Registered Nurse, Ms B

A District Health Board

A Report by the Deputy Health and Disability Commissioner

(Case 12HDC01008)

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Executive summary

Facts

1. Ms A was being nursed in the de-escalation area of a district health board's (the DHB) forensic mental health unit (the unit), which is a medium secure unit. The de-escalation area provides the highest level of care available at the unit. Ms A was admitted to the unit on 2 February 2012 because of her increasingly changeable mood, psychosis, and associated aggressive behaviours.

2. Registered nurse (RN) Ms B had been employed by the DHB as a registered nurse from December 2011. This was her first job as a registered nurse.

3. On 4 April 2012, Ms A was placed in seclusion because of her unsettled mental state and behaviour. She was released from seclusion at 7.10pm that night by the registrar on duty. Ms A was still changeable in mood but able to follow nursing directions. At 9.40pm, Ms A's progress notes state: "Staff to remain vigilant for potential/impulsive hostility/threatening behaviour."

4. On 5 April, Ms A was in the de-escalation area. RN B was assigned to care for Ms A during the shift. RN B was also Ms A's associate key worker.[1] Mental health support worker (MHSW) Ms C, RN D and another client, who was assigned to RN D's care, were also in the de-escalation area.

5. RN B and RN D (a new graduate) were supported by the senior nurse in charge, RN E, and the Clinical Co-ordinator, RN G. Both RN E and RN G were on duty in different but nearby areas of the unit. RN E had been involved in placing Ms A in seclusion the previous day and was aware of staff concerns about her behaviour. Ms A had acted aggressively towards RN E that day.

6. Ms C brought lunch from the kitchen and ate it in the lounge with RN B, RN D, Ms A and the other client. Ms A began swearing at RN D.

7. RN B told Ms A to go to her room for time out. Ms A swore at RN B and went to her room. Ms A then came out of her room and demanded a hot drink. RN B said that she would make her one if she calmed down. RN B moved in the direction of the staff office.

8. Ms A turned and approached RN B, and punched her on the left side of her head. RN B responded by punching Ms A at least twice on the upper part of her body.

9. RN D and Ms C restrained Ms A. One of them pressed the duress alarm and RN E entered the de-escalation area.

10. RN E and a psychiatric registrar decided that Ms A should be given an intramuscular injection (IM) to calm her. RN E left to collect the medication, and RN B followed her. RN G arrived.

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[1] Associate key workers fill in when the key worker is absent.

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11. RN B's ear was bleeding. RN G asked RN B whether she was "ok", and she confirmed that she was. RN B offered to give Ms A the injection, and RN E agreed for her to do so.

12. RN B gave Ms A the IM injection. RN D, Ms C and another MHSW held Ms A while the injection was given. Ms A was then escorted to her room and put into seclusion.

13. RN G asked RN B whether she would like to debrief, and recommended that she see a doctor. RN B declined these offers. No formal debriefing was held with any staff.

Findings

RN B

14. RN B failed to provide services with reasonable care and skill when she punched Ms A and, accordingly, breached Right 4(1)[2] of the Code of Health and Disability Services Consumers' Rights (the Code).

The DHB

15. Adverse comment is made about the DHB in relation to events following the altercation between RN B and Ms A.

RN G and RN E

16. Adverse comment is made about the actions of RN G and RN E in relation to events following the altercation between RN B and Ms A.

Complaint and investigation

17. The Commissioner received a complaint referred by the Nursing Council of New Zealand about the services provided by RN B. The following issues were identified for investigation:

- *The appropriateness and adequacy of the care provided by registered nurse RN B to Ms A on or about 5 April 2012. In particular, it is alleged that RN B assaulted Ms A.*
- *Whether the DHB provided Ms A with an appropriate standard of care in April 2012.*

18. An investigation was commenced on 10 September 2012 in relation to RN B, and extended to include the DHB on 10 April 2013. This report is the opinion of Deputy Commissioner Theo Baker, and is made in accordance with the power delegated to her by the Commissioner.

[2] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

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19. The parties directly involved in the investigation were:

Ms A	Consumer
Nursing Council of New Zealand	Referring organisation
RN B	Provider/registered nurse
The DHB	Provider

20. Information was reviewed from:

Ms C	Mental health support worker
RN D	Registered nurse
RN E	Registered nurse
Mr F	Mental health support worker
RN G	Registered nurse/Clinical Co-ordinator
Mr H	Associate Operations Manager
Ms I	Associate Director of Nursing, Mental Health Directorate

21. Ms A did not wish to comment on the events leading to this complaint, or have any involvement in the investigation.

22. Independent expert advice was obtained from RN Kathryn Brankin, a specialist in psychiatric nursing (**Appendix A**).

Information gathered during investigation

Ms A

23. Ms A (then aged in her early twenties) was being nursed in the de-escalation area of the unit. The unit is classed as medium secure, and caters for the needs of men with lower clinical risk, and women of varying risk. The DHB advised that the de-escalation area is typically used to provide greater security for aggressive or self-harming clients, and that its usual use is for newly admitted or aggressive clients.

24. Ms A was admitted to the unit from prison on 2 February 2012 because of her increasingly changeable mood, psychosis, and associated aggressive behaviours. Her legal status at the unit was as a special patient under the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992.[3]

25. According to Ms A's risk statement, she presented as guarded and suspicious. She was classified as being a current risk of harm to other people, because she had required restraint when being transported to the unit from prison. She also had a history of assaulting prison staff.

[3] A special patient is someone detained under the mental health legislation, who has come into the mental health service via the criminal justice system, as an offender or alleged offender.

HDC

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26. RN E told HDC that Ms A had a history of assaulting staff, and there were not always warning signs. RN E said that it was difficult to read Ms A because she presented as being emotionless.

27. In response to my provisional opinion, the DHB stated that the majority of patients in forensic units have a risk of harm to themselves or others and, accordingly, treatment plans can be tailored and contingencies provided for, to best cater for such risks. The DHB also stated that, due to their prior record through the justice system and duration of stay, the behaviour of patients in forensic units such as this is in fact more predictable than that of patients who present acutely and have no prior record.

Unit staffing

28. The DHB advised that operational and clinical oversight of patients and staff on the unit is provided by a clinical co-ordinator, who is in turn supported by a team leader. At the time of the events leading to this complaint, RN G was the Clinical Co-ordinator, a position she had held for almost two years.

29. The DHB explained further that all of the unit's registered nurses on duty work under the direction and supervision of the designated co-ordinator, who is the senior nurse in charge (24 hours a day, seven days a week). The designated co-ordinator is either the Clinical Co-ordinator or, when that person is not rostered on, a shift co-ordinator.

30. The DHB advised that the care of all patients is discussed at each handover, and the designated co-ordinator assigns clients to the oncoming nurses according to their experience and therapeutic relationship with the client.

31. The DHB explained further that registered nurses on the unit are accountable for directing, monitoring and evaluating the nursing care provided by the mental health support workers, junior nurses and students.

32. In response to my provisional opinion, the DHB said that nurses are actively encouraged to seek guidance and support from more experienced peers.

RN B's background

33. After her nursing training, RN B completed three postgraduate placements (each of three months' duration). These placements included an acute and intensive inpatient mental health service, and another with forensic and intellectual disability inpatients. In 2011, RN B completed the Mental Health New Entry to Specialty Practice programme. The DHB employed RN B as a registered nurse in the unit from late 2011. This was her first job as a registered nurse. On starting work in the unit, RN B had two two-week orientations to the mental health service, including a two-week orientation to the unit.

34. RN B received clinical supervision as part of her graduate programme, but this ceased in November 2011. The DHB advised that on completion of the graduate programme, registered nurses are encouraged to find a clinical supervisor and continue with clinical supervision, but it has no record as to whether RN B did so. RN B advised that she accessed supervision "as and when needed", from a nursing colleague

HDC

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working in the DHB's mental health service. The DHB stated that RN B had been "buddied" with more experienced nurses for several weeks after she began working at the unit.

