Waitemata District Health Board

Registered Nurse, Mr C

A Report by the

Deputy Health and Disability Commissioner

(Case 12HDC00630)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of Contents

Executive summary

1. Mr A, aged 87 years, had been suffering from worsening dementia for around two years. His son, Mr B, held an enduring power of attorney (EPOA) as to Mr A's personal care and welfare, which had not been activated. Mr A had been living alone in his own home and was non-compliant with his prescribed medication regimen (which included aspirin, simvastatin and atenolol).

2. In 2012, on Day 1,[1] Mr A was admitted to a general medical ward at a public hospital after Mr B discovered that Mr A had blood-tinged urine. His current medications were noted as aspirin, simvastatin, and atenolol. Mr B advised the hospital pharmacist that Mr A was non-compliant with his medication. The hospital pharmacist therefore crossed out the medications in Mr A's Admission–Discharge planner and wrote in the progress notes that the medication had been stopped. However, Mr A was administered atenolol and aspirin at 9am on Days 2, 3 and 4 and simvastatin at 6.30pm on Days 2 and 3.

3. At 6.30am on Day 2 Mr A had an unwitnessed fall. Neurological observations were carried out four times that day, then discontinued. Mr B said that he was not informed about his father's fall until late in the afternoon on Day 2.

4. On Day 3 Mr B arrived to visit his father and found that he had been moved to a single room and had a watch in place because of his disruptive behaviour and wandering. Mr B expressed concern to staff about his father's deteriorating state and his behaviour, which was unusual for him. Mr A was placed on constant observation because he was wandering.

5. On Day 4 Mr A was placed on observations every 15 minutes. Registered nurse (RN) Mr C was on afternoon duty on the general medical ward. He had the door locked because of concerns about Mr A wandering. RN C checked Mr A every 15 minutes until 4.45pm, but did not check him at 5.00pm. RN C did further checks at 5.15pm and 5.30pm, but did not do checks at 5.45pm and 6.00pm.

6. At 6.00pm RN C handed over his patients to before taking his meal break, but did not tell her to check Mr A at 15-minute intervals, or when Mr A had last been checked. When RN C returned at 7.00pm he realised that Mr A was missing. At approximately 7.20pm RN C contacted Security, who understood from that conversation that Mr A had gone missing in the previous 10 minutes. Waitemata DHB's CCTV footage later confirmed that Mr A had left the ward at 5.41pm.

7. A member of the public found Mr A at a bus stop and called an ambulance. Mr A was then taken back to hospital.

[1] Relevant dates are referred to as Day 1-8 to preserve privacy.

8. Mr A was found to have a large bilateral subdural haematoma[2] with a midline shift of his brain. Registrar Dr J discussed Mr A's poor prognosis and resuscitation status with Mr B at the bedside. Mr B stated that as Mr A's condition and options were discussed, Mr A, although apparently unconscious, squeezed his hand. Mr B felt that it was inappropriate for Dr J to discuss resuscitation in front of Mr A.

9. Mr A remained unconscious and was provided with comfort cares until he died a few days later. Mr B was concerned that the administration of aspirin may have contributed to his father's death.

Findings

RN C

10. RN C did not make all the required 15-minute checks, failed to hand over Mr A's care adequately when he took his meal break, and failed to ascertain the correct information and convey it to Security after he discovered that Mr A was missing. Accordingly, RN C failed to provide services to Mr A with reasonable care and skill and breached Right 4(1)[3] of the Code.

Waitemata District Health Board

11. Waitemata DHB staff did not undertake the required neurological observations following Mr A's fall on Day 2, and failed to take action as Mr A's condition deteriorated. Furthermore, Waitemata DHB had no formal process for meal break handover of patients by nurses, visual handover was not required, and there was no structure in place to ensure that appropriate staff were present during meal breaks. Waitemata DHB failed to provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

12. Adverse comment is made about Waitemata DHB's failure to clarify whether Mr A's EPOA had been activated.

13. It was the responsibility of Waitemata DHB to clarify the medications Mr A was receiving in the community and ensure that staff were aware of the correct information. Adverse comment is made regarding Waitemata DHB's failure to do so, with the result that Mr A continued to receive medication without any medical review as to the appropriateness of the medication.

14. The communication between Waitemata DHB staff, Mr A, and Mr B was also suboptimal, in that Mr B was not told of his father's fall on Day 2 until later that day, on Day 3 he was not informed about his father's deteriorating mental condition until he arrived to visit, and his concerns about his father's deteriorating mental state expressed during the visit on Day 3 were not escalated. Mr A's life-threatening condition was discussed with Mr B at Mr A's bedside in an inappropriate manner.

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[2] A subdural haematoma is a collection of blood within the outermost meningeal layer of the brain. Subdural haemorrhage is usually associated with traumatic brain injury, and may cause an increase in intracranial pressure, which can cause compression of, and damage to, brain tissue.

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

Complaint and investigation

15. The Commissioner received a complaint from Mr B about the services provided to his father, Mr A, by Waitemata District Health Board. The following issue was identified for investigation:

- *Whether Waitemata District Health Board provided Mr A with an appropriate standard of care between Day 1 and Day 8.*

16. On 10 February 2014 the investigation was extended to include the following issue:

- *Whether RN C provided Mr A with an appropriate standard of care from Day 3 – Day 4.*

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

18. The parties directly involved in the investigation were:

Mr B	Complainant
Waitemata District Health Board	Provider
RN C	Provider/registered nurse

19. Information was also reviewed from the following parties during the investigation:

Coroner	
Dr D	Geriatrician
Dr E	Pathologist
Dr F	Physician and cardiologist
RN G	Registered nurse/Charge Nurse Manager
Dr I	General practitioner

Also mentioned in this report:

RN H	Registered Nurse
Dr J	Registrar
RN K	Registered Nurse
Ms L	Pharmacist
RN M	Registered Nurse
RN N	Registered Nurse
RN O	Registered Nurse
Mr P	Security Officer
Mr Q	Security Officer

20. Independent expert advice was obtained from physician Professor Tim Wilkinson (**Appendix A**) and registered nurse (RN) Diane Penney (**Appendix B**).

Information gathered during investigation

Background

21. Mr A, aged 87 years at the time of these events, lived alone in his own home. He had been suffering from worsening dementia for around two years. On 30 June 2011, a consultant geriatrician, Dr D, reviewed Mr A and reported to Mr A's general practitioner (GP), Dr I, that Mr B had said that Mr A's decline had been more rapid in the previous three to six months. Mr B had reported that Mr A's house was not fit to be lived in because of recurrent leaks flooding the carpet and floorboards from the toilet and bathroom.

22. Mr B told Dr D that Mr A struggled to use the stove and the television, so Mr B had removed the fuse to ensure they were not misused. However, after repeated teaching, Mr A was able to use a simple microwave and kettle.

23. On 29 September 2011, Dr D reported to Dr I that Mr A had not attended his scheduled clinic appointment that day, and had also missed a scheduled CT head scan,[4] as he had become lost on the way to the hospital. Dr D noted that Mr A was reluctant to accept assistance, was getting lost on average once every few weeks, and was not taking his medication, despite being provided with blister packs.

Mr A's status

24. On 14 May 2010, Mr A had completed an enduring power of attorney (EPOA) appointing Mr B as his attorney with regard to personal care and welfare, and property, should Mr A lose the capacity to make decisions in this regard.

25. On 3 November 2011, Dr D wrote to Dr I and Mr B advising that she had examined Mr A that day. Dr D stated that in her opinion Mr A was "mentally incapable", and noted that activation of the EPOA was necessary. Dr D asked Dr I to complete a certificate to invoke the EPOA.

26. On 9 November, Dr I wrote a letter addressed to "To whom it may concern", which states: "This is to certify, that the patient described above ([Mr A]) should have their Enduring Power of Attorney activated for their continuing safety and well-being." There is no record of the required certificate, "*Health practitioner's certificate of mental incapacity for enduring power of attorney in relation to personal care and welfare*", having been completed.[5]

Admission to hospital

27. On Day 1 at 7.49pm Mr A presented at hospital as a result of the discovery of blood-tinged urine. He was accompanied by Mr B. The patient registration form identifies Mr B as Mr A's next of kin and emergency contact person.

[4] Computerised tomography (CT) combines a series of X-rays taken from different angles to produce cross-sectional images.
[5] Form 5, Protection of Personal Property and Rights (Enduring Powers of Attorney Forms) Regulations 2008.

28. RN K completed the emergency department (ED) assessment form and noted that Mr B had noticed pink-tinged colour on Mr A's linen that morning, and that the family were not coping well and Mr A was not compliant with medication. The medications listed were aspirin 100mg,[6] simvastatin,[7] and atenolol.[8] Mr A had bloods taken and underwent an X-ray. It was decided that Mr A should be admitted.

29. On Day 2 at 12.30am Mr A was reviewed by a registrar, who noted that the presenting problems were that Mr A was not coping at home, had double incontinence, was wandering and getting lost, and there were safety issues. Mr A was unable to give any history, and did not know where he was or why he was there. The registrar noted that ED had recommended that Mr A be admitted to the Assessment Treatment & Rehabilitation (AT&R)[9] service, but no beds were available. Mr A was subsequently admitted to the general medical ward.

Medication

30. During Mr A's admission, he was administered atenolol, aspirin, and simvastatin. There is some question as to whether that was appropriate. Given that Mr A later died as a result of a subdural haematoma, Mr B has questioned the administration of aspirin during Mr A's admission.

31. By way of background, in June 2011 Mr A's GP, Dr I, saw Mr A and was concerned that he had not been taking his medications, as the prescriptions due in March 2011 had not been renewed. Mr A told Dr I that he was taking his medications. On 6 September 2011, Dr I reviewed Mr A and prescribed a three-month supply of his usual medications, atenolol, simvastatin, and aspirin. Dr I prescribed no further medication after that time.

32. Mr B told HDC that he is not sure exactly when his father stopped taking his medications, but that he had been unreliable for around 18 months. Mr B arranged for blister packs, but his father still missed the medication. Mr B said that he told the staff when his father was admitted that he had not taken any medication for some time before admission.

