Registered Nurse, Mr B

A District Health Board

A Report by the

Health and Disability Commissioner

(Case 11HDC00128)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Ms A, who at the time of these events was aged 76 years, was receiving long-term care at an Inpatient Mental Health Service. Ms A suffers from paranoid delusions, periods of agitation, distress and depression. She is subject to a compulsory treatment order. Ms A has Chronic Obstructive Pulmonary Disease[1] and frail bones, which increase the likelihood of fracture.

2. On the afternoon of 24 November 2010, registered nurse (RN) Mr B was the senior RN on duty. RN B was the admitting nurse and had allocated the care of Ms A to himself, as she was agitated and he was familiar with her care.

3. During the evening of 24 November, Ms A became increasingly agitated. There was a plan in place to manage these episodes, which included giving her the anti-anxiety drug lorazepam, as required, and placing her in her room for time out. Part of this plan was for Ms A to be taken to the Intensive Psychiatric Care Unit (IPCU) if she did not settle.

4. Ms A was asked to go to her room. She later emerged with faeces smeared over her body and clothes. She had also smeared faeces in her room. RN B and RN D took Ms A to the IPCU bathroom.

5. RN B used unreasonable force to remove Ms A's clothing, by pushing her head onto her chest and pulling her arm to the extent that her arm and hand hit the wall at least twice. When Ms A became agitated in the bath, RN B unplugged the bath leaving Ms A wet, naked and cold in the empty bath for up to five minutes. RN B made derogatory comments about Ms A, observed her from the doorway, and prevented another staff member from going to her aid.

6. RN B decided that Ms A's degree of agitation required her to be placed in seclusion and, aided by RN D, escorted Ms A to the seclusion room. While doing so, RN B pushed Ms A with his knee or thigh sufficiently forcibly to jolt her forward. This was witnessed by RN D and Care Assistant (CA) Ms C.

7. RN D reported the events to IPCU RN E that evening, and to the Inpatient Unit Clinical Manager, Mr G, the following day. The District Health Board (DHB) investigated the allegations. RN B denied using excessive or unreasonable force to restrain Ms A, and denied leaving her in an empty bath or striking her.

Decision

RN B

8. By treating Ms A excessively roughly, RN B did not comply with her right to have services provided with reasonable care and skill. RN B hit Ms A's arm against the wall, forced her head against her chest and pushed her with his knee or thigh.

[1] Chronic Obstructive Pulmonary Disease is the persistent obstruction of the flow of air through the airways, causing shortness of breath, most commonly related to smoking.

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Therefore, RN B breached Right 4(1)[2] of the Code of Health and Disability Services Consumers' Rights (the Code).

9. RN B left Ms A sitting in an empty bath for up to five minutes. By deliberately leaving a vulnerable, elderly woman naked, wet and cold in an empty bath while he made derogatory comments, observed her from the doorway, and prevented another staff member from going to her aid, RN B breached Rights 1[3] and 3[4] of the Code.

10. By using excessive force to remove Ms A's clothing and to escort Ms A to the seclusion room, RN B did not comply with the DHB's restraint and managing challenging situations policies, or the Nursing Council's Code of conduct for nurses, and therefore breached Right 4(2)[5] of the Code.

11. RN B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994.

The DHB

12. In November 2010, the DHB had policies and procedures in place that made clear the DHB's expectations of the standard of behaviour expected of staff. There is evidence that RN B had appropriate training in the relevant policies, but failed to comply with DHB policy. Therefore, the DHB was not vicariously liable for RN B's breaches of the Code.

13. Adverse comment was made about aspects of the medication administration recording and management plan in place at the DHB for Ms A in November 2010.

Complaint and investigation

14. On 3 February 2011, the Commissioner received a complaint from the DHB's Director of Nursing (via the Nursing Council of New Zealand), about the services provided by RN B. On 10 May 2011, Ms A's family confirmed that they supported the complaint.

15. The following issues were identified for investigation:

- *The appropriateness of the care provided to Ms A by RN B.*
- *The appropriateness of the care provided to Ms A by the DHB.*

[2] Right 4 (1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[3] Right 1 states: "Every consumer has the right to be treated with respect."
[4] Right 3 states: "Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual."
[5] Right 4(2) states: "Every consumer has the right to have services provide that comply with legal, professional, ethical, and other relevant standards."

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16. An investigation was commenced on 10 May 2011. This report is the opinion of Anthony Hill, Health and Disability Commissioner.

17. The parties directly involved in the investigation were:

Ms A[6]	Consumer
RN B	Provider/Registered nurse
CA C	Care assistant
RN D	Registered nurse
RN E	Registered nurse
Ms F	Complainant/Director of Nursing

Also mentioned in this report:

Mr G	Inpatient Unit Clinical Manager
Ms H	Senior mental health inpatient service staff
Ms I	Senior mental health inpatient service staff
RN J	Registered nurse
RN K	Registered nurse
CA L	Care assistant
Dr M	On-call doctor
RN N	Senior registered nurse

18. Independent expert advice was obtained from RN Kathryn Brankin, who has specialist knowledge in psychiatric care (attached as **Appendix A**).

19. Clinical advice was obtained from GP Dr David Maplesden (attached as **Appendix B**).

Information gathered during investigation

Ms A

20. Ms A is a 76-year-old woman who has been under the care of mental health services for many years for the management of her paranoid schizophrenia. For most of the last decade, Ms A has lived as an inpatient in the DHB's Mental Health Inpatient Unit. Her illness is characterised by paranoid delusions, periods of agitation and distress, and depression.

21. Ms A's episodes of agitation and distress are manifested by her yelling, refusing or spitting out her medication, and physical aggression towards staff and patients. Her treatment has been complicated by a deterioration in her physical health and a diagnosis of recurrent neuroleptic malignant syndrome,[7] which can be life-

[6] HDC spoke to Ms A during the course of this investigation, but she was unable to provide any information about the incident.
[7] An adverse reaction to neuroleptic or antipsychotic drugs.

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threatening. Most of the time, Ms A is managed in an open ward but, when agitated, she occasionally requires a short stay in the IPCU.

22. Ms A mobilises using a walking frame. She has Chronic Obstructive Pulmonary Disease and frail bones. She requires assistance with all activities of daily living, particularly her personal cares, including showering and toileting, as she is sometimes incontinent. Due to her cognitive impairments, Ms A is forgetful and, at times, disorientated. She is treated under a Compulsory Inpatient Treatment Order made pursuant to the Mental Health (Compulsory Assessment and Treatment) Act 1992, and has been diagnosed as having a treatment-resistant form of schizophrenia.

23. An Indefinite Extension of Compulsory Inpatient Treatment Order was signed on 30 June 2010 by the Family Court Judge.

Ms A's management plan

24. On 12 November 2010, senior mental health inpatient service staff, Ms H, Mr G and Ms I, signed off a management plan for Ms A. The objective of the plan was to provide a safe environment for Ms A, and to keep her mental state stable.

25. The plan states that if Ms A becomes aggressive or threatening, or is yelling, screaming, or throwing water, food or herself on the floor, the following steps need to be implemented:

> "1. Establish nil injury has been sustained.
>
> 2. Request that [Ms A] moves herself to her room, providing assistance if needed.
>
> 3. Administer PRN [as required] medication. If [Ms A] refuses oral medication, administer medication by IMI [intramuscular injection].
>
> 4. If [Ms A] is unable to comply with request she is to be escorted to her room by nursing staff.
>
> 5. [Ms A] is to be given one opportunity to moderate her behaviour. If she is unable to do this she is to be transferred to IPCU. She is to be advised and reminded of this throughout the de-escalation process.
>
> 6. Process for transfer adhered to as per normal procedure.
>
> 7. If [Ms A] is transferred she is to remain in IPCU until she has demonstrated calm behaviour for 24 hours."

24 November 2010

26. On the afternoon of 24 November 2010, senior RN B was the team leader working on Wing A of the Mental Health Inpatient Unit with three other RNs, RN D, RN J and RN K, and Care Assistant (CA) Ms C. Between Wing A (a sub-acute area) and IPCU (a secure area), there were six RNs and two CAs on duty.[8]

[8] Five of the eight staff were female.

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27. The DHB advised that RN B was responsible for providing leadership in the ward for that duty, in terms of shift coordination, as well as being the admitting RN. The admitting RN's duties included entering the admission dates for new patients into the computer and updating information on patients who had been admitted recently, as well as having a clinical caseload. No new patients were admitted to the Inpatient Unit on 24 November 2010.

28. RN B stated that, at the start of the duty at 2.30pm, he allocated patient duties to the staff. RN B allocated the care of Ms A to himself, as he knew her well and considered it unfair to allocate her to less experienced staff. The DHB noted that RN J had 29 years of experience and was also familiar with Ms A and her care requirements. RN B said that because of Ms A's complex needs, he had to factor in an additional two care-hours to her.

29. RN E, who in November 2010 had been working for two years in the Inpatient Unit, stated that allocating two extra hours for Ms A was usual. She said that patients in the unit are allocated on average 1.5 care hours per shift, but Ms A has a big impact on the management of the ward, as she requires four care hours per shift. RN E stated that RN B was responsible for four patients that shift. RN B said that there was a lack of senior staff on that shift. However, the DHB said that the combined nursing experience of the RNs in Wing A on duty for that shift totalled 44 years.

