ABI Rehabilitation New Zealand Limited

A Report by the

Health and Disability Commissioner

(Case 12HDC01495)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Names have been removed (except ABI Rehabilitation and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Executive Summary

1. In 1995 Mr A suffered a traumatic brain injury and developed post traumatic epilepsy causing seizures. Initially, Mr A's seizures were successfully managed with medication in the community. However, following a further brain injury in 2001, Mr A became non-compliant with his medication, suffered a number of seizures, developed psychotic symptoms, and psychiatric services became involved in his care.

2. Mr A was initially treated compulsorily as an inpatient at a district health board's inpatient services (DHB1). In 2003, Mr A was transferred to ABI Rehabilitation NZ Ltd (ABI Rehabilitation), for ongoing compulsory residential rehabilitation services. Mr A remained a resident until his death in mid 2011. Mr A was a difficult client to manage due to his complex care needs and his challenging and aggressive behaviour.

3. Mr A's non-compliance with his medication escalated in 2009 and 2010. When Mr A was non-compliant with his medication, he would suffer from increased seizure activity and aggressive behaviour. In April 2010, Mr A was admitted to the inpatient unit at another district health board (DHB2) after experiencing a grand-mal epileptic seizure precipitated by 15 days of non-compliance with his medication. Following two documented events of aggressive behaviour towards nursing staff and medication refusals, a decision was made to temporarily administer Mr A's medications surreptitiously by crushing them and giving them to him in his food or drink.

4. Mr A was discharged back to ABI Rehabilitation on 17 May 2010. Mr A's medication continued to be administered to him surreptitiously. Mr A continued to experience seizures and, in mid 2011, Mr A was found dead in his room after having suffered a seizure at 11:50pm the previous evening.

5. The investigation identified that there were shortcomings in ABI Rehabilitation's care planning and documentation for Mr A. In addition, instructions to staff on how to administer and manage the surreptitious administration of medication to Mr A, and how to manage and respond to his seizures, were inadequate. There was also no evidence that the plan to administer Mr A's medications surreptitiously was ever reviewed. The documentation of Mr A's seizure activity was suboptimal, and staff failed to ensure that recommended tests and medical reviews were carried out.

6. The Commissioner found that ABI Rehabilitation failed to coordinate and oversee Mr A's care, and that there was a lack of a cohesive approach to coordinate Mr A's care consistent with his needs. ABI Rehabilitation breached Rights 4(1)[1] and 4(5)[2] of the Code of Health and Disability Services Consumers' Rights 1996.

[1] Right 4(1) stated: "Every consumer has the right to have services provided with reasonable care and skill".
[2] Right 4(5) states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services".

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Complaint and investigation

7. On 22 November 2012, the Commissioner commenced an investigation into ABI Rehabilitation New Zealand Limited. The following issue was identified for investigation:

The adequacy of the care ABI Rehabilitation New Zealand Limited provided to Mr A, including the care provided between May 2010 and mid 2011.

8. The parties directly involved in the investigation were:

Mr A	Consumer
ABI Rehabilitation NZ Limited	Provider

9. Information was reviewed from:

ABI Rehabilitation NZ Limited
A district health board (DHB2)
Dr B, Psychiatrist
Dr C, Psychiatrist
Dr D, General Practitioner
Mr E, Social Worker
ACC

Also mentioned in this report:

Mr F	Mr A's brother
Ms G	Operations Manager
Mr H	Nursing Manager
Ms I	Therapy Team Manager
Dr J	Rehabilitation Specialist
Mr K	Residential Support Worker
Mr L	Residential Support Worker
Mr M	Residential Support Worker
DHB1	A district health board

10. Independent expert advice was obtained from in-house nursing advisor, Registered Nurse Dawn Carey.

Information gathered during investigation

Background

11. Mr A suffered a severe traumatic brain injury in 1995, causing bilateral frontal and temporal damage. He developed post traumatic epilepsy, and suffered from absent seizures (where he would appear "blank" for a short period of time) and tonic clonic

seizures.[3] Mr A's epileptic seizures were initially successfully managed with Sodium Valproate syrup, and Mr A managed well in the community.

12. Mr A suffered a further brain injury in 2001 and was admitted to the Neuro-surgical ward at DHB1. Mr A's behaviour allegedly became very difficult. He became non-compliant with his anti epileptic medication and, following a number of seizures and the development of psychotic symptoms, psychiatric services became involved in his care.

13. Dr B was the Registrar, Consultation Liaison Psychiatry at the time of Mr A's 2001 injury. Dr B was asked to assess Mr A's mental capacity and functioning. Dr B recalled that it was clear at that time that Mr A's cognitive and executive functioning were severely impaired as a result of the localization and the extent of his head injury. Dr B advised HDC:

> "Executive functioning, as part of cognitive functioning and largely controlled by the pre-frontal and frontal cerebral cortices, includes the ability to initiate and stop actions, to monitor and change behaviour as needed, and to plan future behaviours when faced with novel tasks and situations or to anticipate outcomes and adapt to changing situations. [Mr A] was severely impaired in all these."

14. Mr A was prescribed risperidone to manage his psychotic symptoms, and he was admitted to the Psychiatric Unit at DHB1 under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (The Mental Health Act).

15. Mr A was transferred from the Psychiatric Unit to the Regional Rehabilitation and Forensic Services on 21 December 2002. Mr A was initially treated in the open ward at the Regional Rehabilitation and Forensic Services but, due to deterioration of his mental state, he was transferred to the secure unit.

Admission to ABI Rehabilitation

16. In 2003, Mr A's clinicians recommended that Mr A receive inpatient treatment and rehabilitation in a unit that specialises in providing care to patients with organic brain syndrome and where the risks that he posed to himself and others could be effectively managed.

17. On 24 July 2003, Mr A was discharged from the secure unit and transferred to ABI Rehabilitation Limited (ABI Rehabilitation). ABI Rehabilitation provides residential and community-based rehabilitation services for people with traumatic brain injury or stroke. ABI Rehabilitation employs providers from medical, nursing, therapy and support services backgrounds.

18. Mr A became a resident at ABI Rehabilitation and he remained a resident there until his death.

[3] A seizure involving the entire body. It is also called a grand mal seizure.

Compulsory treatment status

19. Mr A was treated at ABI Rehabilitation by the Community Mental Health Team pursuant to a Community Treatment Order under section 29 and 30 of the Mental Health Act. Mr A's Compulsory Treatment Order appears to have been predominantly intended to ensure compliance with his medication, because if he was non-compliant with his medication he was a risk to both himself and others. At that time, it was considered by Mr A's treating clinicians that the Mental Health Act was "the only legal way to ensure that [Mr A] continues to be treated in a safe environment" and "to ensure that [Mr A] receives treatment".[4]

20. Mr A remained under the Mental Health Act until 2010. He subsequently received treatment compulsorily pursuant to an order that had been made under the Protection of Personal and Property Rights Act 1998 (the PPPR Act) on 22 April 2010.[5]

21. The move from requiring Mr A to receive treatment pursuant to the Mental Health Act to requiring Mr A to receive treatment pursuant to a Personal Order under the PPPR Act appears to have been instigated because of longstanding concerns from Mr A's psychiatrists about using the Mental Health Act to ensure compliance with Mr A's medication where the medication he was being required to take was not psychiatric medication, but medication for the prevention of seizures.

22. Social worker Mr E, a member of DHB2's Community Mental Health team, advised that he reported to the Community Mental Health team with a three-monthly risk assessment for Mr A, and supported staff at ABI Rehabilitation with respect to Mr A's care and treatment.

ABI Rehabilitation staff

23. In 2010/2011, staff at ABI Rehabilitation included Operations Manager Ms G, Nursing Manager Mr H, Therapy Team Manager Ms I, a part-time Rehabilitation Specialist Dr J, enrolled nurses and client support workers.

24. The Operations Manager reports to the Managing Director. The Operations Manager's accountabilities include operational service delivery, risk management, and analysis and evaluation. This includes ensuring that client management and rehabilitation are delivered according to high quality standards of care and safety, and that systems to achieve and maintain accreditation standards are developed, implemented, and evaluated.

25. The Therapy Team Manager (or Rehabilitation Team Manager)[6] reports to the Operations Manager, and their responsibilities include to manage the therapy team and rehabilitation programme coordinators, to manage and oversee residential clients, to work with other staff to ensure high quality rehabilitation is delivered to all clients,

[4] See Mr A's Discharge Summary, dated 24 July 2003.
[5] A Personal Order was made by the Court pursuant to section 10 of the PPPR Act 1988 on 22 April 2010, which required Mr A to: take his anticonvulsant medication as directed; remain a resident at the facility; and not to drink alcohol.
[6] The job description provided to HDC for the Therapy Team Manager was titled Rehabilitation Team Manager.

and to develop and recommend best practice operational and organisational systems. The Rehabilitation Team Manager has overall responsibility for ensuring that each client's rehabilitation goals and programme are appropriate, reflect best practice and encourage maximum independence and participation in all aspects of daily life.

26. The Nursing Manager[7] reports to the Regional Manager[8] and their responsibilities include managing client caseloads and ensuring safe nursing practice on site. That includes providing clinical guidance for registered and enrolled nurses and rehabilitation assistants, ensuring current best practice guidelines for nursing procedures are in place for all nursing interventions, and ensuring all specialist rounds, clinical tests and referrals for medical interventions are being carried out.

27. The enrolled nurses report to the Nursing Manager and are responsible for implementing individual client rehabilitation plans, as required by the registered nurse.

28. The client support workers report to the Nursing Manager, and their responsibilities include assisting with individual client care needs, activities of daily living as required on an individual basis, and undertaking domestic household chores as required.

29. The specialist in rehabilitation medicine reports to the Operations Manager and the Medical Director, and is responsible for facilitating the medical management of patients under the care of ABI Rehabilitation. The specialist has primary responsibility for inpatient clients. He or she is required to carry out a weekly round of inpatients and document findings and treatment changes, and to be on-call. The specialist is also required to answer calls from general practitioners, consultants and patients and their families in the community, and arrange for assessment of patients by him or herself or other members of the team, as necessary.

Care and treatment challenges at ABI Rehabilitation

30. ABI Rehabilitation advised HDC that Mr A was "a complex management challenge with his different needs being met through multiple agencies". Mr A received mental health care from DHB2, primary care from his general practitioner Dr D, and ongoing neurological rehabilitation following his brain injuries from ABI Rehabilitation. ABI Rehabilitation advised HDC that given the complexity of Mr A's situation, "staff at ABI were working with a large group of providers in an attempt to meet his needs". ABI Rehabilitation advised that it "works in a co-operative model and strives to ensure maximal benefit is gained for the clients in [its] care through this co-operation".