33. Waitemata DHB stated that the admitting team based the initial prescribing of Mr A's medications on the dispensing records available on the electronic TestSafe[10] system,

[6] Aspirin is used long term, at low doses, to help prevent heart attacks, strokes, and blood clot formation in people at high risk of developing blood clots.
[7] Simvastatin is a cholesterol lowering drug used to inhibit the production of cholesterol by the liver.
[8] Atenolol is used alone or in combination with other medications to treat high blood pressure. It is also used to prevent angina (chest pain) and improve survival after a heart attack. Atenolol is in a class of medications called beta blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure.
[9] As part of Older Adults & Home Health, the AT&R Service provides a specialist inpatient service for older people and is dedicated to improving and maintaining the health and independence of older people. The service is a mix of geriatric medicine and rehabilitation for older people, who often have multiple or complex needs.
[10] TestSafe is a medical information sharing service provided by the northern region DHBs. It gives healthcare providers access to diagnostic results, reports and medicines information for their patients. It brings together results from DHB facilities and community laboratories, as well as medications dispensed by community pharmacists.

and the admitting team was not aware that Mr A was no longer taking the medications. The most recent record on TestSafe was from 6 September 2011, and showed prescribing of atenolol, aspirin, and simvastatin.

34. On Day 1, RN K recorded on the ED assessment form that Mr A's current medications were atenolol, aspirin, and simvastatin. The doses and frequency are not stated. Waitemata DHB stated: "After more than 18 months we cannot ascertain whether [RN K] was told this or found it on the 2011 discharge summary. There is no general practitioner referral letter. The staff will have needed to look on Concerto[11] to find out about previous history."

35. Waitemata DHB stated that "as the last dispensing record of regular medicines was only 6 months prior to admission the medical staff would not have been aware of the non-use of those medicines when completing the acute admission". Mr B was present until around midnight on the day of admission, but there is no record of his being consulted about his father's medication.

36. Waitemata DHB advised that on Day 2 pharmacist Ms L completed a medicine reconciliation process and wrote in the progress notes at 10.50am: "Have completed pt [patient] med[ical] hx [history]. Pt [patient] has not been taking any regular meds for approximately 18 months — as per son." Ms L recorded the same information in the Admission–Discharge (A–D) planner. The DHB stated that Ms L crossed out the medications and referenced "as per son". On the medication record there is a tick next to "caregiver" as the source of the medication history, and "son" has been written on the form. The words "from last EDS and Community Dispensary record — Sept 2011" are written under the heading "DRUG NAME". "Sept" has been crossed out and "June" entered. There is no signature against that alteration.

37. Waitemata DHB indicated that a tick on the medication record above the word "son" indicates that Ms L checked Mr A's medications with Mr B on the morning of Day 2 and then put a line through atenolol, aspirin, and simvastatin on the A–D planner. The DHB stated that as it was a long weekend, Ms L could not have accessed Mr A's GP, and may not have been able to access the community pharmacy.

38. Waitemata DHB advised that the information from Mr B on Day 2 that Mr A was not taking any medication was not followed up by the medical team on the post acute ward round because the medical staff do not always refer back to previous pages in the A–D planner, so it is unlikely that they saw the entry. Furthermore, the medical team had already completed the post acute ward round by 9.53am on Day 2.

39. Waitemata DHB stated that "there was nothing on the medication chart to suggest that the pharmacist talked with the medical staff or that they later noticed this change to discontinue the medications".

40. Mr A was administered atenolol and aspirin at 9am on Days 2, 3 and 4. He was given simvastatin at 6.30pm on Days 2 and 3, without any medical review as to whether

[11] An electronic medication reconciliation system.

those medications remained appropriate in view of Mr A's previous non-compliance with the medication.

Falls assessment

41. A falls risk factor score card was completed twice on Day 2 and once on Day 3. On each occasion Mr A was identified as being at a high risk of falls.

Fall Day 2

42. At 6.30am on Day 2, RN M recorded that Mr A had slipped on the wet floor and was found sitting on the floor. The fall was unwitnessed but the patient in the bed next to Mr A had rung the bell. Mr A told RN M that he had slipped on the wet floor after being incontinent of urine.

43. Mr A suffered a laceration to his left eyebrow, and multiple skin tears on his left leg, which were dressed with Steri-strips. A wound chart and an incident report were completed. RN M recorded that the house surgeon had been paged to review Mr A, but gave no new orders, and that neurological observations had been done. The on-call house surgeon referred to the fall in the clinical record as a "[m]inor injury", and recommended "neuro obs as per head protocol" and analgesia as required. The "protocol" referred to is discussed below.

44. Mr A was disorientated as to time and place. His Glasgow Coma Score (GCS)[12] was 14/15. RN M noted: "Pls [Please] ring son later to inform re: fall of pt. — needs constant observation to prevent falls — falls risk assessment filled & red wrist band applied." Waitemata DHB said that Mr B was not contacted at the time of the fall, because it was early in the morning.

45. The DHB stated that Mr B telephoned the ward at 9.00am and was informed of the fall. At 11.15am, RN N recorded that she had spoken to Mr B by telephone. She noted that Mr B had major concerns regarding his father's safety at home, that Mr A was not coping, and that he was incontinent of urine and "has [had] a diaphorea[13] recently". RN N noted that Mr B said that recently his father had had multiple falls and had lost weight. There is no record that RN N advised Mr B of his father's fall that morning. At 1.45pm, RN N recorded that Mr A was confused and disoriented, and had been found packing his belongings saying he was going home. RN N noted: "Medications as charted. Obs [observations] as charted. Liaised with family."

46. In contrast, Mr B told HDC that he spoke to a nurse earlier in the day, and she talked about how his father was getting on at home but did not say anything about the fall. He said that he first learned about the fall later in the afternoon when he called and asked to speak to his father, as he thought the ward would have a portable telephone.

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[12] The Glasgow Coma Scale or GCS is a neurological scale that aims to give a reliable, objective way of recording the conscious state of a person for initial as well as subsequent assessment. A patient is assessed against the criteria of the scale, and the resulting points give a patient score between 3 (indicating deep unconsciousness) and either 14 (original scale) or 15 (the more widely used modified or revised scale).

[13] Diaphoresis is the medical term for profuse sweating or perspiring.

47. Mr B advised HDC:

> "[W]hen [Mr A] had his fall at 6.45am, no-one from the hospital contacted me. All my contact details are on file and although it's been detailed to contact me in his medical notes this was not done. I found out that he had a fall when I rang the hospital late in the afternoon of [Day 2]. I wasn't able to talk to him but left a message that said, '[Mr B] won't come and see you today, having car trouble'. The nurse said, 'and by the way your father had a fall this morning and has a laceration over his left eyebrow and left knee'. I asked if he was OK. They said they had put dressings on his injuries and he was fine."

48. Mr B told HDC that he knew that his father did not want to be in hospital, and that if he went in to see his father he would want to go home with him. The person he spoke to said that he could not talk to his father, so he asked her to tell him that Mr B was not coming in that evening, but would come in the following day. There is no record of a conversation with Mr A after 1.45pm that afternoon.

49. On the evening of Day 2, a registered nurse noted: "[D]ue meds given as charted. Panadol given for slight temp. rise; enc. [encourage] oral fluids." The plan was for a multidisciplinary team (MDT) review of Mr A on the following Tuesday.

Neurological observations

50. Neurological observations (including GCS score, pupil reaction, blood pressure, heart rate, respirations, arm/leg strength, and oxygen saturations) were carried out four times after the fall on Day 2 at 6.40am, 8.15am, 3.25pm and 8.10pm, then discontinued.

51. The National Early Warning Score (NEWS)[14] vital sign monitoring form records that observations were performed between Day 2 and Day 4 as follows:

> Day 2 at 2.10am, 8.15am, 3.25pm
>
> Day 3 at 7.30am, midday, 4pm
>
> Day 4 at 9am, 4pm

52. Waitemata DHB stated that the frequency of observations was not in accord with its policy expectations. The DHB policy regarding vital signs, including NEWS, states:

> "• **In the first 24 hours** of admission, a full set of NEWS observations must be done at least **4 hourly**, or more frequently as the condition shows — NEWS score requirements.

[14] The National Early Warning Score is a guide used to quickly determine the degree of illness of a patient. It is based on data derived from four physiological readings (systolic blood pressure, heart rate, respiratory rate, body temperature) and one observation (level of consciousness, AVPU — the AVPU scale (an acronym from "alert, voice, pain, unresponsive") is a system by which a healthcare professional can measure and record a patient's responsiveness, indicating his or her level of consciousness)). The resulting observations are compared with a normal range to generate a single composite score.

- The observations should continue 4 hourly after this, unless assessed by the charge nurse or medical staff that less frequent is appropriate BUT a full set of NEWS observations must be done at **least 8 hourly**.
- Neurological assessment is undertaken where there has been an injury to the head, where there has been a deterioration in mental condition or as prescribed. Neurological assessment continues hourly until frequency changed by the medical staff or nurse in charge. If utilising the NEWS observation chart, neurological status is recorded with every set of observations using AVPU scale.[15] All observations on the neurological observation chart should be transcribed into the NEWS observation chart and scored appropriately."

53. Therefore, according to this policy, neurological observations ought to have been taken hourly from 6.30am onwards, and NEWS observations ought to have been taken at 6.30am, 10.30am, 2.30pm, 6.30pm and 10.30pm on Day 2, and at 2.30am and 6.30am on Day 3.

54. Waitemata DHB stated that it is not clear why the nurses did not undertake the neurological observations as frequently as the policy specifies, as there is only one reference in the records to Mr A having refused to allow a nurse to take his observations.

Day 3

55. On Day 3 at 11.05pm, RN H recorded that Mr A had refused to allow his observations to be taken and was not orientated to time or place. She noted that Mr A was wandering around the ward entering female patients' rooms and staff areas, and that he was aggressive and threatening towards other patients in the shared room. Mr A was making inappropriate comments to staff and other patients, and his behaviour was described as "labile".[16] RN H recorded: "Regular checks until constant observation in situ."

56. Mr B said that he arrived to visit his father but could not find him. He looked around and found him in a room on his own with a guard sitting outside, who said he was a watch. Mr A was pleased to see Mr B and his wife, and said he wanted to go home.

57. Mr B said that his father was incontinent and his clothes were wet and smelly. A nurse came in, so Mr B asked for some pyjamas for his father, and went with her to get them. When he returned, his father grabbed the pyjamas and screamed, ranted and raved but calmed down about 20 seconds later. Mr B told HDC that his father's personality had changed, and his mood swings went from rage to complete calm, which was out of character for him.

