HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Delay in escalation of care by prison health staff leading to emergency surgery

1. On 22 August 2022, the Health and Disability Commissioner (HDC) received a complaint from Ms A about the care provided to her by clinical staff at […] prison (Department of Corrections). The complaint concerns the delay in escalating Ms A's care following her initial presentation of symptoms on 29 June 2022 until her admission to [her local] hospital Emergency Department (ED) on 5 July 2022, following which she underwent surgery for a burst appendix.

Background

2. On 29 June 2022, Ms A was seen twice by registered nurses (RNs) after a standard morning medication round. The nurses noted that Ms A had been vomiting for the last three days and had been unable to keep food down. Ms A told HDC that one of the nurses told her that she had a 'stomach bug', and at a subsequent appointment, when she said that her symptoms persisted, she was told to 'ride it out'.

3. The prison stated that its Medication Administration Policy at the time required that a nurse completing a medication round would not take full observations of a patient unless it was considered medically urgent. If a patient raises a health concern during the medication round, they are either advised that a nurse will follow up when back in the health centre, or the patient is asked to complete a health request form. The prison denied that clinical staff told Ms A to 'ride it out' and stated that treatment was focused on the management of nausea and vomiting and maintaining hydration, as nurse assessments indicated a possible viral illness and an absence of any red flag symptoms.

4. Ms A was seen by multiple nurses over the next six days due to her nausea, vomiting, and diarrhoea. There are no documented records showing that observations (such as temperature, blood pressure, or pulse), abdominal examinations, and/or description of bowel movements were taken at these assessments. There is also no evidence of a fluid balance chart to monitor Ms A's fluid intake against loss of fluid through vomiting. There is also no clear record of the effect of pain medication provided. While clinical notes record 'nil major fatigue' and no diarrhoea or vomiting, Ms A told HDC that this is inaccurate and does not provide the full picture. The nurses recorded that their clinical impression of Ms A's symptoms was that of a viral infection. On 5 July 2022, Ms A was seen by a medical officer, who ordered blood tests and referred Ms A to the local hospital ED. Clinical records note some observations and abdominal assessments being conducted at this appointment, but Ms A denies that any such assessments were taken and stated that the medical officer did not address any of her questions.

5. Following her admission and further assessment by hospital staff on 5 July 2022, Ms A was considered to have a burst appendix. On 6 July 2022, she underwent an operation to remove her appendix, drain a pelvic abscess, and remove a section of her large intestine. She was

discharged on 14 July 2022 with advice that she be monitored by nursing/medical staff regularly.

6. The Department of Corrections accepted that the nursing assessments and documentation related to the care of Ms A did not meet professional nursing standards and the Department's expectations consistently. However, it stated that its health team were experiencing high volumes of staff vacancies, staff turnover, and unplanned absences at the time of these events. The Department of Corrections told HDC that the prison also had no permanent Health Centre Manager nor access to a Clinical Quality Assurance Advisor at the time.

7. Ms A told HDC that, at the time of these events she was in a vulnerable and dependent state, and the clinical staff did not do enough to escalate her care. She said that the consequences of these events have greatly affected her in her personal life, and she has had to undergo a second operation since the events.

Independent clinical advice

8. Further to the information provided, I sought independent clinical advice from RN Barbara Cornor, who advised the following:

- The assessment and management of Ms A's symptoms (including the failure to undertake abdominal examinations and to monitor vital signs) is a severe departure from accepted standards.
- The failure to escalate Ms A's care in light of her symptoms is a severe departure from accepted standards. The lack of good assessments and consistency in documentation do not provide a clear picture to determine 'deterioration' to enable an opinion of timeliness of the clinical intervention.
- The failure to monitor Ms A's bowel movements is a severe departure from accepted standards.

Responses to provisional report

9. Ms A and the Department of Corrections were given an opportunity to respond to the provisional report.

10. Ms A thanked HDC for its thorough investigation and is grateful for the changes the prison has made since the events. She told HDC that she is still struggling to comprehend the events and will have to bear the lifelong trauma from the events.

11. The Department of Corrections accepted the proposed recommendations and had no further comments to add.

Decision: Department of Corrections — breach

12. In a prison setting,[1] Ms A was heavily reliant on clinical staff to assess and escalate her care so that she could receive the care required in an appropriate and timely manner. I consider that, despite multiple reviews of Ms A between 29 June and 5 July 2022, her symptoms were not assessed or managed appropriately. This included a failure by the RNs to complete abdominal examinations, take and record vital signs, and monitor Ms A's bowel motions, and to document each nursing assessment accurately. As noted by my advisor, RN Corner, bowel monitoring is a basic requirement of any abdominal pain assessment, and it should have been a priority in Ms A's case, as she complained of diarrhoea at the onset of her symptoms.

