Department of Corrections

A Report by the

Deputy Health and Disability Commissioner

(Case 13HDC00207)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mr A complained to HDC about the prison healthcare services he received between November 2012 and March 2013 while an inmate at Spring Hill Corrections Facility (SHCF), Department of Corrections (Corrections). He had complex health needs, multiple prescribed medications, and a medical history including insulin dependent diabetes and hypertension.

2. In particular, Mr A alleged that:

   - between 5 and 7 November 2012 he received the wrong type of insulin;
   - between 2 December and 5 December 2012, there was inadequate nursing assessment of his symptoms, and that following a medical assessment on 5 December he was referred to Hospital 1, where it was diagnosed that he had suffered a mild stroke and had broken his collarbone;
   - pain assessment and medication management that took place in January 2013, after returning from the December admission to Hospital 1, was inadequate;
   - between November 2012 and March 2013 he continually reported pain and required regular analgesia, and his requests for medical review were not actioned; and
   - his subsequent care, between January and March 2013, was deficient.

3. On 6 March 2013, following a medical assessment, Mr A was referred to Hospital 1 for cardiology review. On 8 March 2013, a CT scan showed a suggestion of metastases. Further scanning showed widespread metastases. Palliative radiotherapy and care was undertaken. Mr A died some time later in hospice care.

Findings summary

4. In the course of this investigation, it was found that there was no evidence that Mr A received the wrong type of insulin, although many SHCF nursing staff acknowledged that they did not always record the type or volume of insulin given. There were not sufficiently robust processes in place for accurately documenting the dispensing and delivery of insulin, nor is there evidence of appropriate systems being in place for nurses to liaise with medical officers to discuss proposed changes to diabetic patient management. The lack of medical input obtained by nursing staff when a change was later made to the timing of Mr A's evening insulin delivery was unacceptable.

5. On 3 December 2012, Mr A was found by prison officers to be cold, sweaty and unresponsive. He was assessed by nursing staff but there was limited assessment for signs of a cerebral event. On 4 December, Mr A reported chest and shoulder pain. Monitoring and assessment of his pain was limited. On 5 December, Mr A was seen by a medical officer (Dr C) and referred to Hospital 1's Emergency Department (ED).

6. The nursing assessments of Mr A were inadequate in the lead-up to Mr A being seen by Dr C and referred to Hospital 1 ED, where subsequently he was diagnosed with a fractured clavicle and a mild stroke.

7. The ED discharge summary for 18 December 2012 set out a clear plan and set of instructions for Mr A's management. The actions requested by DHB clinicians were not carried out by nurses, which was not in accordance with the relevant SHCF operating procedure. SHCF's medical officers were not alerted to the plan, and medication changes were not actioned and re-charted promptly.

8. There was a 20-day delay before Mr A was medically reviewed again on 8 January 2013. A scheduled orthopaedic review appointment had been declined (for non-clinical reasons) by DHB1. This was not brought to the attention of the medical officer (Dr B) or rescheduled by nursing staff. Dr B requested that nursing staff formally record an incident report regarding medication administration irregularities. There is no evidence that an incident report was completed.

9. On 25 January 2013, Mr A attended a diabetes clinic appointment. The clinic recommended changes in his insulin dose and suggested that prison health service staff monitor his pain and investigate orthopaedic issues. On 31 January 2013, Mr A was transported to ED owing to chest pain, and was assessed and transported back to SHCF. The discharge summary recommended referral to an orthopaedic clinic. These issues were not brought to the attention of medical officers.

10. On 8 February 2013, DHB1 advised that Mr A had not been scheduled for a shoulder X-ray or ultrasound. No orthopaedic referral had been completed. Medical officers were not made aware of this. The next medical officer review was arranged by nursing staff for 6 March 2013.

11. Poor organisational process, coupled with individual nursing lapses, meant that Hospital 1 discharge summary instructions and medication changes were not promptly brought to the attention of a medical officer, contrary to SHCF operating procedure. In addition, further follow-up outpatient review of Mr A was not arranged by nursing staff in a timely manner.

12. Between November 2012 and March 2013, Mr A regularly reported pain and requested regular analgesia. On 30 and 31 January 2013, he submitted two consecutive health chits requesting his pain be reviewed, which resulted in nursing review. Subsequently, on 4 February, he complained about his lack of access to medical review in relation to his pain. He submitted another health service chit on 6 February.

13. There was a lack of clinical nursing assessment of Mr A's pain (ie, recording of location, intensity and duration, etc), or a documented plan to manage Mr A's pain or evaluate how well the analgesia was working. This did not reflect professional nursing competencies. There were many examples of substandard medication administration documentation on Mr A's clinical file. Failure to identify and address these issues facilitated ongoing omissions and medication irregularities.

Conclusion

14. At the time of these events, Corrections had not taken sufficient steps to ensure that nursing services at SHCF were provided to Mr A with reasonable care and skill.

Accordingly, for the failings identified above, Corrections breached Mr A's right to have services provided with reasonable care and skill, as provided in Right 4(1) of the Code.[1]

Complaint and investigation

15. HDC received a complaint from Mr A[2] about the health care provided to him by Spring Hill Corrections Facility, Department of Corrections. The following issue was identified for investigation:

Whether the Department of Corrections (Spring Hill Corrections Facility) provided care of an appropriate standard to Mr A between November 2012 and March 2013.

16. This report is the opinion of Ms Theo Baker, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

17. The key parties referred to in this report are:

Mr A (dec)[3]	Complainant, consumer
Ms A	Complainant, Mr A's partner
Department of Corrections	Provider
Dr B	Medical officer
Dr C	Medical officer
RN D	Registered nurse
RN E	Registered nurse
RN F	Registered nurse
RN G	Registered nurse
RN H	Registered nurse
RN I	Registered nurse
RN J	Registered nurse
RN K	Registered nurse
RN L	Registered nurse

Also mentioned in this report:

Ms M	Diabetes nurse specialist
Ms N	A senior Corrections staff member
Spring Hill Corrections Facility	Provider

[1] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[2] Via the Office of the Ombudsman.
[3] Mr A passed away shortly after making his complaint to HDC. He verbally advised an HDC investigator at interview that he gave his authority for his partner, Ms A, to continue with the complaint process, and for her to have access to his health information disclosed in the course of the production of this report. Ms A is the executor of Mr A's estate.

18. Information was also reviewed from:

A number of registered nurses involved in Mr A's care	
The Office of the Ombudsman	
DHB1/Hospital 1	Provider
DHB2/Hospital 2	Provider

19. Independent clinical advice was obtained from in-house clinical advisor Dr David Maplesden (**Appendix A**).

20. Independent nursing advice was obtained from in-house nursing advisor Ms Dawn Carey (**Appendix B**).

Information gathered during investigation

Background

21. In November 2012, Mr A had been an inmate at Spring Hill Correction Facility (SHCF), Department of Corrections (Corrections) for approximately a year prior to the events discussed in this report, and was aged in his mid-fifties.

22. Mr A's medical history was complicated and included hypertension, dyslipidaemia,[4] diabetes (for which he had been on insulin since 2005), mild diabetic retinopathy,[5] chronic hepatitis C, and associated liver problems.

23. Mr A's medications included his insulin (described in further detail below); nortriptyline, an antidepressant; metformin, for control of blood glucose; aspirin and metoprolol, for heart related issues; simvastatin, for blood pressure; and omeprazole, for reflux.

Primary healthcare service at SHCF

24. Section 75 of the Corrections Act 2004 states:

> "*Medical treatment and standard of health care*
>
> (1) A prisoner is entitled to receive medical treatment that is reasonably necessary.
>
> (2) The standard of health care that is available to prisoners in a prison must be reasonably equivalent to the standard of health care available to the public."

25. SHCF operates a prison primary healthcare service, which is largely led by registered nurses under the leadership of a manager.[6] Clinics for inmates are held with a prison nurse in attendance and a custodial officer nearby.

[4] A disorder of the metabolism of lipoproteins.
[5] Eye disease associated with diabetes, affecting the blood vessels of the eye.
[6] SHCF Health Service also achieved external RNZCGP Cornerstone Accreditation in 2012. Cornerstone is an accreditation programme specifically designed by the Royal New Zealand College of

26. Mr A accessed SHCF's primary healthcare service regularly during his time at SHCF. The majority of the many nursing staff providing care to Mr A in the period discussed in this report had nursing experience of five years or less. One registered nurse was a new graduate, and many others were in their first year of nursing practice.

27. Two contracted medical officers provided care to Mr A in the period November 2012 to March 2013 — Dr B[7] and Dr C.[8] Dr C told HDC that a contracted prison medical officer role involves weekly on-site prison visits. In addition, prison medical officers are also on call to provide advice to registered nurses outside of clinic visits.

28. The electronic patient management system used at the SHCF primary healthcare service is MedTech. At the time of these events, the contracted medical officers could not access the SHCF MedTech system remotely from an external source.

Overview of Mr A's complaint about SHCF's primary healthcare service

29. In his complaint to HDC, Mr A raised a number of concerns regarding the standard of healthcare provided to him by SHCF. The concerns Mr A raised centred on:

- his insulin management in November and December 2012;
- the standard of nursing assessment and care he received between 2 and 5 December 2012;
- pain assessment and medication management that took place in January 2013 after returning from an admission to Hospital 1; and
- how his subsequent care, including requests to access a doctor and requests to be taken to hospital, was managed from January to March 2013, culminating in him being diagnosed with cancer in March 2013 at Hospital 1.

Insulin management, November–December 2012

30. Mr A took insulin for his diabetes in the form of Humulin-N[9] (a 10ml green vial) and Humulin 30/70[10] (a 10ml brown vial).[11] The two types of insulin have different pharmacokinetic profiles, and are not substitutes for each other. Mr A had been prescribed Humulin 30/70 (in the morning) and Humulin-N (at night) from 27 June 2012 onwards.

General Practitioners for general practices in New Zealand. Accreditation is a self-assessment and external peer review process used by healthcare organisations to assess their level of performance accurately in relation to established standards, and to implement ways to improve the healthcare system continuously.

[7] Dr B was engaged as a visiting medical officer.

[8] Dr C is a vocationally registered general practitioner and Fellow of the Royal New Zealand College of General Practitioners (2012).

[9] 45–48 units of insulin. Humulin-N (sometimes referred to as NPH) is an intermediate-acting insulin preparation, which has an onset of action 1.5 hours after administration, peak action between four and 12 hours after administration, and duration of action 18 hours.
See: http://www.nzssd.org.nz/documents/healthprofs/Insulin%20Range%20150509.pdf.

[10] 72 units. Humulin 30/70 is a mixture of Humulin-N and regular insulin, with onset of action 30 minutes after administration, peak action between two and eight hours, and duration of action 18 hours.

[11] Insulin supplied in New Zealand contains 100 units of insulin per millilitre.

31. Mr A had been given authority by Corrections to self-medicate insulin. He was encouraged to manage this autonomously. However, at SHCF, the re-supply of medication that is self-administered needs to be requested by the inmate prior to medication rounds, and not during them. On request, Mr A would usually be supplied: a vial of Humulin 30/70, a vial of Humulin NPH, and two needles.

32. Nurses who gave out vials to Mr A recorded the delivery of the vials in the MedTech notes. MedTech does not automatically record the times of entries on the daily record. Many of the registered nurse responses received by HDC in relation to this case acknowledge not always recording the type or volume of insulin that was administered to inmates.

33. On 5 November 2012, Mr A presented a health service "chit" (a written request on a standardised prison form) requesting two Humulin 30/70 vials and two green needles. This request was not recorded in MedTech on 5 November 2012.

34. On 6 November 2012, RN D recorded in MedTech:

> "Seen in clinic for BP … given 1x Humulin 30/70, 1x Humulin NPH, 2x green needles."

35. On 7 November 2012, it was recorded that Mr A had requested 2x Humulin 30/70 and 2x green needles two days earlier. RN F recorded:

> "Prisoner was given this yesterday. Triage nurse will have to check what insulin prison has. Placed on communication book."

36. It is not evident from the clinical records that any subsequent check was completed.

37. RN D told HDC that the correct insulin was supplied on 6 November 2012, and that the reference to "2x Humulin 30/70" noted on 7 November 2012 referred to the chit Mr A had presented on 5 November. It was recorded in MedTech that Mr A was unhappy that his 5 November request had not been granted.

38. Nursing staff statements to HDC make reference to Mr A habitually asking for insulin and needle supplies during drug rounds, which was not the appropriate process for accessing such supplies. Corrections told HDC that prison staff raised with the health service their concerns about Mr A's non-compliance with his insulin requests and needle use.

39. On 8 November 2012, after being found to be in possession of five needles when he was allowed to hold only two,[12] Mr A's authority to self-medicate was withdrawn. As a result, Mr A was required to go to the prison health service twice daily to access his insulin doses.

[12] Corrections told HDC that this was outlined in a "consent to hold" agreement with Mr A as part of his authority to self-medicate.

40. Mr A later filled out a prisoner complaint form dated 12 November 2012, in which he complained that he had not been given the correct insulin between 6 and 8 November.

41. Corrections told HDC that in Mr A's case, one of the challenges for the SHCF health service was that often he was non-compliant with his treatment plan, which meant that he required ongoing encouragement to mobilise frequently, to reduce the sugary food he purchased,[13] and to ensure that he maintained in his cell only the required number of needles (two) for self-management of his diabetes.

Usual timing of evening insulin

42. Mr A usually received his evening insulin at around 7pm. The SHCF records entered by RN J on 14 November 2012 make reference to this and state:

> "Approached by nursing staff re: Insulin regime for pt nocte.[14] Nursing staff are to take insulin on medication round as [patient] has his insulin normally at 1900hrs …"

43. On 14 November 2012, Dr C recorded in MedTech that he had discussed with Mr A that nurses would give his evening insulin at around 7pm.

Nursing care 3 to 5 December 2012

3 December

44. At 9.20pm on 3 December 2012, prison officers responded to Mr A activating his emergency bell. Mr A was found by prison staff cold, sweating, and not very responsive.

45. RN F, who was on call, was contacted by prison staff. She saw Mr A in his cell. Her initial advice was to give Mr A his glucose tablets or, if unable to find them, to give him something sweet.

46. RN F then assessed Mr A. His blood sugar level (BSL) was 4.7mmol/L, increasing to 5.1mmol/L.[15] His blood pressure was 180/110mmHg,[16] his pulse was 87bpm, and his oxygen saturation (SpO_2) was 98% on room air.[17] He was noted not to be responding well to the nurse's questions.

47. RN F told HDC that she contacted SHCF and a Hospital 1 ED registrar by telephone. RN F recalls being advised by the ED registrar that Mr A did not need to be referred to hospital. RN F said: "I followed the advice given by the registrar and also asked for [Mr A] to be monitored during the night and to call me if there [were] any changes."

[13] From a list of foods available to inmates for purchase.
[14] At night.
[15] This measures the amount of glucose in the blood at the time the test is taken. A person without diabetes would nearly always have a blood glucose level somewhere between 4.0 and 7.5mmol/L (a "normal" blood glucose level).
[16] Normal reading is considered approximately 120/80mmHg.
[17] Oxygen saturations reflect the haemoglobin in the red blood cells (erythrocytes), and measure how saturated or the extent to which the haemoglobin molecule is bound to oxygen. The value is reported as a percentage, with 94–99% being considered normal.

This advice was documented. The monitoring referred to was to be completed by prison officers, but it is not clear what they understood was meant by the request to monitor or check Mr A during the night.

48. In response to the provisional report, RN F said that she was the on-call nurse on 3 December 2012 and, from where she lived, she could be at the prison in 10 minutes. She said that it is standard practice in New Zealand prisons to leave prisoners in the care of custodial officers and, if it is thought that the prisoner might deteriorate during the night, the nurse will ask that the prisoner is checked for deterioration, in which case the on-call nurse is to be notified immediately.

49. Upon returning to Mr A's cell after her contact with ED staff, RN F recorded:

> "Still no change with prisoner, [observations] remain the same. BSL 5.9[mmol/L]. Prisoner had spat out glucose tablet … Nurse asked Officers to keep checking him through the night and any change to ring her.[18] Time now 23.10."

4 December

50. At 8.27am on 4 December, nursing staff received a telephone call from a prison officer advising that Mr A was unable to get out of bed to attend his 8.30am clinic appointment for insulin administration. The prison officer was advised to take Mr A to the health service for assessment.

51. RN G recorded in MedTech that at 8.50am Mr A arrived at the health service with the support of two prison officers. In response to the provisional opinion, RN G said that she noticed Mr A walk past the desk at which she was working. RN G assessed Mr A. Her notes record:

> "Stated he felt dizzy since last night … Obs BSL 7.4. Temp 35.9, BP 144/84, SpO_2 98% on room air … Vomited small [amount] clear fluid … He stated he is feeling dizzy and has a headache — all over his head … Knows where he is at present …"

52. RN G recorded at 9.20am that Mr A's blood pressure was 159/100mmHg, his heart rate was 87bpm, and his oxygen saturation was 95–98% on room air. Mr A was noted to be coherent and able to answer questions. In response to the provisional opinion, RN G said that it was handed over to her that Mr A was suspected of having ingested a substance, and he was to be put in a day cell for observation. However, this was not documented in MedTech. RN G said she was told that Mr A would not be sent to hospital at that time and would be seen in the morning by the visiting medical officer. She noted that the on-call nurse from the previous shift had contacted Hospital 1 ED, and had been informed that there was no need for admission at that time. RN G said: "I had no reason to question that decision at the time."

