Registered Nurse, Ms C

Capital and Coast District Health Board

A Report by the

Health and Disability Commissioner

(Case 04HDC00735)

Health and Disability Commissioner

Parties involved

Mr A	Consumer (deceased)
Mr B	Complainant/Consumer's father
Mrs B	Complainant/Consumer's mother
Ms C	Provider/Registered nurse
Capital and Coast District Health Board	Provider
Ms D	Provider/Nurse co-ordinator
Dr E	Provider/Consultant psychiatrist
Ms F	Provider/ Registered nurse
Dr G	Provider/Registrar

Complaint

The Commissioner received a complaint from Mr B and Mrs B about the services provided to their son, Mr A, at the acute inpatient psychiatric unit at Wellington Hospital.[1] An inquest was held into Mr A's death, and following a review of the Coroner's findings,[2] an investigation was commenced. The following issues were identified for investigation:

- *The appropriateness of the care and treatment provided by Ms C to Mr A on 7 July.*
- *The appropriateness of the care and treatment provided Capital and Coast District Health Board to Mr A on 7 July.*

Information reviewed

- Information from Mr B and Mrs B, including Capital and Coast District Health Board Sentinel Event Investigation Report (the Sentinel Report)
- Inquest findings and recommendations from the Coroner
- Information from Ms C
- Information from Capital and Coast District Health Board, including
  - Mr A's medical records
  - Actions taken in response to Sentinel Report recommendations

[1] The Coroner described the layout of the psychiatric unit at Wellington Hospital as having three parts: the Intensive Care Unit, the open ward and the day hospital. Mr A was able to walk out of the Psychiatric Unit through a corridor from the open ward without going through the day hospital.
[2] The Coroner's recommendations, and the response by Capital and Coast District Health Board, are listed in Appendix 1.

Names (other than Capital and Coast District Health Board, Wellington Hospital and HDC's independent expert advisor) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

– Actions taken in response to the Coroner's recommendations.

Independent expert advice was obtained from Ms Christine Lyall, registered nurse.

Information gathered during investigation

Overview
This complaint concerns the mental health services provided to Mr A, a 26-year-old, who was diagnosed with a psychotic disorder. He was admitted to the acute inpatient psychiatric unit at Wellington Hospital under the Mental Health (Compulsory Assessment and Treatment) Act 1992. One morning, Mr A left the acute inpatient psychiatric unit. He was found in the grounds of a school and was taken immediately to Wellington Hospital, but died later that day from head injuries.

Following Mr A's death, the Coroner made 11 recommendations and concluded that there were multiple systemic issues within Capital and Coast District Health Board (the DHB) that contributed to Mr A receiving inadequate care during his admission.

Rather than duplicate the Coroner's inquiry, my investigation has focused on the appropriateness of the care and treatment provided to Mr A on the day of his death. I am required to determine two questions: (1) whether any actions or omissions of Ms C or the DHB breached the Code of Health and Disability Services Consumers' Rights; and (2) if so, what future actions should be taken under section 45(2) of the Health and Disability Commissioner Act 1994.

Mr A's past mental health history
Mr A's first contact with the Capital and Coast District Health Board Mental Health Service Early Intervention Service (EIS) occurred in June 1999. At that time his main symptoms included poor sleep, delusions and impulsive behaviour. In July 1999, he was discharged to another region's EIS. Mr A became engaged with the first EIS again in 2000, and on 22 April 2000 he was admitted to the acute inpatient psychiatric unit under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) with a recurrence of bizarre behaviour and delusional belief. At this time it was noted that Mr A was suffering from a psychotic illness. A risk management plan was completed and "possible self harm" was identified as a current risk. He was discharged from the EIS in 2001 when he travelled overseas. Although Mr A's family believed he was unwell while he was overseas, he did not have any further contact with a mental health service until his return to New Zealand.

Admission to hospital in June

When Mr A returned to New Zealand he initially spent the first three days in a New Zealand city. However, when he arrived in Wellington on 5 June his family immediately recognised that he had relapsed into a psychotic state, characterised by suspicion.

On 8 June, his family telephoned the Police for assistance after Mr A threatened to kill one of his brothers and threatened to assault his father, Mr B. Mr B applied for Mr A to be assessed under the Mental Health Act. Mr A was initially taken to the Police cells and was then transferred to the acute inpatient psychiatric unit's Intensive Care Unit (ICU) under Police restraint and escort.

On his admission to the ICU, Mr A showed a lack of insight and refused to answer specific questions. The house officer noted his delusions and bizarre behaviour, and aggression towards family members. He was commenced on olanzapine (an anti-psychotic medication). His risk management plan was completed with a planned date of review for the following day. Mr A's recorded current risk to self was assessed as "moderate" and to others as "serious". He received a risk category "A" rating which meant: "Severe risk; notify Police, responsible clinician, co-ordinator."

Mrs B advised that on 10 June she informed staff that upon his return from overseas she had "discovered a large carving knife" in Mr A's backpack.

