Registered Nurse, RN B

A Report by the
Deputy Health and Disability Commissioner

(Case 18HDC01346)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided by a registered nurse to a man who has lived at the high dependency unit (HDU) in a rest home since 2012. The man has chronic schizoaffective disorder and vascular dementia, and is subject to an indefinite compulsory treatment order. His care plan noted that out of confusion and disorientation, he tended to get unsettled and agitated and exhibit verbal and physical aggression.

2. On 29 March 2018, the man broke a glass pane in a door by kicking it. CCTV footage of the incident shows that in response, the nurse went over to the man, grabbed him by the back of his collar, and pulled him away. The force of the nurse's actions knocked a cup out of the man's hands. The nurse then pulled/pushed the man out of the lounge. The man did not appear to be agitated or to be resisting the nurse.

3. The nurse submitted that he was reacting to an emergency situation at the time. However, he acknowledged that he should have given the man more time to de-escalate, and should have obtained assistance from another staff member.

Findings

4. The Deputy Commissioner considered that the nurse's response to the situation was inappropriate, and that his actions towards an elderly and vulnerable resident were unacceptable and a departure from fundamental ethical and legal standards. The Deputy Commissioner found the nurse in breach of Right 4(2) of the Code. In addition, the Deputy Commissioner considered that the nurse's actions were disrespectful to the man, and therefore found that the nurse also breached Right 1(1) of the Code.

Recommendations

5. The Deputy Commissioner recommended that the nurse attend training on de-escalation, restraint minimisation, and person-centred care, and apologise to the man in writing.

6. The Deputy Commissioner also recommended that the Nursing Council of New Zealand consider whether a review of the nurse's competence is warranted.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a referral from the Nursing Council of New Zealand, referring a complaint from the rest home company about the services provided to Mr A by Registered Nurse (RN) B at the rest home. The following issue was identified for investigation:

- *Whether RN B provided Mr A with an appropriate standard of care in April 2018.*

8. This report is the opinion of Deputy Commissioner Rose Wall, and is made in accordance with the power delegated to her by the Commissioner.

9. The parties directly involved in the investigation were:

Mr A[1]	Consumer
RN B	Provider/registered nurse

10. Further information was received from:

Ms C	Provider/caregiver
Ms D	Provider/caregiver
The rest home company	Provider

11. Independent expert nursing advice was obtained from RN Megan Sendall (Appendix A).

Information gathered during investigation

Introduction

12. This opinion relates to an incident on 29 April 2018 at the rest home. The incident, which was recorded on CCTV, involved RN B having used force when providing services to a resident, Mr A (aged in his seventies at the time of events).

Mr A

13. Mr A's primary diagnoses are chronic schizoaffective disorder[2] and vascular dementia.[3] He has lived at the rest home since 28 November 2012, and resides in the high dependency unit (HDU). Previously he had lived in numerous mental health institutions.

14. Mr A has been subject to an indefinite compulsory treatment order under the Mental Health (Compulsory Assessment and Treatment) Act 1992 since 23 April 2015. What this means is that he can be treated without his consent,[4] and a person treating him can use "such force as is reasonably necessary in the circumstances[5]".

15. Mr A has no enduring power of attorney in relation to personal care and welfare or property. The Family Court appointed [a trustee services organisation] as his property manager. He has no known family or supporters.

[1] Mr A has not been involved in the investigation directly because of his lack of capacity.
[2] A mental health condition that is marked by a combination of schizophrenia symptoms and mood disorder symptoms.
[3] Dementia caused by reduced blood flow to the brain.
[4] Section 59 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.
[5] Section 122B(3) of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Care plan and interRAI assessment

16. Mr A's interRAI assessment dated 5 December 2017 stated that he was subject to "unpredictable aggressive behaviour".

17. His care plan[6] stated:

> "Out of confusion and disorientation as well, I tend to get unsettled, restless and agitated wherein I can be confrontational, verbally and physically aggressive towards others."

18. The agreed support included that staff would provide a safe and comfortable environment for him at all times, and speak to him, encourage him to verbalise his feelings, and divert his attention.

RN B

19. RN B was employed to work at the rest home from January 2011 onwards. His job description included a responsibility to maximise the safety of residents and staff by:

- Actively promoting the minimisation of risk and harm occurring.
- Displaying commitment to maintaining a safe environment for residents and staff.

20. The rest home company stated that RN B was employed in the role of a registered nurse. The rest home company said that for a few months he was assigned as the most senior nurse on the morning shift in the HDU. RN B recalled being given the unofficial titles of "Team Leader" of the HDU and "Unit Coordinator" of the HDU (used interchangeably) from approximately November 2017 onwards, but confirmed that he was employed as a registered nurse.

21. The rest home company stated that it had had no previous concerns or reports about RN B mishandling residents.

Incident on 29 April 2018

22. On 29 April 2018, Mr A was present in the HDU lounge. The following staff members were present: caregiver Ms C; caregiver/activities assistant Ms D; another caregiver[7]; activities coordinator/diversional therapist;[8] and RN B.

CCTV footage

23. The rest home company provided HDC with CCTV footage of the incident. The CCTV footage has no sound recording. It shows a view of the HDU lounge. The front of the nurses' station is visible, with a corridor to the left of this, and doors with glass panes to the right. Three residents can be seen in the footage, and the legs of two further residents

[6] The care plan appears to have been commenced in May 2017, and review of the care plan occurred six monthly.
[7] Who has since resigned from the rest home.
[8] Who has since resigned from the rest home.

can be seen on the right-hand side. No staff members are visible except for a person in the window of the nurses' station (it becomes evident that this was RN B).

24. The incident occurred at approximately 1.18pm. Mr A (one of the partially visible residents) emerges from the far right corner, and slowly walks to the glass doors. Mr A is seen motioning swinging his lower right leg towards the lower glass pane of the door for approximately six seconds. He then kicks into the glass pane approximately three times, breaking it.

25. Two staff members emerge from the bottom left corner of the footage, as well as another staff member from down the corridor.

26. RN B is seen walking out of the nurses' station into the corridor and then going over to Mr A. RN B immediately grabs Mr A by the back of his collar and, using his right hand, pulls Mr A away. The force of RN B's actions knock a cup out of Mr A's hands. RN B then pulls/pushes Mr A out of the lounge. Mr A does not appear to be agitated or to be resisting RN B. The time between RN B walking out of the nurses' station and grabbing Mr A is approximately six seconds.