53. Later, at 10.30am, it was recorded by RN G that Mr A had vomited approximately 100ml of fluid. At 11.15am his blood pressure was 165/99mmHg, his heart rate was

[18] Some entries by prison health service nursing staff are written in the third person.

84bpm, oxygen saturations were 96% on room air, he was easily rousable, and his blood sugar level was 6.8mmol/L. Medical advice was not sought by RN G in relation to these symptoms. RN G said that Mr A's chief complaint was nausea, and secondary to that was a headache, but he did not mention any shoulder or chest pain. She said that his speech was coherent and she saw no facial paralysis.

54. Between 1pm and 9pm, RN H was on duty and provided nursing care to Mr A. He was first seen in the day cell. RN H's notes record: "[Complaining of] headache and [left] upper chest pain. Prisoner stated that chest pain is from manual handling of the prisoner by an officer this [morning] while helping him to move …"

55. RN H told HDC that Mr A's complaints were general unwellness, dizziness, headache, nausea, and muscular pain around his upper chest on movement. There is no documentation of assessment of the chest pain. In response to the provisional opinion, RN H stated that Mr A did not mention a fall, and RN H did not suspect that the pain was cardiac in origin or from a fracture. RN H said that Mr A was able to demonstrate extension and flexion on both elbows when he took his medication, was not supporting or protecting his arm, and gave no indication that he was in severe pain.

56. At approximately 2.15pm, Mr A returned to his own cell. He expressed a desire to walk there. In response to the provisional opinion, RN H stated that he checked Mr A's vital signs prior to his discharge back to his own cell. His blood pressure was 160/99mmHg, his heart rate was 80bpm, and his oxygen saturation was 99% on room air. RN H advised Mr A to rest in his cell. Later, at approximately 7pm, RN H saw Mr A again briefly during an evening medication round and checked his blood glucose level, which was 9.5mmol/L. RN H said that he gave Mr A his insulin to self-administer. It is recorded in MedTech that Mr A still had some discomfort in the upper chest, but that he did not voice any other concerns.

57. In response to the provisional opinion, RN H stated that Mr A appeared to be asymptomatic from his previous complaints, and appeared to have improved from early in the day. RN H stated that Mr A did not make any further contacts for a medical reason that day.

Medical officer review, 5 December

58. On 5 December 2012, Mr A had a scheduled review with medical officer Dr C, and was noted to have moderately elevated blood sugar levels. At that time, Mr A was awaiting cardiology review at DHB1.[19]

59. Mr A was experiencing vertigo, and had elevated blood pressure (190/110mmHg). He also had a tender lump over his left clavicle, consistent with a likely fracture. He was referred by Dr C to Hospital 1 ED.

[19] In early December 2012, Mr A was awaiting a cardiology review appointment from Hospital 1 Hospital owing to continued hypertension. Earlier, in November, Dr C had stopped candesartan medication to treat hypertension, and instead Mr A was commenced on diltiazem to treat the issue. He was also prescribed Voltaren for joint pain.

SHCF management following public hospital review and discharge

Hospital 1 ED review and admission

60. On 5 December 2012, Mr A presented to Hospital 1 with an accompanying letter from Dr C. Hospital staff recorded Mr A's history as: "[H]eadache, dizziness and vomiting x3/7, falling over while walking … headache is frontal and sudden onset 3/7 ago while showering, dizziness since then as well …"

61. Mr A's admission medication list noted Humulin 30/70 [72 units] (morning), Humulin N [45–48 units] (at night), and the antidepressant nortriptyline 75mg (at night).

62. Mr A was noted to also be taking metformin (for control of blood glucose), aspirin, metoprolol (for heart related issues), simvastatin (for blood pressure), omeprazole (for reflux) and Vitamin D.

63. A history of intermittent chest pain was recorded by hospital ED staff. Mr A was experiencing pain over the left clavicle and shoulder. X-rays showed that Mr A had a fractured clavicle.

64. Neurological examination proved difficult because of the left shoulder pain. However, a CT scan of the brain showed ischaemic changes in the right inferior cerebellum consistent with a recent stroke.

65. Mr A was then admitted to the stroke unit, where his modifiable risk factors were addressed[20] and there was multidisciplinary involvement in his rehabilitation.

66. The hospital diabetes clinical nurse specialist notes, dated 14 December 2012, state:

> "Humulin 30/70 to be given ½ hr prior to breakfast and Humulin NPH to be given @2100hrs."

67. On 17 December 2012, Mr A had an MRI scan just prior to being discharged back to SHCF. The MRI confirmed a small infarct[21] in the right posterior cerebellar artery, a likely cause of his stroke.

Discharge from Hospital 1

68. On 18 December 2012, Mr A was discharged from Hospital 1. He had some continued dizziness and unsteady gait, although he was mobilising with the use of a stick.

69. The discharge summary noted:

> "Made good progress able to mobilise safely with a stick. [Patient] happy for discharge and follow-up with physiotherapist at the prison. No swallowing problems."

[20] Control of blood pressure, anti-platelet therapy, diabetes control monitoring, and analgesia for headache and fracture pain.
[21] A localised area of dead tissue due to failed blood supply.

70. A one-month prescription was provided for codeine, 60mg orally, up to four times a day, as required, for pain. Omeprazole was changed to pantoprazole. Metformin was increased to 1g three times daily. Laxsol (for constipation), paracetamol (for pain), and quinapril (for blood pressure) were also prescribed. Nortriptyline was discontinued.

71. The hospital discharge summary refers to follow-up instructions for Mr A to be reviewed by a prison doctor, and for a "fracture clinic follow-up", both within a week.

72. The discharge summary plan also noted that Mr A was to have analgesia for pain control as required, his blood sugar levels were to be monitored for possible hypoglycaemia, he was to be prescribed Stemetil and domperidone (both for nausea and dizziness) as required for two weeks, aspirin lifelong, and clopidogrel[22] for one month, and that glucose and blood pressure control was needed. Mr A's insulin regimen was also reduced to 64 units in the morning and 40 units at night.

Return to SHCF

73. On 18 December 2012, Mr A was seen in the SHCF receiving office rather than the health service, as he was returning to the prison facility. The nursing records note that the hospital discharge paperwork was to be reviewed on return to the main health unit, and that the necessary appointments for review would be made. Nursing staff were responsible for the booking of any follow-up appointments.[23]

74. Mr A did not have his medications re-charted on the day of his return to SHCF after being discharged from Hospital 1, despite there being changes in his medication regimen. Notably, Mr A continued to receive nortriptyline despite not having a prescription for this.

Insulin timing change

75. Corrections' response to HDC states that on 19 December 2012 a plan of care in relation to the timing of insulin to be given was agreed with Mr A. Care plan documentation dated 19 and 21 December 2012 includes reference to "BGL/insulin for afternoon to be done @ 1600hrs in the first aid room".

76. Corrections stated:

> "There were some custodial restrictions at this time in relation to accessing prisoners, therefore a change in the administration of medication was required. A clinical decision was made that there would be no adverse implications for changing this time."

77. There is no record on the SHCF file of medical officer input or a clinical rationale being given for SHCF altering the timing of the evening dose of Mr A's insulin by approximately three hours to 4pm, or re-charting of it as such.

[22] An anti-platelet treatment.
[23] Dr B told HDC that he had also been instructed not to book follow-up appointments.

78. Mr A told HDC that on 19 December 2012 he was told that a new time for receiving his insulin was mid-afternoon instead of his "usual" time of early evening, but without an explanation. He refused the mid-afternoon dose and had no insulin that evening.

79. On 19 December 2012, RN E recorded in the nursing notes:

> "[H]e does not get his Insulin at this [time]. He wanted it at 1930, I tried to explain that he needed his insulin with TEA but he refused … He did not want it at this time. I informed him that we were here to give insulin to him and medical was not going to come back later so you are refusing it. Inmate became very verbal aggressive …"

80. Documentation for 25, 27 and 28 December 2012 shows that Mr A was administered "60 units of Insulin as charted" in the mornings under the supervision of registered nurses. On these three occasions, this was less than had been prescribed at Hospital 1 — which was 64 units. On other dates, the amount of insulin administered was correct.

Further care

81. On 20 December 2012, Mr A was assessed by a physiotherapist. The physiotherapist concluded: "Unfortunately, because [Mr A] appears quite obstructive to being assessed and to receiving advice there is little rehab potential. But fortunately, he is currently safe, independent and only lacking in activity endurance."

82. On 21 December, Mr A complained of severe chest and left shoulder pain, and some dizziness. He reported to nursing staff that he had occipital (base of the skull) pain, hypertension, and agitation. Mr A declined prison transportation in the back of a van to go to the external orthopaedic review appointment, as he felt it was too painful to travel in that manner.[24]

83. The orthopaedic review was not rescheduled, and neither medical officer was informed by nursing staff that the orthopaedic review had not taken place.

84. Mr A was not reviewed again by a prison medical officer from the time of discharge from hospital on 18 December 2012 until 8 January 2013 — 20 days after his discharge.

Medical officer review, Dr B

85. On 8 January 2013, medical officer Dr B reviewed Mr A. This was Dr B's first clinical interaction with Mr A. Dr B made a detailed entry and noted in MedTech that Mr A was reporting persistent vertigo, persistent right shoulder pain, and loss of function, and that he was not receiving the clopidogrel therapy that was prescribed at the hospital on discharge.

86. Dr B reviewed the medications listed at discharge from Hospital 1. He recorded in MedTech that he needed to re-chart as well as rationalise the currently prescribed

[24] Road transportation is the only option for external appointments.

SHCF medication list for Mr A (as he noted that it included administering both diclofenac sodium and ibuprofen — a combination that is contraindicated).

87. Dr B's documented plan included referring Mr A for X-rays and an ultrasound, requesting a physiotherapy review to assess the shoulder injury rehabilitation, and continuing codeine (as required) for two weeks. Dr B requested that a further review of Mr A be organised within two weeks, in order to assess Mr A's response to treatment.

88. Corrections provided HDC with the SHCF local operating procedure document, "Medication — Special Hospital scripts",[25] which outlines the nursing actions and processes expected to be followed when a patient returns to the facility following a hospital admission. This includes that if a medical officer is not available at the time of the prisoner returning, "[t]he script will be reviewed by the Medical Officer within 24–48 hours".

89. Dr C described this process as follows:

> "Medication is dispensed as per clinical scripting/discharge from hospital by the nurses. The medical officer then re-charts this on the medication chart at the next visit. This is the standard process. If there is any confusion medical officers are available on-call."

90. Dr B told HDC that this policy was not followed by SHCF nursing staff, and, when he reviewed Mr A on 8 January 2013, he found that Mr A had not been receiving important medication prescribed in hospital (clopidogrel), had not had other changes in medications actioned, and that Mr A had been continuing to receive medication that had been stopped in hospital (ie, nortriptyline).

91. Dr B was concerned about nursing medication management issues. He told HDC that he asked SHCF health service staff to complete an incident form. No such form appears in the records supplied to HDC by Corrections.

92. Dr B told HDC that he was also concerned at the delay in Mr A receiving medical review following his discharge from Hospital 1. Corrections responded to HDC that the delay was because of the Christmas period, and that 8 January 2013 was the next available appointment slot for medical review.

93. Dr B re-charted several of Mr A's medications. Codeine phosphate 60mg was prescribed as required, up to four times a day, for 14 days — until 22 January 2013. Diclofenac 75mg was prescribed as required up to twice daily. Dr B also decided to re-chart the nortriptyline 75mg (at night) for two weeks to assist with Mr A's pain management. Humulin 30/70 (64 units, morning) and Humulin NPH (40 units, at night) were also re-charted.[26]

[25] Number 4.4.4.
[26] On 18 January 2013, insulin dosage was reduced to 58 units in the morning (30/70) and 38 units at night (NPH).

94. With respect to rescheduling of the orthopaedic appointment, Dr B recorded:

> "Suggest that staff attempt to reschedule his appointment for [left] clavicle fracture [follow-up] with [Hospital 1] as he is still in some pain …"

95. Dr B's expectation was that nursing staff would call the orthopaedic clinic to reschedule the appointment, and that he would be notified if there were any issues with this. His request for rescheduling was not actioned by nursing staff.

December 2012–March 2013

Medication administration deficiencies

96. The nursing medicine administration records for 19 December 2012 to 11 January 2013 indicate that codeine analgesia was often given twice a day (but no times are recorded). Incomplete unit dose packaged prescription medication log sheets[27] for 17–23 January, 7–13 February, and 14–20 February 2013 do not record whether metformin was given at lunchtime. Medication administration records for November 2012 to January 2013 show that no administration times were recorded for diclofenac. There are also numerous instances where there is no clear documentation to verify whether Mr A had received or declined his medications (particularly metformin, quinapril, aspirin, clopidogrel, and pantoprazole). On 19 January 2013, it was recorded that a request for codeine from Mr A was denied, as the RN believed that the prescription had finished. This was incorrect, as the prescription was valid until 22 January.

Radiology decline letter

97. On 15 January 2013, a letter was received by the SHCF health centre from DHB1 advising that Dr B's radiology referral request (for ultrasound and X-ray) had been declined. This was logged electronically by an SHCF health administrator. However, the hard copy of the letter was not placed in a medical officer folder for review, as was the usual practice.

98. Neither Dr B nor Dr C was notified at the time about the radiology decline letter.

99. Dr B, on review of the patient records, stated in his response to HDC that the referral had been declined because it was usual practice for X-ray requests related to accidents (such as falls) to be ACC funded and forwarded to a private radiology provider. There was an administrative error on this occasion, leading to the request being incorrectly sent to DHB1.

Medical officer review, Dr C

100. On 23 January 2013, Mr A was reviewed by Dr C. He noted:

> "Discussed that referral has been made to radiology for X-ray shoulders. Still getting aching pains. [Left] side clavicular fracture. Getting pain also in R

[27] Often referred to as HS 3-2-4 sheets.

shoulder. Wants diclofenac. Advised that he has this charted prn[28] and will need to ask for it. Also aware that codeine is going to be stopped."

101. Dr C recorded that Mr A did not want to take his "blue tablet" (diltiazem), or his stemetil owing to nausea and pain. Dr C discussed with Mr A the risks (including further stroke) of stopping this medication owing to his high blood pressure, and eventually it was decided to continue the medication.

102. In his response to HDC, Dr C reaffirmed that SHCF health service staff did not make him aware of the radiology decline letter, or that Mr A did not have an orthopaedic review rescheduled.

Diabetes clinic appointment, DHB2

103. On 25 January 2013, Mr A, as part of his overall health management, attended a diabetes clinic appointment at another district health board (DHB2). No clinical information relevant to his diabetes management was provided by SHCF health service staff for the attending DHB2 diabetes nurse specialist, Ms M, to view.

104. Mr A's blood pressure was 167/90mmHg. He reported having night-time hypoglycaemic events. In addition to reviewing Mr A's diabetes management, Ms M was concerned about Mr A's general condition and his level of pain. In a reporting letter typed 29 January 2013 to SHCF, she recorded:

"[Mr A] was notably distressed with ongoing pain in his left shoulder, hip and leg, he appeared to be sweating profusely towards the end of the consultation and reported that he was experiencing chest pain that initially started at 2am. This was a stabbing pain that was radiating down his left side."

105. Ms M discussed her concerns with one of the medical registrars, who examined Mr A. An ECG was normal, and so it was decided that the pain was most likely musculoskeletal. The registrar telephoned SHCF and spoke with RN J, who advised that Mr A had been refusing some of his medications (simvastatin and diltiazem), that medical officers at SHCF had seen Mr A for some of the issues identified, and that Mr A was under the orthopaedic team at DHB1. Mr A was also seen by orthopaedic staff, who put his left arm in a sling to assist with the pain from his fractured clavicle.

106. Ms M recorded in the reporting letter that it was recommended that codeine or tramadol be introduced into his medication regimen in view of the pain he was experiencing. She also set out a plan, which included the following actions:

"1. Reduce Humulin NPH evening dose to 32 units

2. GP to monitor ongoing pain and investigate regarding Orthopaedic issues

3. [Mr A] to have carbohydrate/protein snack at night time to reduce the risk of nocturnal hypo[glycaemic attack]s

[28] As required.

4. Staff to contact Diabetes Service if any further advice required regarding either hypo or hyperglycaemia

…

6. GP to please monitor BP and consider alternative medication

…"

107. On the copy of this letter held in SHCF's notes, there are some handwritten comments made by the SHCF health service. A comment next to the advice given by Ms M in her clinic letter at point 2 is "MO [review] *if still needs attention*" (emphasis added).

108. Prior to Mr A's return to the prison following his clinic appointment, RN J noted:

> "Discussed with [Dr C] he has advised that prisoner's pain relief was discontinued, accordingly if prisoner returns with scripts for additional pain relief nursing staff are not to dispense. Assessment of pain will be required from nursing staff … as normal, if pain persists contact on-call MO."

109. Dr C told HDC that he asked for nurses to assess Mr A's pain and to contact him if pain persisted.

Pain management

110. Dr C and Dr B told HDC that they were not notified of any concerns regarding Mr A's pain management over the period 25 January to 6 March 2013.

111. Corrections responded to HDC that Dr C was "briefed regularly … at the daily clinical handovers on several occasions", so a specific request for a medical officer review was not needed.

112. SHCF nursing notes following 25 January reflect that Mr A complained of persistent pain and requested regular, rather than as required, analgesia.