31. ABI Rehabilitation advised HDC that on Mr A's admission, his consultant psychiatrist described Mr A as becoming easily annoyed, and in denial regarding his problems and need for long term care. ABI Rehabilitation advised HDC, "[Mr A's] lack of insight into his health needs was a constant theme in the time he was cared for by ABI and created significant issues for all agencies involved in his care".

[7] The job description provided to HDC for the Nursing Manager was titled Nursing Team Leader.
[8] It is understood that in this case the line of reporting for the Nursing Manager was to the Operations Manager.

32. ABI Rehabilitation staff provided information to HDC about their experiences caring for Mr A. Residential Support Worker, Mr L, advised HDC that Mr A was one of four residential clients who he supported while employed at ABI Rehabilitation. Mr L noted that Mr A was a "reluctant resident". Mr L advised HDC:

> "[Mr A's] behaviour at times was extremely challenging, volatile, intimidating, and unpredictable with an underlying irritability. [At] times threats of physical abuse and violence toward residential clients and staff both ABI and Health Professionals (sic). I have personally witnessed [Mr A] strangle and choke a male staff member."

33. Support Worker Mr K also advised HDC of the difficulties he experienced in supporting Mr A at ABI Rehabilitation. He noted, "[Mr A] was the most difficult and mentally unstable client" and "[Mr A] had difficulties relating to all health professionals and regarded them with general suspicion".

34. Dr J, Rehabilitation Specialist at ABI Rehabilitation, recalled that Mr A "was a challenging [patient] to manage medically", as he had limited tolerance for doctors visits, which made formal examination difficult. Mr A was also noted to exhibit violent and aggressive behaviour, including aggressive behaviour and verbal abuse towards ABI Rehabilitation staff.

Care and treatment planning on admission to ABI Rehabilitation

35. ABI Rehabilitation provided HDC with the following documentation relating to Mr A's admission and early treatment planning at ABI Rehabilitation:

- A copy of a DHB1 "Management Plan" (the Plan) for Mr A, dated 17 July 2003. The Plan noted that Mr A "lacked insight into his illness and the need for medication". The plan recommended consistency of staff approach, structured routines, and options for managing Mr A's aggressive behaviour. There is no evidence that this plan was ever reviewed at ABI Rehabilitation.
- A document entitled "Alert Sheet", dated 18 March 2004, which noted Mr A's diagnoses, and his "risk identification". The "risk identification" noted that Mr A suffered from seizures and post-seizure psychosis, aggressive behaviour, and was non-compliant with medication. It was noted that Mr A was a "risk to others post seizure", and could be verbally abusive and threatening.
- An Interdisciplinary Rehabilitation Plan, dated 22 March 2005, which noted that Mr A occasionally refuses medication and will place medications in his top pocket, and set as a goal for him to take his medications "as prescribed within his own routine 100% of the time". The noted "Intervention" was for staff to observe compliance "vigilantly" and to "Offer food/meal as usually takes".[9]

[9] In response to the provisional opinion, ABI Rehabilitation advised that the Interdisciplinary Rehabilitation Plan was reviewed annually. ABI Rehabilitation was unable to locate copies of the annual review of the Interdisciplinary Rehabilitation Plan; the only updated plan it provided to HDC was dated 15 September 2009.

- An undated document titled "Overall Long Term Goals", which noted that Mr A's long term goals on admission to ABI Rehabilitation included: monitoring of his seizure activity, psychotic episodes and medication requirements; and to become seizure free. A number of interventions were identified to assist with meeting Mr A's Long Term Goals. Those interventions included, "Watch [Mr A] take medication. If he refuses to take meds take them with you and try again later. Regular blood testing for therapeutic levels of dilantin[10] levels especially after seizure activity".

36. Mr A also had an ACC Individual Rehabilitation Plan (for Lifetime Rehabilitation), which was completed in 2005 and to be reviewed in 2015.[11] The purpose of the plan was to "outline the agreed rehabilitation plan to be followed, services to be provided and time frames to assist [Mr A] in [his] rehabilitation". ABI Rehabilitation submitted that Mr A was reviewed by ACC at least annually, although my Office was unable to obtain evidence of that from ACC.

37. While Mr A was a resident at ABI Rehabilitation's residential facility from July 2003, this report will focus predominantly on his care in the years immediately prior to his death in 2011, and only on the issues of the management of his seizures and medication non-compliance. This report is not concerned with the clinical aspects of his rehabilitation management, psychiatric or primary care services where those services do not relate to the above two issues.

Management of seizure activity – policies

38. ABI Rehabilitation provided HDC with a "Seizure Management" policy (the Policy), implemented in August 2003 and reviewed on several occasions with the last review in mid 2011.[12] The Policy states, "All staff are responsible and accountable to monitor and manage seizure activity as per documented guidelines". The Policy requires staff to observe and document seizure activity, and sets out required actions during and immediately following tonic/clonic seizures, complex partial seizures, and absence seizures. The Policy also sets out the requirements for "post-seizure – close observation", which requires, amongst other things, staff to contact the Registered Nurse on duty to inform him/her of the seizure and to seek further advice/support, and a check of vital signs immediately following the seizure and every 30 minutes (or as ordered) until the client is alert.

39. An undated document titled "Recording of Seizure Activity" (for Mr A) was faxed from ABI Rehabilitation's head office to the facility on 17 December 2009. The document states, "It is paramount that both witnessed and non-witnessed seizures are recorded" because, "[w]ithout efficient recording we cannot provide the correct care

[10] Dilantin is the brand name for an epileptic medication. My in-house nursing advisor RN Dawn Carey advised that Dilantin was discontinued in 2005. Accordingly, this document is likely to be from prior to 2005.

[11] Or earlier, if Mr A's needs changed and were not being appropriately met by the plan.

[12] In response to the Provisional Opinion, ABI Rehabilitation advised that the review was completed as part of the root cause analysis investigations carried out by ABI Rehabilitation into the circumstances of Mr A's death, and any variance between this document and Mr A's individualized seizure management plan is reflective of those changes.

for [Mr A]". The document includes information about Mr A's "tonic clonic post seizure activity" and "absent seizure post seizure activity". Also included is information about "staff's response to seizure activity", which notes that if Mr A suffers a seizure "the RN at the main site needs to be informed", that staff must record the length and severity of the seizure as well as whether Mr A suffers breathing difficulties, that Mr A should be placed in the recovery position if found suffering a tonic clonic seizure, and that if Mr A presents with cyanosis the RN will need to be informed and oxygen administered. It is noted that if Mr A's seizure lasts more than three to four minutes, then PRN[13] Stesoloid[14] will need to be administered, and instructions for administering this medication are also included.

40. Mr A's seizure activity was recorded on a "Seizure Record" document, and in his progress notes. It is not clear from the "Seizure Record" on which occasions those seizures were related to medication non-compliance.

Medication compliance

41. At times, while a resident at ABI Rehabilitation, Mr A would become non-compliant with his medication.[15] ABI Rehabilitation advised HDC that Mr A was non-compliant with his medication "due to a total lack of insight into his medical condition". Following periods of non-compliance with his Sodium Valproate, Mr A would experience increased seizure activity and aggressive behaviour, and on occasion he would attempt to leave the facility without permission or accompaniment.[16] ABI Rehabilitation advised that, at such times, Mr A was "unmanageable at ABI", and as a result he was often admitted to DHB2's Mental Health Inpatient Services at those times. Mr A's non-compliance with medication appears from the documentation to have escalated in 2009 and 2010, and that corresponds with an increase in his recorded seizure activity.

42. Following a period of non-compliance with his medication in July 2006, Mr A's psychiatrist recommended that staff spend time with Mr A to persuade him to take his medication. However, if he continued to refuse his medication, and developed signs of deterioration, then consideration should be given to recalling him to the inpatient unit[17] pursuant to section 29(3)(b) of the Mental Health Act so that his medication regime could be re-established as an inpatient.

43. ABI Rehabilitation provided HDC with an undated document headed "[Mr A] Management Plan", which documented a plan for the management of Mr A should he become non-compliant with medication. The plan required that on the first day Mr A's non-compliance should be documented, and discussed with the manager and

[13] PRN is a medical abbreviation, which means "as necessary".
[14] Stesolid rectal tubes are enemas containing the active ingredient diazepam. Diazepam is a type of medicine called a benzodiazepine. Benzodiazepines are used for their sedative, anxiety-relieving and muscle-relaxing effects.
[15] The documentation ABI Rehabilitation provided to HDC indicates that Mr A was non-compliant with his medication in July 2006, March 2009, September 2009, January 2010 and March 2010.
[16] It remained a client goal for Mr A at ABI Rehabilitation to, "Develop an understanding as to why he must take his own medication" (See: "Interdisciplinary Rehabilitation Plan", dated 22 March 2005).
[17] Mental Health and Addictions Service Inpatient Unit at DHB2.

senior nurse, and that staff should "continue to explain to [Mr A] the need for him to take his medication". If on day two Mr A continued to refuse his medications, staff were to document, continue to explain to Mr A the need to take his medication, and to phone DHB2's inpatient unit, the CATT team, and the Police to advise that Mr A is in the second day of non-compliance with his medication. The Police would be advised that they may be called to assist with transferring Mr A to the inpatient unit. If Mr A remained non-compliant on day three, staff were required to phone the manager of ABI Rehabilitation, and contact the inpatient unit to advise that Mr A required admission for non-compliance with medication, and that a Police escort would be required. The CATT team would then be contacted to "ask for [Duly Authorised Office] [-] to be phoned/faxed through to [the] Police", and the Police would arrange an escort for Mr A to the inpatient unit.

44. Mr A was hospitalised after he experienced seizures following non-compliance with his medication on 18 March 2009. The ABI Rehabilitation "Seizure Record" for Mr A records that Mr A suffered one or more seizures on the following dates: 19 March 2009; 3 and 10 May 2009, 11 and 28 June 2009; 3, 4 and 7 July; 28 August 2009; and 4 September 2009.

45. Mr A's "Interdisciplinary Rehabilitation Plan" was updated on 15 September 2009. It documented Mr A's aim to develop an understanding as to why he must take his medication, and listed "education about seizures" and "develop motivation through goal setting" as the strategies to meet that goal.

46. On 18 September 2009, Mr A was reviewed by a rehabilitation medicine specialist who noted Mr A's recent increase in seizure activity and noted, "Unfortunately [Mr A] demonstrates complete lack of insight into the reasons for him being under our care. He feels that he could do without any medication. He doesn't know why he is on the medication. He doesn't believe that he has a seizure disorder requiring treatment".