Mr A's risk management plan was not updated at any stage during the inpatient period of care. The nursing staff formulated a treatment plan, but it was not updated. Mr A was not allocated a primary nurse.

On 13 June, Mr A was further assessed under section 13 of the Mental Health Act[3] and it was decided that a further period of assessment and treatment was indicated. Mr A was reviewed on 17 June, and a plan was made for him to be slowly transitioned out of ICU and to remain under the Mental Health Act while being treated on olanzapine. The multi-disciplinary team reviewed Mr A on 18 June, the main issue for discussion being Mr A's transition to the open ward, which was to start with an escort.

On 19 June, it was noted that Mr A's risk factors had decreased, and that transition, unescorted, to the open ward was appropriate. The plan included continuation of treatment under the Mental Heath Act. At 3.10pm Mr A was absent without leave (AWOL) from the acute inpatient psychiatric unit and returned to the ward at 4.40pm. An incident form was completed by a registered nurse. Mr A's transition to the open ward continued, and on 20 June he was permitted to have short, accompanied leave with his family, but not unaccompanied leave. Mr A assured staff that he would not leave the ward without permission.

[3] Under section 13 a patient is required to undergo further assessment and treatment for up to 14 days.

Between 21 and 23 June Mr A appeared to have little insight into his illness. On 23 June, the plan was for his continued transition to the open ward, unescorted, and for transfer when a bed became available. Accordingly, Mr A was transferred to the open ward on 24 June.

On 26 June, Mr A was seen by a house officer as superficial cigarette burns to his left hand had been observed. No incident form was completed in respect of the burns.

On 27 June, Mr A stubbed a cigarette out on his hand to keep himself awake and to protest at his ongoing detainment. No incident form was completed. Mr A wanted to leave the acute inpatient psychiatric unit, but was transferred back to ICU because of his risk to his family, and his AWOL potential. His insight into his condition remained poor, and on 28 June he remained at high risk of AWOL due to his inability to realise that he was experiencing mental illness.

Mr A returned to the open ward on 1 July. He continued to burn himself; however, no incident form was completed. His risk category was a category A.

A compulsory inpatient treatment order was made by the Family Court pursuant to section 30 of the Mental Health Act 1992.[4] Mr A's acute daily unit status plan on 4 July indicated that his observation category was level 3, which meant that staff should know his whereabouts.

Mr A was AWOL on 5 July. An AWOL form and an incident form were not completed. His acute unit daily status plan was not updated over the weekend.

6 July
On 6 July, registered nurse Ms F recorded the following for the afternoon duty in Mr A's records:

> "Nursing: [Mr A] out with father this evening. Father reported a very stressful day with [Mr A]. [Mr A] expressing paranoid/delusional beliefs about his father/brother. He believes they are trying to rape him. He has requested not to see them. He appears hyper-vigilant & suspicious during 1:1. He attempted to intimidate the writer & postured in a threatening manner towards his father. His affect is very intense & his gaze is fixed & penetrating. He appears frightened & is pressured in speech. He appears pre-occupied & overwhelmed with his psychotic beliefs. He is easily aroused."

Mr B advised the Coroner that he also told Ms F that his son had spoken of euthanasia that evening. Ms F advised the Coroner that she could not recall Mr B passing that information on to her.

[4] Section 30 requires the continued detention of the patient in the hospital specified for the purposes of treatment.

No plan for Mr A's care was made by Ms F at the end of her notes on the evening of 6 July, as she knew Mr A would be in a locked ward overnight, and that her note would be read out in the morning meeting when an appropriate plan would be developed.

Mr A's clinical records for the night duty state:

> "Night: [Mr A] — up to toilet x 1. Otherwise he has slept."

7 July

On the morning duty of Monday, 7 July, the usual nurse co-ordinator was on leave, and the weekend co-ordinator, Ms D, was acting co-ordinator. The co-ordinator normally does not have patients of her own, but on 7 July the ward was short-staffed, requiring that Ms D take a full patient workload and attend to her co-ordinating duties. She was also responsible for three patients cared for by a health care assistant. Ms C advised the Coroner that there were four registered nurses on the ward, whereas usually there were six.

Ms D was present at handover when Mr B's concerns about Mr A's mental state on the afternoon duty of 6 July were mentioned. Ms D advised the Coroner that she focused on the fact that Mr A's thinking had been disturbed and that he had expressed hostility towards his family. Ms D assigned the care of Mr A to registered nurse Ms C.

Ms C came on duty at 7.00am, part way through the handover, and did not hear any discussion about Mr A. Ms C said that Ms D informed her "that [Mr A] had been quite paranoid and delusional the night before and irritable towards family members. She told me he had come from ICU and his paperwork was not up to date. She did not mention that he had gone AWOL at the weekend or that there were other concerns about him."

Ms C advised the Coroner that she was aware that Mr A had been in ICU and that he had had some delusions and paranoia. Ms C had also attended some team meetings where Mr A had been discussed, although she was at those meetings in relation to other clients.