113. On 30 January 2013, RN I recorded:

> "Reports that pain ++ this [morning] and requesting Voltaren, as reports did not sleep last night due to pain … advised that I have no PRN medications with me to give as had not requested. [Mr A] wanting to know if he can see m/o today to discuss his pain issues and advised that the books are full and he needs to put in a health chit …"

114. RN I noted in her response to HDC:

> "In response to [Mr A's] request to see the Medical Officer [on 30 January 2013] I noted that in Medtech under the inactive appointments that [Mr A] was initially booked to see the Medical Officer on the 30/1/13 but the appointment has been cancelled…with a note saying that the appointment was not required."

115. Corrections response to HDC contains the statement:

> "The [manager] … has reviewed the notes relating to [Mr A's] care and has not been able to identify an instance where nursing staff declined [Mr A's] requests for pain relief or a Medical Officer review."

116. The manager's response to HDC acknowledged that there was very limited documentation by nursing staff describing the intensity and type of pain Mr A was having, or the rationale for decisions made.

117. RN J told HDC that as Mr A consumed his "as required" Voltaren supply at a more rapid rate than was prescribed, supplies ran out. A further delivery from the pharmacy was not due until 31 January 2013.

118. On 31 January 2013, Mr A provided SHCF health service staff with two health chits requesting medical review, and regular, rather than "as required", pain relief. Mr A recorded on the chit that his request was urgent.

119. An appointment was booked for Mr A to see a nurse for an assessment. In the interim, "as required" medication was to be dispensed regularly.

120. On 31 January 2013, RN I recorded:

> "[Mr A] reports ongoing frustration regarding his pain. He reports that he feels no one is listening to him. Asked him what his main concerns about the pain were and he reports that he is most concerned about the nerve pain in his [right] hip and the pain in his [right] shoulder. He reports that he is unable to sleep on his side at night due to the pain … he asked why he had not been seen by [orthopaedics] regarding his pain issues. I advised him that I was not aware of any pending appointment and to discuss concerns with [medical officer] at next appointment or to complete a health chit to request discussion."

121. RN I told HDC that she had just returned from leave and had not reviewed Mr A's hospital discharge summary, which indicated that he was supposed to have orthopaedic follow-up.

Hospital 1 ED assessment and discharge

122. On 31 January 2013, at approximately 8.15pm, Mr A complained of severe chest pain and was transported by ambulance to Hospital 1's ED. He had not responded to GTN spray administered by SHCF nursing staff.[29] He was assessed in ED, and a chest X-ray was taken. He was discharged back to the prison, following the ED assessment, at 12.33am on 1 February 2013.

123. The Hospital 1 discharge summary refers to a history of three days of stabbing left chest pain and:

[29] GTN spray is a pump spray that makes the veins and arteries relax and widen (dilate). When the blood vessels dilate in this way there is more space inside them and less resistance, making it easier for the heart to pump blood around the body.

> "2 months of intermittent light headedness and headaches … painful L clavicle, R shoulder and back after fall in December when he had a cerebellar stroke. Was supposed to be reviewed in [orthopaedic] clinic but did not attend appointment … normal clinical examination other than [left] chest wall tenderness … [investigations to exclude acute coronary syndrome undertaken] … treat as musculoskeletal pain … if shoulder is ongoing concern refer back to Ortho clinic."

124. The formal X-ray report (copied to Dr B) noted cardiomegaly (enlarged heart), normal lungs, and "prominent callus formation surrounding the proximal one third of the clavicle with fracture ends not united".

125. This interim report was updated on 12 February 2013 (copied to Dr B), commenting further on the findings about the clavicle, including:

> "Correlation is recommended as to whether the patient is clinically tender in this location and with inflammatory markers. Suggest orthopaedic opinion and further evaluation with CT of the left clavicle."

126. A prescription was given at Hospital 1 for paracetamol and ibuprofen.

127. On 4 February 2013, Mr A complained to SHCF health service staff of inadequate assessment and treatment of his musculoskeletal pain.[30] This was recorded in the notes by RN J.

128. SHCF health service staff recorded that Mr A had taken excessive amounts of the prescribed Voltaren. As a result, staff restricted his access to the medication, so that it would be available only if requested prior to a scheduled drug round.

129. The 4 February 2013 SHCF notes refer to Mr A awaiting the radiology investigations that had been initiated by Dr B's referral of 8 January 2013. There is no reference to the DHB1 decline letter received on 15 January 2013.

130. On 6 February 2013, Mr A submitted a further health chit, stating:

> "I need to see the Doctor if I can't be seen I would like to get another independent Doctor to come and see me for the muscular-nerve pains I am still getting. I asked the nurses after [the] Doctor told me he would see me on the 5th of Feb 2 wks after being seen by him."

131. Mr A also requested Brufen in addition to Voltaren, but was advised by nursing staff that they are not usually given together. An appointment was made for a nursing assessment. Mr A was seen by an RN on 7 February.

132. Despite earlier events and medical officer review, in RN K's response to HDC, he states:

[30] Two written complaints dated 30 January 2013 and 1 February 2013, submitted on a PCO1 template form.

> "Normal procedure for every prisoner is that no appointment is booked for any external contractors, which include our Doctors … without prior nurse assessment … [Dr C] did not document that [Mr A] was to be reviewed for pain and had in fact reduced the level of analgesia available to the patient by stopping the codeine prescription … there were no notes saying he was to be reviewed if there was further pain."

133. On 8 February 2013, SHCF administration staff contacted DHB1 to check the status of Mr A's referrals there, and confirmed that Mr A was not scheduled for a shoulder X-ray or ultrasound, and no orthopaedic referral had been completed. Dr B and Dr C told HDC that they were not made aware of this situation.

134. Dr B does not recall viewing the revised clavicle fracture report dated 12 February 2013. Dr C does not recall seeing the report either.

135. On 15 February 2013, Mr A discussed his pain issues with nursing staff. RN L recorded:

> "Wants to try going without the [blood pressure] medication to see if this will eliminate the pains, headaches that he has been having. States he would rather have a heart attack than have to put up with the pain. States he has put in numerous [chits] [regarding] medication and why he has not seen the Doctor for all his queries. Advised prisoner it was time to leave."

136. On 19 February 2013, Mr A complained at the lack of action regarding his pains and the investigations he was supposed to have had. RN L told HDC that she cannot recall whether she followed up on Mr A's complaints at this point.

137. On 20 February 2013, Mr A requested arnica cream as topical pain relief for his arm pain, and back exercises for his ongoing back pain.

138. On 24 February 2013, Mr A expressed concern at increasing right arm and shoulder pain, and the fact that his X-rays had not been done.

139. On 26 February 2013, Mr A's partner, Ms A, contacted the health centre expressing concern at Mr A's pain and unwellness.

140. At the time of his insulin injection and blood glucose testing on 27 February 2013, Mr A was noted to have a swollen right hand and decreased strength of the right hand.

141. RN K recorded:

> "Spoken with acting [manager] and decision has been made to book for [medical officer] appt at next clinic for discussion around [right] shoulder/arm."

142. The next scheduled review (for 6 March 2013) was six weeks after Mr A's previous review of 23 January.

143. Over the next few days, it was recorded in MedTech that Mr A had intermittent loss of the use of his right hand and complained of numbness of his right thumb. The scheduled medical review was not expedited in response to these symptoms. Mr A had difficulty recapping his needles after administering insulin. Nursing staff reported that there was no consistent pattern to his symptoms.

Medical officer review, Dr C

144. On 6 March 2013, Dr C reviewed Mr A. Mr A stated that he had slipped and injured his right hip on the way to the appointment. Dr C noted no obvious pain over the left clavicular fracture site. Mr A reported decreased mobility of his right shoulder. It was documented that his diabetes and blood pressure control (including risk of another stroke if blood pressure medication was declined) were discussed with Mr A.

145. Dr C organised referrals to Hospital 1 for cardiology review and for further radiology.

146. On 7 March 2013, Mr A complained of a marked increase in back pain and urinary retention with haematuria (blood in the urine). He was observed in the SHCF health centre for several hours before a decision was made to transport him to Hospital 1.

147. On review in Hospital 1 ED, Mr A was noted to have right arm weakness, right arm/shoulder pain, and a painful right leg. He was admitted to hospital.

Diagnosis

148. On 8 March 2013, a CT scan of the head showed frontal lobe and sphenoid sinus masses suggestive of metastases. Further scanning showed widespread abdominal metastatic disease thought to be arising from a gastric cancer, and widespread skeletal metastases involving the left clavicle, right scapula (shoulder), right iliac crest (ridge of the hip), right acetabulum (hip socket) and multiple vertebrae. SHCF was informed that day. Palliative radiotherapy and alendronate infusion[31] were given. OxyContin and OxyNorm for pain relief were commenced in hospital.

149. Mr A was discharged back to SHCF on 22 March 2013, where further palliative care was undertaken. Mr A died some time later in hospice care.

150. Dr C's response to HDC concluded by stating:

> "[Mr A] had difficult and complex needs. This complaint has raised the need for further review of procedures … Medical Officers need quality timely information from nursing staff. I apologise to [Ms A] and to the late [Mr A] for any pain and suffering he endured while incarcerated. [Mr A's] late diagnosis of metastatic terminal gastric cancer may not have changed his prognosis but [I] do agree that comfort cares should have been started earlier."

Changes to health service practice and process

151. Corrections responses to HDC outlined the remedial actions it has taken as a result of this case. Dr C stated:

[31] Used to prevent the spread of cancer in bone.

"Improvements have been implemented on review of [Mr A's] clinical care. There have been delays in access for [Mr A] to medical care. Quality nursing staff information is paramount for offenders and their healthcare."

152. Corrections' response to HDC concluded:

"Prisons are a unique and challenging environment in which to deliver health care. This complaint has shown that systems and processes around the exchange of information within the health team, including the health services staff and medical officers, must be of the highest standard so that we can achieve the standards of care expected of the department and by patients. This level of communication must extend to patients …"

153. Corrections told HDC that the following changes to practice have occurred:

a) A nurse now manages a portfolio regarding emergencies and ensures that recommendations made by a hospital are followed up and all patients who are sent to hospital are booked in for a medical officer review on return. If the medical officer is not available, a telephone consultation will be completed with the on-call medical officer.

b) The management of diabetic patients was audited to ensure that risk assessments are completed appropriately and that prisoners who fit the criteria are able to manage their own medication.

c) Self-medication diabetic audits will be completed every three months to ensure that patients are continuing to be assessed and managed.

d) Processes relating to medication signing sheets have been amended. Signing sheets are not carried over. New signing sheets for any oral medication are in place for administration processes, eliminating confusion around the use of multiple drug signing sheets.

e) Nursing staff who administer weekly medication have been reminded to re-order medication once the last strip has been provided to a patient.

f) All written communications from external agencies are placed in a medical officer's folder for review, recommendation, and sign-off.

g) In-service nursing training sessions (referring to NZNO guidelines) were held reminding staff to document all interactions to do with a patient's health.

h) A process governing where and when on-call medical officer input is sought in relation to patient care has been introduced.

i) Medical officers now have access to MedTech via a Corrections Access Gateway (CAG) system. This allows a user to gain remote access from an off-site computer using a unique log-in.

j) All external referrals are now tracked via a spreadsheet. The data is made available to medical officers to allow review of the status of referrals.

k) Training sessions on pain management and documentation have occurred.

l) Discussions had at team meetings, clinical handover, and clinical governance meetings, will be recorded in the patient notes.

Responses to provisional opinion

154. Responses to the "information gathered" section of the provisional opinion have been incorporated into the report where relevant.

155. In response to the provisional opinion, Corrections stated:

> "While a number of changes have since been initiated to respond to these issues, we acknowledge that there were some significant shortcomings in the quality of care provided by the nursing staff at the time."

156. Corrections submitted: "We note that in the report there are a number of references to the lack of availability of time stamps for MedTech entries. While the time of an entry is not recorded on the daily record itself, they are available through the audit 'tab'."

157. Corrections concluded: "We will continue to work to ensure that the quality of care provided by the Department meets the highest standards."

158. In response to the provisional opinion, RN F said that she realised after reading back through her notes that "they were inadequate and there was information and further assessments that were not documented especially on 3rd December 2012". She stated that she has now changed the way she documents her assessments. She has completed nine months of learning correct documentation at SHCF by discussing and critiquing daily documentation from unidentified nursing notes from MedTech.

159. RN F also submitted that in December 2012 she was in her third year of nursing and, in relation to being advised by Hospital 1 not to send Mr A to hospital on 3 December, she did not feel experienced enough at the time to query a registrar. She stated that if she had a similar case now, she would probably send the patient to ED, and her documentation would have more information in it. RN F said that she had made changes to her practice since December 2012, and has taken part in all education and training opportunities available to her.

160. RN G also submitted that she now writes more in-depth notes and includes absent signs such as if there is no swelling or bruising seen. She said that, since this complaint, the health team has had in-service training on pain management and documentation.

161. RN H accepted that some of his documentation may have been inadequate. He said he was aware that Mr A had a history of usually having increased blood pressure, but was not concerned by the reading because Mr A's blood pressure had previously been much higher.

Opinion: Department of Corrections

Preliminary comments

162. As part of its responses to HDC, Corrections[32] submitted:

> "Health staff working in our prisons are challenged by the environmental routines, some difficult personalities and behaviours, and deal with requests for services and medication that might not be clinically indicated. This makes no excuses for shortcomings in respect of access to health services but seeks to help understand the context and the environment in which health services are provided."

163. HDC's in-house clinical advisor, Dr David Maplesden, an experienced vocationally registered GP, stated:

> "Also very relevant to the events in question is the unique environment in which the clinicians and nurses are operating … and needs to be taken into consideration when variations from 'expected practice' are discussed."

164. I acknowledge that in prisons there are certain challenges faced by both healthcare providers and health consumers that are present to a lesser degree in the community. In particular, I accept that anything, including medications or medical aids, can attract a tradable value in a detention environment; that drug-seeking behaviours may be more prevalent in prison; that the incidence of aggressive or manipulative behaviours may be more common than in the community; and that there may need to be more care taken in protecting the personal safety of all parties.

165. I also recognise that a person being held in custody does not have the same choices or ability to access health services. That is a natural consequence of the loss of liberty that has been imposed by the court. However, it means that they cannot buy over-the-counter medication, speak with a pharmacist, make an appointment to see a physiotherapist or doctor, change doctors if not happy, or take any other step that a person in the community might take in order to be treated. They are entirely reliant on the professional conduct of the staff at the health centre to assess, evaluate, monitor, and treat them appropriately.

166. In relation to the care provided to Mr A by the medical officers, Dr Maplesden concluded in his advice:

> "Care provided by [Drs B and C] was dependent to a large extent on the quality of communication with prison nursing staff. The diagnosis of metastatic cancer as the underlying cause of [Mr A's] various pains was not detected during hospital admissions in December 2012 and January 2013 emphasising the difficulties establishing such a diagnosis when the presenting symptoms are non-specific. This difficulty, coupled with what I believe to be a pattern of suboptimal nursing assessments and reporting, I feel were the primary reasons behind the delayed

[32] Responses were provided by Ms N, a senior Corrections staff member, and a senior Corrections manager.

diagnosis and suboptimal symptom management. Under the circumstances I feel the care provided by [Drs B and C] did not depart from expected standards."

167. I do not rely on Dr Maplesden's opinion of the nursing assessments in forming a view of their adequacy, but I accept Dr Maplesden's advice in relation to the care provided by medical officers Dr C and Dr B, and I am satisfied that it was reasonable in the circumstances.

168. However, in my view, Mr A's nursing care was fragmented and lacking in continuity. There were several nurses involved in Mr A's care. The pattern and extent of nursing deficiencies exhibited by a large number of nursing staff in this case, coupled with ineffective follow-up and communication with the medical officers, indicates systemic issues for which Corrections is responsible.

Pain assessment

169. It is evident that between November 2012 and March 2013 Mr A regularly reported pain, for which he requested regular analgesia. This was particularly prevalent in late January 2013. On 30 and 31 January 2013, he submitted two consecutive health chits requesting his pain be reviewed, which resulted in an initial nursing review. Subsequently, on 4 February, he complained to SHCF staff about his lack of access to medical review in relation to his pain, and what he reported to be ineffective pain relief, and submitted another health service chit on 6 February.

170. The SHCF response to HDC acknowledged that there was very limited documentation by nursing staff describing the location, intensity, duration, and type of pain Mr A was experiencing, or the rationale for decisions made relating to his pain management.

171. This deficiency was most apparent in the period from Mr A's review with Dr C on 23 January 2013 — leading up to his admission to Hospital 1 on 31 January 2013 with chest pain — and his next medical officer review, which was not until six weeks later on 6 March 2013, two days before hospital CT scanning led to a suspected diagnosis of cancer in his head (frontal lobe and sphenoid sinus).

172. I was particularly concerned to read Ms M's description of Mr A's presentation to the diabetes clinic on 25 January 2013. She was sufficiently concerned to seek medical review; to organise a sling from the orthopaedic staff for pain relief; to record in her reporting letter that Mr A was "notably distressed with ongoing pain in his left shoulder, hip and leg, he appeared to be sweating profusely … and he was experiencing chest pain that initially started tat 2am"; and to record in the plan: "GP to monitor ongoing pain and investigate regarding Orthopaedic issues."

173. I do not know why a staff member wrote next to this part of the plan that Mr A was for review "if still needs attention".

174. On 25 January 2013, just prior to Mr A's return to the prison following his diabetes clinic appointment, it was documented that Dr C had specifically requested that nursing staff continue to assess Mr A's pain, and to contact him if it persisted. There is no evidence that this occurred routinely.