35. RN B completed a four-day Calming and Restraint training course in early 2011 and a one-day refresher course shortly prior to the incident. This course teaches break-away and non-combative self-defence.

Employment concerns

36. Ms C told HDC that RN B had argued with Ms A on 4–5 occasions in the weeks prior to 5 April 2012. Ms C said that she had told RN B that RN B was the "well one", and RN B had acknowledged her comments. Ms C said she was not aware of RN B having a difficult relationship with other patients. In response to my provisional opinion, the DHB stated that, at the time, Ms C did not convey to management any concerns regarding RN B.

37. The DHB stated that RN B had previously been spoken to by colleagues about her attitude towards patients, and told that she should modify her approach. Associate Operations Manager Mr H said that he had seen RN B wearing headphones while working, which he reported to the Clinical Co-ordinator, RN G. Mr H also said that there were some "whispers" about RN B, and that Ms A and RN B had previously had a "stand-up argument" after Ms A threw a cup of tea. RN G said that a couple of registered nurses told her that they had told RN B to be less "matronly" and "directing", and to speak to patients "more nicely". RN G said that she was happy with that and took no further action. RN E also advised HDC that RN B had previously argued with a patient. RN E said that RN B had been taken aside, counselled about the appropriateness of her interaction, and given guidance on how to respond in such circumstances.

38. In response to my provisional opinion, the DHB stated that issues relating to RN B's behaviour prior to the incident leading to this complaint were of little consequence, and RN B was due for a performance review meeting in June 2012, at which time possible strategies could have been discussed. The DHB considers that the employment concerns were "minor and managed".

39. RN B states that she had not been spoken to about wearing headphones, and that in fact she had worn these on her way to work, not at work. She said that if there were concerns with her performance they should have been dealt with at the time by way of a formal procedure, where concerns would have been documented, reported and managed in a respectful manner. RN B said that she had been told to be firm with patients, and she does not recall being told that she was too loud. She recalls being told that she was "too soft".

4 April 2012

40. According to the clinical notes, on the morning of 4 April 2012 Ms A presented as agitated, hostile and aroused. She refused to engage with staff and made threats towards staff and their families. Ms A was placed in seclusion because of her

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unsettled mental state and behaviour. She was reviewed by the duty registrar, who recorded in the progress notes: "[S]upplementary IM OLANZAPINE 5mg — offer [orally], if refuses IM."[4]

41. A nurse recorded in Ms A's progress notes that at 2.40pm olanzapine 5mg and lorazepam 2mg were administered to Ms A.[5] Her presentation became more relaxed and, at 7.10pm, she was released from seclusion by the duty registrar. At the time of release, Ms A was described as still changeable in mood but able to follow nursing directions. At 9.40pm, Ms A's progress notes state: "Staff to remain vigilant for potential/impulsive hostility/threatening behaviour."

42. RN B was not involved with Ms A's care on 4 April.

5 April 2012

43. On 5 April, Ms A was in the de-escalation area at the unit. During interviews with HDC staff, RN B, RN G, and Mr H all said that RN B was "in charge" of the de-escalation area that day. However, the DHB stated that registered nurses are not "in charge" while working in the de-escalation area because they are not co-ordinators, but they are responsible for the clients assigned to their care. RN B was assigned to care for Ms A, and was also her associate key worker.

44. The DHB also stated that at the time of the events leading to this complaint, RN G was in a meeting, so RN E, as the most experienced nurse "on the floor", was overseeing the patients within the unit, and available to provide support to other staff if needed.

45. RN B said that, as she had had a handover from the previous shift, she was aware that Ms A had been in seclusion the previous day and would be "on edge". RN B told HDC that, because of her inexperience, she felt "jittery" around Ms A. RN B subsequently stated that she always found herself "jittery" when working in the de-escalation area. She said: "It was a frightening place to work." In response to my provisional opinion, the DHB stated that RN B expressed no concerns to senior staff about caring for clients in the unit and de-escalation area, and in fact often requested to work in the de-escalation area.

46. Ms C, RN D and another client, who was assigned to RN D's care, were in the de-escalation area with RN B and Ms A. RN G told HDC that senior support was available for RN B and RN D (a new graduate) from RN E, who was close by, and from Ms C, who was very experienced.

47. RN D told HDC that she felt unsafe that day because of Ms A's behaviour the previous day. RN D said that she was expecting Ms A to lash out, given her presentation and behaviour on previous occasions. RN D said that she told RN E about her concerns at the start of her shift but RN E reassured her that the evening

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[4] Olanzapine is an atypical antipsychotic medication. At this time, Ms A had been prescribed olanzapine both as a regular (fortnightly) depot injection, and on an "as required" basis.
[5] The medication chart does not record the administration of olanzapine.

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staff had considered it appropriate to release Ms A from seclusion. In response to my provisional opinion, the DHB stated that the decision to release Ms A from seclusion was appropriate, and that when RN D raised her concerns with RN E, they discussed potential management strategies should Ms A's mood escalate. The DHB stated that RN D gave no indication to RN E that she felt unsafe in the de-escalation area.

48. RN E told HDC that she and RN D were "irritated" by the decision to release Ms A from seclusion. RN E had been involved with placing Ms A in seclusion on 4 April after she threatened to stab a staff member with a pen.

49. At around midday on 5 April, Ms A was aggressive, acted in a threatening manner, and directed inappropriate language at RN E when she was delivering medication to the de-escalation area. It appears that this was a result of Ms A having learned that morning that RN E had completed a report recommending that Ms A be placed under a compulsory treatment order. This meant that RN E was no longer able to work therapeutically with Ms A.

50. RN E initially told HDC that she did not speak directly to RN D or RN B about her concerns, because she did not want to "step on [the nurses'] toes". In response to my provisional opinion, the DHB said that this comment had been taken out of context.[6] The DHB stated that RN E had assessed the situation after her confrontation with Ms A, and it appeared that the incident had been effectively defused by RN B and RN D, as Ms A was sitting calmly on the couch in the de-escalation area. The DHB stated that RN E withdrew from the de-escalation area to continue the dispensing of lunchtime medication, as well as "to prevent further evoking [Ms A's] state, as had been discussed and agreed with [RN B]".

51. RN G said she was aware that Ms A had just come out of seclusion, but she was not aware that Ms A had had a confrontation with RN E that morning. RN G said that on 5 April no staff member had expressed concerns about Ms A to her.

Incident between Ms A and RN B

52. Ms C, RN B, RN D, Ms A and another client ate lunch together in the lounge. At around 12.25pm, Ms A began swearing at RN D. RN B told Ms A to go to her room for time out. Ms A swore loudly at RN B and then went to her room.

53. RN D, Ms C, and RN B each gave HDC an account of what happened next.

RN D's account

54. RN D stated that Ms A came out of her room again and swore at RN B: "Where is my […] hot drink?" RN B replied that she would make one if Ms A calmed down.

55. Ms A "turned still swearing and ran about a dozen steps and punched [RN B] twice in the head very fast". Ms A was holding RN B's neck or shoulder with her left hand while punching with her right hand. RN B covered her head with her arms and

[6] The DHB confirmed that RN E had the opportunity to review my provisional opinion, and that her comments had been incorporated into the DHB's response.

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grabbed Ms A's arm and blocked her next punch with her other arm. RN D did not see RN B hit Ms A.

Ms C's account

56. Ms C told HDC that RN B declined to make Ms A a cup of tea and that Ms A took one or two steps and hit RN B three to five times to her head. RN B responded by punching Ms A three or four times, and Ms C grabbed RN B from behind and directed her to the office.

RN B's account

57. RN B told HDC that she was concerned about Ms A's agitation so offered her water, which Ms A declined. RN B then moved in the direction of the office, but Ms A punched her twice, very hard, first to her left ear and then above her left ear. After Ms A punched her, RN B "instantly responded by punching out towards [Ms A] at least twice to the upper shoulder area". RN B said that she "may have thrown punches as a reactive gesture".