13. Due to the inadequate assessment and monitoring of Ms A's symptoms, the nurses at the prison did not escalate her care appropriately, despite the presentation and persistence of her symptoms between 29 June and 5 July 2022. Ultimately, Ms A required an urgent operation on 6 July 2022.

14. From the information provided, and the changes made since the events (set out below), it is clear that insufficient systems and support were in place for the prison clinical staff to perform their roles, including a lack of clinical oversight, insufficient training on clinical documentation, and inadequate guidance regarding managing triage requests. Accordingly, I find the Department of Corrections in breach of Right 4(1)[2] of the Code of Health and Disability Services Consumers' Rights (the Code) by failing to provide appropriate care to Ms A and to escalate her care in light of her symptoms and multiple presentations.

Changes made

15. The prison told HDC that the following changes have been made since the events:

- A Clinical Quality Assurance Advisor (CQAA) has been assigned to the region (which supports the prison health team).
- Medical officer hours have increased by six hours a month to provide additional appointments and support.
- Corrections' National Health Quality and Practice Team updated its Clinical Documentation and Communication Guidelines in 2024.
- MedTech (patient management system) has been updated to encourage documentation against SOAPIE.[3]
- An education session on clinical documentation was held in June 2024, with the recording made available to staff.
- A national clinical documentation audit was conducted across all prison sites (including this prison).

[1] Under section 75 of the Corrections Act 2004, prisoners are entitled to receive medical treatment that is 'reasonably necessary', which must be 'reasonably equivalent' to the standard of health care available to the public.

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

[3] An acronym to describe a framework for clinical documentation: Subjective data, Objective data, Assessment, Plan, Intervention, Evaluation.

- Corrections implemented a new Triage of Health Requests Forms procedure in March 2024, which provides additional guidance and identifies priority levels to manage requests and escalation of care.
- The role of Deputy Commissioner Women's Prisons was established in April 2024 to strengthen connection between frontline operations through a formalised women's prison network and to provide stewardship.
- Peer review meetings for medical officers were established in 2023 to provide a support mechanism and an opportunity to discuss issues.

Recommendations and follow-up actions

16. I recommend that the prison provide a written apology to Ms A for the failings set out in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

17. In addition, I recommend that the prison provide HDC with an update on its intended actions, namely:

- A copy of the updated additional guidance and expectations on assessment and documentation requirements, as well as a summary of the findings of the follow-up audit scheduled for August 2025 with any corrective actions. This is to be provided within three months of the date of this report;
- Evidence that all staff at the prison have completed the Graduate Certificate in Nursing: Rural Assessment of the Deteriorating Patient at Ara Institute of Canterbury, in the form of staff attendance records. This is to be provided within six months of the date of this report;
- Confirmation that its online training module on pain management has been completed, and evidence that the module has been included in training materials. This is to be provided within six months of the date of this report;
- Confirmation that the prison's monthly quality meetings and […] regional clinical governance meetings have been re-established by the CQAA in the form of a copy of the first meeting minutes from each meeting. This is to be provided within three months of the date of this report; and
- A copy of a summary of the findings from the clinical documentation audit to be conducted by the end of November 2025, along with any corrective actions. This is to be provided within six months of the date of this report.

18. A copy of this report with details identifying the parties removed, except the Department of Corrections and the independent advisor on this case, will be sent to the Office of the Inspectorate, the Chief Executive of the Department of Corrections, and the Nursing Council of New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Dr Vanessa Caldwell

Deputy Health and Disability Commissioner

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from RN Barbara Cornor:

'Complaint: Our ref: Independent Advisor:	**Ms [A]/[…] Women's Prison** **C22HDC02054** **Ms Barbara Cornor**

I have been asked to provide clinical advice to HDC on case number **C22HDC02054.** I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in the complaint.

I am aware my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	Registered Nurse Master Nursing
Documents provided by HDC:	1. Letter of complaint dated 22 August 2022 2. […] Women's Prison response date 4 November 2022 3. Clinical records from […] Women's Prison covering the period 3 June 2022 to 2 November 2022 4. Appendices 2,3, and 5 from […] Women's Prison 5. Health Care Pathway Policy Corrections Health Services (received 29/01/2025) 6. Telehealth Triage Guidelines 7. Medication Administration Policy 8. Red Flags Poster Clinical Assessment
Factual summary of clinical care provided complaint:	
Brief summary of clinical events:	Ms [A] reported during the morning medication round of June 29, 2022 she was feeling unwell with diarrhoea and vomiting since the previous "night". She was seen and assessed by Registered Nurses (RN) on several occasions following that date. Her illness is reported as fluctuating, but there is no improvement following a seven-day period.