Ms C checked on her assigned patients, including Mr A, who was asleep. Ms C did not read Mr A's clinical notes and explained that she had to attend the medicine round with Ms D and attend to patients coming to the nurses' station door. Ms C explained that by the time these duties were completed Mr A's notes had been removed from the unit for the morning meeting, although she did have an opportunity to read some of Mr A's notes.

At approximately 9.00am, Mr B telephoned Ms C and asked her if the previous night's incident concerning his son had been documented. Ms C collected Mr A's notes and read out what had been written by Ms F on the afternoon duty of 6 July. Mr B told Ms C that he had more concerns about his son, beyond what was documented. He also said that the note was not enough, and that he would email Dr G, who was psychiatric registrar to Dr E, the consultant psychiatrist. Ms C's recollection is that Mr B said that he would contact the doctor straight away — which Ms C interpreted to mean that Mr B would telephone the doctor.

When she read out Mr A's notes to Mr B, Ms C saw Mr A's Acute Daily Unit Status had not been updated since 4 July and read "observation level 3". Ms C advised the Coroner that there was a heightened concern about Mr A's state of mind, and that if she had had time she would have told the doctors about this concern.

Mr B sent an email to Dr G at 9.50am, but she was away sick and she did not read the email. Dr G advised the Coroner that she had told the ward co-ordinator and the Human Resources Officer at 7.30am that she would not be at work. Ms D could not recall having a conversation with Dr G; however, she recalled becoming aware some time during the morning of 7 July that Dr G would be away that day. Ms C was unaware that Dr G would be absent from the ward.

Ms C told Ms D about her conversation with Mr B, although there is no documentary evidence of this. After completion of the medication round, Ms C found that Mr A's clinical notes had been taken to the team meeting, where patients' risks are reviewed and the level of observation decided. Dr E, the clinician in charge of Mr A's treatment, did not attend the team meeting that day.

Ms C went to see Mr A and found that he was in bed. She spoke to him, but did not discuss any of the concerns raised by Mr B that morning, or any of the concerns noted in Ms F's notes of 6 July. Mr A told Ms C that he had had a good night's sleep and his mood was good. After breakfast Mr A told Ms C he was going to the day hospital and she encouraged him to do so.

ECT

Ms C had been attending electroconvulsive therapy (ECT) training twice weekly for several months and was to attend ECT training that morning. The Coroner noted that Ms C's attendance at ECT training ought to have been well known to management and that her absence "ought to have been factored into the staffing arrangements for the morning". Ms C needed to leave the ward by 9.50am, and Ms D knew Ms C was to attend ECT training. Ms C also advised that, in the past, the nurse co-ordinator had always taken over her patients or allocated them to somebody else. Ms C believed that it was Ms D's responsibility to allocate Mr A's care to someone else. Ms C advised the Coroner that had she been on the ward on the morning of 7 July, she would have made it her responsibility to check on Mr A's whereabouts.

Ms D advised the Coroner that she became aware that Ms C would be absent from the ward for ECT after the medication round had been completed. Ms D did not ask Ms C who would be looking after her patients while she was absent from the ward, as she assumed that Ms C had sorted this out before she left and that Mr A was "okay" — he seemed calm and relaxed.

The DHB explained that the practice of the acute inpatient psychiatric unit was for nursing staff to hand over their client to a colleague and inform the senior nurse, whenever they left the ward. The handover policy in place at the time required a handover at the beginning of each shift, but was silent on further handover during a shift, including when nursing staff left the ward during a shift.

The ECT nurse was running late and she telephoned and asked Ms C to carry out the ECT preparations. This involved ensuring the patients who were to have ECT had their paperwork, prescriptions, and medications prepared prior to ECT.

Ms C handed over her patients to Ms D and informed her that she had agreed to Mr A's request to attend the day hospital.

At 10.30am, Dr E saw Mr A in the open ward courtyard. At 11.00am, Mr A was found in the grounds of a school. He was taken to Wellington Hospital.

Between 11.30am and 12.00pm (the exact time is unclear) Ms C returned to the ward from ECT duties. Ms C thought she saw Mr A eating his lunch in the dining room. It appears that Mr A did not have lunch and had left the ward, although Ms C was not informed.

Ms C noticed that patients had not been given their medication or had the blood tests necessary before medication could be given. She therefore proceeded to take blood samples from other patients in the ward and administered medications until 1.00 to 1.15pm. Following this, Ms C ate her lunch in the handover room with Ms D and continued to answer telephone calls about patients.

Following lunch, Ms C helped a colleague complete AWOL papers for another client. At 2.00pm Mr A was noted to be missing from the ward. The day hospital indicated that they had not seen Mr A for several hours.

The ward telephoned Mr A's home contact number and spoke to Mr A's brother to inform him that Mr A was AWOL. Mrs B telephoned the ward at approximately 2.05pm to enquire about Mr A and was told by Ms C that he had gone AWOL. The CAT (Compulsory Assessment and Treatment) Team was notified, and the Police received a fax from the acute inpatient psychiatric unit at 2.51pm informing them that Mr A had been missing since 12.00pm.

