MidCentral District Health Board

A Report by the
Mental Health Commissioner

(Case 17HDC00296)

Contents

Executive summary

1. This report concerns the care provided to an elderly woman with dementia in an older adult mental health unit. The woman's daughter was the welfare guardian, and accordingly was the appropriate person to give consent on behalf of her mother. The Mental Health Commissioner discussed the importance of providers being aware of consumers' legal status, and obtaining informed consent.

2. The daughter opposed her mother being admitted to the mental health unit. However, the admission was considered the only practicable option in light of increasing behavioural difficulties. In this context, the Mental Health Commissioner commented that it would have been appropriate for MidCentral DHB to consider the legal basis on which it was effecting the admission.

3. The Mental Health Commissioner was critical that the woman was administered intramuscular (IM) lorazepam to restrain her without informed consent from her daughter. He also criticised MidCentral DHB for not giving the daughter sufficient opportunity to provide input into her mother's treatment plan, and had concerns about the overall standard of medical oversight provided in the mental health ward.

Findings

4. The Mental Health Commissioner found MidCentral DHB in breach of Rights 7(1) and 6(2) of the Code of Health and Disability Services Consumers' Rights (the Code) for administering IM lorazepam without informed consent, for failing to consult the woman's daughter prior to the administration, and for other failures in communication with the daughter related to care planning. He found MidCentral DHB in breach of Right 4(1) of the Code for failures related to medication management and medical oversight.

Recommendations

5. It was recommended that MidCentral DHB (a) apologise to the daughter; (b) provide training to mental health unit staff on the Code, informed consent, enduring powers of attorney, welfare guardians, the Mental Health (Compulsory Assessment and Treatment) Act 1992, and restraint and the interaction of respective decision-making rights; (c) conduct an audit of IM medication administration to ensure that informed consent has been obtained appropriately; and (d) provide an update on the efficacy of changes it has made to the older adult mental health service.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Mrs B concerning the care provided to her mother, Mrs A. The following issue was identified for investigation:

   - *The appropriateness of the care provided to Mrs A by MidCentral District Health Board between 7 and 28 October 2016.*

7. This is the opinion of Mental Health Commissioner Kevin Allan, and is made under the authority delegated by the Commissioner.

8. The parties directly involved in the investigation were:

Mrs B	Consumer's daughter and welfare guardian
MidCentral District Health Board	Provider

9. Further information was reviewed from:

A consultant psychiatrist	
Dr C	Provider/house surgeon
RN D	Provider/charge nurse
RN E	Provider/registered nurse
RN F	Provider/community mental health nurse
RN G	Provider/registered nurse
EN H	Provider/enrolled nurse
RN I	Provider/clinical nurse specialist

Also mentioned in this report:	
Dr J	Psychiatrist
Dr K	Senior house officer
Dr M	Psychogeriatrician

10. Independent expert advice was obtained from psychiatrist Dr Jane Casey, and is included as **Appendix A**.

Information gathered during investigation

Background

11. Mrs A, aged 80 years at the time of events, had frontal lobe dementia[1] and expressive aphasia.[2] On 18 November 2015, Mrs A's daughter, Mrs B, was appointed by the Family Court as welfare guardian in relation to all aspects of Mrs A's personal care and well-being.

12. Mrs A resided at a rest home. Rest home documentation states that Mrs B requested that her mother not be sent to hospital if unwell, and that she be kept comfortable at the rest home. Mrs A's records contain contact details for Mrs B, Mrs B's husband, and Mrs B's daughter.

13. In late 2016, Mrs A developed challenging and aggressive behaviour. The rest home was finding it difficult to manage Mrs A, and it was documented that she was verbally aggressive, hitting, biting, pinching, pushing, and ramming her walker into others.

MidCentral DHB

Referral and admission

14. On 3 October 2016, the rest home's general practitioner (GP) referred Mrs A to MidCentral DHB's health services for the elderly. The referral states that the GP had reviewed Mrs A at the rest home that day for her three-monthly check and noted her increasing behavioural difficulties. It states:

> "I am concerned that the Staff will not be able to manage her at the Rest Home should these behaviours continue. She is on regular quetiapine[3] and they have tried increasing this as a PRN (as required) dose, but this has simply over-sedated her. I do feel that specialist assessment is indicated and I would be grateful if you could see her and advise."

15. The GP included a current list of Mrs A's medications.

16. A community mental health nurse, RN F, stated that following receipt of the GP's referral, she contacted Mrs B to organise an urgent assessment of Mrs A's declining condition. Registered Nurse (RN) F met with Mrs B and a rest home nurse on 4 October 2016 to assess Mrs A. RN F completed an "Initial Assessment" form that states: "If unable to manage situation in meantime may require admission via Emergency department." It also notes that there would be ongoing liaison with the registered nurse at the rest home's dementia wing. RN F said that an extra staff member was allocated to help manage Mrs A until she could be reviewed by a psychiatrist.

[1] A form of dementia that occurs when the frontal lobes of the brain begin to atrophy (shrink).
[2] Loss of the ability to produce language (spoken, manual, or written).
[3] An antipsychotic medication.

17. On 7 October 2016, RN F recorded that she had spoken to Mrs B, who "although not keen for her mother to be admitted to Ward A[4] ('too many changes') is willing to accept admission".

18. That day, Mrs A was transferred by ambulance from the rest home to Ward A at MidCentral DHB. House Surgeon Dr C recorded that Mrs A's daughter (Mrs B) and granddaughter had said that they were concerned about Mrs A's medication and morning sleepiness, in that she was unable to get out of bed before 11am. Dr C requested that an MSU (mid-stream urine test) and physical examination be conducted "when able".

19. The notes state:

> "[The family] were very unhappy that [Mrs A] was brought in here against their wishes. They expressed concerns around her becoming very agitated when being moved and also staying in hospital for a long-term, due to risks of infection."

20. The notes record that the family would have preferred Mrs A to move straight to dementia-level care, rather than be admitted to MidCentral DHB.

21. In general, the MidCentral DHB clinical records refer to Mrs B as being Mrs A's enduring power of attorney (EPOA), as opposed to being her welfare guardian. In the admission documentation, Mrs B is listed as Mrs A's next of kin, and Mrs A's granddaughter is listed as another contact person.

22. At 3.50pm on 7 October 2016, Mrs A was reviewed by a psychiatrist, Dr J. Dr J noted that Mrs A had been very restless and agitated, and was pacing up and down and rattling doors. She was also hitting out at staff and throwing objects. Dr J noted: "Attempted to discuss with Enduring Power of Attorney (EPOA), [Mrs B] — No answer on cell phone or [other contact number]."

23. Dr J considered that Mrs A could not be managed in the community. RN F stated that she spoke to Mrs B, who asked whether her mother could be admitted to Ward B.[5] RN F said that she informed Mrs B that Ward B is an assessment, treatment, and rehabilitation ward, and that the staff there would not have the expertise to manage Mrs A's declining condition and related behaviours. Additionally, it is an open ward, and Mrs A could easily walk out. RN F said that she discussed the matter with Dr J, who noted these safety risks and said that admission to Ward B was not an option.

24. RN F said that Mrs B was fully informed of why her mother was being admitted to hospital. With regard to whether the option of transferring Mrs A directly to a dementia unit was considered, RN F stated that as Mrs A was already in a dementia unit and staff were struggling to manage her situation at the rest home, it would have been "a very unsafe option to move her to another dementia unit, [and] it was never considered and was never

[4] Ward A is for those adults who are experiencing a first presentation of moderate to severe mental distress after the age of 65 years. It provides specialist assessment and treatment of older adults.
[5] Ward B is an inpatient ward that cares for people over 16 years of age who require assessment, treatment, and rehabilitation (AT&R).

discussed". RN F stated that she did not understand that Mrs B was opposed to admission to Ward A, and she thought that Mrs B had accepted that her mother was extremely unwell and was being admitted to Ward A for stabilisation of declining dementia, review of her medication, and assessment of her related challenging behaviours.