	Ms [A] was referred to the Medical Officer (MO) for assessment and examination 5 July 2022. On that date, the MO referred her to the Emergency Department (ED) for further assessment.
Question 1. Whether the assessment and management of Ms [A]'s symptoms was reasonable. Please include comment regarding the failure to take and record Ms [A]'s vital signs.	
List any sources of information reviewed, other than the documents provided by HDC:	[…] and […] Health Pathways Te Whatu Ora Health Information and Services Lippincott Procedures NZ New Zealand Nurses Organisation Guideline: Documentation
Advisor's opinion	Abdominal pain is a symptom. Conditions that cause acute abdominal pain usually happen at the same time as other symptoms that develop over hours to days. Ms [A] also had other symptoms such as vomiting and diarrhoea at the commencement of her illness. When a patient complains of abdominal pain, it is important to begin the first assessment with baseline of recordings. Temperature, heart rate, blood pressure, respiratory rate, blood oxygen levels, pain score, a set of neurological observations, and blood sugar level. To provide an overall picture of the possibilities of the cause for the pain and vomiting and diarrhoea, assessment should be focussed on the pain, indigestion, vomiting, nausea, bowel motions, urination, menstruation, and appetite. Assessment of Ms [A] is good for some body systems but does not include an assessment of the abdomen or the type of pain Ms [A] was experiencing. Ms [A] reports pain in most of the clinical encounters with the RNs, but there is no documented level or location of that pain. Pain scores are normally asked of a patient on a level of 1–10, 1 being the lowest and 10 being the worst. Assessing the patient's abdomen can provide critical information about their internal organs. There are four basic techniques of abdominal examination: inspection, auscultation (listening to bowel sounds), percussion (tapping the abdominal wall) and palpation. It is not expected all RNs should complete the auscultation or percussion if they are not trained, but there is no documentation to reflect any of these assessments were completed.

	I note the MO's assessment of the abdominal pain on referral to ED reported "mild tenderness" but no extension or rebound tenderness. Ms [A] reported diarrhoea in the first instance of the illness, but it is documented she "denies any diarrhoea" on 3 July 2022. There is no further documentation to indicate if Ms [A]'s bowels have moved or not, from that date. As part of an abdominal assessment, bowel motions must be a regular report. There is no indication of urination on initial assessment (Ms [A] had been treated for a urinary infection early June). Urinary symptoms were "denied" on 3 July 2022 and it is reported "nil blood in the urine etc". There is no documentation regarding menstruation. Documentation reflects Ms [A]: — is neurologically well although becomes increasingly less energetic and unable to get out of her bed. — Respiratory assessment is completed with reporting "nil shortness of breath", "able to talk in full sentences". — She showed no signs of dehydration but did have "dry lips". — Although warm to touch on several assessments, there is no documented temperature from Ms [A]. — Management of her care is good but inconsistent. — Nurses have documented on most encounters with Ms [A] she is encouraged to keep up the fluids due to vomiting. She was provided with an electrolyte replacement, but there is no indication how much replacement she used, how much fluid she was drinking, or how much fluid Ms [A] was losing through vomiting. — Pain relief (Panadol) was taken, but there is inconsistency in reporting its effect. — Prescription and provision of an anti-nausea (metoclopramide) medication was provided 29 June 2022. Following specific times this was administered, there is no report on its effect except after a period of x3 days where it is documented the anti-nausea was not having any effect. It is a requirement, after giving a medicine that is not part of a daily medication regimen but has been provided to relieve the symptoms of an acute illness, that the nurse will provide an outcome of that medicine's effect.

