Registered Nurse, RN B
Mental Health Facility

A Report by the
Mental Health Commissioner

(Case 19HDC00276)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a man by a registered nurse at a residential mental health facility. The report highlights the importance of performing adequate checks on consumers and maintaining accurate documentation.

2. The nurse was rostered to work an overnight shift, from 11pm until 7am the following morning. As part of his overnight duties, he was to perform three site checks, to ensure that residents were on site during the night.

3. At the time of these events the facility had a list of "Awake night shift" duties for staff to complete when working overnight. The duties included three site checks where staff were required to check that residents were on site during the night.

4. The nurse performed the three site checks at 12.00am, 3.00am, and 6.00am. During the 3.00am check, the nurse did not want to disturb the man by going into his room, and so he performed the check by looking through the bedroom window through a gap in the closed curtains. He thought he could see the man sleeping, as there was a lump in his bed.

5. When the nurse performed the 6.00am check, it appeared that someone was still sleeping in the bed. However, when the nurse entered the room and pulled back the covers, the man was not there. At 7am that day, the man was found deceased off site.

Findings

6. The Mental Health Commissioner was highly critical that the nurse omitted to perform the man's 3.00am check adequately, and failed to sight the man physically. The Mental Health Commissioner found the nurse in breach of Right 4(1) of the Code.

7. The Mental Health Commissioner noted that on three separate occasions on the shift in question, the nurse provided inaccurate information in relation to the man — contradictory documentation regarding his night medications, documentation that the man was asleep at 12.00am when he was awake, and documentation that the man was asleep at 3.00pm despite not sighting him physically. The Mental Health Commissioner considered these documentation deficiencies to be unacceptable, and found the nurse in breach of Right 4(2) of the Code.

8. At the time of events, the nurse — an experienced registered nurse who concurrently had other jobs working as a mental health practitioner — had been a casual employee of the facility for over three years. The Mental Health Commissioner considered that the nurse had been made aware of his duties but failed to perform them adequately. Accordingly, the Mental Health Commissioner found that the facility did not breach the Code.

Recommendations

9. The Mental Health Commissioner recommended that the nurse undertake training relevant to the issues raised in this case, organise for an experienced nurse to carry out a review of his documentation, and provide the man's family with a written apology.

10. The Mental Health Commissioner recommended that the facility update its "Awake night shift" duties to include the need to sight the resident physically during the site security checks.

11. The Mental Health Commissioner also recommended that the Nursing Council of New Zealand consider whether a competency review of the nurse is warranted.

Complaint and investigation

12. The Health and Disability Commissioner (HDC) received a complaint, referred from the Nursing Council of New Zealand, about RN B. The following issues were identified for investigation:

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

13. This report is the opinion of Kevin Allan, Mental Health Commissioner, and is made in accordance with the power delegated to him by the Commissioner.

14. The parties directly involved in the investigation were:

Mr A's family	Complainants
RN B	Registered nurse/provider
Mental health facility/provider	

15. Independent expert advice was obtained from mental health nurse Dr Anthony O'Brien (Appendix A).

Information gathered during investigation

Background

16. Mr A (in his twenties at the time of these events) had a long-standing mental health history including paranoid schizophrenia and psychosis in the context of cannabis and synthetic cannabis use, with his first psychotic episode occurring in his late teens.

17. Mr A had been residing at supported accommodation since 2017, under a court-ordered compulsory community treatment order pursuant to section 29 of the Mental Health Compulsory Assessment and Treatment Act 1992.

18. The facility is a high and complex needs residential service, and is designed to provide community-based recovery and rehabilitation. This involves facilitating a process where

clients determine the aspects of their life they want to change, and the staff support the client to learn and develop the knowledge, skills, and resources to make those changes. The facility told HDC that the service therefore allows clients to have a high degree of autonomy.

19. RN B had been a casual employee of the facility since 2015, whilst working concurrently as a mental health nurse for another community-based service. Subsequently, in 2016 RN B became a full-time employee at a district health board mental health service, but he continued to work casually at the facility, and usually would work one or two afternoon or night shifts per week.

20. This report concerns the care provided to Mr A by RN B on an overnight shift in 2018.

Day 1[1] overnight shift

21. RN B was rostered to work the overnight shift on Day 1, starting at 11.00pm and ending at 7.00am the following morning.

