consults with experienced mental health nurses when confronted with an ethical dilemma.
- Practices within recognised codes of ethics and codes of conduct.

The DHB's Code of Conduct — Guidelines for Mental Health Services Group (July 2003):

Performance of duties

…

You must not:

…

- breach any professional/clinical Code of Practice and/or Code of Ethics that governs your professional practice.

[The DHB] Professional behaviour and Code of ethics — [the alcohol and drug service] (August 2004):

Staff responsibilities to clients

…

- accord priority to alcohol and other drug counselling aspects of their relationship and should not participate in roles incompatible with treatment except where there is compelling justification for doing so.

Personal relationships and professional behaviour

…

- Staff do not enter into sexual or inappropriate relationships with a client in the service. … protection of the rights of the client, including

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the client's right to safe professional care is the supreme responsibility of all staff. Refer to *MHSG Code of Conduct*.

Other If you are in any doubt about how to handle a situation, speak to your Team Coordinator and/or Manager in the first instance.

Opinion

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

Breach — Registered Nurse B

Introduction
According to Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code), Ms A was entitled to have services provided that complied with legal, professional, ethical, and other relevant standards. In the context of this case, Ms B, as a registered nurse, was required to respect the boundaries of a professional relationship with Ms A. As the Commissioner stated in Opinion 04HDC05983:

> "When [a health care provider] has a professional relationship with a client, especially a client with mental health needs, he or she must take extreme care to establish and maintain the boundaries of that relationship. A breach of professional boundaries is a breach of trust and can result in physical and/or emotional harm to the client."

For the reasons given below, in my opinion Ms B failed to ensure that she maintained professional boundaries in her dealings with Ms A. This resulted directly in Ms A suffering harm, as she subsequently believed that she was rejected by Ms B. Ms B also failed to ensure that she was aware of her responsibilities as a nurse to maintain her professional practice, and failed to document important information relating to Ms A's clinical condition. For these reasons, Ms B breached Right 4(2) of the Code, as she failed to comply with professional standards.

Professional and ethical boundaries
There is no question that Ms A was a vulnerable client; in 2005 she was admitted on three occasions for medical detoxification, and she had a history of self-harm. She also suffered from borderline personality disorder. Ms B would have been well aware of these facts, as she cared for Ms A during those three admissions. With the exception of one shift, Ms B cared for Ms A every time she was on duty during her admissions.

Ms B appears to argue that as Ms A was not a current client of the alcohol and drug service; the professional standards do not apply. I do not accept this. At the time when

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Ms B breached professional boundaries, Ms A was still attending the outpatient department of this service. Accordingly, I have taken the view that Ms A was a client of the service, and I have applied the relevant professional standards to her actions. Even if Ms A had not been receiving outpatient care, she was a patient with a high probability of relapse, with a current mental health diagnosis and a history of readmission. Ms B should have recorded this. In response to the provisional opinion, Ms B stated that, had she known that Ms A was receiving care as an outpatient, she would have had no social contact with her. However, Ms B knew that Ms A wanted to receive treatment as an outpatient; Ms B had recorded this in Ms A's clinical notes on 29 June.

Furthermore, even if Ms A had been an ex-client, it would have been inappropriate for Ms B to have commenced an intimate relationship with Ms A without a significant period of time passing, and without first seeking personal clinical supervision. There is an imbalance of power inherent in the relationship between a health provider and a consumer, especially in the mental health or addiction setting. The provider has intimate knowledge of the consumer, and this imbalance of power continues even when the clinical relationship has ceased. If a provider considers that there are exceptional circumstances that might make a relationship permissible it is essential that the matter is brought to personal clinical supervision to explore the motivations and the possible repercussions of moving from a professional relationship to a personal one. This should happen before any such relationship is commenced.

Ms B has admitted that she came to like Ms A as a friend. Although Ms B initially showed some reluctance to meet outside work, she largely ignored her instincts, and agreed to meet Ms A for coffee. Subsequently, Ms B went to Ms A's flat, and then invited Ms A to dinner at her own house. Ms B agreed that she gave Ms A her mobile phone number as well as her private email address — Ms A would also have been aware of Ms B's home address once she had visited her. The sharing of private contact details clearly over-steps professional boundaries, and would have encouraged Ms A to think of Ms B as her friend.