Restraint and medication administration

58. The staff agree that RN D and Ms C restrained Ms A. One of them pressed the duress alarm, which sounded to alert other staff. RN E entered the de-escalation area from the nearby office. She said she had been working on rosters close by because she was concerned about Ms A's behaviour. In response to my provisional opinion, the DHB stated that RN E was "there within seconds". RN E instructed RN D and Ms C to take Ms A down to the ground. RN E assisted by restraining Ms A's legs, as she was kicking out. RN B assisted the others to restrain Ms A by taking her head. Mr F arrived and replaced RN E by restraining Ms A's legs.

59. RN E told HDC that she decided that Ms A should be given an IM injection to calm her, which is a common procedure for agitated patients. In response to my provisional opinion, the DHB said that the psychiatric registrar, who was also present following activation of the duress alarm, recommended an alternative IM injection. RN E went to the surgery room to collect the medication, and RN B followed her.

60. RN G had been in a multidisciplinary meeting all morning. At this point she entered the de-escalation area, checked on the other client, and then went into the surgery room. By this time, RN E and RN G had noticed that RN B's left ear was bleeding. Her earring had been torn out during the incident. RN G initially told HDC that they "mopped [RN B] up a bit" and gave her plasters and wipes to use on her injured ear. RN G described RN B as being "shaky" and "all over the place". RN G said she asked RN B if she was "ok", and she replied that she was. RN B did not tell RN E and RN G that she had punched Ms A.

61. In its response to my provisional opinion, the DHB advised that initially RN E was not aware that RN B had been punched, but assumed the bleeding was a result of the restraint.

62. RN B offered to give Ms A the injection. RN B told HDC that she felt she had to "see it through to the end". RN E agreed that RN B could administer the injection. In

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response to my provisional opinion, the DHB stated that RN B "insisted on administering the IM injection", and that RN E agreed to this in the context of not being aware either that RN B had been assaulted, or of the alleged retaliation. RN G told HDC that the general procedure is for the lead clinician to follow through with medication and, as she was unaware of RN B's alleged assault of Ms A, there was little reason to decline RN B's request to administer the IM injection. RN G stated: "I thought it may have helped her to feel she had managed the situation."

63. RN B and RN E re-entered the corridor and, after Ms A was told what was going to happen, RN D and Ms C held Ms A while RN B gave Ms A the injection. In response to the provisional opinion, the DHB stated that RN E supervised and also assisted with the restraint. The DHB stated further:

> "While in hindsight it might not be considered best practice to allow a nurse involved in an altercation to administer the IM injection, this was a considered decision by the staff at the time where the emergency response required skilled carers to maintain a careful restraint of the client as the IM injection was being administered. The reality of the situation is that when a crisis arises in a care facility and all staff are required to assist, the alternative role for [RN B] would be for her to assist with the restraint as [Ms A] was still kicking and fighting."

64. The DHB also stated that allowing RN B to administer the injection carried low risk of cross infection through body fluid transmission because the bleeding from RN B's ear was minimal. In addition, given that it was Ms A's assault on RN B that caused RN B's ear wound, that risk already existed.

65. Ms A was then escorted to her room and put into seclusion.

Events following the incident

66. Mr F told HDC that, about 15 minutes after the incident, he saw RN B in the office of the de-escalation area. She was holding her bleeding ear and was not receiving any medical attention. Mr F told HDC that RN B said that she was all right but that she had done something wrong — she had hit Ms A. Mr F told RN B that she would probably be "ok" because she had acted in self-defence rather than to hurt Ms A.

67. According to the DHB, the bleeding from RN B's ear was minimal, and she reassured her colleagues that she was all right. The DHB stated that RN B's ear was reviewed by the psychiatric registrar, first aid was provided, and she was advised to seek medical attention and offered assistance with transportation to the medical centre. The DHB stated that RN B agreed to a review by the psychiatric registrar only reluctantly, and declined to seek further medical attention.

68. According to the DHB and RN G, RN B declined an invitation to "defuse",[7] as well as the options of "time out" from the unit or to finish her shift early. Accordingly, RN G

[7] The DHB advised that some staff have misunderstood the use of the terms "defuse" and "debrief". A "defuse" is held immediately after an incident or soon thereafter during the shift, whereas a "debrief" is

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determined that in order to remove RN B from "the area of confrontation", the best option was to ask her to escort a different patient out of the unit, which she did. RN G said: "I was not made aware on [5 April] that [RN B] allegedly punched [Ms A] …"

69. An informal debrief was held between RN E, RN D and Ms C at that time. Ms C told RN E that RN B had punched Ms A several times. Ms C asked RN D if she had seen it, and RN D said that she had not. RN D said that she was focussed on Ms A and did not see RN B hit Ms A.

70. RN B told HDC that after she had escorted the other patient she was telephoned and told to return to the unit to complete the paperwork. In response to my provisional opinion, the DHB said that RN B was called back to complete the documentation, and also because staff had revealed that RN B had struck Ms A. RN B wrote in the progress notes:

> "[Ms A] started pushing boundaries with staff, making +++ demands and utilising inappropriate language towards staff, on three different occasions throughout the day. However, during last occasion [Ms A] assaulted [nurse] with closed fist, resulting in 3 man restrain[t], the DHB approved, and another 3 man escort into seclusion. x2 incident reports completed."

71. On the first incident report, RN B described what had occurred:

> "Patient asked writer for cuppa tea, patient utilising pro[f]ane language toward staff. Staff directed [patient] to wait after time out, however, patient charged writer, punching with closed fist to writer's head."

72. On the second incident report, RN B recorded that Ms A was escorted into seclusion by a three-man team, utilising the DHB's approved hold. Neither incident suggests that Ms A suffered any injury during the incident.

73. RN B recorded in the progress notes that 5mg olanzapine was administered intramuscularly; however, the administration of the medication is not recorded in the medication chart.

74. RN G said that she asked RN B if this was the first time she had been assaulted, and RN B said that it was. In a statement written for the DHB's internal investigation, RN G said that she advised RN B that "sometimes being assaulted brings out feelings of wanting to hit back and that is why it is important for defuses, debriefs and supervision to keep us safe". RN G asked RN B whether she would like to debrief, and recommended that she see a doctor. RN B declined both these offers and said that she would do some exercise to relax. RN G told HDC that at that stage she thought it was the end of the matter.

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more formal, is organised when required in conjunction with the co-ordinator and/or team leader, and takes place on a subsequent day.

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Subsequent events

75. RN G decided that RN B should not continue to work with Ms A and, accordingly, RN B was rostered to work on the "open side" of the facility. RN G told HDC that RN B became "passive-aggressive" towards her after this. The DHB and RN G stated that at that time, RN G was still unaware of RN B's alleged assault of Ms A.

76. RN B said that she was happy not to be working in the de-escalation area. She said that she felt RN G ignored her, both prior to and following the incident, and that she no longer felt safe talking to RN G.

77. RN D told HDC that a few days later, RN B told her that she had hit Ms A in the heat of the moment, and asked RN D for advice. RN D told HDC that she responded that she was unable to offer any advice, as she herself was only a recent graduate.

78. On 10 April, RN B met with Mr H, Associate Operations Manager. She told him that her head was still "tender" and that she had not been to the doctor. Mr H told RN B that it would "probably be best" that she did so, and reminded her that there was an employee assistance programme available. In response to my provisional opinion, the DHB stated that RN B was again advised to seek a medical review, and reminded of support available through the Employee Assistance Programme and supervision.

79. In response to my provisional opinion, the DHB stated that RN B did not raise the "alleged assault" at the meeting with Mr H. The DHB said that Mr H learned of it on 11 April, and then commenced the DHB's investigation process.

80. The DHB's Executive Director advised that "the prevailing picture is of [RN B] declining assessment and treatment and there was no way of persuading her".

81. RN B told HDC that she felt that the unit was unsafe, and her treatment by senior staff made her feel "targeted, embarrassed and unsupported". She acknowledged that her actions were inappropriate, stating:

> "This was not the reaction I wanted to believe I had done … it was unacceptable to me.
>
> …
>
> Initially I did not admit to punching [Ms A], as I couldn't believe that is what I had done."