30. At about 4pm, Ms A became agitated and started shouting at other patients. At 4.45pm Ms A went to the unit's entrance foyer to smoke a cigarette. When RN K asked Ms A to go outside the building to smoke, Ms A became angry and tried to push her walker into RN K. RN K advised RN B that Ms A was becoming agitated and aggressive. RN B recalled that Ms A was in an "agitated psychosis and was shouting and ranting almost continuously".

31. At 5pm, RN D and RN J were administering medication to the patients in the unit clinic room. RN D decided to give Ms A her prescribed PRN (as required) anti-anxiety medication, lorazepam 1mg, in addition to her usual 5pm medication. After taking her medication, Ms A sat in a chair outside the clinic room. When one of the female patients walked up to get her medication, Ms A threw water over her.

32. RN B was in the nurses' station working at the computer and was advised about this second incident involving Ms A. RN D stated that RN B was "sitting on the computer not wanting to do anything". RN B said that due to a "poor junior to senior staffing ratio" and Ms A's high needs, his need to attend to the computer trend care task meant he did not have time to work with Ms A to prevent the escalating situation.

33. RN E advised HDC that if she sees Ms A starting to get distressed, she sits with her to try to calm her, but it is sometimes difficult to orientate her to reality. RN E said that she gives Ms A a warning such as, "If you cannot stop 'X' behaviour then you will need to go to your room", but sometimes she will need extra medication.

34. At 5.50pm, while sitting at the dinner table, Ms A threw an apple at one of the patients at the table. She then started throwing items off her plate and yelling at the

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other patients. RN J took Ms A to her room for time out, in accordance with her management plan.

Removal to IPCU

35. At 6.45pm, RN D encountered Ms A in the hallway and noticed that she had faeces on both arms and her clothing. RN D took Ms A to the bathroom and instructed her to wash her arms. RN D went to Ms A's room and found faeces on the floor and walls of the room and on Ms A's bed. She went to inform RN B, who was working on the computer, of this latest incident and found that CA C was already advising him about the state of Ms A's room.

36. After speaking with RN B, RN D and CA C returned to the lounge and found Ms A there, still in her soiled clothing. One of the other patients was trying to assist Ms A to remove her clothing. Ms A had removed her skirt and, as she was not wearing underwear, CA C wrapped a towel around Ms A's waist. RN B arrived and told Ms A to go to her room. Ms A started yelling at RN B, who then told her that she would be going to IPCU.

37. RN D stated:

> "[Ms A] continued to yell at [RN B]. [RN B] asked me to hold an arm. I refused due to faeces up her arm. [RN B] asked [Ms A] to sit on her walker. [Ms A] refused. I walked around [Ms A] and said to [her] come with me [Ms A]. [Ms A] followed me down the hall to IP."

38. RN D stated that she walked ahead to run the bath in the IPCU bathroom and inform the IPCU staff that Ms A was being transferred. There was no bathplug so RN D used a flannel to block the plughole.

39. RN E, who was working in IPCU that duty, advised HDC that she had little warning about Ms A's transfer. She did not assist with the transfer, but saw the "hurried restraint", and that RN D and RN B were having difficulty transferring Ms A to IPCU. RN E said that Ms A was very distressed. RN E said she had seen Ms A "that bad" only half a dozen times in the two years she had been working in the unit. RN B told HDC that he could not have left Ms A to de-escalate given her physical presentation (undressed and covered in faeces) as it would have been distressing to other patients and undignified for Ms A.

40. RN B advised that Ms A's walker was "probably" left at the entrance to IPCU.

Removal of clothing

41. At about 7pm, RN B arrived in the bathroom with Ms A. CA C accompanied them. RN D stated:

> "[RN B] came in with [Ms A]. [RN B] tested the water to find it was cold and he emptied it and made the bath water warmer for [Ms A].
>
> [Ms A] was standing in the bathroom yelling and had taken off her towel. [RN B] and I put gloves and aprons on, and I wiped [Ms A's] groin area as it was covered

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in faeces. [CA C] assisted to clean [Ms A]. [CA C] got towels, toiletries etc for [Ms A]."

42. RN E said that her first recollection of Ms A in the bathroom that afternoon was of Ms A standing fully clothed by the bath. RN E said she helped get aprons and gloves for the accompanying staff. She next saw Ms A thrashing about in the bath. RN D, RN B and CA C were present, which is the normal number for a restraint team for one person. RN E said that, on occasion, when a patient is transferred to IPCU, the transfer escalates a patient's behaviour, so staff have to de-escalate the patient and/or give appropriate medication before the decision is made whether to seclude the patient.

43. CA C recalls that Ms A's upper body was still clothed when CA C returned from fetching towels. Ms A was positioned against the back wall of the bathroom, with RN D on one side and RN B on her other side. Ms A was refusing to co-operate with the RNs who were trying to remove her top clothing, and she then slumped to the floor. CA C recalls that RN B told her to get some scissors. CA C said she was confused by this instruction and checked with RN B that she had heard correctly. When he confirmed that he required scissors, she went to the IPCU nurses' station to check out a pair of scissors. In a letter to her supervisor, CA C stated that at the moment RN B confirmed that he wanted her to get some scissors, she "witnessed [RN B] wrench [Ms A's] left arm in the air, which resulted in [Ms A] crying and yelling out in a distressed manner". CA C stated that as she was going up the corridor, she could hear yelling coming from the bathroom. She said, "It was not nice. I was in shock."

44. RN D stated that Ms A had on a tight sleeveless top. She said she tried to remove Ms A's clothing by rolling it up, so that faeces would not be transferred to Ms A's face, but the clothing was tight and would not pass over Ms A's elbow. When RN B tried to assist RN D, Ms A resisted and stiffened her arms. RN D told the DHB investigation that:

> "[RN B] pulled [Ms A's] arm up forcefully to get her arm out of the sleeve. [Ms A was] yelling continually and [she] dropped to the floor.
>
> [RN B] asked [CA C] to get the scissors to cut [Ms A's] top off. [CA C] walked off.
>
> [RN B] started to get [Ms A's] top off over her head. [RN B] started to push down forcefully on [Ms A's] head towards her chest repeatedly. [Ms A was] crying and yelling. This appeared to be very forceful. I said stop [RN B] stop, unsure if he heard me. I let go of [Ms A's] arm as [RN B] had got [her] arm to get [the] sleeve out.
>
> [Ms A] did not straighten her arm and [RN B] pulled up [her] arm and hit/flicked it twice against the wall. [RN B] got [Ms A's] arm out of her sleeve and got her top off."

45. RN D stated that while they were attempting to remove Ms A's top she was "a bit wriggly but more compliant than not". RN D's impression was that RN B was

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becoming frustrated and that, when he flicked Ms A's arm against the wall, she "felt this was a deliberate action". RN D said that when RN B pushed down on Ms A's neck she was worried that RN B would break Ms A's neck.

46. RN B advised HDC that when he was pulling Ms A's clothing over her head, because of the awkwardness of the situation, both his and Ms A's arms "slapped" twice against the wall. He told HDC staff that he pushed Ms A's head down but later advised that he pushed Ms A's clothing down in order to get her top off over her head, but he did not push her head down. RN B stated that he believes Ms A was standing at this time, and that he and RN D "had to keep their distance from [Ms A] for their physical safety as she was throwing her arms around".

47. RN B told the DHB investigation that he did not use excessive force towards Ms A. He said that he used "enough force", that he used that amount of force frequently, and that this occasion was not any more excessive than normal. RN B does not recall RN D or any other staff member telling him to stop.

48. CA C said that when she returned to the bathroom with the scissors, RNs D and B were assisting Ms A into the bath. As the scissors were not needed, she took them back to the nurses' station. CA C said that again as she was walking down the corridor she could hear raised voices coming from the bathroom. She passed RN D in the corridor and noticed that she looked "shocked and on the point of tears".

49. In response to my provisional opinion, the DHB advised that the removal of Ms A's clothing may have been best done by a female nurse, and they do not know why RN B felt it necessary to be present when other female and experienced RNs were available.

Bathing of Ms A

50. RN D said that she assisted RN B to get Ms A into the bath, that she gave Ms A two flannels to wash with, and that Ms A started thrashing her legs in the water. RN D stated that RN B walked out, and Ms A turned to her, crying, and said, "He's cruel. He's cruel." RN D helped Ms A to wash her face and upper body.

51. RN D said that RN B returned to the bathroom accompanied by IPCU CA Mr L,[9] and they stood outside the bathroom. RN E, who was working in IPCU that shift, came to the bathroom to ask whether any medication was needed for Ms A.

52. RN D went with RN E to the IPCU nurses' station, and RN E called the on-call doctor for an order for further medication for Ms A. RN D said she saw CA C at the nurses' station and she asked RN E and CA C if they had heard her telling RN B to stop. RN D said that CA C and RN E both replied that all they could hear was Ms A yelling.