Restraint

25. The medication chart states that the indications for use of PRN medication for Mrs A were that risperidone[6] was to be used for agitation or aggression, and lorazepam[7] for agitation or anxiety.

26. RN G stated that she was looking after Mrs A on 7 October 2016 between 3pm and 11pm. RN G said that Mrs A became increasingly aggressive, and an attempt was made to administer oral lorazepam. However, that was unsuccessful, as Mrs A grabbed the medication while trying to ram her stroller into staff. RN G said that over a 20-minute period several attempts were made to administer the medication orally. Thereafter, it was decided in conjunction with Dr C and Ward A charge nurse RN D to administer the medication intramuscularly (IM). RN G noted that both the medical team and RN D supported the decision.

27. RN G stated that the restraint process was very quick, and was undertaken by RN D, assisted by an enrolled nurse (EN). RN G said that she gave the injection with good results. She stated:

> "The decision to restrain a patient and administer an [intramuscular injection] is never taken by me lightly, or any of the other staff, and it certainly wasn't on this occasion. However, when such a decision is made, we (on this occasion the medical and nursing staff) have weighed up the benefits against the negatives. In this case, [Mrs A] was extremely agitated, distressed and aggressive, posing a risk both to herself, other patients and staff and in the end, it became a matter of necessity."

28. Dr C told HDC that she would always discuss the charting or changing of psychotropic medication with Dr J, as there was no registrar on the psychogeriatric team. However, Dr C said that multiple attempts to contact Dr J were unsuccessful. Dr C said that she decided to act for "the safety of the patient and all the other people on the ward and to chart the lorazepam IM" at 3.30pm. She told HDC that she then discussed this with Dr J on his arrival in the ward at 3.50pm, and he agreed with the prescribing. He then made attempts to contact Mrs B (see paragraph 22).

29. A restraint approval register was completed for personal restraint of Mrs A. It states that the explanation given to Mrs A's family was to "ensure safety of staff and [patient] during administration of IM medication". Mrs B signed the form. The form is dated 8 October 2016, but the progress notes state that Mrs B signed the form on 11 October 2016.

[6] An antipsychotic medication.
[7] A benzodiazepam medication.

8 October 2016

30. On 8 October 2016, the MSU sample was collected by RN E and sent to the laboratory. The laboratory records show that the sample was ordered by Dr J. Mrs A was noted to be very unsettled, and became confrontational towards a healthcare assistant. She was administered PRN oral lorazepam at 12.30pm with some benefit. However, her agitation increased in the evening, and she became physically aggressive and attempted to exit the ward. Mrs A was given PRN oral lorazepam at 8.10pm.

10 October 2016

31. On 10 October 2016, a nurse recorded that Mrs A had required personal restraint by three staff members to shower her safely. The nurse completed a restraint evaluation form. At 1.40pm, Mrs A was administered PRN lorazepam for agitation.

32. At 3pm on 10 October 2016, Dr J reviewed Mrs A with Mrs B present. Mrs A's medications were discussed, including that Dr J had changed her medication from quetiapine to risperidone, with PRN lorazepam available for severe agitation. Dr J recorded that risperidone was to be commenced at 0.5mg bd (twice daily), and noted:

> "Daughter does not need to be notified each time [Mrs A] is restrained or has IM meds — understanding of care plan. Would like [Mrs A] to be able to get back to the rest home if possible."

33. Clinical Nurse Specialist (CNS) RN I told HDC that she was not directly involved in Mrs A's admission. However, RN I stated that she received an email from Mrs B on 11 October 2016 wanting to meet to discuss her reluctance for her mother to be on Ward A.

11 October 2016

34. On 11 October 2016, a multidisciplinary team meeting (MDM) was held, and it was noted that Mrs A was tolerating the risperidone well with no major over-sedation. It was also noted that Mrs A appeared to be in pain despite having paracetamol, so codeine PRN was restarted.

35. That afternoon, RN I, RN D, and Mrs B met. RN I said that Mrs B would prefer her mother to be in Ward B, because she had been in Ward B previously. RN D read out clinical entries from the notes, and discussed Mrs A's medication. It is noted that "[Mrs B] had not been informed by [the rest home] about the severity of [Mrs A's] behavioural issues and the impact on the other residents". RN I documented that Mrs B "was satisfied that her mum was getting excellent treatment and the rational[e] for her admission".

36. On 11 October 2016, there is a record that diversional therapy using soft toys was being utilised, and Mrs A appeared to be enjoying that.

13–17 October 2016

37. On 13 October 2016, Mrs A was charted a five-day course of the antibiotic augmentin by a house officer, as the MSU result indicated that she had a urinary tract infection (UTI). The results of the MSU were available on the MidCentral DHB clinical portal on Sunday 9 October 2016. RN G stated that the usual process was that when laboratory results were

available, the laboratory would page the doctor or call the ward, and the doctor would be asked to prescribe antibiotics by the nurse on duty. She said that nursing staff also had the ability to access the DHB clinical portal to review laboratory results. There is no evidence that the MSU result was communicated by the laboratory or checked by nursing staff prior to 13 October 2016.

38. Between 13 and 16 October, there are repeated records of Mrs A appearing to be in pain, and to be less mobile. Regarding Mrs A's pain, EN H documented: "[S]poke to visiting [house surgeon] but with no specific problem was unable to assess. Await better effect from codeine."

39. On 17 October 2016 at 11am, Mrs A was reviewed by a consultant psychiatrist and locum senior house officer (SHO) Dr K. Mrs A had remained in bed that morning and had resisted efforts by nurses to help her to get up. It was thought that Mrs A was over-sedated, and the psychiatrist directed that the lorazepam and risperidone be withheld until she was more alert. At 2.30pm, the psychiatrist reviewed Mrs A again and found that her sedation had improved since the morning. No physical issues were detected.

40. Mrs A was also reviewed by a consultant geriatrician at 3.45pm on 17 October 2016. She was noted to be agitated and aggressive, and it was thought that she was possibly delirious. No physical examination was performed, owing to Mrs A's aggression and agitation. The geriatrician stopped the codeine and recommended non-pharmacological management of Mrs A's behavioural issues where possible.

18–28 October 2016

41. On 18 October 2016, Mrs B was contacted by a Ward A nurse to update her on her mother's condition and the medication changes. Mrs B requested a family meeting to discuss discharge planning, as she felt that her mother had become no more settled since admission, and thought that discharge back to the rest home would be best. However, the family meeting did not occur until 27 October 2016 (detailed below).

42. The clinical records between 19 October 2016 and 25 October 2016 continue to refer to Mrs A's challenging behaviour and to her experiencing pain, including abdominal pain, and constipation. On 25 October 2016, Mrs A was reviewed by Dr K, who thought that the pain was likely to be musculoskeletal pain resulting from use of the standing hoist. Dr K recommended avoiding use of the standing hoist.

43. Mrs A was reviewed briefly by psychogeriatrician Dr M on 26 October 2016. Dr M noted that Mrs A was unwilling to engage, but was not in any distress.

44. An MDM was held on 27 October 2016. The notes state that the rest home team had refused to have Mrs A return there. It was assessed that she required a psychogeriatric level of care, and it was noted that her pain was continuing.

45. At a family meeting later that day, it was decided that Mrs A would be discharged to a specialised dementia-care hospital. A nurse stated that she attended the family meeting on the afternoon of 27 October 2016, and it was very obvious during the meeting that the

family were not happy with the process that had led to Mrs A being admitted to hospital, and the care provided to her in Ward A.

46. Dr M confirmed that Mrs A required psychogeriatric hospital care. Mrs A's family arranged for her to be admitted to the dementia-care hospital, and she was discharged there on 28 October 2016.

Further information — MidCentral DHB

47. MidCentral DHB acknowledged that as Mrs A did not have the capacity to consent to treatment, she should have been treated under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act), or under the Protection of Personal and Property Rights Act 1988 (the PPPR Act) with Mrs B consenting on Mrs A's behalf.