At approximately 3.00pm Mr B telephoned the acute inpatient psychiatric unit. Ms C informed him that Mr A was AWOL and that she did not realise Dr G had been absent for the day and may not have checked her emails.

At approximately 3.30pm Mr A died. At 8.00pm the Police informed staff at the acute inpatient psychiatric unit of his death. The cause of death was severe head injury.

Clinical records

Mr A's clinical records for 7 July appear to have been written after he was found AWOL. The notes state:

> "[Mr A] approached writer at approx 1000hrs requested if he could spend time in day hospital, same encouraged. At approximately 1400hrs he was noticed missing from ward. After discussion [with] other staff members, it appears he was last seen at approx 1200hrs.

Since he is level A AWOL risk, AWOL procedure followed. Parents aware of same. Police notified …."

The notes further state:

"Continue At approx 0900hrs had phone call from [Mr A's father, Mr B], he wanted to know how was [Mr A] also wanted to know whether or not yesterday's incident documented. After briefly glancing at [Mr A's] notes informed him of relevant documentation. He commented that it was more than what was documented. …"

Sentinel Report

The DHB undertook a review and reported on the factual circumstances surrounding the admission and clinical care of Mr A. The review team made the following recommendations:[5]

"**1. The assessment and clinical management provided to [Mr A]**

It is recommended that CAT team Clinical Leader investigate this issue further, and provide a response to the CCMHS Clinical Director explaining the circumstances in detail, and how they met, or fell short of, best practice in light of the concerns expressed by [Mr A's family] and this review team.

It is recommended that it be reinforced to all staff at [the acute inpatient psychiatric unit] that clinically significant occurrences, examinations, or information should be followed by an assessment and plan. These assist the reader in gaining clarity around what the clinician was thinking at the time the observation, assessment or information was received, and ensure that when matters are handed over to other staff, appropriate follow up occurs.

It is recommended that where possible, an Axis II [personality disorder] diagnosis, or the absence of one, be stated. This may assist the understanding of deliberate self harms, and therefore the treatment approach.

It is suggested that if e-mail is to be encouraged as a way of communicating with families in future, the strengths and limitations of this in a ward environment need to be made overt with the family or individual(s) involved. Communicating important or urgent information should never occur exclusively by e-mail.

[5] Background findings have been omitted from quoted text, leaving just the recommendations.

2. The management plan developed for [Mr A], its implementation and on-going review, including reviews of mental health status

It is recommended that the Client Pathway be reviewed by all staff working at [the acute inpatient psychiatric unit], as well as being given greater emphasis in the orientation for all staff new to the unit, including medical staff.

It is recommended that this [incomplete multidisciplinary team review] be brought to the attention of senior clinical staff in the unit, who need to monitor the quality of documentation for these important meetings in an ongoing way.

It is recommended that wherever practicable the patient's primary nurse should be included in interviews with medical staff, such as the Responsible Clinician or registrar.

3. Risk assessment, risk planning, management and monitoring, including risk to himself and others

It is recommended that both the risk management plan and the treatment plan be regarded much more as living documents than appears to have been the case. At weekly multi-disciplinary reviews, any important events and information must be incorporated into the risk management plan and treatment plan so that at any given point in time, the plans are ideally at most one week out of date. This process will facilitate discharge planning, even if it occurs with little warning.

During [Mr A's] last week of care, there appears to have been a loss of important information at successive hand-overs. In particular, the degree of concern apparent on the evening of 6 July was not conveyed to the day staff on 7 July. It is suggested that this issue highlights the importance of clear note-taking, clearly documenting plans, and handing over any concerns to the following shift. Further, at the morning hand-overs, all important events in the last 24 hours should be reviewed. This will obviously lead to an assessment as to the level of acuity, risk and the level of observations necessary.

If concerns are highlighted, previously approved leave may need to be put on hold until any areas of potential risk or concern are clarified. This needs to occur at the beginning of the shift as a matter of priority. The review team is of a clear view that there was a need to assess [Mr A] on the morning of Monday 7 July in light of the concerns documented the previous evening. These concerns related both to [Mr A's] risk to himself (given the references to euthanasia), as well as others (in particular given the references to his family).

It is suggested that a time frame needs to be stated in order to assist monitoring and that perhaps 'sighted at least hourly while on the Unit, or at the Day Program' or some similar wording would assist in this regard.

It is recommended that a single point of access and egress to the ward be established and that a staff member be situated at this point. That staff member could be given the leave entitlement of all patients following the morning meeting and to monitor the ward leave, both in terms of the requirement of any escort and the time frames of leave. Further, this staff member could facilitate visits to the Unit from official visitors, family, whanau or friends, bearing in mind any relevant protocols around these visits.

4. Acute inpatient unit procedures for managing absences from the unit, and their implementation

It is recommended that it may be helpful to reiterate this policy to ward staff at this time and during any future orientation to the Unit.