53. RN E was unsuccessful in contacting the first on-call doctor in order to obtain further medication for Ms A, but contacted the second on-call doctor, Dr M, at about 7.40pm.

[9] CA L has not been contacted by HDC for information about these events. The DHB spoke to him at the time of their investigation, and CA L advised that he was not present when these events occurred and was unable to respond or provide any information.

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Dr M ordered lorazepam 2mg (orally/intramuscularly) and olanzapine 10mg orally for Ms A.

54. In response to the provisional opinion, the DHB advised that it is common for oral and intramuscular routes to be identified for all PRN doses, to enable staff to exercise discretion depending on the situation and the level to which individuals are accepting of treatment. The DHB noted that co-administration of intramuscular lorazepam and olanzapine is not strictly contraindicated, but must be approached with caution. Administering staff are responsible for being aware of any contraindications in medication administration and should discuss with the prescriber if necessary. The DHB stated that staff understood the need to monitor the effects of medication administered to Ms A.

55. CA C said that she returned to the bathroom and found that RN B was standing by the doorway telling Ms A to wash herself. CA C said that Ms A "was not good" whenever RN B spoke to her and threw a facecloth over her shoulder in the direction of the door where CA C and RN B were standing. RN B went to the bath and pulled out the flannel that was being used as a bath-plug, and emptied the bath and returned to the doorway.

56. CA C went into the bathroom to put towels over Ms A, but RN B directed her to stay at the door because of the risk of infection and to wait for RN D to return. She recalls that RN B said, "Imagine living like that," and that Ms A would have been able to hear his comments. RN B does not recall making any derogatory comments. CA C stated that Ms A "was not happy without water and said she was cold". CA C stated that "it seemed like a long wait until [RN D] came back with the medication". CA C stated that she believes that Ms A was in the bath with no water for five minutes.

57. RN D stated that when she returned she saw Ms A sitting cold and upset in an empty bath, with CA C and RN B standing by the door. RN D said she went into the bathroom and put a towel around Ms A's shoulders and then dried her off and dressed her in a pyjama top. RN D said that RN B told her that Ms A had been throwing flannels at staff.

58. RN B advised the DHB that Ms A was not left in an empty bath. He said that he took her out of the bath as soon as it was emptied. When spoken to by HDC about these events, RN B stated that he removed the flannel they were using as a plug and Ms A was left sitting in an empty bath for "a minute or two" before RN D returned and assisted Ms A from the bath. According to the DHB, RN B advised that Ms A was left in the empty bath for "1–2 minutes or several. Few minutes maybe." In response to my provisional opinion, RN B said that Ms A was left in the emptying bath for only up to two minutes to give her time to settle down.

Administration of medication

59. RN B and RN D walked Ms A, who was still agitated, to a nearby bedroom to administer the intramuscular lorazepam. RN D said that Ms A was placed on her stomach on the bed to give the intramuscular injection into her buttock, and that Ms A "wriggled a bit". RN E administered the medication to Ms A and dressed her in a "Molly pull-up" incontinence pad.

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60. Senior registered nurse, Mr N, who was working in IPCU that afternoon, advised the DHB investigation that while he was patrolling the hallway, he observed three staff in attendance with Ms A, and RN B standing in the vicinity of the bathroom doorway. He did not witness Ms A being transferred from the bathroom to the bedroom, but was called upon to help restrain Ms A while she was being given the lorazepam. RN N said that he left to resume his duties as soon as Ms A had had the injection.

61. RN D said that Ms A refused the oral olanzepine she was offered. The refusal is not documented.

Transfer to seclusion room

62. RN D recalls that RN N and RN B decided that Ms A required seclusion. RN B advised that Ms A was calmer after the injection.

63. RN B and RN D escorted Ms A to the seclusion room. CA C said she locked the bedroom door and followed them down the corridor.

64. Ms A is 5 feet (152cm) tall, and RN B is 5 feet 11 inches (180 cm) tall. CA C said that she saw RN B raise his left knee and make contact with the small of Ms A's back three times while they were going down the corridor. CA C said that each time this happened, Ms A arched her back and screamed, although RN B said that this account is exaggerated. CA C said she was shocked by what she saw.

65. RN D said that they had to go from one end of IPCU to the other to get to the seclusion room. RN D stated:

> "[RN B] and I held arms to escort [Ms A] to seclusion room with [CA C] walking behind us. [Ms A] appeared distressed and crying and yelling. As we stopped and waited for [RN N] to open seclusion door (next to clinic) I felt [Ms A's] torso jolt forward. As I quickly turned to look I saw [RN B's] knee coming down from behind [Ms A]. [Ms A was] crying and yelling at this stage."

66. RN B advised the DHB investigation that Ms A resisted when she was asked to walk from the bedroom to the seclusion room and required a two-person restraint to move her to seclusion. He told HDC that Ms A was "uncooperative and writhing". RN B said that during the restraint, after applying pressure to Ms A's wrists in the approved manner, he used a reasonable amount of force to propel her feet forward, by using his thigh against the back of her thigh. He told the DHB that this was a technique that he had been taught some years earlier and was unaware that this was not an approved technique at the DHB. RN B denied that he had brought his knee into the small of Ms A's back. He said that he would never knee a 76-year-old patient in the back and would imagine that if he did she would sustain an injury.

67. CA C noted that RN B was on Ms A's left side and RN D was on her right. RN B noted that CA C said he had kneed Ms A with his left leg, but said he was on Ms A's left side, and it would not have been possible for him to do as CA C stated. However, RN B also told the DHB: "It would have been difficult on [her] left side as I was on her right."

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68. In response to my provisional opinion, RN B said that this comment was inaccurately recorded in the DHB transcript, as he was on Ms A's left side.

69. RN B said he "strongly rejects" putting his knee into Ms A's back. He said he did not use his knee but twice used the thigh to thigh action.

70. In a written statement to the DHB RN B stated:

> "I have been asked whether I thought I had used excessive force during this restraint, to which I replied it was borderline, and although I dislike using this amount of force, I deemed it as a necessary amount, given the aggressive, agitated state my patient was in."

71. RN B documented in the Assessment and Progress notes for 24 November 2010 the sequence of events that resulted in Ms A's seclusion, and he completed an incident report that day.

72. At 10.50pm, RN N recorded that Ms A was admitted to IPCU seclusion, and that the Clinical Director and on-call doctor had been notified.

73. RN E stated that there was no debrief after this incident. She said that the responsible carer, in this case RN B, would normally lead the debrief.

Follow-up care

74. The night staff IPCU RN recorded that Ms A was very unsettled during the night. She sat on the floor most of the night screaming abuse and threats at anyone who appeared at the seclusion room window, despite being administered 5mg of olanzapine.[10]

75. Ms A was monitored in seclusion throughout 25 November as she continued to be agitated. The nursing note that afternoon recorded that Ms A was complaining that her hand and throat were painful, pointing to those areas.

76. On 26 November, a psychiatric house surgeon was asked to examine Ms A. The house surgeon noted that there was no witnessed history of trauma, and recorded:

> "L hand → small bruise on L hand ø [nil] swelling ø pain on palpation, FROM [full range of movement] with no associated pain.
>
> Cervical neck → ø bruises seen, ø swelling, ø pain on palpation and able to do FROM.
>
> [Another doctor] present during examination. No evidence of a fracture. Discussed with [the other doctor] and he was happy for her to be observed and treated with analgesia at present unless her symptoms worsen ..."

77. At 1pm on 27 November, Ms A was transferred back to Wing A.

[10] An atypical antipsychotic used for treating patients with schizophrenia and manic episodes.

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Staff concerns

78. RN D stated that when she walked back to Wing A with CA C after Ms A was settled in seclusion, she asked CA C what she had seen when Ms A was being walked to the seclusion room. CA C told her that she saw RN B put his leg into Ms A's back while she was being walked.

79. When RN D got back to Wing A, she and RN J went out to move their cars. RN D said that when she got outside she started crying and told RN J what had happened in IPCU between RN B and Ms A. RN J told RN D that she needed to report the incident to management.

80. RN D advised HDC that when she got home that night she made notes about the events of that evening. At about 4pm on 25 November she spoke to Inpatient Unit Clinical Leader Mr G. Mr G asked RN D to document her concerns, which she did.

81. CA C did not work again at the Inpatient Unit until 29 November, but on 25 November she telephoned the unit to try to speak to Mr G. Mr G was not available, and Ms I, the shift co-ordinator, was on leave. On the morning of Monday 29 November, Mr G approached CA C and asked her to make a statement about the events that occurred on the evening of 25 November.

82. Later that day RN B spoke to CA C and said that a complaint had been made against him. CA C said she felt intimidated by RN B. He asked her whether she thought that Ms A had been left in the bath for five minutes. CA C told RN B that she did not think they should be talking about this matter.

Follow-up

83. The DHB subsequently conducted an investigation into the events of 25 November 2010.

84. RN B no longer works for the DHB.

Additional information

DHB Restraint Policy

85. The DHB's policy, Restraint — Approval and Management to Enhance Safe Practice, (March 2004) notes:

> "Restraint must always be used in a manner that maximises the safety of the client and others.
>
> It must involve the use of the minimum level of force necessary to achieve and maintain safe control.
>
> De-escalation techniques or other alternative interventions or strategies must be considered and applied except in cases where immediate action is required to prevent serious harm."