48. Regarding the decision to administer IM lorazepam on 7 October 2016, MidCentral DHB stated:

> "Staff attempted to contact Welfare Guardian (Mrs B) on both her mobile and [other] numbers but were unsuccessful. [MidCentral] DHB believes that attempts to contact another family member would be in breach of the Code of Health and Disability Services Consumers' Rights — Right 7(4) Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where (a) it is in the best interests of the consumer."

49. MidCentral DHB acknowledged and apologised for the delay in scheduling a family meeting between 18 and 27 October 2016. It also acknowledged that Mrs B and other members of Mrs A's family did not have as much opportunity to provide input into Mrs A's treatment planning as it may have expected, because the documented care plan goals were not communicated to the family.

50. After reviewing Mrs B's complaint, MidCentral DHB implemented the following actions:

- The Clinical Director met with medical staff and the senior nursing team on Ward A to reinforce that the patient's legal status is to be confirmed and documented, and addressed appropriately.
- A project was commenced to progress the partnership in care with patients/family and significant others. This included offering all family meeting minutes/outcomes from MDMs to the family, and liaising with relevant aged residential care facilities during discharge planning.
- Consumer and family advisors are working with Ward A to support and provide advocacy for patients and families.
- New care plans have been introduced, which reflect the partnership between the patient/family and staff in goal planning.

- The mental health service has introduced safe practice effective communication (SPEC) training, which focuses on de-escalation techniques.
- Steps have been taken to improve the physical environment of Ward A.

51. MidCentral DHB told HDC that the following changes have also been made to its Older Aged Mental Health Service (OAMH):

- The Clinical Nurse Specialist role has been embedded to support the clinical practice standards in nursing (the role had only just commenced at the time of these events).
- Two OAMH psychiatrists have been appointed to support Ward A.
- A Clinical Manager for OAMH has been appointed, who will lead the development of the service in partnership with the senior OAMH psychiatrist.
- An Associate Charge Nurse position for Ward A has been established.
- The multidisciplinary team social worker resource has been increased to a full-time role.
- Daily MDM meetings have been embedded into practice in Ward A.
- An aged residential care outreach service has been piloted, to provide better links and support for aged residential care in meeting the needs of clients who require OAMH care.

Responses to provisional opinion

52. Mrs B was given an opportunity to comment on the "information gathered". Mrs B stated: "[T]here is information in this that we haven't heard before … about mum's behaviour at [the rest home] and [Ward A], or [the rest home's] refusal to have mum back."

53. MidCentral DHB advised that it accepted my provisional recommendations and had no other comments to make on the provisional opinion.

Opinion: MidCentral District Health Board — breach

Introduction

54. Mrs A was suffering from dementia, complicated by severe behavioural and psychological symptoms. Staff at the rest home were finding it increasingly difficult to manage her behaviour, and considered that they were unable to continue providing care for her if her symptoms did not abate.

55. The GP referred Mrs A to MidCentral DHB, and the plan was that she would be admitted to hospital for assessment and treatment. This report considers the process involved in obtaining consent for Mrs A's admission and treatment, and the treatment provided during the period of her admission to Ward A.

Informed consent

Introductory comment

56. On 18 November 2015, Mrs A's daughter, Mrs B, was appointed by the Family Court as welfare guardian in relation to all aspects of Mrs A's personal care and well-being. The records frequently refer to Mrs B as Mrs A's EPOA. However, this is incorrect, as Mrs B had been appointed as her mother's welfare guardian.

57. This mistake, together with the poor communication with Mrs B (detailed further below), indicates that care was not taken to ascertain and understand Mrs B's legal role, and suggests that the relevant documentation had not been sighted. Although the powers of a welfare guardian and an EPOA are similar, it is important that providers are aware of consumers' legal status, and sight and retain copies of the relevant documentation.

58. Except for cases of emergency or necessity, all medical treatment should be preceded by the consumer or a person entitled to give consent on behalf of the consumer, having made an informed choice. In this case, the appropriate person to give consent on behalf of Mrs A was her welfare guardian, Mrs B.

59. It is evident that Mrs A's behavioural difficulties had been worsening, and staff were finding her difficult to manage. A nurse had stated that if the transfer to MidCentral DHB did not take place, Mrs A would be transported to the Emergency Department.

60. My expert advisor, Consultant Psychiatrist Dr Jane Casey, stated that the decision to admit Mrs A to hospital was probably the right decision, as her assessment and management were beyond the scope of the rest home. Dr Casey stated:

> "On the presumption that the community team was of the opinion that admission was the only option and essential, given the serious risks to self and others, the duty of care, and the duty to provide necessaries and protect from injury, as the Welfare Guardian opposed the admission, the correct legal process and protection would have been admission under the Mental Health Act."

61. Mrs B opposed her mother being admitted to Ward A. Section 18(1)(c) of the Protection of Personal and Property Rights Act 1988 states that no court shall empower a welfare guardian and no welfare guardian shall have power to refuse consent to the administering to that person of any standard medical treatment or procedure intended to save that person's life or to prevent serious damage to that person's health.

62. This was a difficult situation for MidCentral DHB staff to find themselves in. In the context of Mrs B not providing consent to the admission, but the admission being considered the only practicable option for Mrs A in light of her increasing behavioural difficulties, it would have been appropriate for MidCentral DHB to consider the legal basis on which it was admitting Mrs A to Ward A. Its options included using the provisions of the Mental Health Act, or seeking a personal order via the Family Court. I note that MidCentral DHB has acknowledged that Mrs A should have been treated under the Mental Health Act.

Restraint

63. On 7 October 2016, Mrs A was significantly agitated, distressed, and aggressive. Attempts to administer oral lorazepam were unsuccessful despite several attempts being made to administer the medication orally over a 20-minute period. It was then decided to administer the medication IM, which was done while Mrs A was restrained. Dr J was unable to be contacted at the time to discuss the use of lorazepam IM, but arrived shortly afterwards and agreed to the prescribing.

64. The records indicate that attempts had been made to contact Mrs B but were unsuccessful, and that these attempts were made after the restraint and IM lorazepam had been given.

65. MidCentral DHB stated that where no person entitled to consent on behalf of the consumer is available, the provider may provide services where it is in the best interests of the consumer, and added: "MDHB believes that attempts to contact another family member would be in breach of the Code of Health and Disability Services Consumers' Rights — Right 7(4)."

66. That is incorrect. Right 7(4) provides that where a consumer is not competent to make an informed choice and give informed consent, and no person to consent on behalf of the consumer is available, the provider may provide services where it is in the best interests of the consumer and a number of other steps have occurred. In particular, if the consumer's views have not been ascertained, the provider must take into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.

67. In the circumstances of the restraint with lorazepam, the views of other family members were not necessary to consider in the first instance, as there had been no attempts made to ascertain the consent of welfare guardian Mrs B, who was the person who could give consent on behalf of Mrs A, prior to the prescribing and administration of the medication to Mrs A. Theoretically, if attempts to contact Mrs B prior to the administration of the medication had been unsuccessful, at that point attempts should have been made to ascertain Mrs A's granddaughter's views, as she was listed as an alternative contact person.

68. Dr Casey advised that it would have been ideal to have had the support of senior staff, and for there to have been considered attempts to contact the welfare guardian or another family member prior to the restraint and administration of the medication. She noted that the failure to do so was a departure from standard acceptable practice.

69. I accept Dr Casey's advice. In my view, irrespective of whether the medication was clinically appropriate, MidCentral DHB restrained Mrs A and administered IM lorazepam without informed consent from Mrs B. When Mrs B was unavailable, MidCentral DHB staff failed to seek the view of another suitable person interested in Mrs A's welfare.

