Care of prisoner with complex health needs
(13HDC00207, 26 June 2015)

Prison healthcare service ~ Medical officer ~ Registered nurse ~ Diabetes ~ Hypertension ~ Nursing assessment ~ Documentation ~ Right 4(1)

A man in his mid-fifties made a complaint about prison healthcare services. He had complex health needs, multiple prescribed medications, and a medical history including insulin dependent diabetes and hypertension.

One day, the man activated his emergency bell, and was found cold, sweating and not very responsive. The following day, the man reported chest and shoulder pain. Assessment for a cerebral event, monitoring of his vital signs and assessment of his pain over this time was limited. Two days after the event the man attended a scheduled review with a medical officer. He reported experiencing vertigo, had elevated blood pressure, and a tender lump on his left clavicle. He was referred to a public hospital's Emergency Department (ED), where it was found he had a fractured clavicle and had recently suffered a stroke.

The ED discharge summary set out a clear plan for the man's management, including changes to his medication, including his insulin regimen, and for a review by a prison doctor and fracture clinic follow-up within a week. Prison health care nurses did not carry out these requested actions, prison medical officers were not alerted to the plan, and medication changes were not actioned and re-charted promptly.

The man refused to attend a scheduled orthopaedic review appointment, as he considered it too painful to travel. This was not brought to the attention of a medical officer or rescheduled by nursing staff.

The man was not reviewed by a medical officer until 20 days following the ED discharge. It was found that the man was reporting persistent vertigo, persistent right shoulder pain, loss of function, and that his medication plan had not been amended in light of the ED discharge summary, meaning that he was not receiving important prescribed medication. The medical officer requested that nursing staff formally record an incident report regarding medication administration irregularities. There is no evidence that an incident report was completed. The medical officer also requested a radiology referral. This was later declined (due to an administrative error), but the medical officer was not made aware of this.

17 days later, the man was at a scheduled diabetes clinic appointment at another DHB. The clinic recommended changes in his insulin dose and suggested that prison health service staff monitor his pain and investigate orthopaedic issues. A few days later, the man was transported to ED owing to chest pain, was assessed and transported back to prison. The discharge summary noted ongoing pain and recommended referral to an orthopaedic clinic. These issues were not brought to the attention of medical officers.

The man continued to complain about a number of painful symptoms to prison staff over the next few weeks, but was not reviewed by a medical officer his next scheduled review, six weeks after his previous review. The medical officer referred the man to hospital for review, where a CT scan showed a suggestion of metastases. Further scanning showed widespread metastases. Palliative radiotherapy and care was undertaken. The man later died in hospice care.

It was held that there were insufficiently robust processes in place at the prison healthcare service for accurately documenting the dispensing and delivery of insulin. Furthermore there was no evidence of appropriate systems being in place for nurses to liaise with medical officers to discuss proposed changes to diabetic patient management.

The nursing assessments and clinical monitoring of the man were held to be inadequate in the lead-up to him being referred to ED, where he was diagnosed with a fractured clavicle and a mild stroke.

Poor organisational process, coupled with individual nursing lapses, meant that public hospital discharge summary instructions and medication changes were not promptly brought to the attention of a prison medical officer, contrary to operating procedure. In addition, further follow-up outpatient review was not arranged by nursing staff in a timely manner.

The man regularly reported pain and requested regular analgesia. There was a lack of clinical nursing assessment of the man's pain (ie, recording of location, intensity and duration, etc), or a documented plan to manage the pain, or evaluate how well the analgesia was working. This did not reflect professional nursing competencies. There were many examples of substandard medication administration documentation on the man's clinical file. Failure to identify and address these issues facilitated ongoing omissions and medication irregularities.

At the time of these events, the Department of Corrections had not taken sufficient steps to ensure that nursing services were provided to the man with reasonable care and skill. Accordingly, for the failings identified above, the Department of Corrections breached his right to have services provided with reasonable care and skill, as provided in Right 4(1).