27. RN B then pulls/pushes Mr A down the corridor away from the HDU lounge while still holding him by the back of his collar. The time between RN B grabbing Mr A and then both no longer being visible to the CCTV footage of the corridor is approximately six seconds.

28. One resident is seen standing up and walking towards staff members and the hallway, with his arms by his side, immediately following Mr A kicking the glass and staff members emerging into the frame. This resident is then seen moving to the left-hand side of the corridor, out of the way, when he appears to realise that RN B is pulling/pushing Mr A towards the corridor. The resident is then seen walking down the corridor after RN B and Mr A. Other than this, none of the visible residents appear to react to Mr A's behaviour.

RN B's account

29. RN B stated that on 29 April 2018 he worked from 6.45am until 3.15pm as a registered nurse and Team Leader, and also had to cover the rest home. RN B said that he did not provide care to Mr A in the morning, but administered his medication at around 8am and 11.45am. RN B stated that he put Mr A's lunchtime medication into ice cream, which Mr A ate. RN B said that he was satisfied that Mr A had ingested all of the medicine, and that Mr A gave the impression that he was calm at that time.

30. RN B said that after completing the lunchtime medication round he went to the nurses' station to update the clinical notes. Mr A remained in the lounge to have a nap. At around 12.30pm, while RN B was still in the nurses' station, he heard a loud sound and looked up to see Mr A with his foot pointing towards an external door, and saw that the lower glass panel of the door had been smashed.

31. RN B told HDC that he went into the lounge and found Mr A near the door. There was glass all over the floor around Mr A, and shards of glass were hanging from the door frame. RN

B said that he was told by one of the care staff that Mr A had kicked the glass door panel two to three times before he broke the glass.

32. RN B said that he spoke to caregiver Ms D, and then went over to Mr A to assess him to make sure he had not been injured by any of the shards of glass. RN B said that he found no blood or skin tears on Mr A's legs, and when he asked Mr A if he was injured or in pain, Mr A responded that he was fine.

33. RN B said that Mr A began to swing his body, which was a warning sign that he was about to attack or provoke a fight. RN B said that he was concerned that Mr A might pick up some of the glass shards and use them as a weapon.

34. RN B stated that another male resident became agitated and began clapping his hands and making sarcastic comments. RN B was concerned that Mr A and the resident would get into a fight, so he decided that the safest thing for the residents was for Mr A to go to his room.

35. RN B said that he asked Mr A three to four times to go to his room, but Mr A ignored him, so RN B considered that the safest action was to escort Mr A from the lounge to his room as quickly as he could. RN B said that Mr A was refusing to go to his room on his own, so he took hold of Mr A's shirt "loosely in between his left and right scapula, as a safety measure, in case he bounced or lashed back". RN B stated: "I then quickly escorted [Mr A] from the lounge to his bedroom. At this stage, he was still agitated, resistive and yelling at me."

36. RN B said that he held Mr A from behind because Mr A was barefoot at the time and the broken glass was behind him. In addition, Mr A had a cup in his hand, and RN B considered that there would be a high risk of Mr A throwing the contents into his face if he held Mr A from the front. RN B also said that he held Mr A from the back to prevent Mr A from escaping his hold, and that holding him from the front would likely have made him agitated or have elevated his mood. RN B stated: "[Mr A] does not like his course of action being interrupted by others. This would have been dangerous, particularly with other agitated residents close to him."

37. RN B said that he did not let go of Mr A while walking him to his room because had he done so, there would have been a high risk of Mr A attacking him. RN B stated: "However, at no point in time did I drag or assault him." RN B said that once he had taken Mr A to his room, he left the room and shut the door. RN B stated that Mr A banged on his bedroom door but stayed inside his room.

38. RN B said that he did not get the care staff to assist him because they looked very shocked, frightened, and unlikely to intervene, and also because Mr A mostly responds to male staff.

39. RN B stated that Mr A is approximately 10cm taller than him. RN B said that often Mr A would hide behind the door or in the garden and jump out in front of staff. He would collect spoons and forks in his pocket and use them as weapons against staff and other

residents. RN B said Mr A had aggressively thrown cups, spoons, and plates at other residents and staff, and would threaten staff with the spoons and forks that he always kept in his pocket. RN B stated:

> "It is fair to say that [Mr A] is at the root of most altercations and assaults in the HDU. [Mr A] has had several incidents during which he has punched residents, inflicting bodily harm" and that [Mr A] can give the impression of being calm just before he 'explodes'.

40. RN B said that after he had taken Mr A to his room, he returned to the lounge to help the other staff to clean up the mess. A caregiver helped him to remove the shards that were hanging on the door panel, and they covered the panel with board and barricaded the area with recliner chairs.

41. RN B said that after about 30–40 minutes he went back to Mr A's room, and Mr A was calm and reading magazines. RN B stated that he assessed Mr A's legs again and noted no injuries, and he left Mr A in his room and returned to the lounge a few minutes later.

RN B's subsequent responses to HDC

42. RN B considers that there is no discrepancy between his statements about what happened and what is shown in the CCTV footage.

43. However, RN B acknowledged to the rest home company[9] that Mr A was calm immediately after kicking the glass. In later responses to HDC, RN B acknowledged that Mr A appeared calm, but stated that this did not mean that he was.

44. RN B also provided a slightly different recollection of events in later responses to HDC. He stated that as he was coming out of the nurses' station, he told Mr A, "Let's go to your room," but Mr A ignored him. RN B said that as he walked towards Mr A, he completed a quick visual inspection of his legs, as they were uncovered, to establish that there was no blood or skin tears, and then took hold of Mr A from behind to stop him walking backwards into the broken glass and to prevent him from throwing the contents of his cup in his face. RN B stated that once he had hold of Mr A, he was able to direct him to his room with little resistance, which was why he did not ask any other staff member to assist. RN B said that after clearing away the broken glass, he returned to Mr A to double check for any skin tears or bruises, and asked if he was in any pain, which he denied.

45. RN B stated that in instances where Mr A and/or other residents were in a heightened state, it was important to diffuse the situation as quickly as possible. RN B said that staff had been directed by the Clinical Manager to de-escalate the situation by removing the resident who was causing the trouble, and take the resident to their room or some other area to calm down. He noted that for Mr A specifically, previously safe seating restraint had been used, but this was not suitable, and so staff had been directed to escort him to his room, where he was able to settle and de-escalate.