22. At the time of these events, the facility had a list of "Awake night shift" duties for staff to complete when working overnight. The duties included three site checks, where staff were required to check that residents were on site during the night. The duties were listed as:

"**2245HRS–2315HRS**	—	Handover
2315HRS–0000HRS	—	Reading Notes and Emails
0000HRS	—	First Site Security Check to be Completed
	—	Documentation of First Site Security Check to be Completed
0000HRS–03000HRS	—	Staff are to complete the Cleaning Tasks on the Cleaning Schedule
0300HRS	—	Second Site Security Check to be Completed
	—	Documentation of Second Site Security Check to be Completed
0300HRS–0600HRS	—	Staff are to complete the Cleaning Tasks on the Cleaning Schedule
0600HRS	—	Final Site Security Check to be Completed
	—	Documentation of Final Site Security Check to be Completed"

23. RN B told HDC that at handover on that evening, he was informed that there were no concerns about Mr A's mental state, behaviour, or physical health, other than that he had refused his medications at 9.15pm. RN B stated that as there were no concerns, Mr A was not required to have regular night checks outside of the usual three site checks at 12.00am, 3.00am, and 6.00am.

[1] Relevant dates are referred to as Days 1–2 to protect privacy.

Night medications

24. RN B stated that during handover, Mr A came into the office and asked for his medication that he had not taken earlier. RN B said that he gave Mr A his night medications at approximately 11.30pm, and Mr A left the office at about 11.35pm and returned to his residence.

25. RN B documented in Mr A's medication chart that the medications were given at 11.30pm, but he documented in the progress notes that they were given at 11.15pm. RN B told HDC that when he was documenting the medication given in the progress notes at the end of his shift, he did not refer back to his initial documentation on the medication chart. As a result, he wrote 11.15pm in the progress notes instead of 11.30pm.

12.00am site check

26. Mr A's first site check was scheduled for 12.00am. RN B stated that at this check he went into Mr A's bedroom and said goodnight to him, and Mr A said goodnight back. RN B said that he also checked the oven in Mr A's kitchen, which was off, as part of the routine safety check that was required to be completed on the first check of the nightshift.

27. RN B documented in Mr A's progress notes: "0000hrs — asleep in bed." RN B stated that he documented that Mr A was asleep because although Mr A did say goodnight, he said it in such a way that RN B could tell that he was drifting off to sleep.

3.00am site check

28. RN B performed his next check on Mr A at 3.00am. RN B stated that as it was 3.00am, and Mr A had had his medications later than usual, he did not want to disturb him by going into his room. RN B noted that the bedroom light was on in Mr A's residence, and stated that Mr A preferred to sleep with the lights on. RN B therefore went up onto the veranda and looked through the bedroom window.

29. In a statement to the Coroner's office, RN B explained that he was able to look through the window because there was a gap in the closed curtains. He stated: "Through the window, I thought I could see that [Mr A] was asleep in his bed, as I could see a lump in his bed which looked like he was lying under the covers."

30. RN B documented this check in the progress notes as: "0300hrs — asleep in bed."

31. In a subsequent meeting between RN B and the facility, it was documented:

> "[RN B] reports that he's culturally sensitive in terms of 'disturbing residents in their sleep', states if there's been 'no movement' i.e. lights turned on in the resident home then he assumes they are asleep. He states he didn't do the 'full check' at 0300 hours i.e. go into resident room and physically check as per 1200 and 0600hours. Instead he checked 'outside' resident houses and noticed no movements or changes to room doors and assumed all residents were in their rooms."

32. RN B acknowledged that, in hindsight, he should have gone into Mr A's bedroom to check on him at 3.00am.

6.00am site check

33. RN B performed his next check on Mr A at 6.00am. RN B reported to the facility that when he performed this check, he peered in through the outside window from the front veranda and saw that the bed looked as if someone was still sleeping in it. However, he noticed that the room door was open at this time, and it had been shut during his 12.00am check. RN B could not confirm whether the door was open or closed at 3.00am.

34. RN B stated that he entered Mr A's room to investigate, pulled back the covers, and found that Mr A was not in bed. RN B said that he was not concerned by this, as Mr A often got up early to wander around the grounds.

35. The facility's subsequent incident report also noted that being out of bed at 6.00am was not unusual behaviour for Mr A. The facility stated:

> "This is not unusual for residents to come and go on site as [the facility] is not a 'lock-up type service', set up to help patients prepare for independent living with their family or friends in the community. [Mr A] had not been present early in the morning several times before."

36. RN B documented the overnight shift in Mr A's progress notes as:

> "[Mr A] had nocte [night] meds around 2315hrs, 0000hrs — asleep in bed, 0300 asleep in bed, he was offsite during 0600hrs check but other than that he had a settled night shift, nil issues."

