Registered Nurse, RN K

Registered Nurse, RN O

Registered Nurse, RN P

Canterbury District Health Board

A Report by the

Deputy Health and Disability Commissioner

(Case 13HDC01375)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mr A had been a resident at a rest home for about a year. Mr A had a complex medical history and had been diagnosed with bi-polar affective disorder.

Admission to the psychiatric hospital

2. On a Friday in mid 2013[1], Mr A was admitted to a psychiatric hospital as a voluntary patient. Registered nurse (RN) RN I conducted Mr A's nursing assessment on admission. The Nurse Manager at the rest home, NM N, had agreed with RN G at the psychiatric hospital that she (RN G) would inform Mr A's family of his admission. However, RN G did not do so.

3. On Saturday, RN I was allocated the care of Mr A on the afternoon shift. As the night progressed, Mr A was adamant that he was going back to the rest home, and asked staff to take him there. Mr A was kept at the psychiatric hospital.

Saturday night shift

4. Overnight on Saturday, RN O and RN K were on duty. RN O stated that routine hourly observations of the whole ward occurred. At 3.30am RN O heard water running in Mr A's room. RN O went to investigate and found Mr A on the floor mostly naked, with his walker frame near the end of the bed.

5. RN O said that she approached Mr A, touched his shoulder and spoke his name approximately three or four times to see if he would rouse. Mr A did not rouse to voice or gentle touch. RN O observed that he was breathing at a normal rate and rhythm and appeared to be asleep. She placed a blanket over him to keep him warm and to maintain his dignity.

6. RN O returned to the office and told RN K, and asked him whether they should wake Mr A. RN K said that he and RN O then observed and assessed Mr A, including his breathing, colour, response, position and comfort. RN K said that in his experience it is not unusual to find patients sleeping on the floor during the night. RN O and RN K made the decision to leave Mr A sleeping on the floor. They did not consider the possibility that Mr A might have fallen.

Sunday morning shift

7. On Sunday, RN Q (shift leader), RN P, RN J, RN R, and Enrolled nurse (EN) EN S were rostered on the morning shift. RN P volunteered to work with Mr A. Following handover, RN P checked on Mr A and said that he appeared to be asleep on the floor on his back, breathing regularly, that his colour was satisfactory, and he did not cause any concern.

8. At approximately 1pm, RN P and RN J attempted to move Mr A from the floor to the chair, during which he did not rouse or make any movement. However, they needed help, and so asked RN R to help lift him into a chair.

[1] Relevant dates are referred to as days of the week to protect privacy.

Sunday afternoon shift

9. RN I was in charge of the afternoon shift. She said that RN P told her at handover that Mr A was still asleep as a result of over-sedation, because he had been given 40mg temazepam the previous night. RN I checked Mr A with RN P at RN P's request, and found Mr A sitting in a chair. RN I said that when she touched Mr A she noticed that his body felt cold, and he looked very pale. RN I took Mr A's observations and, together with RN P, transferred him to the bed. He did not show any signs of responding to staff.

Transfer to the public hospital

10. RN I called the duty house surgeon, who came to review Mr A and rang an ambulance to transfer him to the public hospital. At 5.05pm the ambulance arrived.

11. The duty nurse manager at the public hospital telephoned Mr A's son, Mr D, and told him to go to the hospital straight away. Mr A's family had not been advised of his admission to the psychiatric hospital, nor had they been contacted during his stay there.

12. Mr A arrived at the Emergency Department at approximately 5.34pm. Following a CT scan, a large subdural bleed on the right side of the brain was identified but was considered too extensive to treat. Mr A died at 11.51pm.

Findings

13. RN O failed to assess Mr A adequately when she found him on the floor at 3.30am on Sunday. RN O did not provide Mr A with services with reasonable care and skill and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[2] RN K also failed to assess Mr A adequately and breached Right 4(1) of the Code.

14. RN P failed to review Mr A's clinical notes correctly, and failed to assess him adequately. For these reasons, RN P did not provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code. Adverse comment is also made about RN P's failure to respond to the concerns raised by her colleagues.

15. CDHB staff failed to communicate with Mr A's family regarding his admission to the psychiatric hospital. By not doing so, CDHB did not comply with legal standards and breached Right 4(2) of the Code.[3]

16. CDHB breached Right 7(7) of the Code,[4] as Mr A was prevented from leaving the psychiatric hospital despite his voluntary status and his express wish to return to the

[2] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[3] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."
[4] Right 7(7) of the Code states: "Every consumer has the right to refuse services and to withdraw consent to services."

rest home. CDHB also failed to ensure continuity of care, and breached Right 4(5) of the Code.[5]

17. Adverse comment is made about CDHB regarding the environment, culture, and its failure to ensure that its staff were familiar with its policies and protocols at the psychiatric hospital. Adverse comment is also made about RN Q's suboptimal leadership.

Complaint and investigation

18. The Commissioner received a complaint from Mr B about the standard of care provided to his father, Mr A, while he was a patient at the psychiatric hospital. The following issues were identified for investigation:

- *The appropriateness of the care provided by RN P to Mr A in 2013.*
- *The appropriateness of the care provided by Canterbury District Health Board to Mr A in 2013.*

19. On 10 September 2014, the investigation was extended to include the following issues:

- *The appropriateness of the care provided by RN O to Mr A in 2013.*
- *The appropriateness of the care provided by RN K to Mr A in 2013.*

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

21. The parties directly involved in the investigation were:

Mr B	Complainant (consumer's son)
Mr D	Consumer's son
Consumer's wife	
Consumer's ex-wife	
Canterbury District Health Board	Provider
The rest home	Consumer's rest home
Dr C	Consultant psychiatrist
Dr E	Registrar
GP and psychiatric medical officer	
Dr F	House officer
RN G	Registered nurse
RN H	Registered nurse

[5] Right 4(5) of the Code states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services".

RN I	Registered nurse
RN J	Registered nurse
RN K	Registered nurse
RN L	Registered nurse
RN M	Registered nurse
NM N	Nurse Manager, the rest home
RN O	Registered nurse
RN P	Registered nurse
RN Q	Registered nurse
EN S	Enrolled nurse

Also mentioned in this report:

Dr T	Neurologist

22. Information was also reviewed from the New Zealand Police.

23. Independent expert nursing advice was obtained from Registered Nurse Toni Dal Din (**Appendix A**).

Information gathered during investigation

Background

Mr A

24. Mr A had been a resident at the rest home for about a year. His wife had lived at another rest home since her health had deteriorated. Mr A visited her fortnightly.

25. Mr A had a complex medical history and had been diagnosed with bi-polar affective disorder. In addition, he had a number of co-morbidities, including (amongst other things):

- hypothyroidism;
- ventriculoperitoneal shunt inserted for presumed normal pressure hydrocephalus;[6]
- a stroke (CV);
- myocardial infarction;[7]
- hypertension;[8] and
- previous prostatectomy.[9]

[6] Ventriculoperitoneal shunts are inserted when there is too much cerebrospinal fluid in the brain and spinal cord (hydrocephalus), which causes higher than normal pressure on the brain and can cause brain damage.
[7] A myocardial infarction (heart attack) occurs when blood stops flowing properly to a part of the heart, and the heart muscle is injured because it is not receiving enough oxygen.
[8] High blood pressure.
[9] A surgical operation to remove all or part of the prostate gland.

26. Mr A mobilised with a walking frame and was a known falls risk.

27. Since 2002, Mr A had been cared for by a specialist mental health service (MHS). Mr A had had three admissions to the psychiatric hospital over that time. He had not had an inpatient admission for mental health issues since 2006.

28. Mr A had resided in several different rest homes before the rest home. He was referred to the Psychiatric Service for the Elderly (PSE) by either the MHS team or a rest home on four occasions, once in 2001, once in 2011, and twice in 2012. The referrals requested an assessment of his needs and/or assistance relating to his rest home placements. None of the referrals sought a transfer of care from MHS to PSE, although one requested a "comprehensive review of needs". A transfer of care was not suggested by PSE in response to the referrals.

29. Rest home clinical records show that Mr A was reviewed 23 times by his GP during the six and a half months he was there. Mr A's GP was steadily reducing his medications because of his poor function, including his falls risk. Mr A's GP told CDHB that following the reduction in Mr A's medication, his speech and his ability to play music improved.

Inpatient Unit X

30. Inpatient Unit X is an inpatient ward at the psychiatric hospital that typically treats patients aged 18–65 years. At the time of Mr A's admission, RN L was acting Charge Nurse Manager (CNM), as the regular CNM was on leave during that period.

31. Inpatient Unit X opened to patients shortly before Mr A's admission. It had been created by dividing and refurbishing another ward into two separate units.

32. RN L said that he contacted all new staff who were to work in Inpatient Unit X to offer orientation. RN L stated that there was no formal orientation guide or checklist. He said that the orientation consisted of him showing the new staff the ward layout. RN L stated: "I am satisfied that all staff were provided with the opportunity for an orientation to the new [Inpatient Unit X]."

MHS Inpatient Falls Prevention & Management Protocol

33. The MHS Inpatient Falls Prevention & Management Protocol (Falls Protocol)[10] provides that a fall is a sudden unintentional change in position causing an individual to land at a lower level on an object, the floor or other surface. The Falls Protocol also states that a fall includes the situation where a person found on the floor cannot explain how he or she got there.

34. The Falls Protocol states that, following a fall, the nursing review should include recording baseline observations, and recording neurological observations where a head injury has occurred or cannot be excluded. A medical review should be arranged if there are signs of injury or possible injury, and the consumer's family/whānau must be informed of the fall as soon as possible.

[10] Issue date 18 April 2013.

Medication review

35. On Wednesday, prior to Mr A's admission to the psychiatric hospital, the Nurse Manager (NM) at the rest home, NM N, telephoned Mr A's registered nurse from MHS, RN G, alerting her that Mr A had become elevated in mood over the previous three days. RN G asked whether Mr A's GP had changed any of his medications, and for the rest home staff to send through his prescription sheet for the MHS registrar, Dr E, to review. Dr E advised that Mr A's risperidone[11] should be increased to 2mg bd (twice daily), his temazepam[12] be increased from 10mg to 20mg, and his lorazepam[13] PRN (as required) be increased up to a maximum of 4mg per 24 hours.

Friday

MHS review

36. On Friday at 3.15am, staff from the rest home found Mr A lying on the floor laughing. He was transferred back to bed. At 2.30pm he was reviewed by RN G and Dr E. Dr E made an entry in the progress notes that Mr A:

- presented as energised (walking very fast with his walker frame, frequently leaving it and mobilising without it);
- was pressured,[14] expansive,[15] giggly and flirtatious; and
- was very frail physically and a significant falls risk.

37. Dr E noted that staff from the rest home said that Mr A had not been sleeping, had been very demanding, had been in and out of other residents' rooms, and had had at least one fall in the past 24 hours because of mobilising without his frame. Dr E had also noted that the rest home staff had not noticed any improvement from the recent increase in his medications.

38. Rest home staff stated that they felt unable to care for Mr A adequately in his current mental state. Dr E contacted consultant psychiatrist Dr C, who agreed to admit Mr A to the psychiatric hospital. Dr C stated that she discussed the need for Mr A's admission to hospital with Dr E, and they also discussed his recent fall at the rest home, and that he might need "specialling"[16] in hospital.

39. Dr E recorded in Mr A's progress notes a request that a physical examination of Mr A be conducted, including a "thorough neuro". Dr E recorded that Mr A appeared to be leaning to the right side while mobilising, and that he had a history of left side weakness, and noted: "C[o]nsider CT head." Dr E further increased Mr A's risperidone to 4mg and his PRN lorazepam to a maximum of 6mg per 24 hours. There

[11] Risperidone is an antipsychotic drug mainly used to treat schizophrenia, schizoaffective disorder, the mixed and manic states of bipolar disorder, and irritability in people with autism.
[12] Temazepam is a drug used for treating anxiety.
[13] Lorazepam is a drug used for treating anxiety.
[14] "Pressured" is a term used to describe someone with pressured speech. It is where someone talks at an accelerated pace as if motivated by an urgency that is not apparent to the listener. It is a common symptom of bipolar disorder.
[15] An expansive mood is where someone is relaxed, frank and communicative.
[16] "Specialling" refers to a level of nursing observation.

is no record of any consultation between Dr E and the consultant, Dr C, about Mr A's medication, particularly the doses and interactions.[17]

Transfer to hospital

40. Following Mr A's review at the rest home, RN G telephoned Inpatient Unit X to advise staff that Mr A was coming into hospital. She spoke to a clinical nurse specialist, who completed an Admission Reviews Form (the form does not have a place for staff to record who completed the form). For "family involved/consulted", "no" was ticked, "vulnerability risk" was ticked, and "falls risks" has an asterisk beside it. At the bottom of the form it states that Mr A "may need 1:1 special".[18]

41. At approximately 4.15pm, RN G and Dr E transported Mr A from the rest home to the psychiatric hospital by car. There is no record of whether Mr A was agreeable to being admitted to the psychiatric hospital. Mr A's family were not contacted and advised of the transfer from the rest home to the psychiatric hospital.

Admission to the psychiatric hospital

Voluntary patient

42. Mr A was admitted to the psychiatric hospital as a voluntary patient. There is no record of any consideration of the use of the Mental Health (Compulsory Assessment and Treatment) Act 1992, nor is there any record of Mr A's competence being assessed.

Family contact

43. The CDHB Specialist Mental Health Service policy titled "Family and Whanau Involvement in the Consumer's Treatment" states that "Specialist Mental Health Services are committed to respectful and responsive relationships with family and whanau that support and promote participation and partnership". The policy states that staff have a responsibility to build partnership with families and provide opportunities, with the consumer's consent, to be involved in assessment and admission, clinical reviews, planning reviews, discharge and the like. The policy also states that the extent to which family members are involved in treatment and support is ultimately the consumer's decision, and staff will ensure that the consumer has the opportunity to review his or her family's involvement regularly.

44. The CDHB Serious Incident Review Report states that NM N had agreed with RN G that she (RN G) would inform Mr A's family of his admission to the psychiatric hospital. However, RN G did not do so. CDHB stated:

> "A broad range of MHS staff had responsibilities regarding contacting [Mr A's] family when he was admitted to the psychiatric hospital, including inpatient, outpatient, nursing and medical staff. Despite this, [Mr A's] family were not informed of his admission to the psychiatric hospital."

[17] The CDHB's Serious Incident Review Report noted that Mr A's doses of psychotropic medications were outside the ranges normally suitable for older people.
[18] See footnote 16.

Admission assessment

45. RN I told HDC that she had known Mr A for some time because she had nursed him while she was a member of the community mental health team. RN I stated that, on admission, Mr A presented as flirtatious, irritable with elevated mood, and very disorientated, and at times he was difficult to understand with slurred speech. She stated that Mr A's level of unwellness, and his accent, made him hard to understand at times.