It is recommended that more care is taken to clearly identify who the primary contact is, and in the event of being unable to contact that person, who the secondary contacts are.

5. Acute inpatient unit milieu in regards to patient focus, mix and numbers, culture of care, treatment and facilities as it relates to the day of this incident

It is recommended that the allocation of primary nurse be the responsibility of the Team Leader and Clinical Nurse Specialist rather than staff deciding themselves who they will take on any given shift.

It is recommended that a more detailed assessment of staffing and ward milieu issues be an area to focus on by [the acute inpatient psychiatric unit] management staff.

It is recommended that senior [acute inpatient psychiatric unit] management staff and clinicians complete an audit of clinical documentation and policies.

6. The support and advice provided to [Mr A] and his family including communication between both parties

From the family's perspective, and from a model of best practice, it would have been preferable if the first meeting had occurred closer to the time of admission.

7. Inter-relationship of staff and clients between [the ward] and Day Hospital

It is recommended that a much tighter policy be implemented around referrals to the Day Hospital, including that these referral decisions come from the morning meeting or multi-disciplinary team review, and that such referrals are completed and delivered to the Day Hospital before the patient's first visit. The ward nurse should retain responsibility for any monitoring, observations and liaising with the Day Unit staff as may be appropriate. The Unit Nurse also retains responsibility for clearly documenting

in the patient's clinical notes what activities, behaviour, achievements or problems may have occurred during the day.

It is recommended that steps are taken to change [the] process [of destruction of referrals after clients from the in-patient unit are discharged] so that all referrals are placed on the client's primary file after discharge from the unit.

8. Identification of any other issues raised as a result of this investigation

It is recommended that all staff, including medical staff, be orientated to important processes and documentation on the Unit. With particular focus on the importance of risk management planning, treatment plans, the client pathway, lines of responsibility, processes regarding decision making around leave, the importance of the daily morning meeting and clearly documenting the outcomes from this.

Staff should wear identification badges at all times, as per protocols.

9. Recommend any further actions C&C DHB should take as a result of this incident

It is recommended that consideration be given as to whether a separate process needs to be carried out in respect of the staff most centrally involved in this issue."

Coroner
An inquest was held in the local Coroner's Court into the death of Mr A. The Coroner made a number of recommendations, as follows:

"1. That steps be taken immediately to establish strong clinical leadership within the Board's Psychiatric Unit and that a proper system of supervision, clinical oversight and support of nursing staff[6] be laid down and maintained at all times. The clinical staff member(s) appointed to supervise and support nurses should be freed of other duties and may be designated Charge nurse(s) or nursing co-ordinator(s).
2. That special care be taken by the Board to ensure that the Mental Health Services risk management system developed by it be maintained at the level of safety needed to achieve for New Zealanders the objective set out in S.3(1)(a) of the New Zealand Public Health and Disability Act 2000, namely '*the improvement, promotion and protection of their health*' and the attainment of the objective set out in S.22(1)(a) of that Act, namely the improvement, promotion and protection of the health of people and of communities. The Board should also ensure, in terms of S.3 of the Health and

[6] A recommendation in the same terms was made by this Court to the Board in its Findings into the death of [a lady] [Note: Footnote numbers have been altered in merging into the Commissioner's Opinion.]

Disability Services (Safety) Act 2001 the safe provision of psychiatric services to the public.

3. That the Board lay down and maintain a safe and proper system of ensuring that patients who are the subject of continued detention, in terms of S.30 of the Mental Health (Compulsory Assessment and Treatment) Act 1992, are prevented from absenting themselves from its hospital premises without leave.

4. That the Board ensures every inpatient has assigned to him or her an identified primary nurse with whom such patient can establish a therapeutic relationship and whose function is, inter alia, to co-ordinate assessment, treatment and management.

5. That steps be taken immediately to ensure that Mental Health Services risk assessment and risk management plans be updated immediately the nature and degree of patient risk changes so that the existence of such new and/or increased risk and plan for management thereof is made known to all persons to whom such knowledge is material for the purposes of assessment, treatment, management and care.[7]

6. That Psychiatric Unit staffing numbers be increased immediately to such level as will ensure that the workload of staff members is at all times of manageable proportions and does not pose a risk to patient safety AND that the Board give immediate attention to the steps needing to be taken to improve working conditions in its psychiatric unit and lift staff morale.

7. That in planning, structuring and staffing the new Psychiatric Unit of the Regional Hospital about to be constructed, the Board take into account and implement best international principles and practices for the delivery of psychiatric services of the kind intended to be delivered by such new Unit.

8. That steps be taken to ensure that there be present at every daily team meeting, and at every weekly multi-disciplinary meeting, at least one staff nurse with personal knowledge of the history, diagnosis and treatment of each patient falling for assessment and at least one registered medical practitioner being a registrar in psychiatry or vocationally registered psychiatrist; that the daily assessment and treatment plan be recorded in each patient's clinical notes; and that the Inpatient Acute Unit Daily Status Plan be completed each day. Level 3 of the Daily Status Plan category '*observation'* requires to be redefined so as to fix the periodicity of the documented observations required to be carried out.