86. The policy sets out the approved types of restraint, the associated best practice, potential risks of each method, monitoring and the interventions to reduce risk. The

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methods of restraint described are, Holding Limbs, Person Team Full Restraint, Mittens/Hands Restraints, and Seclusion Mental Health Inpatient Unit Only.

87. The DHB requires that a Seclusion Recording Form and a Seclusion Observation record is completed whenever a patient requires restraint by seclusion, to record the care requirements and monitoring of the patient being restrained.

88. The DHB provides a policy on Restraint Debriefing. The policy states that the DHB requires staff to debrief following every incident where restraint has been used. It states:

> "An initial debriefing should occur as soon as possible following the use of restraint and definitely before staff go their separate ways. There is a staff debrief form that needs to be completed and sent to the Quality & Risk Team to be attached to the Event report."

89. The DHB's August 2009 policy statement in relation to the management of challenging situations states:

> "[The] District Health Board (the DHB) recognises its responsibilities under the Health & Safety legislation to provide a safe environment for staff, patients and others, and for supporting staff whose safety is threatened by aggressive and/or violent behaviour. [The DHB] will use the minimum amount of force to prevent, contain and/or manage an aggressive incident."

90. The DHB defines restraint as, "a serious intervention that requires clinical rationale and oversight. It is not a treatment in itself, but is one of a number of strategies used to limit or eliminate clinical risk. Restraint should only be used in the context of ensuring, maintaining, or enhancing the safety of the person, staff or others."

91. The scope of the policy states:

> "This policy applies to ALL employees of [the DHB]. It sets out [the DHB] standards in relation to the use of restraint. The aim is to minimise the use of restraint and to ensure that, when practised, it occurs in a safe and respectful manner."

92. The DHB's 2009 manual, Personal Restraint Techniques — Managing Aggression and Violence, states:

> "It becomes apparent that the concept of reasonable force is important. How much is too much & how do you know what is too much? Since the concept of *Reasonable Force* is difficult to define, a more useful and safer concept is that of *Minimum Force.* …
>
> All use of force, however much or little, must be justifiable for the circumstances. If a less forceful alternative is available, it should be taken. … There is a duty of care that all health care workers have. An attitude change is what is perhaps

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required. Being able to walk away; to talk a client out of their anger, to utilise de-escalation skills/techniques."

93. The DHB provides training for its mental health service staff in the calming and restraint of patients. The DHB's four-day Calming and Restraint course is a competence-based course with a specific skill set to enable staff to safely manage aggressive or potentially aggressive behaviour and challenging situations. The course is based on the Health and Disability Services Restraint Minimisation and Safe Practice Standards NZS 8134.2.2008.

94. The DHB's policies and procedures are on the network. All staff have access to the network and are required to learn the appropriate policies and procedures. Staff have work books that test their ability to show where the policies and procedures are found. There are beginning education classes in such subjects as minimal force, de-escalation techniques, and calming and restraint classes. There are two restraint experts on the ward, and staff know who in the team has been trained in restraint. The Inpatient Unit staff have a refresher on calming and restraint annually, which is a two-day course. Staff sometimes debrief after an incident and review how similar incidents could be handled in future. Staff are expected to attend supervision, which is one-on-one time with an experienced colleague to reflect on and show best practice. Some staff see their supervisor every fortnight, some every month, others less frequently.[11]

RN B

95. RN B's orientation and training in DHB mental health processes were: Introduction to Risk Assessment, December 2001, Introduction to Mental Health Act, February 2002. His initial training in Calming and Restraint Training was in April 2003, and he attended refresher courses in this topic in September 2005, October 2006, July 2007, October 2008 and March 2009. RN B underwent specific training for senior RNs and, in April 2008, was authorised by DAMHS[12] to complete seclusion reviews.

96. RN B advised HDC that he was "wary" of Ms A as a result of an incident that occurred in 2003, when Ms A kicked a door, which resulted in a moderate injury to his hand.

97. RN B advised that there was a high senior staff turnover at the unit. He said he struggled to bring up issues of concern with management. RN B said that staffing at the inpatient mental health unit was inadequate and staff were constantly under high pressure. In contrast, the DHB advised that the inpatient service has a "healthy (within acceptable percentages) turnover of staff" and that the staffing group in the months leading up to this event was consistent, with little or no change. The DHB also stated that the inpatient service in which RN B worked had a good nursing structure in place, which would have allowed him to express any concern he may have had to any number of senior staff.

98. RN B stated that supervision is available to staff when they become stressed dealing with difficult patients like Ms A. It was often difficult, due to shifts, to organise time

[11] This information was provided by RN E.
[12] Director of Area Mental Health Services.

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to have supervision; however, he sometimes had supervision twice a week. The DHB noted that supervision is always available to staff and "should be used consistently and not just as required".

99. RN B stated that the changes he would make if he were in similar circumstances would be that he would "take a step back and take more time". He said that he would be insisting on more staff, as Ms A is a "big drain on resources".

RN B's response to provisional opinion

100. RN B's responses have been included in the opinion where appropriate. In addition, RN B submitted that while he could have "taken pause and dealt with [Ms A's] behaviour in a more considered way", his responsibility was also to the other patients.

101. RN B said that the junior staff looked to him for support and physical strength to contain patients, such as Ms A, who act out in a "psychotic manner". He said that Ms A was agitated and disruptive before the bathroom event, and that, in hindsight, the de-escalation with the suggested PRN medication before the bath may have assisted. He noted that on a practical level, however, Ms A was covered in faeces, and the hygiene risk for both her and other patients needed to be addressed promptly.

102. RN B states that with hindsight his restraint was "borderline in its appropriateness". However, he denies treating Ms A excessively roughly, hitting her arm against the wall, forcing her head against her chest, striking her back with his knee, and deliberately leaving her naked, cold and wet in the bath.

The DHB's response to provisional opinion

103. The DHB stated that engaging Ms A in care planning and delivery is difficult because of her fluctuating mental state, cognitive impairment and often unintelligible speech. Despite this, the DHB accepts that staff should have documented that there had been regular attempts to engage Ms A in her care planning and treatment.

104. There were a number of care plans in place for Ms A at the time and, given Ms A's complicated presentation, numerous interventions were employed to manage her behaviour, which staff applied at their discretion. The DHB responded to Ms Brankin's concern that there is no time limit on how long Ms A is to remain in her room, saying that this is completely dependent on her mental state and safety. The DHB stated that "becoming too prescriptive and negating professional nursing discretion in this type of management can lead to inflexible interventions not tailored for the presenting situation". However, the DHB also accepted that the information regarding care and treatment of Ms A was fragmented and should have been managed in a more organised way.

105. The DHB said that staff have worked hard over the years to transfer Ms A to a more appropriate environment that she could call "home". These attempts were unsuccessful because of Ms A's presenting mental state, physical health and behavioural challenges. The DHB advised that they are making efforts to assist Ms A to transfer to a more appropriate community environment.

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106. The DHB advised that the Mental Health Inpatient Service has developed a sensory modulation room, and staff have undergone training. Sensory modulation is part of Ms A's current care and treatment.

107. The DHB advised that the medication chart has now been updated in accordance with the role of the National Medication Chart.

Relevant standards

108. Health and Disability Services (Restraint Minimisations and Safe Practice) Standards[13]

Standards New Zealand has produced standards for the Health and Disability sector.[14] The foreword to the Standard states:

> "The main intent of NZS 8134.2 is to reduce the use of restraint in all its forms and to encourage the use of least restrictive practices. It is crucial that providers recognise which interventions constitute restraint and how to ensure that, when practised, restraint occurs in a safe and respectful manner.
>
> Restraint should be perceived in the wider context of risk management. Restraint is a serious intervention that requires clinical rationale and oversight. It is not a treatment in itself, but is one of a number of strategies used by service providers to limit or eliminate a clinical risk. Restraint should only be used in the context of ensuring, maintaining, or enhancing the safety of the consumer, service providers, or others. All restraint policies, procedures, practices and training should be firmly grounded in this context."

The standards are:

1 Services demonstrate that the use of restraint is actively minimised.

2.1 Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint and ongoing education on restraint use and this process is made known to service providers and others.

[13] NZS 8134.2:2008.

[14] Standards New Zealand explains standards on its website as follows: "Standards are agreed specifications for products, processes, services, or performance.
New Zealand Standards are developed by expert committees using a consensus-based process that facilitates public input.
New Zealand Standards are used by a diverse range of organisations to enhance their products and services, improve safety and quality, meet industry best practice, and support trade into existing and new markets."

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2.2 Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

2.3 Services use restraint safely.

2.4 Services evaluate all episodes of restraint.

2.5 Services demonstrate the monitoring and quality review of their use of restraint.

3.1 Services demonstrate that all use of seclusion is for safety reasons only.

3.2 Seclusion only occurs in an approved and designated seclusion room."

109. The Nursing Council of New Zealand Code of conduct for nurses, November (2009), states:

"PRINCIPLE FOUR

The nurse justifies public trust and confidence.