	— Ms [A] was advised to maintain hand washing and isolation to keep others safe from the possible gastric virus/infection.
What was the standard of care/ accepted practice at the time of events? Please refer to relevant standards/material.	Inconsistency in reporting indicates assessment and management is not at an accepted standard. — Level and locality of pain will provide updates on symptoms, give some indication of the progress and if the care/ treatment is relevant and effective. — A fluid balance chart or chart to indicate fluid intake and number of vomits and what was being vomited would have provided an indication of how the gut was working and reflected if a level of dehydration was evident. — No reports of bowel activity for abdominal pain indicate this has not been asked of the patient. Corrections Department "The Red Flag Poster" (May 2022) for clinical staff states for "severe abdominal pain with: acute swelling to abdomen; fever/septic appearance; PV bleeding; haematuria, rebound tenderness and guarding, Call 111, Seek urgent assistance from MO if onsite, Arrange transfer to ED". As these assessments were not completed, this was not actioned. Te Whatu Ora Health Information Services available 24 hours to all New Zealanders advise treatment for vomiting and diarrhoea caused by gastroenteritis is in accordance with the same treatment as RNs advised and encouraged of Ms [A] during the seven-day period. Te Whatu Ora also advised the symptoms could last for 7–10 days but if symptoms continue after 4 days or the pain worsens to seek a health provider. Ms [A] had health support during the seven-day period.
Was there a departure from the standard of care or accepted practice?	The departure from the standard of care or accepted practice is severe.
How would the care provided be viewed by your peers?	Peers currently working within a hospital setting indicate the care is what they would expect of a viral illness but the failure to complete an abdominal examination at any stage of Ms [A]'s symptoms, or the enquiring of the bowel motions is a huge gap in the requirements of an RN. They reflect this is "basic" learning in nurse assessment.
Please outline any factors that may limit your	

assessment of events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	Review and training for basic abdominal assessment of patients with acute abdominal pain.
Question 2: Whether it was reasonable to wait until 5/7/2022 to escalate for medical review given her deteriorating symptoms. Please indicate at what point escalation to MO was appropriate.	
List any sources of information reviewed other than the documents provided by HDC.	[…] and […] Health Pathways Te Whatu Ora Health Information and Services Lippincott Procedures NZ
Advisor's opinion:	The symptoms documented by the RNs do not reflect as deteriorating but as a condition not improving. Unfortunately, there is no baseline assessment or continuity of the documentation for this reviewer to effectively determine a level of deterioration over the period, except the reports of continued vomiting. Ms [A] states she was "vomiting a bucket of bile a day" and after a week "couldn't walk on my own" and fellow inmates were supporting her daily needs. This is not reflected in any nurse documentation. Letters provided by fellow inmates reflect that Ms [A] was very unwell and her condition had deteriorated. There is documentation to state the pain had stopped, then further documentation to state the pain had returned. There is no full assessment or consistency in assessment of all symptoms Ms [A] is reporting. There is no documentation of bowel activity. Information sourced via Te Whatu Ora information suggests, for those with gastro-enteritis, clinical intervention (nurse) should be sought after three to four days and medical intervention after five to seven days. Nurses were assessing, although not at an accepted level, daily or twice daily.

	The MO assessed Ms [A] on day three of her symptoms and has documented the illness as "viral". A further appointment was made with the MO after 5 days of symptoms. The day prior to that appointment it is documented that, according to custodial staff, Ms [A]'s vomiting increased. RNs report an appointment has been made and to continue with fluids and wait till the MO appointment. The lack of good assessments and consistency in documentation do not provide a clear picture to determine "deterioration" to enable an opinion of timeliness of the clinical intervention.
What was the standard of care/ accepted practice at the time of events? Please refer to relevant standards/material.	At the time of the events and due to the lack of assessment documented, this departure from standard of care/accepted practice is severe. Consistency in basic and follow-up assessments and documentation would provide a clearer picture of progress, treatments and outcomes.
Was there a departure from the standard of care or accepted practice?	This is a severe departure from the expected standard of care.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	ED nurses. All nursing documentation should provide a "story" of the illness journey for that person. Nurses should provide their own assessment and not continue to treat a patient on a proposed diagnosis of an MO.
Please outline any factors that may limit your assessment of the events. Recommendations for improvement that may help to prevent a similar occurrence.	Review and training of documentation requirements. NZNO Guideline: Documentation provides examples of documentation frameworks to ensure all information is included.

Question 3: Comments on the failure to monitor Ms A's bowels	
List any sources of information reviewed other than the documents provided by HDC.	[…] and […] Health Pathways Lippincott Procedures NZ
Advisor's opinion:	To assist in the provision of a diagnosis, to observe the progress of abdominal pain, bowel monitoring is a basic requirement of any abdominal pain assessment. This is also priority as Ms [A] complained of diarrhoea at the onset of her symptoms.
What was the standard of care/ accepted practice at the time of events? Please refer to relevant standards/material.	This deviation from accepted practice is severe.
Was there a departure from the standard of care or accepted practice?	
How would the care provided be viewed by your peers? Please reference the views of peers who were consulted.	Bowel monitoring of any person under health care is a daily necessity. Regular daily to twice-daily bowel monitoring of a patient with abdominal symptoms must be a priority.
Recommendations for improvement that may help to prevent a similar occurrence in the future.	Review of assessment of abdominal pain to assist to determine a possible cause/diagnosis.'