82. RN B did not reapply for her Annual Practising Certificate when this expired on 30 June 2012, and no longer works for the DHB.

Changes implemented during HDC investigation

83. Following this incident, the DHB conducted an investigation, and RN B was suspended. RN B resigned during the investigation.

84. The DHB subsequently implemented a buddy/mentor system in the unit for nurses who have recently graduated. They are allocated a senior nurse buddy for around six

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months, or as long as the newly graduated nurse needs. The nurses work side-by-side during this time.

85. The Associate Director of Nursing, Ms I, stated that staffing on 5 April 2012 was at normal levels, and that not much had changed following the incident, as it was a one-off event, covered by existing policies. In response to my provisional opinion, the DHB stated that no changes have been made to the investigation process, and that instances such as this are extremely rare and can be managed on a case-by-case basis.

Additional information from RN B

86. RN B reviewed the advice from my independent expert advisor, RN Kathryn Brankin, and submitted an additional response to HDC. RN B offered a further reflection on the events leading to this complaint, and what she has learned from the experience.

87. RN B's comments include the following:

> "No one has the right to assault you and if they do, you have a right to defend yourself. Had this experience been one of slow motion, I would have utilised a different approach, however, it wasn't. I look back on this incident and see such a small amount of support from the unit, and therefore the employer. This situation, also had a huge impact on my life, working in an environment like this is really stressful and takes a lot of factors for a successful outcome."
>
> and:
>
> "In my reflection, I have learnt that my actions were inappropriate. I had crossed the line, by making physical contact with a patient, [who] was in my care. I was responsible for [Ms A's] care and safety in this incident and am able to see this, and therefore accept and take responsibility for this."

Responses to provisional opinion

88. Responses have been included in the "information gathered" section where appropriate. In addition, the following responses were received:

The DHB

89. The DHB submitted:

- If graduate and second year nurses were not able to work with patients with high needs or unpredictable behaviours, they would be unable to work in any inpatient mental health unit.

- RN B was not a new graduate because she qualified 17 months prior to 5 April 2012. RN B had been working in the unit for "some four months".

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- RN B gave the impression that she was engaged in regular supervision, but the DHB does not record the content or frequency of staff members' supervision.

- Contrary to the opinion of HDC's expert advisor, RN Kathryn Brankin, that de-escalation techniques were not employed following Ms A's confrontation with RN E on 5 April, both one-to-one nursing and a low-stimulus environment were employed to defuse the situation.

- The provisional opinion and some staff have misunderstood the use of the terms "defuse" and "debrief" at the DHB. A "defuse" is held immediately after an incident or soon thereafter during the shift, whereas a "debrief" is more formal, is organised when required in conjunction with the co-ordinator and/or team leader, and takes place on a subsequent day.

- Senior staff have "reflected deeply on this isolated incident" and believe RN B was well trained and supported to manage such a confrontation, and that all reasonably practicable steps were taken to prevent RN B acting as she did.

RN B

90. RN B submitted:

- The evidence indicates that she may have punched Ms A in the upper shoulder area, but not in the head.
- She was acting in self defence to protect herself from a vicious assault by a patient who was not well and dangerous.
- Her actions were reasonable in the circumstances. She was an inexperienced nurse who found herself for the first time in a situation where she had to react in a certain way to protect herself.
- She was in a "dire situation" and experienced shock when attacked without warning. She used minimal force and did not harm the patient.
- She has put her life on hold for over a year, reflected on what happened, and accepted full responsibility for her conduct.

Opinion: RN B

Introduction

91. Section 48 of the Crimes Act 1961 states: "Every one is justified in using, in the defence of himself or herself or another, such force as, in the circumstances as he or she believes them to be, it is reasonable to use." This is reflected in the the DHB policy on restraint minimisation and safe practice.

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92. However, as noted in previous HDC opinions, "It is … plainly unprofessional to physically assault a patient. This is so fundamental that it requires little further comment."[8] Nonetheless, in this case, I have considered RN B's actions in the context of her experience and the environment she was working in.

Care of Ms A prior to incident — No breach

93. Ms A had been removed from seclusion on the evening of 4 April. My expert, Ms Brankin, advised that it appears to have been appropriate for Ms A to exit seclusion at that time in the context of her presentation and the wider drive for restraint minimisation.

94. At around midday on 5 April, Ms A was abusive towards RN E. Ms Brankin advised that this incident was not sufficient grounds for further seclusion, but it provided warning signs that Ms A's risk to others was increasing. Ms Brankin stated that there is no evidence that de-escalation techniques such as medication, lowering the stimulus of the environment, or one-to-one interactions were employed at that time. However, in response to my provisional opinion, the DHB stated that one-to-one nursing and a low-stimulus environment were employed.

95. Around lunchtime, Ms A began abusing RN D. RN B asked Ms A to go to her room, which was consistent with Ms A's treatment plan, as seclusion was to be used only as a last resort. Ms Brankin advised that, given RN B's limited experience, the care provided seems adequate. I do not consider that RN B's care of Ms A at that time breached accepted standards.

Physical assault — Breach

96. Ms A initially complied with RN B's instruction to go to her room. However, she returned, wanting a hot drink. There are some discrepancies in the accounts of staff present regarding Ms A's interaction with RN B at this point.

97. Ms C said to HDC that Ms A hit RN B three to five times to her head and then RN B punched Ms A three or four times. Ms C said she grabbed RN B from behind and directed her to the office. When Ms C was subsequently interviewed regarding this incident as part of a DHB investigation, she stated that she thought RN B punched or swung at Ms A four or five times, and that the punches connected in the face/head region.

98. RN D told HDC that she saw Ms A punch RN B twice, but did not see RN B throw any punches, because she was concentrating on Ms A. Both RN D and Mr F said that RN B admitted to them after the incident that she had hit Ms A. RN B, in her response to HDC, said that she punched Ms A at least twice in the upper shoulder area and "may have thrown punches as a reactive gesture". I find it more likely than not that RN B punched Ms A at least twice on the upper part of her body.

99. Shortly prior to the incident, RN B had attended calming and restraint refresher training. However, Ms Brankin commented that this was RN B's first experience of a

[8] Opinion 05HDC13588, Opinion 07HDC20395, Opinion 11HDC00877 available at www.hdc.org.nz.

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physical assault at work, and reactions in practice are often different from training situations. Ms Brankin added that new nurses often find restraint a difficult task, and Ms A's verbal abuse earlier in the day may have lowered RN B's threshold for responding in an appropriate manner.

100. To react to physical violence from a patient by punching back is not acceptable professional practice. Ms Brankin advised that RN B's action of punching Ms A was a moderate departure from expected standards.

101. Ms Brankin stated that "having a new graduate nurse looking after the intensive care de-escalation area, which would indicate a client with high needs and potentially unpredictable behaviours, sets up a vulnerable environment, for both client and nurse". However, the DHB submitted that RN B was not a new graduate, having been in her position for four months, and she had been well trained and was appropriately supported. The DHB also stated that RN B was not in charge of the de-escalation area, and that RN E was the most senior nurse on the floor and available to provide support to other staff if needed. I still consider that RN B was relatively inexperienced and, as stated by Ms Brankin, the reality of a sudden assault may cause a person to react intuitively, rather than recalling and applying his or her training.

102. I have considered the submissions made by RN B's lawyer, outlined above. The evidence supports a finding that RN B punched Ms A in the upper body area. I accept that RN B was responding to an assault by a patient. I am aware that attacks on staff do occasionally occur in a mental health setting, and this is a significant challenge for staff, and I do have some sympathy for RN B's predicament. However, I am satisfied that RN B had received appropriate training in how to respond, and that her actions amounted to more force than was reasonable in the circumstances. While it appears that Ms A was not harmed in the incident, I consider that is by luck, rather than any controlled actions on RN B's part. I accept Ms Brankin's advice that when faced with a sudden assault, a staff member may act intuitively, but I cannot condone the conduct of a nurse punching a patient. It follows that I do not consider that RN B's actions were reasonable, as submitted by her lawyer.