Criteria

The nurse:

…

4.3. uses professional knowledge and skills to promote patient/client safety and wellbeing.

…

4.6 takes care that a professional act or any omission does not have an adverse effect on the safety and wellbeing of patients/clients."

Opinion: Breach — RN B

110. RN B was the senior registered nurse on duty on Wing A of the mental health service Inpatient Unit on the afternoon of 24 November 2010.

111. Ms A, aged 76 years, who had for many years been under the care of the DHB's mental health service for management of paranoid schizophrenia, had lived as a patient in the Inpatient Unit for a decade. Ms A's illness was characterised by episodes of agitation, distress and depression, when she would exhibit verbal and physical aggression towards patients and staff.

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112. Ms A is subject to an Indefinite Compulsory Inpatient Treatment Order under the Mental Health (Compulsory Assessment and Treatment) Act 1992. What this means is that she can be treated without her consent,[15] and a person treating her can use "such force as is reasonably necessary in the circumstances".[16]

113. Although it was not necessary to obtain Ms A's consent to the treatment, the Code applies in all other respects. In particular, she was entitled to have services provided with reasonable care and skill, and consistent with accepted standards, and she was entitled to be treated with respect and with due regard for her dignity.

114. The use of restraint to enable a nurse to provide treatment is an example of use of force. In this case, restraint was required to remove Ms A's clothes to enable nurses to clean her. Restraint was also used to enable medication to be administered, and to escort Ms A down the corridor to the seclusion room.

115. The DHB provided the mental health service staff with instruction on the consideration of the term "reasonable force" in its 2009 manual, *Personal Restraint Techniques — Managing Aggression and Violence*. The DHB's view is that the concept of reasonable force is difficult to define, and a more useful and safer concept is that of minimum force, and that all use of force, however much or little, must be justifiable.

116. The issue is whether the force RN B used was reasonable. This is measured by looking at all the circumstances, including the relevant guidelines, policies and procedures. In this case, there is no issue raised about the use of restraint to administer medication to Ms A when she was distressed following the bath. However, other staff raised concerns about RN B's use of restraint or force to remove her clothes and to escort her down the corridor.

Removal of clothing

117. On the evening of 24 November 2010, after an episode of agitation and aggression for which she had been sent to her room for "time out", Ms A appeared in the ward lounge with faeces on her clothing and arms. The nurses had the task of cleaning her. She was taken to the bathroom in the IPCU for a bath. RN B and RN D had difficulty removing her tight top without smearing faeces on her face. RN D said that RN B pushed "forcefully" down on Ms A's head in an attempt to remove her clothing. RN D said she was concerned that RN B would break Ms A's neck and told him to stop. RN D said that she let go of Ms A's arm because RN B had taken hold of Ms A's arm to get her sleeve out. RN D said that when Ms A did not straighten her arm, RN B pulled up her arm and hit/flicked it twice against the wall.

118. Both RN D and CA C stated that Ms A was screaming.

119. In contrast, RN B says that removing Ms A's top was awkward, and that, in the process, her hand and his slapped against the wall twice. He does not accept that he

[15] Section 59 Mental Health (Compulsory Assessment and Treatment) Act 1992.
[16] Section 122(B)(3) Mental Health (Compulsory Assessment and Treatment) Act 1992.

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was rough in his handling of her, and does not recall RN D telling him to stop. RN B initially said that he pushed Ms A's head down, but later said he did not do so.

120. RN D's evidence is supported by the care assistant, Ms C, who reported that she "witnessed [RN B] wrench [Ms A's] left arm in the air, which resulted in [Ms A] crying and yelling out in a distressed manner". CA C said she noticed that RN D was upset immediately after the incident. RN D completed an incident report and told her supervisor about the incident the next day.

121. I find that it is more likely than not that RN B forced Ms A's head down against her chest and hit or flicked her arm against the wall at least twice. Although I understand that Ms A was unco-operative with RN B, there was no urgent necessity to remove her clothing. I note that other staff were more successful in managing her. For example, RN D was able to get Ms A to follow her to the bathroom without use of the restraint that had been proposed by RN B, and RN D and CA C were also able to wipe Ms A's groin area without apparent difficulty. RN D stated that while they were attempting to remove Ms A's top she was "a bit wriggly but more compliant than not".

122. The use of force to remove Ms A's clothing was a form of restraint. The DHB policy in relation to restraint notes that it is a serious intervention, and "should only be used in the context of ensuring, maintaining or enhancing the safety of the consumer, service providers or others". The policy also states that "[i]t must involve the use of the minimum level of force necessary to achieve and maintain safe control", and that de-escalation techniques or other alternative interventions or strategies must be considered and used except where immediate action is required to prevent serious harm.

123. Independent registered nurse Kathryn Brankin, who has specialist knowledge in psychiatric care, advised HDC that taking into consideration Ms A's age and her physical condition of Chronic Obstructive Pulmonary Disease and frail bones, the physical handling of Ms A would need to be done with great care. Ms Brankin commented that the physical restraint and removal of clothing may have best been done by a female nurse. She noted that there appeared to be a lack of concise communication between the staff working with Ms A, and no clear leader directing the care of Ms A when she was in an agitated stated and having her clothing removed. Ms Brankin said, "Without a clearly articulated plan of care for this … leads to reactive decision making." The DHB stated in response to my provisional opinion that RN B should have provided leadership. The DHB agreed that the removal of clothing may have best been done by a female nurse, and said that it does not "see why [RN B] felt it necessary for himself to be present when other female and experienced registered nurses were available".

124. RN B did not appear to hear or react to his colleague's request to stop. Ms Brankin considered RN B's departure from the professional and clinical standard to be severe.

125. I appreciate that the task of removing Ms A's tight soiled clothing was difficult, and made more difficult when she resisted. Ms A's behaviour was challenging, but there is no evidence that when Ms A was in the bathroom with RN B and RN D she posed a

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risk of harm to herself or others. It is difficult to imagine the risk a small, elderly woman would pose when having her clothing removed, such that it would justify forcefully pushing her head onto her chest, and twice flicking her arm to strike the wall. Both CA C and RN D, who had been working in the unit for two years and 18 months respectively, were shocked by RN B's behaviour. I do not accept RN B's submission that he was "wary" of Ms A because he had been injured while managing her seven years earlier. RN B says that the force he used to remove Ms A's clothing was reasonable in the circumstances. I do not agree. I consider that the force RN B used to remove Ms A's clothing was excessive.

Dignity and respect

126. Once Ms A was placed in the IPCU bath, she was given two flannels to wash herself with, but she continued to act in an agitated manner, thrashing her legs in the water. She repeated: "He's cruel." RN D helped Ms A to wash her face and torso, while RN B stood at the doorway. RN D then went to the IPCU nurses' office to arrange further sedation for Ms A with the IPCU nurse, RN E.

127. When CA C returned to the bathroom, after returning the scissors to the nurses' office, she found RN B standing at the bathroom door telling Ms A to wash herself. Ms A threw a facecloth in the direction of the doorway. RN B went into the bathroom and pulled out the flannel that had been placed in the plug-hole, and let out the bath water.

128. When CA C went into the bathroom to cover Ms A with a towel, RN B told her to stay where she was until RN D returned. CA C recalls that RN B said, "Imagine living like that", and that Ms A would have been able to hear his comments. CA C stated that Ms A "was not happy without water and said she was cold". Some minutes later, RN D returned to the bathroom and, seeing Ms A sitting cold and upset in the empty bath, dried her off and dressed her in a pyjama top.

129. RN D said that RN B and CA C were standing at the bathroom door and that RN B told her that Ms A had been throwing flannels at staff. In my view, Ms A was unable to injure RN B by throwing a facecloth at him.

130. Ms Brankin stated that removing the flannel plug from the bath and draining the water, leaving Ms A in the bath, naked, "appears to have no nursing based reason", and was "lacking in compassion and uncaring". RN B stated in response to my provisional opinion that Ms A "needed some time to settle down as the water was draining out".

131. There is some debate over the length of time Ms A remained in the empty or emptying bath. However, I remain of the view that this was a callous and unkind act on the part of RN B. He deliberately left a vulnerable, elderly woman naked and cold in the bath while he made derogatory comments, observed her from the doorway, and prevented another staff member from going to her aid. In my view this was a serious breach of Ms A's right to be treated with dignity and respect and, therefore, I find that RN B breached Right 1 and Right 3 of the Code.

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Escort to seclusion

132. Ms A's agitation and aggression had escalated on the evening of 24 November 2010. Her management plan, signed off twelve days earlier, provided staff with a seven-step plan to manage her challenging behaviour. The staff had followed the first steps of removing her from the environment that may have been triggering the episode, and had administered her PRN medication. Her responsible carer, on this occasion RN B, was advised of her escalating behaviour. The plan noted that if Ms A was given an opportunity to moderate her behaviour and was unable to do so, then she was to be transferred to the IPCU, after being advised that this was to occur. When Ms A returned to the ward lounge from her bedroom with faeces smeared on her clothing and arms, RN B told Ms A that she was going to the IPCU.