Family communication

70. MidCentral DHB acknowledged the delay in scheduling a family meeting with Mrs B between 18 and 27 October 2016, and acknowledged that Mrs A's family did not have as much opportunity to provide input into Mrs A's treatment planning as it may have expected, because the documented care plan goals were not communicated to the family.

71. Dr Casey considered that Mrs B was not informed or prepared enough to understand this phase of her mother's illness and the requirement for further assessment and management. Dr Casey stated:

> "There was a failure to consistently engage her, hear the story of her mother, and allow her time to express her views, indeed grieve and understand the situation. Given the initial opposition to admission and clear distress, there should have been extra time and effort afforded to this family."

72. Dr Casey advised that the lack of consistent engagement and regular and timely meetings with Mrs A's family is a departure from standard acceptable practice of a moderate degree.

73. I accept Dr Casey's advice. I consider that it was essential to involve Mrs A's family, particularly Mrs B as her welfare guardian, in Mrs A's care planning. This was important given that Mrs B was the one person who could give consent for Mrs A's treatment, she clearly had concerns about her mother's admission, and she could have contributed usefully with information about her mother's personality and preferences. I am not satisfied that the goals of Mrs A's admission to Ward A were communicated to Mrs B adequately, nor was Mrs B given sufficient opportunity to provide input into Mrs A's treatment plan, or the decision to discharge Mrs A, and to where. In my view, the communication with Mrs A's family was inadequate in the circumstances.

Conclusion — informed consent

74. Right 7(1) of the Code states that "services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law … provides otherwise". In the above circumstances, I am not satisfied that the administration of IM lorazepam under restraint was undertaken with informed consent. Accordingly, I consider that MidCentral DHB breached Right 7(1) of the Code.

75. Right 6(2) of the Code states that before making a choice or giving informed consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent. Given that Mrs B, as welfare guardian, was not consulted prior to the use of IM lorazepam, and there were other failures in communication with her regarding Mrs A's care planning in Ward A, I find that MidCentral DHB breached Right 6(2) of the Code.

Standard of care — medication management and medical oversight

76. Dr Casey stated that pharmacological approaches to manage severe behavioural symptoms are considered where those symptoms are severe, disabling, or syndromal, and

where risk of significant harm exists. She advised that the decision regarding which antipsychotic to use is a clinical one based on a careful risk/benefit analysis for each patient. Dr Casey stated that the administration of IM medication to an elderly person with dementia is a rare event, but may be appropriate in situations where there is a significant risk of harm. I accept this advice.

77. By 13 October 2016, after six days of treatment with risperidone, Mrs A's mobility had declined. Dr Casey stated that although risperidone conferred some benefit, it is not apparent that the clinicians considered whether its administration may have affected Mrs A's mobility. Dr Casey noted that the medication chart states that the indications for use of PRN medication were that risperidone was to be used for aggression, and lorazepam for anxiety. However, it appeared to be at the nurses' discretion to decide which PRN medication was used.

78. Dr Casey stated:

> "People with Dementia who experience agitation should be offered a trial of SSRI antidepressants and there is better evidence for escitalopram and sertraline. Other pharmacological options that may have been considered include venlafaxine, mirtazapine, olanzapine or memantine."

79. I accept Dr Casey's advice. In my view, greater attention should have been paid to Mrs A's medication regimen, and changes to her physical ability in light of her medication changes.

80. I also note that an MSU was taken on 8 October 2016 by RN E, and that the laboratory records show that it was ordered under Dr J's name. The results were available the following day (Sunday 9 October 2016), and showed that Mrs A had a UTI. However, the results were not reviewed until 13 October 2016, at which time Mrs A was prescribed antibiotics by a house officer. There is no evidence that the result was paged to a doctor or telephoned to Ward A in line with the usual practice at MidCentral DHB, nor is there evidence that the result was checked on the MidCentral DHB portal by any MidCentral DHB staff until 13 October 2016. I am concerned that there was a delay in initiating antibiotic treatment for Mrs A's UTI, and consider that multiple medical, nursing, and laboratory staff involved in Mrs A's care could have reviewed and communicated the result to a prescriber on Ward A in a more timely manner.

81. After the MSU test result was reviewed and the UTI diagnosed, Mrs A was prescribed antibiotics, but she was not examined physically. She was seen by a geriatrician on 17 October 2016, when it was noted that she was over-sedated and the lorazepam was decreased. The geriatrician was unable to examine Mrs A owing to her aggression/ agitation. Mrs A's next physical review was on 25 October 2016, when Dr K noted musculoskeletal pain presumably caused by the standing hoist. A consultant review with Dr M occurred on 26 October 2016.

82. Dr Casey highlighted that Mrs A had only three physical reviews throughout her 20-day stay, each of which was limited. Dr Casey considers that there were delays in treating Mrs

A's UTI, and also her change in mobility, abdominal pain, constipation, and limb, joint, and generalised pain. Dr Casey noted that there was no review specifically to ascertain whether the risperidone had resulted in extra-pyramidal side effects.[8] The differential diagnosis for Mrs A on 17 October 2017 included delirium; however, Dr Casey advised that it is not clear whether all reversible factors had been excluded, and noted that there is no documentation that a CT scan of Mrs A's brain had been considered. She added that there was no repeat MSU to see whether the UTI had cleared. Dr Casey stated: "The medical oversight and reviews of [Mrs A's] care, in my opinion, were inadequate both in timeliness and scope." She concluded:

> "[Mrs A] had multiple medical and physical issues. The nurses signalled to senior and medical staff at various times throughout the admission that there were concern[s] about pain, infections, constipation, mobility, falls risk and high nursing needs. A comprehensive assessment and management plan is the expected standard in a specialised inpatient unit. There were deficiencies in the assessment and approach, a lack of clinical leadership and direction in care and a lack of timely medical reviews."

83. Right 4(1) of the Code states that every consumer has the right to have services provided with reasonable care and skill. I accept Dr Casey's advice, and I consider that, overall, there were aspects of Mrs A's medical oversight that were suboptimal, including an inadequate level of review of Mrs A and her medication regimen in light of changes in her symptoms and physical ability, and a delay in identifying a UTI and initiating treatment. As a consequence, Mrs A's pain, infections, constipation, and psychological symptoms were not managed appropriately. For these reasons, I find that MidCentral DHB failed to provide services to Mrs A with reasonable care and skill and breached Right 4(1) of the Code.

Recommendations

84. I note that after reviewing Mrs B's complaint, MidCentral DHB took a number of actions to improve its services. I welcome those initiatives. Having taken account of those actions, I recommend that MidCentral DHB provide a written apology to Mrs B for the failings identified in this report. The apology is to be provided to HDC within three weeks of the date of this report, for forwarding.

85. I also recommend that within three months of the date of this report, MidCentral DHB undertake the following and report back to HDC with evidence of the outcome:

a) Provide training to all Ward A staff on the Code of Rights, informed consent, EPOAs, welfare guardians, the Mental Health Act, and restraint and the interaction of respective decision-making rights. The training schedule, including refresher training, is to be provided to HDC.

[8] Extrapyramidal side effects (EPS), commonly referred to as drug-induced movement disorders, are among the most common adverse drug effects patients experience from dopamine-receptor blocking agents.

b) Conduct an audit of a sample of current residents' records, where PRN IM medication has been given, to ensure that informed consent has been obtained appropriately, and, dependent on the outcome of the audit, outline any follow-up actions to be taken.

c) Provide an update on the efficacy of the changes it has made to the OAMH service.

Follow-up actions

86. A copy of this report with details identifying the parties removed, except the expert who advised on this case and MidCentral DHB, will be sent to HealthCERT, the Director of Mental Health, and the Office of the Ombudsman, 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 Dr Jane Casey:

"Thank-you for the request to provide expert advice to the office in relation to the complaint from [Mrs B] about the standard of assessment and care provided to her mother, [Mrs A], during the period of 7 October 2016–28 October 2016. In considering this request, to the best of my knowledge I have no personal or professional conflict of interest. I have read and understood the Commissioner's Guidelines for Independent Advisors and agree to comply by them.