175. Ms Carey advised me:

> "In my opinion, the nursing approach to assessing [Mr A's] pain experience was suboptimal. I base this on the lack of objective pain assessment documentation and the continued reporting of symptoms without variation of nursing response … It is expected that the plan for managing the health consumer's pain is documented and that administered analgesia/therapies are routinely evaluated for effect … it is absolutely paramount that the RN ensures that clinical knowledge and objective assessment inform the subsequent plan to action or deny the request for review … In my opinion, the provided care does not reflect RN professional competencies[33] and demonstrates significant departures from the expected standards of nursing care."

176. I accept Ms Carey's advice. Medical officer review usually had to be preceded by nurse assessment. Therefore, given its importance in ascertaining whether a medical opinion or further medical opinion should be sought, I am critical of the lack of clinical nursing assessment of Mr A's pain (ie, recording of location, intensity and duration, etc), or a documented plan to manage Mr A's pain, or evaluate how well the analgesia in use was working. I would be equally critical of a health service provider who provided treatment (including medication) without an assessment of likely cause of pain and evaluation and monitoring of the efficacy of the treatment.

177. In Ms Carey's opinion, the care does not reflect professional competencies. These competencies are fundamental to nursing practice in New Zealand, and reflect the standard at which all nurses must practise. In particular in this instance, in my view there was a failure to meet the following basic nursing competencies:

> "2.2 Undertakes a comprehensive and accurate nursing assessment of health consumers in a variety of settings"
>
> and
>
> "2.6 Evaluates health consumer's progress toward expected outcomes in partnership with health consumers."

Insulin delivery documentation and management

178. Mr A alleged that he received the incorrect type of insulin on 6 November 2012. His complaint about this issue came about after the health service withdrew his authority to self-administer owing to non-compliance with needle possession rules.

179. RN D's 6 November 2012 entry in MedTech records that Mr A was appropriately given a vial of Humulin 30/70, a vial of Humulin NPH, and two needles.

180. In November 2012, during the period that Mr A was self-administering insulin, registered nurses who dispensed vials recorded the delivery of insulin medication in the Medtech notes — a system that does not automatically record time of entries. My

[33] Nursing Council of New Zealand (NCNZ), *Competencies for registered nurses* (Wellington: NCNZ, 2007).

nursing advisor, Ms Dawn Carey, advised that the accuracy of recording precisely what was given to an inmate, and when, could have been improved, as there was no specific management system in place for documenting checks from the pharmacy to delivery of insulin, and that many registered nurses responding to HDC during this investigation acknowledge that they did not always record the type or volume of insulin given to inmates.

181. Ms Carey's advice notes:

> "[S]ome of the RN responses acknowledge that they did not always record the type or volume of Insulin administered to [Mr A] and have changed their documentation practice accordingly. I agree that such documentation is required and especially when the health consumer is varying the dose of a medicine as [Mr A] did routinely."

182. In addition, it is evident from the clinical records of 14 November 2012 that Mr A's evening insulin was usually to be administered at around 7pm, and that such a regimen had had medical input. Therefore, I am concerned that on his return from Hospital 1 on 18 December 2012, the timing of Mr A's evening insulin doses was altered the following day by a number of hours, from approximately 7pm in the evening back to about 4pm in the afternoon (for reasons cited as custodial restrictions), without any documented reference to medical officer input or clinical rationale for the change, or re-charting of the change.

183. Dr Maplesden advised:

> "Unless there is evidence there was medical direction based on sound clinical rationale for altering the 'nocte' dose of insulin to mid-afternoon (in which case it should have been recharted as such), I would regard this as a … departure from expected standards (if a unilateral nursing decision had been made to alter the timing of a charted medication) … [Mr A] should have received his insulin in accordance with the regime he had been stabilised on in [Hospital 1] and that was charted as 'nocte' in the hospital discharge summary."

184. I refer to Dr Maplesden's opinion here because it also demonstrates that a medical practitioner would expect to be consulted about such a change.

185. I am critical that there were not sufficiently robust processes in place for accurately documenting the dispensing and delivery of insulin, nor is there evidence of appropriate systems being in place for nurses to liaise with medical officers to discuss any proposed changes to diabetic patient management, whether these were initiated by an inmate's return from a hospital admission, or by custodial processing matters. The lack of medical input obtained by nursing staff into the change to the timing of Mr A's insulin delivery was unacceptable. In my view, it is evidence of poor professional decision-making by the nursing staff, as well as a lack of communication and collaboration amongst the health team.

Nursing care 3–5 December 2012

186. On the evening of 3 December, Mr A used his emergency bell. He was noted by prison officers to be cold, sweaty and unresponsive. RN F saw Mr A in his cell. Her initial advice was to give Mr A his glucose tablets or, if unable to find them, to give him something sweet.

187. RN F then assessed Mr A and performed observations. He was not hypoglycaemic, but his blood pressure was high at 180/110mmHg, and his pulse was 87bpm. He was noted not to be responding well to her questions. RN F contacted a manager and a Hospital 1 ED registrar by telephone, and then asked for Mr A to be monitored during the night by prison officers, which she said was standard practice if it is thought that a prisoner might deteriorate during the night. She said that the Hospital 1 ED registrar advised her that Mr A did not need to be referred to hospital.

188. Ms Carey advised that the initial nursing advice to prison officers on 3 December was appropriate. However, she stated:

> "Based on the observations reported when the RN arrived — significant hypertensive, reduced responsiveness without hypoglycaemia — I am critical that there is no commentary that relates to assessing for signs/symptoms of a cardiovascular or cerebral event … I am also critical that the advice from the ED Registrar was not questioned when there was no noted improvement in [Mr A's] clinical presentation … I am especially critical that a requirement for ongoing monitoring would be handed to a non-health practitioner.
>
> In my opinion, the expected standard of nursing assessment and monitoring would have necessitated further and more frequent vital sign monitoring by a health practitioner … [RN F] should have arranged for the transfer of [Mr A] to the ED and have provided ongoing monitoring whilst the transfer was being arranged."

189. At 8.27am on 4 December, nursing staff were informed that Mr A was unable to get out of bed to attend his 8.30am clinic appointment for insulin administration. Mr A was taken to the health service for assessment.

190. RN G recorded in MedTech that at 8.50am Mr A arrived at the health service with the support of two prison officers. RN G assessed Mr A. Her notes included recording that Mr A was dizzy, had vomited clear fluid, had complained of a headache 'all over his head', and he knew where he was.

191. RN G recorded at 9.20am that Mr A's blood pressure was 159/100mmHg, his heart rate was 87bpm, and his oxygen saturation was 95–98% on room air. RN G said that Mr A was handed over to her as being suspected of having ingested a substance. This was not documented. Mr A was put in a day cell for observation.

192. At 10.30am Mr A had vomited approximately 100ml of fluid. At 11.15am his blood pressure was 165/99mmHg, his heart rate was 84bpm, oxygen saturations were 96% on room air, he was easily rousable, and his blood sugar level was 6.8mmol/L.

Medical advice was not sought by RN G in relation to these symptoms. RN G said that Mr A did not mention shoulder or chest pain.

193. Ms Carey advised:

> "In my opinion, [Mr A] was monitored appropriately by [RN G]. I am mildly critical of the lack of assessment regarding [Mr A's] headache such as onset, description of pain etc should have been sought. I am also critical that his need for support to mobilise was not further evaluated or assessed. In my opinion, [Mr A's] reported symptoms and medical history should have resulted in advice being sought from the [medical officer] or from [Hospital 1] ED …"

194. Between 1–9pm on 4 December, RN H was on duty and provided nursing care to Mr A. He was first seen in the day cell. Mr A was complaining of a headache and upper chest pain.

195. RN H told HDC in her response that Mr A's complaints were general unwellness, dizziness, headache, nausea, and muscular pain around his upper chest on movement. There was no documentation of assessment of the chest pain.

196. At approximately 2.15pm, Mr A returned to his own cell. Vital signs were recorded as having been taken prior to Mr A returning to his cell. Mr A was advised by RN H to rest in his cell. Later, at approximately 7pm, RN H saw Mr A again, and it was recorded in MedTech that Mr A still had some discomfort in the upper chest.

197. Ms Carey was critical of the lack of comprehensive pain assessment, and was of the opinion that the nursing care by RN H departed mildly from accepted standards in relation to assessment and documentation.

198. On 5 December 2012, Dr C referred Mr A to Hospital 1's ED, and Mr A was subsequently diagnosed by ED staff as having a fractured clavicle and having suffered a mild stroke.

199. I accept, and agree with, Ms Carey's advice that the nursing care provided in the two days prior to 5 December was inadequate. I remain critical of the standard of nursing assessments and clinical monitoring of Mr A (particularly given his known risk factors, including hypertension, and particular set of clinical symptoms) by RNs F, G, and H in the lead-up to Mr A being seen by Dr C on 5 December and referred to Hospital 1 ED. Again, I do not consider that these nurses demonstrated the basic nursing competencies outlined above.

Nursing communication with medical officers post hospital admissions

200. On 5 December 2012, Mr A was seen at Hospital 1 ED, having been referred by Dr C, and he was discharged back to SHCF on 18 December 2012.

201. The ED discharge summary was detailed, and set out a clear plan and set of instructions for Mr A's management, future review (in a week's time), and medication regimen changes. However, the actions requested by DHB1 clinicians were not

carried out by SHCF nursing staff in a timely manner. This led to medication changes not being actioned and re-charted swiftly. In particular, I am concerned that the hospital instruction for discontinuing the antidepressant nortriptyline was not actioned.

202. Acknowledging that the Christmas holiday period fell around this time, there was nonetheless a lengthy 20-day delay before Mr A was reviewed by a medical officer again. In this period, Mr A also refused transportation to an orthopaedic outpatient consultation. The issue of that appointment not going ahead was not brought to the attention of the medical officer by nursing staff, and was not rescheduled.

203. On 25 January 2013, Mr A attended his diabetes clinic appointment at DHB2. After medical and orthopaedic review, and telephone liaison with SHCF, the diabetes clinic, by letter of 29 January 2013, recommended changes in Mr A's insulin dose, and that medical staff monitor his pain and investigate his orthopaedic issues.

204. Dr C and Dr B told HDC that they were not notified of any concerns regarding Mr A's pain management over the period 25 January to 6 March 2013, and no orthopaedic investigations were initiated.

205. In addition, on 31 January 2013, Mr A was transported to Hospital 1 ED owing to chest pain, and was assessed and transported back to SHCF. The hospital discharge summary noted that Mr A had not attended his orthopaedic appointment, and recommended referral back to the orthopaedic clinic if there was ongoing pain. The associated X-ray report also suggested an orthopaedic opinion and further evaluation of the left clavicle. This was not brought to the attention of medical officers.

206. On 8 February 2013, DHB1 advised SHCF health service staff that Mr A was not scheduled for a shoulder X-ray or ultrasound, and no orthopaedic referral had been completed. Again, Dr B and Dr C were not made aware of this situation. The next medical officer review was arranged by health service staff for 6 March 2013, six weeks after Mr A's previous medical review of 23 January 2013.

207. In relation to the 18 December discharge, Ms Carey advised:

> "The discharge medication regime from [Hospital 1] does not appear to have been reviewed adequately or changes communicated to the pharmacy …
>
> In my opinion, [Mr A] experienced a significant delay — twenty days — before he was reviewed by the [medical officer] upon discharge from [Hospital 1] … I am concerned that there is no evidence that the nursing staff communicated [Mr A's] clinical presentation on 20–21 December 2012 to the [medical officer]. This presentation included occipital pain; hypertension, agitation and the refusal to attend his fracture clinic appointment …
>
> Accurate documentation is a critical element of nursing practice. Clinical records must be accurate, concise and include the care that is given or planned. Discussions held with the wider healthcare team and the health user also need to

be captured.[34] In my opinion, the SHCF system for keeping abreast of external provider's plans was suboptimal. Based on the available evidence I also consider that the quality of clinical communication from [the] RN team to [medical officer] team to be suboptimal and not patient centered. In my opinion, nursing staff prevented [Mr A] having appropriate access to medical care and review. I am especially critical that decisions to prevent access were in isolation of clinical assessment or clinical rationale. If the RN role was to 'triage' [Mr A's] need for medical care then I view the provided nursing care to have significantly departed from expected standards."

208. I am concerned that poor organisational process, coupled with individual nursing lapses, meant that the Hospital 1 discharge summary instructions and medication changes were not promptly brought to the attention of a prison service medical officer — as they should have been, and in line with the SHCF operating procedure "Medication — Special Hospital scripts" — and I am critical that a further follow-up Hospital 1 outpatient review of Mr A was not arranged in a timely manner.

Medication administration and documentation

209. Mr A's co-morbidities and medical conditions meant that he received a large number of prescribed medications. I am alarmed by the many examples of substandard quality of medication administration documentation identified on Mr A's clinical file.

210. As described earlier, the nursing medicine administration records include examples of entries where no times are recorded, and there are incomplete unit dose packaged prescription medication log sheets, and instances where documentation lacks clarity to be able to verify whether Mr A had received or declined his medications (particularly in the case of metformin, quinapril, aspirin, clopidogrel, and pantoprazole). I also note that on three occasions (25, 27 and 28 December 2012) Mr A was administered 60 units of insulin in the morning — less than had been prescribed upon discharge from Hospital 1 on 18 December, which was 64 units.

211. I am concerned that these problems continued to occur despite Dr B indicating to HDC that he had raised concerns about the issue on 8 January 2013, and had asked nursing staff to formally record an incident report. There is no evidence that any incident report was instigated or completed. Failure to identify and address these issues facilitated ongoing medication irregularities.

212. Ms Carey advised:

"Safe medication administration is an indicator that sits within RN competencies[35] …When a task such as medication administration is delegated, the RN retains accountability[36] for ensuring that the prescribed medication is offered and that the documentation reflects this. Safe medication administration means there is an

[34] New Zealand Nurses Organisation (NZNO), *Documentation* (Wellington: NZNO, 2010).
[35] Nursing Council of New Zealand (NCNZ), *Competencies for registered nurses* (Wellington: NCNZ, 2007). See competency 2.1.
[36] Nursing Council of New Zealand (NCNZ), *Guideline: Direction and delegation* (Wellington, NCNZ, 2008).

> expectation that the RN looks at when the previous dose of a medication was administered. If this had been done, incidences where [Mr A] either did not receive his prescribed medications or there was a documentation omission would have been realised in a timely fashion and captured in the relevant incident process. Such actions enable an acknowledgement of the error, the opportunity to analyse the factors that facilitated the error, and to ensure that practice supports quality care rather than error prone care. I have found no contemporaneous nursing documentation which refers to incident processes — electronic or hard copy — being completed for the identified incidences where [Mr A] received contraindicated medications, inappropriate dosing, or may not have received his prescribed medications. I am critical of this."

213. Adequate documentation is not about "defensive medicine". Documentation is the means by which a nurse and other healthcare providers can monitor a patient, evaluate treatment, and ensure continuity of care.

214. In my view, these numerous deficiencies indicate that multiple nursing staff were either not reviewing previous medication dosages prior to administration — meaning there was collective failure to act in accordance with professional expectations and nursing competencies for safe medication administration — or, that nursing staff were reviewing the records prior to seeing Mr A and were aware of existing medication irregularities, but were failing to act on this knowledge and instigate remedial action and/or appropriate incident processes. Either scenario, to my mind, flags issues pertaining to nursing culture, the degree of compliance checks being undertaken at the facility, and quality improvement activities in this custodial setting. I accept, and agree with, Ms Carey's advice that nursing care in relation to Mr A's medication management departed from accepted standards.

Conclusion

215. Corrections has a legal obligation[37] and responsibility to operate its health services in a manner that provides inmates with a standard of care that is reasonably equivalent to that available to the public. It also has responsibility for the actions of its nursing staff, and an organisational duty to facilitate continuity of care in the prison healthcare environment. This includes ensuring that nurses and contracted medical officers work together and communicate effectively, and ensuring that all nursing staff comply with professional standards and facility operating procedures. The systems within which such a team operates must function effectively to achieve this.

216. As this Office has stated previously, failures by multiple staff to adhere to policies and procedures suggests an environment and culture that does not sufficiently support and assist staff to do what is required of them.[38] In my view, Corrections as an organisation bears overall responsibility for Mr A's deficient care. I acknowledge that remedial action has since been taken to address issues identified by this case.

[37] Section 75 of the Corrections Act 2004.
[38] Opinion 07HDC16959 (20 May 2008), page 18.

217. However, at the time of the events, I consider that Corrections had not taken sufficient steps to ensure that nursing services at SHCF were provided to Mr A with reasonable care and skill. Accordingly, for the failings identified above, Corrections breached Mr A's right to have services provided with reasonable care and skill, as provided in Right 4(1) of the Code.

Recommendations

218. In my provisional report, I proposed the following recommendation:

a) Explore the enhancement of MedTech with relevant software engineers, in particular in relation to time of entries and management of patient referrals.

219. In response, Corrections stated: "In regards to changes being made to MedTech we have investigated a number of possible options but are unfortunately currently restrained from making substantive changes. This is due primarily to the challenges we have accessing external agencies electronically with the high levels of electronic security required in relation to the exchange of information to and from the Department. There are on-going discussions on this matter that we hope will provide some resolution."

220. I recommend that, within three weeks of issue of this report, Corrections provide a written apology to Mr A's partner, Ms A. The apology is to be sent to HDC in the first instance, for forwarding.