133. Ms A was escorted to the IPCU in order to have a bath to remove the faeces she had smeared. It appears that there was no formal plan, at that time, to move her to seclusion. As previously noted, although RN B was Ms A's assigned nurse, there did not appear to be a clear leader directing the care of Ms A while she was in an agitated state. RN B had received training in restraint, had attended a senior seclusion nurse training seminar, and was authorised to complete seclusion reviews. It appears that RN B, with IPCU senior RN N, made the decision to transfer Ms A to seclusion as she was being given an intramuscular injection of sedation, after her bath.

134. The IPCU seclusion room is some distance from the bathroom and the bedroom where Ms A received the sedation. RN B and RN D escorted Ms A to seclusion, walking on either side of her. Ms A was distressed and crying and yelling. However, neither CA C nor RN D observed that Ms A actively resisted being moved.

135. CA C walked behind and recalls that RN D was on Ms A's right and RN B on her left. CA C said that she saw RN B raise his left knee three times making contact with the centre of Ms A's back as they proceeded down the corridor. CA C stated that each time this occurred, Ms A arched her back and screamed.

136. RN B disputed CA C's allegation. He said that if he was on Ms A's left he could not have raised his left leg to the centre of her back; however, he told the DHB that he was on Ms A's right. In response to my provisional opinion, RN B submitted that he was on Ms A's left side and "did not make any contact with [Ms A's] back". It is apparent that either one of RN B's knees or his thigh did come into contact with Ms A. RN D reported that while she waited for RN N to open the door to the seclusion room, she felt Ms A jolt forward. RN D said she quickly turned and saw RN B's knee coming down from behind Ms A, and that Ms A was crying and very distressed.

137. RN B stated that Ms A was resisting when she was walked to the seclusion room, and required a two-person restraint to move her there. He said that during the restraint, he was applying pressure to Ms A's wrists in the approved manner, and propelled her forward by pressing his thigh against the back of her thigh. RN B said that this is a technique he had been taught in a previous employment position and was unaware it was not a DHB-approved technique. He said he used only reasonable force to move Ms A. RN B stated that he uses that amount of force frequently, and his actions when restraining Ms A were "nothing more excessive than normal".

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138. RN D and CA C saw Ms A arch her back, and RN D saw RN B's "knee coming down". RN D and CA C were distressed by RN B's actions and the effect it had on Ms A, and reported their concerns about RN B's rough handling of Ms A to the DHB mental health unit management. Ms A was examined by the house surgeon when she complained about pain in her left hand and neck. She had a small bruise on her left hand, but no other injuries were found.

139. I find it more likely than not that RN B pushed Ms A either with his knee or thigh, sufficiently forcibly to jolt her forward. I note that Ms A is a frail, elderly woman who normally requires a walking frame to mobilise.

140. In my view, RN B used unreasonable force several times while he was escorting Ms A to the seclusion room. Taken together with his earlier treatment of Ms A in the bathroom, forcing Ms A's head down and causing her arm to strike the wall, RN B's actions were in direct conflict with the restraint policy and procedure promulgated by the DHB. His actions also contravened the Nursing Council's Code of conduct for nurses — that the nurse take care that a professional act does not have an adverse effect on the safety and wellbeing of patients — and amount to a breach of Right 4(2) of the Code. In addition, in light of her age and frailty, RN B failed to provide Ms A with services with reasonable care and skill on 24 November 2010, and, in the circumstances, this was a serious breach of Right 4(1) of the Code.

Summary

141. Ms A was frail and vulnerable. RN B did not comply with Ms A's right to have services provided with reasonable care and skill, by treating her roughly and unkindly. RN B hit or flicked Ms A's arm against the wall, forced her head against her chest, and pushed her with his knee or thigh sufficiently forcibly to jolt her forward. Therefore, RN B breached Right 4(1) of the Code.

142. By deliberately leaving a vulnerable, elderly woman naked, wet and cold in the bath while he made derogatory comments, observed her from the doorway, and prevented another staff member from going to her aid, RN B breached Right 1 and Right 3 of the Code.

143. By using excessive force to remove Ms A's clothing and using unreasonable force while he was escorting Ms A to the seclusion room, RN B did not comply with the DHB's restraint and managing challenging situations policies, and the Nursing Council's Code of conduct for nurses. This conduct was therefore a breach of Right 4(2) of the Code.

Opinion: Adverse comment — The District Health Board

Vicarious liability

144. The DHB had an obligation to provide Ms A with appropriate care. As RN B's employer at the time of these events, the DHB is vicariously liable for his breaches of

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the Code, unless it can show that it took reasonable steps to prevent those breaches from occurring.

145. The DHB provides training for its mental health service staff in the calming, de-escalation and restraint of patients. The course is based on the Health and Disability Services Restraint Minimisation and Safe Practice Standards NZS 8134.2.2008. The DHB has policies on the management of challenging behaviour and restraint. The restraint policy sets out the approved methods of restraint, the associated best practice, potential risks of each method, monitoring, and interventions to reduce risk. The DHB requires that when a client is deemed to require seclusion, a Seclusion Recording Form and a Seclusion Observation record are completed. The DHB's policies and procedures are on the network. All staff have access to the network and are required to learn the appropriate policies and procedures.

146. I am satisfied that the policies and systems operating at the DHB's mental health service in November 2010 provided RN B with a clear expectation of the standard of care and behaviour expected of staff. Although RN B had not had an update in Calming and Restraint Training in the 20 months preceding these events, I am of the view that he was aware of his responsibilities and obligations. I am also satisfied that the appropriate corrective measures were taken when these events were disclosed. Therefore I find that the DHB is not vicariously liable for the actions of RN B on 24 November 2010.

Direct liability

Management of Ms A's behaviour

147. My expert, Ms Brankin, commented that the DHB's Calming and Restraint Education Workbook (2009) indicated that only one and a half hours in the four-day/twenty-eight-hour course is dedicated to de-escalation of client behaviour. Ms Brankin stated that this is in direct conflict with the Ministry of Health's guidelines and other national guidelines, which aim to reduce seclusion and restraint events throughout New Zealand. However, in response to my provisional opinion, the DHB clarified that the last three days of the course are devoted to practical skills, which include de-escalation.

148. My expert, Ms Brankin, said that the events of 24 November 2010 appear to have been the result of a busy acute unit, with limited staffing, attempting to provide care for a complex client whose "home" for several years has been an acute unit in an inpatient psychiatric hospital. Ms Brankin noted that there appeared to be an absence of a place Ms A "can call home" and that kept her and others safe. Ms A's past behaviour had led to violence towards staff and other clients, and led to conflict in her ongoing therapeutic engagement, staff burnout and powerlessness, and limited treatment options. However, the DHB advised that there were six registered nurses and two care assistants to care for 22 patients, which was a sufficient number of staff. It also advised that it had worked hard to transfer Ms A to a place she could call "home".

149. Ms Brankin was concerned about aspects of Ms A's management plan, which was documented on 12 November 2010. Ms Brankin stated that Ms A's management plan

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highlights the importance for all staff to have a consistent approach with Ms A, but in her view, this would prove difficult for the following reasons:

- There is no documentation of partnership with the client or that Ms A was aware of the plan. This is a core component to cultural safety and a requirement of nursing practice as reflected in the Nursing Council's Competencies for Registered Nurses.

- The plan does not take into consideration Ms A's cognitive impairment.

- There was no documentation regarding Ms A's triggers and individual behaviours that indicate early warning signs and ongoing escalation.

- The core driver of the plan appears to be zero tolerance of aggressive behaviour. The objectives listed are not measurable, for example, there is no time limit on the period Ms A is to be in her room, or how it is assessed that she may leave her room.

- Point 2 of the plan refers to "providing assistance if needed" and point four, "she is to be escorted". This could be interpreted as walking with Ms A to her room, to requiring a full restraint.

150. Ms Brankin noted that there appears to be a long interval between the time that the DHB's policy; Restraint — Approval and Management to Enhance Safe Restraint was issued in March 2004, and when it was reviewed in January 2011. However, in response to my provisional opinion, the DHB advised that this policy was in fact revised in March 2005, November 2009 and November 2011.

151. Ms Brankin said that "the staff us[ed] a limited repertoire of therapeutic skills in this incident". However, the DHB noted in response to my provisional opinion that staff other than RN B had been able to utilise more therapeutic skills to calm and direct Ms A without using physical restraint.

Medication management

152. My clinical advisor, vocationally registered GP Dr David Maplesden, commented on Ms A's medication management on 24 November 2010.

153. Dr M verbally prescribed immediate doses of lorazepam 2mg (orally/intramuscularly) and olanzepine 10mg (orally). The DHB accepts that its Verbal Orders Policy, which requires the prescriber, or his or her delegate, to countersign a verbal order within 24 hours, was not followed in Ms A's case. Dr Maplesden advised that this represents a mild departure from expected standards.

154. Dr Maplesden also noted that the medication administration sheet for Ms A does not record the mode of delivery that was actually used when options were given regarding mode of delivery (eg, either oral or intramuscular). Dr Maplesden advised that this increases the risk of inappropriate co-administration of medications. Dr Maplesden suggested that the administration chart be reviewed to require recording of the chosen mode of delivery, to avoid this possibility.

