Assessment of mental health patient found on floor (13HDC01375, 2 June 2015)

Registered nurse ~ Psychiatric hospital ~ District health board ~ Mental health ~ Fall ~ Assessment ~ Voluntary patient ~ Environment ~ Culture ~ Policies ~ Communication ~ Continuity of care ~ Rights 4(1), 4(2), 4(5), 7(7)

An elderly man who had a complex medical history and had been diagnosed with bi-polar affective disorder, was admitted to a psychiatric hospital as a voluntary patient. The man's family was not informed of his admission.

The following day, a registered nurse (RN) was allocated the care of the man on the afternoon shift. As the night progressed, the man was adamant that he was going back to his rest home, and asked staff to take him there. The man was kept at the hospital.

Overnight, two RNs were on duty. At 3.30am an RN heard water running in the man's room. She went to investigate and found the man on the floor mostly naked, with his walker frame near the end of the bed. The man did not rouse to voice or gentle touch. The RN 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. Both RNs then observed and assessed the man, including his breathing, colour, response, position and comfort. They made the decision to leave the man, as it was not unusual to find patients sleeping on the floor during the night. They did not consider the possibility that the man might have fallen.

The next day, following the morning shift handover, an RN checked on the man 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. At approximately 1pm, the man was lifted into a chair.

The RN in charge of the afternoon shift was told at handover that the man was still asleep as a result of over-sedation. The man's observations were taken and he was transferred to the bed. He did not show any signs of responding to staff. The duty house surgeon reviewed the man and rang an ambulance to transfer him to the public hospital. Following a CT scan, a large subdural bleed on the right side of the brain was identified but was considered too extensive to treat. The man died that evening.

It was held that two of the RNs failed to assess the man adequately when they found him on the floor, breaching Right 4(1). One RN breached Right 4(1) for failing to review the man's clinical notes correctly and failing to assess him adequately. Adverse comment was made about an RN's failure to respond to the concerns raised by her colleagues.

It was also held that the DHB did not comply with legal standards and breached Right 4(2) for the failure of its staff to communicate with the man's family regarding his admission to hospital. The DHB breached Right 7(7) as the man was prevented from leaving hospital despite his voluntary status. The DHB also failed to ensure continuity of care, and breached Right 4(5). Adverse comment was made about the DHB regarding the environment, culture, and its failure to ensure that staff were familiar with policies and protocols.

Adverse comment was also made about the shift leader's suboptimal leadership.