Ms Clarissa Broderick, my expert advisor, stated:

> "A nurse with ten years' post registration experience, and having studied mental health at postgraduate level would be expected to have a good understanding of boundaries. Nurses know it is not acceptable to accept invitations to meet socially with clients or ex clients, nor is it acceptable to exchange phone numbers. It is a breach of the Nursing Council of New Zealand's Code of Conduct, and a significant departure from what would be considered acceptable."

In her defence, Ms B stated that when she qualified in 1995, the Code of Conduct for Nurses did not specifically mention anything about boundaries. She also stated that she had received no specific training on the maintenance of professional boundaries. I share Ms Broderick's view that this is not good enough. I endorse Ms Broderick's statement:

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> "It is entirely the individual nurse's responsibility to be familiar with the Code of Conduct and competencies for the registered nurse scope of practice."

Ms B has agreed that she was concerned about boundaries the first time Ms A asked her out for coffee. This was when she should have sought advice from a senior colleague, or from a professional organisation. She did neither. Following the first meeting for coffee, Ms B accepted an invitation to Ms A's home. Prior to that second meeting, Ms B contacted NZNO for advice. Although the accounts differ between Ms B and the NZNO representative of the extent of the advice given, I believe that it is more likely than not that the account of the NZNO representative is accurate: that she did not give Ms B a clear indication that a friendship would be acceptable with an ex-client.

This is supported by Ms B's response to the provisional opinion, where she stated that the NZNO contact provided her with clarification that, along with the advice from her clinical supervisor, resulted in her discontinuing contact with Ms A. I note that at the meeting dated 20 January 2006 with her employers, Ms B stated that the NZNO representative "told her she was not doing anything wrong". Ms B appears to have subsequently amended her view of what she was advised by NZNO.

In any event, Ms B accepted that [the NZNO representative] left a message asking Ms B to call her back, yet Ms B did not do so. In my view, she should have.

Ms B has argued that her relationship with Ms A was not intimate, and that therefore the professional standards are unclear on what is accepted practice. Ms Broderick advised:

> "By definition, to invite and accept invitations to someone's home, particularly if you are the only guest, implies intimacy. Therefore it is reasonable to deduce that the relationship was an inappropriate intimate relationship."

In response to the provisional opinion, Ms B said that she and Ms A were "acquaintances" and there was nothing intimate about Ms A coming to her house and staying for dinner. Ms B stated:

> "I am aware of my responsibilities and unequivocally respond that I did not breach this fundamental professional obligation."

However, as shown in Opinion 04HDC05983, there is no need to find that there has been physical intimacy to conclude that professional boundaries have been crossed. By interacting with Ms A in the manner she did, providing private contact details, allowing Ms A to visit her home and have dinner, and meeting outside work, Ms B encouraged Ms A to see her as a friend. Ms B appears to have ignored the effect such a relationship could have on Ms A, especially considering her diagnosis of borderline personality disorder. In particular, I note that Ms Broderick advised that such patients are likely to become involved in intense and unstable relationships.

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Reporting of Ms A's condition
Ms B stated that Ms A contacted her several times, intoxicated, and told Ms B that she had relapsed. Ms B has said that, with hindsight, she should have contacted the alcohol and drug service team with this information. I disagree that this is only apparent with hindsight. In my view she should have recognised the need to act on this information at the time. Ms B knew that Ms A's relapse may have been due in part to her rejection by her. As Ms A had previously self-harmed, Ms B was required to do more than just encourage Ms A to access the alcohol and drug service herself, and it appears that Ms B's judgement was impaired by the personal relationship that had developed between them.

In her defence, Ms B stated in her response to the provisional opinion that on 21 December 2005, during one of the meetings held as part of the internal investigation, she discussed with her manager, Ms C, the referral of Ms A to the service. However, my criticism relates to the period in November and early December during which, according to Ms A, Ms B was calling in an intoxicated state. While I understand that it was difficult for Ms B to make a clinical record of her contact with Ms A because the notes were no longer present on the ward, as an experienced nurse Ms B should have recognised the need to act on the information about Ms A, and document it appropriately.