47. The ABI Rehabilitation "Seizure Record" for Mr A records that Mr A suffered one or more seizures on the following dates: 20, 25, 28, and 29 November 2009; 4, 17, and 18 December 2009; 9, 10, 11, 12, and 16 January 2010; 10, 13, 14 and 17 February 2010.

48. On 22 February 2010, Mr A was reviewed for ACC. The report documented Mr A's seizure activity and aggressive behaviour following periods of medication non-compliance, and it was noted that Mr A required encouragement to take his medication. The report noted:

> "Other strategies in place regarding managing his behaviour include informing his brother on the first day that [Mr A] does not take his medication. The DHB Acute Mental Health Service (CAT team) is informed on the third day that he has not taken his medication and are notified that he is likely to have a seizure and have deteriorating behaviour with psychotic symptoms. Staff report some frustration at the timeframe for CAT team involvement and believe that by the third day without medication it is too late to prevent a deterioration in [Mr A's] behaviour. Staff believe that input from the CAT team at an earlier stage would more successfully

> manage the situation than waiting until he has had a seizure, as by this stage it can be too late to prevent the psychosis".

49. In the "strategies" section of the report, it is noted, "[Rehabilitation medicine specialist] to continue to explore legal options to reduce the incidence of [Mr A's] seizure cycle and to work with the CAT team to encourage more prompt intervention when [Mr A] refuses his medication".

50. ABI Rehabilitation provided HDC with a document, dated 2 March 2010, which sets out instructions for staff on "how to act when [Mr A] leaves the unit, whilst non-compliant with taking his medication".

51. Mr A's "Seizure Record" recorded that he experienced seizures on: 18, 20, 21, 22, and 23 March 2010. Mr A was hospitalised on 23 March 2010.[18]

52. On 29 March 2010, ABI Rehabilitation staff met with Mr A's brother and Welfare Guardian, Mr F, and a Community Mental Health Social Worker. A behavioural analysis conducted by staff using Mr A's progress notes dating from February 2009 had noted certain triggers for Mr A's medication non-compliance, and the purpose of the meeting was to discuss those triggers. A plan was made for the management of those triggers.

53. Mr A's "Seizure Record" records that Mr A suffered seizures on 14, 21 and 22 April 2010.

Admission to inpatient unit in 2010

54. ABI Rehabilitation Staff took Mr A to DHB2's Accident and Emergency Department on 22 April 2010 after he experienced a grand-mal epileptic seizure, precipitated by a period of 15 days of non-compliance with his medication.

55. Mr A was medically cleared and discharged by the Accident and Emergency Department; however ABI Rehabilitation staff were reluctant to return him to the residential facility because of his aggressive and violent behaviour. Mr A was assessed by the on-call Psychiatrist, who changed Mr A's status under section 29(3)(a) of the Mental Health Act from a Community Treatment Order to an Inpatient Order. Mr A was then admitted to the inpatient unit. His responsible clinician under the Mental Health Act at that time was Psychiatrist Dr B.

56. Dr B advised HDC that Mr A's aggressive and violent behaviour continued "during and well into half the time of his hospital admission", and accordingly he was detained in the closed intensive care unit. Dr B further advised:

> "[Mr A] steadfastly refused medication during his hospital admission, which prolonged this status quo, whilst at the same time rendering him at an increased risk of having epileptic seizures with subsequent risk of further deterioration of his mental state … Additionally it was most difficult to treat [Mr A's] oppositional

[18] On this occasion, Mr A was discharged on 24 March, but readmitted on 25 March 2010, unwell and confused. He was discharged on 29 March 2010.

> behaviours with the usual tranquilizing neuroleptic medications as these lower the 'seizure [t]hreshold', which in turn would increase the already high risk for epileptic seizures."

57. On 5 May 2010, following two documented events with aggressive behaviour towards nursing staff and medication refusals, a joint decision was made by medical and nursing staff for Mr A's medication to be crushed and given in his food or drink without his knowledge. Dr B advised HDC, "[t]his happened in view of [Mr A's] increasingly hostile attitude". Dr B also advised HDC:

> "This was a well deliberated decision and as such signed and documented in the file by three nurses and his temporary [responsible clinician], as I was on leave during that week.[19] The decision was discussed with [Mr A's] family, with [Mr F] as [enduring power of attorney], who agreed and sanctioned the measures on [the] family's behalf. On 7 May 2010 the Clinical Head of Department and Director of Area Mental Services assessed [Mr A] and documented his endorsement of this method of dispensing medication to continue."

58. ABI Rehabilitation staff did not provide input into the decision to administer Mr A's medications in that way.

59. Dr B advised HDC that he returned from leave on 10 May, and was made aware of the decision to administer Mr A's medication surreptitiously. He noted that when he subsequently assessed Mr A, the medication had started to take effect with a gradual improvement in Mr A's mental state, and a subsequent transfer to the "open" ward. On 11 May, Dr B endorsed the decision to administer Mr A's medication surreptitiously as a temporary policy. Dr B advised HDC, "[t[his was meant for at least the time that Mr A was to be admitted in [the inpatient unit] and possibly for a period of time of re-settling into his familiar surroundings and routines at [ABI Rehabilitation]". Dr B advised HDC that the decision to administer Mr A's medications in that way "was reviewed repeatedly within the weekly multi-disciplinary ward meetings".

60. Dr B noted that Mr A's mental state and behaviour continued to improve. He advised HDC that before Mr A was discharged, "a number of professional meetings and telephone communications took place with [ABI Rehabilitation]". An unsigned note[20] written by Dr B on 11 May 2010 notes, "Frequent contact and case conferring between [the inpatient unit] medical/nursing staff, family, and [ABI Rehabilitation] are taking place, and the next case-conference is scheduled for Friday 14th May, including the Community psychiatrist in order to effect a future short-, medium-, and long-term planning (sic)."

Discharge back to ABI Rehabilitation and instructions for medication management

61. Mr A was discharged back in to the care of ABI Rehabilitation on 17 May 2010, and his psychiatric care was transferred back to his community Psychiatrist Dr C. Mr A's

[19] Dr B was on leave from 1 May to 10 May 2010.
[20] It is not clear who the note is to, or what its purpose is.

Discharge and Coding Summary from DHB2, dated 17 May 2010, noted, "Tablets to be crushed and given with food if oral meds are refused".

62. ABI Rehabilitation advised that instructions on how to follow Mr A's medication plan, initiated at the inpatient unit were forwarded to ABI staff. ABI Rehabilitation provided HDC with a copy of a Management Plan for Mr A, dated 10 May 2010. The Management Plan is not on letterhead, and the author of the Management Plan is not identified. However, under the heading "Care Plan – Updated 10/5/10" the following is noted: "Maintain safety of staff and co-clients through close supervision – at times requiring 1:1"; "Administer charted medications – approval for [Mr A's] (tablet) medications to be crushed has been given by [Dr B] – use liquid syrup for Epilim and Panadol – place in Milo. Lactulose in coffee"; and "Observe regularly to maintain safety due to epilepsy. Observe for tonic-clonic or absence seizures (as noted by [Mr A] blanking out and appearing pre-occupied)".

63. Attached to the Management Plan document is a sheet headed "Administration of [Mr A's] medication. 17/05/10". The following is recorded under that heading:

> "[Mr A] has been receiving his medication in his cups of Milo and Coffee for over a week. Staff at [the inpatient unit] have noticed a mass improvement in [Mr A] since this practice was adopted. [Mr A] is unaware that this is the case and believes that he is medication free!
>
> Mr F has given permission to administer [Mr A's] medication in this manner, and is supportive that this continues here at [the facility].
>
> Staff are not to discuss any part of [Mr A's] medication plan with him.
>
> [Mr A's] Topamax has not been changed. Staff are to offer [Mr A] his Tablet in the morning. If [Mr A] refuses, staff will walk away and prepare the medication for concealment. Staff are to crush [Mr A's] Topamax and place it in a drink for [Mr A]. This can be done over a prolonged period in order to avoid [Mr A] detecting the medication.
>
> Staff are not to offer [Mr A's] evening dose and instead mask it in a drink.
>
> [Mr A] has been getting his Epilim in a liquid form all at once at 18:30 in a cup of Milo as it is a sweet drink and helps to mask the sweet tasting Epilim. This however could be spread out over maybe two cups if staff prefer.
>
> Risperidone has also been changed to a liquid form and will also be given in a cup of coffee or Milo. This will take place after the Epilim has been given. Possibly at 20:00."

64. ABI provided no additional evidence of instructions given to staff about the management and monitoring of Mr A's medication following his discharge from hospital on 17 May 2010 until his death in 2011, or that the decision to administer Mr A's medication in this way was formally reviewed.

65. In response to the provisional opinion, ABI Rehabilitation advised that it was not the understanding of ABI Rehabilitation staff that the practice of concealment of Mr A's medications was temporary. ABI Rehabilitation advised, "While the discharge report from the inpatient unit on 17/5/10 suggested that medications should be given surreptitiously only if they were refused by [Mr A], it should be clarified that [Mr A] had routinely declined his oral medication while in our care". It further advised that, the hope at the time of Mr A's discharge from the inpatient unit on 17 May 2010 was "that the concealed medication method would not be required when [Mr A] gained insight". However, "[Mr A] did not gain insight into his condition, and continued to refuse oral medication when it was offered to him". ABI Rehabilitation advised that Mr A would become angry and threaten to leave ABI if it was suggested he take medications.

66. ABI Rehabilitation advised that Mr A began refusing to take his medication immediately on discharge from the inpatient unit, and while staff "persevered with offering medication to [Mr A] before it was given disguised in drinks, the actual process of offering the medication agitated [Mr A]".

67. ABI Rehabilitation advised that Mr A would "aggressively" decline his medications and, accordingly, staff reverted to the instruction to crush his medication and give it to Mr A with his food.

Ongoing medication management and monitoring, and seizure activity

68. ABI Rehabilitation advised that staff monitored Mr A to ensure the drink into which his medication was mixed was completely consumed to ensure all of his medication had been taken. ABI Rehabilitation advised HDC, "This is commented on frequently in the clinical records". ABI Rehabilitation further advised:

> "This plan of action was most unusual … and while successful in improving [Mr A's] seizure management, created problems for ongoing management as [Mr A] was not aware that he was still taking medication and became very reluctant to take any additional medicines unless he wanted to take them, e.g. Panadol. It also made it difficult to gain [Mr A's] consent to take blood samples to assess drug levels."

