Decision 22HDC00290
11 August 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Failure to provide safe environment in hospital

Introduction

1. On 8 February 2022, the Health and Disability Commissioner (HDC) received a complaint from Mr A regarding the care provided to his mother, Mrs B, by Hutt Hospital (Health New Zealand | Te Whatu Ora (Health NZ) Capital, Coast & Hutt Valley). The complaint concerns whether Health NZ provided Mrs B with a safe environment while she was a patient at Hutt Hospital.

Background

2. Mrs B was admitted to the inpatient ward at Hutt Hospital from 30 January 2022 until 11 February 2022 for postoperative management following amputation of her leg. She was in a female-only room with three other patients, but the wider ward was mixed gender.[1]

3. Over the course of Mrs B's admission, a confused male patient[2] began to show Mrs B unwanted attention, including touching her when she was sleeping, watching her as she was being washed or changed, making inappropriate sexual comments, and going through her belongings. Incidents were recorded on 1, 3, 4, 5,[3] 7, 8, and 10 February 2022. However, both Mrs B and Mr A told HDC that more incidents occurred than is recorded in the clinical notes.

4. Health NZ told HDC that initial action[4] taken to manage the male patient's behaviour between 1 and 3 February included medication, a sensor mat, additional nursing time, redirection, regular checks, and an alarm bracelet.[5] A further consultation with a psychiatrist occurred, and an intensive team approach was undertaken following escalating behaviour over the following days (4–6 February). Following an incident on 7 February, event forms were completed[6] and a one-on-one healthcare assistant was assigned to the male patient

[1] In response to the provisional opinion, Health NZ told HDC that the majority of wards nationwide are mixed gender.
[2] Referenced throughout as the 'male patient'.
[3] In response to the provisional opinion, Health NZ told HDC that it does not have any documentation regarding an incident on 5 February, and there is no record of an incident on 5 February in the documentation provided to HDC. However, in a response dated 4 April 2022, Health NZ stated that based on its records, incidents occurred on 1 ,3, 4, 5, 7, 8, and 10 February.
[4] In response to the provisional opinion, Health NZ told HDC that duty nurse managers were informed following the first incident, and they supported the team to implement the policy on management of confused patients.
[5] In response to the provisional opinion, Mrs B told HDC that the alarm bracelet was put on the male patient to stop him going through the main doors, but it did not warn staff that he had entered her room.
[6] A safety, security, and privacy management form was completed on 7 February 2022 due to the male patient's behaviour towards staff, including assaulting staff. The incident was assigned an SAC 4 rating (a rating and triage tool used for adverse event reporting, as set out by Te Tāhū Hauora Health Quality & Safety Commission (HQSC)). An SAC 4 rating can refer to either a minor or minimal event, with minor indicating an increased level of care. An increased level of care was documented on the form completed by staff.

on a 24/7 basis.[7] On 8 February it was documented that after a further incident in which the male patient entered Mrs B's room, Mrs B was offered a private room,[8] and the male patient's bed placement was reviewed. Mrs B's family made a complaint on 9 February, and staff met with Mrs B to update her on the safety measures that had been put in place.[9, 10] Following a further incident on 10 February, a security guard was posted outside Mrs B's room, and she was moved further away from the door. Mrs B was discharged at approximately 2pm on 11 February.

5. Mr A told HDC that these incidents affected Mrs B's recovery and sleep, causing the family to discharge her early on 11 February and manage her care at home. Mr A said that while a security guard was put in place, the guard did not seem to be aware of the reason for being there and was inconsistent in monitoring the male patient. In response to the provisional opinion, Mrs B told HDC that it was not until the family spoke with the guard that they realised that the guard had not been told that he had been put outside Mrs B's door to stop the male patient entering Mrs B's room. The guard told the family that he would check with management, and, following this, the guard was fully aware that the male patient was not allowed into Mrs B's room.

6. Mr A told HDC that these events have had a significant impact on Mrs B, and, as a result, she is frightened to return to hospital. In response to the provisional opinion, Mrs B told HDC that as a result of her experience at Hutt Hospital, she has been diagnosed with post-traumatic stress disorder.

Health NZ response

7. Health NZ told HDC that staff addressed these incidents in accordance with Health NZ policy.[11] When it was evident that the incidents had escalated, senior nursing staff and senior clinical clinicians and managers were advised. A coordinated approach was taken to prevent further incidents, based on the recommendations of the team involved in the care of the male patient and Health NZ policy. Due to resourcing constraints, there was no feasible option to move the male patient from the ward to a place where his behaviour could be managed better.

8. In response to the provisional opinion, Health NZ told HDC that support from senior nursing staff was accessed from the first incident on 1 February, along with strategies in line with hospital policy for managing confusion. Staff provided support to Mrs B and redirected the male patient in addition to adjusting his treatment plan.

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[7] In response to the provisional opinion, Health NZ told HDC that ward staff were supported by duty nurse managers, a weekend house officer, a senior medical officer, and orderlies, to manage the situation.

[8] Mrs B declined this option and said that this was because it took 15–20 minutes for her call bell to be answered, and she felt safer in a shared room.

[9] In response to the provisional opinion, Health NZ told HDC that senior nursing staff met with Mrs B on 8, 9, 10, and 11 February.

[10] Health NZ told HDC that these included intensive medical and nursing management of the male patient, and the male patient being monitored by a one-on-one minder, and all staff were made aware of the need to re-direct the male patient from Mrs B's room. The male patient also had a medical and psychiatric review, with his medication increased.