46. RN I admitted Mr A and completed the admission documentation. RN I completed page one of the "Acute Inpatient Service Admission Checklist" but did not complete page two ("Actions Relating to Family/Whanau" are on page two of the checklist).

47. RN I conducted a physical examination of Mr A and noted that he had "no obvious physical injuries, wounds, bruises etc". "No issues with bladder" was noted despite his incontinence, and no disabilities in speech and gait were recorded, despite his speech difficulties and need to mobilise with a walking frame.

48. Mr A and RN I signed the initial treatment form. The form provides: "I have the right to refuse any treatment or withdraw my consent to treatment at any time (unless provided by law e.g. Mental Health Act)".

49. In Mr A's progress notes, RN I recorded that Mr A was a falls risk, he had had a fall the previous day, and he was listing to the left. She recorded that Mr A was incontinent of urine, would require toileting, and wore incontinence pads. She also recorded that he was an AWOL (Absent Without Leave) risk, and noted that he should be nursed on a "known whereabouts" basis because he was continually talking about going back home.

Medical review

50. At 7.45pm, House Officer Dr F conducted a brief medical check of Mr A. Dr F stated that he was asked by the nurses to see him "as per protocol", and did not receive any other information regarding Mr A's admission. Dr F said that he did not have any documentation other than the request for physical examination from the nurse and a brief note that Mr A had been admitted.

51. Dr F spoke to Mr A, conducted a brief examination, and noted that Mr A's gait was "slow". Dr F said that Mr A told him that slowness had been long-standing, and that he did not have any current symptoms. Dr F stated that he felt that Mr A's gait was caused by a combination of stroke and hydrocephalus. Dr F stated: "His admission was mainly a psychiatric problem and therefore I had not instigated further investigations other than routine bloods and ECG.[19] After the brief encounter, I have not met Mr A since." Dr F did not record Mr A's dysarthria,[20] use of a walking frame, or truncal lean.

[19] ECG or electrocardiogram is a test that checks for problems with the electrical activity of the heart.
[20] Dysarthria is a condition in which there is difficulty controlling or coordinating the muscles used when speaking, or weakness of those muscles.

Medication

52. RN I administered Mr A PRN lorazepam 1mg at 6.20pm. At 9pm, RN I administered Mr A sodium valproate 1000mg, lithium 500mg, risperidone 2mg, Laxsol 2 tablets, paracetamol 1g and temazepam 40mg. At 9.30pm, he had an increased level of agitation and restlessness, and was given lorazepam 1mg.

53. Overnight, Mr A was nursed with 60-minute observations, and was asleep on all checks prior to 5am, when he was awake briefly before going back to sleep.

Saturday

54. On Saturday at 2.51pm, RN H noted in Mr A's progress notes that his speech was slurred and he was restless. She noted that he had spent most of the shift "wandering around ward with 4 wheel 2 caster, mostly using it well however occasionally caught away from it. When standing still or seated [he listed] over to the left requiring prompting/support to rebalance." She also recorded that Mr A was preoccupied with the doors, pushing the door release button several times. He was noted to be a moderate falls risk and an AWOL risk, and was on 30-minute observations.

55. RN I was allocated the care of Mr A on the afternoon shift. The shift commenced at 3.10pm. In Mr A's progress notes she recorded that he was very pleasant during the early part of the shift but, as the night progressed, he was adamant that he was going back to the rest home that night, and asked staff to take him there. RN I noted that he remained at risk of going AWOL and was observed pushing the door release at the main entrance in an attempt to leave the ward. Mr A was not taken back to the rest home and remained at the psychiatric hospital.

56. RN I also recorded in Mr A's progress notes that he was a moderate to high risk of falls because he was walking without using his walker, and because of the medication that he had been administered. RN I noted that Mr A was given PRN lorazepam as charted. He refused to take it from her, but another nurse was able to give him the medication. The clinical notes record: "PRN lorazepam 1mg given at 19.30 and 21.30 with some settling effect."

57. RN I recorded in Mr A's progress notes that he was prescribed 40mg temazepam at night but he agreed to take only 20mg of the prescribed dose, so the extra 20mg was left in a pottle in the drug cabinet. RN I stated that later in the evening Mr A became restless but eventually went to sleep.

Saturday night shift

58. RN O stated that she was on duty on the night shift on Inpatient Unit X with RN K plus a staff member who floated between all four wards. RN O said it was her first shift working on Inpatient Unit X with new colleagues and new patients. RN K said that this was his second shift following his transfer to Inpatient Unit X.

59. RN O stated that she and RN K received a verbal handover from the afternoon shift staff nurse.

60. RN O stated that routine standard hourly observations of the whole ward were commenced as per ward/CDHB protocol. RN K did the 11pm round with a staff nurse from the afternoon shift. At approximately 1.30am, Inpatient Unit X received a new admission, and RN O oriented that patient into the ward.

61. RN O stated that this was her first time nursing Mr A. She said that Mr A was asleep at the commencement of the shift, but there was a period of about two hours in the early morning when he was awake. She overheard him briefly talking in his bedroom and, at about 2am, observed him sitting on the side of his bed. RN O stated that Mr A did not indicate during the rounds that he required any help, and he appeared comfortable.

62. RN O stated that at 3.30am, when she was on her way back to the office after having checked a patient, she heard water running in Mr A's room, so she went in to investigate. She stated:

> "The bedroom light was on and I found [Mr A] lying on his bedroom floor, mostly naked. He had socks on his feet and a shirt that was semi tucked underneath and to the side of him. The hot water was running in his en-suite and I turned this off. [Mr A's] walker frame was near the end of the bed close to the entrance of the en-suite. [Mr A] was lying next to and closely alongside of his bed with his feet facing the en-suite and head toward head end of his bed. He was lying on his back but slightly on his right side, with his left arm resting on his chest."

63. RN O approached Mr A, touched his shoulder, and spoke his name approximately three or four times to see if he would rouse. Mr A did not rouse to voice or gentle touch. She observed that he was breathing at a normal rate and rhythm and appeared to be asleep. RN O did not consider the possibility that Mr A could have had a fall.

64. RN O placed a blanket over Mr A to keep him warm and to maintain his dignity because he was mostly naked. She told HDC: "[Mr A] was observed to respond in facial movement and slightly stirred when the blanket was placed over him but he did not wake."

65. RN O returned to the office and told RN K the above information. She asked RN K whether they should wake Mr A. RN K stated that he and RN O observed and assessed Mr A including his breathing, colour, response, position and comfort. RN K said that in his experience it is not unusual to find patients sleeping on the floor during the night. He said: "This could be in a semi or undressed state, with or without bedding, driven by their illness, or purely a matter of choice." RN K also did not consider the possibility that Mr A could have had a fall.

66. RN K said that they had not heard Mr A fall or call out prior to their assessment of him and, as he appeared to be quite comfortable and was sleeping soundly, he (RN K) was prepared to let Mr A continue to sleep.

67. RN K stated that during the hourly observation checks at 4am, 5am, 6am and 6.50am it was observed that Mr A was comfortable with appropriate colour, was breathing

soundly and appeared to be asleep. No vital signs were recorded overnight. At 6am, RN K recorded in the progress notes: "Checked and attempted to rouse at 0600hrs. Snoring soundly and looks comfortable. Will check again at 0700hrs with day staff."

68. RN K acknowledges that he did not undertake adequate physical and neurological assessments of Mr A but, instead, based his assessment on the experience he has had in the past with patients with mental illness. RN K stated that undertaking those assessments may have led to Mr A's fall being discovered sooner.

69. RN O stated that she checked on Mr A during the night more frequently than usual in between checking on other patients because he was lying on the floor. She stated that those checks were not formally documented and were something she did with the expectation that he would eventually wake and either get himself back into bed independently or require assistance to do so. RN O stated that on one occasion she spoke Mr A's name out loud to see if he would rouse, but he did not do so.

70. RN O stated:

> "From previous experience and my personal observation in mental health it is not unusual to find patients who are elevated in mood, to be disorganised, muddled or forgetful and driven fighting tiredness and sleep to eventually succumbing to this, or the eventual effect of PRN medication or sleep medication during whatever it may be that they are doing and in any number of awkward positions such as being on the floor. When working with patients who are manic in presentation, resetting their sleep routine/pattern to normal is an essential component to recovery. Therefore, sleep becomes a primary course of action. Weighing up the fine balance between beneficial and unbeneficial is considered at all times. In my experience, sometimes waking a patient can potentially stimulate and return them back into an elevated state. As [Mr A] had already been awake for a period of time during the night and considering there were only a few hours remaining until morning it was not considered unethical to allow hi[m] to sleep briefly while on the floor which was carpeted and had underfloor heating."

Handover to morning shift

71. RN K stated that, at 6.50am, RN J arrived, and together they conducted a routine check of the patients. When they reached Mr A's room, Mr A still appeared to be sleeping soundly and comfortably. RN K said that he updated RN J about the events of the night and asked RN J whether she wanted RN K and RN O to lift Mr A back onto his bed, and RN J replied that the day shift would look after that. In response to my provisional opinion, RN O said that she also recalls offering to assist the morning shift nurses to move Mr A. RN O and RN K both stated that, had their offer been accepted, moving him would have provided a further opportunity for his consciousness to be assessed.

72. RN O stated that at 7am she gave the handover to RN P, RN J, RN R and RN Q, during which she read out the ISBAR report[21] from the afternoon shift and verbally passed on information from the night shift. RN O stated: "I reiterated to my colleagues the events surrounding [Mr A] with the rationale for the actions taken given." In response to my provisional opinion, RN O said that, at handover, she recalls saying that she had not heard Mr A fall, and that "the possibility of a fall or the fact that more assessment should be undertaken was not raised by her colleagues who she handed over to".

Sunday morning shift — Staffing

73. On Sunday, the duty nurse manager was RN M. RN M stated that he was aware of Mr A's presence on the ward but had had no contact with him, and was not alerted to any issues with his care.

74. There were five staff working on the new ward that shift, four registered nurses and an enrolled nurse. RN Q was the shift leader. She stated that the ward had a high acuity and had "recently been opened as a new ward, with many features dreadfully incomplete, as is the current state, making it a difficult working environment". She said she was responsible for the allocation of patients to the nurses, and that she allocated Mr A's care to RN P because she (RN P) had asked to care for Mr A. RN Q said that RN P was well known for her holistic care of older patients with complex needs, and she (RN Q) was very confident of RN P's skill.

RN P

75. RN P is a registered nurse with a restricted scope of practice (mental health). She said that she had been employed by CDHB for many years, and had worked on the acute ward for much of that time. That ward had had an established core group of senior registered nurses for many years.

76. RN P stated that, at the time of these events, there were significant changes to the nursing rosters, which had a negative impact on the functioning of Inpatient Unit X. In response to my provisional opinion, she said that the changes made to the nursing roster also had a personal impact on her. She noted that during the weekend shifts there were no nurse managers or clinical nurse specialists on duty. In addition, shortly prior to Mr A's death, two clients whom she had nursed had committed suicide. RN P stated that on Friday at her regular supervision session she discussed with her supervisor that she felt as though she was struggling. Her supervisor suggested that she access EAP (employment assistance) counselling, and she was in the process of organising that support at the time of these events.

77. RN P noted that, on Sunday, three of the nurses (including herself) were working on the new ward for the first time. She stated that she found working in the new ward difficult, and felt overwhelmed and claustrophobic. She said that "there had been no induction or orientation to the new ward, no team development before the ward

[21] ISBAR (Identify, Situation, Background, Assessment and Recommendation) is a mnemonic created to improve safety in the transfer of critical information. The "I" in ISBAR is to ensure that accurate identification of those participating in handover of the patient is established.

opened and the regular CNM was on leave", and there were additional problems that morning as the alarm displays were not accurate and there were problems with the locks on the doors, the lighting was poor, and there was limited access to the computers. RN P stated: "Overall I felt we were lacking in the leadership needed for the move to be completed in a safe and professional manner."

Sunday morning shift — Care of Mr A

RN P

78. RN P said that she volunteered to work with Mr A on that shift because she was the only staff member who knew him from his previous admissions. RN P stated that she had not nursed Mr A since 2006, but recalled that when she had last nursed him, he would sometimes slump and lie on the floor.

79. RN P said that RN K told her that Mr A had been administered 40mg temazepam and PRN lorazepam in addition to his other medications. She stated:

> "I was cognisant that this was a significant quantity of sedating medication for any patient, particularly for [Mr A] who was elderly and physically frail. There was nothing in discussion with [RN K] that raised any concern about his presentation that alerted me to the possibility of a fall or other medical concern. I assumed from our discussion and my prior knowledge of [Mr A] that he had put himself on the floor as he had done previously and that the extent of his medication meant he was deeply asleep."

80. RN P stated that before reading the clinical notes she checked on Mr A and he appeared to be asleep on the floor on his back breathing regularly, and his colour was satisfactory and did not cause any concern. He was warm from the under-floor heating, and she placed a towel in the doorway to keep the door partly open to ensure privacy but also so that she and the other nurses could see him and hear him if he moved. RN P said: "As there had been no observable change in his presentation from hand over from the night shift, I did not complete a physical assessment at that time. I expected that he would be awake during the shift and my intention at this time was to move him mid-morning if he had not woken naturally."

81. RN P said that she reviewed the clinical records and noted that Mr A's medication had been increased. She felt that his presentation was similar to her previous experience of him, and that he was continuing to sleep because "everything had caught up with him from his admission and he was heavily sedated". Separate electronic patient information was used by the public hospital MHS and, as Mr A's outpatient notes had not arrived, she planned to review his notes more fully and add to the treatment plan later.

82. RN P recorded in Mr A's progress notes at 2.13pm: "… [A]ppears [t]emazepam 40mgs and PRN [l]orazepam utilised yesterday ? having sedating effect. Morning medications [withheld]." RN P stated that she withheld Mr A's morning medication as she felt he needed to sleep, given his unsettled psychiatric presentation on the previous two shifts, and his need to sleep off the effects of his sedating medication.

However, she did not get him up mid-morning as she had planned because a new patient was transferred to Inpatient Unit X, and her workload then became hectic.

83. RN P stated that she did observation checks of Mr A at 9am, 9.30am, 2pm and 2.30pm, and she was also required to second-check the controlled drugs, answer phones, and access a computer to commence her notes. She also started a treatment/care plan for Mr A.

84. RN P said that, on reflection, she should have discussed the new patient transfer with the shift leader, RN Q, and not agreed to take on the extra workload, as the result was that her work acuity increased and took her focus away from Mr A. RN P stated that around mid-morning she noticed RN J and EN S coming out of Mr A's room, and asked them if everything was all right. Her recollection is that they raised no concerns. She said that they then walked away, so she assumed there were no issues and did not go into Mr A's room herself, as she did not wish to disturb him. RN P stated:

> "With hindsight, I believe I missed an opportunity when I observed my colleagues coming out of [Mr A's] room to ask them for assistance to make [Mr A] more comfortable and undertake a more comprehensive physical assessment of him."