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155. There is no record of the immediate dose of olanzepine having been given. Staff recalled that Ms A refused the medication. This refusal should have been documented on the medication administration chart.

Summary

156. There were some deficiencies in the care the DHB provided to Ms A. Specifically, Ms A's management plan and medication management were sub-optimal, and attempts to engage Ms A in her care planning were not documented. Information regarding Ms A's care and treatment was fragmented within the health record. The DHB should reflect on its failings in this case. However, I accept that the DHB provided staff training on de-escalation of client behaviour, and it is clear from the actions of the staff who reported RN B's conduct that the culture within the DHB did not accept such conduct.

Other comment

157. RN D and CA C are to be commended for reporting this unfortunate incident. I acknowledge that this may not have been easy for them and, in my view, their actions show their concern for patient welfare.

Recommendations

158. RN B has apologised in writing to Ms A and her family for his breaches of the Code. I recommend that the DHB:

- review its criteria for formulating client management plans, in light of Ms Brankin's comments, and advise HDC by **12 March 2013** what actions have been taken in relation to this; and
- review its medication administration chart to require the recording of the chosen mode of delivery by **12 March 2013**.

Follow-up actions

- RN 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 with details identifying the parties removed, except the name of the experts who advised on this case, will be sent to the Nursing Council of New Zealand, who will be advised of RN B's name.

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- A copy of this report with details identifying the parties removed, except the name of the experts who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings decided to issue proceedings, which are pending.

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Appendix A: Independent expert psychiatric care advice

The following expert advice was obtained from RN Kathryn Brankin:

"Response of expert health professional for HDC regarding complaint of [Ms A]. (11/00128). I have read and agreed to follow the Commissioner's guidelines for independent advisors.

I am a Registered Nurse who works for the Canterbury District Health Board in acute mental health inpatient unit which caters for the Canterbury population ages between 18–65 years. We do cater for clients older than this if they have an active psychiatric illness which is not aged related and is still being treated by an adult outpatient team.

My training consists of general and obstetric hospital based training in the late 1970's which was then followed in 1983 by a two year bridging course in mental health nursing at Sunnyside hospital, this is now known as Hillmorton Hospital in Christchurch.

My experience has included working for an NGO as a team leader, providing supported accommodation and recovery care for level two and level three clients. I have held various staffing roles, as a Registered Nurse within the Canterbury District Health Board mental health services. Since 2002 I have worked in a 28 bed, open acute inpatient unit. My position is a staff nurse working rostered shift, as well as relieving the Charge Nurse Manager and Clinical Nurse Specialists as required. My continual practical nursing experience has spanned from 1977–2011. From 1983 I have specialised in mental health nursing practice.

Expert Advice Required

Please comment generally on the standard of care provided to [Ms A] by [RN B] and [the] DHB.

What standards apply in this case?

Were these standards complied with?

Standards that apply in this case, and do not appear to be complied with, based on the information I have been provided with, are the:

- New Zealand Nursing Council competencies for Registered Nurses (Nursing Council of New Zealand, 2007).
- Standards of Professional nursing practice (Draft Copy) (New Zealand Nurses Organisation, 2011).
- Code of Health and Disability Services Consumers' Rights (Health and Disability Commissioner, 2004).
- Nursing Council Code of Conduct (Nursing Council, 2009).

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[RN B]

1. Please comment on whether [Ms A's] anger and aggression, as described on the 24th of November 2010 was appropriately managed.
2. Do you consider any alternative action could have been taken to de-escalate the situation?

As documented in the nurses progress note and [RN D's] statement dated 30/11/10, on her recall of events on the 24/11/2010 PM shift, [Ms A] was agitated and disruptive three hours prior to the bathroom event. There were indications that [Ms A] was expressing her anger. There is no evidence in file copy of the documentation provided that there was a treatment plan, a personal safety plan or early warning signs or triggers which indicate potential for escalating behaviour.

Examples of increasing agitation include [Ms A] being asked to move to the approved smoking area by [RN K]. [Ms A] attempted to 'ram' the RN with her walker. She was offered and accepted her oral 1700 hours medications and PRN medication, but then appeared to throw water at a fellow client. This appears to have occurred outside the clinic. At no time, as per documentation was her assigned nurse, [RN B] involved in these early interactions, though he was informed. Best practice would suggest that the assigned nurse would engage in therapeutic rapport with the client and be responsible for medication dispending to assigned clients. From the documentation it appears this ward has assigned medication nurses and clients come to a clinic at set times to have medications administered.

Due to [Ms A's] increasing agitation directed at a particular client i.e. threw water whilst outside clinic, part of her de-escalation and to allow the medication to have therapeutic effect, was not sitting [Ms A] in the dining room with other clients which may have proved beneficial due to her being over stimulated. Levels of agitation and aggression will decrease in an environment where there is no overcrowding, there are quiet spaces for people, and routines and rules are not too rigid (Canterbury District Health Board, 2011, P.17). As [Ms A] is well known (per [RN B's] statement) and her ten-year history in an acute inpatient unit, [Ms A's] triggers and individual behaviours which indicate on-going escalation may be well known to staff, but there is no provided documentation indicating these, or her individual early warning signs, which would be helpful to prevent increased risk to [Ms A] and others.

As documented in the Communication, De-escalation and Interpersonal Skills Orientation Handbook, published by the Canterbury District Health Board (2011) escalating behaviours lead to escalating needs. There are four stages of escalation. The first of these is triggering events where frustrated behaviours may be seen and the individual is trying to meet a need (all behaviour is a form of communication). The second stage of escalation is defensive anger and generally difficult behaviours. The third stage is crisis where direct or overt comments which may be offensive are expressed by the individual. This can then move to rage and threats. The fourth stage of escalation is violence.

The newly documented (12/11/2010) management plan, Author: [Ms H], was followed with the objective of providing a safe environment for [Ms A] and for [Ms

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A's] mental state to remain stable. There is no documentation on the management plan from the information I have received or any evidence that [Ms A] has had this management plan discussed with her or her family. The management plan does not appear to be underpinned by partnership with client, which is a core component to cultural safety and also a requirement of nursing practice as reflected in the Nursing Council Competencies for Registered Nurses (2007).

Taking into consideration the age of the client and her physical conditions for example a diagnosis of Chronic Obstructive Pulmonary Disease and frail bones with potential to facture, which requires pharmacological treatment, physical handling of [Ms A] would need to be done with great care.

The need for physical restraint to bath [Ms A] and remove her clothing may have best been done by the female nurse she walked to the bathroom with. Giving PRN medication prior to the bath may have allowed a calming environment. Distress both to staff and [Ms A] may have been escalated due to pressure of time (three staff assisting the bathing process leaving two staff on a ward with 18 other patients). There appeared to be a lack of concise communication between the staff who were working with [Ms A] at the time of the reported incident. The lack of a clearly articulated plan of care for this incident leads to reactive decision making. Furthermore, there is no documentation of any quotes, instructions or conversations had with [Ms A] during the entire incident, except to say de-escalation was used. The de-escalation skills used are not described in the provided documentation. An example of this is [RN B]. He stated he 'switched off' when [Ms A] was screaming and did not appear to hear or react to his colleague's request to 'stop, stop, stop!' There appeared to be no clear leader directing the care of [Ms A] whilst she was in an agitated state and having her clothing removed.

Removing the plug (flannel) from the bath and draining of the bath water, whilst leaving [Ms A] in the bath naked appears to have no nursing based reasoning. This appears to be lacking in compassion, is uncaring, and breaches a person's right to be treated with dignity and respect.

Once in seclusion the documented distress and potential presence of psychotic symptoms of [Ms A] are clearly evident. Verbal orders for two milligrams of intramuscular Lorazepam and 10 milligrams of intramuscular Olanzapine to be given, by the on call doctor is contraindicated as per Medsafe data. This contraindication is due to the increased risk (especially in elderly) of respiratory and cardiac suppression (Medsafe, 2011). In relation to [Ms A], she is at increased risk of these factors due to age and impaired respiratory function. Giving intramuscular medication to elderly people who have a lack of muscle mass is not recommended due to potential for increased absorption rate which increases the risk of side effects and over sedation. According to nursing progress notes and individual RN statements, [Ms A] was given intramuscular 2 milligrams of Lorazepam and not intramuscular olanzapine, thus averting a potential adverse reaction. [Ms A] was given intramuscular olanzapine 5 milligrams eight hours later.

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[The] DHB

1. Please comment on whether the management plan for [Ms A] was appropriate.

2. Please comment on whether the policies provided by [the] DHB regarding managing aggression and violence, and restraint, are adequate for patients such as [Ms A].

3. Any other comments you wish to make.

There are three signatures of staff members on the management plan, representing the mental health inpatient services. There are no professional qualifications listed on the management plan, so I am unsure if this document has been developed by a mix of members of the multi-disciplinary team.