37. RN B then performed handover to the oncoming day staff, and went home at approximately 7.10am.

Subsequent events

38. At 7am on Day 2, Mr A was found deceased off site.

39. The facility commenced an internal investigation into the incident the same day, and found that on entering Mr A's room, it appeared that he had left his room with his bed "semi-made" to make it look as if someone was in the bed.

40. Upon learning of Mr A's death, RN B informed the facility that his night check notes from Day 2 were not accurate. RN B was stood down until a subsequent meeting was held, in which he explained that he did not perform a full check at 0300 hours. During this meeting, it was noted that RN B was aware that residents had been known to slip out the back door during the night without staff being aware, as they see only the front door from the main office, hence the reason for vigilance in ensuring that the night checks are thorough. The meeting notes document:

> "[RN B] acknowledges there's a possibility that [Mr A] may not have been on site at 0300hrs and takes full responsibility for his negligence of not conducting a full room check as per policy."

41. The facility's internal investigation concluded:

> "The findings are that [Mr A passed away in the morning]. Staff responded in accordance with policy by contacting appropriate people in a timely manner and support has been put in place for all affected parties. Additionally, it has been confirmed that [RN B] has inaccurately reported an overnight check where he did not complete the check in line with the service practice."

42. RN B's casual contract with the facility was terminated.

Further information

RN B

43. RN B told HDC that his understanding of what was to occur when a check on a client was performed during an overnight shift, was that these checks required staff to sight the client when they were on site in their residence. However, he stated that he was not aware of a policy, and no one ever informed him that these checks required him to go into the room if he could sight the resident in other ways such as through a window.

44. RN B told HDC that he wishes to offer his "heartfelt and sincere condolences to [Mr A's] family for their loss and the grief they have gone through", and to offer his apologies for the part that he had to play.

45. RN B said that since this incident, he has reflected a lot about what happened and how he can change his practice so that something like this does not happen in the future. He stated that he now realises how important it is to go into the room and physically check on the resident, in case they have staged the room to make it look as if they are in the room, when they are not.

46. In terms of his documentation, RN B stated: "I now make sure I check all my documentation to ensure it is accurate and that it does not conflict with other documentation I have completed."

The facility

47. The facility told HDC that unfortunately there were no signs to indicate that Mr A was experiencing any suicidal ideation, and noted that a mental health assessment carried out one week prior to his death had indicated that he was a low risk to himself or others. The facility stated that the notes preceding Day 2 also indicate that there were no issues with low mood or depression, or anything that suggested that Mr A posed a risk to himself.

48. The facility told HDC that it had made RN B aware of his duties, and stated:

> "We do stand by the fact that we provided [RN B] with ample guidance and clarity around his duties and this was a straightforward task. Particularly for someone who had been a registered nurse for 4 years."

49. The facility noted that RN B did not sight Mr A, and that is the fundamental issue with the 0300 check he performed. The facility stated that RN B saw a shape on the bed through

the window, but he did not see any part of Mr A, and this "clearly and undeniably does not constitute *sighting the person*".

50. The facility told HDC that following these events, it incorporated the issues of risk assessment when there are no obvious signs of self-harm or suicidal ideation into an organisational project focusing on support for service users at various stages of their recovery. It has also employed an Alcohol and Other Drug Counsellor and implemented an Alcohol and Other Drug specific psycho-education group.

Responses to provisional opinion

51. Mr A's mother was provided with an opportunity to comment on the "information gathered" section of the provisional decision. Where appropriate, her comments have been incorporated into this report.

52. RN B was provided with an opportunity to comment on the provisional opinion, and advised that he accepts the decision to find him in breach of the Code.

53. The facility was provided with an opportunity to comment on the provisional opinion, and advised that it is in full agreement with the report and, as such, had no further comments to make.

Relevant standards

54. The New Zealand Nurses Organisation Standards of Professional Nursing Practice (NZNO Standards of Practice) states:

> "Nurses are responsible and accountable for their practice.
>
> Nurses:
>
> …
>
> 1.4: provide documentation that meets legal requirements, is consistent, effective, timely, accurate and appropriate;"

55. The Nursing Council of New Zealand (Nursing Council) Code of Conduct for Nurses (Nursing Code of Conduct) states:

> "**Principle 4**
>
> Maintain health consumer trust by providing safe and competent care
>
> **Standards**
>
> …
>
> 4.8 Keep clear and accurate records …"

56. The Nursing Council Competencies for Registered Nurses (Nursing Council Competencies) include the following:

> "**Competency 1.1**
>
> …
>
> Indicator: Demonstrates knowledge of, and accesses, policies and procedural guidelines that have implications for practice.
>
> …
>
> **Competency 2.3**
>
> …
>
> **Indicator:** Maintains clear, concise, timely, accurate and current health consumer records within a legal and ethical framework.
>
> Indicator: Demonstrates literacy and computer skills necessary to record, enter, store, retrieve and organise data essential for care delivery."