Other staff

85. RN Q stated that her involvement in Mr A's care during the shift was minimal. However, she was aware that he had been lying on the floor since 3am. She said it was not unusual in the acute mental health setting for patients to sleep on the floor. RN Q said:

> "Several times through the shift I stopped at his room, briefly visually observed him, and asked [RN P] if there was any change in his condition. Given his previous level of activation, and the medications given, his sleeping for a lengthy period appeared unremarkable. […] I understood that some recordings had been taken in the afternoon, which I'd been told by [RN P], but did not appear of sufficient concern to contact the House Surgeon[.]"

86. RN J was on the morning shift in Inpatient Unit X. She was allocated three patients for the day (but not Mr A). RN J stated that it is protocol on the ward to do half-hourly observations. There is a tick sheet and each staff member has allocated times when they will sight each patient and tick them off. That is usually done in one hour lots, so each staff member will do it twice in that hour. If a patient is not sighted on the round, the staff member will find the patient's key nurse and try to find out where that person is.

87. EN S said that she went into Mr A's room at 8.45am because she was concerned that nothing seemed to be being done for Mr A. She said she told RN P of her concerns, and was told by RN P that Mr A was over-sedated and that she (RN P) wanted to leave him to sleep until lunchtime.

88. EN S said she did an observation round at 11am and found that Mr A was still on the floor. She said:

> "I applied sternum rub, called his name and there was still no response, then a nurse came past ([RN J]) and I said to [RN J] that I was concerned and she said she was also concerned. [RN J] told me she had also questioned [RN P] about this and she also felt dismissed by her."

89. EN S said that she spoke to RN P and advised her what she had done, but that RN P again dismissed EN S's concerns about Mr A, and said: "Don't you think I know what I am doing?" EN S said she told RN R of her concerns about Mr A, and RN R replied that she also was concerned, but was aware that RN P intended getting Mr A up after lunch.

90. RN J stated that she is unsure how many rounds she did that day, but during the rounds Mr A appeared to be sleeping on the ground and was snoring. She said that on two occasions she went into his room and tried to rouse him by shaking his shoulder and calling his name, but he did not stir. During one round performed by EN S, both she and RN J went into Mr A's room and tried to wake him by calling his name and touching his shoulder. RN J stated that "on exiting the room [RN P] ([Mr A's] key nurse) told us to leave him asleep, he was fine".

91. RN J stated:

> "Throughout the day I commented to [RN P] and to the Charge Nurse, [RN Q], that I thought more attempts should be made to arouse [Mr A] due to his presentation the night before and the need for him to have his medication. I was told to look after my own patients and to leave [Mr A] to sleep."

92. RN R stated that her first encounter with Mr A was when she did the ward checks. The Observation Sheet shows that RN R conducted her first half-hourly observation check on Mr A at 8am. She opened the door of his room and observed that he was lying on the floor and appeared to be breathing, as his chest was moving. She then closed the door and carried on with the ward checks. She recalls discussion between a couple of nurses on the shift, and that they were all voicing their concerns about Mr A's care. She cannot recall the whole conversation or when the conversation occurred.

93. In response to my provisional opinion, RN P said that she has no recollection of the other staff "raising or drawing their concerns to [her] attention regarding Mr A's presentation". In particular, RN P told HDC that she has no recollection of:

a) the conversation with EN S noted in paragraph 89 above; or

b) EN S telling her that she (EN S) had applied a sternum rub and that Mr A had not responded; or

c) RN J advising her on two occasions that she (RN J) had tried to rouse Mr A by shaking his shoulder and calling his name; or

d) RN Q approaching her with concerns; or

e) informing RN I that she had taken Mr A's observations.

94. However, RN P said that she does recall:

a) RN J bringing other issues involving other patients to her attention but not Mr A; and

b) RN R asking about Mr A, but not in a manner that she understood at the time was expressing concern.

95. RN P also stated: "Irrespective of whether the nurses raised their concerns with me or with [RN Q] during the shift or not, I take full responsibility for not having properly assessed [Mr A] that day."

Mr A moved to a chair

96. At approximately 1pm, RN P and RN J went into Mr A's room to move him onto a chair. RN J said that they attempted to move Mr A from the floor to the chair, during which he did not rouse or make any movement. RN J said that she told RN P "that it didn't seem right, that he ought to stir or something". RN J said that RN P told her that Mr A was just over-sedated because he had been given 40mg temazepam the previous night. RN J said she repeated that this was not right, and that RN P replied: "Thanks, you are a new grad. I know what I'm doing. I have known [Mr A] for years, it's better that he sleeps."

97. RN J then said that they could not move Mr A alone, so she asked RN R to come in and help move him. RN R said that she took Mr A's feet, RN P took his upper body, and RN J took his legs. RN R stated that Mr A appeared warm, and he was pale and was breathing, but he did not respond to being lifted into the chair. RN R then helped to lean him forward to dress him in a shirt. She said she was surprised that they did not put Mr A into bed, but was happy that he was being lifted off the floor, as he had been lying there for a long period.

98. RN R stated that she asked what was wrong with Mr A, and RN P told her that he had been given 40mg temazepam, but then corrected herself and said that he had been given 30mg temazepam and had not slept for days.

99. RN J stated that RN R said to RN P that something was not right, but was "brushed off" by RN P. RN R stated that she had no reason to question RN P further, as she was aware that RN P was a senior nurse who had been working in mental health for many years and had knowledge of Mr A's health issues, what medication had been charted, and what he had taken. RN R stated that she had no knowledge of Mr A's medical or mental health history, and had not read his clinical notes or medication chart. She stated that RN P was confident and dismissive of her questioning, and that led her to believe that RN P had the ability to make sound decisions.

100. In contrast, RN P stated: "[M]y recollection is that neither of them mentioned any concerns to me about his condition." She stated that her focus was on getting Mr A off the floor and into the chair and, if the nurses had told her that they were concerned,

she would have responded to them immediately and discussed their concerns with them.

101. RN P stated that while they were putting on Mr A's shirt, she observed that his skin was warm, his breathing was regular, and he was not slouched or dribbling. She said she visually checked for facial weakness, and that she found no resistance when dressing him. She said that Mr A was not falling forwards, and there was no stiffness in his body. She was aware that he had had previous strokes, and she checked for any prominent lean, but he did not fall to the left or the right. RN P did not document these observations.

102. RN P stated that she discussed Mr A with RN Q, and said:

> "We both discussed what it was like in previous times when patients came into the wards manic and would sleep the entire shift. In terms of the conversation I understood that we both believed he was asleep. […] [RN Q] did not raise any issues or concerns regarding [Mr A] with me at that time about the length of time he had been asleep."

103. RN P acknowledged that she failed to recognise the change in Mr A's physical state. She said: "If I had completed a comprehensive physical assessment I would have been able to act on the results and discuss these with my colleagues and the house surgeon." RN P also said that there was nothing to stop the other three nurses undertaking their own physical assessments of Mr A. None of the nurses informed the duty nurse manager of their concerns.

Handover to afternoon shift

104. RN I was in charge of the afternoon shift on Sunday. Her shift commenced at 3.10pm, but she told HDC that she was at work by 2.30pm. Handover was at 3.10pm, and she said that RN P told her that Mr A was still asleep as a result of over-sedation, because he had been given 40mg temazepam the previous night. RN I said that RN P told her that she had taken Mr A's vital observations, and they were within the normal range. RN J said that she was present at the handover, but she had not seen RN P take vital observations at any time during the day. RN P made no record of any observations.

105. RN I stated that after staff allocation she checked Mr A with RN P at RN P's request, and found Mr A sitting in a chair. RN I said that when she touched Mr A she noticed that his body felt cold, and he looked very pale. Mr A's body temperature was 33.3–34.3°C,[22] his heart rate was 50 beats per minute,[23] respirations 12 breaths per minute,[24] blood pressure 125/65mmHg,[25] and he had been incontinent of urine.

Ambulance called

106. RN I and RN P transferred Mr A to the bed and put him in a recovery position. He did not show any signs of responding to staff. RN I called the duty house surgeon, who

[22] Normal body temperature is 37°C.
[23] Normal resting heart rate for an adult ranges from 60 to 100 beats a minute.
[24] Normal respiration rate for an adult at rest ranges from 12 to 16 breaths per minute.
[25] Normal is 120/80mmHg.

came to review Mr A and rang an ambulance to transfer him to the public hospital. RN I stated that she shifted furniture out of Mr A's room to allow for better access, before going out to the main entrance to meet the ambulance crew to guide them to the ward.

107. At 5.05pm the ambulance arrived at the psychiatric hospital, and the crew were provided with a verbal handover. Mr A was moved from the bed to the trolley, and then became acutely unwell with obvious respiratory distress, dry retching, and change in the colour of his face. He was assessed by the ambulance staff, who later told CDHB that he had a Glasgow coma scale of three,[26] "snoring" respirations, and was not able to be roused. His pupils were fixed, and he was centrally cyanosed[27] and had a respiratory rate of eight breaths per minute. His body temperature was low at 34.1°C.

108. The duty nurse manager at the psychiatric hospital telephoned Mr A's son, Mr D, who lives in another region, and informed him that his father was "critical", and that he needed to go to the public hospital straight away. Mr D contacted his brother, Mr B, who lives nearby, and Mr B went directly to the Emergency Department (ED) at the public hospital.

Arrival at ED

109. Mr A arrived at ED at approximately 5.34pm. Following a CT scan, a large subdural bleed[28] on the right side of the brain was identified, with further bleeding of the cerebellum[29] and the fourth ventricle.[30] Following discussions between the medical and neurosurgery teams at the public hospital, it was decided that the bleed was too extensive to treat actively. Discussions took place with Mr B, who was present, and with Mr D by telephone. Mr A was ventilated until Mr D arrived. At 11.15pm his breathing tube was removed, and he died at 11.51pm.

Contact with family

110. Following Mr A's death, the CDHB review team met with Mr A's sons and his former wife. The family expressed concern about a range of issues, including the lack of family involvement in Mr A's care.

111. Mr A's family did not know that he had been admitted to the psychiatric hospital, and the first time they became aware that he was not at the rest home was when Mr D received the call to say that his father was critical and on his way to the public hospital.

[26] Indicating deep unconsciousness.
[27] Central cyanosis (usually recognised by blue colour around the core, lips, and tongue) is often due to a circulatory or ventilatory problem that leads to poor blood oxygenation in the lungs. It develops when arterial oxygen saturation drops to ≤85%–≤75%.
[28] A subdural bleed is a type of haematoma, usually associated with traumatic brain injury. Subdural haematomas are often life-threatening when acute.
[29] The cerebellum is a region of the brain that plays an important role in motor control. It may also be involved in some cognitive functions such as attention and language, and in regulating fear and pleasure responses.
[30] The fourth ventricle is one of the four connected fluid-filled cavities within the human brain.

112. The family was also concerned that their father had not contacted them while he was at the psychiatric hospital, especially when he wanted to leave the hospital, as they felt that the failure to make contact was out of character.

113. They were also concerned at the manner in which Mr A's desire to leave the hospital was managed, given that he was a voluntary patient, and noted that Mr A's family members were often able to settle him when he was agitated or distressed. Mr A's wife, who lived separately from him, had also not been told by MHS staff that he had been admitted to the psychiatric hospital.

Other comment

RN P

114. RN P told HDC that education sessions on the medically deteriorating patient were not available to her.

115. RN P stated that since these events she has been assessed comprehensively by a consultant psychiatrist who considers that she was experiencing an acute stress disorder, and that it is likely that her performance was influenced at that time by her mental state, rather than indicating more pervasive deficits in her professional attitudes or conduct. She said that she continues to require medical support.

RN K

116. RN K stated that staff morale was low at the time of the incident, and had been low for some years because of the changes proposed and brought about by restructuring and rebuilding, on top of the effects of the on-going earthquakes. Teams who had worked together for years were being split up, and staff were being transferred whether they agreed or not. He said that there was no formal orientation, and the new Inpatient Unit did not appear to be properly equipped, as it was equipped with second-hand items from older wards.

117. RN K said that he was not aware of the Falls Protocol (discussed at paragraphs 33 and 34), and does not recall the protocol being brought to his attention at any time. He said that he had been employed by CDHB for about four years at that time, and when his employment commenced he did not receive an induction.

RN O

118. RN O stated that there were additional factors present at the time, in particular the restructuring and transfer of staff. In response to my provisional opinion, she said that the poor work environment at the psychiatric hospital, and the ongoing construction within and around Inpatient Unit X at the time of Mr A's death, placed a great deal of stress on the hospital staff.

119. RN O told HDC that she also did not receive any training on the Falls Protocol, and does not recall the protocol being brought to her attention.

CDHB

120. CDHB stated that it does not accept that the changes made to the nursing rosters impacted negatively on Inpatient Unit X. It stated that the service went through a

robust consultation process with staff and unions to realign staffing from three 28-bed wards into four 16-bed wards. The staff mix in the three existing wards was made up of two-thirds existing staff and a third new staff from outside the service.

121. CDHB said that the staff complement for Inpatient Unit X was made up of a third from each of the three existing wards, and staff were able to have input into the roster and the team they preferred to work with when the nursing structure was circulated. CDHB said that only a small number of staff asked for a change.

Subsequent events

RN P

122. CDHB conducted an internal investigation into the care provided by RN P to Mr A. RN P is no longer employed at CDHB.

CDHB Serious Incident Review

123. A Serious Incident Review was undertaken by CDHB and completed on 6 January 2014.

Police investigation

124. Following Mr A's death, the Police commenced an investigation.

125. In the course of the Police investigation, expert advice was obtained from a neurologist, Dr T, who noted that Mr A had had an intra-ventriculoperitoneal CSF shunt for suspected normal pressure hydrocephalus inserted in 2010, which may have predisposed him to a subdural haematoma and a rapid expansion of the bleed.

126. Dr T noted that Mr A was being administered aspirin and clopidogrel,[31] which would have increased any bleeding tendencies. Mr A had been sedated with 20mg temazepam and 2mg lorazepam. Dr T said that Mr A's usual dose was 40mg temazepam, but the total dose of benzodiazepines[32] (temazepam and lorazepam) he received was equivalent to that. Dr T stated that temazepam is well absorbed and has a relatively short elimination half-life of approximately 10 hours. Peak levels of the drug occur 35–65 minutes after administration of the capsules.

127. Dr T said that peak concentrations of lorazepam occur approximately two hours following administration, and the half-life of lorazepam in human plasma is approximately 12–16 hours. He stated that "taken at 9pm the sedatives are likely to have produced significant depression of consciousness at 3am". He opined:

> "I have reviewed his CT scan which shows a large subdural haematoma sufficient to threaten life but also shows a brain stem haemorrhage which has ruptured into the fourth ventricle … It seems fairly certain that he fell, suffered a rapidly progressing subdural and brain stem compression then secondary brain stem haemorrhage."