103. RN B's lawyer submitted that RN B "does not deserve any worse punishment … for acting in the same manner as a normal person would have acted in similar circumstances". This submission shows a lack of appreciation of the fact that as a nurse providing care to a patient, RN B was not in the same position as "a normal person". She must comply with the standards expected of a nurse. As stated in the introduction to the Nursing Council of New Zealand's Code of Conduct:

> "Nurses are expected to uphold exemplary standards of conduct while undertaking their professional role."

104. The Council goes on to discuss the values that underpin the Code of Conduct:

> "Nurses are privileged in their relationships with health consumers. Nurses need to establish trusting relationships with health consumers to effectively provide care that involves touch, using personal information, emotional and physical support,

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and comfort. Health consumers need to be able to trust nurses to be safe and competent, not to harm them and to protect them from harm."

105. In the course of this investigation, RN B provided her own reflection, in which she acknowledged that her actions were inappropriate, that she was responsible for Ms A's care and safety, and that she is governed by the Code of Conduct.

106. Taking into account all matters, I consider that RN B failed to provide services with reasonable care and skill and, accordingly, breached Right 4(1) of the Code. Physical assault of a patient is a serious matter, and normally I would refer conduct of this type to the Director of Proceedings. However, in light of the combination of the following factors, I have decided not to do so in this case:

- RN B has been held accountable by being suspended from her employment. She subsequently resigned and has since put her nursing career on hold, pending the outcome of this investigation.
- RN B has expressed remorse and has provided a detailed reflection that shows insight and learning from these events.
- While I consider that RN B had reasonable training and support, and must be held to the standards of any reasonable nurse in those circumstances, I acknowledge that she lacked experience.
- There is no evidence that Ms A suffered any significant physical injury.
- I do not consider that the public interest requires further action in this case.

Opinion: The DHB

Liability for RN B's breach — No breach

107. DHBs have legislated responsibilities to provide safe, quality services, and must comply with relevant service standards issued under the Health and Disability Services (Safety) Act 2001. The Health and Disability Sector Standards set out basic responsibilities, including: the responsibility to ensure that consumers receive services in accordance with consumer rights legislation (NZS8134.1.1.1); and the responsibility to ensure that consumers receive timely, appropriate and safe services from suitably qualified/skilled and/or experienced providers (NZS8134.1.2.8).

108. In addition, under section 72 of the HDC Act, employers are liable for acts or omissions by an employee unless they prove that they took such steps as were reasonably practicable to prevent the employee from breaching the Code. It is therefore also necessary to consider whether the DHB is vicariously liable for RN B's breach of the Code.

109. There is evidence that the DHB provided RN B with both initial and refresher training in appropriate restraint techniques.

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110. The DHB stated that all registered nurses in the unit work under the direction and supervision of the designated co-ordinator, who is the senior nurse in charge. The designated co-ordinator is either the Clinical Co-ordinator, RN G, or a shift co-ordinator.

111. On 5 April 2012, the designated co-ordinator was RN G. She allocated two junior nurses to the two patients in the de-escalation area. The nurses were supported by an experienced MHSW, Ms C.

112. RN G was at a meeting that morning and not available to support the nurses on the floor. However, RN E, who sometimes fulfilled the role of shift co-ordinator, was working in the office adjacent to the de-escalation area, and available to support staff in that area if required. RN G noted in her response to my provisional opinion that she considered RN E to be a very experienced nurse, and was confident that she would have sought support from her (RN G) if required.

113. The DHB stated that registered nurses are not "in charge" while working in the de-escalation area because they are not co-ordinators, but they are responsible for the clients in their care. The registered nurses are also accountable for directing, monitoring and evaluating nursing care provided by the mental health support workers, other junior nurses and students.

114. RN G and Mr H both told HDC that RN B was in charge of the de-escalation area that day. It is concerning that the DHB and senior staff do not appear to share the same understanding of RN B's role at this time. However, I accept the DHB's submission that RN B was not in charge of the de-escalation area. She was the most senior of the nursing staff present in the de-escalation area, and she was expected to take primary responsibility for the patient assigned to her.

115. RN E initially told HDC that she did not speak directly to RN D or RN B about her concerns regarding Ms A because she did not want to "step on [the nurses'] toes". However, in response to my provisional opinion, the DHB (with input from RN E) stated that RN E had assessed the situation after her confrontation with Ms A, and it appeared that the incident had been effectively diffused by RN B and RN D, as Ms A was sitting calmly on the couch in the de-escalation area. The DHB stated that RN E withdrew from the de-escalation area to continue the dispensing of lunchtime medication, and so as not to provoke Ms A further, as had been discussed and agreed with RN B.

116. I have carefully considered the information provided to HDC indicating that RN B may have had performance issues prior to 5 April 2012. Some of the information provided is contradictory. RN G, for example, said that a couple of registered nurses told her that they had told RN B to be less "matronly" and "directing", and to speak to patients "more nicely", while RN B said that she had been told to be firm with patients, and recalls being told she was "too soft". I accept that the performance issues identified were relatively minor, and that it may have been appropriate to manage these informally and in the course of a routine performance review process. However, DHBs must take particular care to ensure that inexperienced nurses are provided with

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appropriate guidance, training, and support to address any performance issues and enable them to adjust to the demands of being a mental health nurse.

117. I note also that although RN B advised HDC that she found the de-escalation area a frightening place to work and that she felt "jittery", there is no evidence that she voiced her concerns to RN G or senior colleagues. According to RN G and the DHB, RN B had requested to work in the de-escalation area.

118. In these circumstances, I do not consider that the DHB is vicariously liable for RN B's breach of the Code, or directly liable for the assault on Ms A. However, I do have some concerns about events following the altercation between Ms A and RN B.

IM injection — Adverse comment

119. Following the altercation between RN B and Ms A, RN B asked to administer the IM injection that had been drawn up by RN E, and was permitted to do so.

120. Ms Brankin advised:

> "The task of administering the [intramuscular] injection is also a technical skill that requires a nurse's full attention and ensuring the site is correctly chosen and prepared for medication administration. The need for extra precaution is also necessary in the context of giving medication during a restraint, due to needle stick injury, placement of needle being disrupted due to movement and infection control issues. As [RN B] had just experienced significant violence it is questionable whether her cognitive and emotional states were stable enough to prevent or react to any issues that could have taken place during the procedure."

121. In addition, Ms Brankin advised that there was a risk to Ms A of body fluid transmission in this situation.

122. In its response to my provisional opinion, the DHB advised that RN B was "insistent" on giving the injection, and that she was permitted to do so under RN E's supervision. At this time, both RN E and RN G were unaware of RN B's alleged assault of Ms A. The DHB also confirmed that RN E was unaware that RN B had been punched by Ms A, assuming instead that RN B's injury was the result of the restraint.

123. The DHB stated further that the bleeding from RN B's ear was minimal, and that as the cause of the injury was Ms A's assault on RN B, the risk of cross infection already existed. Despite this, I consider that there was an increased risk of body fluid transmission in this situation.

124. Furthermore, three other registered nurses and the psychiatric registrar were available. I accept that RN B did not initially disclose that she had been punched, or that she had retaliated. However, I remain of the view that given her injury and her presentation at that time — described by RN G as "shaky" and "all over the place" — she should not have been permitted to administer the injection.

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Continued duty — Adverse comment

125. Ms Brankin stated that the decision to allow RN B to continue working following the assault appeared to be what RN B wanted to do at that time. While this appears to have been the case, I am concerned about this decision. Following the assault and after Ms A had been given the IM olanzapine, RN B was asked to escort another patient out of the unit. While RN B was away from the unit, RN E met with Ms C and RN D. Ms C told RN E what she had seen, including that RN B had punched Ms A. In my view, as soon as senior nursing staff became aware of that allegation, RN B should not have had further contact with consumers pending further investigation.

