Inadequate monitoring of sedated patient (02HDC08692, 31 October 2002)

Psychiatric nurse ~ Public hospital ~ Mental health services ~ Compulsory assessment and treatment ~ Seclusion ~ Sedation ~ Standard of care ~ Right 4(1)

A complaint was made by a former Acting Director of Area Mental Health Services about a registered staff nurse. The complaint was that the registered staff nurse: (1) while the patient was in a locked seclusion room, did not enter his room at any time during the night to undertake regular monitoring as instructed by medical staff; and (2) did not observe and report the patient's deteriorating condition to medical staff.

The patient, a 41-year-old man with a mild intellectual handicap, was compulsorily admitted to hospital, sedated, and locked alone in a seclusion room for an extended period of time. The nurse was aware that the patient had been asleep for most of the preceding 24 hours, had required nursing assistance to turn on the previous shift, had a poor intake of fluids, and had strained breathing when lying flat. The nurse did not go into the patient's room all night — all observations were done through the window. The patient died. The Coroner found that his death followed a period of immobility. The pathologist's findings of hypostasis and early pneumonia indicated that the patient had almost certainly been lying still for some hours before his death.

The Commissioner reasoned that:

1 the nurse's assessment of an appropriate balance between rest and observation fell below the standard expected of a reasonable and competent nurse;
2 as an absolute minimum, the nurse was obliged to carry out regular, meaningful assessments of the patient's colour, breathing, position, activity and behaviour (as required by each of the relevant policies in place at the time);
3 careful and accurate observation was particularly important for this patient, in the light of concerns expressed during handover; and
4 had the nurse regularly monitored the patient's condition during the early hours of the morning, it is likely that she would have been alerted to his deteriorating state of health.

Although there was some inconsistency between the hospital's seclusion policy and the Ministry of Health Guidelines, consideration of the patient's best interests should have been the nurse's first concern. Guidelines and protocols are not a substitute for professional, clinical judgement, and need to be interpreted in the light of relevant circumstances. A nurse faced with apparently inappropriate or contradictory guidelines or protocols should seek guidance from a senior member of the team rather than risk compromising patient safety by rigidly following a document.

The registered staff nurse breached Right 4(1) in that she failed to provide the appropriate standard of care.

With regard to the public hospital, the Commissioner commented that it appeared that the patient should not have been in seclusion during the night, and expressed concern at the inconsistency between various seclusion policies, the paucity of new drug education, the lack of an ECG machine on the ward, the confusing clinical record format, and the delay in the arrival of the resuscitation team. However, as the hospital had responded appropriately to these concerns following the internal inquiry and

inquest recommendations, and given the length of time that had elapsed since the incident occurred, no further action was taken.