[31] Clopidogrel is an oral antiplatelet agent used to inhibit blood clots in coronary artery disease, peripheral vascular disease, and cerebrovascular disease.
[32] Benzodiazepines are a class of psychoactive drugs.

128. Dr T considered that Mr A suffered a rapidly progressive and severe bleed, suggesting a very rapid progression to coma. He advised that it would have taken minutes to hours after the bleed for the deeper coma to develop.

129. The Police advised HDC that its investigation is now closed.

Action taken following the incident

130. Following a Serious Incident Review, CDHB implemented a number of systems improvements, including (amongst other things) the following:

a) All Acute Intervention Service nursing staff have completed the Fall Training course and a record of attendance has been kept. A proposal has been developed to ensure the course is incorporated into the mandatory training requirements for all nurses. The Fall Screening tool is included in all admission files, which is audited weekly by the clinical nurse specialists.

b) Any consumer who has a fall is followed up by the CNM/Clinical Nurse Specialist or after-hours clinical team co-ordinator to ensure strategies are put in place, and these are reviewed as required.

c) Training has also been provided to staff in identifying levels of consciousness and identifying the deteriorating patient.

d) The admission checklist has been reviewed to ensure that family are contacted at the point of admission and, if that is not possible, it is handed on to the next shift to do so. The service is developing systems to ensure family contact at all critical points of care.

e) The on-call arrangements for psychiatrists on the weekend have been reviewed to ensure that they review all patients who have been admitted within the previous 24 hours but have not had a psychiatrist review.

f) A memo has been sent to all doctors in the Specialist Mental Health Service to clarify that, in the community, the consumer's GP takes responsibility for prescribing for their patients.

g) The Specialist Mental Health Service policy titled "Prescribing Medication" has been branded obsolete, and the need to pay attention to prescribing in the elderly has been added to the emergency sedation policy.

h) The roles and responsibilities of the nursing shift leaders have been clarified.

131. In response to my provisional opinion, CDHB advised that it has made the following recent changes to its Adult Inpatient Service:

a) CDHB has established a new layer of clinical leadership called Clinical Team Coordinators to coordinate after-hours multidisciplinary teams. The Clinical Team Coordinators are responsible for providing advanced clinical care, advice, and guidance to inpatient staff and are expected to take a leadership role in complex situations.

b) The new graduate nurse orientation package now includes a multi-layered learning framework called "Speak Up", which is designed to help new graduates speak out safely if they have concerns about patient care.

132. RN K told HDC that a number of changes were implemented following Mr A's death, including:

a) The introduction of the Early Warning Score system to aid in recognising clinically deteriorating patients.

b) Baseline observations are now taken routinely on all patients on admission regardless of the state of their physical health.

c) Staff will now record and hand over to other staff that a patient has a preference to sleep on the floor. If a patient is found asleep on the floor and it is not recorded as his or her preference, the patient will be roused and his or her observations taken.

133. RN K stated:

> "This incident has had a profound effect on me personally and professionally. On a personal level, I feel responsible, as do many of my colleagues. As well as changes that have been employed throughout the ward, I have also made changes in my practice. I am more strongly aware of the need to gain a fuller picture of the patients under my care …"

134. RN O stated that following Mr A's death, the course "When Caring for the Medically Compromised Patient" was introduced and made mandatory for all staff.

135. RN O told HDC that she is particularly vigilant at keeping up to date with all new and amended CDHB policies. RN O now also writes a brief note on each patient during handover to give herself a general overview of the ward.

136. RN P told HDC that every day she reflects on this incident and her role in it. She stated that she accepts responsibility for her part in the series of factors that led to Mr A's death.

Responses to provisional opinion

137. Responses to my provisional opinion were received from CDHB, RN O, RN K, RN P, and RN Q. Where appropriate, the responses have been incorporated into the "Information gathered" section above or in the section that follows.

CDHB

138. In response to my provisional opinion, CDHB stated:

> "We continue to empathise with [Mr B] and his family for the loss of [Mr A]. We deeply regret the circumstances of his death while he was in our care. We let [Mr A] and his family down and we accept the findings outlined in your provisional opinion.
>
> …

We are committed to implementing your recommendations in this care and will report back to you as required.

Canterbury DHB acknowledges our responsibility for the care we provide to patients and we are sorry for the shortcomings in our care of [Mr A]."

RN K

139. In response to my provisional opinion, RN K's legal advisor stated: "[RN K] has accepted that in hindsight (particularly given the training he has since received) he could have and should have assessed [Mr A] more thoroughly."

140. RN K's legal advisor also commented that "the failure to recognise the possibility of a fall and assess more closely must be seen as a systemic issue".

RN O

141. In response to my provisional opinion, RN O's legal advisor stated: "[RN O] has accepted that in hindsight she could have and should have assessed [Mr A] more thoroughly particularly given the training she has since received."

142. RN O's legal advisor also made the comment that "the failure to recognise the possibility of a fall and assess more closely must be seen as a systemic issue".

RN P

143. RN P made the following comments in response to my provisional opinion:

a) "I want to make it clear that I fully accept the proposed breaches found against me, and that I acknowledge and take full responsibility for my own actions on that day."

b) RN P agrees with the expert nursing advice and said that she should have reviewed Mr A's clinical notes more fully and should have provided him with an appropriate standard of care by undertaking a full and proper assessment of him. RN P said: "Had I undertaken a full assessment of him when I took over his care in the morning, it would most probably have revealed abnormal values that would have prompted me to have contacted the Medical Office or House Surgeon for medical review."

c) Due to her own health impediment at the time, she did not recognise there was any clinical issue with Mr A's presentation.

RN Q

144. In response to my provisional opinion, RN Q stated: "I accept the Deputy Commissioner's view that I should have undertaken more proactive management of [Mr A's] care." RN Q also advised that she has already taken steps to address the recommendations in the report.

Relevant standards

145. The New Zealand Standard Health and Disability Services (Core) Standards NZS8134.1:2008 (NZHDSS) provides (amongst other things) the following:

> "Standard 1.10 Consumers and where appropriate their family/whanau of choice are provided with the information they need to make informed choices and give informed consent."

146. The NZHDSS notes that mental health and addiction services should be proactive to facilitate and empower family/whānau in their role of supporting their family member, and states: "[S]ervices should ensure information is shared, that there is family involvement, and consultation in the planning and decision making process."[33]

Opinion: RN O — Breach

147. RN O was on night duty during the night of Saturday/Sunday. At the commencement of the shift, Mr A was asleep, but he was awake for about two hours in the early morning. RN O overheard him talking in his bedroom and, at about 2am, observed that he was sitting on the side of his bed. Mr A did not indicate to RN O that he required any help, and she concluded that he appeared comfortable.

148. At 3.30am, when returning from having checked another patient, RN O heard water running in Mr A's room. She investigated and found that the light was on and Mr A was lying on the floor naked apart from socks on his feet, and had his shirt semi-tucked underneath him. RN O approached Mr A, and touched his shoulder and spoke his name three to four times to see if he would wake, but he did not respond. She observed that he was breathing at a normal rate and rhythm and appeared to be asleep.

149. RN O covered Mr A with a blanket, and his face moved and he stirred slightly. RN O returned to the office and told the other nurse on duty, RN K, what had happened. RN O and RN K concluded that Mr A was sleeping and, although he was observed at 4am, 5am, 6am and 6.50am, no vital signs were recorded.

150. My expert advisor, RN Toni Dal Din, advised me that there were several missed opportunities to assess Mr A more closely. Mr A was found on the floor mostly naked with the tap running, he was a known falls risk, and he had been given medications that were sedating in their action. RN Dal Din noted that no specific observations were taken, for example his pulse, blood pressure, temperature or neurological observations such as pupil examination. RN Dal Din advised: "I believe a reasonable nurse would have put all these signs together and deduced that there was a high possibility that [Mr A] had fallen." I accept RN Dal Din's advice.

[33] NZHSS page 8.

151. The Falls Protocol defines a fall as including a situation where a person is found on the ground or floor and cannot explain how he or she got there. In this case, Mr A was not able to explain why he was on the floor.

152. The Falls Protocol also states that, following a fall, the nursing review should include recording baseline observations, and recording neurological observations where a head injury has occurred or cannot be excluded. A medical review should be arranged if there are signs of injury or possible injury, and the consumer's family/whānau must be informed of the fall as soon as possible.

153. In response to RN Dal Din's discussion of the requirements of the Falls Protocol, RN O stated that she did not receive any training on the Falls Protocol, and does not recall it being brought to her attention. In my view, the content of the Falls Protocol stipulates the standard of care any reasonable consumer should expect from a competent nurse in any setting, whether a hospital, rest home, or other facility. The obligation on a nurse to provide services with reasonable care and skill exists regardless of the existence or knowledge of an organisational protocol or policy. This is a fundamental nursing skill and duty. Therefore, even if RN O was not aware of the Falls Protocol, I consider that she should have been aware of the need to assess Mr A adequately, and should have done so.

154. I note that RN O has accepted that in hindsight she could have, and should have, assessed Mr A more thoroughly.

155. Accordingly, I consider that RN O did not provide Mr A with services with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: RN K — Breach

156. RN K was working with RN O during Saturday night. At around 3.30am, RN O informed him that she had entered Mr A's room to ascertain the reason she could hear water running, and found Mr A mostly naked on the floor beside his bed.

157. RN K and RN O went to Mr A's room, and RN K observed and assessed Mr A, including his breathing, colour, response, position and comfort. RN K said that in his experience it is not unusual to find patients sleeping on the floor during the night. He said that they had not heard Mr A fall or call out and, as Mr A appeared to be quite comfortable and was sleeping soundly, RN K was prepared to let him continue to do so.

158. The Falls Protocol defines a fall as including a situation where a person is found on the ground or floor and cannot explain how he or she got there. In this case, Mr A was not able to explain why he was on the floor.

159. The Falls Protocol also states that, following a fall, the nursing review should include recording baseline observations, and recording neurological observations where a head injury has occurred or cannot be excluded. A medical review should be arranged if there are signs of injury or possible injury, and the consumer's family/whānau must be informed of the fall as soon as possible.

160. RN Dal Din noted that no specific observations were taken, for example Mr A's pulse, blood pressure, temperature or neurological observations such as pupil examination. RN K has acknowledged that he did not undertake adequate physical and neurological assessments of Mr A, and said that he based his assessment on the experience he has had previously with patients with mental illness. RN K said that he was not aware of the Falls Protocol, and does not recall it being brought to his attention at any time during the four years he had been employed by CDHB. He also did not receive an induction at the commencement of his employment with CDHB.

161. RN K stated that this incident occurred when he was on his second shift following his transfer to Inpatient Unit X, and that he had received no orientation to the new ward. He noted that staff morale was low at that time. In my view, the failure to assess Mr A adequately cannot be mitigated by a lack of orientation or poor staff morale.

162. I accept RN Dal Din's advice that there were several missed opportunities to assess Mr A more closely and, as he was found mostly naked on the floor with the tap running and was a known falls risk, and had been given sedating medications, a reasonable nurse would have put together all those signs and deduced that there was a high possibility that Mr A had fallen, and would have taken his observations.

163. I note that RN K has accepted that in hindsight he could have, and should have, assessed Mr A more thoroughly.

164. In my view, the content of the Falls Protocol stipulates the standard of care any reasonable consumer should expect from a competent nurse in any setting, whether a hospital, rest home, or other facility. The obligation on a nurse to provide services with reasonable care and skill exists regardless of the existence or knowledge of an organisational protocol or policy. This is a fundamental nursing skill and duty. Therefore, even if RN K was not aware of the Falls Protocol, he should have been aware of the need to assess Mr A adequately, and should have done so. For these reasons, I consider that RN K failed to provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: RN P — Breach

Introduction

165. RN P was an experienced mental health nurse who had been employed by CDHB for many years. On Saturday morning, she volunteered to be allocated the care of Mr A

because she knew him from previous admissions. The team leader, RN Q, agreed because she thought RN P was experienced in dealing with older consumers.

166. I would like to acknowledge that RN P has fully accepted responsibility for her departures in the standard of care provided to Mr A.

Failure to review clinical notes correctly

167. RN P stated that she read Mr A's clinical notes and noted that his GP had reduced his medication, and that his behaviour had deteriorated. Mr A's outpatient notes had not arrived, and she planned to review his notes more fully and add to his treatment plan later.

168. RN P stated that RN K told her that, on Saturday evening, Mr A had been administered 40mg temazepam and PRN lorazepam in addition to his other medications. RN P recorded in the progress notes for Sunday: "[A]ppears [t]emazepam 40mgs and PRN [l]orazepam utilised yesterday ? having sedating effect." In contrast, the progress notes made by RN I on Saturday state that Mr A took only 20mg of temazepam instead of the 40mg that was prescribed, and 20mg of temazepam was still in a pottle in the drug cupboard. The notes also state: "PRN lorazepam 1mg given at 19.30 and 21.30 with some settling effect."

169. In my view, it was RN P's responsibility to review Mr A's clinical notes accurately in order to ascertain the medication from the records, including the dosage that had been administered to Mr A.

Failure to assess Mr A

170. RN P withheld Mr A's morning medication because she felt he needed to sleep given his unsettled presentation on the previous two shifts, and his need to sleep off the effects of his sedating medication. She said that she did not get him up mid morning, as she had planned, as a new patient was transferred to Inpatient Unit X and her workload became hectic.

171. The Falls Protocol defines a fall as including a situation where a person is found on the ground or floor and cannot explain how he or she got there. In this case, Mr A was not able to explain why he was on the floor.

172. The Falls Protocol also states that, following a fall, the nursing review should include recording baseline observations, and recording neurological observations where a head injury has occurred or cannot be excluded. A medical review should be arranged if there are signs of injury or possible injury, and the consumer's family/whānau must be informed of the fall as soon as possible.

173. RN Dal Din advised that RN P's general observations of Mr A's colour and breathing were appropriate for a limited time. However, no physical assessment was performed during RN P's shift. RN Dal Din advised that a physical assessment should have covered, as a minimum, body temperature, pulse, breathing (looking for any abnormal rate, rhythm or difficulties), level of consciousness, blood pressure, and checking the size of the pupils and their reaction to light.

174. RN I said that RN P told her that she had taken Mr A's vital observations and they were within the normal range. However, RN P made no record of any observations. RN P acknowledged that she did not complete a comprehensive physical assessment of Mr A.

175. RN Dal Din stated: "[Mr A's] presentation did not change for this whole shift, further assessment was required to investigate other causes for this loss of consciousness." He advised that RN P should have intervened by at least two hours after noticing that Mr A's presentation had not changed.

176. RN Dal Din stated:

> "If the above physical assessment was completed and repeated at regular intervals (15 minutes to hourly dependent on the findings) it would have most probably revealed some abnormal values that would have prompted the RN to contact a Medical Officer or House Surgeon who would have completed a further examination, which in turn could have prompted an earlier admission to the Emergency Department."