69. ABI Rehabilitation advised HDC that the medication plan "continued to be guided by the Mental Health team with the consent of [Mr A's] brother and proved to be the only way to successfully provide [Mr A's] anti-convulsant medication". It further advised, "I would agree with hindsight that the complexity of the problem relating to [Mr A's] medication compliance required more frequent review. However, I do not want the impression that we were acting alone in this plan … we certainly were under the impression we were working in conjunction with [Mr A's] Mental Health service providers and his brother …".

70. Dr J noted that it was difficult to accurately establish whether Mr A's medication dosage needed to be increased or decreased. She noted that staff were good at ensuring Mr A had his anticonvulsant medication, but because of the circumstances, it was difficult to guarantee that he was getting the correct doses. Accordingly,

decisions about Mr A's medications were made on clinical presentation, rather than data. Even then, it was not clear whether an increase in medication was appropriate, for example, staff reported seizures but staff were also aware that Mr A may not have had all his recent medication. Dr J noted that she was not aware of any increase in the number or frequency of Mr A's seizures.

71. Dr C reviewed Mr A on 1 June 2010 and noted that Mr A was "settled from a psychiatric perspective in that he had no psychotic symptoms", but that he was "non-adherent to his medication". Dr C advised HDC that, following a discussion with Mr A's "ward doctor" and a review of the notes, he found no reason to revisit Mr A's medication administration plan. The progress notes report that on that date, Mr A was informed of the consequences of continued non-compliance with his medication, and that the surreptitious administration of his medication was suspended on that date. It appears, however, that this suspension was only for 24 hours, after which the surreptitious administration plan was re-instated by a registered nurse (see below).

72. On 2 June 2010, ABI Rehabilitation Regional Manager Ms G emailed Dr C and Dr B to advise that Mr A was threatening to move out of the facility. She noted in her email that Mr A "has been non-compliant with medication since yesterday", and advised the doctors of the plan in place should Mr A remain non-compliant or if Mr A tried to leave the facility. A note was made in the progress notes that, "medication is not be (sic) concealed … staff are to follow the management plan". ABI Rehabilitation advised that, "As there was no resolution to the problem of compliance … and no alternative offered by the Mental Health team, concealment of medications was adopted as the standard method of giving [Mr A] his medication".

73. Mr A's "Seizure Record" records that Mr A suffered seizures on 5 and 7 June 2010; and 3 July 2010. Dr J reviewed Mr A on 6 July 2010. In her report of her assessment, Dr J recorded, "Staff notes that he has his meds in food or drink and sometimes might not be getting all of the medication, but is for the most part redirectable".

74. On 2 September 2010, Dr D prescribed Fosamax (once weekly) for Mr A for osteoporosis. ABI Rehabilitation advised HDC that Mr A declined to follow Dr D's treatment plan for Fosamax and accordingly he was not administered this medication.

75. Mr A's "Seizure Record" records that Mr A suffered seizures on 15 July 2010; 21 August 2010; and 27 September 2010. On 9 November 2010, Dr J reviewed Mr A and noted, "Staff noted a recent seizure. His drug level was sub therapeutic … I have also increased his sodium valproate from 2000mgs to 2200 mgs per day in divided doses". Mr A's "Seizure Record" does not record that Mr A suffered a seizure on 9 November 2010 or on the days prior to 9 November 2010.

76. Mr A's "Seizure Record" records that Mr A suffered further seizures on 16 and 23 November 2010; and 25 and 26 January 2011.

77. Dr J reviewed Mr A on 3 February 2011, following staff concern that Mr A was experiencing neurological decline. Dr J recommended checking Mr A's anti convulsant drug levels to ensure that therapeutic levels were being achieved. Dr J's

record of this review states, "We will check a sodium valproate level. If sub-therapeutic we will increase the dose. If it is therapeutic and staff perceives continued decline we will refer for a head CT, EEG and neurologic review". The review record notes do not state who was responsible for checking Mr A's Sodium Valproate level, and it does not appear that the note was copied to Mr A's general practitioner. There is no evidence in the clinical record that any of these investigations occurred. Mr A's medication regime was not altered.

78. When questioned by ABI Rehabilitation Therapy Manager Ms I on 5 May 2011, Dr J advised "No, I don't know that I did carry out these actions – that is a justified criticism". In her response to HDC, Dr J advised that she recalled recommending that Mr A's Sodium Valproate level be checked and that "[t]he usual protocol is for patient[s] to arrange for labs through their GP. [Mr A] was encouraged to follow up with his GP but declined to do so". Dr J did not review Mr A again.

79. ABI Rehabilitation also advised HDC that, while it was Dr J who suggested Mr A's Sodium Valporate levels be checked, it was the responsibility of Mr A's general practitioner to manage that process. ABI Rehabilitation advised HDC, "[a]gain [Mr A] could not be convinced to do this". ABI Rehabilitation noted that Dr J continued to use Mr A's clinical condition as the primary measure of the success of his anti-convulsant therapy. It noted, "[i]n hindsight we, at ABI, should have ensured the gathering of this sample was followed up on more actively in consultation with [Dr D] to be sure all efforts had been made to assess that [Mr A's] sodium valproate treatment was at therapeutic levels". However, ABI Rehabilitation noted that given the process adopted to administer Mr A's medication, obtaining his consent for a blood sample would have been difficult. ABI Rehabilitation further advised that in future, "[it] will make a careful assessment of client's who require medication in this manner to ensure safety systems are in place before [it] accept[s] the admission". ABI Rehabilitation also advised that it is investigating how it can improve communication between service providers to ensure Medical Officer orders are attended to.

80. Mr A was noted to have suffered a tonic/clonic seizure in early 2011.

81. A month before his death, Mr A was reviewed by Dr C. Dr C had no concerns about Mr A's condition at that time.

82. Mr A was noted to have suffered two episodes of absent seizures while at rest a week later. The seizures were recorded in the seizure records and clinical notes, but further medical intervention was not requested.

83. ABI Rehabilitation advised HDC, "[t]he clinical notes record [Mr A] as being physically quite settled through this period of time". However, the clinical records record that Mr A suffered six episodes of urinary incontinence in the weeks prior to his death. The clinical records indicate that a review by Dr J was requested, and the Nursing Manager also requested that a mid stream urine test be taken to determine whether Mr A's urinary incontinence was seizure related or indicative of a urinary tract infection. There is no documentation indicating that Mr A was reviewed by Dr J at that time, or that he was reviewed by the Nursing Manager.

84. At a staff meeting two weeks prior to Mr A's death, Ms I and a Residential Support Worker (incorrectly) reported that Mr A had been free of observed seizure activity throughout the month.

85. ABI Rehabilitation advised HDC there is no observed seizure activity or urinary incontinence (that may indicate that Mr A had suffered an unobserved seizure) identified in Mr A's clinical records in the week leading up to his death. However, ABI Rehabilitation provided HDC with a document headed "[Mr A's] incontinence", which documents that Mr A's bed was found wet between 7 and 8:30am on one occasion.

Events leading up to Mr A's death in mid 2011[21]

86. Mr A went to his home town for the day. When Mr A returned at 4:10pm he was noted to be pale and shaking, and he went to his room for a rest. Residential Support Worker Mr M reported checking on Mr A at 5:45pm and finding him on his bed with broken cigarettes on his chest. Mr M considered that Mr A may have suffered an absent seizure. Mr M noted that Mr A appeared very fatigued, and that Mr A declined his dinner, but took his medications with a drink. That information was recorded in the Handover Sheet for the pm shift. ABI Rehabilitation's Incident Investigation Report noted that Mr M "suggested the 'need to keep an eye on [Mr A] over the next 24 hours'". It is not clear to whom Mr M made this suggestion.

87. Residential Support Worker Mr L was responsible for Mr A's care that evening. Mr L checked Mr A at 10:50pm, and reported that he looked "dishevelled and fatigued".

88. Mr L reported hearing loud rapid breathing consistent with a seizure from Mr A's room at 11:50pm. Mr L checked Mr A and noted that Mr A was having a tonic/clonic seizure, which lasted approximately two minutes. Mr L recalled that Mr A had fallen off the bed on to his back, and he was lying on his back between the bed and table. Mr L placed Mr A in the recovery position during the seizure to protect his airway, and stood at Mr A's feet to maintain observations. Mr L reported that he stayed with Mr A for about 20 to 25 minutes. Mr L recalled that Mr A recovered from his seizure quickly, and got up and made a cup of tea in the kitchen and had a cigarette before returning to his room.

89. Mr L completed an incident form and noted Mr A's seizure on the recording chart. He then notified Ms I of the seizure via text message. Ms I did not receive the text message until the following morning.

90. ABI Rehabilitation advised that Mr A was noted to be awake intermittently between 12:40am and 3am, and was having hot drinks and smoking cigarettes. There is a record on the document "[Mr A's] incontinence" that Mr A suffered from incontinence at 1am. Mr L noted that the last time he saw Mr A during his shift was when Mr A carried wet sheets out to the laundry to be washed at 3am.

[21] At this time, Mr A was taking the following medications: Topamax 100mg twice a day; Thiamine HCL 100mg at night by tablet; Sodium Valproate syrup 55mls given in divided doses throughout the day; risperidone syrup 3mls given once a day; and Flixotide Inhaler two puffs twice a day.

91. There are no further notes in the clinical record by Mr L.

92. Mr L recalled discussing Mr A with Residential Support Worker Mr K at handover in the morning, and before he went off shift at 7:20am. He recalled that he informed Mr K of Mr A's condition when he returned from his home town the previous day, and of the seizure at 11:50pm. Mr L recalled showing Mr K a copy of his Incident Report for the 11:50pm seizure, and he said that he covered "all the basics" for the shift handover protocol. He also recalled that they discussed getting Mr A up and giving him his medications. A "handover sheet" was completed, which recorded Mr A's seizure.

93. Mr K found Mr A dead in his room at 12:30pm.

94. Mr K wrote an Incident Report. In the report, he noted that he had left Mr A to sleep after his seizure the night before, because "[t]he normal procedure for the day shift was to allow [Mr A] to rest in his room until he arose and comes out of his room". Mr K also recorded, "the last time I was on shift (day shift) after [Mr A] had had seizures, [Mr A] came out of his bedroom at 12:15pm". Mr A had not come out of his bedroom by 12:15pm and so at 12:30pm Mr K checked on Mr A. At that time, Mr K found Mr A in his room slumped between the bed and a set of drawers against the wall. Mr A reportedly had one leg in his jeans and a jacket over his head. Mr K checked Mr A and noted that there was no sign that Mr A was breathing. Mr K contacted Ms I, and was advised to call the ambulance and the Police, which he did.