58. Mr B said that he told the nurse: "Something's wrong — he's not usually like this — he didn't used to throw wobblies and never swore or behaved like that." The nurse said that his father had been disruptive, going into other patients' rooms and arguing with their visitors.

[15] See footnote 13.
[16] A labile mood is one characterised by emotional instability or dramatic mood swings.

59. Mr B told HDC: "I was very clear that he never behaved like that. They should have contacted me straight away about his behaviour. They had my number and I would have come."

60. RN H noted that Mr A had been visited by his son, who had expressed concern about his father's mental state.

61. Waitemata DHB acknowledged that "staff may not have been fully aware of the implications of a subtle or unexpected behaviour change following a fall" and said that more information should have been sought from the family regarding any changes in Mr A's behaviour.

62. In response to my provisional opinion, Waitemata DHB explained:

> "Unfortunately nursing staff were managing what they understood to be dementia and delirium. They did not recognise the possibility that [Mr A's] behaviour was out of the ordinary for him because they had no previous knowledge of him except what had been documented about his pre-admission cognitive impairment."

63. Mr A was moved from the four-bed room to a side room, and it was decided that a healthcare assistant would remain with him continuously and provide constant observations. Mr B said that he wanted to be involved in the MDT meeting on the following Tuesday.

Day 4

64. On the morning of Day 4, RN O recorded that Mr A had been watching TV most of the shift and had been given his medications. RN O noted that the plan was to move to "15/60 checks — if not manageable may need constant observations — need to assess and order later as required". Waitemata DHB told HDC that 15-minute checks are "a team effort and that all staff must be aware of which patients require such checks".

RN C

65. On Day 4, RN C was on afternoon duty in the general medical ward. RN C stated that he was registered as nurse in 2009, and had been working at the hospital since mid 2009. He said that his role on Day 4 was to coordinate the ward, which had 35 beds, as well as take care of five patients. He had four patients in a four-bed room and Mr A in a single side room.

66. RN C said that at handover on Day 4 he was told that he should reassess Mr A if necessary to determine whether he required constant supervision, rather than 15-minute checks (as noted by RN O). RN C stated that he did not think constant supervision was necessary, as Mr A had improved from the previous day and there had been no changes in his condition since the morning shift.

67. RN C stated that, at 4.00pm, he decided to lock the ward door to the outside because of his concern about Mr A's wandering. RN C said he telephoned Security and asked them to lock the doors because a patient in the ward was wandering, and he put a note

on the door saying, "Please do not let the patients out", so that visitors were aware that the door was locked for a reason.

68. RN C said that he told all the staff and the ward clerk that the door had been locked to prevent Mr A from getting out. Other patients were able to leave the ward by asking staff to push a button in the nurses' station.

Checks undertaken

69. RN C checked Mr A every 15 minutes until 4.45pm. RN C stated that he did not do the check at 5.00pm because he had to check the blood sugar levels of his other patients. He did further checks at 5.15pm and 5.30pm. He stated that he became busy feeding another patient and subsequently could not check Mr A at 5.45pm and 6.00pm.

70. With regard to the instruction that if 15-minute checks were not manageable, a constant observer should be ordered, RN C stated that he understood that to mean that, if Mr A's behaviour was not manageable, a watch could be ordered, rather than that it pertained to his nursing workload.

71. RN C said that initially Mr A was in his room watching television, but then he began to wander. The nursing team successfully redirected him to the communal rooms or his own room, and he decided to stay in the TV room with some of the other patients.

72. In response to my provisional opinion, Waitemata DHB submitted that RN C provided "what care he could in the circumstance of a busy medical ward", noting that he was caring for five patients (including Mr A) and was the shift co-ordinator that evening. Waitemata DHB stated that "in retrospect [RN C] should not have been trying to do so many things as a nurse and should have sought a watch for [Mr A]".

Meal break

73. Waitemata DHB advised that nurses' meal breaks are generally 45 minutes, as the nurses add the 15-minute tea break that they are allocated mid shift to the 30-minute meal break. The DHB advised that when investigating this incident it discovered that some nurses had been taking 60 minutes, as they had been factoring in the travel time to and from the ward.

74. Charge Nurse Manager RN G advised HDC that when registered nurses go for their meal breaks they must hand over the care of their patients to another registered or enrolled nurse. She advised that handovers must be done within the nursing team to ensure there is a spread of experienced and inexperienced nurses left on the ward, and that handover must include the patient's current status and whereabouts.

75. RN C stated that when the meal breaks for staff began at 5.00pm, three nurses went on their break, leaving another three on the ward, and that, during that time, he was busy doing blood sugar levels, and feeding and attending to his other patients.

76. RN C told HDC:

> "[W]hen the registered nurses came back from their break I and the other two nurses went on ours. Before going for the break at 1800 hours I handed over to [RN H] who was looking after the 4 bedded room next to mine. I told her that [Mr A] was in the TV room, as that is what I believed to be the case. I thought she would know that he was on 15 minute checks because she had been his nurse the previous night and we had all been told this at handover that afternoon."

77. RN C said that he gave a very brief handover to RN H while she was walking to feed a patient and was outside that patient's room. He said that he did not tell her when he had last checked Mr A.

RN H

78. Waitemata DHB advised that RN H was a new graduate nurse, and the handover to her was not as clear as it should have been. The DHB stated that RN H was caring for her own six patients and was asked by RN C to oversee his five patients while he was on his meal break.

79. Waitemata DHB advised that RN H later stated that she was overwhelmed with the 11 patients for whom she was then responsible, and was not made aware that she needed to check Mr A at 15-minute intervals, or told when he had last been checked. Waitemata DHB said that RN H was involved with feeding one of RN C's patients and washing another who was incontinent, and was not aware until RN C returned at 7.00pm that she should have been checking on Mr A every 15 minutes.

Discovery of Mr A's absence

80. RN C stated that when he returned at 7.00pm he checked for Mr A in the TV room and Mr A's room, and then realised that Mr A was missing. RN C said that he asked RN H whether she knew where Mr A was, but she said she did not check Mr A so did not know where he had gone.

81. RN C informed the other nurses in the ward, and they searched each room and the toilets.

82. Waitemata DHB supplied HDC with the reportable event summary completed by Security at 7.20pm, which outlines the events as: "[A]t approx 1920 received call from [general medical ward] Co-ord [RN C] pt was missing in the last 10min he was confused we then did a search with the cctv cameras and a brief search of front of house no one fitting the discption [description]."

83. RN C said that Mr B arrived and was very worried that his father could not be located. RN C stated:

> "When I was certain [Mr A] had left the ward I informed Security, the DNM (Duty Nurse Manager) and the Police. I did not tell Security that [Mr A] had been missing for ten minutes. I would not have put a time on his absence as I did not know how long he had been missing, as I had just come back from my break and was not aware when he had last been checked."

84. Mr B told HDC that he and his wife arrived to visit his father. They went into the hospital and headed for the lifts. A woman from the ward said: "Do you know they are looking for your father?" Mr and Mrs B went up to the ward. Mr B said that there were "nurses and two security dudes milling around" at the nurses' station and one security officer was looking at the computer. He asked where his father was, and a female nurse said he had been gone for only 10 minutes and was probably in the ward somewhere and they were looking for him.

85. Mr and Mrs B looked all around the ward and then went back to the nurses' station. The security officer said that they were searching the grounds and buildings. Mr B said, "No he will go home," and the security officer said they could not search outside the hospital. Mr B said that it was a bitterly cold night.

86. Mr B told HDC that the security officer later said that his father had been seen on CCTV "striding out the door like a man on a mission".

87. The reportable event summary notes that at 7.26pm the Security Officer, Mr P, entered the ward to talk to RN C and found Mr A's family were there, so Mr P explained to them what would happen with regard to the search. Mr P asked RN C whether he was sure of the details, and he responded, "Yes [Mr A] was in the TV room." The report notes that at 7.28pm Mr P called the Duty Nurse Manager, who had nothing but a page from [RN C.] I said I would call the police." Mr P called the police at 7.30pm, and they arrived at 7.55pm.

88. In his retrospective note (untimed but made after an entry at 10.16pm), RN C recorded: "I realised that pt was not in the ward. Searched everywhere in the ward. Informed Security, Informed DNM. Security informed Police."

89. In a statement to the Coroner, Mr B said that when he arrived to visit Mr A, one of the patients told him that his father was missing. Mr B went to the ward and found that there was no one in his father's room. He was informed that Security was looking for his father, and then the Security Officer arrived in the ward and explained how the search would be conducted. The Security Officer asked Mr B for a description of Mr A, and advised that as Security could not look for Mr A outside the hospital, they had informed the Police that Mr A was absent.

90. Mr B said that when he asked how his father could be missing when there was a watch on him, the nurse said that due to funding cutbacks they could not keep a watch on Mr A all the time, because the cost came out of the ward budget. Waitemata DHB stated that it is correct that constant observers are funded from the ward budget, but that this was not the reason the decision was made to move Mr A to 15-minute checks. During the night of Day 3, he had been more settled and, during the morning shift on Day 4, although still wandering, he was easily directable and there were no more aggressive outbursts. Accordingly, the decision was made to remove the constant observer and place Mr A on 15-minute checks.

91. Mr B said that he assumed that his father might catch a bus home, so they drove to Mr A's home to look for him. The police then advised that Mr A had been found and taken back to the hospital.

92. The patient report form completed by the ambulance service indicated that it was called by a member of the public who had found Mr A sitting at a bus stop speaking incomprehensible words. The ambulance arrived at the bus stop at 7.51pm and arrived back at the hospital at 8.05pm.

93. Waitemata DHB advised that subsequent review of the CCTV footage confirmed that Mr A left the ward at 5.41pm. The DHB considers it likely that Mr A left with some departing visitors. A review was conducted by security officer Mr Q on Day 6, which includes a note: "[P]atient seen leaving at 17.41 on CCTV and reported missing at 19.20, not 10 minutes as reported by ward but nearly 3 hours later."

94. Waitemata DHB advised HDC: "We accept that the comment about missing for 10 minutes is inaccurate. This matter was dealt with in a formal management process with [RN C]."