177. In my view, RN P failed to think critically about Mr A's presentation. She was aware that he had been lying on the floor since at least 3.30am and had been found mostly naked with the water running in his en suite. When he was moved from the floor to a chair at around 1pm, he did not rouse. No observations had been recorded at all since he was found on the floor. In my view, a reasonable registered nurse in her situation would have undertaken an adequate assessment of him.

178. In my view, RN P should have completed a physical assessment of Mr A. I accept RN Dal Din's advice that RN P's failure to provide Mr A with adequate care was a serious departure from accepted standards for a registered nurse.

Conclusion

179. Accordingly, I find that by failing to review Mr A's clinical records correctly and to conduct an adequate assessment, RN P did not provide services to Mr A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Concerns not addressed — Adverse comment

180. RN J stated that throughout the day she commented to RN P about her concerns regarding Mr A, and that RN P told her to look after her own patients and leave Mr A to sleep. RN R stated that she recalled discussion between a couple of nurses on the shift, and that they were all voicing concerns about Mr A's care, but she cannot recall the whole conversation or when that conversation took place. However, RN R said that at approximately 1pm when she was assisting RN P to put Mr A into a chair, she voiced her concern that something was not right, but was brushed off by RN P. EN S stated that she and RN J went into Mr A's room and tried to wake him by calling his name and touching his shoulder, and that when they left the room RN P told them to leave him asleep as he was fine.

181. In contrast, RN P stated that she has no recollection that either RN R or RN J expressed any concerns to her about Mr A's condition.

182. In light of the accounts of RN J, RN R and EN S, I find it more likely than not that RN P was alerted to the concerns of the other staff. RN P's response to the concerns of the other nurses was inadequate, and I consider that a reasonable nurse confronted with so many concerns would have acted upon them.

Opinion: Canterbury District Health Board

Introduction

183. A hospital should have effective systems in place, and ensure that its staff are aware of the systems and are adequately trained and supported to comply with them. In this case, there was a lack of effective service planning, co-ordination and collaboration to maintain services that were safe for patients and staff. The staff and systems existing at CDHB let down Mr A, as is discussed below. However, I consider that CDHB also failed to provide services to Mr A with reasonable care, and is directly responsible for those failures.

184. I note that CDHB has accepted my findings and has acknowledged its responsibility for the shortcomings in the care provided to Mr A.

Family contact — Breach

185. Mr A's family were not aware that he had been transferred from the rest home to the psychiatric hospital. The first time they became aware of this was on Sunday when the duty nurse manager telephoned Mr D and told him that his father was "critical", and that Mr D needed to go to the hospital straightaway. Mr D contacted his brother, Mr B, who went to the ED. Mr A's wife was also not contacted.

186. The New Zealand Standard Health and Disability Services (Core) Standards NZS8134.1:2008 (NZHDSS) provides: "Consumers and where appropriate their family/whanau of choice are provided with the information they need to make informed choices and give informed consent."[34] The NZHDSS notes that mental health and addiction services should be proactive to facilitate and empower family/whānau in their role of supporting their family member, and states: "[S]ervices should ensure information is shared, that there is family involvement, and consultation in the planning and decision making process."[35]

187. Although Mr A was a voluntary patient, RN I assessed him as an AWOL risk and noted that he should be nursed on a "known whereabouts" basis because he was talking about returning to the rest home. On Saturday, RN I recorded that Mr A was again stating a wish to return to the rest home that night and asking staff to take him

[34] NZHSS Standard 1.10.
[35] NZHSS page 8.

there. He was observed pushing the door release at the main entrance in an attempt to leave the ward.

188. Mr A's family have expressed concern about the way in which Mr A's desire to leave the hospital was managed given he was a voluntary patient. They say that Mr A's family members were often able to settle him effectively when he was agitated or distressed, and yet they were not contacted.

189. The CDHB Specialist Mental Health Service policy titled "Family and Whanau Involvement in the Consumer's Treatment" states that "Specialist Mental Health Services are committed to respectful and responsive relationships with family and whanau that support and promote participation and partnership". The policy states that staff have a responsibility to build partnership with families and provide opportunities, with the consumer's consent, to be involved in assessment and admission, clinical reviews, planning reviews, discharge and the like. The policy also states that the extent to which family members are involved in treatment and support is ultimately the consumer's decision, and staff will ensure that the consumer has the opportunity to review his or her family's involvement regularly.

190. The CDHB Serious Incident Review Report stated that NM N had agreed with RN G that she (RN G) would inform the family of Mr A's admission to the psychiatric hospital. However, she did not do so. CDHB stated: "A broad range of MHS staff had responsibilities regarding contacting [Mr A's] family when he was admitted to the psychiatric hospital, including inpatient, outpatient, nursing and medical staff. Despite this, [Mr A's] family were not informed of his admission to the psychiatric hospital." This was contributed to by RN I's failure to complete page two of the Admission Checklist ("Actions Relating to Family/Whanau" are on page two of the checklist).

191. The consequences of these omissions were that Mr A's family were not given the opportunity to assist him when he was agitated or distressed and, in addition, as he did not regain consciousness, they did not have an opportunity to speak to him prior to his death.

192. CDHB staff failed to communicate with Mr A's family regarding his admission to the psychiatric hospital. I find that CDHB failed to comply with legal standards and, accordingly, breached Right 4(2) of the Code.

Voluntary treatment — Breach

193. Every consumer must be presumed competent unless there are reasonable grounds for believing that the consumer is not competent.[36] There is no record of Mr A's competence being assessed during his admission at the psychiatric hospital.

194. There is no record of any consideration of the use of the Mental Health (Compulsory Assessment and Treatment) Act 1992 in order to treat Mr A compulsorily. He signed the initial treatment form, which informed him that he had the right to refuse or withdraw consent for treatment at any time. Furthermore, Right 7(7) of the Code

[36] Right 7(2) of the Code.

states: "Every consumer has the right to refuse services and to withdraw consent to services."

195. The psychiatric hospital had a responsibility to verify Mr A's legal status and to be clear about the legal basis on which it was providing services. Mr A repeatedly expressed the desire to leave the ward, and made efforts to do so. On Friday, RN I recorded that Mr A was an AWOL risk and that he was continually talking about going back home. On Saturday, RN H, who was on the morning shift, recorded that Mr A was preoccupied with the doors, pushing the door release button several times, and was a moderate AWOL risk. That evening, RN I recorded that Mr A was adamant that he was going back to the rest home, and asked staff to take him there. She noted that he remained at risk of going AWOL and was observed pushing the door release at the main entrance in an attempt to leave the ward. Mr A was not taken back to the rest home, and remained at the psychiatric hospital.

196. I do not consider that the staff at the psychiatric hospital gave appropriate consideration to Mr A's voluntary status. It is clear from the records that Mr A attempted to leave the psychiatric hospital on at least three occasions, and asked staff to take him back to the rest home. In my view, in attempting to leave the ward, Mr A was making an attempt to refuse services on those occasions. In the absence of a compulsory treatment order, Mr A was free to leave if he wished to do so. I find that by preventing Mr A from exercising his right to refuse services and withdraw his consent to services, CDHB breached Right 7(7) of the Code.

Continuity of care and documentation — Breach

197. On Friday, Mr A was reviewed by registrar Dr E. Dr E recorded a request that a physical examination of Mr A be conducted, including a "thorough neuro". Dr E noted that Mr A appeared to be leaning to the right side while mobilising, and had a history of left side weakness, and recorded "consider CT head".

198. RN I admitted Mr A as a voluntary patient and conducted a physical examination, noting that he had no obvious injuries, wounds or bruises, no issues with his bladder, and no disabilities in speech and gait.

199. On Friday at 7.45pm, house officer Dr F conducted a brief medical check of Mr A because he had been asked by the nurse to see him "as per protocol". Dr F did not receive any other information about Mr A's admission, and did not have any documentation other than RN I's request for a physical examination and a brief note that Mr A had been admitted. Although Dr E had suggested a CT scan of Mr A's head, a scan was not performed. There was no direct handover between Dr E and Dr F.

200. As discussed in a previous opinion,[37] good handover is essential when different doctors and nurses take over responsibility for a patient's care.

[37] See Opinion 11HDC00532, available at www.hdc.org.nz.

201. RN Dal Din stated: "[D]irect handover is critical for the continuity of patient care and fundamental to ensuring quality of care and patient safety. Clinical handover is a high risk scenario for patient safety."

202. When Mr A was admitted to the psychiatric hospital there does not appear to have been a discussion between Dr E and the consultant psychiatrist, Dr C, about Mr A's medication, particularly the doses and interactions. The CDHB's Serious Incident Review Report noted that the doses of psychotropic medications were outside the ranges normally suitable for older people, and there was no reported evidence of balancing benefits against risks such as sedation and falls. RN Dal Din advised that, without proper monitoring, the medication combination added to Mr A's clinical risk.

203. Dr T noted that Mr A was being administered aspirin and clopidogrel (two anticoagulants), which would have increased any bleeding tendencies. He was also a known falls risk. However, because of the separate electronic patient information used by the public hospital and MHS, the staff at the psychiatric hospital were not fully aware of Mr A's history.

204. In addition, there are a number of inconsistencies in the documentation of medical issues in Mr A's clinical records. For example, Dr E described Mr A as leaning to the right, and RN I described him as "listing to the left". In a progress note made at admission, RN I noted that Mr A was difficult to understand and incontinent of urine, but her physical examination reported that he had no issues with his bladder and no disabilities, including speech and gait. RN I did not complete page two of the admission checklist, and that information was not completed by nursing staff on subsequent shifts. Had the admission checklist been completed, it may have prompted staff to consider whether Mr A's family had been notified or involved in his care.

205. CDHB failed to ensure continuity of care in that there was no direct handover between Dr E and Dr F, and no consultant oversight of the doses of Mr A's psychotropic medications, and the documentation of his medical issues in his clinical records was inconsistent. Furthermore, because of the separate electronic patient information used by the public hospital and MHS, the staff at the psychiatric hospital were not fully aware of Mr A's history. Overall, I consider that there was a lack of continuity of care and, accordingly, I find that CDHB breached Right 4(5) of the Code.

Environment — Adverse comment

206. The nurses concerned in providing care to Mr A have pointed to a number of challenges in the physical working environment, including the disestablishment of long established teams, new facilities, and the effects of the on-going earthquakes. Inpatient Unit X was created by dividing and refurbishing an old ward into two separate units. Staff from the old ward were familiar with the old layout and experienced some disruption during the refurbishment process.

207. With regard to orientation, RN L said that he contacted all new staff from other areas of the hospital who were to work in Inpatient Unit X, with an offer of orientation. However, there was no formal orientation guide or checklist, and the orientation

consisted of RN L showing new staff around the ward. RN Dal Din advised: "[I]n my experience with similar processes in my current work place it is advantageous to allow for 1–2 weeks orientating staff and trying out the facilities when units are refurbished." He noted that the regular CNM was on annual leave at that time, which was not ideal.

208. In my view, the changes that had been made do not excuse the individual lack of critical thinking by a number of nurses. However, there appears to have been a lack of consideration by management of the possible effects that the break-up of long-established teams and an unfinished ward could have on staff performance, and the need for support.

Culture — Adverse comment

209. I am concerned about the culture existing at the psychiatric hospital at that time. RN J, EN S and RN R all had concerns about Mr A, which they raised with RN P; however, they did not take their concerns to the next level. In addition, RN J stated that she commented to RN Q that she thought more should be done to rouse Mr A because of his presentation the previous night and the need for him to have his medication.

210. I am alarmed that Mr A could lie on the floor from 3.30am until 1pm with no observations being recorded and no thorough assessment being conducted. At least five nurses on the day shift were aware that Mr A was on the floor. However, no one questioned his status. I am troubled that RN J, EN S and RN R felt that they could not escalate their concerns because of the seniority of RN P. I appreciate that RN P was a very experienced nurse; however, in my view, the nurses who remained concerned should have escalated their concerns. RN Dal Din noted that the nurses could have taken their concerns to the charge nurse or the duty nurse manager. He advised: "I have seen this happen when nurses are concerned about the welfare of a patient and there is an impasse between team members as to the right course of treatment or care options. It is useful for an independent person to be involved in the discussion and options." I agree with RN Dal Din and consider that the nurses should have raised their concerns with a more senior staff member.

211. In my view, this appears to have been an example of dysfunctional group dynamics where the less experienced staff felt disempowered and unable to advocate for Mr A despite their concerns about his presentation.

Policies and protocols — Adverse comment

212. While I have been critical of individuals for not being aware of basic nursing obligations, it is also essential that CDHB ensures that its staff are familiar with its policies and protocols and comply with standards. Induction and orientation to policies and protocols is an important organisational duty. I am concerned about CDHB's omissions in the following areas:

a) RN K stated that he did not receive an induction at the commencement of his employment with CDHB.

b) RN K and RN O both told HDC that they were not aware of the Falls Protocol and do not recall it being brought to their attention by CDHB.

c) RN P stated that education sessions on the medically deteriorating patient were not available to her.

213. In my view, it is essential that staff are made aware of all current policies and protocols. I note that since this incident CDHB has provided training to its staff on falls, in identifying levels of consciousness, and in identifying the deteriorating patient.

Opinion: RN Q — Adverse comment

214. RN Q was the shift leader on the day shift on Sunday. Her role included allocating patients to nurses, and she said that her expectation was that senior nurses would discuss concerns with her and she would be responsible for seeking further advice if required, and she would regularly check on the less experienced nurses and advise them as required.

215. RN Q said that she allocated RN P to care for Mr A because RN P had a holistic approach to the care of older patients with complex needs, and had worked with Mr A previously. RN Q stated that she was very confident in RN P's skill and history of care for elderly patients.

216. RN Q said that her involvement in Mr A's care during the shift was minimal, but several times during the shift she stopped at his room and observed him briefly and asked RN P whether there was any change in his condition. RN Q considered that, given Mr A's previous level of activation and the medications he had been given, it was unremarkable that he would sleep for a lengthy period. She understood from RN P that some recordings of vital signs had been taken, but did not ascertain what they were.

217. RN Dal Din advised:

> "It is surprising that [RN Q] was not concerned that [Mr A] had been on the floor for a 12 hour period without any physical observations being done. On the face of it, there appears to have been a passive approach to managing [Mr A]."

218. I agree with my expert that there were missed opportunities for RN Q to have ensured the proactive management of Mr A. In my view, RN Q should have intervened earlier, ensured that further investigations were undertaken, including Mr A's observations, and generally provided leadership.

219. RN Dal Din stated: "I believe that [RN Q] did not provide [Mr A] with adequate care." In my view, RN Q's actions were suboptimal and displayed a regrettably

"hands off" style of leadership. While I have found that RN Q did not breach the Code, I have serious concerns at her lack of leadership on Sunday.

Recommendations

220. In response to the proposed recommendations in my provisional opinion, CDHB, RN K, and RN O each provided written apologies for forwarding to Mr A's family.