[7] A recommendation in the same terms was earlier made by the Coroner to the Board in its Findings into the death of [a gentleman].

9. That all Mental Health Services professionals be reminded of *The National Mental Health Standards*[8] indicating a duty on the part of such professionals to involve carers, family and whanau in the provision of Mental Health Services and of the need for consultation in relation to the nature and extent of the risks flowing from a patient's condition and the safe management of those risks AND that there be made available to Psychiatric Unit staff at all times suitable facilities for interviewing carers, family and whanau in private with a view to accurate and complete note-taking.

10. That standard channels of communication of information be established and carers, family and whanau informed in order that information may be passed safely between those persons and Board staff. Transmission of information outside designated and approved channels should be discouraged. Consideration should be given to the sharing of information by email facility under safe and approved conditions.

11. That steps be taken to draw to the attention of all health professionals working in Mental Health Services, both medically and non-medically qualified, the need for proper note-taking, including the making of a proper record of all professional communications."

In respect of the care provided by Ms C, the Coroner accepted that the nurse caring for Mr A on the day of his death was "pressed for time and that inadequate staff staffing levels and lack of supervision and support made for real difficulty on her part in discharging her professional duties".

Subsequent events
Attached at Appendix 1 are the comments of the Board in response to the Coroner's findings.

Independent advice to Commissioner

The following expert advice was obtained from Ms Christine Lyall, registered nurse:

> "I have been requested by the Commissioner to provide an opinion on case number 04 00735. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

[8] The National Mental Health Standards, Ministry of Health, June 1997; see also 'Guidelines for Involving Families and Whanau of Mental Health Consumers/Tangata Whai Ora in Care, Assessment and Treatment Processes' Community Liaison Committee of the Royal Australian and New Zealand College of Psychiatrists, January 2000.

I am a Registered Nurse (Registration number 069024), gaining registration in 1979 with mental health nursing defined as my scope of practice. I have a Bachelor of Nursing degree (Otago Polytechnic, 1999) and a Master of Arts (Applied) in Nursing (Victoria University of Wellington, 2004).

The majority of my almost thirty year career has been spent in inpatient units. The last five of these have been in either senior clinical or managerial positions. My current position is that of Unit Manager in an acute inpatient mental health unit.

Supporting Information

Letter of complaint from [Mr and Mrs B] (pages 1–2)

Notification letters to the parties (pages 3–11)

Information from [Mr and Mrs B], including Sentinel Event Investigation Report (pages 12–51)

Coroner's report (pages 52–81)

Information from [Ms C] (pages 82–106)

Information from Capital and Coast District Health Board, including Sentinel Event Investigation Report Recommendations (pages 107–373)

I have been requested by the Commissioner to provide expert advice on a number of questions. These are:

1. *Should [Ms C] have considered [Mr A's] clinical notes when she commenced duty on 7 July?*

2. *What action, if any, should [Ms C] have taken to follow up [Mr B's] concerns about his son, following their telephone conversation on 7 July?*

3. *Was it appropriate for [Ms C] to allow [Mr A] to attend the day hospital?*

4. *Did [Ms C] communicate adequately with [Ms D], ward co-ordinator, regarding the transfer of [Mr A's] care prior to [Ms C] attending ECT duties?*

5. *Who was responsible for [Mr A's] care in [Ms C's] absence at ECT duties?*

6. *Should [Mr A's] attendance at the day hospital have been monitored in [Ms C's] absence at ECT duties? If so, how often?*

7. *What action, if any, should [Ms C] have taken from approximately 12.00pm (her return from ECT) until 2.00pm (when [Mr A] was noted to be missing) concerning [Mr A's] care (including his whereabouts)?*

8. *Did [Ms C] take appropriate action when she realised that [Mr A] was missing from the ward at 2.00pm?*

9. *[Ms C] became aware that [Mr A] was missing at 2.00pm. The [local] Police received a fax at 2.51pm notifying them that [Mr A] was AWOL. Was this delay acceptable?*

1. Should [Ms C] have considered [Mr A's] clinical notes when she commenced duty on 7 July?

The New Zealand Nursing Council Competencies for Entry to the Register of Comprehensive Nurses (2002)[9] recognises that nurses make professional judgements that will enhance nursing practice. There are specific mental health performance criteria related to the professional judgement competency. Three of these criteria are: assesses situations in a mental health setting in a manner that reflects an understanding of safety issues and patient/consumer needs; identifies the mental health care needs of the patient/consumer in partnership with the patient/consumer, their family and whanau; makes clinical nursing judgements based on current nursing knowledge, psychotherapeutic principles and critical reflection (p11). Another of the competencies, management of the environment, states the nurse assesses risk factors and identifies strategies that maintain own, patient/consumer and others' safety (p15).