95. ABI Rehabilitation advised HDC that the staff working late on the night of Mr A's seizure, and on the day he died "erred in their decision to let [Mr A] sleep without more frequent observations being carried out through the night to ensure his safety".

96. Mr K provided a statement to HDC, in which he noted the following:

> "… checking [Mr A] and going into his bedroom was dangerous and risky … There was never a guarantee that you would meet [Mr A] in a favourable disposition and would not be either physically or verbally abused, or both. Therefore working with [Mr A] was difficult. When [Mr A] had seizures staff would place [Mr A] in the recovery position, make sure there were no restrictions around his throat and cover him with a blanket and remain with the client until they recovered. The post seizure protocol was to monitor the client after seizures at regular intervals (every five minutes initially then at regular intervals up to two hours). This was done by [Mr L]. The difficulty staff had was [Mr A's] unpredictability and with his post seizures this was more heightened and staff (and clients) were at a greater risk. Adding to this was [Mr A's] very protectiveness of his room and possessions and as observations were through opening his door, staff risked being abused either physically or verbally.
>
> In working with [Mr A] and being in similar circumstances previously, it was not uncommon for [Mr A] to remain in bed for longer periods of time, post seizure. As recorded in my initial statement after a previous seizure, [Mr A] had remained in his bedroom until 12:15pm. Therefore it was only after this time that I became

> concerned for [Mr A's] wellbeing. As a result I knocked on his door and asked whether he was okay. On not receiving a response I knocked on his door again and then gingerly opened his bedroom door and noticed his position. Even at this stage I was concerned about whether he could attack me and at an arms length touched [Mr A] on the shoulder. It was apparent at this stage that [Mr A] had been dead for some time."

97. Mr L advised HDC that observations and checks of Mr A in his room were "extremely difficult" and placed staff at risk because of Mr A's behaviour. He noted that risk to staff safety was heightened following a seizure, and that Mr A would often verbally abuse staff and threaten them with physical violence if staff "intruded the privacy of [Mr A's] bedroom". Mr L advised that observations of Mr A were by way of his open bedroom door "if he allowed it to remain open", and that "unwanted observation checks by staff of [Mr A] in his room may lead to behaviour escalating to the point staff risk being physically assaulted". He noted that "[s]taff feared for their personal safety as a result making routine checks of [Mr A] in his bedroom an extremely difficult task".

Incident Report

98. ABI Rehabilitation conducted a Root Cause Analysis into Mr A's death. The resulting Incident Investigation Report, dated 23 May 2011, noted:

> "[T]he topic of checking on [Mr A] came up – and [a staff member] said he knew how hard it is to check on [Mr A] when you have to peep through the keyhole or look through the hinge of the door to see that he is okay. It wasn't clear if this procedure was only used with [Mr A] or was part of how all clients were checked on in their bedrooms".

99. ABI Rehabilitation subsequently advised HDC:

> "The practice of observation 'through the key hole', while included in the initial investigation report, was in fact a misunderstanding of the observation practice used by staff employed at [the facility]. The physical layout of [Mr A's] room meant this was not actually possible. The observation practice used by staff is described in the statements provided from [Mr L] and [Mr K]."

100. The Incident Investigation Report noted the following issues with the care of Mr A:

- Mr A's medications were difficult to manage. The decision to administer his medications surreptitiously was made "after lengthy discussions involving all the clinical staff involved in his care, the local Police officer and [Mr A's] brother, who was also his welfare guardian".
- Because Mr A's medications were being administered in his drinks, it was difficult to assess how much of the dose of medication he was actually taking. The report noted that staff "… had not been given specific instruction regarding how best to mix the medications into [Mr A's] drinks or the importance of documenting how much of the dose had been given (if it could be estimated)".

- Although Mr A required close observation following his seizure at 11:50pm on the day before his death, he was left unobserved between 3am and 12:30pm the following day.
- Staff were not entering Mr A's room when attempting to observe him; rather, staff had adopted a practice of looking through the key hole of Mr A's room.[22]
- Other than the unanswered text message sent to the on-call manager following Mr A's seizure at 11:50pm, no further attempt was made to contact the on call manager to inform her of Mr A's seizure, as per the protocol.
- "Adherence to a house routine (mopping floors etc.) appears to have been the priority over attention to the Clients".
- Staff made no entries in Mr A's clinical records after 3am.

101. The following recommendations were made in the Incident Investigation Report:

- "If the administration of medications is facilitated by dissolving in liquid or mixing with food the client must be aware that a medication is being given to enable the staff administering the drugs to assess that all the medication was actually given. This in turn makes an assessment of its therapeutic effect possible".
- "A definition of 'Close observation' needs to be agreed to allow staff to know what the expectations are when this level of observation is required". Best Practice Guidelines clarifying the expectations of staff when close observation is required were completed on 12 July 2011.
- "When staff need to contact on call managers this should be done via a phone conversation and not via text". Revised procedures for contact with the on call manager were completed on 21 July 2011.
- "The on call manager **MUST** confirm they have received the message, it is not sufficient to send the message, the sender must know it has been received" (emphasis in original).
- "Staff to be made aware that client care and safety is the priority over routine household tasks".
- "Notes need to be made primarily in the clinical record and not as a secondary record".

Opinion: Breach – ABI Rehabilitation NZ Ltd

Introduction

102. I accept ABI Rehabilitation NZ Ltd's advice that Mr A was "a complex management challenge", and Rehabilitation Physician Dr J's comment that Mr A was "a

[22] As noted above, ABI Rehabilitation has since advised HDC that this finding was made in error.

challenging [patient] to manage medically". Mr A had multiple care needs that were being met by a number of different providers, and ABI Rehabilitation was working with those providers to attempt to meet his needs. Mr A's limited tolerance for doctors visits coupled with his at times violent and aggressive behaviour clearly presented several challenges to the providers caring for him at ABI Rehabilitation.

103. However, despite these challenges, Mr A was entitled to have services provided to him in accordance with his rights under the Code. This included the right to have services provided with reasonable care and skill (Right 4(1)), and the right to co-operation among providers to ensure quality and continuity of services (Right 4(5)).

104. In my view, there are aspects of the care and treatment Mr A received that were not delivered in accordance with his rights under the Code. In particular, I am concerned about ABI Rehabilitation's care planning and documentation, the management of Mr A's medication administration, and the management of Mr A's seizure activity. For the reasons set out below, I consider that ABI Rehabilitation breached Mr A's rights under the Code in those three areas.

Care planning and documentation

105. Mr A developed post traumatic epilepsy following his brain injury in 1995, and he suffered from absent and tonic clonic/grand mal seizures. Mr A was prescribed Sodium Valproate to manage his seizures.

106. Following Mr A's second brain injury in 2001, Mr A became non compliant with his medication. He also developed psychotic symptoms and was referred to psychiatric services. Mr A's psychotic symptoms stabilised on medication; however he remained subject to compulsory treatment orders until his death in 2011,[23] predominantly to ensure that he remained compliant with his epileptic medication. If Mr A was non-compliant with his medication, he would experience increased seizure activity and aggressive behaviour, which would make him a risk to himself and others.

107. Mr A was a resident at ABI Rehabilitation from July 2003. Little documentation was provided to HDC regarding ABI Rehabilitation's care planning for Mr A on his admission to ABI Rehabilitation. ABI Rehabilitation submitted that Mr A was reviewed by ACC at least annually, although my Office was unable to obtain evidence of that from ACC. ABI Rehabilitation also submitted that Mr A's Interdisciplinary Rehabilitation Plan was reviewed annually, although it was unable to provide evidence of that.

108. Given Mr A's complex management needs, it would have been prudent for ABI Rehabilitation to carefully plan, monitor, and update Mr A's care needs in clear and unambiguous care and management plans. Even if annual reviews were carried out for (and by) ACC, such reviews would not be sufficient to show that ABI Rehabilitation met its care planning obligations. As noted by my expert nursing advisor, registered

[23] Mr A was treated compulsorily in accordance with orders made under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) until 2010, after which he was treated compulsorily in accordance with a Personal Order made pursuant to section 10 of the Protection of Personal and Property Rights Act 1988 (the PPPR Act).

nurse Dawn Carey, "care plans or management plans should describe the assessment, planning, implementation, evaluation and review of delivered care". I accept Ms Carey's advice that Mr A's "overall long term goals" and care plans were appropriate in a residential rehabilitation setting. However, I have been given no evidence that those plans were regularly reviewed and updated. Ms Carey advised me that because Mr A was a long-term resident, it would have been reasonable for his general long-term care plan and his needs to be reviewed on a six-monthly basis. The only plan that appeared to have been updated on 10 May 2010 was, as noted by my advisor, generic in nature and did not contain enough information to guide or direct staff.

109. I am also concerned that several documents pertaining to Mr A's care and treatment planning and management are undated and/or the author is not identified. The purpose of care and treatment planning is to inform all providers who provide services to a client on how to provide safe services to that client, consistent with that client's needs. It is important that other providers are able to identify the author of certain care and treatment planning documents, so that person can be consulted with, or information clarified, if the need arises. It is also important that care and treatment planning documents be dated, so providers know that the care they are providing remains consistent with the client's needs. This was particularly important in the case of Mr A, whose complex care and treatment needs were being met by a number of different providers and services.

110. I accept my advisor's advice that the quality of the documentation supplied by ABI Rehabilitation falls short of the expected standard, and I am critical of ABI Rehabilitation's apparent failure to regularly review and update Mr A's care planing documents to ensure they remained appropriate and relevant to his needs.

Management of medication administration

111. ABI Rehabilitation provided HDC with a document titled "[Mr A] Management Plan", which documented a plan for the management of Mr A should he become non-compliant with his medication. The plan was undated and accordingly it is not clear when the plan was put in place.

112. Mr A's non-compliance with his medication appears to have escalated in 2009 and 2010. Mr A was hospitalised in March 2009 and March 2010 after he experienced seizures following a period of non-compliance with his medication. Mr A was also hospitalised in April 2010 after experiencing a grand mal seizure precipitated by a period of 15 days of non-compliance with his medication. Mr A was medically cleared and discharged from the Accident and Emergency Department, but was admitted to DHB2's Inpatient Unit due to his refusal to take his medication and his corresponding risk of seizure activity and violent and aggressive behaviour.

113. Mr A continued to refuse his medication at the inpatient unit. Accordingly, a decision was made by Mr A's treating clinicians, in consultation with Mr A's family, that Mr A's medication would be administered surreptitiously, either crushed in his food or drink without his knowledge, as a temporary policy. As Dr B described, this appears to have been a "well deliberated decision" that was regularly reviewed while he was an inpatient at the inpatient unit.