Brain haemorrhage

95. On readmission, Mr A was found to have a GCS of 9/15 and bilateral extensor plantar responses.[17] A CT scan was undertaken at 9.00pm and showed a large bilateral subdural haematoma[18] with a midline shift of his cerebrum (brain). The result was discussed with the on-call neurosurgeon at another hospital, and a decision was made that surgical intervention was not indicated.

Discussion with registrar

96. Mr B told HDC that a security officer met them outside the hospital and took them into the family room. A nurse told them that his father was "not looking good" and had sustained life-threatening injuries while out of the hospital grounds. Mr B stated that he was informed that his father had been missing for more than two hours, despite his having been told earlier that it was about 10 minutes.

97. Mr B was taken to see his father, who appeared to be unconscious. Mr B said that he pulled back the bedclothes, looked at his father, and noted that he had no fresh injuries. He said that his father was thin and bruised easily.

98. Registrar Dr J discussed Mr A's condition with Mr B. In his complaint, Mr B stated that he was holding his father's hand when Dr J said that his father's condition was life-threatening and possibly non-survivable. Mr B stated that, at that time, his father could squeeze his hand on command and that, as Mr A's condition was discussed, Mr

[17] The plantar reflex is a reflex elicited when the sole of the foot is stimulated with a blunt instrument. The reflex can take one of two forms. In normal adults the plantar reflex causes a downward response of the hallux (flexion). An upward response (extension) of the hallux can identify disease of the spinal cord and brain in adults. If the hallux dorsiflexes and the other toes fan out, this indicates damage to the central nervous system.

[18] A subdural haematoma is usually associated with traumatic brain injury. Blood gathers between the dura mater and the brain.

A squeezed his hand. Mr B stated: "[H]is depth of consciousness and my perception of his awareness was contradictory to the doctor's."

99. Mr B said that he insisted on going somewhere else to talk, but the doctor argued with him and said that his father could not understand. They then went to an area with computers, and the doctor pointed out his father's head on a screen and showed him the brain bleed. The doctor said that the information had been sent to a neurologist at another hospital, who would give an opinion.

100. Mr B said that he went back to his father and, although he tried to get him to do so, his father never again squeezed his hand.

101. The same doctor came over again and said that he wanted to talk about resuscitation. Mr B replied, "Don't discuss it in front of him", but the doctor again said that his father could not hear them so it was "okay". Mr B said that he walked away, and the doctor followed and told him that it was up to him to make the decision about resuscitation.

102. Mr B said that he told the doctor he did not want a decision made until they had heard back from the neurologist. The doctor said that his father's brain had moved, and the neurologist's opinion was that his father should not be treated.

103. Mr B said that he told the doctor about a conversation he had had earlier with his father, in which "[they] talked about dying and [his father] said he did not want to hold on tooth and claw and had had a full life. He said we should let nature take its course."

104. In his complaint, Mr B said he felt that Dr J showed a lack of compassion by discussing resuscitation in front of his father. Mr B said he told Dr J that he saw no point in resuscitating only to have his father die again, and that the doctor should let nature take its course.

105. Dr J noted at 11.00pm that aspirin and oral medications should be stopped, and that a discussion had been conducted with the EPOA about Mr A's resuscitation status. Dr J noted at 11.30pm that Mr A was not for resuscitation.

106. Mr A remained unconscious and was provided with comfort cares until he died a few days later.

107. Mr B stated that Dr J told him that his father had suffered a serious life-threatening non-survivable injury to his head while he was out of the hospital. Dr J documented in the clinical notes: "Traumatic bilat subdural haemorrhage? acute on chronic."

108. Waitemata DHB agreed that Mr A had sustained an injury to his head from the fall on Day 2, and said that the injury is referred to in the records by the nurses throughout the days after his fall. The DHB stated that, at the time Mr A was readmitted, the medical staff did not identify new injuries, but the CT scan of his head identified a significant cerebral haemorrhage. On Day 6 at 4.31pm a doctor noted that the family

had attended a meeting with Dr F, at which the events were discussed. The doctor noted: "[L]ikely/possible subdural from fall on ward which enlarged/or 2nd subdural when went out of ward."

109. Forensic pathologist Dr E advised the Coroner that the bilateral subdural haemorrhage was the result of blunt trauma, likely due to a fall in the context of cerebral atrophy due to Alzheimer's and vascular type dementia.

110. Dr E said that histological examination of the brain suggested a relatively recent event of probably a matter of several days. The report stated that histologic aging is not sufficiently precise to determine whether the subdural haemorrhage was temporally related to the fall on Day 2 or had occurred during Mr A's period of absence from the ward on Day 4.

111. The report noted that following Mr A's Day 2 fall in hospital, his behaviour changed over several days. The report concluded that the clinical history suggests the possibility of a developing subdural haematoma leading to behavioural changes following the initial fall, and that subsequent falls during his absence from the ward may well have contributed to a developing subdural haemorrhage. Dr E stated that it is possible that the subdural haemorrhage resulted from a fall during Mr A's period of absenteeism on Day 4.

112. Mr B said that the aspirin administered to his father could have exacerbated his brain bleed. Waitemata DHB stated that "it is conceivable that [three doses of 100mg aspirin] could have led to a greater degree of bleeding around the brain".

113. Waitemata DHB advised that, although following Mr A's fall on Day 2 the on-call medical staff referred to the fall in the clinical record, they did not recommend further assessment or treatment. Waitemata DHB stated that consideration should have been given to undertaking a CT head scan after the fall.

114. Waitemata DHB said that the medical ward round documentation is not in the clinical progress notes, as is usual, but instead is in the A–D planner. The DHB stated that this is not consistent with the clinical documentation policy, which stipulates that documentation is to be in chronological order without gaps. The impact of the failure to record in the progress notes was that the nurses would have needed to look in at least two places to find a medical plan.

115. Since these events, Waitemata DHB has arranged for the falls sticker to be changed to include the date and time when families are notified, and the post-fall documentation form has a prompt to call the family, and the date and time of the call has been added.

116. Waitemata DHB stated in a letter to HDC that since this incident it has reiterated to staff that 15-minute checks are a "team effort", and that all staff must be aware of which patients require such checks. However, on 1 October 2013, Waitemata DHB advised HDC that 15-minute checks are the responsibility of the nurse who looks after the patient, "not just anyone's responsibility". At that time, the check form provided for ticks next to the time of the check, and did not require a name or signature. The

form has since been changed to require signatures as well as a tick, and there is now a guideline for managing people needing observation, and the form is a record of that process.

117. Waitemata DHB said that it has been working with all wards to alter the process of handover to require visual handover, especially when a patient has cognitive impairment. Wards have also introduced a team-based structure for staffing on a shift, so that someone from the team who knows the patients and their needs is always available when meal breaks occur.

118. Waitemata DHB stated that RN C's advice to Security that Mr A had been missing for 10 minutes was inaccurate. Waitemata DHB stated: "[T]his wrong time may have delayed the process of searching for [Mr A] by ten minutes because Security had to look on CCTV for longer to find the actual time he left the ward."

119. The DHB advised that the matter had been dealt with by way of a formal management process undertaken with RN C. A formal "point in time" assessment of RN C's practice was arranged, which confirmed that he was competent according to the Nursing Council of New Zealand's competencies. A performance management plan was developed, and he was required to work on day shifts and attend more learning sessions to focus on his responsibility for patient-centred care and managing complex patient workloads. He has subsequently been transferred to another ward and continues, with professional coaching, to work as a level 2 competent registered nurse.

120. The DHB acknowledged that the communication with Mr B on the evening of Day 4 would have appeared confusing, and apologised for the miscommunication. The DHB stated that Mr B arrived on the ward while the staff were looking for his father and, "[d]epending on who he spoke to at the time of his arrival, he will have been told differing information based on what the person knew".

121. Waitemata DHB said that communication issues with regard to speaking to Mr A's family in front of Mr A while he was unconscious have been addressed with the medical staff in terms of general patient and family communication, giving bad news, and general sensitivity and compassion. The head of the medical division has completed a professional qualities reflection (PQR) with the registrar who was looking after Mr A.

122. Waitemata DHB has now documented the process for reporting missing patients, and the process is covered as part of general service education of new shift coordinators, and covered in depth in the ward shift coordinator training sessions. Duty nurse managers have also had training as part of a case review to cover this type of scenario.

123. Over the past 18 months, Waitemata DHB medical division nursing staff have received training on care of the elderly with dementia, delirium and ongoing needs. There has been emphasis on post-fall management as part of the falls prevention project. The DHB has appointed a nurse specialist for dementia care, and her role

includes staff teaching. Assessment of patients with a head injury has been included, and is an ongoing teaching element.

124. The hospital pharmacists have been reminded to contact the ward team directly if there are any concerns with medication.

125. Waitemata DHB stated: "We acknowledge that the care provided to [Mr A] fell short of our expected standards. In particular, consideration should have been given to undertaking a CT head scan after the fall in which he sustained the head laceration ([Day 2]). Waitemata DHB apologises for these failures."

Response to provisional opinion

126. The following responses to the provisional opinion were received from Waitemata DHB and RN C, in addition to the responses incorporated into the "information gathered" section above.

Waitemata DHB

127. Waitemata DHB highlighted some of the practical difficulties faced by staff in relation to dealing with EPOA activation. It advised that it is not possible to have a central register of EPOAs or Certificates of Mental Incapacity, and that staff therefore rely on family members to provide evidence of EPOA and its activation. While training on EPOA activation is available, in this case staff did not recognise that Dr I's letter was not effective to activate the EPOA. Waitemata DHB stated:

> "The only way staff could have recognised that [Dr I's letter was not effective to activate the EPOA] was if they knew exactly what the prescribed format was and this relies on the DHB ensuring all clinical staff members are educated about the format."

128. Waitemata DHB stated that it has learnt from these events and has made continuous improvements to its systems and processes to assist staff with the management of complex and frail patients.

RN C

129. RN C submitted that he was part of a team caring for the patients on the ward on the night of Day 4, and that he took reasonable actions in the circumstances to comply with his duties to Mr A under the Code. In particular, RN C acknowledged that Mr A was assigned to him that night and that he (RN C) was "the main person responsible for making checks". However, RN C does not accept that it was "entirely his responsibility" to make those checks, and noted Waitemata DHB's advice that 15-minute checks are a team effort and all staff must be aware of which patients require such checks.