[11] Hutt Valley DHB 'Partners in Care — Close Observation and Engagement policy and Adult Delirium guidelines' 2020 and Hutt Valley DHB 'High risk behaviour flow chart' 2020.

9. Health NZ told HDC that a one-on-one healthcare assistant was assigned to the male patient on a 24/7 basis from 7 February. Health NZ said that these shifts were covered, with the exception of the afternoon shift and night shift on 10 February and the morning shift on 11 February. Usual protocol where shifts are not covered is to reallocate staff or provide cohort minding or frequent checks. An external security guard was requested by duty nurse managers and commenced at 5.30pm on 10 February 2022. Health NZ said that specific instructions given on 10 February 2022 could not be located. An external security guard was provided with instructions at 12.45pm on 11 February, which included that security guards were to be placed by the door to ensure staff and patient safety. Health NZ said that Mrs B and the male patient were in different rooms, and Mrs B was offered a private room, which she declined. Health NZ stated that consideration was given to transferring the male patient to another ward, but this was decided against because of the complexity of patients on the alternative ward and because this may have increased the confusion of the male patient.

10. Health NZ told HDC that this was a complex situation. Health NZ acknowledged that the male patient had high and complex health needs that required intensive management but said that there was no option to move him from the ward at the time. Health NZ maintains that it took reasonable actions to provide an appropriate standard of care. However, it acknowledged that despite the measures put in place, the incidents continued to occur. Health NZ apologised for this and for the emotional distress this caused.

11. As a result of the complaint, Health NZ accepted that there were areas where improvements could be made, including additional reporting on the incident reporting system regarding the specifics of intrusive behaviour to flag concerns to senior managers. In addition, orderlies and security staff would have benefitted from further specific detail on the issues, including the risk of sexually inappropriate behaviour.

Responses to provisional opinion

Mrs B

12. Mrs B was provided with an opportunity to comment on the 'information gathered' section of the provisional opinion, and her comments have been incorporated throughout the report where relevant.

Health NZ Capital, Coast and Hutt Valley

13. Health NZ was provided with an opportunity to comment on the provisional opinion, and its comments have been incorporated throughout the report where relevant. Health NZ advised that it accepts that, despite the active mitigations put in place, there was a failure to provide Mrs B with a safe environment while she was in hospital, and it apologises for this. Health NZ also advised that it accepts the proposed recommendations.

Opinion

14. Right 4(4) of the Code of Health and Disability Services Consumers' Rights (the Code) states that every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

15. Mrs B should have been provided with a safe environment while she was a patient at Hutt Hospital. I acknowledge that Health NZ did take steps to address the behaviour of the male patient towards Mrs B, which included providing a one-on-one healthcare assistant to

monitor the male patient (7 February) and a security guard (10 February). However, I note that these actions were taken after an escalation in behaviour, and these incidents had been occurring from 1 February. In addition, it appears that the instructions and information given to the healthcare assistant and security guard were unclear, evidenced by Mrs B's recollections and the continued incidents after the measures were put in place. In my view, without the appropriate information, the utility of these measures was limited. I am also concerned that the nature and frequency of these incidents was not recorded accurately in the clinical notes.

16. I accept that Health NZ told HDC that safety measures were put in place from 1 February and that these measures intensified as the male patient's behaviour escalated. However, I remain critical that these measures were not effective in keeping Mrs B safe and that the incidents continued until she was discharged.

17. I acknowledge that, due to resourcing constraints, the male patient was unable to be moved from the ward. Despite this, I have concerns that the male patient remained in the ward when it was clear that his behaviour was escalating and could not be managed adequately by the measures taken to minimise the risk of harm to Mrs B. Accordingly, I find that Health NZ breached Right 4(4) of the Code.

Changes made since events

18. Health NZ told HDC that these events have been used to develop a risk approach around gaps in the service, namely for older adults who have challenging behaviours, to identify the safest and most appropriate treatment place for them. As a result, Health NZ developed an action plan, which includes the following:

- Refresher education on incident reporting specific to patient groups;
- Incorporating additional patient safety prompts into team meetings in the wards;
- Updating security guards, orderlies, and minders on specific risks identified by multidisciplinary team meetings, including risks relating to sexually inappropriate behaviour;
- Commencing a project to implement principles of same-gender bays to enhance patient dignity, privacy, and safety;
- Changing the ward layout to include a more suitable low-stimulation space for patients who are confused or agitated, with this to be implemented over the next three years; and
- Plans to install a security system at the front door of the ward connected to the nurses' station.

Recommendations

19. I recommend that Health NZ Capital, Coast and Hutt Valley:

a) Provide a written apology to Mrs B for the deficiencies identified in this report. The apology is to be sent to HDC, for forwarding to Mrs B, within three weeks of the date of this report;

b) Provide an update to HDC on the action plan, within three months of the date of this report; and

c) Prepare and present an anonymised case study based on these events for the wider education of relevant clinical staff at Hutt Hospital. The case study should detail the actions taken and decisions made by staff, the results of these actions/decisions, and the appropriate course that should have been taken. Evidence confirming the content and delivery of the presentation, and to whom it has been presented and when, is to be provided to HDC within six months of the date of this report.

Follow-up actions

20. A copy of this report with details identifying the parties removed, except Health NZ Capital, Coast and Hutt Valley and Hutt Hospital, will be sent to Te Tāhū Hauora Health Quality & Safety Commission and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Carolyn Cooper
Deputy Health and Disability Commissioner