114. However, I have concerns about the management of Mr A's medication administration following his discharge from the inpatient unit back to the care of ABI Rehabilitation on 17 May 2010.

115. Ms Carey opined that the medication charts and progress notes "[g]enerally show a good level of compliance with administering [Mr A's] prescribed medication". However, the instructions to staff concerning how to administer Mr A's medications and on the recording of his medication consumption were inadequate. For example, the discharge summary from the inpatient unit noted that Mr A's tablets were to be crushed and given with his food "*if* oral meds are refused" (my emphasis). It appears that the plan on discharge was that Mr A was to be offered his oral medications first and, only if he refused, were those medications to be crushed and given to him surreptitiously with his food. However, ABI Rehabilitation provided HDC with a document titled "Management Plan for [Mr A]", dated 10 May 2010 but unsigned and not on letterhead, which does not provide that Mr A was to be offered his oral medications first. As noted by my advisor, within Mr A's progress notes, there is "strong evidence that [ABI Rehabilitation] staff were not offering Mr A his medications prior to concealing them in a drink". ABI Rehabilitation advised HDC that while staff persevered with offering medication to Mr A before it was given disguised in drinks, the actual process of offering the medication agitated Mr A, and he began refusing to take his medication immediately on his discharge from the inpatient unit on 17 May 2010. Accordingly, following discussion with Dr C and Dr B in June 2010, concealment of Mr A's medications "was adopted as the standard method of giving Mr A his medication". The practice, however, does not explain the inconsistencies in the instructions given to staff concerning how to administer Mr A's medications, as reflected in the discharge summary from the inpatient unit and the "Management Plan for [Mr A]", dated 10 May 2010, for which ABI Rehabilitation was responsible.

116. Staff were not instructed to witness Mr A's consumption of the total volume of medicated drink. As noted by Ms Carey:

> "When a staff member administers medications via a volume of liquid they are responsible for the supervision of the client until the drink is consumed or discarded. Safe medication administration also requires the accurate documentation of whether a medication dose has been consumed or not. This ensures that any lack of compliance with administered medications is captured and evaluated for risk."

117. As noted by my advisor, there is evidence in the clinical record that "there were some changes back and forth" in respect of the decision to administer Mr A's medications surreptitiously, but the notes do not consistently record who was involved in those decisions or the clinical rationale for them. For example, Mr A's progress notes on 1 June 2010 record a suspension of the surreptitious administration of Mr A's medication, but that appears to have been reversed 24 hours later.

118. It is not evident that clear and consistent instructions were given to ABI Rehabilitation staff about the management of Mr A's medication and, where changes were made to

his medication management plan, which staff were involved in those decisions and the clinical reasoning for those decisions is not always apparent. As noted by Ms Carey, this was contrary to the requirements set out in the Health and Disability Services Standards,[24] and it indicates that there was a lack of a cohesive approach to co-ordinating Mr A's delivery of care consistent with his needs. In my view, this was inadequate care.

119. It is also clear that the intention of Mr A's clinicians at the inpatient unit was for the surreptitious administration of Mr A's medication to be a temporary policy. However, there is no evidence that this plan was reviewed at any stage following his discharge from the inpatient unit in May 2010. ABI Rehabilitation advised that it was not the understanding of staff that the practice of concealment of Mr A's medication was temporary. Regardless of whether the plan to administer Mr A's medication surreptitiously was to be temporary or otherwise, it should have been regularly reviewed. My advisor opined that the failure to revisit the plan to administer Mr A's medication surreptitiously, "put staff in an almost untenable situation in relation to their ability to provide safe care to [Mr A]". I accept her advice that it would have been reasonable for the plan to administer Mr A's medications surreptitiously to have been reviewed within three months from its implementation; unless Mr A's progress was deemed different from expected thus triggering the need for an earlier review. In this case, the report on 2 June 2010 that Mr A was thinking and stating that he was medication free was such an event, which should have triggered an urgent review of Mr A's medication needs.

120. ABI Rehabilitation should have given its staff clear and unambiguous guidelines for the management and monitoring of Mr A's medications, and should have reviewed Mr A's medication administration plan at least three monthly. It failed to do so. I find that ABI Rehabilitation breached Right 4(1) of the Code for failing to adequately manage and monitor Mr A's medication administration following his discharge from the inpatient unit in May 2010 until his death in 2011. The significance of this failure is evident in Mr A's increased seizure activity and the corresponding failures to monitor and respond to that increased seizure activity (see below).

Monitoring of, and response to, Mr A's seizure activity

121. ABI Rehabilitation had a Seizure Management policy and a policy for the "Recording of Seizure Activity" for Mr A (Mr A's seizure management plan), dated December 2009. I accept Ms Carey's advice that these documents met the required standard.

122. The Policy requires staff to contact the registered nurse on duty when a client has a seizure, and this is also required by Mr A's seizure management plan. In this case, the registered nurse was notified of Mr A's seizure via text message without further liaison, which was not appropriate. Furthermore, following Mr A's seizure, care support worker Mr L placed Mr A in the recovery position, maintained observations, stayed with Mr A for 20 to 25 minutes, and recorded the seizure. However, there was

[24] Standards 3.5 and 3.12, Standards New Zealand (NZS) *8132:2008 Health and disability (general) services standards* (Wellington: NZS, 2008).

no physical observation of Mr A after 3am until he was discovered deceased 9.5 hours later. ABI Rehabilitation should have ensured staff were complying with its policies.

123. I accept my advisor's advice that the documentation of Mr A's seizure activity from 27 September 2010 was suboptimal, and a departure from the expected standard of care. In particular, this is evidenced by the following:

- ABI Rehabilitation kept a seizure record for Mr A, and seizures were also recorded in the progress notes along with episodes of urinary incontinence which may have been indicative of an absent seizure. The "Recording of Seizure Activity" for Mr A provides that it is "paramount that both witnessed and non-witnessed seizures are recorded" to ensure that the "correct care" could be provided to Mr A. However, there is a lack of coherency between the seizure record and the progress notes, particularly in relation to the recording of urinary incontinence indicative of possible absent seizures.

- As noted by my advisor, the incidence of seizure activity reported in the progress note entries in the weeks leading up to his death is not reflected in the seizure record, which reported no seizure activity. In actuality, Mr A was experiencing seizures on a regular basis at that time.

124. In addition, in my view, Mr A's seizure activity was not adequately responded to by ABI Rehabilitation staff. In particular:

- Early in 2011, Dr J was asked to review Mr A following staff concern that Mr A was experiencing neurological decline. Although Dr J recommended that Mr A's Sodium Valproate levels be checked it does not appear that that recommendation was followed through. There did not appear to be a coherent policy and/or procedure at ABI Rehabilitation to ensure that medical officer orders were followed up.

- That was not the only time in which staff recommendations for Mr A's management were not followed. Throughout the month before his death Mr A was noted to be suffering from urinary incontinence, and was noted to be fatigued. The notes record that staff raised concern about Mr A's condition and it was noted that "[Dr J] will investigate". There was a further request in the medical records from the Nursing Manager requesting a mid stream urine test to determine whether Mr A's incontinence was seizure related or indicative of a urinary tract infection. There is no documentary evidence that Dr J or the Nursing Manager reviewed Mr A at that time. This was inadequate care.

125. There was a failure to co-ordinate and oversee Mr A's care in relation to the management of his epilepsy and seizures. In particular, I am concerned that:

- Mr A's observed seizures were not documented consistently between the seizure record and the progress notes, and that staff incorrectly reported in the month before his death at a staff meeting that Mr A had not suffered seizures that month;

- ABI Rehabilitation failed to ensure appropriate reviews of Mr A's needs took place; and

- ABI Rehabilitation failed to ensure that staff were monitoring Mr A's condition as needed.

126. In my view, ABI Rehabilitation's monitoring of, and response to, Mr A's seizure activity was inadequate, and ABI Rehabilitation breached Right 4(1) of the Code.

127. In my view, there was also a lack of co-ordination with Dr J following Mr A's increased seizure activity in early 2011 (including a failure to request review and ensure blood tests that she recommended were carried out). In this respect, I find that ABI Rehabilitation breached Right 4(5) of the Code.

Recommendations

128. I recommend that ABI Rehabilitation:

- provide a written apology to Mr A's family for its breaches of the Code. This apology should be sent to HDC by **30 May 2013** for forwarding to Mr A's brother, Mr F.

- review its Seizure Management policy, medication administration policies, and its documentation and auditing policies, with particular regard to Ms Carey's recommendations regarding medication administration and the improvement of seizure activity documentation, and advise HDC of the outcome of those reviews by **30 May 2013**.

- develop a process for the implementation of medical officer orders and advise HDC that such a process has been implemented by **30 May 2013**.

Follow-up actions

- A copy of the final report with details identifying the parties removed, except the experts who advised on this case and ABI Rehabilitation will be sent to the Ministry of Health Services and the DHB2.

- A copy of the final report with details identifying the parties removed, except the expert who advised on this case and ABI Rehabilitation will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A - Independent expert advice to the Commissioner

The following expert advice was obtained from in-house nursing advisor, Registered Nurse Dawn Carey:

"My name is Dawn Carey. I am a registered nurse with a valid annual practising certificate from Nursing Council of New Zealand (NCNZ). My qualifications are Dip in Higher Education in Nursing (Southbank University, London, UK 1998), PG Dip in Advanced Nursing (University of Auckland 2007).

1. Thank you for the request that I provide clinical advice in relation to the care provided to the late [Mr A] by [ABI Rehabilitation]. 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. My comments are limited to the clinical management of [Mr A] at [ABI Rehabilitation]; namely the adequacy of the monitoring set in place for his medication administration and the adequacy of the management of his seizure activity.

   I have reviewed the documentation on file: [Mr A's] clinical notes; response documentation from [ABI Rehabilitation] including the incident investigation report, staff statements, handover sheets, and policy documents. I have also reviewed the comprehensive HDC complaint summary and have chosen in the interests of brevity not to reiterate this here as the background to this case.

2. On 18 March 2004, [Mr A] was admitted under the care of [ABI Rehabilitation] under the Mental Health Act (MHA) 1992. From 22 April 2010 [Mr A] was also subject to a Personal Order (PO) under section 10 of the Protection of Personal and Property Rights Act (PPPRA) 1988. This PO required [Mr A]:
   i. To take his anti-convulsant medications as directed
   ii. To remain resident at [ABI Rehabilitation]
   iii. To abstain from alcohol

   The [ABI Rehabilitation] admission 'Alert Sheet' (AS) lists severe traumatic brain injury (TBI), seizure activity, and alcohol dependence as relevant diagnoses for [Mr A]. There is also a separate adult management asthma plan suggesting that he also had asthma. Identified risks include;
   – Psychosis post seizure, increased confusion, increased irritability, risk of assault.
   – Non compliance with medications –> seizure activity; complex partial, absence, tonic clonic.
   – Risk to others post seizures, assault risk, decreased tolerance of young people (11-17 years).
   – Alcohol dependence, substance abuse (if available).