130. RN C acknowledges that his failure to make the requisite checks at 5.00pm, 5.45pm and 6.00pm was "not ideal" but submitted to HDC that "the reality is that this was a busy time on the ward […] and at such times a nurse has to respond to the urgent matters which may mean that other things that are less pressing are unable to be completed". RN C also acknowledges that his handover to RN H was "not ideal" and that he ought to have checked Mr A's whereabouts before going on his meal break.

131. RN C maintains that he did not advise Security that Mr A had been missing for 10 minutes.

Opinion: Breach — RN C

132. On the afternoon of Day 4, RN C was responsible for Mr A's care. At handover he was told that he should reassess Mr A if necessary to determine whether he required constant supervision, rather than checks every 15 minutes. RN C stated that he did not think constant supervision was necessary, as Mr A had improved from the previous day and there had been no changes in his condition since the morning shift.

133. At 4.00pm RN C decided to have the ward door locked because he was concerned about Mr A's wandering. RN C put a note on the door saying, "Please do not let the patients out," in order to make visitors aware that the door was locked for a reason. RN C said that he told all staff and the ward clerk that the door had been locked to prevent Mr A from getting out. Other patients were able to leave the ward by asking staff to push a button in the nurses' station.

15-minute checks

134. In his response to my provisional opinion, RN C submitted that he was part of a team caring for the patients on the ward, and that it was "not entirely his responsibility" to monitor Mr A. RN C also acknowledges that Mr A was assigned to him on Day 4, and that he was the "the main person responsible for making checks". I remain of the view that RN C was responsible for making observations of Mr A every 15 minutes. RN C conducted the 15-minute checks until 4.45pm, but did not check at 5.00pm. He conducted further checks at 5.15pm and 5.30pm, but did not make the required checks of Mr A at 5.45pm or 6.00pm. RN C acknowledges that these omissions were "not ideal".

135. RN C stated that at 6.00pm he handed over his patients to RN H and told her that Mr A was in the TV room. However, RN C did not hand over that Mr A was on 15-minute checks, or any other information about his condition, and said that this was because RN H had been Mr A's nurse the previous night,[19] and that all staff had been told at handover that afternoon that Mr A was on 15-minute checks.

[19] At that time Mr A was not on 15-minute observations, and constant observations were introduced at that time.

136. The DHB stated that RN H was overwhelmed by having to care for 11 patients during the meal break, and said she was not made aware that she needed to check Mr A at 15-minute intervals, or told when he had last been checked, and it was not until RN C returned at 7.00pm that RN H became aware that she should have been checking on Mr A every 15 minutes.

137. In my view, RN C's management of Mr A's observations was unsatisfactory. It is concerning that he did not observe Mr A at 5.00pm, 5.45pm or 6.00pm because he was too busy with other patients. I note RN C's comment that this was a busy time on the ward, and that he was required to respond to urgent matters at the expense of "things that are less pressing". However, in my view, the omission to complete Mr A's checks does warrant some criticism.

138. However, his decision to hand over to another nurse without having checked on Mr A for half an hour, and without fully briefing that nurse, is unacceptable. As noted by RN G, handover must include the patient's current status and whereabouts. RN C's belief that Mr A had remained in the TV room was not reliable in the circumstances of his not having carried out a 15-minute check since 5.30pm. As RN C did not do the 6.00pm check, he did not know where Mr A was, and did not hand over that Mr A was on 15-minute checks or any other information about his condition. RN C acknowledges that his handover to RN H was "not ideal".

139. I accept that RN H had cared for Mr A the previous day when he had been very confused, and had recorded: "Regular checks until constant observation in situ." I also accept that RN H had attended handover at the beginning of the shift, when Mr A was discussed. However, in my view, information as to Mr A's current status should have been handed over to RN H. In my view, RN C's failure to do so was negligent.

Discovery of Mr A's absence

140. RN C stated that after he returned at 7.00pm he checked for Mr A in the TV room and realised he was missing. RN C said that he informed the other nurses in the ward, and they searched each room and the toilets. When that was unsuccessful, the records show that at 7.20pm he informed Security and the Duty Nurse Manager that Mr A was missing. Security officer Mr P called the police at 7.30pm, and the police arrived at 7.55pm.

141. RN C maintains that he did not tell Security that Mr A had been missing for 10 minutes. RN C told HDC: "I would not have put a time on his absence as I did not know how long he had been missing, as I had just come back from my break and was not aware when he had last been checked." I note that RN C had been back from his break for approximately 20 minutes when he contacted Security.

142. In contrast, Mr B stated that he was told that his father had been missing for only 10–15 minutes. The reportable event summary completed by Security also indicates that RN C told Security that Mr A "was missing in the last 10min". Similarly, the subsequent Security review of events by Mr Q on Day 6 includes a note: "[P]atient seen leaving at 17.41 on CCTV and reported missing at 19.20, not 10 minutes as reported by ward but nearly 3 hours later."

143. In my assessment of this matter, I have carefully balanced RN C's version of events against the information recorded by Security. It appears that Security understood from their discussion with RN C that Mr A had been missing for 10 minutes, as initially Security viewed the CCTV footage for only the 10–15 minutes prior to Mr A having been found to be missing. Mr B also believed that Mr A had been missing for 10 minutes. However, RN C denies having made any such statement. In the circumstances, I am unable to make a factual finding as to what specific communications took place between RN C and Security. That said, I find it more likely than not that RN C failed to ascertain that the last time Mr A had been sighted was at 5.30pm.

144. A subsequent review of the CCTV footage confirmed that Mr A left the ward at 5.41pm. The two missed checks at 5.45pm and 6.00pm were lost opportunities to discover Mr A's absence promptly.

Conclusion

145. RN C did not make all the required 15-minute checks, failed to hand over Mr A's care adequately when he took his meal break, and failed to ascertain the correct information and convey it to Security after he discovered that Mr A was missing. I consider that RN C's actions in this regard were careless. Accordingly, RN C failed to provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: Waitemata District Health Board

146. A DHB is responsible for ensuring that it has robust systems in place to provide an appropriate standard of care to its patients. It is also responsible for taking reasonably practicable steps to ensure that its staff understand, and are compliant with, its policies, procedures and guidelines. Several deficiencies in Mr A's care have been identified in this opinion. I consider that failures by the DHB at an organisational level contributed to these deficiencies.

Mr A's status — Adverse comment

147. It is apparent that staff at the hospital believed that Mr A lacked the competence to make decisions on his own behalf. This had been signalled in Dr D's correspondence with Dr I. It is apparent that Dr D, Dr I and Mr B all believed that the EPOA had been effectively activated. I note Waitemata DHB's comments regarding the practical difficulties faced by staff in dealing with EPOA activation. However, I remain of the view that it was nonetheless Waitemata DHB's responsibility to clarify Mr A's status, in particular whether his EPOA had actually been activated.

148. Section 99D of the Protection of Personal Property and Rights Act 1988 provides that a certificate of the donor's mental incapacity must be in the prescribed form, and Regulation 4 specifies the form that must be used.

149. Right 7(4) of the Code provides that where a consumer is not competent to give informed consent, and there is no one entitled to give consent on the consumer's behalf (such as an active EPOA), providers may nonetheless provide services where it is in the best interests of the consumer and reasonable steps have been taken to ascertain the views of the consumer. Right 7(4)(c) provides further that if the consumer's views cannot be ascertained, providers are required to take into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.

150. On 9 November Dr I wrote a letter addressed to "To whom it may concern", which states: "This is to certify, that the patient described above ([Mr A]) should have their Enduring Power of Attorney activated for their continuing safety and well-being." The letter was not in the prescribed form.

151. There is no record of the required certificate having been completed. Accordingly, I find that the EPOA was not activated.

152. Despite this, staff at the hospital acted on the basis that the EPOA appointing Mr B as EPOA had indeed been activated. This Office has previously commented on the need for clarity about the status of incompetent consumers, particularly with regard to the consent for treatment and the communication of health information.[20] In this case, I would have expected Waitemata DHB to have been aware of the legal requirements and sighted the medical certification required to activate the EPOA, or otherwise ensured that the EPOA was activated.

153. However, with the exception of the specific areas in which I have found that Mr A's rights were breached, I accept that services were provided in Mr A's best interests, taking into account Mr B's views as required by Right 7(4) of the Code.

Medications — Adverse comment

154. In June 2011 Dr I became concerned that Mr A was not taking his medications, as renewal of his prescriptions would have been due in March 2011. However, Mr A told Dr I that he was taking his medications. On 6 September 2011, Dr I reviewed Mr A and prescribed three months' supply of his usual medications, atenolol, simvastatin and aspirin. Dr I prescribed no further medication for Mr A after that time.

155. Waitemata DHB stated that the admitting team based the initial prescribing of Mr A's medications on the dispensing records available on the electronic TestSafe system, and that the admitting team was not aware that Mr A was no longer taking the medications. The most recent record on TestSafe was from 6 September 2011, when a three-month supply was prescribed. Waitemata DHB stated: "[A]s the last dispensing record of regular medicines was only 6 months prior to admission the medical staff would not have been aware of the non-use of those medicines when completing the acute admission." In my view, Waitemata DHB staff should have questioned the lack of a further prescription after 6 December 2011.

[20] See 11HDC00940 and 08HDC20957, available at www.hdc.org.nz.

156. On Day 1, when Mr A was admitted to hospital, the triage/initial assessment nurse, RN K, wrote the medications atenolol/aspirin/simvastatin on the ED/ADU assessment sheet. Waitemata DHB said that it cannot ascertain where RN K found that information.

157. My expert advisor physician, Professor Tim Wilkinson, stated that it is usual for previously prescribed medication to be given when a person is admitted to hospital. He noted that it is sometimes difficult to obtain an accurate picture of how much of the intended medication had been taken when the person was at home or unsupervised.

158. I note that Mr B, who was closely involved in his father's care, was present at the hospital until midnight on the day of his father's admission (Day 1), but there is no record of any discussion with him at that time regarding his father's current medications. However, Mr B said that he told the staff when his father was admitted that he had not taken any medication for some time before admission. In my view, there should have been a discussion with Mr B, and this should have been recorded fully.

159. I note that the hospital pharmacist, Ms L, discussed Mr A's medications with Mr B the following day. She completed a medicine reconciliation process and wrote in the A–D planner and the progress notes: "Have completed pt [patient] med[ical] hx [history]. Pt [patient] has not been taking any regular meds for approximately 18 months — as per son." She crossed out the medications, but her entry in the progress notes was not followed up by the medical team. Waitemata DHB stated that this was because the medical staff do not always refer back to previous pages in the A–D planner and, at the time Ms L completed the medicine reconciliation process, the medical team had already completed the "post-acute" ward round.