I am a Consultant Psychiatrist, specialising in Old Age Psychiatry, employed for the last 16 years in a private capacity and at the Auckland District Health Board, as a specialist in the Mental Health Service for Older People. I am an Honorary Senior Lecturer at the University of Auckland. I worked in Canterbury Hospitals for 10 years prior to this, as a Consultant Psychiatrist and Psychogeriatrician and Senior Psychogeriatric Registrar. I worked for 4 years as the Senior Lecturer in old age psychiatry for the University of Otago. I obtained my MBChB from the University of Auckland, 1987; I am a Fellow of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP), 1994 and a Member and immediate past Bi-national Chair of the Faculty of Psychiatry of Old Age.

I have read the

a) Letter of complaint dated […]
b) MidCentral DHB's letter to complainant dated 13 January 2017
c) MidCentral DHB's response dated 23 March 2017
d) Clinical records from MidCentral DHB covering the period 7 October 2016–28 October 2016

I have been asked to review the documents and provide an opinion as to whether the care provided by MidCentral DHB was reasonable in **the circumstances and, in particular:**

1. The decision to administer IM lorazepam to [Mrs A]
2. The clinical appropriateness of the overall pharmaceutical management of [Mrs A's] behaviour and psychological symptoms of Dementia while she was an inpatient in [Ward A]
3. Whether there was any obvious deficiency in care contributing to [Mrs A's] deterioration in mobility and apparent general deconditioning while she was in [Ward A]
4. Any other comments on [Mrs A's] clinical care while she was in [Ward A]
5. The adequacy of the DHB response to [Mrs B's] complaint and suggestions

<u>Review of Clinical Information</u>

[Mrs A], as an 81-year-old woman residing at [the rest home] was referred by [her general practitioner] to the Older Person's Mental Health Service of Mid-Central Health, on 7 October 2016.

The presenting problems were significant behavioural and psychological symptoms of Dementia, of verbal and physical aggression; resistiveness to care, episodic hitting and biting staff and running her walker into other residents. The diagnosis was of a Dementia, presumably Vascular Type, moderately severe. There was a background of cerebrovascular disease confirmed by a CT head scan, in June 2014. Other medical problems included a history of a small bowel resection in 2013, hypertension, gait disorder, degeneration of the lumbar spine and a tendency to constipation.

The GP referral dated 3 October 2016 was noted to be an urgent referral. The GP stated that he had reviewed [Mrs A] for her three month check at [the rest home] and that there had been *'increasing difficulties managing the behaviours over the last month or so'.* The GP performed a standard physical examination and arranged for routine investigations, with no superimposed organic cause elucidated. He stated that he was concerned that the staff would not be able to manage [Mrs A] at [the rest home] should the behaviours continue. He went on to note that [Mrs A] was on regular Quetiapine, but an increasing dose of this had simply resulted in over-sedation.

The medications on referral were Paroxetine 20 mg mane, Quetiapine 12.5 mg at 1400 and evening, 12.5 mg prn, Quinapril 20 mg mane, Omeprazole 20 mg mane, Simvastatin 40 mg nocte, Paracetamol 500 mg qid, Codeine phosphate 15 mg prn, Inhalers and regular laxatives.

The Initial Assessment by [RN F], Community Psychiatric Nurse dated 6 October concluded with the Impression *'declining cerebrovascular disease with related challenging behaviours, non-fluent dysphasia, medications particularly mane quetiapine over sedating, doubly incontinent'.* The plan was to *'liaise with [Mrs B]/EPOA (daughter) and admit to [Ward A] via ambulance — R/N [the rest home] to organise'.*

[Mrs A] was admitted to [Ward A] on 7 October 2016. The admitting note by the Nurse noted that [Mrs A] arrived in the morning via ambulance from [the rest home]. The admitting House Officer performed a medical and physical review. The initial medications charted did not include simvastatin and included ferrous sulphate suggesting there was a medication reconciliation.

The house officer obtained collateral history from [Mrs A's] 'daughter and granddaughter', noting they were *'concerned about her morning sleepiness — she is unable to get out of bed before 11'*. It is further noted that they were *'very unhappy that she was brought in here against their wishes. They expressed concerns around her becoming very agitated when being moved, and also when staying in hospital long-term due to risks of infection. They would like her to move straight to Dementia level care'.*

The afternoon nursing shift note states that [Mrs A] was reviewed at the start of duty in the company of her daughter. As the afternoon progressed, [Mrs A] became

increasingly distressed and agitated with exit-seeking behaviours. The nursing notes state *'redirections attempts, patient responded by ramming stroller into staff, patient bearing teeth at staff, stating "I'm going to get you"'.* The nurse then offered [Mrs A] a cup of tea or a lie down, but was unable to reassure her. There was increasing distress and it was noted that the *'agitation was escalating'.* It is then stated *'Decision made to give pm lorazepam IM as previous attempt to administer oral tablet met with patient trying to grab medication and ramming staff with stroller'.* It is then noted that the *'patient settled quickly post*-IM'. However, it is also noted that [Mrs A] was *'very aggressive during administration of lorazepam, drew blood on arm of enrolled nurse, tried to bite and shove enrolled nurse with hip'.* For the rest of the duty, it is noted that [Mrs A] was *'settled and showing humour'.*

[Mrs A] was reviewed by [Dr J], Consultant, on the afternoon of her admission. It was noted that since her arrival, [Mrs A] had been very *'restless, agitated, pacing up and down ward and rattling doors … hitting out at staff and throwing objects'.* There was limited comprehension of speech and no meaningful verbal response was elicited. It was noted that [Mrs A] was administered lorazepam 0.5 mg IM for this agitation. With the history that quetiapine had resulted in sedation and a previous report of response to risperidone, the quetiapine was switched to risperidone with PRN lorazepam available for *'severe agitation'.* [Dr J] also noted that he *'attempted to discuss with EPA, [Mrs B], no answer on cellphone or hospital extension'.*

The rest of the nursing entry from that day focusses on [Mrs A's] physical state, with the nurse's impression being that there was a probable UTI, for which the House Officer was called requesting a review and potential treatment of the symptoms. The House Officer advised that they would not prescribe for *'asymptomatic patients',* and suggested that a MSU be collected in the first instance. [Mrs A] slept well overnight, however it was noted *'incontinence of offensive urine'.*

On 8 October 2016, PRN oral lorazepam was given at 12.30, with a noted benefit, however this was short-lived. The nurse also noted *'She needs constant supervision and reminding to use walker as very high falls risk'.* It was also noted that [Mrs A] was *'reluctant with assistance for personal cares, but accepting throughout and appreciative at the end'.*

On the afternoon shift of 8 October, the agitation increased in the evening; with exit-seeking behaviours and physical aggression. The nurse elected to allow [Mrs A] to 'de-escalate on own, allowing to wander and try doors', and was able to administer 0.5 mg lorazepam orally. However, when [Mrs A] required assistance with toileting she became 'combative, requiring three staff to ensure patient did not fall as she was trying to sit on the floor'. There were attempts to 'bite staff', hitting out and pinching, and this required 'physical restraint, figure of 4, to remove from bathroom to room'.

On 9 October 2016, it was noted by an enrolled nurse that [Mrs A's] mood was variable but generally irritable, and required full assistance with activities of daily living, including diet and fluids. [Mrs A] was reported to be compliant with charted

medication. Behaviours recorded included 'hitting out at staff' and 'attempting to throw food and drinks … Sitting out in foyer area — she has to be sat with when like this — unsafe'.