   These risks were addressed by various management plans which instructed [ABI Rehabilitation] staff on what actions to take should [Mr A] either be non-compliant with his anti-convulsant medications for an extended period of time or

leave the facility and not return within an appropriate time frame. [Mr A's] brother, (EPA) and [the] police were aware and it seems in agreement with these plans.

A decision to administer [Mr A's] medication surreptitiously in his drinks was approved on 11 May 2010 via a letter by [Dr B], Consultant Psychiatrist. This decision was initially made whilst [Mr A] was an in-patient at [DHB2] and agreed by the multidisciplinary team practitioners involved in his in-patient care. [Mr A's] brother (EPA) was also aware and in agreement with this plan. A memo to [ABI Rehabilitation] staff dated 17 May 2010 notes this practice and the resultant marked improvement in [Mr A's] behaviour. This memo explained the actions that [ABI Rehabilitation] staff should adopt should [Mr A] refuses his offered Topamax medication and they need to administer it surreptitiously. The author of this memo is not identified.

Also on file is documentation relating to [Mr A's] seizure management – signs and symptoms of tonic clonic and absence seizures; required staff actions in the event of a prolonged seizure and following a seizure; and [Mr A's] typical behaviour and affect during the post-ictal period. The staff registered nurse (RN) needed to be informed should [Mr A] have any seizure activity and in the event of a tonic clonic seizure, be notified immediately.

3. Review of submitted documentation and comments

i. [Mr A] has long term goals and care plans (CP) as is appropriate in a residential rehabilitation setting. However, these documents appear to be historic rather than detailing the current agreed plan of care for [Mr A] e.g. *Regular blood testing for therapeutic levels of dilantin levels especially after seizure activity.* Dilantin is the trade name of Phenytoin. Medication lists from [Mr A's] GP show that this medication was discontinued in 2005. The submitted "Interdisciplinary Rehabilitation Plan" is also out of date with no evidence of reviews occurring.

I acknowledge that one of [Mr A's] "Management Plans" reports *care plan updated 10/05/10* and lists 7 bullet pointed interventions. However, these interventions are generic in nature and do not contain enough information to guide or direct other staff members. To meet legislative requirements care plans or management plans should describe the assessment, planning, implementation, evaluation and review of delivered care. In my opinion, the quality of the submitted documentation falls short of the expected standards.

ii. Whilst [Dr B's] letter – 11 May 2010 – does refer to the decision to administer [Mr A's] medication surreptitiously as a *temporary policy*, I can find no documentation pertaining to a formal review of this plan. Also it is also not obvious as to who would initiate a review of this policy or what timescale was envisaged.

iii. The DHB2 discharge summary – 18 May 2010 – emailed to [Mr A's] GP, [Dr D] reports; *tablets are to be crushed and given with food if oral meds are refused…This has been discussed and approved by [Mr F]…who has EPOA.* This discharge summary includes amendments from the initial prepared summary and I am unsure as to whether all the relevant health care providers were receiving the same information.

Within the PN there is strong evidence that [ABI Rehabilitation] staff were not offering [Mr A] his medications prior to concealing them in a drink. This is in contrast to the reported actions of staff at [DHB2]; "*…[inpatient unit] staff have been placing [Mr A's] medication in his food when client refuses same".* In my opinion, the lack of a cohesive approach to co-ordinating [Mr A's] delivery of care against his needs facilitates such ambiguities.

iv. I note that following the decision to administer [Mr A's] medications surreptitiously, there were some changes back and forth. Unfortunately it is not always apparent who was involved in these decisions or the clinical reasoning behind the changes. The [ABI Rehabilitation] progress notes (PN) report that on 1 June 2010, [Mr A] was informed on the consequences of continued non compliance with his medication at a meeting with his social worker and [Dr C] (Psychiatry MOSS Community Mental Health Services (CMHS). This led to an initial suspension of the surreptitious administration of [Mr A's] medication for 24 hours before being reinstated by [an RN]. I note a PN report on 2 June 2010 re-confirming that *medication is not be concealed …staff are to follow the management plan* . This is reported as countermanded on 4 June 2010 by [an RN] following a phone call from [Dr C]. In my opinion the instructions for administering [Mr A's] medications and recording his consumption were inadequate.

v. On 3 February 2011 [Dr J] outlines a medical plan that reports "*we will check a sodium valproate level. If sub therapeutic we will increase the dose…"* This plan is also recorded contemporaneously in the PN. There is no evidence that this blood test was ever done or followed up further. [Mr A's] anti-convulsant regime continued unchanged.

vi. [A month before Mr A's death] the PN reports that [Mr A] had two witnessed absent seizures. [Two days later] he was presumed to have had an unwitnessed seizure due to urinary incontinence and being fatigued. Further urinary incontinence is reported [a few days later]. [Several days later] *Incontinence & poss seizure activity at night. Some fatigue observed but improved as the day went on.* Further incontinence is recorded in entries on [three occasions]. *[Dr J] contacted regarding concerns for [Mr A's] wellbeing, [Dr J] will investigate.* This is followed up with a request from the *nursing team leader* to obtain a MSU from [Mr A] to determine whether his incontinence is seizure related or indicative of a urinary tract infection. Also reported is that the urine *doesn't look concentrated, no signs of blood or cloudiness and no strong odour* although a formal urinalysis was unable to be performed. There is no documentation relating to [Mr A] being

clinically reviewed by [Dr J] or the nursing team leader. As registered and enrolled nurses retain responsibility for evaluating the care given by non registered care givers and for care/tasks that they delegate[25], this is a moderate departure from the expected standards of nursing care.

vii. Also in the PN, further urinary incontinence is recorded [a few days before Mr A's death] but with no corresponding concerns about fatigue or unwellness. On [the day prior to his death] [Mr A] is recorded as a *little pale in face…shaking a lot…Absent seizure x2, … gave meds via hot drinks …need to keep eye on [Mr A] next 24 hrs, no other issues.* At 11.50pm staff observe [Mr A] experiencing a tonic-clonic seizure – *duration 2 minutes…placed into recovery position…close obs continued through shift. Incident seizure record completed. On call [Ms I] notified via text…01.00am urinary incontinence...03.00am cigarette, resettled to bedroom, Client appears to have had minimal sleep…has a 'scratch' on his nose.*

GP [Dr D] is the author of the next entry in the PN reporting [Mr A] was certified as deceased on [date], following *likely asphyxiation following seizure activity during the night.*

viii. I have reviewed the instructions to staff concerning how to administer [Mr A's] medication and consider these inadequate. This is acknowledged within the [ABI Rehabilitation] incident investigation report (IIR). The Medication charts and PN entries generally show a good level of compliance with administering [Mr A's] prescribed medication. On the whole [ABI Rehabilitation] staff do take care to record that they sighted [Mr A] consume the administered medicated drink.

It seems the failure to commence [Mr A] on Fosamax Plus on 2 September 2010 relates to a prescribing error rather than a medication administration omission.

ix. Seizure Management Policy (SMP) – this is a separate policy document from the five page document (FPD) that offers guidance on how to specifically manage [Mr A's] seizure activity. Of concern are areas where one contradicts the other – e.g. *SMP (d) Check vital signs immediately following seizure and every 30 minutes (or as ordered) until client is alert.* This advice is not part of [Mr A's] specific seizure management documentation and I am unsure as to whether vital signs relate to levels of alertness and consciousness or observations such as respirations, pulse etc. I would recommend that the SMP and further documents that are based on it are reviewed clinically. I acknowledge that after [Mr A's] tonic-clonic seizure on [the day before his death] the completed documentation gives a good picture of [Mr A] during post-ictal phase.

Despite the specific instruction – consistent within the relevant documentation – to contact the RN should [Mr A] experience a seizure, this does not appear to have happened as regularly as required. There is a suggestion, based on the wording in the FPD that non-urgent notification may have been considered acceptable for

[25] Nursing Council of New Zealand (NCNZ), *Guideline: direction and delegation* (Wellington: NCNZ, 2008).

when [Mr A] experienced absent seizures. For an individual with established epilepsy this seems reasonable once timely notification did occur. The decision to contact the duty RN via text following [Mr A's] tonic-clonic seizure on [the day before his death] and the failure to liaise further is a mild-moderate departure from the expected standards of care.

x. Completed 'seizure records' for [Mr A] spanning 2009 to [his death in] 2011 were reviewed. I note that two absent seizures are recorded in [the month prior to his death], which is also confirmed by the contemporaneous documentation in the PN. This is in contradiction of the report related at [the] staff meeting. I note that the incidence of seizure activity as reported by the PN entries during [the weeks prior to his death] 2011 is not reflected in the seizure record documentation. No seizure activity was reported whilst in actuality [Mr A] was experiencing seizures on a regular basis.

Also there was a reporting change where incidences of nocturnal urinary incontinence were no longer recorded as indicative of an unwitnessed seizure. Urinary incontinence was established as a usual feature of [Mr A] having a tonic-clonic seizure and reported as such up to 27 September 2010. In my opinion the documentation of [Mr A's] seizure activity from this date was suboptimal and constitutes a moderate departure from the expected standards of care.

xi. [ABI Rehabilitation] decided to investigate [Mr A's] death to ascertain whether any service revisions were needed. [Mr A] was discovered at 12.30pm on [date] slumped against the wall of his bedroom, apparently in the process of getting dressed. There had been no physical observation of [Mr A] after 3am until he was discovered deceased some nine hours later. The submitted IIR is based on the assumption that [Mr A] was *free of observed seizure activity or urinary incontinence* [in the weeks leading up to his death]. Unfortunately this report is contradicted by the entries in the PN and also by entries in the 'seizure record'. A series of recommendations were agreed as part of the IIR. The list of these and the implementation timescale is on file and in the interests of brevity I will not reiterate them here.