221. I recommend that, within four months of issue of this report, Corrections undertake the following and report back to HDC:

b) Provide an update and evidence of the completion, progress and effectiveness of all changes made to care as outlined in points (a) to (l) at paragraph 153, including providing copies of audit results.

c) Develop a diabetic management system where checks and delivery of insulin are documented (for example, the requested insulin is checked and logged by two nurses when leaving the pharmacy, and this is subsequently checked and signed for by the dispensing registered nurse and the recipient prisoner when delivered).

d) Share the learning from this case across all correctional health services as part of a quality improvement initiative.

e) Review the work of the Health Quality and Safety Commission (HQSC) in relation to reducing medication errors and safe administration processes.

f) Adopt regular and ongoing quarterly auditing processes to review compliance with appropriate medication administration practices and documentation standards expected of registered nurses.

g) Explore the implementation of a communication tool such as SBAR[39] to frame interdisciplinary clinical communication.

Follow-up action

222. A copy of this report with details identifying the parties removed, except the experts who advised on this case, Spring Hill Correction Facility, and the Department of Corrections, will be sent to the College of Nurses Aotearoa Inc, the Nursing Council of New Zealand, the Health Quality and Safety Commission, the Royal New Zealand College of General Practitioners, DHB1, and the Office of the Ombudsman, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[39] Available from http://www.ihi.org/resources/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx.

Appendix A — Independent clinical advice to Deputy Commissioner

The following independent clinical advice was obtained from in-house clinical advisor Dr David Maplesden:

> "1. Thank you for the request that I provide clinical advice in relation to the complaint from [Mr A] and his partner [Ms A] about the care provided to [Mr A] by health care personnel at Springhill Correctional Facility (SHCF). In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have viewed the available documentation including: complaint documentation from [Mr A] and his partner [Ms A]; response from Dept of Corrections; response from [DHB1]; [Hospital 1] clinical notes; SHCF health centre notes from 1 December 2012; correspondence from Office of the Ombudsman. Since advice provided on 5 August 2013 I have had the opportunity to review statements from most SHCF health staff involved in [Mr A's] care together with detailed responses from the SHCF medical officers (MOs) involved ([Dr C] and [Dr B]) and a further response from [Ms N], [a senior Corrections staff member] dated 20 February 2014.
>
> There are several aspects to [Mr A's] complaint:
>
> (i) he was given the wrong insulin on 5–7 November 2012
>
> (ii) he received poor care from nursing staff on 2, 3 and 4 December 2012 after suffering a fall secondary to a stroke, and fracturing his clavicle. [Mr A] states he was told he had received too much insulin on 2 December 2012 when his symptoms appeared and was then accused of 'being on drugs'. On 3 December 2012 he received no medications. On 4 December 2012 he was kept in a locked room in the medical unit and not observed, then returned to his cell without a medical assessment. On 5 December 2012 he was finally seen by a Doctor and sent to [Hospital 1] where he was diagnosed with a recent stroke and fractured clavicle.
>
> (iii) On 19 December 2012 [Mr A] was told the new time for his insulin was mid-afternoon (1630–1700hrs) instead of his 'usual' time of late evening (1830–1930hrs) without any explanation. He refused the mid-afternoon dose and was not given any insulin that evening.
>
> (iv) In mid-January 2013 [Mr A] did not receive pain relief and nortriptyline as charted and there were delays in administration of his insulin.
>
> (v) [Ms A] states that on her partner's discharge from [Hospital 1] he initially improved but then had a gradual deterioration in his pain control and general condition, and that despite requesting *another opinion by a Dr and or to be taken to hospital* his requests were denied. At home leave in early March 2013 [Ms A] noted [Mr A] to be in pain, sweating profusely and to have *no/little strength now in his right arm and leg …* Shortly after this [Mr A] was admitted to hospital after a fall where he was diagnosed with metastatic terminal gastric cancer.

2. Issue 1 (i): Humulin-N (NPH) is an intermediate-acting insulin preparation with onset of action 1.5 hours after administration, peak action between 4 and 12 hours and duration of action 18 hours. Humulin 30/70 is a mixture of Humulin-N and regular insulin with onset of action 30 minutes after administration, peak action between 2 and 8 hours and duration of action 18 hours[1]. They have different pharmacokinetic profiles and are not substitutes for each other. SHCF medications charts show [Mr A] was prescribed Humulin 30/70 72U mane and Humulin N 45-48U nocte from 27 June 2012. On file is a prisoner complaint form dated 12 November 2012 in which [Mr A] has complained about not being given the correct insulin over the period 6–9 November 2012.

3. I am unable to determine from the notes supplied precisely what occurred over this period — whether or not [Mr A] received his correct insulin supplies/doses and, if not, why not. There is a response from Dept of Corrections to [Mr A] dated 28 September 2012 implying there were difficulties with supply of insulin prior to the events in question. On review of the clinical notes, it is evident [Mr A] was self-managing his insulin administration until around 8 November 2012. Clinic notes on 3, 4 and 5 November 2012 indicate there was a problem getting supplies of [Mr A's] oral medications and he missed some doses over this period as a consequence. The February 2014 response from [Ms N] is unclear as to whether or not [Mr A] actually missed doses of medication in that she lists the medications [Mr A] did not receive on the morning of 2 November 2012 and then states *a second signing sheet was also found* which showed [Mr A] had been administered his morning medications.

4. On 6 November 2012 clinic notes record ... *given 1x Humulin 30/70, 1x Humulin NPH, 2x green needles.* On 7 November 2012, notes refer to *2x Humulin 30/70, 2x green needles* being supplied the previous day, with retrospective notes indicating [Mr A] had expressed concern that he had been given the wrong insulin supplies. However, a response from the RN involved ([RN D] — response dated 13 June 2014) confirms the correct insulin was supplied on 6 November 2012 and that the reference to *2x Humulin 30/70* noted on 7 November 2012 referred to a chit [Mr A] presented for future supplies. In apparent response to [Mr A's] complaints and concern at compliance with his insulin and needle use, from 8 November 2011 he was required to come to the prison clinic on a twice daily basis to access his insulin doses. Statements from nursing staff refer to [Mr A] habitually asking for insulin and needle supplies during the drug round which was not the appropriate process for accessing such supplies. His lack of cooperation with appropriate process was evidently the primary reason for withdrawal of his self-medication privileges as noted above. It remains unclear why [Mr A] should have provided the detailed complaint he did regarding access to and provision of supplies of insulin if, as the responses reviewed suggests, correct medications were supplied. As there are many aspects of this complaint requiring expert nursing review, I will leave it to such an expert to determine whether the documentation processes surrounding supply of insulin to [Mr A] were sufficiently robust to minimise errors in supply. However, I do not think it is

[1] See: http://www.nzssd.org.nz/documents/healthprofs/Insulin%20Range%20150509.pdf

possible to determine unequivocally that there were errors in the supply of insulin to [Mr A] in early November 2012.

5. Issue 1(ii): SHCF notes outline nurse attendance and assessment on 3 December 2012. The nurse evidently discussed [Mr A's] presentation with the ED registrar who advised he did not need to be seen (unclear precisely on what information this advice was based). In her response dated 13 June 2014, [RN F] confirmed she contacted a manager and the ED registrar on 3 December 2012 and *I followed the advise given by the registrar and also asked for [Mr A] to be monitored during the night and to call me if there was any changes.* 'Monitored' in this context appears to refer to visual contact by a guard on a regular basis rather than clinical monitoring. In a response from the [Hospital 1] ED director, it is noted that none of the male clinical staff on duty in the department at the time of the call recall having a discussion with prison staff but they receive many calls a day and no record is kept. However, it is common practice for the MO to advise the caller to send the patient to ED if they have ongoing concerns. The clinical notes for 3 December 2012 refer to [Mr A] being found by prison staff *cold, sweating and not very responsive …* nurse recording included blood sugar 4.7 then 5.1, BP 180/110, P 87 and O2 saturations 98%. He continued to have reduced responsiveness although no complaint of pain. On review shortly before the nurse left the premises (2310hrs) *Still no change with prisoner, obs remain the same … asked Officers to keep checking him through the night …* I am somewhat concerned that the ED registrar was not contacted again when [Mr A's] condition failed to improve and there was no capacity to undertake regular clinical monitoring through the night. There was no clear diagnosis for [Mr A's] symptoms (he had not been obviously hypoglycaemic and had not responded to glucose tablets in any case) and he had had multiple risk factors for a cardiovascular/cerebrovascular event. This aspect of care required further expert nursing comment.

6. On 4 December 2012 nurse notes indicate [Mr A] was complaining of giddiness and was vomiting. Insulin was withheld because of lack of food intake, and some observations were undertaken. [Mr A] was retuned to his cell in the early afternoon after apparently improving with symptomatic treatment (metoclopramide and Enerlyte). During the night medication round *nil concerns voiced.* However, there is reference to [Mr A] complaining of left upper chest pain (? related to his fractured clavicle). The response from [RN G] who provided care for [Mr A] on the morning of 4 December 2012 confirms he was observed regularly (and contemporaneous notes support this) and his room was not locked.

7. On 5 December 2012 [Mr A] was reviewed by a MO and noted to have moderately elevated blood sugar levels (had not been receiving insulin as *too crook to go to medical*), was still suffering from vertigo and had elevated blood pressure, and had a tender lump over the left clavicle consistent with a fracture. He was referred to [Hospital 1] ED. There may be some concerns at the adequacy of [Mr A's] nursing assessments and surveillance over the period in question, and delays in seeking a medical review. I recommend this aspect of the complaint also be critiqued by the nursing expert. It was appropriate for the MO to arrange review of [Mr A] in a secondary care facility.

8. [Hospital 1] notes record [Mr A's] admission there on 5 December 2012 with a history of *headache, dizziness and vomiting x3/7, falling over while walking … headache is frontal and sudden onset 3/7 ago while showering, dizziness since then as well …* A longer history of intermittent chest pain was also described and current pain over the left clavicle and shoulder. Neurological examination was difficult because of the left shoulder pain. X-rays showed a fractured clavicle (treated with broad arm sling) and CT scan of the brain showed ischaemic changes in the right inferior cerebellum consistent with a recent cerebellar stroke, which was consistent with [Mr A's] neurological symptoms. This was managed by admission to the stroke unit where modifiable risk factors were addressed (control of blood pressure, anti-platelet therapy commenced, diabetes control monitored, analgesia for headache and fracture pain) and there was standard MDT involvement in [Mr A's] rehabilitation. MRI on 17 December 2012 prior to discharge back to SHCF showed findings consistent with a small infarct in the right posterior cerebellar artery territory. At the time of discharge (18 December 2012) [Mr A] was still experiencing headaches, dizziness and unsteady gait although was mobilising with a stick with comments on the discharge summary including *Made good progress able to mobilize safely with a stick. PT happy for discharge and followup with physiotherapist at the prison. No swallowing problems.* I could not identify any particular deficiency in [Mr A's] management in [Hospital 1] although it is somewhat surprising he was diagnosed with widespread metastatic disease, including cerebral secondaries, within three months of discharge.

9. [Mr A's] admission medication list included Humulin 30/70 72U mane, Humulin N 45–48U nocte and nortriptyline 75mg nocte (together with metformin, aspirin, metoprolol, omeprazole and Vitamin D). Nortriptyline was stopped shortly after admission and did not appear on the list of discharge medications. Diabetes clinical nurse specialist notes date 14 December 2012 state *Humulin 30/70 to be given ½ hr prior to breakfast and Humulin NPH to be given @2100hrs.* Discharge medication list included Humulin 30/70 64U mane and Humulin NPH 40U nocte. The most recent medication chart on record is dated 8 January 2013 (recharting of all medications). At this time, regular nortriptyline 75mg nocte was prescribed as was Humulin 30/70 64U mane and Humulin NPH 40U nocte. On this date PRN pain medications were diclofenac 75mg BD and codeine phosphate 60mg to QID for two weeks (I presume to be reviewed after this time). I could find nothing to suggest [Mr A] had his medications recharted following discharge from hospital despite there being changes in his regime, and he was apparently not reviewed by a prison MO from the time of discharge (18 December 2012) until 8 January 2012. When he was finally reviewed, the MO ([Dr B]) noted [Mr A] had multiple complaints including: persistent vertigo (PRN treatment for this not forthcoming because *? script expired*); persistent right shoulder pain and loss of function; not receiving clopidogrel therapy prescribed on hospital discharge — *patient reports not receiving and currently contained in blister packs*; medication on discharge from hospital are noted and need to rechart and *rationalise* the current medication list as *was prescribed both diclofenac and ibuprofen*; noted that [Mr A] had not been prescribed a previously prescribed

medication (nortriptyline) on discharge from hospital but *may have been restarted on this under nurse decision as unclear to me if MO authorised ….*

10. Responses reviewed since my original advice clarify to some extent the issues noted above. [Ms N] provided a prison policy document *Medication — Special Hospital scripts* that outlines the processes expected to be followed when a patient returns to the facility following a hospital admission. This includes *the script will be reviewed by the Medical Officer within 24–48 hours* if the MO was not available at the time. The response from [Dr B] dated 4 June 2014 indicates this policy was not followed and he found, when he reviewed [Mr A] on 8 January 2013, that the patient had not been receiving important medication prescribed in hospital (clopidogrel), had not had other changes in formulations actioned, and had been continuing to receive medication that had been stopped in hospital (nortriptyline). The nortriptyline was recharted by [Dr B] to assist with [Mr A's] pain management. [Dr B] was sufficiently concerned at the lapse in medication management on this occasion that he requested staff to complete an incident form. I have been unable to find a copy of the incident form in the material on file. [Dr B] was also concerned (as was I) at the delay in [Mr A] receiving a medical review following his discharge from [Hospital 1]. [Ms N] states the delay was because 8 January 2013 was the next available appointment slot. However, given [Mr A's] post-admission diagnoses (clavicular fracture and CVA) and his ongoing complaints of pain and dizziness (some retrospective when he saw [Dr B] but severe chest and shoulder pain documented on 21 December 2012, and dizziness severe enough for him to decline transport to his scheduled orthopaedic review the same day) and persistently elevated blood pressure (up to 170/120 on 27 December 2012) I am concerned that a more timely clinical review was not expedited. The concerns documented by [Dr B] on 8 January 2013 are also largely related to the failure by staff to arrange a timely medical review for [Mr A] on his discharge from [Hospital 1]. I think the medication management errors and failure to arrange timely review are very significant departures from expected nursing practice but it is most appropriate for the nursing expert to comment further.

11. Complaint 1(iii): nursing notes indicate [Mr A] was unwilling to have his evening insulin in the mid-afternoon as *he wanted it at 1930 … I tried to explain that he needed his insulin with TEA but he refused …* [Mr A] was told he could not come back to have insulin at a later time. I am concerned at this sequence of events. It is not documented that there was medical direction to change [Mr A's] insulin from the charted 'nocte' dose (confirmed by the CNS at [Hospital 1] to be around 2100hrs) to a time closer to 1630–1700hrs. [Ms N] states *There were some custodial restrictions at this time in relation to accessing prisoners, therefore a change in the administration of medication was required. A clinical decision was made that there would be no adverse implications for changing this time.* Unless there is evidence there was medical direction (MO) based on sound clinical rationale for altering the 'nocte' dose of insulin to mid-afternoon (in which case it should have been recharted as such), I would regard this as a moderate departure from expected standards (if a unilateral nursing decision had been made to alter the timing of a charted medication). I reiterate that [Mr A] should have received

his insulin in accordance with the regime he had been stabilised on in [Hospital 1] and that was charted as 'nocte' in the hospital discharge summary. MO notes 14 November 2012 had included *discussed insulin and that nurse will be giving insulin at 1900hrs.* If a MO was involved in the management decision to alter the timing of insulin administration, this should have been clearly documented in the medical file.

12. With respect to complaint 1(iv) clinic notes for 18 January 2013 refer to staff being late administering [Mr A] his insulin because *the guards would not open his cell* at the appropriate time. As a consequence [Mr A] refused his insulin that evening, although blood sugars the following morning were quite reasonable. Consistency of timing of insulin dosing has some importance in adequate management of the condition, and prison staff should be taking all practical steps to ensure the regime is administered consistently and in accordance with the prescribed instructions. There is reference on 19 January 2013 to unavailability of codeine requested by [Mr A] for pain relief as *? script has finished ... Prisoner stated that he will get officers to ring health if he needs more pain relief during the day.* There is no subsequent reference to [Mr A] requesting pain relief that day. Medication charts appear to indicate nortriptyline was supplied as charted on 18 January 2013, and that it may have been given in the morning and evening of 19 January 2013 (although drug administration charts are somewhat difficult to follow). The nurse advisor may be best placed to comment on her interpretation of the medication charts as they relate to this period.

13. Physiotherapist assessment was undertaken on 20 December 2012 and was notable in that suspicion was raised of inconsistencies in [Mr A's] presentation based on physical observations and [Mr A's] recounting of symptoms. The physiotherapist also noted *Unfortunately, because [Mr A] appears quite obstructive to being assessed and to receiving advice there is little rehab potential. But fortunately, he is currently safe independent and only lacking in activity endurance.* These observations were based on the recent diagnosis of cerebellar infarct supported by CT and MRI scans. There was no reason for the physiotherapist to suspect [Mr A] had an underlying rapidly progressive malignancy that may have been contributing to his atypical presentation. The clinical 'reassurance' that [Mr A] had suffered a cerebrovascular event might also have affected the perceptions of his subsequent clinical course by nursing and medical staff at SHCF.