On the evening of 10 October 2016, Dr J reviewed [Mrs A] in the company of her daughter [Mrs B]. It is noted that the presentation was discussed, including the *'ongoing fluctuating agitation and aggression needing IM medication over the weekend'.* The medications were discussed including the change from quetiapine to risperidone, and the plan to *'titrate up (as needed) if tolerated'.* There was a discussion *of* the *'risk/benefits of medication of med and sedation/falls risk need to balance against risks from leaving her in an untreated agitated state'.* Risperidone was commenced at 0.5 mg bd. The concluding paragraph stated: *'Daughter does not need to be notified each time [Mrs A] is restrained or having IM meds — understanding of clear plan. Would like [Mrs A] to be able to get back to [the rest home] if possible'.*

On the afternoon of 10 October, [Mrs A] was *'tearful, trying out the main door and was knocking on it. Required several prompts to redirect her. One-to-one care given; initially for four hours due to wandering around the ward; leaving her stroller behind. Short period of irritability, clenched her teeth, sharp states'*. The nurse went on to note *'Tried to deescalate using therapeutic communication and became amenable. Sat on chair and watched TV'.*

A multi-disciplinary team meeting was held on 11 October, where it was noted that [Mrs A] was tolerating the risperidone *'with no major over-sedation'.* [Dr J] also noted *'Appears she is in pain despite regular paracetamol. Was on codeine pm at [the rest home] — restart but monitor for constipation'.* The iron tablets were ceased and it was noted that a family meeting would be held on [Dr M's] return. A physiotherapy review was undertaken which recommended continuing to encourage the use of the stroller within the unit, and acceptance of the falls risk.

In the afternoon there was a meeting with the CNS, [RN I], the Charge Nurse, [RN D] and [Mrs B]. It was noted that *'[Mrs B] had not been informed by [the rest home] about the severity of [Mrs A's] behavioural issues and the impact on the other residents'.* The issues regarding the admission and lack of communication were discussed. The treatment and length of stay were *'discussed at length'* and concluded that *'[Mrs B] was satisfied that her mum was getting excellent treatment and the rational (sic) for her admission.'*

Over the day of 11 October, [Mrs A] was reported to have been *'largely settled and cooperative', 'but the mobility remains poor, slow shuffling gait and need one assist'.* Diversional Therapy with soft toys was used on both shifts, and she was observed to be *'playing with her teddy bears and toy dog and enjoying the same'.*

On 13 October, it was noted by the nurses that there was a change in mobility with *'difficulty to stand/transfer … leaning heavily backwards. Standing sling hoist required to take to the toilet'.* Later in the shift it was noted that [Mrs A] *'Got up with her*

walking frame. Not taking directions. High falls risk'. The covering House Officer reviewed the MSU result and charted a course of augmentin. In the afternoon, risperidone 0.5 mg PRN was utilised and noted to have a settling effect.

On 13 October the nurse noted resistance to ADLs and queried whether PRN lorazepam would be required, as well as pain relief prior to mane ADLs. This was commented upon again by the afternoon shift, along with concern that there was generalised pain; with deeper pain in the *'right elbow'.* On that shift, regular risperidone was given early as [Mrs A] was very *'agitated — restless, verbally aggressive, refused and agitated with interventions, put herself at risk by walking without aid'.* The risperidone was noted to have had a good effect.

On 15 October there was less aggression noted, and PRN lorazepam was not required. The nurse on the morning shift queried whether [Mrs A] was in pain stating *'locality unclear'.* On the night shift PRN risperidone was employed for verbal aggression. [Mrs A] was awake for much of the night *'being specialed most of the shift'.*

On the evening shift of 16 October, a further nurse noted [Mrs A] as seeming to be in pain intermittently, and that she had tried to stand several times *'but pain stopping her — where? abdomen'.* This nurse spoke to the visiting House Surgeon but *'with no specific problem was unable to assess'.*

On 17 October, [Mrs A] was reviewed by [a] Consultant Psychiatrist. [Mrs A] had not arisen from bed that morning, and was resisting nurses when they were trying to help her get up. It was noted *'behavioural relatively more settled'* but it was queried whether or not there was some over-sedation and the lorazepam and risperidone were withheld until [Mrs A] was more alert. There was also a review by a Senior House Officer on 17 October, with no new findings on physical examination and it was concluded that the *'overall sedation has significantly improved since this morning'.* The abdomen was reported to be soft and non-tender, and the blood pressure was required to be checked later in the day. By the evening [Mrs A] had become *'agitated and aggressive — verbally and spitting'.* The possibility of a delirium was noted by a brief review by a second consultant. Codeine was stopped and it was recommended that there be non-pharmacological management of the behavioural issues, where possible. During the afternoon there was the reemergence of significant behaviours and PRN risperidone was administered orally.

On 18 October, a phone call was made to [Mrs B] to update her on the fluctuating condition and the medication changes. It is noted that [Mrs B] requested for a family meeting to be held to discuss discharge planning *'as she thinks her mother is no more settled since admission'* and that discharge back to [the rest home would] be for the best. It is noted on this day that the results of the laboratory investigations were normal.

On 19 October, PRN lorazepam 0.25 mg was given for anxiety. In the afternoon 0.5 mg risperidone was administered for *'aggressive manner and resistive to help,*

hallucinating, appears disturbed about something'. It was also noted in this shift that [Mrs A] appeared to grab her stomach in pain on the left lower side of the abdomen.

On 20 October 2016, [Mrs A's] case and the 'current difficulties with mobility' were discussed with the Charge Nurse ([RN D]) by the attending enrolled nurse. It is noted that [Mrs A] was in pain, again in the abdomen and possibly in the right chest, arm and shoulder. [Mrs A] was able to mobilise but was slow. The bowels had opened but were not a normal motion; *'with a smear only and remains black and sticky, and the urine continued to be of an offensive odour'.*

[Mrs A] was reviewed by the physiotherapist, who noted a lean to the right side, but [Mrs A] was unable to mobilise at that point in time and the advice was to continue to use a standing hoist 'as required'.

On 21 October, PRN lorazepam was required for anxiety and agitation, in the late morning. In the afternoon it was noted that [Mrs A] was very slow to stand from a sitting position due to '? *painful knees'.* The urinary symptoms were again noted, along with faecal incontinence. It was noted by the social worker that a family meeting was to be arranged for discharge planning back to [the rest home].

On 22 October it was noted that the bowel motions remained *'black and sticky looking'.* This was again noted on the evening of 22 October; where there was double incontinence of a *'large black soft stool'.*

[Mrs A] was reviewed by [a] House Officer on 25 October. Cream was charted for a groin rash. The pain was diagnosed as likely musculoskeletal pain, possibly related to the standing hoist. It was also noted that the faecal result was normal, with no 'clostridium difficile or red blood cells'. It was advised that the bowel motions continued to be monitored. Ibuprofen PRN was charted for general body pain. Over this period, of a few days, the PRN used was that of lorazepam 0.25 mg, usually mid-afternoon, on a daily basis. There was no PRN risperidone employed.

The multi-disciplinary meeting and family meeting occurred on 27 October 2016. It was noted that the [rest home] team reviewed [Mrs A] and had declined her return. It was assessed that [Mrs A] would need Psychogeriatric level of care due to the lability, physical aggression, resistiveness to cares and intrusive behaviours. It was noted that the pain was continuing and the codeine was re-trialled again. The Psychogeriatrician in this meeting, [Dr M], confirmed the level of care to be Psychogeriatric Hospital Care.

The family meeting minutes noted *'[Mrs B] asked about the mobility and the significant deterioration in the hospital'.* It was noted that the family did not want [Mrs A] to remain in hospital anymore, and that they had been in contact with [the dementia-care hospital] for her permanent discharge to that residence. [Mrs B's] husband *'was the spokesperson and stated that the family had been very upset about*

the overall care of their grandmother'. The example given was *'a healthcare assistant lying all over the counter, and the family found this very disrespectful'.*

Discharge planning was underway on 28 October 2016. It was advised that an ambulance was the recommended mode of transfer by the House Officer. The family advised that they would organise a mobility taxi, and accompany the patient. [Mrs A] was discharged on the morning of 28 October, with the note stating *'the patient was transferred to wheelchair … nurse and family to take belongings to taxi and discharge to [the dementia-care hospital] at 13:15 hours. [The dementia-care hospital] was phoned to confirm the patient was leaving and the discharge paperwork was given to the daughter'.*

Comments and Opinion

a. Comments on the Admission process to Ward A

[Mrs A] had the diagnosis of a Dementia, Vascular Type, complicated by severe behavioural and psychological symptoms. The GP referral stated that on the three month check the staff were finding it increasingly difficult to manage the behaviours and ongoing residency was not sustainable unless there was some moderation of the symptoms. The referral was marked urgent and there was a timely response from the community team with the plan to admit to hospital for assessment and treatment. It is not evident in the notes as to who liaised with [Mrs A's] daughter and Welfare Guardian, [Mrs B], prior to admission.