Opinion: RN B — breach

Introduction

57. RN B was rostered to work the overnight shift, starting at 11.00pm and ending at 7.00am the following morning. As part of his shift duties, RN B was required to perform three security checks to ensure that residents — such as Mr A — were on site during the night. In addition, he was required to document these checks. RN B admitted that he did not complete the full check at 3.00am.

58. Mr A was found off site at 7am, deceased by apparent suicide. On examination of his room, it appeared that he had left his bed "semi-made" to make it look as if someone was in the bed.

59. As a healthcare provider, it was RN B's responsibility to ensure that he provided Mr A with services in accordance with the Code of Health and Disability Services Consumers' Rights (the Code). RN B's check of Mr A was suboptimal, and I have also found issues with his documentation. In my view, RN B failed to provide care to Mr A with reasonable care and skill, and did not adhere to professional standards.

Inadequate check at 3.00am

60. At 3.00am, RN B performed a site check on Mr A. However, RN B did not go into Mr A's room as he did not want to disturb him, and instead checked on Mr A through the bedroom window. RN B stated: "Through the window, I thought I could see that [Mr A] was asleep in his bed, as I could see a lump in his bed which looked like he was lying under the covers."

61. RN B confirmed that his understanding of an overnight check is that the staff were required to sight the clients in their residence when they were on site. However, he stated that no one ever informed him that the checks required him to go into the room if he was able to sight the resident in other ways such as through a window. My expert nursing advisor, Dr Anthony O'Brien, advised:

> "It is my opinion that a registered nurse should not have to be specifically informed of this. An employer could reasonably expect that an observation meant that the consumer had been physically sighted."

62. In a meeting between the facility and RN B subsequent to these events, it was documented:

> "[RN B] acknowledges there's a possibility that [Mr A] may not have been on site at 0300hrs and takes full responsibility for his negligence of not conducting a full room check as per policy."

63. RN B also acknowledged to HDC that he was aware that during an overnight check, staff were required to sight clients when they were on site in their residence. RN B stated that he now realises how important it is to go into the room and physically check on residents, in case they have staged the room to make it look as if they are in the room, when they are not.

64. Dr O'Brien advised:

> "The standard of expected practice is that clients should be physically sighted at each scheduled check. An indirect sighting (for example of a 'lump' in a bed, observed through a window) is not an adequate check and does not meet the expected standard. It is not at all uncommon for clients to arrange their bedding to give the impression they are present, when they are not. Failure to physically sight a client may mean that their absence goes unnoticed, and attempts are not made to locate them. In some circumstances this could lead to suicide."

65. Dr O'Brien considers that RN B's failure to sight Mr A physically at the 3.00am check constituted a severe departure from the accepted standard of care.

66. I agree with this advice. Regardless of whether or not the check required him to go inside the room, it is clear that RN B was aware of the need to sight Mr A physically, which he did not do at the 3.00am check, and instead relied on a lump under the covers as evidence of Mr A's presence. As a consequence of RN B's failure it was not possible to ascertain whether Mr A was present in his room at 3.00am. Had Mr A been discovered out of his room at 3.00am, staff members would have been alerted to the situation and may have been able to locate him earlier.

67. In the context of a high and complex needs mental health service, checks are required to ensure that the residents are safe. It is therefore vital that residents are sighted physically to confirm their safety, and that these checks are performed adequately. I am highly

critical that RN B omitted to perform Mr A's 3.00am check adequately, and therefore failed to provide Mr A with services with reasonable care and skill. I therefore find RN B in breach of Right 4(1)[2] of the Code.

Documentation

68. RN B administered Mr A his night medications at 11.30pm, and documented this in Mr A's medication chart. However, in Mr A's progress notes, RN B documented that the medications were given at 11.15pm. RN B told HDC that this error occurred because he did not refer back to the medication chart when he completed the progress notes at the end of his shift.

69. As per the facility's "Awake night duties", RN B documented each site security check he performed during his shift. After the first site security check of Mr A, RN B documented, "0000hrs — asleep in bed", despite Mr A being awake and responsive to RN B at this time. RN B stated that he documented that Mr A was asleep because although Mr A did say goodnight, he said it in such a way that RN B could tell that he was drifting off to sleep.