[9] During the internal investigation.

46. RN B acknowledged that the policy "Behaviours That Challenge" refers to others being removed from imminent harm, but said that as they had been directed by the Clinical Manager to remove Mr A, he therefore considered that this direction should be followed, rather than the policy "Behaviours That Challenge".

47. RN B stated:

> "This incident has been the turning point of my career. Having reflected on the event, while I still consider that I was reacting to an emergency situation which required the removal of [Mr A] from the area, for his safety and the safety of others, in hindsight I should have asked another staff member to assist me, so that we could have guided [Mr A] to safety.
>
> Instead, much to my regret, I removed [Mr A] on my own which did require some force.
>
> I do not consider that I would react in such a way in the future …"

48. RN B also said that he realises that he should have given Mr A much more time to respond to his request to go to his room, but stated that at the time, he felt that he needed to get Mr A out of harm's way as soon as possible. RN B said that given the reflection and learning he has undergone since this event, this is not how he would react now.

Reports of incident and subsequent events

49. The progress notes completed by RN B that day do not refer to Mr A having been agitated or aggressive. RN B completed an incident report that also did not refer to Mr A having been agitated or aggressive during the incident. At the end of the incident report, RN B recorded:

> "Investigations/Findings: [Mr A] has unpredictable behaviour and can do things out of nowhere, staff just needs to monitor him closely so that they can prevent things before it happens they need to be proactive not reactive."

50. The rest home company stated that approximately one week later, the diversional therapist present during the incident reported her concerns about the incident to the rest home's Manager. The Manager then initiated an investigation into the incident, including interviewing witnesses.

Statements from witnesses

51. Ms D told the rest home company[10] that after Mr A kicked the glass door, RN B said to Mr A something to the effect of, "What have you done". Ms D said that she saw RN B put his hand on Mr A's collar, and Mr A went with RN B without resisting, but said something to RN B (which she could not recall). She noted that Mr A's behaviour was unpredictable and it was difficult to anticipate his actions.

[10] In a statement dated 21 May 2018.

52. In a further statement to HDC, Ms D said that when Mr A kicked the glass panel, she was a few steps away. RN B was in the nurses' station, and he could see and hear what Mr A was doing, but she could not see Mr A directly because she was occupied with doing something else. Ms D stated that RN B said to Mr A, "What are you doing? Go to your room," before he grabbed Mr A. She said that RN B did not speak to her before he went over to Mr A, and the only time he asked for assistance was to clean up the glass and cover the panel after he had taken Mr A to his room.

53. Ms C told the rest home company[11] that she recalled Mr A kicking the glass and it breaking, and all staff including RN B running to the scene. She said that RN B put one hand on Mr A's neck and the other hand around his shoulder. When asked whether she saw RN B touch the resident, she replied, "Yes, forcefully in my opinion." She recalled that RN B did not ask Mr A anything, and just told him to go to his room in an increased tone. She confirmed to HDC that this recollection is correct.

54. A caregiver told the rest home company that she recalled seeing Mr A wobbling as he had just woken up, and then suddenly he kicked the glass. She said that he appeared half asleep and was calm. She recalled RN B appear to hold Mr A on his clothes around his neck area, and could not see where the other hand was. She also noted that Mr A has unpredictable behaviour and needs to be taken away from an area of accident immediately, as he will become a threat to himself or others.

55. The activities coordinator recalled that she was by the door of HDU and heard a loud bang. She then saw RN B holding Mr A from his collar at the back and pushing him to his room. She recalled: "I was facing both of them and I can clearly hear [Mr A] saying 'Listen to me mate'. He got pushed in, [Mr A's] feet appeared that toes was just on the ground and the door got shut."

56. In response to these statements, RN B noted that Ms C and the Activities Co-ordinator did not work in the HDU, and therefore may have been unaware of the de-escalation measures required for Mr A in the HDU. In relation to Ms D's statement, RN B noted that from the CCTV footage, she was behind him when he went from the nurses' station to Mr A, not several steps away from Mr A when he kicked the glass. RN B is unsure why Ms D did not hear him when he spoke to her, and said that he definitely did speak to her.

Outcome of the rest home company's investigation

57. Following the investigation, the rest home company dismissed RN B for serious misconduct, stating that he was negligent, failed to provide person-centred care, and breached his duty of care and responsibility.

Further information — rest home company

58. The rest home company told HDC that it considered that RN B used excessive and unreasonable force with Mr A.

[11] In a statement dated 17 May 2018.

59. The rest home company stated that the CCTV footage shows that the way in which RN B approached Mr A and physically moved him out of the lounge is not consistent with how it expects a resident to be escorted. The rest home company said that on reviewing the CCTV footage and following discussion with staff, it had identified that Mr A's demeanour was calm prior to and after breaking the glass door. The rest home company stated: "We have not found evidence that [Mr A] resisted [RN B's] approach prior to him reaching [Mr A] and grabbing his shirt."

60. The rest home company noted that the CCTV footage is a video only with no sound capacity, but said that Ms D had not reported having had any conversation with RN B. The rest home company stated that it had no evidence that any of the staff present during the incident identified that any other resident was agitated or aggressive. The rest home company noted that the CCTV footage provides a limited view of the other residents, but does not show any residents being agitated.

61. The rest home company noted that the CCTV footage indicates that there was very little time between Mr A breaking the glass and RN B reaching him and grabbing his shirt. The rest home company stated:

> "It is our view that the few seconds that passed would have been insufficient for [Mr A] to be reasonabl[y] considered to be ignoring [RN B's] request. It is our view that [Mr A] was not given sufficient time to respond."

62. The rest home company told HDC that techniques for management of Mr A's behaviours that challenge could include the staff members removing themselves or other residents from his vicinity, distracting him, escorting him away from the vicinity of others, or doing a range of such interventions.

63. As outlined above (paragraph 45), RN B told HDC that the best de-escalating technique was to escort Mr A to his room, but that even when Mr A had been escorted by two people, sometimes he had been resistant, in which case "it would unfortunately be necessary to hold him against his will to escort him to his room".