221. I recommend that RN P provide a formal written apology to Mr A's family. The apology is to be sent to HDC for forwarding, within three weeks of the date of this report.

222. I recommend that the Nursing Council of New Zealand consider undertaking a competence review of RN P if/when she recommences practice as a registered nurse and, if required, arrange the necessary and appropriate training.

223. I recommend that RN O and RN K undertake further training on identifying levels of consciousness, identifying the deteriorating patient, and falls management, and provide evidence to HDC that the training has been undertaken, within three months of the date of this report.

224. I recommend that RN Q undertake further leadership training, and provide evidence to HDC that the training has been undertaken, within three months of the date of this report.

225. I recommend that CDHB undertake the following within three months of the date of this report:

a) Audit the changes implemented since Mr A's death and report to HDC on the results of the audit.

b) Provide evidence that all relevant staff at the psychiatric hospital have been provided training on patients' legal status, the involvement of family members in patient care, handovers including clarification as to the responsibilities for physical assessment and medical handover, and CDHB's existing policies.

c) Provide evidence of ongoing refresher updates of the training provided to staff.

d) Consider whether a policy requiring that staff concerned about a patient's condition escalate their concerns to a senior clinician is required, and report to HDC on the outcome of its consideration.

e) Review the on-call arrangements with psychiatrists on the weekends to assess the effectiveness of the arrangements, and report to HDC on the outcome of its review.

f) Review electronic patient information systems to ensure that staff have access to required information, and report to HDC on the outcome of its review.

g) Conduct an audit of the documentation practices at the psychiatric hospital, and report to HDC on the results of its audit.

h) Review its handover processes and prepare a report to HDC on the outcome of its review.

Follow-up actions

226. • A copy of this report with details identifying the parties removed, except the expert who advised on this case and Canterbury District Health Board, will be sent to the Nursing Council of New Zealand, and it will be advised of the names of RN O, RN K, and RN P.

• A copy of this report with details identifying the parties removed, except the experts who advised on this case and Canterbury District Health Board, will be sent to DHB Shared Services and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

• A copy of this report will be sent to the New Zealand Police and the Coroner.

Appendix A — Independent clinical expert advice to the Commissioner

The following expert advice was obtained from Registered Nurse Toni Dal Din:

"**Preamble**

I have been asked by the Commissioner to provide preliminary expert advice on case number 13/01375. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Qualifications

I began my nursing career as a Psychopaedic Nurse in 1982. I completed a general and obstetrics-bridging programme for comprehensive registration in 1987. I hold a postgraduate certificate in Forensic Psychiatric care. I completed my Masters of Arts degree in nursing at Victoria University of Wellington in 2006. I am currently a member of Te Ao Maramatanga College of Mental Health Nurses and a Fellow of the College of Nurses Aotearoa (NZ).

Over the last 30 years I have undertaken various clinical and leadership roles within general health, intellectual disability, and mental health including the forensic psychiatric area. I have also undertaken the statutory role of a Director of Area Mental Health Services both on a permanent and relieving basis.

The purpose of this report is to provide independent expert advice about whether the nursing staff at Canterbury DHB (CDHB) provided an appropriate standard of care to [Mr A] (deceased), from the time of his admission to the psychiatric hospital on [Friday] until his transfer to the public hospital on [Sunday].

Background

Admission

[Mr A] was admitted from a rest home to [Inpatient Unit X] at [the psychiatric hospital] on [Friday afternoon]. The staff at the rest home were concerned that for the previous three days he had been elevated in mood and difficult for them to manage within that environment. They reported that he had sustained at least one fall in the previous 24 hours. The psychiatric registrar assessed [Mr A] as a reasonable risk with impaired insight/judgment, very frail physically and representing a significant falls risk.

Night shift [Saturday night]

Staff on duty were [RN O] and [RN K].

Overnight on [Saturday] [Mr A] was reported as asleep at the beginning of the night shift. At 2 am and 3 am [Mr A] was reported to be talking to himself. At 3.30 am [RN O] found [Mr A] on the floor, semi-naked, with his en-suite tap running. He did not rouse to voice or gentle touch and was observed to be breathing at a normal rate. She informed the other night shift nurse, [RN K]. They

assessed [Mr A] including his breathing, colour, response, position and comfort and concluded that he was asleep. They covered him with a blanket. During 60 minute observations at 4 am, 5 am, 6am and 6.50 am, the [RN O] and [RN K] reported that [Mr A] was comfortable with appropriate colour, breathing soundly and appeared to be asleep.

Day shift [Sunday]

Staff on duty were [RN Q] (shift leader), [RN P], [RN J], [RN R], [EN S].

[Mr A's] care was handed over at 7 am. [RN P] asked to look after [Mr A] on the day shift. [RN P] thought that [Mr A] was over-sedated and asleep as he had been administered 20mg of temazepam and 2mg of lorazepam. She decided to leave him to sleep throughout the morning and planned on getting him up late morning.

At 1 pm [RN P] was assisted by [RN J] and [RN R] to place [Mr A] in a chair and to change his shirt. [Mr A] did not rouse during the procedure.

Half hourly observations were conducted throughout the shift with each nurse taking it in turn. [EN S], [RN J] and [RN R] claim to have approached [RN P] to express their concerns regarding [Mr A] but were disregarded. [RN P] denies that the nurses expressed any concern with her. [RN Q] stopped by [Mr A's] room several times during the shift and observed him briefly and asked [RN P] if there was any change in his condition.

The RN on the afternoon shift taking over [Mr A's] nursing care took [Mr A's] observations and sought immediate medical assistance. [Mr A] was assessed and taken to the public hospital where he subsequently passed away.

Complaint

The HDC received a complaint from [Mr A's] son, [Mr B]. [Mr B] has sought an investigation into the conduct of the nursing staff.

HDC also received a separated referral from NCNZ regarding [RN P's] involvement (CDHB reported [RN P] to NCNZ).

Supporting Information

I have had available to me a large number of documents that I have reviewed for the purpose of this report.

Complaint
1. Mr B's complaint dated […]
2. CDHB's letter to NCNZ dated […]

Notification
3. HDC notification letter to CDHB dated […]
4. HDC notification letter to [RN P] dated […]

CDHB

5. CDHB report to the Coroner dated […]
6. CDHB letter to the Coroner dated […]
7. Serious Incident Review completed […]
8. CDHB response dated […]
9. CDHB response dated […]
10. CDHB response dated […]
11. CDHB staff rosters
12. CDHB policies
    - Acute Inpatient Service SPF;
    - MHS Inpatient Falls Prevention and Management Protocol;
    - Family/Whanau Involvement in Consumer's treatment;
    - Observation including specialing;
    - Observations [Inpatient Service];
    - Use of Emergency Sedation;
    - MHS Orientation Booklet; and
    - Supervision.
13. CDHB response dated […]

[RN P]

14. [RN P's] response dated […]
    - [Report to Coroner];
    - Numerous testimonials; and
    - Performance reviews.
15. [RN P's] response to notification dated […]
16. [RN P's] employment file and training record from CDHB

Statements from other staff involved

17. Statement of RN I] dated […]
18. Statement of [RN O] dated […]
19. Statement of [RN K] dated […]
20. Statement of [RN Q] dated […]
21. Statement of [RN R] dated […]
22. Statement of RN L] dated […]
23. Statement of [RN J] dated […]
24. Statement of [Dr F] dated […]
25. Statement of [EN S] dated […]

Medical records

[Mr A's] medical records

Police Photographs

The photographs taken of [Mr A's] bedroom and corridor area outside his bedroom.

Expert Advice Required

I have reviewed the information provided and have the following comments and observations regarding the overall standard of care provided:

1) Canterbury District Health Board

The overall care that was provided to [Mr A] was not appropriate for a number of reasons that are described in the Canterbury District Health Board Serious Incident Review Report. The findings from this review identified significant problems with:

> Processes and communication in relation to the first physical examination following admission. The key issue appeared to be a lack of direct handover between the [team] registrar and house surgeon, which was described as creating vulnerability in the system. I concur with this as direct handover is critical for the continuity of patient care and fundamental to ensuring quality of care and patient safety. Clinical handover is a high risk scenario for patient safety. Dangers include discontinuity of care, adverse events and legal claims of malpractice (Wong et al, 2008).
>
> A key issue was that the [team] registrar suggested to consider a CT scan of [Mr A's] head, which appears to have been missed by the admitting team; the report describes adverse consequences as a result of this.
>
> Family involvement. It was clear that a number of opportunities for family involvement were evident throughout the admission processes but was not acted on. I understand how disappointed the family must be with this as there was no opportunity for [Mr A's] sons or wife to be involved in any decisions relating to his care. It appears that the family have been involved in [Mr A's] care over past admissions including in [the rest home].
>
> The Ministry of Health document, Rising to the Challenge: The Mental Health and Addiction Service Development Plan (SDP) 2012–2017 states that families and whanau have a fundamental role in supporting recovery and wellness (p7). In addition to this the SDP describes positive participation by families and whanau as being one of the guiding principles (p9) and an expectation in service delivery.
>
> Pathways of care for people over 65 years with significant medical and psychiatric difficulties. [Mr A] was clearly suitable for a transfer of care to the Psychiatric Service for the Elderly (PSE). I agree with the findings of the incident review report that PSE would have been better placed to care for [Mr A's] complex physical and psychiatric difficulties including the risk of falls. In my experience a specialised mental health for the older persons services would have available to them equipment such as low beds and various protocols.
>
> Clinical Responsibility, communication and liaison amongst [the] team, GP and the rest home. It appears from the incident review report that there were

different assumptions about who was taking clinical responsibility for managing aspects of [Mr A's] psychiatric care, including medication changes and monitoring lithium and sodium valproate levels.

Medication issues were evident, failure to detect the interactions and potential risks associated with the prescribing of two anticoagulant medications in 2012 was described in the report. Communication and guidance to the rest home staff about the potential falls risks associated with large doses of PRN Benzodiazepines was not evident to the reviewers. On admission to [the psychiatric hospital], there does not appear to have been any discussion between [the team] registrar and psychiatrist, especially doses and interactions. Doses of psychotropic medications were described as outside the ranges normally suitable for older people and there was no reported evidence of balancing benefits with risks, for example sedation and falls. I agree with the reviewers' comments relating to this issue, without proper monitoring these combinations added to the clinical risks.

Communication between medical staff: [the] Mental Health Service and other divisions of the CDHB. It was noted that clinical events prior to [Mr A's] 2013 admission to [the psychiatric hospital] including prescription of two anticoagulants in 2012, increased risk of intracranial bleeding following VP shunt operations necessitating effective management of falls risks were not recognized and managed by [the team's] medical staff. Again the review team mentioned communication problems, separate electronic patient information systems used in the public hospital and in Specialist Mental Health Services was likely to have led to the adverse outcome.

Management of falls risk at [the] ward. Omissions identified in [Mr A's] care were not consistent with the MHS and CDHB wide policies/protocols for falls prevention and management.

Management of people who are voluntary patients and wish to leave [the ward]. The review team commented on the potential for [Mr A's] legal rights to have been breached. I concur with this; in my experience there did not appear to be real informed consent to stay voluntarily on admission and it was clear that [Mr A] was withdrawing any assumed consent by asking to leave. The use of the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992 should have been considered, if the treating team wished to detain [Mr A] against his will. It is surprising that this process was not invoked by an acute mental health inpatient ward.

Reviews by medical staff following admission. [Mr A] was not reviewed by a consultant psychiatrist on admission or during the next 24 hours of his care notwithstanding the availability of a consultant being rostered on call. In my experience in working in a number of District Health Boards, consultant psychiatrists on call will generally be called to review new admissions within

the first 24 hours of admissions, particularly people admitted with high and complex needs.

Documentation: Inconsistencies in documentation of medical issues in the clinical file were identified by the review team. Documentation was missing and plans not updated. The contacts and disclosure form contained incomplete and inaccurate information and should have been updated and amended; this coupled with the incomplete admission checklist led to staff not notifying [Mr A's] family of his admission, which as previously mentioned has added to their concerns about the care of [Mr A].

Comment

All of these abovementioned issues were identified and described in the CDHB serious incident review report as significantly contributing to the adverse outcome for [Mr A]. Collectively they provide enough evidence to support the view that the overall standard of care provided to [Mr A] by the Canterbury DHB was not appropriate.

2) [RN I], including her admission assessment

[RN I] admitted [Mr A] on the [Friday afternoon shift]. She states that she had nursed him a number of times as an outpatient; she did not recall nursing him as an inpatient. [RN I] confirms that she completed the admission documentation and nursing medical and physical examinations and falls risk screen.

It is evident that [RN I] did not contact [Mr A's] family to inform them of this admission; if this had been done, the family would have had an opportunity to contribute to [Mr A's] care. This was clearly an issue and not helpful for the family.

[RN I] was on duty again on the [Sunday afternoon shift] and she began her duty at 1430hrs. She states she was in charge of this shift and completed handover at 1510hrs. She then allocated patients to staff. Immediately after allocation she checked on [Mr A] with [RN P] at her request because the handover indicated that he had been unable to be roused since the early hours of the morning. She stated that [Mr A] was sitting in a chair.

[RN I] touched [Mr A] and noticed his body felt cold and that he looked very pale. His BSL was 7.4. She noted she had difficulty obtaining a reading. [Mr A] was transferred to the bed and put into the recovery position. [RN I] called the duty house surgeon and he subsequently reviewed [Mr A] and phoned an ambulance for admission to [the public hospital].

[RN I] accompanied [Mr A] to the public Hospital.

Comment

I consider that the overall standard of care [RN I] provided to [Mr A] was appropriate. She acted quickly to contact the duty house surgeon once she had assessed [Mr A] on the [Sunday afternoon shift].

It would have been useful if she had contacted the family to inform them of the admission on the [Friday afternoon shift], however this was not subsequently done by following shifts either.

There were some aspects of the admission documentation not completed. In my experience, it is not uncommon in a busy acute admission ward, for some of the documentation not to be completed immediately. In most cases the documentation would be added to over the next 24 to 48 hours by subsequent shifts.

3) [RN O], including whether I consider the actions she took when she found [Mr A] on the floor were appropriate. Also comment on her assessment of [Mr A] and the subsequent care she provided to him on the night shift

[RN O] [is an experienced RN, and completed the Canterbury DHB New Graduate Mental Health Nurse Programme]. She has worked in the acute mental health services at [the psychiatric hospital] since that time.

[RN O] was on night shift [Saturday night] and was working with another experienced nurse, [RN K] on this shift. [RN O] stated that this was the first time she had worked with [Mr A]. However [she] described [Mr A] as being well known to mental health services. [RN O] described [Mr A's] presentation on afternoon shift as extremely elevated, he had been a high profile on the ward and he had been busy and driven in behaviour. She states that she was not aware of his physical health issues apart from there being a falls risk.