70. After RN B's second site security check of Mr A, he documented that Mr A was "asleep in bed" at 3.00am despite not physically sighting Mr A and therefore confirming this. RN B stated: "Through the window, I thought I could see that Mr A was asleep in his bed, as I could see a lump in his bed which looked like he was lying under the covers."

71. Dr O'Brien advised that clinical documentation and recorded observations should provide an accurate and reliable record of nursing care provided. He stated that nurses and other clinicians should have confidence that what is recorded in the clinical notes is exactly what took place, not an approximation. He advised:

> "I believe that in respect of the inaccurate recording of the 0300 check … RN B's practice represents a severe departure from the expected standard. In relation to the recording of the 0000 check and the timing of medication given around 2330hrs RN B's practice represents a mild departure from the expected standard."

72. I accept this advice. In addition, the Nursing Council of New Zealand Code of Conduct for Nurses states that nurses must "[k]eep clear and accurate records". Furthermore, the New Zealand Nurses Organisation Standards of Professional Nursing Practice states that nurses must "provide documentation that meets legal requirements, is consistent, effective, timely, accurate and appropriate".

73. It is clear that RN B's documentation for the overnight shift on Day 1–Day 2 contravened the above guidelines, and was neither accurate nor appropriate. On three separate occasions on this shift, RN B did not meet acceptable standards and provided inaccurate information in relation to Mr A:

- Contradictory documentation regarding Mr A's night medications;

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

- Documentation that Mr A was asleep at 12.00am when he was awake; and
- Documentation that Mr A was asleep at 3.00pm despite not sighting him physically.

74. In my view, these documentation deficiencies are unacceptable. The importance of the clinical record is well established, and I am critical of RN B's inaccurate documentation and failure to adhere to the documentation standards set out for nurses. Accordingly, I find that RN B breached Right 4(2)[3] of the Code.

Opinion: Mental health facility — no breach

75. As a health service provider, the facility was responsible for providing services in accordance with the Code. In this case, I consider that the errors that occurred were individual failures, and did not indicate broader systems or organisational issues.

76. At the time of these events, RN B — an experienced registered nurse who concurrently had other jobs working as a mental health practitioner — had been a casual employee of the facility for over three years. RN B told HDC that whilst he was not aware that he was required to go into a client's room if it was possible to sight the resident in other ways such as through a window, he acknowledged that he was aware of the requirement to physically sight the client during the security checks. He acknowledged that, in hindsight, he should have gone into Mr A's bedroom to check on him at 3.00am. The facility told HDC that it had made RN B aware of his duties, and stated:

> "We do stand by the fact that we provided [RN B] with ample guidance and clarity around his duties and this was a straightforward task. Particularly for someone who had been a registered nurse for 4 years."

77. Dr O'Brien considers that registered nurses should not have to be informed specifically that they have to go into a resident's room in order to perform an observation, and that an employer could reasonably expect that an observation meant that the consumer had been sighted physically. He advised that he does not have any concerns about the service provided by the facility, and stated:

> "I believe [the facility] had sound policies in place at the time of this incident. There was ample guidance available to [RN B]. The required practice is very straightforward, and apparently understood by [RN B]."

78. I accept this advice. It is clear from his responses to both the facility and HDC that RN B was made aware of his duties, and that he failed to perform them adequately on the morning of Day 2.

79. Accordingly, I find that the facility did not breach the Code.

[3] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards."

80. However, I note that the "Awake night shift" duties list does not state explicitly that the resident must be sighted physically during the site security check, and I have recommended that this list be updated accordingly.

Recommendations

81. I recommend that RN B:

a) Participate in a course/training relevant to the issues raised in this case (documentation and resident checks), and provide HDC with his reflections and learnings from the course/training and this complaint, within three months of the date of this report.

b) Organise for an experienced nurse to carry out a review of his documentation, over a three-week period, and report on the adequacy of the documentation. Evidence that this has been done, as well as the outcome of the review, is to be sent to HDC within three months of the date of this report.

c) Provide Mr A's family with a written apology 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.

82. I recommend that the facility update its "Awake night shift" duties to include the need to sight the resident physically during the site security checks. Evidence that this has been done is to be provided to HDC within two months of the date of this report.

83. I recommend that the Nursing Council of New Zealand consider whether a competency review of RN B is warranted.

Follow-up actions

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

85. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Nursing Council of New Zealand and the district health board, and they will be advised of RN B's name. The district health board will also be advised of the name of the facility.

86. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Director of Mental Health, the New Zealand College of Mental Health Nurses/Te Ao Māramatanga, and the Mental Health Foundation, 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 Anthony O'Brien:

"Report prepared by Anthony O'Brien, RN, PhD, FANZCMHN

Preamble
I have been asked by the Commissioner to provide expert advice on case number C19HDC00276. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Qualifications
I qualified as a registered male nurse in in 1977 (later changed to registered general nurse) and as a registered psychiatric nurse in 1982. I hold a Bachelor of Arts (Education) (Massey, 1996), a Master of Philosophy (Nursing) (Massey, 2003) and a Doctor of Philosophy in Psychiatry (Auckland, 2014). I am a past President and current Fellow of Te Ao Maramatanga, the New Zealand College of Mental Health Nurses. I am currently employed as Nurse Specialist (Liaison Psychiatry) with the Auckland District Health Board and Associate Professor in Mental Health Nursing with the University of Waikato. My recent clinical experience involves assessment and care of people in acute mental health crisis, and advising on care of people with mental health or behavioural issues in the general hospital. My academic role involves teaching postgraduate mental health nurses, supervision of research projects, and research into mental health issues. I have been closely involved with professional development issues, including development of the College of Mental Health Nurses' Standards of Practice. I have previously acted as an external advisor to mental health services following critical incidents, and as advisor to the Health and Disability Commissioner.

The purpose of this report is to provide independent expert advice about matters related to the care provided to [Mr A] by [RN B] during his [Day 1]/[Day 2] nightshift at [the facility].

I do not have any personal or professional conflict of interest in this case.

Instructions of the Commissioner are:

Please provide comment on:

1. The adequacy of checks provided by [RN B] at:
(a) 12.00am on [Day 2] (subsequently referred to as 0000hrs).
(b) 3.00am on [Day 2]
(c) 6.00am on [Day 2].
2. The adequacy of [RN B's] clinical documentation and recorded observations.
3. The adequacy of policies [the facility] had in place at the time of this incident.
4. Your recommendations for improvement in this case. As part of your analysis, please comment on the changes [the facility] advises they have made or are considering in response to this incident.

5. Any other matters in this case that you consider warrant comment or amount to a departure from the expected standard of care or accepted practice.

In relation to the above issues I have been asked to advise on:

a. What the standard of care/accepted practice is;
b. If there has been a departure from the standard of care or accepted practice, how significant a departure it is, using the terms mild, moderate or severe; and
c. How the care provided would be viewed by your peers
d. Recommendations for future improvements that may help to prevent a similar occurrence in the future.

I have had the following documents available to me for the purpose of writing this report:

1. Referral of complaint from Nursing Council of New Zealand [2019]
2. Complaint to the Nursing Council of New Zealand made by [the facility] [2019].
3. Copy of [RN B's] record of payment of practising certificate fee showing PC expiry date of […].
4. Letter from [the facility] to HDC.
5. [RN B's] statement to HDC.
6. [RN B's] statement to [the] Coroner's Court.
7. Clinical notes from [the facility]
8. Incident report completed by [the facility]
9. Medication signing sheet.
10. [Facility] handover sheet for [Day 1].
11. [Facility] shift planners [Days 1–2].
12. [Facility] support plans for [Mr A]
13. Email from [the] DHB, to [the facility] concerning medication.
14. Seizure Care Plan and Meal Program for [Mr A]
15. Plan for whānau contact.
16. [Facility] Job Description, November 2014.
17. [Facility] Person Specification for Qualified Mental Health Professional (Residential)
18. [Facility] Shift duty lists (hourly staff duties) for day, evening and night shifts.
19. Section 34 order for indefinite extension of community treatment order dated [2018].
20. Certificate of Clinical Review of Condition of Patient Subject to Community Treatment Order dated […].
21. [RN B's] academic transcript from [tertiary institute].
22. Copy of [RN B's] certificate of registration from Nursing Council of New Zealand […].
23. Two reference checks provided by [facility] staff for [RN B] [names and dates]
24. HDC's guideline for independent advisors.

Background

[Mr A] was a [man in his twenties] who was a client of the community located [facility]. His clinical notes indicate that he heard voices, had been a user of synthetic