64. The rest home company stated that it does not agree with RN B that staff would use physical restraint holds on Mr A, and staff have advised that when Mr A's behaviour escalates to the point that he cannot be redirected, they remove people and furniture from Mr A's vicinity. The rest home company said that staff have advised that when Mr A's behaviour is escalated, trying to force him to do something that he does not want to do is a known trigger, which will result in further escalation and aggression from Mr A. The rest home company stated that the way in which RN B approached Mr A and the way he physically removed him out of the lounge is not consistent with how they expect a resident to be "escorted".

65. The rest home company noted that no information in Mr A's long-term care plan supports RN B's statement that Mr A would be likely to use broken glass as a weapon. RN B

acknowledged this, but noted that a hazard report from April 2016 described Mr A removing window panes.

66. The rest home company stated that all the staff present had had previous training and experience with working with residents with behaviours that challenge, and its investigation into the incident suggested that Mr A's behaviour had not escalated to an extent that the staff could not redirect him.

The rest home company — facility, policies, and training

Environment

67. RN B raised concerns about the staff-to-resident ratio and staffing levels at the HDU.

68. The rest home company stated that the staff-to-resident ratio in the HDU was 1:3. It said that staffing levels are consistent with its contractual requirements as set by the district health board.

69. The rest home company stated that the most recent HealthCERT audit found that a safe and appropriate environment was being provided for residents. The rest home company advised that the environment has not changed since the events in April 2018.

Guidelines and policies

70. RN B raised concerns that while the rest home company had policies in place, it did not have policies tailored to the HDU, and he considers that the lack of such policies compromised the safety of residents and staff.

71. The rest home company told HDC that it has policies and training packages that relate to calming and restraint, including behaviours that challenge, and dementia (effects and behaviours that challenge education package, facilitator guide, participation workshop). It does not have policies solely for the HDU or any of its other psychogeriatric units, and to date this has not been deemed necessary.

72. The rest home company's "Restraint" policy [current version at the time of events] outlined that restraint is used as a last resort to maintain the safety of the resident/client, staff, and others.

73. The rest home company's "Behaviours That Challenge" policy [current version at the time of events] provided the following:

> "**Preventing behaviours that challenge**
>
> *It is important to recognise that behaviours associated with dementia are not* ***bad***[12] *behaviour on the part of the person — these symptoms are often associated with chemical changes in the brain or by social and environmental triggers —* ***the behaviours are due to the dementia*** *…*

[12] Emphasis in original.

Responding to behaviours that challenge, an outburst of behaviour:

Key steps

- ***Firstly —*** *remove others from imminent harm. It's better that we ensure the dignity of the person displaying the behaviour by moving others out of the area (including visitors) if required …*

The main thing is to remain calm, speak in a quiet manner and use the person's name …

Respect the dignity and rights of the resident during and after the episode.

Try de-escalation techniques — ie diffuse the situation. Offer a cup of tea, take them outside, open the door, take them for a walk …

Major outbursts

Make others safe — remove them from the area …

Caregivers should seek assistance of the Registered Nurse if the resident doesn't start to respond to the soothing actions of staff …

Calm the situation, remove extra staff. If required give the resident some space — if they are safe and others aren't at risk there is no harm leaving them to settle — this may well defuse the situation …"

74. The rest home company stated that its Behaviours That Challenge policy advises that other residents are to be moved away from a resident who is becoming aggressive, and provides rationale for the advice. However, the document is a guideline rather than a policy, and it expects a registered nurse to use professional judgement to determine whether it is safer and more appropriate to move the resident who is showing signs of aggression, or to move the other people away from that resident. The rest home company stated that its concerns stemmed from how RN B interacted with and moved Mr A, who at the time was in a calm state.

75. In response to this, RN B maintained that staff had been directed by the Clinical Manager to remove Mr A when his behaviour deteriorated.

Education sessions

76. The rest home company stated that it has a national education programme schedule for all care homes that includes mandatory education sessions, optional education sessions, and competency assessments. Staff are expected to attend all mandatory education sessions, achieve the necessary level of competency, and attend additional sessions as required. The rest home company keeps records of staff attendance at education sessions.

77. The rest home company stated that RN B undertook regular restraint competency assessments throughout his employment, and the most recent before the incident concerned was completed on 6 February 2018. The rest home company said that RN B also

undertook education on behaviours that challenge, both as part of an in-service programme, and with external providers.

Reassessment

78. RN B said that he considered that Mr A needed the higher level of care offered by the district health board's [older persons and rehabilitation ward].

79. The rest home company stated that the main criteria for a resident to be admitted to the HDU is that the resident is not able to be managed in any dementia unit because of being aggressive to residents, family members, or staff. The rest home company suggested that it is common for aged-care residents to have multiple diagnoses, and stated that Mr A was assessed regularly by the mental health team with regard to his health, treatment plan, and ongoing care within the HDU.

80. The rest home company said that if concerns that a resident required reassessment of the level of care arose, typically the issue would be raised by the nurses involved in the resident's day-to-day care. Its expectation is that if a nurse is concerned that a resident is not at an appropriate level of care, the nurse will document the concerns and bring them to the attention of the Clinical Manager. The rest home company said that if the nurse is interRAI trained, it would expect the nurse to commence the 72 hours of data collection that is part of the reassessment process, and bring their concerns to the attention of the medical staff. The rest home company stated that RN B did not commence the interRAI reassessment process for Mr A, and there is no record that RN B documented or shared any concerns.

81. In response to this, RN B stated that he did bring his concerns about Mr A's behaviour and need for reassessment to the attention of the Clinical Manager. RN B said that he did not complete any interRAI reassessments for Mr A himself, as he was not Mr A's key worker or primary nurse.

Responses to provisional opinion

RN B

82. RN B was given an opportunity to comment on the provisional opinion, and advised that he accepted the findings and proposed recommendations.

Relevant standards

83. Standards New Zealand has produced standards for the Health and Disability sector.[13] The foreword to the *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards*[14] states:

> "The main intent of NZS 8134.2 is to reduce the use of restraint in all its forms and to encourage the use of least restrictive practices. It is crucial that providers recognise which interventions constitute restraint and how to ensure that, when practised, restraint occurs in a safe and respectful manner.
>
> Restraint should be perceived in the wider context of risk management. Restraint is a serious intervention that requires clinical rationale and oversight. It is not a treatment in itself, but is one of a number of strategies used by service providers to limit or eliminate a clinical risk. Restraint should only be used in the context of ensuring, maintaining, or enhancing the safety of the consumer, service providers, or others. All restraint policies, procedures, practices and training should be firmly grounded in this context."