At 0330hrs she heard water running and went to investigate, she found the light on and [Mr A] lying on his bedroom floor, mostly naked. The hot water was running in his ensuite and she turned it off. [Mr A] was lying close to his bed, feet facing the ensuite and on his back, but slightly on his right side, with his left arm lying on his chest.

[RN O] gently touched him and tried to rouse him; however he did not rouse at that time. She observed that he was breathing, with a normal rate and rhythm, appearing asleep. She placed a blanket on [Mr A] who appeared to respond with a facial movement and slightly stirred when the blanket was placed over him, but did not wake.

[RN O] then spoke with [RN K] informing him of this information. [RN K] then observed [Mr A] and both RNs agreed from their physical observations (good colour, normal breathing rate and rhythm) that he was asleep. They discussed this and decided that sleep was a priority for [Mr A].

[RN O] explained that [Mr A's] room was diagonally across and two rooms away from the office and neither of them had heard any noise that would indicate a fall; however she earlier explained that she was on her way back to the office from undertaking 15 minute observations on another patient, so may not have heard a fall if it had happened. She explained that it appeared to her that [Mr A] had been either attempting to take off or put on clothes, either sitting on his bed or the floor.

[RN O] then describes her experience with working with patients with elevated mood who often resist going to sleep and eventually ending up sleeping on the floor. She mentioned weighing up whether this was beneficial or not. She mentioned also that sometimes waking someone who [is] in this situation can stimulate them leading to further elevation in mood. She did not consider it unethical to allow him to sleep on the floor consider[ing] there were only a few hours remaining till morning.

[RN O] continued to observe [Mr A] who appeared to continue to sleep. She explained that she heard [Mr A] snoring. She stated that there was nothing that alerted her or [RN K] that [Mr A] had anything physically wrong with him.

Comment

From this description of events and observations I believe that there were several missed opportunities to assess [Mr A] more closely. [Mr A] was found on the floor mostly naked with the ensuite tap running, he was a known falls risk plus he had been given PRN medications that were sedating in their action.

[Mr A] was described by [RN O] as lying on his back on the floor unrousable and appeared to her to have been either undressing or dressing. No physical observations such as pulse rate, blood pressure, temperature or neurological observations such as pupil examination were taken. I believe a reasonable nurse would have put all of these signs together and deduced that there was a high possibility that [Mr A] had fallen.

In addition the Canterbury DHB Specialist Mental Health Services Inpatient Falls Prevention and Management Protocol defines a fall as 'a sudden unintentional change in position causing an individual to land at a lower level, on an object, the floor or other surface'. 'This includes situations where a person found on the ground or floor or other lower level cannot explain how they got there'.

The protocol then describes actions under Nursing Review, most importantly record baseline observations and record neurological observations where head injury has occurred or cannot be excluded (e.g. an un-witnessed fall).

Therefore I am of the opinion that [RN O] did not provide [Mr A] with adequate care and her actions were a moderate departure from expected standards for a RN.

4) [RN K], including whether you consider the care he provided to [Mr A] on the night shift was adequate

[RN K] has been a Registered Nurse [for about 15 years]. [RN K] was on night shift [Saturday night] and was working with [RN O].

[RN K] explains that observations were undertaken on patients at varying intervals during the duty (fifteen minute, thirty minute and hourly). [RN K] states that his recollection of handover was that there was a mention that [Mr A] had been 'irritable and flirtatious' during the shift. There may also have been mention of a risk of falls.

[RN K] states that [RN O] was carrying out routine 60 minute observations on all patients on the ward while he was admitting a new patient. He also stated that [RN O] had reported to him that [Mr A] had been talking to himself following the 0200hrs and 0300hrs rounds.

[RN K] then explains that about 0330hrs, [RN O] informed him that she had found [Mr A] semi naked on the floor beside his bed. She also stated that between 0315hrs and 0330hrs she heard water running in [Mr A's] room. Upon entry to his room she found the hot tap was running in the ensuite so she turned it off. She said he was breathing, appeared comfortable and that she had put some blankets over him for 'his dignity and warmth'.

[RN K] then followed [RN O] to [Mr A's] room where he observed and assessed [Mr A] including his breathing, colour, response, position and comfort. They discussed the situation and decided to make him comfortable by covering him up with several blankets and to reassess him every hour.

[RN K] explains that in his experience it is not unusual to find patients sleeping on the floor during the night, [and that] this could be in a semi or undressed state, with or without bedding, driven by illness or purely a matter of choice. [RN K] also states that there was no noise of [Mr A] falling or calling out (his room was very close to the office).

[RN K's] expectation at that time was that [Mr A] appeared quite comfortable and was sleeping soundly. He was prepared to let him continue to do so. [Mr A] appeared to sleep on all subsequent hourly observation rounds.

At approximately 0650hrs [RN K] and a day shift nurse [RN J] conducted a routine check of patients throughout the ward and [RN K] updated [RN J] on the events of the night. He asked [RN J] if she wanted assistance to lift [Mr A] back on his bed, [and] she responded by saying that the day shift would look after this.

[RN K] explained that [RN O] conducted handover with the day shift staff.

Comment

From this description of events and observations as with [RN O's] description, I believe that there were several missed opportunities to assess [Mr A] more closely. [Mr A] was found on the floor mostly naked with the ensuite tap running, he was a known falls risk plus he had been given PRN medications that were sedating in their action.

General observations of breathing, colour, response, position and comfort were undertaken. However no physical observations such as pulse rate, blood pressure, temperature or neurological observations such as pupil examination were taken. I believe a reasonable nurse would have put all of these signs together and deduced that there was a high possibility that [Mr A] had fallen.

Again the Canterbury DHB Specialist Mental Health Services Inpatient Falls Prevention and Management Protocol was not followed. Therefore I am of the opinion that [RN K] did not provide [Mr A] with adequate care and his actions were a moderate departure from expected standards for a RN.

5) [RN Q] (shift leader), including comments about her level of supervision during the daytime shift
[RN Q] [is an experienced nurse].

[RN Q] explains that she was the shift leader on the [Sunday day shift]. There were three other RNs and one EN working with her on that shift. She describes the ward as having a high acuity. It had recently been opened as a new ward with many features dreadfully incomplete, making it a difficult working environment.

[RN Q] explained her role as shift leader as allocating patients to nurses and arranging a buddy system for coverage of meal breaks. Her expectation is that senior nurses would discuss any concerns with her and she would be responsible for seeking further advice. With less experienced nurses she would regularly check on them and advise as required.

[RN Q] states that at the 0700 handover it was conveyed that [Mr A] had been admitted the previous day in a highly elevated phase of his bi-polar illness. She had previous dealings with [Mr A's] mental health care, but not for many years. He was reported as having been energised and activated. She was informed that he had been administered PRN lorazepam 1mg orally at 1930hrs and 2130hrs and temazepam 20mg (time unknown) to induce sleep. It was reported that there was little immediate effect and he had remained agitated into the early hours of the morning.

[RN Q] understood from the handover that at approximately 0300hrs he was observed to be lying on the floor and was made comfortable with bedding, he was in this position when day shift commenced. She explains that it is not unusual in an acute mental health setting, for patients to sleep on the floor. She describes her understanding of the two most common reasons as for those with past trauma, who find an unfamiliar bed untenable and those in some phase of mania, who will be made comfortable wherever they feel they can rest.

[RN Q] allocated [RN P] to care for [Mr A] as she had a holistic approach to care with older patients with complex needs and she had worked with [Mr A] previously.

[RN Q] explained that she was very confident in [RN P's] skill and exemplary history of care for patients who are elderly and/or with co-existing medical conditions.

[RN Q] states that her involvement in [Mr A's] care during the shift was minimal. Several times during the shift she stopped at his room, briefly observed him and asked [RN P] if there was any change in his condition. Given his previous level of

activation and the medications given, his sleeping for a lengthy period appeared unremarkable.

When [RN Q] gave the handover report to the afternoon shift she conveyed the information. She understood from [RN P] that some recordings were taken, but did not explain what they were. She stated that they were not of sufficient concern to contact a house surgeon.

Comment

It appears that [RN Q] had great confidence in [RN P's] ability to manage patients like [Mr A]. This is not unusual when managing experienced nurses. It is surprising that [RN Q] was not concerned that [Mr A] had been on the floor for a 12 hour period without any physical observations being done. On the face of it, there appears to have been a passive approach to managing [Mr A].

I believe that there were missed opportunities for proactive management of [Mr A] and believe that [RN Q] could have discussed [Mr A's] care directly with [RN P] during the course of the shift and possibly could have intervened earlier, suggested observations be undertaken and to contact the duty house surgeon.

I believe that [RN Q] did not provide [Mr A] with adequate care and her actions were a mild departure from expected standards for a RN.

6) [RN P] (notified), including comments about:

a) her assessment of [Mr A] and her decision/rationale for leaving him on the floor to sleep;
b) the care she provided to [Mr A] throughout the daytime shift and her subsequent assessments; and
c) if the Commissioner was to find that [RN J], [EN S] and [RN R] did raise concerns with [RN P], please provide comments about [RN P's] response to their concerns.

[RN P] has been a registered nurse [for nearly 20 years, with a restricted scope of practice (Mental Health)]. [RN P] explains that to her knowledge she has never had any formal complaint or concern raised about her practice. She adds that she has been highly regarded by her colleagues and the DHB managers. [RN P] has always received positive reports, appraisals and feedback. She included 19 references from nursing and medical colleagues supporting this statement. This is evidenced within the HDC information folder. [RN P] states that many of her colleagues refer to her nursing practice on [Sunday] as being out of character.

[RN P] described a number of departmental issues relating to changes in the ward, staff changes and recent suicides that were evident around this time. These included:

- Restructuring/rebuilding of the acute ward
- Construction disruption

- Health and safety concerns
- Effects of the Christchurch earthquakes
- Changes to the nursing rosters and skill mix
- Splitting of existing nursing teams
- Low staff morale and high absenteeism
- High vacancy rates

[RN P] described attending a regular supervision session on [Friday] and discussed with her supervisor that she felt she was struggling. Her supervisor suggested accessing the Employee Assistance Scheme (EAP), which [RN P] agreed would be helpful and was in the process of organising this at the time of [Mr A's] death.

[Sunday]

[RN P] was rostered on morning shift with [RN Q], shift leader, [RN M] Duty Nurse Manager, [EN S], [RN J] and [RN R]. [RN P] states that for three of these nurses it was their first day on the new ward.

[RN P] described working in the new unit overwhelming and claustrophobic due to the size of the unit. She described additional environmental problems related to it being a new building and model of care.

During staff allocation [RN P] volunteered to take over [Mr A's] care for the duty as she knew him from previous admissions, last one being in 2006.

[RN P] recalled working with [Mr A's] wife and she had said that at times in supported accommodation [Mr A] would put himself on the floor and his wife would need to call an ambulance to get him off the floor as she couldn't manage him.

[RN P] recalled having an informal conversation with [RN K] who said that [Mr A] had an unsettled night, he spoke about how he had been awake and that staff had heard the tap running in his room also they noticed he was asleep on the floor. [RN P] also recalls that [Mr A] had received temazepam and PRN lorazepam in addition to his regular medications during the previous evening shift.

[RN P] described her caseload of 4 clients with varying needs. [RN J] was buddied with [RN P] for the shift and had three patients. From [RN P's] description of the shift it seemed to be a busy one.

[RN P] visually checked [Mr A] at 0730hrs before reading some clinical notes. He appeared asleep on the floor on his back, breathing regularly and his colour was satisfactory, he did not cause any concern. His breathing was described as calm. She stated that he was warm from the under floor heating and she placed a towel in the doorway to keep the door partially open to ensure privacy but also allow for him to be seen by staff.

[RN P] stated that because there had been no observable change from night shift she did not complete a physical assessment at that time. She expected that he would be awake during the shift and her intention at this time was to move him mid morning if he had not woken naturally.

[RN P] then reviewed [Mr A's] clinical records and noted that the GP had reduced medication and [Mr A's] behaviour had deteriorated. She also noted that he had fallen before admission, that increased medication had been recommended. [RN P] felt that his presentation was similar to her previous experience of him (2006) and that he was continuing to sleep because everything had caught up with him from his admission and he was heavily sedated.

[RN P] had planned to review [Mr A's] notes further. However the outpatient notes had not arrived. She withheld his morning medications.

[RN P] then described her workload as becoming hectic for a number of reasons.

Around mid-morning she noticed [RN J] and [EN S] coming out of [Mr A's] room; she explained that she was surprised as this was not usual practice. She asked them if everything was alright and if there was anything she should be doing differently. Her recollection is that they raised no concerns. [RN P] reflected that in hindsight this would have been an opportunity to ask them for assistance to make him more comfortable and undertake a more comprehensive physical assessment of him.

At approximately 1300hrs [RN P] and [RN J] went to move [Mr A] onto a chair; [RN R] asked if they wanted some assistance. They lifted him onto the chair with difficulty. They put his shirt on and covered him with a blanket. [RN P] does not recall either of the other RNs mentioning any concerns. [RN P] stated that if they had told her they were concerned, she believes she would have responded by discussing it with them.

[RN P] stated that [RN R] asked her what was going on with [Mr A] and [RN P] replied that he had been given temazepam night sedation and PRN lorazepam which he was sleeping off. She goes on to say that at that time she did not interpret [RN R's] question as her raising concerns about [Mr A's] clinical condition. [RN P] acknowledged that [RN R] would have had a better general medical knowledge than her and if she had been advised of concerns about [Mr A's] condition she would have listened.

[RN P] explained that she was available to discuss [Mr A] at any time with the shift leader [RN Q]. [RN P] stated she did discuss [Mr A] with [RN Q] later in the shift and they both agreed that he was asleep.

Comment

I will comment specifically on the three areas identified above:

a. [RN P's] assessment of [Mr A] and her decision/rationale for leaving him on the floor to sleep.

[RN P] made an initial assessment that [Mr A] was asleep as this was what was handed over to her from the night shift. [Mr A's] general observation of colour and breathing appeared to be within normal limits and did not concern [RN P]; this would have been appropriate for a limited time and her original intention was to do further assessment of physical observations later in the morning. However no detailed physical observation assessment was done until the afternoon shift that afternoon. A reasonable nurse would have intervened within the 12 hours that it took to act on this situation. I do not believe that [RN P's] assessment was adequate.

[RN P's] decision and rationale for her actions again would have been appropriate for a short time limited period as there were a number of indicators that would lead a RN to assume that [Mr A] was asleep and this was due to recovering from a prolonged period of agitation due to mania and the fact that he had been sedated with temazepam and lorazepam the previous night. However [Mr A's] presentation did not change for this whole shift, further assessment was required to investigate other causes for this loss of consciousness.

b. Comment on the care she provided to [Mr A] throughout the daytime shift and her subsequent assessments.

Given the above information, the care that [Mr A] received throughout the shift was not appropriate. [RN P] should have completed a physical assessment of [Mr A] and asked colleagues for assistance to make him more comfortable before 1500hours and afternoon shift had started.