4. Comments

i. Documentation – Clinical documentation and care planning is subject to compliance with Health and Disability Services Standards[26] and where it is completed or over seen by a registered or enrolled nurse, NCNZ competencies[27,28] also. Overall the documentation within the submitted PN meets the expected standards. However, the submitted care plans and evaluation of interventions

[26] Standards New Zealand (NZS), *8132:2008 Health and disability (general) services standards* (Wellington: NZS, 2008).
[27] Nursing Council of New Zealand (NCNZ), *Competencies registered nurses* (Wellington: NCNZ, 2007).
[28] Nursing Council of New Zealand (NCNZ), *Competencies for the enrolled scope of practice* (Wellington: NCNZ, 2010).

demonstrates a mild departure from the expected standards of clinical documentation.

In my opinion, the approach to documenting [Mr A's] seizure activity from 27 September 2010 was suboptimal and demonstrates a moderate departure from the expected standards of care.

When care is delegated to care givers the registered nurse or enrolled nurse retains responsibility for evaluating the care given[29]. As such I am critical of the failure of [ABI Rehabilitation] clinical management to review or audit [Mr A's] clinical file whilst he was under their care. Auditing and reviewing clinical files provide the necessary checks and balances and is part of quality and risk management systems.

In addition to the action plan detailed in the IIR, I would recommend that [ABI Rehabilitation] review their documentation recording and auditing policies as part of the learning within this case. In my opinion the lack of a cohesive approach to documentation facilitates ambiguities and leads to gaps in clinical care. I concur […] that there is a need for the development of processes around the implementation of MO orders.

ii. I agree with the IIR finding that the instructions to staff concerning the surreptitious administration of [Mr A's] medications were inadequate. I do acknowledge that based on the PN documentation and reviewed medication charts that staff were mindful of the need to ensure that [Mr A] consumed all of the proffered medicated drink. In my opinion the failure to revisit the plan, to administer [Mr A's] medication surreptitiously, put staff in an almost untenable situation in relation to their ability to provide safe care to [Mr A].

iii. It is contentious whether more regular observations would have meant that the outcome of [Mr A's] death would have been avoided. However, a more diligent approach to recording his actual seizure activity and seeking a timely review by the registered nurse and [Dr J] could very well have meant a different outcome for [Mr A]. Documentation in the PN shows that [Mr A] had regular seizure activity in [the weeks leading up to his death], which was not acted upon by [ABI Rehabilitation] staff. This failure is a moderate departure of the expected standard of care.

iv. I remain critical of the quality of guidance given to the care givers at [ABI Rehabilitation]. I acknowledge that the IIR recommendations have a detailed plan to ensure clarity around terms such as 'close observations' and how to contact the site manager. In my opinion this is appropriate.

v. I consider that there was a failure within [ABI Rehabilitation's] system to co-ordinate and oversee [Mr A's] care in relation to managing his epilepsy. Despite

[29] Nursing Council of New Zealand (NCNZ), *Guideline: direction and delegation* (Wellington: NCNZ, 2008).

named key workers there is little evidence of a provider acting as an advocate for this man. This opinion is informed by the failure of [ABI Rehabilitation] to ensure a review of [Mr A's] needs, the failure to refer him for a medical review following increased seizure activity, the failure to ensure ordered blood tests were carried out, the failure to ensure new prescribed medications were commenced, and the failure to ensure that staff were monitoring his condition as needed.

5. Clinical advice
   In summary, I consider that the care provided to [Mr A] by [ABI Rehabilitation] in relation
   - to the adequacy of medication monitoring to be a moderate departure from the expected standards of care
   - to the adequacy of the management of his seizure activity to be a moderate departure from the expected standards of care"

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

On 18 March 2013, Ms Carey provided the following additional advice:

1. "**Medication management:**
   I am of the opinion that the instructions concerning the surreptitious administration of [Mr A's] medication whilst he was resident at a [ABI Rehabilitation] facility were inadequate. I base this opinion on the level of instruction concerning medications contained in the "Management Plan dated 10 May 2010" and the "Administration of [Mr A's] medication 17 May 2010". Neither document instructs staff of the need to witness [Mr A's] consumption of the total volume of medicated drink. When a staff member administers medications via a volume of liquid they are responsible for the supervision of the client until the drink is consumed or discarded. Safe medication administration also requires the accurate documentation of whether a medication dose has been consumed or not. This ensures that any lack of compliance with administered medications is captured and evaluated for risk. In my opinion the need for detailed instructions is also a requirement of Health and Disability Services Standards 3.5 and 3.12[30].

   Registered nurses are accountable for ensuring that all health services that they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards[31]. Any decision to delegate care to a non registered care giver is a professional judgement

[30] Standards New Zealand (NZS), *8132:2008 Health and disability (general) services standards* (Wellington: NZS, 2008).
[31] Nursing Council of New Zealand (NCNZ), *Competencies for registered nurses* (Wellington: NCNZ, 2007).

made by the RN. As such, it must take into account the health status of the client, the complexity of the task being delegated and whether the person has the necessary knowledge, skills and experience to carry out the delegated task. The RN remains responsible for monitoring and evaluating the outcomes of delegated care and tasks[32]. In my opinion, an example of the required additional instructions for the safe surreptitious administration of [Mr A's] medication would include;

- Supervise [Mr A] when he is drinking fluids with added medications.
- Supervision needs to be maintained until [Mr A] has consumed the total volume of medicated fluid or discards / refuses it.
- Staff must accurately record whether [Mr A] has consumed his complete dose of administered medicated – total volume of medicated fluid – or not. Incidences of incomplete consumption need to be recorded and reported to a RN / shift supervisor on a daily basis.
- Staff need to ensure that other clients do not accidentally pick up or consume [Mr A's] medicated drinks. Should this occur or be suspected it must be reported immediately to RN/shift supervisor/medical practitioner.

2. **Failure to review the plan for surreptitious medication administration:**
Health and Disability Services Standards 3.8 – require that individualised service delivery plans are evaluated in a comprehensive and timely manner detailing the degree of achievement / response to interventions; and where progress is different from expected, suitable changes are made to the service delivery plan[33]. Whilst this Standard does not specify what constitutes a "timely manner", it is reasonable to expect that [Mr A's] 'plan to surreptitiously administer medication' would be reviewed within three months; unless the progress was deemed different from expected, which would require an earlier re-evaluation of the interventions / plan of care. As a RN I consider the events reported in email correspondence – dated 2 June 2010 – as constituting progress different from expected. This email reports [Mr A] thinking and stating that he is medication free, does not need his medication and will *pack his bags and move back to his house in […]*. This email also reports that [the] Police were updated as to [Mr A's] threat to leave [the ABI Rehabilitation] residential facility and him now being non-compliant with medications. As a RN I am of the opinion that the events reported in this email should have triggered a relatively urgent need for an interdisciplinary review of [Mr A's] medication needs and how best to cater to them. I note that the [ABI Rehabilitation] EN and Nursing Team Leader Position Descriptions both specify "*ongoing monitoring of client-centred nursing interventions and review/re-evaluate"* as a key accountability. Accepting that [ABI Rehabilitation] may disagree that a review should have been triggered by the events on 1 June 2010, I remain of the opinion that a review should have occurred within 3 months of [ABI

[32] Nursing Council of New Zealand (NCNZ), *Guideline: Direction and delegation* (Wellington: NCNZ, 2008).
[33] Standards New Zealand (NZS), *8132:2008 Health and disability (general) services standards* (Wellington: NZS, 2008).

Rehabilitation] agreeing to administer [Mr A's] medication surreptitiously – by end of August 2010.

I would recommend that [ABI Rehabilitation] develop guidelines that would make future decisions to administer medications without a resident's agreement, safe and client-centred. These guidelines should be part of the [ABI Rehabilitation] Medication Policy. Guidelines should include reason for decision, who is responsible for reviewing client progress and need for surreptitious administration to be continued, when review will occur, detailed administration guidelines for staff, amended medication administration sheet that allows for capturing whether total volume of medicated fluid/diet consumed or not, instructions as to who to notify and when to notify should client refuse medicated fluid or take incomplete dose or another client mistakenly consumes medicated fluid.

3. **Management of seizures:**
   As a RN I consider the Seizure Management Policy and the five page document – which offers specific guidance about [Mr A's] seizure activity – as meeting the required standard.

4. **Documentation of seizure activity:**
   Concerning advice for [ABI Rehabilitation] on how to ensure better record / capture seizure activity in the future, I would recommend that the Seizure Record chart is revised. In my opinion type of seizure, duration of seizure, and whether witnessed or unwitnessed are pertinent information that need to be included more prominently on this document. Features that accompany a client's seizure activity such as incontinence should also be captured. I would also advise that the EN or Registered Nurse leader reviews this document when they are notified of a seizure episode. [ABI Rehabilitation] Seizure Management policy states that this notification needs to occur. I would also recommend that [ABI Rehabilitation] develop a documentation audit policy where clinical files are randomly reviewed and assessed for compliance with standards and [ABI Rehabilitation] policies. The incidences where staff also captured [Mr A's] seizure activity in his clinical file were of the expected standards and I agree that these were appropriate and necessary entries.

5. **Clinical documentation review and audit processes:**
   As [Mr A] was a long-term resident at [ABI Rehabilitation] it is reasonable that his general long-term care plans and a review of his needs occurred on a 6 monthly basis. I note that on the submitted care plans – dated 15 September 2009 – that this is also the timescale recorded. However, I have been unable to find any evidence of a review occurring. As discussed in item 2, I do not consider the plan to surreptitiously administer medications as being part of a long-term care plan.

   In my professional opinion auditing clinical files is necessary to ensure that an organisation is meeting its required registration and legislative requirements. When staff teams include unregistered practitioners; auditing provides opportunities to check that the organisation's standards are being met, provide opportunities for education and training, and provide registered practitioner

oversight. It is reasonable that clinical files are randomly reviewed every 3-4 months depending on an organisation's size and workload. In my experience valuing the audit process and providing feedback supports staff members to meet their professional expectations as a healthcare provider[34, 35, 36,37].

6. **Paragraph 4(iv):**
   I am critical of the quality of guidance given to the caregivers at [ABI Rehabilitation] in relation to:

   - The surreptitious administration of medication
   - Seizure management of [Mr A]

   I am critical of the failure of [ABI Rehabilitation] as an organisation to provide the necessary checks and balances to ensure that the care delegated to and provided by non registered care staff was of the expected standards."

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[34] Standards New Zealand (NZS), *8132:2008 Health and disability (service) standards* (Wellington: NZS, 2008).
[35] New Zealand Nurse Organisation (NZNO), *Documentation* (Wellington: NZNO, 2010).
[36] Nursing Council of New Zealand (NCNZ), *Competencies for the enrolled nurse scope of practice* (Wellington: NCNZ, 2010).
[37] Nursing Council of New Zealand (NCNZ), *Competencies for registered nurses* (Wellington: NCNZ, 2007).