84. The relevant standards are:

> "1 Services demonstrate that the use of restraint is actively minimised.
>
> 2.1 Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint and ongoing education on restraint use and this process is made known to service providers and others.
>
> 2.2 Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.
>
> 2.3 Services use restraint safely.
>
> 2.4 Services evaluate all episodes of restraint.
>
> 2.5 Services demonstrate the monitoring and quality review of their use of restraint."

85. The Standards New Zealand *Health and Disability Services (Core) Standards 8134.1:2008* state:

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[13] Standards New Zealand explains standards on its website as follows:

> "Standards are agreed specifications for products, processes, services, or performance.
>
> New Zealand Standards are developed by expert committees using a consensus-based process that facilitates public input.
>
> New Zealand Standards are used by a diverse range of organisations to enhance their products and services, improve safety and quality, meet industry best practice, and support trade into existing and new markets."

[14] NZS 8134.2:2008.

"1.3.7 Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect."

86. The Nursing Council of New Zealand *Code of Conduct for Nurses* (June 2012) states:

"Respect the dignity and individuality of health consumers

Standards

1.1 Respect the dignity of health consumers and treat them with kindness and consideration. Identify yourself and your role in their care.

1.2 Take steps to ensure the physical environment allows health consumers to maintain their privacy and dignity.

…

1.6 Practise in a way that respects difference and does not discriminate against those in your care on the basis of ethnicity, religion, gender, sexual orientation, political or other opinion, disability or age.

1.7 Do not prejudice the care you give because you believe a health consumer's behaviour contributed to their condition.

…

1.10 Take steps to minimise risk and ensure your care does not harm the health or safety of health consumers."

Opinion: RN B — breach

Introduction

87. RN B was the registered nurse on duty in the HDU at the rest home on 29 April 2018.

88. Mr A had been a resident in the HDU since 28 November 2012. Mr A's illness was characterised by episodes of agitation, in which he would exhibit verbal and physical aggression towards residents and staff.

89. As a healthcare provider, RN B had an obligation to provide services to Mr A that complied with the Code of Health and Disability Services Consumers' Rights (the Code). This included treating consumers with respect and providing services that complied with legal and ethical standards.

90. Mr A is subject to a Compulsory Treatment Order under the Mental Health (Compulsory Assessment and Treatment) Act 1992. This means that he can be treated without his consent,[15] and a person treating him can use "such force as is reasonably necessary in the

[15] Section 59 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

circumstances".[16] Any use of force must be consistent with relevant guidelines, policies, and procedures.

91. The core issue in this case is RN B's treatment of Mr A that day — specifically, whether RN B's response to Mr A's behaviour was appropriate, and whether he used reasonable force while he was escorting Mr A out of the room and down the corridor.

Incident on 29 April 2018

92. I have considered the evidence presented and have reached the following conclusions in relation to the events that occurred on 29 April 2018.

93. The events as recorded on the CCTV footage are that after Mr A broke a glass pane in a door by kicking it, RN B went over to Mr A, grabbed him by the back of his collar using his right hand, and pulled him away. RN B then pulled/pushed Mr A down the corridor away from the HDU lounge while still holding Mr A by the back of his collar.

94. As outlined above, initially RN B stated that Mr A was agitated, resistive, and yelling at him as he was removed from the HDU lounge. However, RN B acknowledged to the rest home company, and later to HDC, that Mr A was or appeared calm. Additionally, the CCTV footage and statements provided by other staff who were present at the time of the incident do not support that Mr A was agitated or resisting RN B's actions. I therefore consider it more likely than not that Mr A was neither agitated nor resisting RN B's actions.

95. RN B said that after Mr A kicked the window and broke it, he spoke to a caregiver and assessed Mr A to make sure he had not been injured by any of the shards of glass. RN B said that he found no blood or skin tears on Mr A's legs and he asked Mr A if he was injured or in pain, and Mr A responded that he was fine. RN B stated that Mr A began to swing his body, which was a warning sign that he was about to attack or provoke a fight. RN B said that he was concerned that Mr A might pick up some of the glass shards and use them as a weapon.

96. RN B stated that another male resident became agitated and began clapping his hands and making sarcastic comments. RN B said that he was concerned that Mr A and the resident would get into a fight, so he decided that the safest thing for the residents was for Mr A to go to his room as quickly as possible.

97. RN B stated that he asked Mr A three to four times to go to his room, but Mr A ignored him, and was refusing to go on his own to his room, so he took hold of Mr A's shirt "loosely in between his left and right scapula, as a safety measure, in case he bounced or lashed back". RN B said: "I then quickly escorted [Mr A] from the lounge to his bedroom. At this stage, he was still agitated, resistive and yelling at me."

98. I do not accept all of RN B's account, as it is not supported by the CCTV footage or the accounts of other staff who were present. It is apparent that RN B came into the lounge and almost immediately took hold of Mr A. There were approximately six seconds

[16] Section 122B(3) of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

between RN B leaving the nurses' station and grabbing hold of Mr A. In my view, it is implausible that in those six seconds, RN B spoke to a caregiver, assessed Mr A for injuries, asked Mr A if he was injured or in pain and Mr A responding that he was fine, Mr A beginning to swing his body, RN B considering another resident becoming agitated and deciding to remove Mr A, and RN B asking Mr A three to four times to go to his room and Mr A ignoring him.

99. In relation to RN B's account that another resident was agitated, the rest home company stated that it has no evidence that any of the staff present during the incident identified that any other resident was agitated or aggressive. The rest home company noted that the CCTV footage provides a limited view of the other residents, but does not show any residents being agitated. Given the evidence available, I am unable to make a finding as to whether another resident was behaving in this way.

100. RN B then pulled Mr A away and pushed him down the corridor to his room while retaining hold of his collar.

101. My expert advisor, RN Megan Sendall, stated:

> "Aggression is a common symptom exhibited in people with a mental health diagnosis and/or people with cognitive change who are assessed and require HDU care. It is managed primarily with compassionate support. Medication is used where indicated.
>
> Management of challenging symptoms of mental illness and/or cognitive change requires the provision of skilled care with a strong focus on identifying triggers related to problematic symptoms. De-escalation techniques are used to modify symptoms and manage residents in a group environment.
>
> Symptoms of aggression may be present as part of a complex condition affecting mood. These could include symptoms of cognitive change or present as a manifestation of altered reality. In a secure environment, it is expected that staff will de-escalate symptoms of aggression and diffuse the situation. Using non-threatening language and calm gentle behaviour is key. Leaving the resident to cool down is important. Not aggravating them further is another primary expectation."