The decision to admit to hospital was probably the right decision as the assessment and management was beyond the scope of [the rest home]. However, given that these symptoms and signs had been present for some time, the process of admission may have been improved with a meeting in the community with [Mrs B] and [rest home] staff to discuss concerns, requirements and expectations of the admission to [Ward A]. The admission appears to have happened precipitously the following day and when [Mrs B] arrived on the ward she expressed the serious concern that [Mrs A] was admitted *'against their wishes'.* The option of transferring directly to a Dementia Unit was raised by [Mrs B] and it is not evident in the notes if this was considered nor the reasons why this may not have been achievable. On the presumption that the community team was of the opinion that admission was the only option and essential, given the serious risks to self and others, the duty of care, and the duty to provide necessaries and protect from injury, as the Welfare Guardian opposed the admission, the correct legal process and protection would have been admission under the Mental Health Act.

1. The decision to administer IM lorazepam to [Mrs A]

[Mrs A] was administered IM lorazepam on the afternoon of the day of admission. The indications were significant agitation and distress, and verbal and physical aggression. The nursing staff had tried non-pharmacological management such as redirection, diversion, distraction, reassurance, fluids, and offered oral lorazepam. The house surgeon charted the lorazepam PRN at 1530 and the medication was administered at

1550. The consultant was informed and it was noted that [Mrs A's] daughter and EPOA was phoned and was uncontactable.

The management of severe behavioural symptoms in the context of Dementia is challenging. The RANZCP Professional Practice Guidelines, 2016, state that the first-line approach to management of BPSD is a person-centred, psychosocial, multidisciplinary treatment plan. Pharmacological approaches are considered where symptoms are severe, disabling, or syndromal and where a risk of significant harm exists. In an acute situation, when the safety of the patient or significant others are at risk, the common law principle of necessity allows a doctor to act in an emergency in the best interests of a patient unable to provide valid consent to their own treatment. Informed consent from the appropriate individual(s) should then be obtained as soon as practicable if treatment is to be continued. The administration of IM medication to an elderly person with Dementia, in my knowledge and experience, is a rare event.

The house officer noted the escalating aggression and charted the lorazepam PRN as a po/IM option. There is no note that there was a team discussion, resolution and plan that restraint and IM medication was now the only option. It is not evident in the notes that a registrar or consultant were consulted at the time of the decision making. The nursing staff presumably would have been aware at handover of the opposition of the Welfare Guardian to the admission. Given this factor, it would have been ideal to have had the support of senior staff and there to have been considered attempts to contact the Welfare Guardian or another family member prior to the restraint and administration of the medication. Section 111 of the Mental Health Act could have been considered.

It is noted on 10 October that IM medication was required *'over the weekend'.* It is not apparent in the nursing notes that the PRN lorazepam was IM and the recorded mode of administration on the 8 October at 2010 is unclear.

2. The clinical appropriateness of the overall pharmaceutical management of [Mrs A's] behaviour and psychological symptoms of Dementia while she was an inpatient in [Ward A]

The decision to re-trial the risperidone was based on the history of previous efficacy of this medication and the report of the side-effect of sedation with quetiapine. The RANZCP Guidelines state that the decision regarding which antipsychotic to use is a clinical one based on a careful risk–benefit analysis for each patient. Risperidone is the only oral medication approved in Australia and New Zealand for use in behavioural disturbances associated with Dementia.

Lorazepam is a medication used across clinical settings for the management of acute agitation, aggression and associated distress. In the context of Dementia, the NICE Guideline Committee recommends the use of intramuscular lorazepam for behavioural control in situations where there is a significant risk of harm.

There is evidence in the notes that risperidone conferred some benefit yet it was not considered that it may have been impacting on mobility. If that had been established there are other psychotropic medications that may have been trialled. The lorazepam was also efficacious, particularly for anxiety states. On the medication chart the indications for the PRN for both medications were agitation with risperidone specifying aggression and lorazepam specifying anxiety, however, as to which PRN medication was used seemed to be at the nurses' discretion.

On 13 October the nurse noted a change in mobility with difficulty to stand, a lean and a standing sling hoist required to take to the toilet. It is also evident that the mobility fluctuated. This was the 6th day of treatment with risperidone. The ?covering house officer reviewed the MSU result and prescribed antibiotics. There was no physical examination. There was a review by the physiotherapist. The next psychiatric reviews and physical examination were on 17 October. Over-sedation was noted, and the lorazepam dose and maximal daily dose was decreased accordingly. The next medical physical review was 25 October. There was a final brief consultant review on 26 October, 2 days before discharge.

The role and efficacy of the paroxetine was not reviewed. People with Dementia who experience agitation should be offered a trial of SSRI antidepressants and there is better evidence for escitalopram and sertraline. Other pharmacological options that may have been considered include venlafaxine, mirtazapine, olanzapine or memantine.

3. Whether there was any obvious deficiency in care contributing to [Mrs A's] deterioration in mobility and apparent general deconditioning while she was in [Ward A] and

4. Any other comments on [Mrs A's] clinical care while she was in [Ward A]

The clinical records indicate that the nurses strove to care well for [Mrs A]. The nurses did employ some person-centred approaches such as reassurance, diversion, and toy therapy, however, there was no behavioural management plan evident in the notes that captured these non-pharmacological approaches. The 'Social Profile' form was incomplete but it was noted that [Mrs A] liked 'food, people watching and talking, animals and getting nails painted'. There is no evidence of consideration of these interests or availability of other non-pharmacological approaches such as music, massage, recreation and animal-assisted therapy or sensory modulation techniques. The nurses also indicated that [Mrs A] required 1:1 care for significant parts of shifts yet it is not evident that a 'special' or extra nursing staff were in place.

The nursing staff indicated on numerous entries that various clinical issues needed review and it is not clear why this was unable to be achieved. It is to be noted that an enrolled nurse took her concerns to the Charge Nurse on 20 October. There was a delay in treating the UTI, a change in mobility, abdominal pain, constipation, and limb, joint and generalised pain. There was no review specific to ascertain if the risperidone had resulted in extra-pyramidal side effects. There were only three physical reviews

throughout the 20 day stay where the patient was examined and all were limited; on the day of admission where it is noted *'for physical exam when able',* on 17 October when [Mrs A] was sedated, and included a brief neurological examination, and on the 25 October for the groin rash and musculoskeletal pain which was attributed to the standing hoist.

The differential diagnosis on 17 October included Delirium. It is not clear if all reversible factors had been excluded. It is not documented if a CT Brain was considered. There was no repeat MSU to see if the UTI had cleared. The constipation and persisting black stools were noted 11 days after cessation of the iron tablets. There was no repeat abdominal examination or discussion whether there should be further investigations. The medical oversight and reviews of [Mrs A's] care, in my opinion, were inadequate both in timeliness and scope.

[Mrs B] indicated to the inpatient team at the outset that she was opposed to the admission. There was a meeting with the Consultant early in the admission on 10 October. It is evident in the notes that some nursing staff engaged with [Mrs B] and provided updates when able. A formal discussion was had with the Charge Nurse and the CNS on 11 October where the senior nurses formed the view that [Mrs B] was 'satisfied' with the admission and treatment for her mother, but this was not followed through upon with an update meeting. [Mrs B] requested a further meeting with the team and medical staff for discharge planning on 18 October. The meeting was unable to be held until 27 October.