cannabis, and used non-synthetic cannabis. [Mr A] was also a client of [the] DHB mental health services. He had been treated under a community treatment order since at least 2017, and that order was indefinitely extended [in] 2018. At the time of his death on [Day 2] [Mr A] was a resident in [the facility]. [RN B] was employed by [the facility] on a casual basis, and was on the night shift on [Days 1–2]. [RN B] noted [Mr A] to be absent on a scheduled check at 0600 on [Day 2]. This did not cause concerns as it was not uncommon for [Mr A] to leave [the facility] for brief periods of time, then return. [The facility] is [a] voluntary community based service. At 1345pm on the afternoon [Mr A] had not returned to [the facility]. Police contacted [the facility] to inform them that at 0700hrs a man fitting [Mr A's] description had been found [deceased] in an apparent suicide. The man was subsequently confirmed to be [Mr A]. The main focus of this report is on the adequacy of nursing care provided by [RN B] on the morning of [Day 2] (the period known as 'night shift', from 2300–0700hrs). In particular the focus is on the adequacy of the check provided by [RN B] at 0300 that morning and on [RN B's] documentation. On the 0300 check [RN B] did not enter [Mr A's] room, but rather observed him through a window. He did not directly sight [Mr A]. [RN B] assumed that the lump he observed in [Mr A's] bed was [Mr A]. [RN B's] written record states that [Mr A] was asleep in his bed at 0300hrs. When [RN B] became aware of the death of [Mr A] he acknowledged that he had made an error in his clinical notes.

The following section of this report responds to the Commissioner's questions.

1. The adequacy of checks provided by [RN B] at:
a) 12.00am on [Day 2] (subsequently referred to as 0000hrs).
b) 3.00am on [Day 2]
c) 6.00am on [Day 2].

The standard of care/accepted practice
The standard of expected practice is that clients should be physically sighted at each scheduled check. An indirect sighting (for example of a 'lump' in a bed, observed through a window) is not an adequate check and does not meet the expected standard. It is not at all uncommon for clients to arrange their bedding to give the impression they are present, when they are not. Failure to physically sight a client may mean that their absence goes unnoticed, and attempts are not made to locate them. In some circumstance this could lead to suicide. This comment applies to [RN B's] 0300 check. The other checks appear to have been adequate.

If there has been a departure from the standard of care or accepted practice, how significant a departure it is, using the terms mild, moderate or severe;

I believe this to be a severe departure from the expected standard, compounded, as noted below, by inaccurately recording that the check had been made.

How the care provided would be viewed by your peers?

I believe the care provided would be regarded by my peers as a severe departure from the expected standard.

Recommendations for future improvements that may help to prevent a similar occurrence in the future.
A similar occurrence can only be prevented by [RN B] gaining an appreciation of the importance of this area of practice and improving his own practice in making scheduled checks. Supervision by an experienced RN would assist with this. I do not believe there is any change [the facility] could make in its processes that would prevent checks not being made. I note that [the facility] is to review its policies around risk, and that is a positive stance. However I would not like to see a service such as [this] become excessively risk focussed as a result of this incident. In my opinion an excessive risk focus would not improve the quality of the service provided by [the facility]. Current thinking is to accept that there is always an element of risk. Acknowledging risk provides an opportunity for consumers, clinicians and support staff to work collaboratively to manage risk.

2. The adequacy of [RN B's] clinical documentation and recorded observations.
a) The standard of care/accepted practice
Clinical documentation and recorded observations should provide an accurate and reliable record of nursing care provided. Nurses and other clinicians should have confidence that what is recorded in the clinical notes is exactly what took place, not an approximation. If, for some reason, there is a departure from planned care, that should be recorded, with the rationale.

b) If there has been a departure from the standard of care or accepted practice, how significant a departure it is, using the terms mild, moderate or severe
In this case a scheduled check, clearly planned as part of standard care at [the facility], was not carried out. An inaccurate record was made that the check was carried out. While it is commendable that [RN B] acknowledged an 'error' in his documentation, in his letter to the coroner [RN B] does not appear to appreciate the full significance of this lapse in standards. In his letter to the coroner [RN B] maintains that viewing what he believed to be [Mr A] through his window constituted a check and is not inaccurate. Another departure from the accepted standard is [RN B's] record that [Mr A] was asleep on his 0000hrs check, despite the fact that [Mr A] spoke to [RN B]. The documentation of 'asleep' is therefore inaccurate. Finally [RN B] inaccurately recorded the timing of medication administration at around 2330 hours on [Day 1]. Although the difference in timing is relatively small, about 15 minutes, the record is still inaccurate. I believe that in respect of the inaccurate recording of the 0300 check his documentation [RN B's] practice represents a severe departure from the expected standard. In relation to the recording of the 0000 check and the timing of medication given around 2330hrs [RN B's] practice represents a mild departure from the expected standard.

c) How the care provided would be viewed by your peers?
I believe my peers would regard the failure to physically sight [Mr A] at 0300, and the inaccurate recording of this check as representing a severe departure from the

expected standard. I believe my peers would regard the inaccurate recording of [Mr A] as asleep, when he was awake, and of the timing of the 2330 medication administration as a mild departure from the expected standard.

d) Recommendations for future improvements that may help to prevent a similar occurrence in the future.
Comments provided in relation to adequacy of checks also apply here. A period of having an experienced nurse review [RN B's] documentation while working alongside [RN B], would help prevent a future lapse in the standard of documentation.