160. There is nothing on the medication chart to suggest that Ms L talked with the medical staff or that they noticed the instruction to discontinue the medications. Subsequently, Mr A was administered atenolol and aspirin at 9.00am on Days 2, 3 and 4. He was given simvastatin at 6.30pm on Day 2 and Day 3. In his complaint, Mr B said that the aspirin could have exacerbated his father's brain bleed, and Waitemata DHB agreed that "it is conceivable that [three doses of 100mg aspirin] could have led to a greater degree of bleeding around the brain".

161. In my view, it was the responsibility of Waitemata DHB to clarify the medications Mr A was receiving and ensure that all staff were aware of the correct information. I am concerned that this did not occur in this case. In particular, it appears that Waitemata DHB staff did not note the lack of a repeat prescription after 6 September 2011, and did not record the information provided by Mr B at the time of his father's admission. There also appears to have been a breakdown in communication between the pharmacist and the medical staff regarding Mr A's medication. As a result, Mr A continued to receive medication without a medical review as to whether those medications remained appropriate in view of his previous non-compliance, which I consider to be suboptimal in the circumstances.

Care provided — Breach

Neurological observations following fall

162. At 6.30am on Day 2, Mr A was found sitting on the floor having fallen. Mr A suffered a laceration to his left eyebrow and multiple skin tears on his left leg, which were dressed with Steri-strips. A wound chart and an incident report were completed.

163. Mr A had suffered an injury to his head. Waitemata DHB policy states that neurological assessment must be undertaken where there has been an injury to the head, and that the neurological assessments should continue hourly until the frequency is changed by the medical staff or nurse in charge.

164. Neurological observations were carried out four times on Day 2, and then discontinued. The NEWS vital sign monitoring form records observations done after the fall on Day 2 at 8.15am and 3.25pm; Day 3 at 7.30am, midday and 4pm; and Day 4 at 9.00am and 4.00pm.

165. Waitemata DHB stated that this frequency of observations was not in accordance with its policy expectations, which require that in the first 24 hours of admission a full set of NEWS observations must be done at least four hourly, and thereafter observations should continue four hourly unless assessed by a charge nurse or medical staff that less frequent assessment is appropriate, and a full set of NEWS observations must be done at least eight hourly. Waitemata DHB stated that it is not clear why the nurses did not undertake the neurological observations as frequently as the policy specifies.

Response to deteriorating condition

166. Mr A displayed a number of problems, such as being disorientated, confused and wandering. He began entering other patients' rooms and was aggressive and threatening towards them. In addition, he was making inappropriate comments to staff, and his behaviour was described as "labile". Mr A was moved to a single room and a watch was commenced.

167. On Day 3, Mr B raised concerns with a nurse about his father's mental state. He told HDC that his father's personality had changed, and that his mood swings went from rage to complete calm, which was out of character for him. However, no medical review was arranged. My expert advisor, Professor Wilkinson, stated that "as the events unfolded, and it transpired that [Mr A's] condition was deteriorating, then this should prompt a re-evaluation, including consideration of a CT scan".

Handover

168. On Day 4 at 6.00pm RN H, a relatively inexperienced nurse, was required to assume responsibility for 11 patients for an hour while other staff took a meal break. RN C handed over his patients to RN H and told her that Mr A was in the TV room. However, RN C did not hand over that Mr A was on 15-minute checks, or any other information about his condition. The DHB stated that RN H was overwhelmed by having to provide care to 11 patients for an hour while three staff were away from the ward. Although RN H had provided care for Mr A the previous day, at that stage he was not on 15-minute checks, and his condition was different from that on Day 4.

169. Waitemata DHB did not have a policy or process at that time that required visual handover, or that a team member who knew the patients and their current needs was available during meal breaks.

Conclusions

170. The failures by Waitemata DHB staff to undertake the required neurological observations following Mr A's fall on Day 2, and take action as Mr A's condition deteriorated following the fall, were suboptimal. Furthermore, Waitemata DHB had no formal process for handover of patients by nurses, and visual handover was not required. There was no structure in place to ensure that appropriate staff were present during meal breaks. Accordingly, I find that Waitemata DHB failed to provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

Communication — Adverse comment

171. Mr A suffered a fall at 6.30am on Day 2. Waitemata DHB advised that Mr B was not contacted at that time because it was early in the morning. At 11.15am RN N recorded that she had spoken to Mr B but made no record of having advised him of his father's fall that morning. Mr B said he was not told at that time. RN N's notes are detailed and comprehensive, and I consider that if the fall had been discussed it would also have been recorded. Therefore, I find that RN N did not tell Mr B about the fall at that time.

172. Mr B stated that he was advised of the fall when he rang the hospital later that afternoon.

173. In my view, it was unsatisfactory to have failed to advise Mr B of his father's fall at the first reasonable opportunity after the fall. Mr B was recorded as being Mr A's next-of-kin and contact person. The Health and Disability Services (Core) Standards[21] state that "[s]ervices should ensure information is shared, that there is family involvement, and consultation in the planning and decision-making process if the family/whanau are the primary caregiver".[22] The standards state that consumers have a right to full and frank information and open disclosure from service providers.[23] Furthermore, information must be provided in an appropriate format and a timely manner.[24]

174. As stated above, when Mr B arrived to visit his father on Day 3 he discovered that his father had been moved to a single room. Mr B expressed concern to a nurse about his father's uncharacteristic mental condition and behaviour during the visit. However, those concerns were not acted upon.

175. When Mr B arrived at the ward on the evening of Day 4 he was incorrectly told by a female nurse that his father had been missing for only 10–15 minutes. However, I accept that the staff believed that to be correct at the time.

[21] NZS 8134.1.1:2008.
[22] Ibid at page 8.
[23] Standard 1.9.
[24] Standard 1.10.3.

176. Mr B was concerned that, after his father's readmission, Dr J had two conversations in Mr A's presence in which Dr J said that Mr A's condition was life-threatening and possibly non-survivable, and discussed his resuscitation status. Mr B stated that when his father's condition was discussed, Mr A squeezed his hand. Although I am unable to make a finding as to whether Mr A was able to understand, I consider that the manner in which the conversation was conducted may have been insensitive and inappropriate.

177. Overall, I find that the communication between Waitemata DHB staff, Mr A, and Mr B was suboptimal, in that Mr B was not communicated with effectively about his father's medication, was not told of his father's fall on Day 2 until late that day, was not advised of his father's deteriorating condition until he arrived to visit his father, his concerns about his father's deteriorating mental state were not adequately responded to and discussed with him, and Mr A's life-threatening condition was discussed at his bedside in an inappropriate manner.

Summary

178. I am critical of the lack of clarity regarding Mr A's competency status, in that Waitemata DHB staff appear to have acted on the basis that Mr A's EPOA had been activated (when in fact it had not). I am also concerned that Waitemata DHB staff failed to clarify the medications that Mr A was receiving and ensure that all staff were aware of the correct information in this regard. As a result, Mr A continued to receive medication without a medical review as to whether those medications remained appropriate in view of his previous non-compliance.

179. Waitemata DHB staff failed to undertake the required neurological observations following Mr A's fall on Day 2, and take appropriate action as Mr A's condition deteriorated. Furthermore, Waitemata DHB had no formal process for handover of patients by nurses, and visual handover was not required. There was no structure in place to ensure that appropriate staff were present during meal breaks. Accordingly, Waitemata DHB failed to provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

180. In addition, the communication between Waitemata DHB staff, Mr A, and Mr B was suboptimal.

Recommendations

181. I recommend that RN C apologise to Mr A's family within three weeks of the date of this report.

182. I recommend that Waitemata DHB apologise to Mr A's family within three weeks of the date of this report and, within three months of the date of this report, provide evidence to HDC of having complied with the following recommendations:

a) Arrange for an audit of the documentation practices in the general medical ward.

b) Review the DHB's handover processes and prepare a report on the outcome of the review.

c) Review the training of nursing staff in the medical division regarding the care of elderly patients with dementia.

Follow-up actions

183.
- A copy of this report with details identifying the parties removed, except the experts who advised on this case and Waitemata DHB, will be sent to the Nursing Council of New Zealand, and it will be advised of RN C's name.

- A copy of this report will be sent to the Coroner.

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

Appendix A — Independent advice to the Commissioner

The following expert advice was obtained from Professor Tim Wilkinson:

"I have been asked to provide an opinion to the Commissioner on Mr A, ref 12/00630. I have read and agreed to follow the Commissioner's Guidelines for Independent Advisors. My qualifications are: Bachelor of Medicine and Bachelor of Surgery from the University of Otago, Fellowship of the Royal Australasian College of Physicians, Fellowship of the Royal College of Physicians (London), Master of Clinical Education from the University of New South Wales, Doctor of Philosophy from the University of Otago and Doctor of Medicine from the University of Otago. I have worked as a Consultant Physician in Geriatric Medicine at The Princess Margaret Hospital in Christchurch, New Zealand, since 1994 and I am also a Professor in Medicine at the University of Otago, Christchurch. In my clinical work I deal with common problems faced by older people, particularly those that threaten their independence. I see older people in their homes, in Outpatient Clinics and in Inpatient Wards.

The instructions from the Commissioner are as follows:

'Please comment generally on the standard of medical care provided to [Mr A] at [the public hospital] [in 2012].

Please ensure your advice covers the following.

Was [Mr A] appropriately assessed following his fall at 6.30am on [Day 2], and was the treatment plan appropriate?

Was further investigation of potential head injury indicated when [Mr A] was reviewed during the post acute ward round later that morning?

Waitemata DHB has advised that it considers earlier consideration should have been given to a CT head in the context of fluctuating behaviour and a history of multiple recent falls, particularly the in hospital fall which resulted in a head injury. Do you agree, and if so, at what point should the cr head/further investigation [have] been considered?

Were there any issues of concern with respect to communication or documentation? If so, please explain.

Are there any aspects of the care provided by Waitemata DHB that you consider warrant additional comment? If so, please explain.

If, in answering any of the above questions, you believe that Waitemata DHB did not provide an appropriate standard of care, please indicate the severity of the departure from that standard.'