102. As noted in the *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards*, restraint should be used only in the context of ensuring, maintaining, or enhancing the safety of the consumer, service providers, or others. Furthermore, the Health and Disability Services (Core) Standards place an obligation on providers to ensure that "[c]onsumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect".

103. I acknowledge that working with residents with dementia can be challenging. However, the use of unreasonable force is completely unacceptable — whatever the circumstances. Furthermore, there was a marked imbalance of power between Mr A, who is an elderly resident with longstanding mental health issues and dementia, and RN B, who is an experienced registered nurse. People such as Mr A can be particularly vulnerable to abuse,

and the fact that the person has dementia can make it harder to establish whether abuse is taking place, and by whom.

104. RN Sendall advised that several alternative courses of action could have been utilised, including calmly talking and supporting Mr A with any distress if present, calmly guiding/removing him from the communal space, or leaving him quietly if it appeared that he needed to refocus. RN Sendall advised that RN B reacted inappropriately. She considers that person-centred care was not provided in this instance, and that RN B's care was a significant departure from expected care.

105. I agree. In my view, RN B used unreasonable force while he was escorting Mr A out of the lounge to his room. RN B's actions were in direct conflict with the "Restraint" and "Behaviours That Challenge" policies and procedures promulgated by the rest home company. I note that RN B had received regular restraint competency assessments throughout his employment, and also had undertaken education on behaviours that challenge, both as part of an in-service programme and with external providers. His actions also contravened the Nursing Council's Code of Conduct for Nurses — to respect the dignity and individuality of health consumers.

Behaviours that Challenge Policy and direction by Clinical Manager

106. In relation to the "Behaviours That Challenge" policy directing staff to remove other residents rather than the individual displaying the behaviour, RN B submitted that he had been advised by the Clinical Manager to remove Mr A when his behaviour escalated, rather than to remove other residents. I note that the rest home company advised that managing Mr A's behaviour could include escorting him away from the vicinity of others, or undertaking a range of such interventions, and that nurses are expected to use their professional judgement to determine whether it is safer and more appropriate to remove the resident or to remove other people. I note RN Sendall's advice that one of the alternative courses of action was to calmly guide and remove Mr A from the communal space. I accept that escorting Mr A away or removing him was one of the options available to RN B.

107. However, I do not consider the Clinical Manager's direction to have suggested the manner in which RN B escorted Mr A and the use of force clearly used by RN B. In my opinion, alternative courses of action to manage Mr A's behaviour should have been utilised, as suggested by my expert advisor, the rest home company, and RN B himself. I note that RN B was a senior nurse in the HDU, and had considerable experience at the rest home.

108. I do not accept that RN B's actions were necessary to protect Mr A, staff, or other residents.

109. I note that subsequently RN B acknowledged that he should have given Mr A more time to respond to his request, and obtained assistance from another staff member, and that he has reflected and would not react in this way in future.

Policies

110. RN B also submitted that the policies in place were not tailored to the HDU, and he considers that not having such policies compromised the safety of residents and staff. RN Sendall advised that review of the policies that were available to RN B reflected that all documents were comprehensive, clear, up to date, and evidence based. She advised that the policies, documentation, and information provided to staff were suitable to the nature of care provision at the rest home, and also provided resources and references to best practice, alongside processes to guide staff in providing client-centred care.

111. I accept this advice, and consider that the rest home company had appropriate policies in place.

Conclusion

112. RN B's response to the situation was clearly inappropriate. To act in this way towards an elderly and vulnerable resident is a departure from fundamental ethical and legal standards, and is unacceptable. Accordingly, I find that RN B breached Right 4(2) of the Code. In my opinion, RN B's actions were disrespectful to Mr A, and therefore I find that RN B also breached Right 1(1) of the Code.

Other comment

113. Mr A had no family or friends to advocate on his behalf and, as such, he was especially vulnerable to abuse. The actions of the staff member who reported the incident to the rest home's management are to be commended. In addition, the rest home company acted promptly to enforce its expectation of person-centred care. I agree with RN Sendall's comments:

> "Policy developed by [the rest home company] reflected a requirement for staff to facilitate an open environment where concerns could be addressed professionally. The organisation acted promptly and appropriately to support and respect staff that came forward with concerns around the event involving [Mr A] ... The organisation acted prudently as an advocate for [Mr A] in respect to the event on 29 April 2018 and his diminished ability to respond to the event personally."

Recommendations

114. I recommend that RN B:

a) Formally apologise in writing to Mr A for the breaches of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

b) Arrange and attend training on de-escalation, restraint minimisation, and person-centred care. Evidence of the content and attendance is to be provided to HDC within five months of the date of this report.

115. I recommend that the Nursing Council of New Zealand consider whether a review of RN B's competence is warranted.

Follow-up actions

116. RN B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

117. A copy of this report with details identifying the parties removed, except the name of the expert who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN B's name.

118. A copy of this report with details identifying the parties removed, except the name of the expert who advised on this case, will be sent to HealthCERT and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

119. The Director of Proceedings decided to take disciplinary proceedings in the Health Practitioners Disciplinary Tribunal. In October 2021, the Tribunal found RN B was guilty of professional misconduct. RN B was censured, ordered to pay a fine, and had conditions placed on his practice including that he complete a Safe Practice Effective Communication course, and that for a period of 12 months he engage in monthly professional supervision.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Megan Sendall:

"[Rest home]

[Rest home owner]

Ref: C18HDC01346

Assessment of care provided to [Mr A] was conducted through review of requested documents and CTV footage supplied to the Office of the Health and Disability Commissioner by [the rest home].

Key areas for consideration relate to care provision, in particular actions taken following an event involving [Mr A] on 29 April 2018 in the facility's HDU where [Mr A] resided.

The expert advice provided is limited to comments related to two questions/ statements raised by the Commissioner's office:

1. [RN B's] actions in response to [Mr A's] behaviour on 29 April 2018

2. The adequacy of [the rest home company's] policies in relation to restraint and de-escalation.

For both questions/statements the following is also requested:

- What is the standard of care/expected practice?
- If there has been a departure from the expected standard of care or accepted practice, how would this be viewed by your peers?
- Recommendations for improvement that may help a similar situation occurring in the future.