Documentation of medication — Adverse comment

126. I note that while RN B recorded the IM injection of olanzapine in the progress notes, it was not recorded on the medication administration chart. This was not the first time this had occurred. The previous day, another nurse had given Ms A an oral dose of olanzapine and recorded this in the progress notes but not on the medication administration chart. Failure to accurately record medication given is always concerning; in an environment such as this it carries additional risks.

Support for RN B following assault — Other comment

127. In my provisional opinion, I raised some concerns regarding the adequacy of the support provided to RN B following the incident. I noted the accounts provided to HDC by RN G and Mr H. RN G stated that she and RN E "mopped [RN B] up a bit" and suggested that she consult a doctor. RN G said that she offered RN B the opportunity for a debrief, but this was declined. Mr H stated that when he met with RN B five days after the incident, she reported having a "tender" head. RN B said that she had not seen a doctor, and Mr H said that it would "probably be best to do so".

128. My expert advisor, Ms Brankin, noted that it would have been appropriate to support RN B practically to get access to the medical treatment she required. Ms Brankin also stated that RN B may have benefited from some support and assistance with documentation, noting in particular that Ms A's nursing notes contain very sparse information in relation to the shift during which the incident occurred.

129. In response to my provisional opinion, the DHB provided further information regarding the support provided and/or offered to RN B following the assault. The DHB reiterated that RN B was encouraged to seek medical attention, and noted that she was offered transportation to the medical centre. RN B declined this, and agreed only reluctantly to be seen by the psychiatric registrar. The DHB stated that RN G offered RN B the option of "time out" away from the unit, or to conclude her shift early.

130. RN G stated that she explained to RN B the importance of debriefing after an assault, and offered to arrange this, but RN B declined. RN B stated that she did not feel safe talking to RN G.

131. I accept that it appears that reasonable efforts were made to ensure that RN B received appropriate support following the incident. The fact that RN B appeared to resist these

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efforts may well have been a reflection of her inexperience. It is important that all DHBs ensure that their senior staff working in such challenging environments recognise this risk and take steps to address it.

Opinion: RN G

IM injection — Adverse comment

132. RN G was the Clinical Co-ordinator at the unit. She was responsible for allocating staff to clients each day, and for the clinical and operational oversight of patients and staff, including Ms A and RN B.

133. Although RN G was the designated co-ordinator on 5 April 2012, she was in a meeting that morning. Following the altercation between RN B and Ms A, RN G went into the surgery room where RN E was drawing up the IM injection. RN G observed that RN B was "shaky", "all over the place", and bleeding from her ear.

134. Despite this, RN B was permitted to give Ms A the IM injection, under RN E's supervision.

135. In response to my provisional opinion, RN G said that she was not aware of RN B's alleged assault of Ms A at that time. RN G also thought that allowing RN B to administer the injection might have helped her to feel that she had managed the situation. As outlined previously (see paragraphs 119–124), I remain of the view that it was inappropriate for RN B to have given Ms A this injection. In my view, RN G should have intervened.

Opinion: RN E

IM injection — adverse comment

136. RN E was an experienced nurse at the unit. At around midday on 5 April 2012, RN E had a confrontation with Ms A. The DHB advised that RN E assessed the situation after her confrontation with Ms A, and it appeared the incident had been effectively diffused by RN B and RN D, as Ms A was sitting calmly on the couch in the de-escalation area. The DHB stated that RN E withdrew from the de-escalation area to continue the dispensing of lunchtime medication, and to facilitate Ms A's de-escalation.

137. RN E then heard the altercation in the de-escalation area and responded "within seconds". While other staff were involved in restraining Ms A, RN E went to the surgery room to draw up an injection. RN B followed, and asked to administer the injection. RN E agreed that she could do so. At this time, RN E was unaware that RN B had been punched by Ms A, assuming instead that RN B's injury was the result of

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the restraint. RN E was also unaware of RN B's alleged assault of Ms A. Nevertheless, as outlined previously (see paragraphs 119–124), I am of the view that it was inappropriate for RN B to have given Ms A this injection. In my view, RN E should not have agreed to RN B's request.

Continued duty — Adverse comment

138. A short time after the incident, Ms C told RN E that RN B had punched Ms A. I consider that as soon as RN E was alerted to this, she should have taken action to remove RN B from contact with consumers pending further investigation, or at least relayed Ms C's allegation to RN G.

Recommendations

139. As noted above, RN B is not currently practising as a registered nurse. In these circumstances, I recommend that RN B provide a written apology to Ms A. The apology is to be sent to this Office within three weeks of the date of this report.

140. I recommend that the DHB review its procedures and protocols relating to the management of violent incidents, and the debriefing of, and support provided to, staff after such incidents and, within three months of the date of this report, report back to HDC on the outcome of these actions.

Follow-up actions

141.
- RN B will be referred to the Nursing Council of New Zealand with a recommendation that, in the event that she reapplies for a practising certificate, Council assess the appropriateness of RN B returning to nursing. In the event that RN B does return to nursing, I recommend that Council determine any necessary conditions on her practice, supervision and monitoring, and training needs, and advise HDC accordingly.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN B's name.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand Nurses Organisation and the New Zealand College of Mental Health Nurses.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A — Independent expert advice to the Commissioner

The following expert advice was obtained from RN Kathryn Brankin, a specialist in psychiatric nursing:

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

From documentation received, including the handwritten progress notes for [Ms A] there is one written progress note authored, 5th April 2012, B Shift, by [RN B]. This note was written post the incident which [RN B] was assaulted by [Ms A]. The progress note states 'pushing boundaries with staff, making +++ demands and utilising inappropriate language towards staff, on three different occasions throughout the day'. No examples of actual statements made by [Ms A] are included in this progress note. There is no mention of de-escalation techniques utilised, or offering of medication. In the medication file provided there is no evidence of what medications were administered on the 5th April 2012.[9] In the progress note there is a brief mention of the assault which took place, that a three man restraint took place in the approved manner and there is reference to the two incident reports which were completed. After the assault the nursing staff made the decision to seclude [Ms A] and administered 5mg Olanzapine via IM injection. This was administered during the incident. On first reading the progress note, which outlines the assault event, it [is] not initially clear that the RN documenting the event is the RN [who] was assaulted by [Ms A] ('[Ms A] assaulted [nurse] with closed fist.'). The special incident forms provide slightly more information in relation to the event.

From the interviews with fellow colleagues, in relation to the assault event and previous working relationship with [RN B], [Ms C], states there had been four or five verbal arguments between [RN B] and [Ms A]. A mental health support worker had reminded [RN B] that she was the well one. These verbal altercations may provide evidence that there were already difficulties within the therapeutic relationship and communication between [RN B] and [Ms A]. On the day of the incident [RN B] had experienced verbal abuse from [Ms A]. [Ms A] had also verbally abused [RN E]. On the previous day to the incident [Ms A] had been in seclusion due to presenting as agitated, hostile and aroused, refusing to engage with staff and making threats towards staff and their family. The Registrar's impression of [Ms A's] presentation on the 4th April was that she was experiencing 'psychotic exacerbation secondary to stressors of past 24 hours'. Olanzapine IMI was due in two days' time and there were queries as to whether the prescribed dose was therapeutic. The Registrar also notes there was evidence of mood disorder including brittle mood, pressured speech and tearfulness. The Registrar had charted PRN IMI or PO Olanzapine 5mg. [Ms A] accepted the prescribed PRN Olanzapine 5mg and 2mg of Lorazepam the night before the assault incident. This led to her presentation becoming more relaxed and she

[9] The medication records subsequently obtained indicate that Ms A was administered diazepam that morning.

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exited seclusion at 1910 hours. At this time she was described as still being labile in mood, but able to follow nursing directions. The progress note directs staff to remain vigilant for potential impulsive, hostile, threatening behaviour. [Ms A] exiting seclusion at this time appears appropriate in the context of her presentation and the wider drive for restraint minimisation, as outlined in the Te Pou (2008) document which outlines alternative interventions to seclusion and decreasing restraint events.