14. On 21 December 2012 it is recorded that [Mr A] refused to go to [Hospital 1] for his orthopaedic review (he states this was because of severe vertigo he was suffering at the time). Increased pain levels were noted on 21 December 2012 and PRN analgesia supplied. Improved mobility was noted on 28 December 2012 although this appeared somewhat variable and dependent on whether or not [Mr A] was aware he was being observed. There were no particular comments expressing concern at [Mr A's] general condition through late December 2012 and early January 2013, although there was almost daily observation recorded. However, there was reference to ongoing pain on several occasions. It is not evident there was any attempt made to reschedule [Mr A's] orthopaedic clinic appointment or that either MO involved in his management were informed at the

time that the appointment would need to be rescheduled. In hindsight this was unfortunate as subsequent X-rays of the clavicle performed for unrelated reasons showed abnormal healing of the clavicle fracture and raised the possibility of metastatic disease (see below). While [Mr A's] outlook and prognosis would not have been affected by an earlier diagnosis, there may have been more attention paid to quality palliative care and symptom control had the diagnosis been known in late December 2012 or early January 2013 rather than in March 2013.

15. [Mr A] was reviewed by the prison MO [Dr B] on 8 January 2013 (see section 9). The MO notes [Mr A] had ongoing physical complaints and also complaints with the service he had received from prison nursing staff. Physical complaints included ongoing pain from the left clavicle fracture, and vertigo (prochlorperazine recharted). [Mr A] also complained of increasing right shoulder pain since his initial fall (referred for X-rays and ultrasound and ACC form completed 8 January 2013) and codeine to be continued for two weeks. On 15 January 2013 a letter from [DHB1] noting the radiology referral request (ultrasound/X-ray) had been declined was received at the health centre and entered into [Mr A's] file. [Dr B] states in his response that it was usual practice for X-ray requests related to accidents to be forwarded to a private radiology provider and there appears to have been an administrative error on this occasion leading to the request being sent to [DHB1]. Neither [Dr B] nor [Dr C] were ever notified of receipt of the radiology decline letter and it was never brought to their attention. With respect to rescheduling of the orthopaedic appointments, [Dr B] recorded *Suggest that staff attempt to reschedule his appointment for L clavicle fracture FU with [Hospital 1] as he is still in some pain …* There is nothing in the clinical notes to suggest this request was actioned and it is evident no attempt was made to reschedule the appointment. [Dr B's] expectation was that nursing staff would call the orthopaedic clinic to reschedule the appointment and he would be notified if there were any problems with this. The apparent oversights by nursing staff relating to the declined X-ray and non-attended orthopaedic appointment I think have contributed to delays in [Mr A] receiving appropriate further investigation of his pain, and represent departures from expected practice which the nursing expert will further quantify. [Dr B] requested a review of [Mr A] within the time frame of the codeine prescription provided (two weeks) in order to review any investigations and [Mr A's] response to treatment. This review was provided by [Dr C] on 23 January 2013.

16. There is no reference to overall deterioration in [Mr A's] condition in the nursing notes during January 2013 although there is reference to ongoing requests for analgesia. On 23 January 2013 [Mr A] was reviewed by prison MO [Dr C] who noted *discussed that referral has been made to radiology for xray shoulders … still getting aching pains L side clavicular fracture. Getting pain also in R shoulder. Wants diclofenac. Advised that he has this charted prn and will need to ask for it. Also aware that codeine is going to be stopped … wants to go back to gym …* There is nothing in the 'outbox' module of the PMS to suggest [Dr C] made a new referral for X-ray investigations at this point and it appears he was under the impression the original X-rays ordered by [Dr B] were still awaited ie clinic staff had not informed him of the 'decline' received over a week earlier. In

his response dated 15 December 2013, [Dr C] confirmed he was not aware of the radiology decline letter or that [Mr A] did not have an orthopaedic review rescheduled. Following his assessment of [Mr A] on 23 January he felt the patient's pain could be adequately controlled using NSAID alone, and PRN diclofenac was available to him for this purpose.

17. On 25 January 2013 [Mr A] attended a diabetes clinic appointment at [Hospital 2]. He was not accompanied by any clinical information relevant to his management (eg recent blood sugar readings, reference to recent hospital admission) and health centre staff should reflect on this oversight. The attending diabetes nurse specialist was sufficiently concerned about [Mr A's] general condition (in obvious pain, tachycardic, hypertensive, sweating) to organise registrar review (medical and orthopaedic). She notes that [Mr A] *was notably distressed with ongoing pain in his left shoulder, hip and leg …*. Brief reviews by the medical and orthopedic registrars were undertaken at [Hospital 2], a sling provided to [Mr A] and advice given to reintroduce codeine or Tramadol in view of the pain [Mr A] was experiencing. The registrar telephoned the health clinic and was advised by staff that [Mr A] had been refusing some of his medications (diltiazem) and *also advised there is always 2 sides to a story … At 1525hrs* [a senior nurse] *phoned* [the medical registrar] *explained that MO has seen this prisoner for some of the issues she has identified and that the prisoner is under the orthopaedic team at [DHB1] …* The [diabetes clinic] letter recommended changes in [Mr A's] insulin dose and *GP to monitor ongoing pain and investigate regarding orthopaedic issues …* There are handwritten comments adjacent to the advice contained in the letter (unclear whether this is per nurse or MO) with the comment next to the advice quoted above being *MO r/v if still needs attention.* Prior to [Mr A's] return to the prison following his clinic appointment, health staff contacted [Dr C] and noted *discussed with MO … he has advised that prisoner's pain relief was discontinued, accordingly if prisoner returns with scripts for additional pain relief nursing staff are not to dispense. Assessment of pain will be required from nursing staff and APSO as normal, if pain persists contact on-call MO.* The distinct impression I gain from the documented comments by prison health centre staff, reinforced in the complaint, is that staff did not believe [Mr A's] complaints of pain were genuine, at least in regard to the severity of pain. Certainly, the day-to-day prison health centre notes do not appear to reflect the nature and degree of [Mr A's] pain compared with the impression he gave to [Hospital 2] staff. Whether this was inaccurate reporting by staff, or poor reporting from [Mr A] is not clear. However, subsequent to the conversations of 25 January 2013, staff should have been particularly vigilant in their assessment of [Mr A's] pain and reporting of his pain management back to the MO. [Dr C] and [Dr B] state they were not notified of any concerns regarding [Mr A's] pain management over the period 25 January–6 March 2013 and [Dr C] states that on 25 January 2013 *I asked for nurses to assess [Mr A's] pain and to contact me if pain persists* (and this was documented). In [Ms N's] response dated 22 January 2014 she states [Dr C] was *briefed regularly … at the daily clinical handovers on several occasions …* but does not specify that [Mr A's] condition was discussed or the content of any discussion.

18. Nursing notes subsequent to the diabetes clinic review do reflect [Mr A's] complaints of persistent pain and request for regular rather than PRN analgesia. On 30 January 2013 provider [RN I] has recorded *Reports that pain++ this am and requesting Voltaren, as reports did not sleep last night due to pain … advised that I have no PRN medications with me to give as had not requested*. [Mr A] *wanting to know if he can see m/o today to discuss his pain issues and advised that the books are full and he needs to put in a health chit …* This is a disturbing consultation particularly in light of the recent [Hospital 2] consultation. It is apparent the patient was denied both adequate pain relief and timely MO review of his pain. A response from [RN J] refers to [Mr A] having consumed his PRN Voltaren supply at a more rapid rate than was prescribed which is why supplies 'ran out' with a further delivery from the pharmacy not due until 31 January 2013.

19. On 31 January 2013 [Mr A] provided 'chits' requesting MO review of his pain and regular rather than PRN pain relief. Notes record *nurse appt booked to discuss pain and complete assessment.* In the interim, PRN medication was to be dispensed regularly. Nursing notes later on 31 January 2013 ([RN I]) record *reports ongoing frustration regarding his pain. He reports that he feels no one is listening to him. Asked him what his main concerns about the pain were and he reports that he is most concerned about the nerve pain in his R) hip and the pain in his R) shoulder. He reports that he is unable to sleep on his side at night due to the pain … he asked why he had not been seen by Ortho regarding his pain issues. I advised him that I was not aware of any pending appointment and to discuss concerns with m/o at next appointment or to complete a health chit to request discussion.* This interaction, too, is concerning. Prison staff had, less than a week previously, informed the [Hospital 2] registrar that [Mr A] was being followed up by the [Hospital 1] orthopaedic service but are now acknowledging they are not aware of any planned follow-up (and apparently had failed to organise such follow-up following recommendation by [Dr B] earlier in the month). [RN I] explains that she had just returned from leave and had not reviewed [Mr A's] hospital discharge summary which indicated he was supposed to have orthopaedic follow-up, although ironically her response was accurate in light of the preceding events discussed. It is apparent that despite being asked previously by [Dr C] to report to him any change in [Mr A's] pain status, staff are requesting [Mr A] to organise MO review per a 'chit' yet are failing to action the 'chit' he had already presented requesting MO review. I feel these are all significant departures from expected practice which my nursing colleague may wish to comment on further, although I note events later on 31 January 2013 overtook [Mr A's] request for MO review.

20. Later on 31 January 2013 [Mr A] complained of severe chest pain and was transported to [Hospital 1] ED, being discharged back to the prison following assessment there. The discharge summary refers to a history of three days of stabbing left chest pain and *2 months of intermittent light headedness and headaches … painful L clavicle, R shoulder and back after fall in December when he had a cerebellar stroke. Was supposed to be reviewed in ortho clinic but did not attend appointment … normal clinical examination other than L chest wall tenderness …* [usual investigations to exclude acute coronary syndrome

undertaken] … *treat as musculoskeletal pain … if shoulder is ongoing concern refer back to Ortho clinic.* A chest X-ray was performed with the formal report (copy to [Dr B]) noting cardiomegaly and normal lungs and *there is prominent callus formation surrounding the proximal one third of the clavicle with fracture ends not united.* This interim report was replaced on 12 February 2013 (again copy to [Dr B]) with a report commenting further on the clavicle findings including *correlation is recommended as to whether the patient is clinically tender in this location and with inflammatory markers. Suggest orthopaedic opinion and further evaluation with CT of the left clavicle.* A prescription was given for paracetamol and ibuprofen. Comment: The ED review was in some ways reassuring that [Mr A's] pain did not have a sinister basis with unremarkable examination findings (as recorded) and the X-ray, as reported initially, being consistent with the healing known clavicle fracture. However, the final report indicated a need for formal review and referral (see further comments below).

21. Nursing notes for 4 February appear to indicate [Mr A] was receiving both Voltaren and ibuprofen for his pain although I could not confirm this on the available medication charts. This would be an inappropriate combination, although this was recognised by nursing staff, and illustrates the need for formal MO review of an inmate's medications following discharge from hospital, and charting of those medications initiated or changed in the hospital as clinically indicated. The facility charting policy has been provided (see section 10) although it does not appear the policy has been followed consistently.

22. Health staff notes dated 4 February 2013 include a response to a complaint made by [Mr A] regarding inadequate assessment and treatment of his musculoskeletal pain. Staff note [Mr A] has taken in excess of the prescribed regime for his PRN Voltaren and therefore restrict his access to the medication to being available only if requested prior to a scheduled drug round (rather than acknowledging the requests might be a sign of suboptimally controlled pain). The notes refer to [Mr A] *currently awaiting appt* for the radiology investigations initiated by [Dr B] on 8 January 2013 ie again no acknowledgement of the letter received on 15 January 2013 stating the appointment had been declined.

23. Nursing notes in early February 2013 refer to [Mr A's] ongoing complaints of pain and request for additional pain relief, physiotherapy and MO review. On 6 February 2013 he submitted a health 'chit' stating *I need to see the Doctor if I can't be seen I would like to get another independent Doctor to come and see me for the muscular-nerve pains I am still getting. I asked the nurses after Doctor tole me he would see me on the 5th of Feb 2 wks afta being seen by him.* [Mr A] also requested Brufen in addition to Voltaren but was advised by the nurse *they are not usually given together.* A nurse appointment was made for assessment. Comment: Given [Mr A's] ongoing pain issues and the implication he was to be followed up by [Dr C] following the review of 23 January 2013, and noting events in the interim ([Hospital 2] registrar comments and [Hospital 1] ED assessment) and [Dr C's] request that the MO be notified if there were ongoing pain issues, I find it hard to comprehend why yet again nursing staff did not arrange a timely MO review for [Mr A], or notify the MO of [Mr A's] concerns. The response from [RN K] states *normal procedure for every prisoner is that no appointment is*

booked for any external contractors, which include our Doctors … without prior nurse assessment … [Dr C] *did not document that he was to be reviewed for pain and had in fact reduced the level of analgesia available to the patient by stopping the codeine prescription … there were no notes saying he was to be reviewed if there was further pain.* This statement I feel reflects potential weaknesses in several areas: review of clinical documentation ([Dr C] had specifically requested ongoing review of [Mr A's] pain as had the [Hospital 2] registrar (see section 17); no formal process in place for objective review and recording of a patient's pain levels when pain is being monitored; lack of clinical initiative — the implication by [RN K] that [Mr A's] complaints of pain were not notified to the MO because there was no specific instruction to do so. I am sure the nursing expert will have further comment on these issues.

24. The response from [Ms N] contains the statement *The [manager] … has reviewed the notes relating to [Mr A's] care and has not been able to identify an instance where nursing staff declined [Mr A's] requests for pain relief or a Medical Officer review.* [RN I] notes in her response: *In response to [Mr A's] request to see the Medical Officer* [on 30 January 2013] *I noted that in Medtech under the inactive appointments that [Mr A] was initially booked to see the Medical Officer on the 30/1/13 but the appointment has been cancelled by the [manager] with a note saying that the appointment was not required.* I am unable to clarify further the basis for the cancellation. The question here is whether timely and clinically appropriate review was ever arranged in response to [Dr C's] advice, [Mr A's] requests and to the clinical presentation and I believe the answer is emphatically no.

25. Notes for 8 February 2013 indicate health staff contacted [Hospital 1] to ascertain the status of [Mr A's] referrals there and confirmed [Mr A] was not currently scheduled for a shoulder X-ray or ultrasound and no orthopaedic referral had been done. It is unclear what action they took on gaining this information but both [Dr B] and [Dr C] state they were not made aware of this situation.

26. Notes on 15 February 2013 refer to [Mr A] discussing his pain issues with nursing staff — *wants to try going without the BP medication to see if this will eliminate the pains, headaches that he has been having. States he would rather have a heart attack than have to put up with the pain. States he has put in numerous PC01's re medication and why he has not seen the Doctor for all his queries. Advised prisoner it was time to leave.* It is not apparent nursing staff took any definitive action with regard to the pain issues expressed by [Mr A] on this occasion. On 19 February 2013 [Mr A] again complained at the lack of action regarding his pains and the investigations he was supposed to have had undertaken. The RN involved on both occasions (RN L) states she cannot recall whether she followed up on [Mr A's] complaints at this point.

27. On 20 February 2013 [Mr A] requested arnica cream as topical pain relief for his arm pain, and back exercises for his ongoing back pain and on 24 February 2013 [Mr A] again expressed concern at increasing right arm and shoulder pain and the fact his X-rays had not been done. [RN K] states *an e-mail was sent* (not clear to whom) *to follow this up*. On 26 February 2013 [Mr A's] partner contacted

the health centre expressing concern at [Mr A's] pain and unwellness. At the time of his insulin injection he was noted to have a swollen right hand and decreased strength of the right hand. [RN K] recorded *Spoken with acting HCM and decision has been made to book for MO appt at next clinic for discussion around R shoulder/arm.* Comment: Some five weeks following his previous review, nursing staff have arranged for [Mr A] to have access to a MO for clinical review. In my opinion this review was unreasonably delayed and resulted in suboptimal management of [Mr A's] underlying (and as yet undetected) condition. [Ms N] states in her response that [Mr A] was receiving codeine, oxynorm, voltaren, paracetamol and ibuprofen for pain control in February 2013. While strong opioids (oxynorm) were prescribed in March 2013 following his discharge from [Hospital 1], I can find no records to suggest he was receiving oxynorm in February 2013 nor any clinical documentation to suggest the codeine was recommenced following [Dr C's] directive of 25 January 2013 that the NSAID should be sufficient analgesia.

28. Over the next few days, [Mr A] was observed to have intermittent loss of the use of his right hand and to complain of numbness of his right thumb. He had difficulty recapping his needles after administering insulin although nursing staff report there was no consistent pattern to the symptoms. [Mr A's] scheduled MO appointment was finally undertaken on 6 March 2013, there having been no attempt to expedite it in light of the progressive right arm weakness despite [Mr A's] past history of stroke. [Dr C] reviewed [Mr A] on 6 March 2013 ([Mr A] stated he had slipped and injured his right hip on the way to the appointment) and noted no obvious pain over the left clavicular fracture site. Decreased mobility of the right shoulder was evident and *referral was made for xray and scan 8/1/2013.* Diabetes and blood pressure control (including risk of another stroke if blood pressure medication was declined as [Mr A] had been doing) were discussed. Referral was made to [Hospital 1] for cardiology review (later declined) and radiology (unsure what investigation was ordered). It is not clear that the symptoms of intermittent right sided weakness were conveyed to [Dr C] by either nursing staff or [Mr A], and it appears right shoulder pain and reduced mobility secondary to this could have affected an objective review of right arm power. Multiple issues were addressed at the consultation although I would have expected a formal review of the pain management regime which was apparently suboptimal at this point (there is no reference in the clinical documentation to alteration in the regime). Current hip and back pain appeared related to the fall that morning with no evidence of bony injury thus pain related to the fall would generally be self-limiting. Overall, I feel the standard of clinical assessment and management by [Dr C] was adequate on this occasion with outstanding issues (hypertension and chronic right shoulder pain) being adequately addressed by way of specialist referral, and with no acute problem evident.