I have available to me copies of:

1. Letter of complaint
2. Clinical records
3. Initial response from Waitemata DHB, dated [2012]

4. Further information from Waitemata DHB, letter dated 5 April 2013 (with enclosures)
5. HDC letter of notification of investigation
6. Response to notification from Waitemata DHB, dated 1 October 2013
7. Information from Coroner

   a. Report from [Dr E], forensic pathologist, dated [2012]
   b. Addendum report from [Dr F], undated
   c. Sentinel Investigation Report, undated
   d. Report from [Dr F], dated [2012]
   e. Report from [RN G], dated [2012]
   f. Statement from [Mr B], dated [2012]
   g. Coronial Autopsy Report from [Dr E], dated [2012]

I agree with your summary of the situation, but in essence [Mr A] had well-established dementia to the point where he was no longer capable of managing his personal care and welfare. On [Day 1] [Mr A] was admitted to [a general medical ward] at [the] Hospital. At 6.45am on [Day 2] [Mr A] had an unwitnessed fall. The nurse contacted the on-call house surgeon, who reviewed [Mr A] at 7am. He was also reviewed on a consultant ward round later that morning. [Mr A's] son was informed about the fall at around 9am. On [Day 1], [Mr A] had been prescribed aspirin, atenolol, and simvastatin on the basis of previous dispensing records (Sept 2011) but it transpired that [Mr A] had not been taking any regular medications for approximately 18 months. [Mr A] was given three doses of aspirin and atenolol and two doses of simvastatin over the next three days. Because of some restlessness and [Mr A's] desire to leave the hospital, a 24-hour watch was assigned from 7pm on [Day 3] until 7am the next morning. On [Day 4], 15-minute checks were planned throughout the day, and these were undertaken excluding 5pm, 5.45pm, 6pm, 6.l5pm, 6.30pm, and 6.45pm. The nurse looking after [Mr A] that evening returned from his meal break at 7pm and was unable to find [Mr A]. At 7.45pm, a member of the public found [Mr A] 2.2 km from the hospital, called an ambulance for [Mr A], and he was returned to [the hospital]. A CT head was performed at 9pm. This showed large bilateral subdural haemorrhages with midline shift of his cerebrum. It was decided that surgical intervention would not be appropriate and that [Mr A] should be treated palliatively. [Mr A] died on [Day 8]. The pathologist who undertook the post-mortem was unable to determine when the subdural haemorrhages might have occurred. I note also the concern raised by [Mr A's] son about discussions around resuscitation that were undertaken between a medical registrar and [Mr A's] son, that were undertaken in the room while [Mr A] may have been unconscious.

In my opinion, this situation raises four issues:

1. the assessment of the fall and ordering of the CT scan,
2. communication,
3. the administration of medications, and
4. the unwitnessed departure of [Mr A] from the hospital

In relation to the assessment following the fall and timing of the scan, it is my opinion that the actions taken were appropriate. The assessment after the fall was

timely and sufficient. The plan for subsequent observations was reasonable. It is my opinion that it would not be routine to arrange another scan of the brain following any fall. Instead, closely observing the patient and acting accordingly is common practice. [Mr A's] behaviour seemed to deteriorate following the fall but there could be many explanations for this, not the least of which would be the discomfort from the fall and his being in an unfamiliar environment. Waitemata DHB has suggested an earlier CT scan could have been considered. While I agree it could have been considered, it is my opinion that such a course of action would not necessarily have been expected. As the events unfolded, and it transpired that his condition was deteriorating, then this should prompt a re-evaluation, including consideration of a CT scan. However, it is my opinion that even performing the CT scan earlier would not necessarily have prompted any change in management.

There are two issues related to communication. The first relates to the contacting of [Mr A's] son following the fall. In my opinion, and given the nature of the circumstances, I believe that deferring contacting relatives until daylight/working hours is polite and reasonable. [Mr A's] son states that he contacted the ward first, rather than the ward contacting him. The hospital notes clearly outline an intent to contact [Mr A's] son, so it is not necessary to determine if the ward staff would have followed through on their intention. The second issue relates to discussions around resuscitation undertaken between the medical registrar and [Mr A's] son that were undertaken in the room while [Mr A] may have been unconscious. The issue here is that [Mr A] may have been able to hear the conversation but not participate in it. As such, it is my opinion that this should not have occurred in that context, and instead should have been undertaken out of earshot of [Mr A]. It is my opinion that this discussion in the same room as [Mr A], would meet with mild disapproval from one's peers.

In relation to the administration of previously prescribed medication, it is usual for previously prescribed medication to be given when a person is admitted to hospital. However, it is sometimes difficult to obtain an accurate picture regarding how much of the intended medication had been taken when the person was at home or unsupervised. I am aware that many hospitals are trying to improve this situation. In my opinion, the current action around this did not differ significantly from normal practice.

Finally, there is the issue of [Mr A] leaving the hospital while he was meant to be closely monitored. I note that you intend to obtain a separate nursing opinion regarding this. However, it is my opinion that if the intention is to watch a patient at 15-minute intervals because they are at risk of leaving the hospital, and this was not done as intended, then this is not an acceptable standard of care. I would judge this would meet with moderate disapproval from one's peers. In stating this, one could make an argument that it should meet with severe disapproval but, in mitigation, I am aware that most hospital environments, particularly general medical wards, are open and accessible and therefore not conducive to retaining patients who are determined to leave.

Yours sincerely

Professor Tim Wilkinson, MBChB, MClinEd, PhD, MD, FRACP, FRCP"

Appendix B — Independent advice to the Commissioner

The following expert advice was obtained from RN Diane Penney:

"My name is Diane Penney. I have been a registered nurse since 1975 and have a current practicing certificate.

I am currently Project Manager responsible for the Midland Acute Coronary Syndrome pilot initiated by the Minister of Health. Much of the work has been around improving patient flow and equity of access from secondary to tertiary services.

I am due to start in a new role as Charge Nurse Manager in Thames Hospital.

I have a sound knowledge of nursing work, the patient and work flow in the acute inpatient ward setting. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Conflict of Interest
I have no known conflict of interest. I do not have prior knowledge of [Mr A], nor do I have a working relationship with any department or service in [the] Hospital or Waitemata DHB.

I have been provided with copies of the clinical records for [Mr A], and on request received copies of the incident reports and security documentation relating to his admission.

[Mr A] (deceased) [NHI]
[…]

[Mr A] was admitted on [Day 1] with a background of dementia and inability to care for himself. As he was considered at significant risk of leaving the ward, a "watch" was initiated, changing to a 15 minute observation.

On [Day 4] [Mr A] left the ward unnoticed at 1741 hours and was found 2 hours later at a local bus stop about 2 kms from the hospital.

He was reported missing to hospital security by nursing staff at 1920hrs.

A CT scan after returning to hospital via ambulance, indicated a large inoperable bilateral subdural haemorrhage. The impression of the Medical registrar was that it was a traumatic event and [Mr A] subsequently died on [Day 8].

My response will be set out under the headings as requested by the Commissioner.

Paragraph 11 and 37
[Mr A] was seen in ED at 12.30am by General Medicine.

- The name of the clinician who examined [Mr A] is not able to be deciphered, despite a specific space and instructions to print name. The locator […] is identifiable.
- Noted in clinical notes: son has EPOA (enduring power of attorney)

Medications

ED / ADU Assessment form

[RN K] has written in specific space as responsible for completion of form

- Atenolol / aspirin / simvastatin noted. Dose and frequency nor source of information stated.

[Mr B] indicates in his letter ([2012]) that his father had 'not been on heart medication for about a year'

Current Medication Sheet

- Source of information noted as Caregiver with 'son' handwritten, with a second source Community Pharmacy
- Written in body of DRUG NAME is written 'From last EDS and Community Dispensary record — Sept 2011'.

Sept has been crossed out and June entered. There is no signature against this although the writing is more like entries of the Pharmacist than of the admitting clinician.

- [Ms L's first name] (surname not decipherable) pager 1749 makes note: 'Hasn't been on regular medications for +/- 18 months as per son. To confirm Phcy / GP / Son'
- A tick over son indicating information confirmed and atenolol / aspirin / simvastatin have lines through them with T/S Sep 11 written

The standard of documentation above is a mild departure from expected standards.

Adult Medication Chart

- Name of prescriber/s and registration number, nor other basic information required on front of chart are completed. There are five nurse names as administrators, although only one has required registration number written.

On admission [Day 1] the following were prescribed:

- Atenolol and aspirin prescribed on '[Day1]' and given at on or near 9am on [Day2] / [Day 3] / [Day 4].
- Simvastatin prescribed on '[Day1]' and given 1830 [Day 2] and [Day 3]. It was not given at 1830 on [Day 4] as [Mr A] was already missing from ward although nurses were unaware at that stage.
- Chlorvescent prescribed [Day 2] however none recorded as been given.

- Paracetamol prescribed '[Day 1]' and given orally [Day 2] 0900. Noted by nurse as 'analgesia post fall for discomfort' on day of in-hospital fall.
- Paracetamol was also given on either [Day 3] or 4] (unable to decipher from photocopy, however nursing notes indicate medications given as charted).
- On [Day 2] at 10.50hrs the Pharmacist ([Ms L] ? 1749) has written 'have completed pt med Hx. Pt has not been taking any regular meds for approximately 18 months as per son'.
- The underlining of (any) in clinical records indicate writer emphasis and a desire for the issue to be addressed.
- There is no entry in clinical notes from medical staff relating to the Pharmacist entry and the nursing entries simply state 'regular medications given'.

The Waitemata DHB response (paragraph 35) acknowledges that it is 'conceivable that aspirin could have led to a greater degree of bleeding around the brain' [but] it does not address the following:

- Although [Mr B] had EPOA in matters regarding his father, was present in ED till midnight on the day of admission, and his father was known to have dementia, there was no discussion with him regarding medications.
- The Pharmacist entry in the clinical notes was either simply not read, noted by comment, or questioned by nurses who should have read previous entries in the notes nor the medical registrar on the medical ward round of [Day 3].

This is a mild departure from expected standard.

Unwitnessed fall

Soon after admission to the ward, [Mr A] was found sitting on the floor in his urine, at 06.30hrs. He had new injuries on his left eyebrow and multiple tears on his left leg.