[Ms A's] treatment plan addresses her challenging behaviours and provides methods of de-escalation that may be useful in [Ms A's] treatment. This plan was being followed by [RN B], when she directed [Ms A] to go to her room. It is not clear in the documentation whether or not [Ms A] had been administered medication in the morning, prior to the assault.

Specific Comments in relation to requested Expert Advice

1. The decision to release [Ms A] from seclusion on 4th April.

As previously mentioned seclusion reduction is a national mission, as directed by Te Pou. The drive for restraint minimisation is focussed on ensuring clients can receive services in the least restrictive environment (Te Pou, 2008). In [another] District Health Board's Specialist Mental Health Services' draft policy on seclusion (2013), the use of seclusion is described as being incompatible with the aims of recovery and trauma informed care and treatment. This policy makes special reference to Forensic Services 'it is acknowledged that there is a requirement for the forensic service to manage extreme behaviours. For Consumers who require a forensic service and present with extreme imminent risk, a specific management plan that stipulates rationale for continuation of seclusion and a clinically desired pathway shall be developed for a consumer' (P. 9).

In relation to the care of [Ms A], specifically her exiting seclusion on the 4th April, the decision for [Ms A] to exit seclusion was made by two RNs and the actions were congruent with [Ms A's] treatment plan and provide evidence of staff attempting to provide care that is least restrictive and enhances the therapeutic relationship.

2. [RN B] being placed 'in charge' of the de-escalation area.

In my experience having a new graduate nurse looking after the intensive care de-escalation area, which would indicate a client with high needs and potentially unpredictable behaviours, sets up a vulnerable environment, for both client and nurse.[10] The vulnerability of this situation is further enhanced by the lack of oversight actually on the unit, from senior nursing staff. The Senior Nurse, [RN E], was aware of the escalating verbal abuse, as some of this abuse was also

[10] In its response to my provisional opinion, the DHB noted that the unit is classed as a medium secure unit. Intensive care facilities are provided at a different unit.

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directed at her. The DHB as stated by [Mr H], Associate Operation Manager, [advises that] following the incident they look after new nurses more. New nurses to the unit now have a buddy or mentor for up to six months (Interview with [Mr H], 21 November, 2012). This would indicate there was little support for new nurses prior to the event. I would consider [RN B] being placed 'in charge' of an area where clients with high needs are placed as being an inappropriate action for her level of experience and the needs of [Ms A].

There is clear evidence, as documented in the interview with [RN E], that there were concerns from staff about [RN B's] interactions with clients in the de-escalation area and [RN B] had previously been removed from working in this area due to arguing back at patients and ignoring requests to remove her headphones. There is no documentation of any mentoring or action plan to address these issues, except to remove [RN B] from the de-escalation area. Also noted in this interview, was that there had been communication issues with [RN B]. It is unclear what is meant by this. [RN E] stated that she would not have wanted to 'step on' [RN B's] and [RN D's] toes by taking action prior to the incident. [RN E's] concerns, and lack of response, as would be expected in her role as Senior Nurse, indicate a milieu of non-action and may indicate the high job stress of being subjected to verbal and physical assaults, and the high turnover of mental health nurses, as stated by the [NZNO Industry Advisor] (2013). Of note the [the DHB] had [over 400] reported incidences of patients 'lashing out' in 2012.

An interview with [RN G], Clinical Co-ordinator, was held on the 21 November 2012. [RN G] explained her role is to allocate staff to patients for the day and coordinate what is happening each day. [RN G] reports that she was at an MDT meeting on the 5th April from 0900–1230 hours, meaning she was not actively involved in the activities of the ward during this time. [RN G] states that the de-escalation unit is the highest level of care they provide. [RN G] also states she was comfortable with having two Junior Nurses working in this Unit, as [RN E] was nearby and [Ms C] was a very experienced Mental Health Support Worker. Despite the stated experience of the Mental Health Support Worker, Nursing Council Direction and Delegation guidelines require Registered Nurses to direct and monitor the care provided to workers such as unregulated Support Workers (Nursing Council of New Zealand, 2012). The combination of junior staff, lack of assertive oversight by experienced staff and the challenging behaviours of a client, has led to an extremely unpredictable, volatile environment for client and staff. [RN G's] action of placing [RN B] in charge of the de-escalation [Unit] is not fitting with the already known issues that [RN B] had in this high care area.

In relation to departure of expected standards of care, I believe that the management decision to place [RN B] in charge of the de-escalation area is a moderately severe departure from the standards. Furthermore management's inaction in relation to previous concerns about [RN B's] interactions with clients has also departed from expected standards of practice.

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3. The care provided to [Ms A] immediately before she punched [RN B].

[Ms A] had experienced recent stressors in her life in the 48 hours prior to the event, [and had a] past history of assault and violence. Violence and verbal aggression are known ways which [Ms A] responds to stressors. These factors in combination with [Ms A's] lack of insight and her documented acute unwellness were aspects of her presentation that were documented in progress notes. It is unclear if [Ms A] was prescribed regular medication, aside from the IM Olanzapine. It is questionable whether psychotropic medications prescribed were effective in treating her psychotic symptoms. The Registrar had also documented the possibility that the Olanzapine was not in therapeutic range. In my clinical experience, in the early stages of establishing a client on an IMI regime, it can take some time to adjust doses to maintain wellness or decrease acute psychotic symptoms.

[Ms A] was already in the de-escalation area and was then asked to go [to] her room due to abusive outbursts; the RN was also thought to be in the process of responding to [Ms A's] demand for a drink. There is no evidence of one to one time with [Ms A] in an attempt to de-escalate her. Constant verbal abuse from [Ms A] towards [RN B] and her statement that she was a 'bit jittery', could have potentially led to inadequate nursing interventions prior to the assault, however this is unclear. [RN B's] action of requesting [Ms A] go to her room is following the treatment plan. The Support Worker suggests [RN B] was forceful in her manner when making this request. This could have provoked a counter-therapeutic relationship and further escalated [Ms A's] hostility towards staff. Transference and counter transference issues must also be considered in relation to this incident. As per the treatment plan, seclusion was only to be used as a final resort. The verbal abuse that was directed at [RN E] earlier in the shift would not have provided sufficient grounds for seclusion to be utilised, however [Ms A's] threatening behaviour and manner were warning signs that her risk to others was increasing. There is no evidence that de-escalation techniques were employed at this time, such as PRN medication, lowering stimulus of environment, one to one interactions. In the context of [RN B's] experience the care provided appears to be adequate, however with more senior support other interventions may have been utilised, although it is impossible to say whether this would have changed the outcome. Of note [RN E] did not appear to offer any support or direction to the staff in the de-escalation area. Themes of avoidance seem to be evident, i.e. when staff informed [RN E] they were fine when she asked them how they were going due to [an] increase [in the] level of noise she heard, [RN E] being concerned but not wanting to 'step on [RN B's] toes'.

4. The reaction of [RN B] to being punched.

NB: Commissioner's finding on disputed fact: 'It is more likely than not that [RN B] punched [Ms A] around the head area at least twice.'

Constant verbal or physical assault is extremely stressful and impedes on an individual's wellbeing. The NZNO biannual nursing workforce survey (2013)

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suggests workplace injury is impacting on the morale of nurses. Nurses have been identified as the most at risk group of workers for being exposed to violence (Victoria Government, 2005). [RN B] had recently attended a calming and de-escalation one day refresher course.

[RN B's] response of punching [Ms A] is not an accepted professional practice, in response to violence from a patient. While it is accepted that equal force may be used to defend one's self, calming and restraint training provides education on techniques to use when violence is imminent or occurring. However, how an individual reacts in a training session and how one acts in the reality of practice is likely to be different, as it was in this event. [RN B] was likely to be unaware of her actual response to violence in the workplace, as this was the first time she had experienced a physical assault at work. This physical assault, in conjunction with verbal abuse earlier that day, may have lowered her threshold to act in a manner which was appropriate within a professional context. Bigwood and Crowe's (2008) research also highlights the theme of nurses experiencing anxiety associated with physical restraint. New nurses also found restraint a difficult task to process.