29. The issue of review of the revised clavicle fracture X-ray report dated 12 February 2013 remains unresolved. [Dr B] does not recall viewing the report and states [Dr C's] signature is evident on the report. [Dr C] does not recall seeing the report and notes it was requested by [Dr B] with copies of the report addressed to him. I do not think it is possible to resolve this issue further other than to suggest

the facility has robust processes in place to ensure potentially abnormal results are acted upon in a timely manner, and that such a process is auditable. In most general practices 'hard copy' reports are scanned on to the PMS and into the provider's 'in-box' where review and actions are recorded and are auditable. However, noting [Dr C's] finding on 6 March 2013 that [Mr A] was not particularly tender over the clavicular fracture site, it seems unlikely high priority would have been given to CT scanning of the area even had such a request been made following receipt of the revised report.

30. On 7 March 2013 [Mr A] complained of a marked increase in back pain and urinary retention with haematuria. He was observed in the prison health centre for several hours before a decision was made to transport him to [Hospital 1] for review. On review in ED [Mr A] was noted to have right arm weakness, R arm/shoulder pain and painful right leg. CT of the head showed frontal lobe and sphenoid sinus masses suggestive of metastases and further scanning showed widespread abdominal metastatic disease thought to be arising from a gastric cancer, and widespread skeletal metastases involving the left clavicle, right scapula, right iliac crest, right acetabulum and multiple vertebrae. Palliative radiotherapy and Alendronate infusion was given but chemotherapy was not thought to confer any survival benefit given the widespread nature of the disease. Further palliative care was undertaken and [Mr A] died [some time later under hospice care].

31. While I do not feel diagnosis of [Mr A's] widespread cancer several weeks earlier than the eventual diagnosis would have impacted favourably on his prognosis, he was denied the opportunity for earlier commencement of adequate palliative care, particularly adequate pain control, and this impacted negatively on his quality of life in January and February 2013. There are several issues I have raised relating to the quality of nursing care [Mr A] received, particularly as it relates to pain assessment, medication management, communication with [Mr A's] medical providers and provision of access to [Mr A's] medical providers. These issues will no doubt be addressed further by the expert nursing advisor.

32. Care provided by [Drs B and C] was dependent to a large extent on the quality of communication with prison nursing staff. The diagnosis of metastatic cancer as the underlying cause of [Mr A's] various pains was not detected during hospital admissions in December 2012 and January 2013 emphasising the difficulties establishing such a diagnosis when the presenting symptoms are non-specific. This difficulty, coupled with what I believe to be a pattern of suboptimal nursing assessments and reporting, I feel were the primary reasons behind the delayed diagnosis and suboptimal symptom management. Under the circumstances I feel the care provided by [Drs B and C] did not depart from expected standards.

33. Also very relevant to the events in question is the unique environment in which the clinicians and nurses are operating and this has been discussed to some degree in [Dr B's] response and needs to be taken into consideration when variations from 'expected practice' are discussed. A UK report on prison

healthcare[2] summarised some of these issues as: *There are particular challenges in maintaining a healthcare ethos to thrive in an environment where the highest priorities are maintaining order, control and discipline. These include:*

i. *Custody affects care in that it removes the opportunity for self-care and independent action, inmates have to ask staff for the most simple health care remedies.*
ii. *The health care teams' access to inmates may have to be curtailed in the interests of security.*
iii. *The proposed actions of medical staff may clash with security considerations.*
iv. *Nurses may be asked to carry out duties unrelated to health care.*
v. *Some patients may be manipulative, try to obtain medication they do not require and create suspicion amongst health care staff of all prisoners.*
vi. *The health care centre is often seen as a sanctuary or 'social care' option for some prisoners, in particular those who are being bullied*

In the case of [Mr A], who had a history of non-cooperation and obstructive behaviour with clinical and non-clinical staff, item (vi) may have particular relevance to the assessment and interpretation of [Mr A's] pain behaviours, and items (ii) and (iii) may have had some influence on some of the medication administration issues discussed.

34. Another UK publication on management of chronic pain in secure settings[3] emphasises the challenges involved: *Confirming a diagnosis of persistent pain in a secure setting is even more challenging because the proportion of patients presenting with false symptoms to acquire analgesic medications for personal use or as currency is greater than in routine clinical practice in the community … Common antecedents of persistent pain may include a history of trauma or a defined episode of tissue damage. The symptoms should bear an intuitive temporal relationship with the putative cause and onset/exacerbation of pain. Persistent pain is usually accompanied by an observable decrement in physical, social and emotional function, but with possible day-to-day variation, such that inconsistency across time does not necessarily denote that the pain is not real*. The publication cited might be a valuable resource for prison staff if they do not have such a resource currently available.

35. Taking into account the discussion above, while I acknowledge the challenges faced by health staff in the custodial environment I feel there were deficiencies in nursing care and administration that require further review by a nursing expert and I recommend such a review is undertaken. A number of remedial actions and process improvements have been noted in the responses received and the adequacy of these should also be reviewed."

[2] Marshall T et al. Health care in prisons: A health care needs assessment. University of Birmingham. 2000.
[3] Public Health England. Managing persistent pain in secure settings. 2013. Accessed July 2014 at http://www.nta.nhs.uk/uploads/persistentpain.pdf

Appendix B — Independent nursing advice to Deputy Commissioner

The following independent clinical nursing advice was provided by in-house nursing advisor, Ms Dawn Carey:

"1. Thank you for the request that I provide clinical advice in relation to the complaints from [Mr A] and [Ms A] about the care provided to [Mr A] whilst he was detained at Spring Hill Corrections Facility (SHCF). [Ms A] is the partner of [Mr A] and the Executor of his estate. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the available documentation on file: complaints from [Mr A] and [Ms A]; correspondence from the Office of the Ombudsman; responses from Department of Corrections (Corrections) including staff statements, [Mr A's] MedTech notes from 1 November 2012–5 April 2013, medication administration record (MAR) sheets [Diclofenac sodium 3 November 2012–14 January 2013, Codeine phosphate 19 December 2012–11 January 2013, 'blister pack' medications 19 December 2012–9 January 2013, Prochloperazine malente 21 December 2012–1 January 2013, Nortriptylline 25 December 2012–8 January 2013, Laxsol 20 December 2012–1 January 2013, Codeine phosphate 12–21 January 2013, Notriptylline 9–22 January 2013, Clopidogrel 10–19 January 2013, 'blister pack' medications 9 January–5 February 2013, Diclofenac sodium 12 January–10 February 2013, 'blister pack' medications 7–11 February 2013, 'blister pack' medications 12–2 March 2013, 'blister pack' medications 3–5 March 2013, Oxynorm 22–26 March 2013, blister pack' medications 22–27 March 2013, Roxithromycin 23–27 March 2013, Dexamethasone 23–27 March 2013, Oxycontin 22–27 March 2013, Oxynorm 26–27 March 2013, Mylanta 23–25 March 2013], Prescribed Medication Charts (PMC) 8 January 2013, Medication Log Sheets (HS 3-2-4) [10–16 January, 17–23 January, 7–13 February 2013, 14–20 February 2013, 22–26 March 2013], Drug administration Chart (DAC) 1–3 February 2013, Medication Log Sheet (B.06.08.F1) 26 March 2013; response from [DHB2] including copy of [diabetes clinic] letter; response from [DHB1] including [Hospital 1] clinical file; Clinical advice from Dr D Maplesden.

3. Prior to his death [Mr A] complained about the standard of care that he received from SHCF. His complaint issues are that:

   - He was given the wrong insulin on 5–7 November 2012. [Mr A] was prescribed Humulin N (green vial) and Humulin 30/70 (brown vial) and had self-medication administration authority. He alleges that on 6 November 2012 the RN gave him two green vials. The RN has documented that one vial of Humulin N and one vial of Humulin 30/70 was given.
   - He received poor care from nursing staff on 2, 3 and 4 December 2012 after suffering a fall secondary to a stroke, and fracturing his clavicle.

- On 19 December 2012 he was told the new time for his insulin was mid-afternoon (1630–1700hrs) instead of his 'usual' time of late evening (1830–1930hrs) without any explanation. He refused the mid-afternoon dose and was not given any insulin that evening.
- In mid-January 2013 he did not receive pain relief and nortriptyline as charted and there were delays in administration of his insulin.

I have been asked to review the nursing care provided to [Mr A] and to provide advice on the standard and appropriateness, particularly in relation to:

- pain assessment;
- medication management (including his insulin regime);
- nursing care 3–5 December 2012, including nursing interactions with [Hospital 1] Emergency Department (ED) staff;
- communication with his medical providers;
- provision of access to his medical providers for review;
- whether nursing staff followed medical officer (MO) instructions appropriately;
- the time taken to arrange a medical review for [Mr A] on his discharge from [Hospital 1] on 18 December 2012;
- whether nursing staff appropriately followed Corrections policy and procedure.

I have also been asked to review:

- the received responses and to comment on the adequacy of the specified remedial actions and process improvements;
- the documentation processes surrounding the supply of insulin to [Mr A] and advise whether they were sufficiently robust

4. Provider response(s)
Detailed responses have been received from the providers involved. For the purpose of brevity the content of these responses will not be repeated in full. Corrections reports that while a formal investigation has not been made into [Mr A's] complaint, the relevant notes have been reviewed by a manager. In summary, this review determined that:

- no incident could be identified where nursing staff declined [Mr A's] request for analgesia
- no incident could be identified where nursing staff declined [Mr A's] request for a MO review
- there is very limited documentation describing the clinical presentation of [Mr A's] pain experience or the rationale for the decisions made. To rectify this training sessions and team discussions about pain assessment and documentation needs have taken place.

In response to specific questions, Corrections reports that:

- [Mr A's] right to self manage his Insulin was revoked due to him not complying with specified requirements and holding more needles than authorised.
- A plan of care in relation to his insulin management was agreed with [Mr A] on 19 December.
- A clinical decision was made that there would be no adverse implications for changing the Insulin administration time from nocte to mid afternoon.
- [Mr A] declined to attend his external appointment at [Hospital 1] due to the discomfort of the prison escorting van.
- The [DHB1] letter declining the referral for an Xray and ultrasound was not reviewed by the MO. Changes to how external provider information is processed and reviewed have been made.
- [Mr A] was reviewed almost daily by the SHCF nursing team and had his blood pressure taken most days.
- In February 2013, [Mr A] was receiving Codeine phosphate, Oxynorm, Diclofenac sodium, Paracetamol and Ibuprofen to manage his pain

5. **Pain assessment**

Following a review of the submitted documentation, I note the following:

i. On 8 January 2013 Codeine phosphate was prescribed four times a day (QID) PRN for 14 days. This analgesia was generally administered two times/day (BD). A request for Codeine phosphate was denied on 19 January, with documentation reporting it as … *nil available on nurse ? script has finished …*

The received RN response reports checking [Mr A's] prescription and noting that it was *for two weeks only. The patient was advised of this on 23/01/2013 when I saw him in clinic.*

Comment: In my opinion [Mr A's] prescription for Codeine phosphate was still valid on 19 January 2013.

ii. The need to complete a pain assessment for [Mr A] is documented in Medtech notes (25 January 2013) and on a handwritten handover sheet (31 January).

iii. Throughout January 2013 [Mr A] regularly reported pain; regularly requested analgesia; complained that his prescribed analgesia was ineffective; and reported that pain was impacting on his ability to sleep.

iv. Following advice about the process to request a MO appointment, two 'health chits' were submitted by [Mr A] on 31 January 2013. Response to the 'chits' was a same day nursing appointment to discuss pain and *complete assessment.* At the nursing appointment [Mr A] was advised *... to discuss concerns with m/o at next appointment or to complete a health chit to request discussion.*

v. Further 'health chits' seeking a medical review and complaining of continuing pain are referred to in the nursing Medtech entries during February 2013.
vi. 27 February: Due to swollen hands affecting his ability to hold his Insulin pen, an appointment for MO review was made for 6 March 2013.
vii. On 7 March [Mr A] was transferred to [Hospital 1] ED due to complaints of difficulty passing urine and increased pain following a fall the day before. Medtech notes on 8 March, report SCHF being informed ... *prisoner has lesion on his brain ...*
viii. Oxycontin and Oxynorm was commenced at [Hospital 1]. These medications were continued at SHCF when [Mr A] was discharged from [Hospital 1] on 22 March 2013.

Comments:
In my opinion, the nursing approach to assessing [Mr A's] pain experience was suboptimal. I base this on the lack of objective pain assessment documentation and the continued reporting of symptoms without variation of nursing response. I disagree strongly with a RN suggesting that pain assessment is only required when a MO specifies it. Pain assessment should cover the location, intensity, duration, and factors that alleviate/aggravate it. It is expected that the plan for managing the health consumer's pain is documented and that administered analgesia/therapies are routinely evaluated for effect.

The provider acknowledges that [Mr A] could not access a MO review without undergoing a nurse appointment and assessment first. In such circumstances it is absolutely paramount that the RN ensures that clinical knowledge and objective assessment inform the subsequent plan to action or deny the request for review. Whilst I note the remedial actions taken by the provider; I remain critical that a health consumer would require analgesia on a regular basis, complain about pain regularly, be reviewed by nursing staff due to submitted 'chits' detailing pain, have care reviewed by nursing leaders in response to his complaints about pain and lack of medical access, and still not be adequately assessed. In my opinion, the provided care does not reflect RN professional competencies[1] and demonstrates significant departures from the expected standards of nursing care.

6. **Medication management**
Following a review of the submitted documentation, I note the following:

i. 7 November [Mr A] requested ... *2xHumulin 30/70… Prisoner was given this* yesterday. *Triage nurse will have to check what insulin prison has. Placed on communication book.*

There is no contemporaneous reportage confirming that this check was done. Subsequent reportage details [Mr A] expressing anger and frustration. After being found to have five needles — was allowed to hold two — his authority to self medicate was withdrawn.

[1] Nursing Council of New Zealand (NCNZ), *Competencies for registered nurses* (Wellington: NCNZ, 2007).

ii. Upon transfer from [Hospital 1] on 18 December, [Mr A's] medication regime was altered; this included his Insulin being reduced to 64 units morning and 40 units night and Metformin being increased.

iii. 19 December 2012 [Mr A] refused his Insulin administration. Untimed contemporaneous notes report … stated *that he does not get his Insulin at this. He wanted it at 1930, I tried to explain that he needed his insulin with TEA but he refused … He did not want it at this time I informed him that we were here to give insulin to him and medical was not going to come later so you are refusing it …*

As this RN is no longer employed at SHCF no response statement has been submitted. I note that previous instructions report *14 November 2012 … Nursing staff are to take insulin on medication round as pt has his insulin normally at 1900hrs …*

The Corrections response does not specifically acknowledge [Mr A's] allegation that the RN was attempting to administer his Insulin hours earlier rather than approximately 30 minutes earlier. I would consider administration of Insulin some hours earlier than prescribed to be a severe departure from expected standards. I have found no documentation to support the Corrections response that a plan of care in relation to Insulin administration was agreed on 19 December.

iv. Documentation shows that [Mr A] was administering *… 60 units of Insulin as charted …* under supervision of RNs. This dose is reported on 25, 27 and 28 December 2012. This is less than was prescribed by [Hospital 1] and without further commentary by the RN scribe.

v. 25 December [Mr A] was recommenced on Nortriptylline medication. Whilst the discontinuation of Nortriptylline is reported to SHCF via the [Hospital 1] discharge summary — 18 December 2012 — it does not appear to have been noted by the SHCF health care team or communicated to the relevant pharmacy. [Mr A] continued to be administered Nortriptylline — 14 occasions — without a valid prescription. Noting that the medication was being administered, MO [Dr B] represcribed a two week course on 8 January 2013.

vi. While [Mr A] frequently refused his prescribed Simvastatin and Dilitiazem there are also incidences when there is no documentation to verify that he was given or refused to take these medications as prescribed.

vii. There are numerous incidences spanning December–February inclusive when there is no documentation to verify that [Mr A] was given or refused to take his prescribed [Metformin, Quinapril, Aspirin, Clopidogrel, Pantoprazole] medications.

viii. Based on incomplete HS3-2-4 documentation [Mr A] did not consistently receive his lunch time dose of Metformin.

ix. Contrary to the prescription, [Mr A] was administered Diclofenac sodium 75milligrams (mgs) Slow Release (SR) tablets on three occasions in the

same twenty hour period. This is more than he was prescribed or is recommended.

x. [Mr A] was administered both Diclofenac sodium and Ibuprofen. This combination is contraindicated and should not have been administered.

xi. Prior to March 2013 the administration times for 'as required' (PRN) medication is consistently not recorded. I am critical of this.

Comments

Safe medication administration is an indicator that sits within RN competencies[2]. It is a nursing competency that all RNs are deemed to have achieved following successful completion of their undergraduate education, examinations and registration. [Mr A's] complaint alleges that he did not receive the correct Insulin during November 2012. The provider disputes this. While the contradictions within the provider's responses make it difficult to accept this assurance, I cannot definitively determine whether errors occurred during this period or not. However, due to the noted examples (section 6), I do consider that the general provided nursing care in relation to medication management did depart from the expected standards.