In my view, it is impossible for a health care provider to retain objectivity and professional judgement if she is engaged in a personal relationship with her client. In failing to recognise the need to document and act on the information about Ms A's condition, Ms B has clearly demonstrated why it is so important for professional boundaries to be maintained.

Summary

I am concerned that Ms B has attempted to excuse her behaviour by saying that Ms A was not a current client, and that there was no physical relationship. This shows a serious lack of understanding by Ms B of her responsibility as a registered nurse, both to maintain professional boundaries, and to maintain and regularly update her knowledge of professional standards. While it is clear that Ms B's initial instinct was not to engage socially with Ms A, she made significant errors of judgement in the face of Ms A's persistent approaches.

By failing to ensure that she maintained professional boundaries, by failing to ensure that she maintained her knowledge of professional standards, and by failing to document important clinical information, Ms B failed to provide a standard of care that complied with professional standards. Accordingly, she breached Right 4(2) of the Code.

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Opinion: No Breach — The District Health Board

Vicarious liability
In addition to any direct liability for a breach of the Code, an employing authority may be vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for any breach of the Code by an employee. Section 72(5) affords a defence for an employing authority if it took such steps as reasonably practicable to prevent the act or omission in question. Ms B was an employee of the District Health Board (the DHB). The DHB had clear policies and guidelines and provided clinical supervision to Ms B. When Ms B approached her supervisor about her relationship with Ms A, she was told emphatically that it was not appropriate. In my opinion the DHB took reasonable steps to prevent the act in question and is not vicariously liable for Ms B's breach of the Code.

Other matters

Ms B stated that she decided to break off all contact with Ms A after meeting with Ms D on 25 October, yet she has given my Office different accounts of when she acted on this: she told my Office "late October" and told the internal investigation "early November". However, Ms A knew information that Ms B agreed came from her — the time and place of the Christmas party, and that Ms B was applying for a vacancy. These items of information did not become available until mid-November. Ms B stated that the only telephone conversations she had with Ms A after 25 October were very brief, with her encouraging Ms A to go to the alcohol and drug service.

In the response to the provisional opinion, Ms B confirmed that actual contact did not cease until 21 November, some weeks after she took advice from Ms D and NZNO. Ms B said that Ms A was stalking her and ringing her unnecessarily and that she "may well have discussed … very briefly" the staff Christmas party with Ms A. Ms B said that she has not misled anyone about this. However, I find it somewhat implausible that if Ms B was feeling stalked she would share with Ms A information about the Christmas party or her job plan. It seems unlikely that Ms A would be given this sort of information if the contact was as limited as Ms B has described. In my view there is some inconsistency in Ms B's responses as to when, exactly, she discontinued contact with Ms A.

I note that in the recent *Director of Proceedings v Dr N* (58/Med05/15D) the Health Practitioners Disciplinary Tribunal considered the conduct of a doctor who deliberately hindered an investigation by this Office and stated:

> "The Tribunal believes that misleading the Commissioner was Dr N's most culpable misconduct. No health professional should mislead the Commissioner or any other person about their records.

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> The Tribunal is in no doubt Dr N's actions in misleading the Commissioner were likely to bring discredit to the medical profession. Furthermore Dr N's behaviour justifies a disciplinary sanction for the purposes of protecting the public and maintaining professional standards and to punish Dr N."

Dr N was fined $10,000 in relation to the finding of professional misconduct for obstructing the investigation.

Follow-up actions

- Ms B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of this report will be sent to the Nursing Council of New Zealand, with a recommendation that a competence review of Ms B's practice be considered.
- A copy of this report, with details identifying the parties removed, except the name of Ms B, will be sent to the New Zealand Nurses Organisation.
- A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings considered the matter and decided not to issue any proceedings. Whilst Nurse B overstepped professional boundaries, it was unlikely that the Health Practitioners Disciplinary Tribunal would find that her conduct amounted to professional misconduct. The consumer did not support further proceedings and so there was no reason to issue proceedings in the Human Rights Review Tribunal or in any other forum.