To enable these competencies to be met it is accepted practice for the nurse allocated to particular patients/consumers to read the clinical notes relating to those particular patients/consumers as well as to be involved in the shift hand-over. It is not clear why [Ms C] did not attend the entire morning shift hand-over, missing the report on [Mr A].

The [acute inpatient psychiatric unit] Policy and Procedural Guidelines for Hand-over (Staff) state that a 'clear accurate summary of everything that has happened in the last 24 hours will be given to all staff at the beginning of each shift both in terms of the clinical area that they are assigned to and the wider unit community'.[10]

The progress notes from the afternoon of the 6th July indicate, as reported by [Mr A's] father, that there had been a change in [Mr A's] presentation evidenced by being paranoid and delusional toward family members. The nurse report states [Mr A] 'appears hyper-

[9] New Zealand Nursing Council Competencies for Entry to the Register of Comprehensive Nurses (amended 8 February 2002) p10.
[10] Supporting Information supplied, Information from Capital and Coast District Health Board, including Sentinel Event Investigation Report Recommendations p144.

vigilant & suspicious during 1:1. He attempted to intimidate the writer & postured in a threatening manner towards his father. His affect is very intense & his gaze is fixed & penetrating. He appears frightened & is pressured in speech. He appears pre-occupied & over-whelmed with his psychotic beliefs. He is easily aroused'.[11]

It is reasonable to assume that this change in presentation would have been discussed at shift hand-over.

The hand-over coupled with reading clinical notes assists staff to formulate a plan for patients/consumers in their care.

2. What action, if any, should [Ms C] have taken to follow up [Mr B's] concerns about his son, following their telephone conversation on 7 July?

The progress note written by [Ms C] on the morning of the 7th July indicates that [Mr A's] father continued to be concerned about [Mr A's] welfare. This was conveyed in a telephone conversation to [Ms C] at about 0900. [Ms C] was aware she would be absent from the ward for approximately two hours at ECT training. It is not unreasonable for a nurse in this position to convey these concerns to the Responsible Clinician and senior ward staff. The National Mental Health Sector Standard (2001)[12] 16.11 states that 'A review of the individual plan shall also be completed when significant changes for the person receiving the service occur.

This shall include and is not limited to ensuring reviews are conducted when the person receiving the service:

(a) Requests a review;
(b) Has a decline in his/her health;
(c) Self-injures or injures another person;
(d) Has a legal status change;
(e) Declines treatment and/or support;
(f) Is exiting the service in an unplanned way.'

It is clear from the progress notes on the evening of the 6th July and [Mr B's] phone call on the morning of the 7th July that there was a decline in [Mr A's] health and that a review of the individual plan by the treatment team would have been appropriate.

The prescription of risperidone 1mg. daily in addition to regular olanzapine on the 2nd July (p234), the granting of the application for [Mr A] to be detained under Sec. 30 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 on the 3rd July (p245) and the increase in risk rating to serious in the inpatient acute unit daily status plan for the

[11] Ibid pp319–320.
[12] NZS 8143:2001 National Mental Health Sector Standard, Ministry of Health p38.

week preceding the 7th July (p234–235)[13] indicate several reviews should have been conducted.

3. Was it appropriate for [Ms C] to allow [Mr A] to attend the day hospital?

In light of the concerns outlined above and the absence of a documented risk assessment a review should have occurred prior to [Mr A] attending the day hospital. [Ms C][14] states she informed [Ms D] of [Mr B's] phone call. There is no documentary evidence in the clinical notes of this.

4. Did [Ms C] communicate adequately with [Ms D], ward co-ordinator, regarding the transfer of [Mr A's] care prior to [Ms C] attending ECT duties?

[Ms D] was not the usual co-ordinator, she usually worked weekends in the role of co-ordinator. [Ms C] assumed that [Ms D] fully understood what attending ECT training meant, both for [Ms C] and the patients/consumers allocated to her care. It is clear there was confusion.[15] The usual custom and practice was for nurses to hand over their client load to a colleague and to inform their senior nurse when leaving the ward.[16] It seems this hand-over did not occur in a manner that ensured there was no confusion. This is a serious departure from usual custom and practice.

5. Who was responsible for [Mr A's] care in [Ms C's] absence at ECT duties?

The CCDHB sentinel [event] investigation report states that [Ms C] 'did not consider [Mr A] had any particular concerns that warranted an individual hand-over of care. No hand-over was made to the day hospital.'[17] It is clear from the Clinical Director's (CCDHB) response[18] that custom and practice dictated that it was usual for the nurse leaving the ward to hand-over patients/consumers in their care to another nurse. There does not appear to have been a nurse responsible for [Mr A's] care during [Ms C's] absence at ECT duties. This is a serious lapse of usual practice.