When a task such as medication administration is delegated, the RN retains accountability[3] for ensuring that the prescribed medication is offered and that the documentation reflects this. Safe medication administration means there is an expectation that the RN looks at when the previous dose of a medication was administered. If this had been done, incidences where [Mr A] either did not receive his prescribed medications or there was a documentation omission would have been realised in a timely fashion and captured in the relevant incident process. Such actions enable an acknowledgement of the error, the opportunity to analyse the factors that facilitated the error, and to ensure that practice supports quality care rather than error prone care. I have found no contemporaneous nursing documentation which refers to incident processes — electronic or hard copy — being completed for the identified incidences where [Mr A] received contraindicated medications, inappropriate dosing, or may not have received his prescribed medications. I am critical of this.

7. **Nursing care 3–5 December 2012, including nursing interactions with [Hospital 1] ED staff**

Following a review of the submitted documentation, I note the following:

i. On 3 December at 9.20pm, the Prison Officers responded to [Mr A] activating his emergency bell. The Officers noted him to be cold, sweaty and not very responsive. [RN F] was on-call and contacted. Her initial advice was to give [Mr A] his glucose tablets or if unable to find them to give him something sweet. Upon RN assessment, [Mr A's] blood sugar level (BSL) was 4.7mmols/L, increasing to 5.1mmols/L after washing his

[2] Nursing Council of New Zealand (NCNZ), *Competencies for registered nurses* (Wellington: NCNZ, 2007).
[3] Nursing Council of New Zealand (NCNZ), *Guideline: Direction and delegation* (Wellington, NCNZ, 2008).

hand. Blood pressure (BP) was *180/110, prisoner's BP is normally high, pulse 87*, oxygen saturations (SpO_2) *98%* on room air. He was noted to be *not responding well to nurse's questions …* The RN reports contacting the [Hospital 1] ED Registrar, and being advised that *he didn't think he needed to see him.* Upon return to [Mr A's] cell … *Still no change with prisoner, obs remain the same. BSL 5.9. Prisoner had spat out glucose tablet. Nurse asked Officers to keep checking him through the night and any change to ring her. Time now 23.10.*

ii. 4 December — *Phone call received at 0827:– prisoner is unable to get out of bed to attend his 0830 appointment for insulin.* Observations taken at 8.50am by [RN G] report [Mr A] walking with support of two Officers. … *Stated that he felt dizzy since last night. Obs BSL 7.4. Temp 35.9, BP 144/84,* SpO_2 *98% on room air … Vomited … He stated he is feeling dizzy and has a headache — all over his head … Knows where he is at present …*
9.20am *BP 159/100,* Heart rate (HR) *87bpm,* SpO_2 *95–98% on room air. Coherent and able to answer questions …*
10.30am *had vomited approx. 100mls … time not witnessed … Observed approx. 10min intervals.*
11.15am *BP 165/99, HR 84bpm,* SpO_2 96% *on room air, easily rousable, BSL 6.8*

iii. RN H provided care to [Mr A] between 1–9pm. [Mr A] was reviewed in the Day Cell until he left at approximately 2.15pm to return to his own cell. Notes report *… c/o head ache and L upper chest pain. Prisoner stated that chest pain is from manual handling of the prisoner by an officer this am while helping him to move …* RN statement reports that [Mr A's] *complaints were general unwellness, dizziness, headache, nausea, muscular pain around his upper chest on movement.* Within the Medtech system there is no evidence that RN H completed an incident system report.

iv. MAR sheet shows that [Mr A] received 75mgs Diclofenac sodium on two occasions on 4 December 2012. No administration times are recorded. This medication usually requires adequate diet to be taken also.

8. **Comments**

[RN F] — In my opinion, the initial advice given by [RN F] to the Prison Officer on 3 December 2012 was appropriate as [Mr A] was a known diabetic. Based on the observations reported when the RN arrived — significant hypertensive, reduced responsiveness without hypoglycaemia — I am critical that there is no commentary that relates to assessing for signs/symptoms of a cardiovascular or cerebral event. [Mr A's] known diabetes and hypertensive status appears to have stopped the RN from evaluating his symptoms objectively. I am also critical that the advice from the ED Registrar was not questioned when there was no noted improvement in [Mr A's] clinical presentation. I disagree with [RN F's] response that she treated [Mr A] according to the symptoms that he had. I am especially critical that a

requirement for ongoing monitoring would be handed to a non-health practitioner.

In my opinion, the expected standard of nursing assessment and monitoring would have necessitated further and more frequent vital sign monitoring by a health practitioner. In my opinion, [RN F] should have arranged for the transfer of [Mr A] to the ED and have provided ongoing monitoring whilst the transfer was being arranged. I consider that the provided care departed moderately from expected standards in relation to assessment, monitoring and documentation.

[RN G] — In my opinion, [Mr A] was monitored appropriately by [RN G]. I am mildly critical of the lack of assessment regarding [Mr A's] headache such as onset, description of pain etc should have been sought. I am also critical that his need for support to mobilise was not further evaluated or assessed. In my opinion, [Mr A's] reported symptoms and medical history should have resulted in advice being sought from the MO or from [Hospital 1] ED by [RN G]. I consider that the provided care was a mild–moderate departure in relation to assessment.

[RN H] — There is no contemporaneous evidence that [RN H] assessed [Mr A's] left upper chest area for injury. I am mildly critical that [Mr A's] vital signs were not taken prior to his discharge from the Day Unit. In my opinion, there was again an opportunity to perform a comprehensive pain assessment in relation to [Mr A's] persistent headache that was unrelieved by analgesia. I consider that the care provided departed mildly in relation to assessment, monitoring and documentation.

9. **Communication with medical providers; whether nursing staff followed MO instructions appropriately; time taken to arrange MO review when discharged from [Hospital 1] on 18 December 2012.**

Following a review of the submitted documentation, I note the following:

i. [Mr A] was discharged from [Hospital 1] on 18 December 2012. He was reviewed in the *... receiving office due to staffing ... Will review d/c paperwork on return to main health unit and make necessary appointments.* The RN statement refers to completing this task. Specified plan from [Hospital 1] included —

Review with prison Doctor in 1/52

Fracture clinic follow up 1/52 please

ii. [Mr A] was reviewed by MO [Dr B] on 8 January 2013. Specified plan included *new ACC claim record, refer for xrays and USS, request repeat physio review with a view to assessment of rehab of R shoulder injuy. ... Cont codeine ... PRN for next two weeks ... See me in two weeks for review of multiple issues recommended ...*

iii. 15 January — [the] Health Administrator logs that [DHB1] declined the Xray and Ultrasound referral which was sent by MO [Dr B] on 8 January.

iv. 23 January — [Mr A] was reviewed by [Dr C], who *discussed that referral has been made to radiology for xray …* Discussion also included the risks in [Mr A] stopping his Diltiazem medication. As this situation had been addressed by [Dr C] already, an appointment made by the RN for 25 January to discuss this was cancelled.

v. 25 January — [Mr A] attended [a diabetes clinic]. The lack of accompanying documentation compromised the clinicians' ability to fully evaluate his glycaemic control and general health status. However, there was sufficient concern about [Mr A's] pain experience for SHCF health services to be telephoned. Upon return from [the diabetes clinic], [Mr A] reported some of the recommendations, *was told to by Doctor… because he had lost weight and should be reducing his insulin. Also stated he was told he should be on different BP meds …* The clinic letter detailing the assessments and plan was processed and sent to SHCF some time after the appointment. Date of typing the clinic letter is reported as 29 January 2013. Whilst there is no entry logging its receipt at SCHF, there are handwritten notes on the submitted file copy.

vi. 31 January — [Mr A] was transferred to [Hospital 1] ED at approximately 8.15pm with radiating chest pain unrelieved by GTN spray. His discharge summary — 1 February, 12.33am — advises *give pain relief as needed for pain. If shoulder is an ongoing concern GP to refer back to Ortho clinic.* The receipt of this letter is noted by SHCF RN.

vii. 4 February — Entry by a senior nurse [RN J], in response to a submitted complaint from [Mr A]. His complaint relates to pain; the fact that [the diabetes clinic]Doctor was told by SHCF RN that [Mr A] was booked to attend [Hospital 1] for his shoulder/ligaments to be sorted out and that he has now been told that there is no appointment *… I'm in pain continually and not able to sleep because of it …*

viii. 7 February — [Mr A] submits a health chit requesting to see the MO and complaining that *… Doctor told me he would see me on 5th Feb 2wks afta been seen by him …*

ix. 8 February — [the] Health Administrator logs contacting [DHB1] and being informed that there was no referral for ultrasound scan.

x. 19 February — *Requesting to see MO … Wants to know the reason as to why he is not being seen re back/shoulder … Requests to have reasons in writing. States [Dr B] has not followed up with what he was going to do. Complaining ++++++ …*

xi. 26 February — *Ph call today from partner … stating [Mr A] is very unwell and hasn't seen MO … Suggest ongoing pain issues d/w MO at next clinic …* When [Mr A] was seen later that day, he was noted to have difficulty with testing his BGL due to a swollen right hand. The RN and a manager agreed to book a MO appointment for the next clinic — 6 March.

Comments

As noted in section 6, the discharge medication regime from [Hospital 1] does not appear to have been reviewed adequately or changes communicated to the pharmacy. This resulted in a series of medication errors, which I view to be significant departures from expected standards. I am also critical [Mr A] did not receive his prescribed Codeine phosphate as requested or prescribed.

In my opinion, [Mr A] experienced a significant delay — twenty days — before he was reviewed by the MO upon discharge from [Hospital 1]. I note that the provider response reports that this was due to the Christmas holiday period. Whilst such periods do create scheduling challenges I am concerned that there is no evidence that the nursing staff communicated [Mr A's] clinical presentation on 20–21 December 2012 to the MO. This presentation included occipital pain, hypertension, agitation and the refusal to attend his fracture clinic appointment due to the small van *make him uncomfortable.* Despite MO [Dr B's] documented plan and the reportage that a RN was present at the consultation, I have found no documentation showing that the requested review with the physiotherapist occurred or that a follow up appointment with MO [Dr B] was made.

It is not clear whether [Dr C] was aware of [the diabetes clinic]letter or the [Hospital 1] (1 February) discharge summary. It is also not clear whether [RN J] was aware of the [Hospital 1] discharge summary and recommendation for a MO referral should [Mr A] have ongoing issues with his shoulder. It is also not clear whether [Dr C] was aware of [Mr A's] repeated requests to access him. I am critical that nursing staff would not pass these requests on and would not check whether follow up appointments should have been made or not. I acknowledge the Corrections response reports that [Dr C] was present at the clinical handovers on his weekly clinic days. Nursing staff perceived that his presence meant that he was briefed and kept appropriately informed about [Mr A's] health status. However, on some pertinent issues [Dr C] reports not being informed or aware. The lack of nursing documentation and nursing advocacy for [Mr A] make it difficult to dispute this position.

Accurate documentation is a critical element of nursing practice. Clinical records must be accurate, concise and include the care that is given or planned. Discussions held with the wider healthcare team and the health user also need to be captured[4]. In my opinion, the SHCF system for keeping abreast of external provider's plans was suboptimal. Based on the available evidence I also consider that the quality of clinical communication from RN team to MO team to be suboptimal and not patient centered. In my opinion, nursing staff prevented [Mr A] having appropriate access to medical care and review. I am especially critical that decisions to prevent access were in isolation of clinical assessment or clinical rationale. If the RN role was to 'triage' [Mr A's] need for medical care then I view the provided nursing care to have significantly departed from expected standards.

[4] New Zealand Nurses Organisation (NZNO), *Documentation* (Wellington: NZNO, 2010).

10. **Documentation Processes for recording delivery/administration of Insulin**

I have not received documentation that details the process in place for recording delivery of Insulin. I note that in November 2012 — when [Mr A] was holding and administering his Insulin — the 'dispensing' RN was recording the delivery in the Medtech notes. I note that the Medtech system does not automatically record time of entries. In my opinion, this process can facilitate complaints such as [Mr A's] allegation that he did not receive the correct Insulin vials. I note that within SHCF, resupply of medication that is self-administered needs to be requested prior to the medication rounds. I would recommend that the provider considers developing a system where checks and receipt are documented e.g. the requested Insulin is checked and logged by two nurses when leaving the pharmacy. The Insulin is subsequently checked and signed for by the dispensing RN and the prisoner when delivered.

I note that some of the RN responses acknowledge that they did not always record the type or volume of Insulin administered to [Mr A] and have changed their documentation practice accordingly. I agree that such documentation is required and especially when the health consumer is varying the dose of a medicine as [Mr A] did routinely.

11. **Compliance with Corrections Policies and Procedures**

The 'Medication — Special Hospital scripts' Procedure details nursing actions that should have happened when [Mr A] was discharged from [Hospital 1] on 18 December 2012. There is no evidence that these steps were done, which in my opinion facilitated medication errors over a sustained period of time. This Procedure also specifies that the MO review the new script within two days. As discussed in Dr Maplesden's advice this action appears to have not occurred either.

12. **Remedial actions and process improvements**

In my opinion, poor documentation practices impacted on all issues within this complaint. I note that remedial actions include auditing and education to ensure that documentation processes meet expected standards. I would strongly encourage Corrections review to share the learning from this complaint across all correctional health services. Whilst I agree and consider that the remedial actions are appropriate, I consider that many of them should have been in place from the outset.

I note that work has been initiated around diabetic patient management. I am unsure whether this has included a process where the 'receipt' of Insulin vials etc is signed for by the recipient prisoner. In my opinion, such an action would be part of a robust medication dispensing system and valid to this complaint. I agree with the provider that 'carrying over' MAR signing sheets and having multiple sheets for the same time period can facilitate errors. I note that remedial actions have addressed this issue. I agree that this is appropriate. I would recommend that Corrections review the work of Health

Quality and Safety Commission in relation to reducing medication errors and safe administration processes. In my opinion, audit processes should also be adopted to review medication administration practices/documentation of registered nurses and when the task is delegated. I would also recommend that Corrections consider implementing a communication tool such as SBAR[5] to frame interdisciplinary clinical communication.

Additional comments

To meet requirements clinical entries should include the time of documentation. I note that the electronic documentation system used by the provider does not easily support health professionals to meet this requirement. Acknowledging that this affects many health providers I would still recommend that Corrections consider exploring this with the relevant software engineers.

13. **Clinical advice**

I note that the majority of nurses providing care to [Mr A] had 5 years or less experience before gaining employment in SHCF. One was a new graduate with others also in their first year of nursing practice. However, registered nurses are accountable for ensuring that all health services that they provide are consistent with their education and assessed competence[6], meet legislative requirements and are supported by appropriate standards[7]. This is the expectation even when the RN is inexperienced and working in the particularly challenging environment of a correctional facility.

Of relevance, section 75 of Corrections Act, 2004 (Medical treatment and standard of health care) states that:

(i) *A prisoner is entitled to receive medical treatment that is reasonably necessary*

(ii) *The standard of health care that is available to prisoners in a prison must be reasonably equivalent to the standard of health care available to the public*

Following a review of the submitted documentation, I am of the opinion that the standard of nursing care provided to [Mr A] at SHCF did not meet legislative or professional requirements.

I consider that the provided nursing care in relation to:

Pain assessment — was suboptimal and a moderate departure from expected standards of nursing assessment.

[5] Available from http://www.ihi.org/resources/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx

[6] Nursing Council of New Zealand (NCNZ), *Competencies for registered nurses* (Wellington: NCNZ, 2007).

[7] For example Health & Disability Services Standards (2008); The Medicines Act (1981) and associated regulations; The Misuse of Drugs Act (1975) and associated regulations.

Medication management — was a severe departure from expected standards of safe medication administration.

Nursing care 3–5 December 2012 — care was provided by three RNs. I consider that the provided care departed from expected standards.

Nursing interactions with [Hospital 1] Emergency Department (ED) staff on 3 December 2012 — was suboptimal.

Provision of access to his medical providers for review — was suboptimal and a moderate–severe departure from expected standards.

Whether nursing staff followed medical officer (MO) instructions appropriately — No.

Time taken to arrange a medical review for [Mr A] on his discharge from [Hospital 1] on 18 December 2012 — I consider that there was a significant delay and that nursing staff were not appropriately responsive to [Mr A's] clinical presentation during this time.

Corrections Policies and Procedures — In my opinion nursing staff did not comply. I am also critical that procedures were not in place to check and support compliance.

Remedial actions and process improvements — I consider that the actions specified are appropriate and generally adequate. I do consider that further actions are required to prevent a similar complaint. I would strongly recommend that audit processes are adopted to review RN and delegated medication administration practices/documentation on a regular basis.

Processes for recording the dispensing of Insulin vials — In my opinion these were not sufficiently robust.

Dawn Carey (RN PG Dip)
Nursing Advisor
Health and Disability Commissioner
Auckland"

Ms Carey provided the following further comment:

"I have reviewed the response to [the provisional opinion] sent on behalf of [RN H]. I have also reviewed the relevant contemporaneous entry and note that [Mr A's] blood pressure (BP), pulse and oxygen saturations are recorded, which negates my mild criticism that [Mr A's] vital signs were not taken prior to his discharge from the Day Unit. I remain critical of the lack of comprehensive pain assessment and continue to hold the opinion that the nursing care by [RN H] departed mildly from accepted standards in relation to assessment and documentation."