As documentation states, with the assistance of colleagues, [RN B] assisted with the restraint and was responsible for [Ms A's] head when she was taken to the floor. Despite the physical altercation [RN B] appears to have appropriately participated in the restraint process. In my experience I have noted fellow colleagues unable to participate in the restraint process due to their fear post being assaulted, hence leaving their colleagues at risk. [RN B] did not do this.

Taking into account all provided information I believe [RN B's] action of punching [Ms A] is a moderate [departure] from expected standards of practice, in the context of the lead up to the assault and the rapid manner which the actual assault appears to have taken place.

5. [RN E's] decision to allow [RN B] to give the IM injection.

In the documented interview with staff, [RN E] stated [RN B] came into the surgery and her ear was bleeding. [RN G] also appears to be there at the same time and asked [RN B] if she was ok, to which [RN B] replied 'Yes'. [RN B] offered to give the IM injection. There is no evidence in the statements that this offer was challenged, debated or declined.

[RN D] describes [RN B] as explaining the procedure to [Ms A] before administering the injection and proceeded to undertake the task whilst [Ms A] remained in restraint. NB: [RN E] reports IM Lorazepam was administered, however [RN B's] progress note for this day states IM Olanzapine 5mg was given. There is no clear documentation within the medication file provided for further clarification of this. The medication chart I have available is only photocopied

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until the 25th March for regular medications.[11] This confusion is a clear example of why it may have been inappropriate for [RN B] to be involved with the process of administering IM medication. This task requires a Registered Nurse to be fully aware of what medication they are giving, correct dose, correct route, correct time, correct patient, and expected response.

The task of administering the injection is also a technical skill that requires a nurse's full attention and ensuring the site is correctly chosen and prepared for medication administration. The need for extra precaution is also necessary in the context of giving medication during a restraint, due to needle stick injury, placement of needle being disrupted due to movement and infection control issues. As [RN B] had just experienced significant violence it is questionable whether her cognitive and emotional states were stable enough to prevent or react to any issues that could have taken place during the procedure. Furthermore, it is documented that [RN B] was bleeding from the ear. It is also documented that [RN E] and [RN G] briefly attended to the bleeding whilst in the surgery, however the issue of on-going bleeding and placing colleagues and the client at risk of body fluid transmission are relevant to this situation.

Although [RN E's] decision could be considered to go against best practice, the event needs to be considered in the context of crisis management and staffing resources available at the time of the event. An injection has to be given by an RN and there were three RNs available (who were not involved in the physical restraint). I believe this action to be a moderate departure from expected standards, due to the risks posed to the client and also to the nursing staff, due to risk of poor execution of the task. This does not appear to have happened, however potential risk was elevated and this was not necessary.

6. [The DHB's] follow-up with [RN B] after the incident, including the offer of a formal debriefing and medical treatment to [RN B].

Although [RN B] was verbally offered the chance for debrief, per [RN G's] interview, there appears to be limited follow through with this opportunity. [RN G] offered her the opportunity to debrief, stating it was part of her job to offer this. This may have already set up a boundary for [RN B] to engage, documentation does not state [RN B] had the chance to gain information that would help her understand what debriefing was, concepts of professional safety in this process and who would undertake the debriefing. Being recently assaulted may have made [RN B] more vulnerable to exposing the emotional impact.

Noting that [RN G] and [RN E] had 'mopped her up a bit', in [relation] to the bleeding ear injury, this appears to be a superficial act of caring for their colleague. When [RN B] declined to go and see a doctor, there appears to be little support offered to her in doing this. [RN B] stating she will go for [some

[11] HDC subsequently obtained copies of the medication charts for regular and as required medications prescribed and administered in April 2012. The chart makes no reference to Ms A being administered Olanzapine on 5 April 2012.

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exercise], may be an indication that these are ways she normally manages her stress levels. I would suggest it would have been more appropriate to have practically supported [RN B] to get access to the medical treatment she required. As this was the first assault [RN B] had experienced, and was an assault to the head, compassion shown towards a colleague at this time may have allowed [RN B] to take up the formal offer of debriefing. Individuals respond to stress in various ways. From my past experience, after colleagues have been assaulted, some prefer to stay on site in the presence of their colleagues to vent issues and have easy access to support if needed. Due to the privacy of mental health work, it can be very difficult to gain support from external resources, and colleagues may be one of the only supports available.

As documented in [RN B's] interview, she stated she could not think of anyone she wanted to talk to about the incident, but also stated she did not feel safe talking to [RN G]. The interview does not elaborate as to why this is. Access to a mentor or buddy, who would have provided on going support and the chance to safely vent would have been a beneficial resource in this event. Supervision (reflective process) had not been undertaken since [RN B] was in the new graduate programme. This would have been another vital opportunity for [RN B] to reflect on the situation, her role and understanding the dynamics which were taking place between herself and [Ms A].

Although the intentions behind moving [RN B] into the open wing of the ward were undertaken in response to recent events and to ensure [Ms A's] needs were met therapeutically, it is unclear how [RN B] was supported during this process, or given an explanation as to why this directive was given.

I believe the actions taken in relation to offering [RN B] debriefing and medical treatment and any further formal or informal support to be of a low standard.

7. The decision to allow [RN B] to continue working on the unit that day, after the incident had occurred.

The decision to allow [RN B] to continue to work on the unit, that day, after the incident had occurred appeared fitting with what [RN B] wanted to do at that time. The incident occurred at approximately at 1225 hours, as the shift would have finished around 1530, allowing time for [RN B] to reflect on the incident and being around staff allowed [RN B] to be informally monitored by staff, especially since she had declined medical intervention and had been hit in the head. [RN B] escorted a client to a group after the incident, which gave her time away from the ward. It is unclear whether [RN B], or any of her colleagues had been able to have a break away from the intensive ward environment all day, ie, morning tea and lunch.

In cases where there has been an adverse situation it may have been better practice for colleagues to support and assist with documentation, particularly in [Ms A's] nursing notes, which are very sparse in the information they give in relation to the shift the incident occurred.

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Additional Comments

There is evidence of a lack of professional conduct from [RN B], such as reports that she was wearing headphones whilst on shift and that staff had some concerns in relation to her 'passive aggressive comments', and verbal responses and mannerisms towards clients. It would have been best practice to have these issues addressed formally at the time, and not postponed to address at the pending performance appraisal. This is not fitting with management ensuring clients have access to appropriate standards of care and also does not reflect management supporting new nurses to develop practice and address any performance issues in the least stressful manner. [Mr H] refers to hearing 'whispers' about [RN B's] behaviour. I would question why these 'whispers' were not proactively followed up. This is not helpful to retaining and promoting nursing development.

References

Bigwood, S., & Crowe, M. (2008). 'It's part of the job, but it spoils the job': A phenomenological study of physical restraint. *International Journal of Mental Health Nursing,* 17. DOI: 10.1111/j.1447-0349.2008.00526.x.

[Another] District Health Board. (2013). *Seclusion Draft.* [Another] DHB: Specialist Mental Health Services.

New Zealand Nurses Organisation. (2013). What's affecting working nurses. *Kai Tiaki Nursing New Zealand,* 19(4), P11.

Nursing Council of New Zealand. (2012). *Competencies for registered nurses.* Author: Wellington, New Zealand.

Te Pou. (2008). *Developing alternatives to the use of seclusion and restraint in New Zealand mental health inpatient setting: Seclusion: Time for a change.*

Torre, B. (2013). *Assaults at hospital increase job stress.* Retrieved from http:/www.stuff.co.nz.

Victoria Government. (2005). *Occupational violence in nursing: An analysis of the phenomenon of code grey/black events in four Victorian hospitals.* Retrieved from
http://www.health.vic.gov.au/__data/assets/pdf_file/0008/17585/codeblackgrey.pdf

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