- The nurse entry indicates a comprehensive account of [Mr A's] admission, including having a bottle at the bedside and call bell within reach and a ***Falls Risk Assessment Score Card*** was completed at 7.05hrs after the patient had fallen and has 'keep bed low at all times' checked.
- The incident report completed by [RN M] indicates that the bed was in low position.
- [Mr A] was seen by the OCHS (on call house surgeon) with no new orders except for neuro obs as per ward protocol and PRN analgesia. His injuries [were] described as minor.
- Neurological observations were carried out four times on [Day 2] and discontinued.
- The ward round of [Day 2] at 09.53hrs, acknowledges the fall. [Mr A] is described as 'Alert, well, communicative. Can identify Prime Minster, however not day of week or his address.'

[Mr B] indicates that [he] was not aware that his father had a fall until he phoned in the afternoon of [Day 2].

- [RN N] indicates in the entry at 11.15hrs that a conversation had taken place with [Mr B] and falls at home discussed, although the documentation does not specifically indicate that he had been advised of his father's fall at 0630hrs.

Given the entry is a comprehensive record of matters discussed, I would expect that if [Mr B] was told of his father's fall that morning, that it would be documented in the 11.15hrs entry.

This is a mild departure from expected standards.

The DHB response that notification of the fall to family was delayed because it was [a public holiday] is not addressed in the ***Corrective action*** in paragraph 42.

- The description of the sticker does not provide a timeframe for notifying a patient's family. Rather it simply will document the time and date family were advised and will not prevent a delay.
- Hospital staff may continue to make a decision based on their own perception, rather than the needs of patient and their family.

Changing behaviour

On [Day 3] the nursing entry indicates that [Mr B] raised concerns about his father's mental state.

[Mr B] described in his letter that his father's personality had changed and his mood swings were from rage to complete calm and this was out of character for him.

- Previous nurse entries described [Mr A] as disorientated and confused although could be re-orientated.
- Wandering was a problem and when [Mr A] was found on the ground floor of the hospital on the evening of [Day 2], Security were notified, so the doors to the ward would remain locked.
- The Dr round on [Day 3] at 8.23hrs the entry says 'Nil c/o (complaints) No (indecipherable) issues. Plan: Await MDT (Multi disciplinary Team)'.
- The nurse entry of the afternoon shift of [Day 3], documents that [Mr A] refused to enable the staff to take obs. (BP / pulse / temperature / oxygen sats) and replace a dressing he had removed. He was compliant with taking medications.
- He had started to enter other patient rooms and was becoming aggressive and threatening towards them.
- He was making inappropriate comments to staff and his behavior was described as labile.

[Mr A] was moved to a single room and a 'watch' overnight was commenced and it was reported he slept for most of the night and on the morning of [Day 4] the constant watch was removed and a 15 minute check commenced.

15/60 patient check form

The 15 minute observation of [Mr A] was the responsibility of all nurses on the ward and the form is ticked each 15minutes. There is neither a name, signature nor initial to identify who maintained responsibility at what time.

- The nurse entry of the morning shift in the clinical records reports that [Mr A] was in his room for most of the shift watching TV and was able to be redirected when wandering around ward. He was described as 'not aggressive or abusive this shift'.
- [Mr A] left the ward unnoticed in the early evening and was found by a member of the public some distance from [the hospital], and an ambulance was called and [Mr A] returned to [the hospital].

The DHB response (paragraph 40) does not accurately reflect all aspects over that period of time including:

- The time frame between documented checks was 1.5 hours.
- Meal breaks according to the Nurses and Midwives collective agreement (MECA) are 30 minutes in duration.
- It would be reasonable to assume the nurse responsible for [Mr A's] care over the shift would complete a check before leaving the ward, the nurse relieving would complete the next 2 checks, and returning nurse checks again 45mins after having left for meal break.

The nurse entry in the clinical notes does not provide times of events that led to the discovery that [Mr A] was missing from the ward.

- **1645hrs:** Noted on 15/60 Patient check form ticked that [Mr A] was seen.
- **1700hrs:** No entry made on form
- **1715hrs:** Form ticked that [Mr A] was seen
- **17.30hrs:** Form ticked and [Mr A] reported as seen in lounge talking to other patients.

DHB response indicates that at 1900hrs nurse returns from tea break, looks for [Mr A] and unable to find him, advises the [ward's] nursing staff and Duty Manager.

- The nurse's entry in clinical notes does not give time returned from meal break. DHB response does not provide time of alerting Security**.**

Incident form #97068

- RN C reports that security alerted 1900hrs
- Security log call from Ward Coordinator at 19.20hrs. Stated to security that 'patient last seen 10 mins ago'
- Security state [Mr A] unable to be located after search of CCTV within specific timeframe and of front of house

- **19.26hrs:** Security go to [the ward] to find that [Mr B] had arrived to visit his father unaware was missing.
- Ward staff confirmed with Security they were sure of details and patient was last seen in TV room.
- Contacted security colleague who confirmed using CCTV, that no one exited ward 10 near time indicated by nurse.
- **19.28** Security contacted [the Duty Manager] who indicated she had only received a page from the ward.
- **19.30** Further search of CCTV indicated [Mr A] had left the ward at 1741hrs and police called.
- **19.55:** Police arrived on site
- **19.47:** Member of public calls ambulance after [Mr A] found at bus stop
- **20.20** patient arrived by ambulance to [the hospital]
- **20.24**. Duty Manager informed by security and police stood down

This is a severe departure of expected standards of care.

Clinical notes
[Mr A] is returned to hospital via ambulance.

- GCS (Glascow Coma Score) now 10/15 (previously 14/15). BP 200/80. Temp 34.9. Impression: head injury ? acute on chronic /SDH (sub dural haematoma). Stop aspirin.
- Subsequent CT showed [Mr A] had a large sub dural haemorrhage with R side > left side. Midline shift.

[Mr B] describes his distress by the manner in which he was told of the CT results and Neurosurgical consult in front of his father, only to be told 'Don't worry he can't hear us, he's unconscious'.

- In paragraph 19 the DHB apologises for the perceived insensitivity and lack of compassion of the medical registrar.
- It does not however describe any corrective action taken with the medical registrar to ensure a change in practice.

This is a mild departure from an acceptable standard of care.

Corrective Actions by the Waitemata DHB.
Paragraph 42:
The DHB response that notification of the fall to family was delayed because it was [a public holiday] is not addressed.

The description of the sticker does not provide an expected timeframe for notifying a patient's family. The sticker will document the time and date family were advised and will not prevent a delay.

Without the addition of an expected timeframe on the sticker, there is potential for staff to continue to make a decision to contact family, based on their own perception, rather than the needs of patient and their family.

Paragraph 45:
The DHB response (paragraph 40) does not accurately reflect all aspects over the time period when no checks were documented.

- The time frame between documented checks was 1.5 hours. Meal breaks are 30 minutes in duration.
- A maximum number of checks by another nurse covering a meal break would have been two if a meal break of 30 minutes was taken.
- The nurse indicates and later confirms with security that [Mr A] had been missing for 10 minutes at 1900hrs.
- The log kept by Security indicates the initial call from ward was 1920hrs. Presumably the nurse spent some time looking for [Mr A] before reporting him missing to Security.
- CCTV footage shows [Mr A] exiting the ward at 17.41hrs. This was 11 minutes after the last documented check at 17.30hrs and 4 minutes before the next check was due at 17.45hrs.

The DHB describes addressing the issue of meal breaks and cover to allow more adequate cover over break times.

This does not address the following:

- The nurses on the ward did not check [Mr A] every 15 minutes after 1730hrs.
- The nurse returning from meal break on or near 1900hrs, advised and then confirmed with Security that [Mr A] had been missing for 10 minutes knowing that it was considerably longer since he had actually been physically observed in TV lounge.
- In reality [Mr A] had not been seen since the 1730 check and had exited the ward at 17.41hrs.

This caused delay to the Security team initiating an appropriate search on the CCTV and on the ground for [Mr A].

Paragraph 47:
The DHB indicates in letter that this case would be formally discussed at the Mortality and Morbidity conference of Medicine and Health of Older Person.

- The response does not indicate whether the ED clinicians would be involved in the conference.

The remedial actions of the DHB have addressed some issues arising from this case, however it is my opinion that the DHB could have taken further remedial action that would ensure the staff involved were given the opportunity to learn from the events and adjust practice accordingly.

These issues are:

- The DHB does not describe any corrective action taken with the medical registrar to ensure a change in practice when speaking with family in front of their unconscious family member.
- The ED assessment and admission notes documented and charted medications that [Mr A] had not taken for at least a year. Had [Mr B] been consulted at the time, he would have advised them of this. There is no evidence the DHB has addressed this with the nurse who carried out the initial assessment.
- There are differing descriptions around what happened when it was discovered when [Mr A] had left the ward. The DHB does not describe any ongoing education of nursing staff regarding the process of whom to notify and actions to take.
- It is impossible to identify who has checked a patient using the 15/60 patient check when a tick is used to indicate completion of a check. An initial or signature would provide an improved method of audit.
- The DHB acknowledge that staff may not have been fully aware of implications of subtle or unexpected behavior change following a fall, particularly in patients with dementia, and this would be discussed by medical staff at the M&M meeting, however does not indicate that any educational in-service had been provided to ensure nursing staff were made aware.
- There is no evidence the DHB has addressed the issue that the medication chart was not altered following the changes and notes made by the pharmacist. The medications subsequently administered to [Mr A] included aspirin which the DHB acknowledges could conceivably lead to a greater degree of bleeding around the brain.
- The standard of some documentation is worthy of mention. Indecipherable signatures with no specimen signature to compare make it difficult if not impossible to identify the writer using just the clinical records for reference. The entry by the pharmacist relating to important and correct information was neither acknowledged as been noted, nor acted upon which meant [Mr A] had aspirin administered a number of times.

In conclusion, I have identified a number of concerning issues in the expected standards of care provided when [Mr A] was admitted to [hospital].

In particular, despite the order to observe him every 15 minutes, he was not observed by hospital staff for at least 2 hours during which time he was able to leave the ward and hospital unnoticed. Incorrect or untrue information supplied to the security regarding the last time he was actually seen, delayed the appropriate response for searching. When [Mr A] was returned to the hospital by ambulance he had injuries to his head that were not present when he was on the ward.

It is my opinion that this is a severe departure from expected standards of care.

The other issues, identified above amount to mild departures from expected standards of care which is noted in the body of this report."