The core driver of the management plan appears to be zero tolerance of aggressive behaviour. The objectives which have been listed are not measurable. There is no mention of time limit when [Ms A] needs to go to her room, for example how long she must remain there and how it is assessed if [Ms A] is able to leave her room and engage in the normal ward milieu. There is no documentation of partnership with the client, or identification that the client is aware of the management plan (in documentation I have received). [Ms A] has an extensive and long history of engagement with mental health services and appears to have spent most of the last decade in the acute inpatient unit, as stated in documentation from [Dr …], dated 23 May 2011. The management plan does not take into consideration [Ms A's] cognitive impairment. There is no documentation provided in the management plan, which would enhance positive behaviours, i.e. working on the client's strengths or early warning signs of increased agitation and/or deterioration in state of wellness. For example as documented in her progress notes at 1500 hours on the 24/11/2010, she had been actively engaging in a therapeutic activity run by the Occupational Therapist and was discussing her previous overseas travels. This indicates [Ms A] was likely to be engaging in reality. The management plan highlights that it is important for all staff to have a consistent approach with [Ms A]. From the documented management plan this would prove difficult. For example 'providing assistance if needed' when [Ms A] has been requested to go to her room. The level of assistance could be interpreted as walking with [Ms A] to her room, to requiring a full restraint. This includes point two and point four of the management plan. The limitations of a busy acute unit, with limited staffing appears to be an influential factor in attempting to provide care for a complex client whose 'home' appears to be an acute unit in an inpatient psychiatric hospital for several years. [Ms A's] past behaviour within this unit has led to violence towards staff and other clients and there appears to be an absence of place she can call home that keeps her and others safe. This leads to a conflict in on-going therapeutic engagement, staff burn out and powerlessness and limited options of treatment. This is mirrored in her care and the staff using a limited repertoire of therapeutic skills in this incident.

In regards to question two as outlined above, the Calming and Restraint Education Workbook (2009) which includes the four day education workshop and its booklet.

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Each of the four days is broken down to cover various aspects of the workbook. Day one, one and a half hours is dedicated to triggers and de-escalation. This consists of:

- de-escalation and calming aspects
- Identifying and comparing own triggers to ability to de-escalate
- Brainstorming and feedback

Within the course of twenty eight hours in total over four days, one and a half hours is dedicated to de-escalation. The emphasis on the important skills of de-escalating appears to be minimised within this course. This is in direct conflict with the Ministry of Health and other national guidelines which aim to reduce seclusion and restraint events throughout New Zealand. To support the implementation of this goal, updated relevant education needs to be provided (Te Pou, 2008). I note [RN B] had not had an update on calming and restraint education since March 2009. The documentation provided by [the] District Health Board, Restraint — Approval and Management to Enhance Safe Restraint, which I note was issued in March 2004 and reviewed again in January 2011. There appears to be a lengthy time lag for updating policy to reflect current safe practice guidelines. This may indicate that the management plan was written reflecting the 2004 policy prior to review in 2011, so hence did not take into consideration best practice guidelines on restraint and seclusion (Te Pou, 2008).

As stated in the Calming and Restraint Education Workbook provided by [the] District Health Board (2009), the aims and objective is, 'participants will competently be able to demonstrate the necessary skills and techniques to manage aggressive and challenging situations therapeutically and safely. This includes the ability to acknowledge the impact that restraint has on the person's physical and mental well-being' (P.5).

New Zealand Nursing Council competencies for Registered Nurses (Nursing Council of New Zealand, 2007) that have not been met by [RN B], based on documentation provided include.

Domain One. Professional Responsibility.

Competency 1.1: Accepts responsibility for ensuring that his/her nursing practice and conduct meet the standards of the professional, ethical and relevant legislated requirements.

This is evidenced by actions that were undertaken by [RN B] including leaving [Ms A] in a bath naked without water, physical force utilised during restraint, no evidence of reflecting on nursing practice.

Competency 1.2: Demonstrates the ability to apply the principles of the Treaty of Waitangi/ Te Tiriti o Waitangi to nursing practice.

Protection of a client, participation and partnership.

Competency 1.4: Promotes an environment that enables client safety, independence, quality of life, and health.

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Ability to meet this competency may be limited due to resources provided by the DHB. For example no plug for bath, nursing staff had to use a flannel.

Domain Two. Management of Nursing Care.

Competency 2.1: Provides planned nursing care to achieve identified outcomes.

From documentation provided on the management plan, outcomes were achieved but causing much distress to staff and client.

Competency 2.2: Undertakes a comprehensive and accurate nursing assessment of client in a variety of settings.

Nursing documentation/progress notes was provided. I requested a medication record and received part of it. There is no evidence of the verbal order provided by the Doctor or the PRN medication which was administered. This should be clearly evident on the medication form, which is referred to as an MR4. Doses or effect of medication was not documented in nursing notes. As all progress notes are handwritten there is lack of clarity/ability to clearly understand the notes due to handwriting styles. This is evident in all progress notes, not just [RN B's] notes.

Competency 2.4: Ensures the client has adequate explanation of the effects, consequences and alternative of proposed treatment options.

Due to instructions on the provided management plan, for example consistency from staff in following the plan, there is no documentation that this plan had been discussed with [Ms A] or staff on the floor. [RN B] appears to be following an insufficient management plan. ? This was the first time management plan had been enacted and often limitations of a plan are not noted until plan is undertaken in a real situation.

Competency 2.8: Reflects upon, and evaluates with peers and experiences nurses, the effectiveness of nursing care.

No documentation provided to give evidence of this.

Domain Three. Interpersonal Relationships

Competency 3.2: Practices nursing in a negotiated partnership with the client where and when possible.

[RN B] stated that he 'switched off' during this event.

Competency 3.3: Communicates effectively with clients and members of the health care team.

No evidence of this. The team acknowledges there was no debriefing post-event. No evidence of a lead role within the calming and restraint event.

…

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From review of all the documentation provided to me in regards to this case, the appropriate standard of care provided to [Ms A] was not met. Themes of staff burnout, staffing resources and expectations of the ability of staff to cope with the complex needs of [Ms A] in a challenging setting led to a gradual erosion of best practice, including reflective practice by all multi-disciplinary team members. The expectations of the management plan to provide clear guidance and result in positive outcomes for both [Ms A] and staff, including the District Health Board, is unrealistic based on the lack of holistic care and the limitations of the acute inpatient unit environment for an elderly woman, where the average age of other consumers is 40. Whilst a lot of staffing resources was being put into [Ms A's] care at the time of this incident the health and safety of the two staff left on the ward and the other 18 patients may have been compromised.

I believe the professional and clinical practice standards were at the severe end of the spectrum (refer to my notes on the standards of professional care) from the RN and the DHB.

References

Canterbury District Health Board. (2011). *Communication, De-escalation and Interpersonal Skills.* Author: Christchurch, New Zealand.

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Nursing Council of New Zealand. (2007). *Competencies for registered nurses.* Retrieved from http://www.nursingcouncil.org.nz

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Te Pou. (2008). *Best practice in reduction and elimination in seclusion and restraint: Seclusion a time for a change.* Retrieved from http://www.tepou.co.nz."

Further advice

Ms Brankin was asked to comment on the degree to which the DHB's management plan for [Ms A] departed from accepted standards. She replied: "From a recovery/strengths model the treatment plan was of a very poor standard, so moderate."

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Appendix B: Independent clinical advice — Dr David Maplesden

"(i) The DHB policy on telephoned prescriptions requires the prescriber giving the order, or their delegate (who presumably must be legally able to sign a prescription), to countersign the prescription within 24-hours of the order being given. This policy has not been followed with respect to verbal orders for stat doses of Movicol (3 November 2010), lorazepam and olanzapine (24 November 2010) which must represent a mild departure from expected standards.

(ii) When options are given regarding mode of delivery of PRN or regular medication (eg lorazepam 0.5–1mg po/im 9 September 2010, olanzepine 2.5–5mg po/im 11 November 2010) the actual mode of delivery is not recorded on the medication administration sheet. This increases the risks of inappropriate co-administration of drugs via a parenteral route (eg co-administration of im olanzepine and im lorazepam which is a contraindicated combination). While the practice of recording options in mode of delivery as a single entry on a medication chart is not uncommon, I wonder if this practice requires review, or at least a section on the administration chart to record the chosen mode of delivery. I acknowledge there are a minority of situations in which this information could be potentially critical, but co-prescribing (and hence administering) of PRN IM olanzapine and lorazepam is one of them. This is a systemic issue, with no evidence [Ms A] actually received simultaneous IM doses of olanzepine and lorazepam at any stage.

(iii) The regular medication chart shows that [Ms A] was charted lorazepam as IM or oral administration on a regular basis, but regular olanzepine was charted as oral only.

(iv) Taking into account [Dr M's] additional advice (as per my e-mailed comments of 13 September 2012), and assuming there was no potential for inadvertent co-administration of im lorazepam and im olanzepine, [Dr M's] management of [Ms A] on 24 November 2010 was consistent with expected standards with the exception of compliance with the DHB 'Verbal orders' policy.

(v) It remains unclear whether [Ms A] received the stat dose of oral olanzepine prescribed by [Dr M] on 24 November 2010. It was charted as a stat 'once only' dose rather than PRN, therefore if the doctor's orders were not followed (as appears to be the case) the reason for this should have been documented on the drug chart. Failure to do this, or to have recorded the timing of administration if the medication was given, is a mild to moderate departure from expected standards."

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