3. The adequacy of policies [the facility] had in place at the time of this incident.
I believe [the facility] had sound policies in place at the time of this incident. There was ample guidance available to [RN B]. The required practice is very straightforward, and apparently understood by [RN B]. I don't think there is a need to complicate this situation by adding additional policies.

4. Your recommendations for improvement in this case. As part of your analysis, please comment on the changes [the facility] advises they have made or are considering in response to this incident.
I have made some comments relevant to this question above. The main onus of responsibility for improvement is on [RN B]. If [RN B] was still employed by [the facility] I would suggest a period of supervision, however that is not possible for [the facility]. The incident report goes well beyond the immediate issues and takes the opportunity to learn from this adverse event, albeit that in my opinion [the facility's] current policies did not contribute to this tragedy. I note that the Nursing Council, in referring this case, have made an assessment of medium risk to public safety. [RN B] remains employed by [the] DHB. For that reason I recommend that the case is referred back to the Nursing Council. If there is a way of notifying [the] DHB the Commissioner should perhaps consider that.

Any other matters in this case that you consider warrant comment or amount to a departure from the expected standard of care or accepted practice.
There are no other matters that I consider warrant comment."

The following further expert advice was obtained from Dr Anthony O'Brien:

"Report prepared by Anthony O'Brien, RN, PhD, FNZCMHN

I have been asked by the Commissioner to provide further advice on case number C19HDC00276. This follows my initial advice on February 2, 2020. [RN B] has since provided an additional statement (July 4th 2020) and [the facility] [has] responded to a letter from the Commissioner.

In the light of these further responses I have been asked if the information provided changes any aspects of my initial advice, or if I have any further comments to make in relation to the care provided to [Mr A] by [RN B] and [the facility].

I have read over my initial advice and referred, where necessary, to the original documents provided. There were three matters considered in my initial advice. They were observations made by [RN B] at 12.00am on [Day 2], 3.00am [Day 2], and 6.00am [Day 2]. These observations all occurred in the night before [Mr A's] death. Other issues considered were the adequacy of [RN B's] clinical documentation, and [the facility's] policies. In my initial advice I concluded that in respect of the 0300 observation and its documentation the lack of direct observation and the documentation that such an observation had been made was a severe departure from the expected standard. In his second statement [RN B] acknowledges in section 1 that a check through a window does not constitute an adequate check. However [RN B] states in section 2 of his second statement that he was not informed that he should enter the room. It is my opinion that a registered nurse should not have to be specifically informed of this. An employer could reasonably expect that an observation meant that the consumer had been physically sighted. It might be helpful to note that a consumer could possibly be sighted through a window, but the point in this case was that [Mr A] was not sighted at all, but the documentation stated that he had been sighted. My opinion that this is a severe departure from the expected standard is unchanged. In relation to the 12.00am check and the recording of medication there is nothing in [RN B's] additional statement that changes my opinion that these incidents represent a mild departure from the expected standard. I note that [RN B] is receiving clinical supervision which is helpful in reviewing an improving practice.

I have read the response provided to the Commissioner by [the facility] and the additional documentation of clinical notes and policies. I don't have any concerns about the service provided by [the facility], or [the facility's] policies. There is an issue of [Mr A's] documented risk assessment being almost 12 months old (acknowledged in [the facility's] response to the Commissioner), which is not consistent with [the] policy of such assessments being no more than six months old. I don't believe it is appropriate to treat a review of risk as a 'paper based exercise' (section 5 of [the facility's] response): it should involve a considered review of all the issues rather than just restating the same information. However I accept that [Mr A's] needs were well understood by [the facility]. He had recently been moved to a more intensive form of residential support and had been offered help with his substance use. There is no suggestion that there was additional risk that had not been identified. The psychiatrist assessment of [date] is thorough and notes that [Mr A] was at low risk of harm to himself just a week before he ended his life. This unfortunate incident reminds us of the dynamic and changeable nature of risk. Assessments of individuals as being 'low risk' are only valid as long as there is no change in the consumer's circumstances. In the face of this challenge clinicians' focus needs to be on providing the highest standard of care for all consumers rather than relying too much on risk assessment, important as risk assessment is. It is my impression that [the facility's] policies and practices are adequate to provide the appropriate standard of care.

I hope this report is helpful. Please get in touch if there are any issues that require clarification.

Anthony O'Brien RN, PhD, FNZCMHN"