The following is my response to the questions/statements.

1. [RN B's] actions in response to [Mr A's] behaviour on 29 April 2018

- What is the standard of care/expected practice?

Aggression is a common symptom exhibited in people with a mental health diagnosis and/or people with cognitive change who are assessed and require HDU care. It is managed primarily with compassionate support. Medication is used where indicated.

Management of challenging symptoms of mental illness and/or cognitive change requires the provision of skilled care with a strong focus on identifying triggers related to problematic symptoms. De-escalation techniques are used to modify symptoms and manage residents in a group environment.

Symptoms of aggression may be present as part of a complex condition affecting mood. These could include symptoms of cognitive change or present as a

manifestation of altered reality. In a secure environment, it is expected that staff will de-escalate symptoms of aggression and diffuse the situation. Using non-threatening language and calm gentle behaviour is a key. Leaving the resident to cool down is important. Not aggravating them further another primary expectation. Leaving personal cares until residents are more likely to cooperate is advised. Ensuring alternatives are provided, for example showering at a more settled time of the day, offering food alternatives or diverting attention when triggers are identified is required.

The personality of HDU staff alongside their key knowledge and skills is an important factor in providing care in a group HDU environment. The manner in which staff approach residents may be a catalyst for a service user's subsequent behaviour. Confrontational interactions are never supported by the industry as a whole. Guidelines for restraint include using restraint as a last resort.

[The rest home company's] documentation identified [Mr A] had a history of aggressive behaviour/symptoms. Many people with a long history of mental health issues have experienced inpatient care a number of times. They may bring with them past behaviours/symptoms that have initiated their entry to service to a secure setting. Past experiences can influence their current behaviours in particular experiences around negative care or treatment and include feelings of loss of liberty.

Staff were required to manage [Mr A's] aggression to include a focus on safety and respectful care. This is in keeping with [the rest home company's] policies, procedures, code of conduct and adherence to the Resident Code of Rights. Person centred care is at the heart of [the rest home company's] documents and training provided to staff. The ethos of the organisation requires all decisions related to a resident's care and well-being to be made in the person's best interest at all times.

[RN B] was employed for 7 years in the organisation prior to the event with [Mr A] on 29 April 2018 and had been promoted to team leader in the HDU during that time. He had been involved in staff training and exposed to experiences that provided him with opportunities for professional growth. In particular experiences related to the care of people with cognitive change.

In his position as RN and as team leader, he was required to model safe, gentle care in keeping with [the rest home company's] values, philosophies and policies. He was clearly required to provide patient centred care at all times.

On April 29 2018, [RN B] did not meet the organisation's expectations regarding professional practice during the witnessed event that occurred with [Mr A]. Although [Mr A] had used force to break glass and remained in the immediate area, he was described by other staff as calm following the event. *CTV footage confirmed staff testimony.*

[RN B] chose to use physical force to remove [Mr A], when the resident presented as calm. He was described as using force spontaneously without considering alternatives. These could have included:

1. calmly and compassionately talking and supporting him with any distress if present
2. calmly guiding/removing [Mr A] from the communal space to his room, guiding and supporting him with gentle words
3. working with him to ascertain any precipitating factors/trigger for his action
4. leaving him quietly if it appeared, he needed to refocus.

I have read [RN B's] rationale in the statement provided by him, that [Mr A] could be reactive and aggressive and therefore to avoid this behaviour he chose to remove him forcibly on that basis. It is my belief that his actions could have triggered further distress by doing this.

Restraint practice is an option if the safety of the resident is in question or the safety of those around him/her. In this case it was not an immediate issue even though glass was broken and other residents were nearby. [Mr A] was observed by others to be calm at the time of being removed to his room.

- <u>If there has been a departure from the expected standard of care or accepted practice, how significant a departure do you consider this to be?</u>

[RN B] departed from the expected standard of care by not following the organisation's policies and procedures relating to respectful person-centred care. In particular he failed to follow the restraint policy. He did not meet the requirements of the Resident Code of Rights and used force in a situation that did not, in my opinion require it.

How this would be viewed by your peers?

I believe my peers would view this as using force to manage a challenging situation when alternative actions should have been employed. Person centred care was not provided in this instance.

There are many challenging symptoms of advanced mental illness and cognitive change that occur regularly in HDUs. These present staff with opportunities to treat residents like [Mr A] with gentle respectful care. Leaving people to cool down and taking time to listen are strategies that are most often utilised. Alongside these strategies, setting boundaries for behaviours, guiding and talking through appropriate responses are also used. The challenges are many and frequent in this level of care and require staff to maintain professional judgement and competency around parameters for restraint.

During this event [RN B] made a significant departure from expected care.

- Recommendations for improvement that may help a similar situation occurring in the future.

I believe [the rest home company] provided staff with training, orientation, competency development, documentation, supervision and accountabilities to meet industry expectations, and requirements of the District Health Board contract and Health and Disability Sector Standards.

Policy developed by [the rest home company] reflected a requirement for staff to facilitate an open environment where concerns could be addressed professionally. The organisation acted promptly and appropriately to support and respect staff that came forward with concerns around the event involving [Mr A]. They maintained confidentiality throughout the process of investigation. [The rest home company] followed sound human resource processes and offered support to [RN B] through EAP. I believe they acted with concern for resident safety, and the standard of care and professionalism provided by team leader [RN B] on 29 April 2018. The organisation acted prudently as an advocate for [Mr A] in respect to the event on 29 April 2018 and his diminished ability to respond to the event personally.

I have not identified any recommendations for improvement for [the rest home and the rest home company].

2. The adequacy of [the rest home company's] policies in relation to restraint and de-escalation.

- <u>What is the standard of care/expected practice?</u>

Any organisation providing older persons services, in particular services provided to older people with cognitive change and/or mental health diagnoses, are required to provide a suite of policies and documents to support safe appropriate care. These should reflect the residents' reduced ability to provide consent. Policy should also reference the complexity of symptoms of cognitive change that impacts residents' ability to self-manage and report issues.