5. The adequacy of the DHB response to [Mrs B's] complaint and suggestions

The DHB response to [Mrs B] was written by [the] Service Director. It is noted that the letter of complaint was written the day after discharge, 28 October, and the response was dated 13 January. This seems an unacceptable delay to address the concerns.

The treatment without consent of the Welfare Guardian and the legal desirability for this or consideration of the Mental Health Act was noted. However, the trauma of the admission process and the failure to inform and engage [Mrs B] and the family at the outset was not understood or acknowledged.

The coordination of care paragraph noted the unacceptable delay in scheduling the family meeting.

The partnership working between staff and health care consumers noted that there was documentation of [Mrs A's] goals of care yet these *'were not communicated to you'.* The title of the nursing care plans is 'Care plan done in consultation with client.' There is one entry on 17 October where the issues with mobility and the use of a standing hoist where it is noted *'D/W daughter re rationale'.* The response acknowledges that [Mrs B] *'did not have as much opportunity to provide input into the treatment planning as we may have expected'.* The evidence in the notes is that [Mrs B], as the advocate and voice for [Mrs A], had very little opportunity to provide input. It is noted that this falls below the expected standards and improvements are

expected in the team. It is not delineated in the first response as to how this is to be achieved. However, the letter from [the] General Manager, dated 23 March 2017, stated there is an Action Plan but this was not made available to me.

The recorded communication with [Mrs B], described as 'regular updates' were outlined in the response. The frequency and timeliness of communication was not addressed. The lack of communication was described as 'running in parallel' and 'confused lines of communication'. This explanation seems to defend the team yet it is not evident in the notes as to who the treating team were communicating with. Further, this is in conflict with the paragraph above where it is acknowledged that there was a lack of partnership between the clinical team and [Mrs A's] family. This is then acknowledged in the statement that the OAMH 'should have established a clear agreement by which they could work together with yourself and your family'.

The concerns re the use of restraint and sedation were responded to with a focus on the date of 17 October. The restraint recording procedure was complied with as evident in the clinical records. The rationale for the use of psychotropic medications was explained. As stated, [Mrs A] was reviewed by two consultants and medications moderated on 17 October. However, there is not the evidence in the clinical records that [Mrs A] was 'regularly assessed' by medical staff nor is there convincing evidence that 'all aspects of care being well documented'.

The response concluded with the acknowledgment that the therapeutic milieu of [Ward A] needs to be reviewed and enhanced if it is going to aspire to be a unit with a Dementia-friendly, person-centred approach to care.

Summary

The behavioural and psychological symptoms of Dementia are a challenging aspect of the syndrome to adapt to, and to assess and manage. It is generally accepted in clinical practice that the key to understanding many behaviours is the application of person-centred care. This means knowing people, their history and their unmet needs, and trying to establish triggers and develop responses that are adapted to the person's unique circumstances.

A change of environment and admission to hospital is a stressful event for any person and their family. It is evident in the notes that [Mrs B] was not informed or prepared enough so as to understand this phase of the syndrome and the requirement for further assessment and management. There was a failure to consistently engage her, hear the story of her mother, and allow her time to express her views, indeed grieve and understand the situation. Given the initial opposition to admission and clear distress, there should have been extra time and effort afforded to this family. It may be that the outcome of replacement at psychogeriatric hospital care remained the same, but it is the process that matters to patients and their families.

The nurses also signalled to senior and medical staff at various times throughout the admission that there were concerned about pain, infections, constipation, mobility, falls risk and high nursing needs. I have outlined some of these omissions in detail and

this may be seen as unrealistic expectations given the presentation, or to be highly critical of [Ward A]. However, in my experience of inpatient care of the older person, a comprehensive assessment and management plan is the expected standard in a specialised inpatient unit. If these reviews were not able to be done, due to the condition of the patient or lack of available medical staff, or not done because it was discussed and decided not to be pursued, this should be clearly documented.

As outlined in RANZCP Psychiatry services for older people: A report on current issues and evidence to inform the development of services and the revision of RANZCP Position Statement 22, 2015, 'inpatient care should be provided as part of a continuum of care, with the older person only moving from care in the community where there are clear indications for admission where ever possible occur in environments adapted appropriately for the needs of older people. Staffing should be multidisciplinary, supported to develop specialised skills and provided with leadership who have specialised skills in providing mental health care to older people'.

The retrospectoscope can be a harsh judge. There are no doubt circumstances and dynamics which may have complicated the situation and even be mitigating factors. However, the clinical records as they stand, indicate that there were deficiencies in the assessment and approach and a lack of clinical leadership and direction in care. From the consumer perspective, this was compounded by a failure to engage, listen, inform and support the family, to a sufficient degree, at a time of great stress and need. A public hospital inpatient service needs to set the gold standard for the specialised care of an older person with Dementia.

Yours sincerely,

Dr Jane Casey
MBChB, FRANZCP, MFPOA
Consultant Psychiatrist and Psychogeriatrician"

The following further expert advice was obtained from Dr Casey:

"Further to report dated 8 July 2017 I wish to confirm my opinion as follows:

1. The decision to admit [Mrs A] against the wishes of the activated Enduring Power of Attorney, necessitated that the Mental Health Act, 1988, to be the correct legal process to admit a non-consenting individual to hospital and to commence treatment. The need for admission appears to have been communicated to the substitute decision-maker, (Welfare Guardian). The admission and treatment plan process is not clearly documented and along with the subsequent omission of the use of the MHA, this is a significant departure from standard acceptable practice, of a moderate degree.

2. The decision to administer the IM lorazepam was made due to escalating agitation and aggression and could be considered to be a psychiatric emergency in this

regard. The common law principle of necessity allows a doctor to act in an emergency in the best interests of a patient unable to provide valid consent to their own treatment. Informed consent from the appropriate individual(s) should then be obtained as soon as practicable if treatment is to be continued. Given that the inpatient team would have been aware of the opposition of the welfare guardian to the admission, it would have been ideal to have had the support of senior staff and there to have been considered attempts to contact the welfare guardian or another family member prior to the restraint and administration of the medication. Section 111 of the Mental Health Act could have been used. It is noted that the welfare guardian was contacted as soon as possible after the event. This process is a departure from standard acceptable practice, but given the need to act in what was considered to be an emergency, this departure is of a mild degree.

3. [Mrs A] had multiple medical and physical issues. The nurses signalled to senior and medical staff at various times throughout the admission that there were concerns about pain, infections, constipation, mobility, falls risk and high nursing needs. A comprehensive assessment and management plan is the expected standard in a specialised inpatient unit. There were deficiencies in the assessment and approach, a lack of clinical leadership and direction in care and a lack of timely medical reviews. These issues are a significant departure from standard acceptable practice, of a moderate degree.

4. It is evident in the notes that [Mrs A's] daughter and welfare guardian, [Mrs B], was not informed or prepared enough so as to understand this phase of the syndrome and the requirement for further assessment and management. There was a failure to consistently engage her, hear the story of her mother, and allow her time to express her views, indeed grieve and understand the situation. Given the initial opposition to admission and clear distress, there should have been extra time and effort afforded to this family. It may be that the outcome of re-placement at psychogeriatric hospital care remained the same, but it is the process that matters to patients and their families. The lack of consistent engagement and regular and timely meetings is a significant departure from standard acceptable practice of a moderate degree.

I have discussed this case in broad and general terms with a senior peer and colleague in Old Age Psychiatry. This colleague concurred with my opinion that the overall assessment and management plan for [Mrs A], and the process for the family, fell significantly below expected standards for an inpatient unit that specialises in the care of the older person.

I trust this clarifies the opinion and apologise for the delay.

Yours sincerely,

Dr Jane Casey
MBChB, FRANZCP, MFPOA
Consultant Psychiatrist and Psychogeriatrician"