I believe that [RN P] did not provide [Mr A] with adequate care and her actions were a serious departure from expected standards for a RN.

c. If the Commissioner was to find that [RN J], [EN S] and [RN R] did raise concerns with [RN P], please provide comments about [RN P's] response to their concerns.

This is a difficult area to comment on due to the inconsistency of accounts of conversations. [RN P] advised investigators that she had no recollection of 'brushing off' or acting in a dismissive way towards her colleagues. She stated that she had no recollection that concerns were raised with her that day from other nursing staff. Furthermore [RN P] has no recollection that another nurse had said to the investigators that she had applied a sternum rub to [Mr A] with no response, and that the nurse had told [RN P] of this. [RN P] stated that if this had occurred she would have acted on it.

[RN J]

[RN J] is a newly graduated nurse who was on the New Entry to Specialty Practice (NESP) in mental health nursing. In her statement to the investigators [she] stated that on two occasions while completing observational rounds, she went into [Mr A's] room and tried to rouse him by shaking his shoulder and

calling his name. [Mr A] did not stir on these occasions, during one round done by [EN S] and [RN J] [and] when they exited [Mr A's] room [RN J] stated that [RN P] told both nurses to leave him asleep, he was fine.

[RN J] explained that throughout the day she commented to [RN P] and to the charge nurse ([RN Q]), that she thought more attempts should have been made to rouse [Mr A] due to his presentation the night before and the need for him to have his medication. [RN J] stated that she was told to look after her own patients and leave [Mr A] to sleep.

After lunch (approximately between 1230 to 1330hrs) [RN J] was asked by [RN P] if she could help put [Mr A] into a chair. During this [Mr A] did not rouse or make a move. [RN J] stated that she said to [RN P] that it didn't seem right, that he ought to stir or something. [RN P] replied 'He's just over sedated due to the medications last night'. [RN J] stated that she said again this isn't right and was told 'Thanks you are a new grad. I know what I am doing. I have known [Mr A] for years, its better he sleeps'.

[RN J] then called [RN R] for extra assistance, [and] when they got [Mr A] into the chair [RN R] said 'something is not right here'. She was brushed off by [RN P].

[RN J] explained that she was present at afternoon handover and [RN P] handed over that [Mr A] was still asleep due to his over sedation from the previous night, but she had taken his vital observations and they were within the normal range. [RN J] stated that she had not seen [RN P] take vital observations at any time throughout the day.

[EN S]

At the time of this event, [EN S] had been working for Canterbury DHB [for a few years] and had only been working in the acute inpatient services for [a short time]. [EN S] attended handover and recalls being told that [Mr A] was found on the floor at 0300hrs and that he couldn't be woken and put back to bed and that his hot tap was running.

[EN S] stated she was alarmed by this information, no one else appeared alarmed and nothing further was discussed. [EN S] explained that [Mr A] was not her patient. She was allocated to do observation rounds at 1100hrs. However she stated that she went into his room earlier, at 0845hrs as she was concerned and nothing seemed to be being done for [Mr A].

[EN S] then spoke to [RN P] and explained that she was concerned. [RN P] said that he was over sedated and she wanted him to sleep this off and that she would let him sleep until lunchtime. [EN S] repeated that she was concerned and [RN P] became annoyed and [EN S] felt dismissed by her.

At 1100hrs [EN S] was completing her allocated observation round and went into [Mr A's] room. [Mr A] was still on the floor; she described applying a sternum

rub, called his name and there was still no response. [RN J] then joined [EN S] and [EN S] told [RN J] that she was concerned. [RN J] said she was concerned as well and said that she had also questioned [RN P] about this and also felt dismissed by her.

[EN S] again spoke to [RN P] and explained the above conversation and her concern. She stated that [RN P] again dismissed her concerns and said 'don't you think I know what I am doing?'

[EN S] also told [RN R] her concerns and she also said she had concerns and that [RN P] was going to get him up after lunch.

[EN S] had no further direct contact with [Mr A].

[RN R]

[RN R] has been a registered nurse [for about 20 years] and transitioned to mental health [after completing] a post graduate certificate in mental health. She had been working in the [acute inpatient services unit] [for a short time]. She explained that [the] unit had been split into [two units] shortly before the incident.

[RN R] attended handover and recalls the night shift handing over that [Mr A] had been sleeping on the floor. They stated that they were not able to get him off the floor. She could not recall if they mentioned how long he had been on the floor.

[Mr A] was not one of her allocated patients. She described her duties and said that she was allocated to do 30 minute ward checks throughout the shift.

[RN R] explained that her first encounter with [Mr A] was when she did the ward check, she was unsure of the times. On her first check she noticed he was lying on the floor. He appeared to be breathing as she took the time to check that his chest was moving. She then left and carried on with the rest of the ward check.

Her next encounter was when she was asked by another RN who had come out of his room to help lift him off the floor. She went into [Mr A's] room where [RN P] and the other RN were in attendance. [RN R] described lifting [Mr A] onto a chair. He appeared warm and pale in colour and he was breathing but he did not respond when being lifted into the chair. [RN R] described putting [Mr A's] shirt on. She explained being surprised that they didn't put him into his bed, but happy he had been lifted off the floor. [RN R] then asked [RN P] what was wrong with him and she stated that he had been given 30mg of temazepam and that he hadn't slept for days. [RN R] described being surprised by the dose as she felt this was a large dose for an elderly gentleman. She was unaware at this time what time [Mr A] had received the Temazepam. [RN R] believed that at the time [Mr A] was not responding because he was sleep deprived and had been heavily sedated.

[RN R] explained that she had no reason to question [RN P] as she was aware that [RN P] was a senior nurse who had been working in mental health for many years. [RN R] was not aware of [Mr A's] medical or mental health history as she had not

read his clinical notes or medication chart. She stated that she had no knowledge of any falls or whether anything had happened in hospital that explained his lack of response. She explained that [RN P] was confident and dismissive of her questions and this led her to believe that she had the ability to make sound decisions.

[RN R] then continued her duties and had no further contact with [Mr A] for the rest of the day. She stated that her contact with [Mr A] would have been between ten and fifteen minutes over the whole shift.

She said she did not discuss this further with [RN P] as she believed [RN P] would know what she was doing and she would have discussed him with others if she had any concerns. However she stated that there was discussion about [Mr A's] care between a couple of nurses on the morning shift; she cannot recall the whole conversation but remembers they were all voicing their concerns about [Mr A's] care. She cannot recall if it was before or after she helped lift him into his chair.

Comment

After reviewing all the statements from these nurses, if the Commissioner was to find that [RN J], [EN S] and [RN R] did raise concerns with [RN P], I am of the belief that [RN P's] response to their concerns was inadequate. A reasonable nurse confronted with so many concerns would have acted on them. I note that this was also stated by [RN P] in her statement.

I am not in a position to make comment on the validity of each of the statements contained in the investigation.

The statements from [RN J], [EN S] and [RN R] seem consistent in their content. It appears that all three of these nurses had less experience than [RN P] within the acute inpatient services.

A possible action open to them could have been to take their concerns further to the Charge Nurse, only [RN J] mentioned that she commented to [RN Q], or if this was unsuccessful the Duty Nurse Manager could have been called. However they did not do so. In my experience I have seen this happen when nurses are concerned about the welfare of a patient and there is an impasse between team members as to the right course of treatment or care options. It is useful for an independent person to be involved in the discussion and options.

I don't believe that these three nurses deviated from the expected standards of care. I believe that they provided a level of care consistent with their experience levels. They did explain in their statements that they had questioned the care [Mr A] was receiving. However they didn't appear to take their concerns to the next level. I believe that the above course of action could have assisted to resolve any issues relating to the right options.

7) The orientation of staff to [the Ward] as described by [RN L].
[RN L] was acting in the position of Charge Nurse Manager [while] the regular CNM was away on leave. [Inpatient Unit X] opened [shortly before [Mr A's] admission].

[RN L] was tasked to ensure the new ward was ready for opening. Part of this task was to orientate new staff to the ward. [The] ward was created by dividing and refurbishing the [old acute ward into two separate units]. Staff from [the old ward] were familiar with the old layout and worked around workmen and builders during the refurbishment process. Various parts of the ward were closed off at different times to allow refurbishment.

[RN L] explained that he contacted all of the new staff from other areas of the hospital who were to work in [Inpatient Unit X] to offer orientation. This contact was made personally, either by telephone or by internal mail. [RN L] commented that some staff were on annual or sick leave at the time and received an orientation at a later date. Some staff declined an orientation stating they would do so when they started on the ward. One [acute ward] EN requested a one day orientation and this was provided [the day before opening].

There was no formal orientation guide or checklist. Orientation consisted of [RN L] showing new staff around the ward. They were shown the ward layout including offices, bedrooms, clinic, interview rooms, lounges, dining, occupational therapy room, housekeeping, laundry, sensory room, de-escalation room and high care area. Staff were shown the location of duress alarms, duress panels, fire alarms, fire panel, fire hoses, extinguishers and evacuation areas. In the clinic, staff were shown the location of the emergency trolley, other emergency equipment and medication storage and how to access the drug keys.

[RN L] stated that he was satisfied that all staff were provided with the opportunity for an orientation to the [new inpatient unit].

Comment
From the information provided above it appears that there were opportunities for everyone to be orientated to the new unit with flexible options relative to length and timing. Orientation was provided in the week [prior to opening].

In my experience with similar processes in my current workplace it is advantageous to allow for one to two weeks orientating staff and trying out the facilities when units are refurbished. Sometimes this is not possible if the refurbishment project is delayed.

It is not clear why the regular CNM was permitted to be on annual leave over this critical period, allowing the responsibility to fall on an acting CNM.

Given this situation [RN L] did well to manage this process.

In reviewing all the documentation presented I am not of the opinion that the care provided to [Mr A] was influenced by issues relating to orientation of staff.

8) Comment on whether it is common to find a patient asleep on the floor in a mental health ward?
From the information provided in statements by staff members, several of the RNs explained that it is not unusual in an acute mental health setting for patients to sleep on the floor.

[RN Q] explained that this can be for various reasons such as:

- Post trauma where people find an unfamiliar bed untenable
- Those in some phase of mania who will be made comfortable wherever they feel they can rest

[RN K] described that in his experience this could be driven by illness or purely a matter of choice.

[RN O] explains her experience with working with patients with elevated mood who often resist going to sleep can eventually end up sleeping on the floor.

In my experience also there are occasions I know of in the acute mental health ward setting where people will sleep on the floor for similar reasons to those mentioned by the RNs in this investigation. This is mainly driven by illness or choice; I am particularly aware of the choices people who have been homeless will make to sleep on the floor.

In most cases I am aware of, this will be known to staff and it will be noted within the patient's management plan with any particular guidance for staff as required.

9) Comment on the accepted practice regarding half hourly observations.
Observation and engagement policies vary greatly from setting to setting. I have reviewed the CDHB Observation including specialing policy and it is relatively consistent with policies I am familiar with. The policy is due for review this month August 2014, I am aware that the National Directors of Mental Health Nursing group and Te Ao Maramatanga, NZ College of MH Nurses have completed a literature review of observation and engagement policies and research and have developed a draft position statement. I recommend that CDHB use this document to assist with the review of their current policy once the position statement has been finalised.

10) Comment on the level of contact that the nursing staff had with [Mr A's] family.
After reviewing all of the documentation available I don't believe the level of contact with [Mr A's] family was adequate. Nursing staff missed opportunities to contact them about the admission from the rest home and subsequent care. This led to an urgent contact on [Sunday evening], after [Mr A] was admitted to the public hospital and the prognosis was poor.

11) Comment on [Mr A's] voluntary status and his requests to return to the rest home.

As mentioned previously on page five of this report.

People who are voluntary patients and wish to leave locked mental health units have the right to leave that unit unless they are compulsorily detained and assessed under the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992. The review team commented on the potential for [Mr A's] legal rights to have been breached. I concur with this; in my experience there did not appear to be real informed consent to stay voluntarily on admission and it was clear that [Mr A] was withdrawing any assumed consent by asking to leave. The NZ Bill of Rights Act section 22, Liberty of the person states that everyone has the right not to be arbitrarily arrested or detained. The use of the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992 should have been considered, if the treating team wished to detain [Mr A] against his will. It is surprising that this process was not invoked by an acute mental health inpatient ward, where this occurrence would be common.

12) Comment on the adequacy of CDHB's policies.

What I have read of the Canterbury DHB policies, Service Provision Framework and Specialist Mental Health Services orientation booklet for staff appear adequate. I commented above specifically about the Observation including Specialing Policy. The Supervision Policy is similar to what I am used to in my current workplace setting.

The Service Provision Framework is a detailed document with clear expectations around clinical practice and pathways. However it is currently four years old and I noted that in section four the Clinical Functioning, Professional Specific Skills — Nursing Staff, it refers to the Nurses Act 1977; this has been superseded by the Health Practitioners Competency Assurance Act 2003.

13) Comment on the changes implemented by CDHB.

From the information contained in the Canterbury DHB Serious Incident Review Report [dated …], specifically page 30 the changes implemented since the event appears adequate.

14) The changes recommended in the CDHB's Root Cause Analysis Report.

The recommendations proposed in the Root Cause Analysis Report also appear to be adequate.

15) Comment on the ward and clinical working environment and the background and situational stressors noted by [RN P].

Taking all of the information into consideration it did appear that there were challenges relating to the physical working environment, much change and new facilities. I believe that there were situational stressors that could have impacted on [RN P] at the time of this event. However there were others that were not affected by these.

[RN P] was described by numerous medical and nursing colleagues as being a good nurse and the behaviours and actions on that day seemed out of character. [RN P] has provided some reflections about this in her statements. However on that day [RN P] did not provide [Mr A] with an appropriate standard of Care.

Summary

Unfortunately in this case multiple factors were evident, such as a patient with high and complex needs. Systemic issues such as documentation system issues, including different Electronic Medical Records between [the public hospital] and [the psychiatric hospital], communication between clinical disciplines, clinical handover, human factors, environmental factors, which all lined up to contribute to a tragic outcome.

It appeared that a decision was reached by a number of nursing staff that [Mr A] had eventually fallen asleep after being sedated to manage an elevated mood and difficulties managing [Mr A's] behaviour. This was not explored or assessed further to rule out any other cause, for example an unwitnessed fall or any other reason for him to be unrousable for 12 hours.

Staff did not consider any other explanation or alternative so followed a particular plan and course of action. The assumption that [Mr A] was sleeping proved to be wrong in this case with a tragic outcome. [Mr A] was unresponsive to stimuli for 12 hours.

References:

Mental Health (Compulsory Assessment and Treatment) Act 1992

Ministry of Health. 2012. *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*. Wellington: Ministry of Health.

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Wong MC, Yee KC, Turner P. (2008) Clinical Handover Literature Review.

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