Review of policies and documents provided by [the rest home company] available to [RN B], reflected all documents were comprehensive, clear, up to date and evidence based. Documents provided included training material internally used to manage challenging symptoms of dementia and mental illness. De-escalation training documents were appropriate, clear and easy to follow. In my opinion the volume of training activities is appropriate to the setting and provide staff with relevant information to provide person centred care. Oversight and monitoring related to training adherence of specialised/appropriate skills, modelling and supervision, all contribute to safe care. Continued knowledge and skill development for staff related to restraint and de-escalation is required. It is concluded that [the rest home] provided ongoing appropriate support following staff orientation, professional development and training.

- <u>If there has been a departure from the expected standard of care or accepted practice, how significant a departure do you consider this to be?</u>

I believe [the rest home company] provided policies, documentation and information to staff suitable to the nature of care provision at [the rest home]. They also provide resources, referenced to best practice alongside processes to guide staff in providing client centred care.

I do not believe [the rest home company] has departed from the expected standard of care or practice in this case. However, an individual RN, employed by [the rest home] did not meet the organisation's expectations and level of professionalism when making a critical decision responding to a resident with symptoms of mental illness/cognitive change.

- <u>How this would be viewed by your peers?</u>

I believe resources, documents and policies provided by [the rest home and the rest home company] meet industry expectations and those of my peers working in this area of care.

- <u>Recommendations for improvement that may help a similar situation occurring in the future.</u>

I have no recommendations for improvement regarding policy provision in relation to restraint and de-escalation in [the rest home and the rest home company].

Signed

M. Sendall

Megan Sendall RN"

The following further advice was received from RN Sendall:

"Additional advice regarding the care and treatment of [Mr A] 29.4.18.

I have read and reviewed the following documents provided by the Office of the Health and Disability Commissioner related to the complaint C18HDC01346:

1. Second statement of [RN B]
2. Response from [the rest home company]
3. Response from [an NZNO lawyer] on behalf of [RN B]

In response to [an NZNO lawyer's] document outlining 'significant concern':

- *'she (Megan Sendall) appears to have had little regard to the seriousness of the situation'*
- *'there is no consideration of just how high the need of the residents were'*

- *'alternatives were not appropriate in the situation'*

I offer the following:

I have 40 years' experience as a nurse. The last 20 years have been dedicated to primary health, in particular Aged Residential Care (ARC). I have depth and breadth of experience in health education, RN professional development, clinical services related to ARC and in particular psychogeriatric (PG) care. I have held both District Health Board (DHB) and primary health ARC/dementia related advisory roles. I currently hold three separate health related roles that influence my findings around the care provided to [Mr A].

In my role as Clinical Advisor, formally Clinical Director for an organisation providing aged care services across five DHBs, I provide clinical expertise for a range of secure dementia services including nine separate secure psychogeriatric (PG) level facilities. Three of these facilities are the only service providing PG care in their region/DHB.

The role requires me to manage complex admissions from both Mental Health (MH) and DHB inpatient units into PG level care. I advise into both DHBs, and the provider arm regarding appropriate entry to service and the management of people with complex conditions. Many issues I manage relate to appropriate care and treatment, the use of restraint and the management of extreme symptoms of cognitive change. I am responsible for managing restraint levels in the organisation and lead clinical governance as part of a wider quality system to respond to any trends or issues. I work with and provide direction to staff regarding restraint. This includes the outcomes of inappropriate restraint. I remain updated on national and international restraint and seclusion trends.

In a second current role as lead DHB auditor, I am involved in hospital and rest home certification. This includes reviewing the care provided to people with cognitive change and those with a mental health diagnosis in both hospital and community settings. This extends to forensic units. I understand the Ministry of Health goals for zero seclusion in 2020 and the international trends regarding minimal or no use of restraint. I have knowledge and understanding related to the growing international trend related to upholding human rights for people with diminished capacity.

I have contributed to national reviews of the pharmacological management of people with a Dementia diagnosis. I also contribute to local and national projects related to anti-psychotic medication reduction in PG facilities. I currently monitor the use of antipsychotics across nine facilities. I have written and sponsor an antipsychotic project for ARC.

[RN B] explained the high needs of the residents in his care at [the rest home]. PG services represent the highest need required for Dementia related services in ARC. Secure PG facilities are monitored closely by each DHB due to the low bed numbers, specialised care required and high cost of service provision. Psychogeriatric physicians,

clinical nurse specialists and others, support the provision of care, treatment and management of symptoms of these frail and unwell residents. The day to day complexities related to interactions between residents are managed routinely as part of normal service provision.

There are times when residents require re-assessment. It may be that their symptoms are problematic in terms of safety for themselves and others. In these cases, residents can return to DHB services for a higher level of specialist medical and nursing input. Following review, they are routinely returned to community facilities to live in home like communal situations. Provider relationships with community MH teams, inpatient MH units and DHB Older Persons services are important to support the management of these residents in the short and long term.

In my experience, the situation highlighted in the event with [Mr A] is not uncommon in New Zealand (NZ) PG facilities. Systems and processes are designed in PG services to minimise the risk of these events happening. There are many people requiring close attention and care to divert unwanted symptoms at any given time. RNs lead service provision to provide direction and delegation for health care assistants and others. Should problematic symptoms present it is the RN's responsibility in the first instance, to trigger a resident reassessment or to work with a GP or DHB specialists to reduce the symptoms. There are a wide range of strategies utilised to influence the reduction of these symptoms other than pharmacological responses.

[RN B] referred in his second statement to the restraint policy provided by [the rest home]. My reference to the policy not being followed by [RN B] refers to the CTV footage when no de-escalation strategies were employed prior to [RN B] restraining [Mr A]. De-escalation strategies are documented in the policy to guide staff in managing such events. Restraint is used as a last resort after all attempts to de-escalate are completed. All restraint policies in NZ must meet the Health and Disability Sector Standard requirements. In this case [the rest home company] has completed third party review in the form of Designated Audit Agency audits as directed by the Ministry of Health. The restraint policy used by [the rest home] was fit for purpose at the time of the event. [RN B] failed to follow the Restraint Policy.

Therefore, in response to the recent documentation provided to me, including [RN B's] latest statement, and considering the information presented by the provider, I maintain the belief that alternative management of the situation involving [Mr A] on April 29 2018 should have been undertaken. My belief remains that [RN B] reacted inappropriately. I believe the organisation, [the rest home company] provide[s] policies, guidelines, mentoring and education in keeping with national requirements. Additionally, it is my belief that they acted prudently regarding the management of this issue to protect [Mr A] and potentially others from receiving inappropriate care.

Yours sincerely,

Megan Sendall RN"