[13] Supporting Information supplied, Information from Capital and Coast District Health Board, including Sentinel Event Investigation Report Recommendations.
[14] Supporting Information supplied, Information from [Ms C] p85.
[15] Ibid p123.
[16] Supporting Information supplied, Information from Capital and Coast District Health Board, including Sentinel Event Investigation Report Recommendations p123.
[17] Supporting Information supplied, Information from [Mr and Mrs B], including Sentinel Event Investigation Report p31.
[18] Supporting Information supplied, Information from Capital and Coast District Health Board, including Sentinel Event Investigation Report Recommendations p123.

6. Should [Mr A's] attendance at the day hospital have been monitored in [Ms C's] absence at ECT duties? If so, how often?

The usual documented level of observations should have continued irrespective of [Mr A's] location. The New Zealand Nursing Council's Competencies[19] state that a nurse

- Communicates clearly, verbally, and/or in writing, when giving instruction about client care to nurse assistants/enrolled nurses, health service assistants or client's family/carers. (p6)

- Obtains, documents and communicates relevant client information. (p12)

- Determines the level of care required by individual clients and makes appropriate decisions when assigning care, delegating activities and providing direction [and supervision for enrolled] nurses and others, including health service assistants or family/carers. (p10)

- Recognises the potential for physical, psychological and cultural risk to all people who enter the health care environment and takes steps to promote safety. (p14)

- Identifies potential risk factors within the mental health setting and community environments. (p15)
- Assesses risk factors and identifies strategies that maintain own, patient/consumer and others' safety. (p15)

One of the seventeen principles for guiding service delivery and development described in Moving Forward[20] is 'ensuring **consistent safety standards** to protect the health of consumers and the public'.

The CCDHB did not have policies in place to ensure risk assessment was documented and hand-over of consumers occurred in a safe and timely manner. The CCDHB has since this incident developed a number of policies regarding hand-over of nursing responsibility and level of observation.[21]

The Blueprint for Mental Health Services in New Zealand[22] is clear with regard to an individual's safety while accessing mental health services.

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[19] New Zealand Nursing Council Competencies for Entry to the Register of Comprehensive Nurses (amended 8 February 2002).
[20] Moving Forward (1997) Ministry of Health.
[21] Supporting information supplied, Information from Capital and Coast District Health Board, including Sentinel Event Investigation Report Recommendations p154–188.
[22] The Blueprint for Mental Health Services in New Zealand (1998) Mental Health Commission, p53–54.

5.10.3 Clinical responsibilities for reducing the risk of harm

The potential for an individual to harm themselves or others, or to be harmed by others, is sometimes increased as a result of a mental illness and the change in life circumstances it may create. For this reason, procedures designed to reduce the risk of harm are an integral part of clinical practice (and the recovery approach); they should be stated as formal requirements for the provision of any clinical service in any setting, in order to maximise safety for all people. Services should implement the *Guidelines for clinical risk assessment and management in mental health services* (1998) which have been developed by Ministry of Health in partnership with the Health Funding Authority specifically to provide a basic framework to guide and aid mental health clinicians to better assess and manage clinical risk.

Guidelines for community and hospital services need to cover the following:

• ***Individual assessment of the potential for harm***

Services require clear protocols for assessing the risk of harm for all people on first contact with mental health services and then regularly as part of their ongoing treatment. This assessment should be based on all available information about past and present harmful behaviour.

• ***Individual plans for reduction of risk of harm***

Once the risks of harm have been identified in an assessment, steps to address them need to be clearly set out in individual agreed recovery plans. A designated key worker works with the individual to oversee the design, implementation and review of the plan, and, where appropriate, family/whanau and others are involved in the development and actioning of it.

7. What action, if any, should [Ms C] have taken from approximately 12.00pm (her return from ECT) until 2.00pm (when [Mr A] was noted to be missing) concerning [Mr A's] care (including his whereabouts)?

It is usual practice in areas where I have worked that when returning to duty the nurse would receive a verbal hand-over from the person covering in his/her absence. Once this had occurred it is reasonable to expect the nurse to inform the consumers allocated to him/her that they have returned to the ward. Usual levels of observations would be continued. It would be reasonable to expect any registered nurse to be aware of the whereabouts of the person in their care at any given time. If not on the ward then it would be expected that the nurse would be able to account for the consumer's whereabouts and who they had gone on leave with. [Ms C] stated she thought she saw

[Mr A] having his lunch but did not confirm this.[23] This failure to ascertain patient/consumers whereabouts denotes a serious departure from usual practice.

In [Mr A's] case he was able to take short accompanied periods of leave. The Policy and Procedural Guideline for Observation of Clients[24] states that level of observation to be clearly noted in progress notes and on the management plan, this had not occurred. The progress notes on the morning of the 6th July state that [Mr A] 'is aware of his leave status, will discuss tomorrow with [Dr E].'[25]

The clinical notes supplied as supporting information do not demonstrate regular documentation of the level of observation or clinical risk assessment. This may be a systemic issue which the CCDHB will need to address.

8. *Did [Ms C] take appropriate action when she realised that [Mr A] was missing from the ward at 2.00pm?*

The decision to place [Mr A] absent without leave was appropriate. There were two cover sheets in [Mr A's] file. While this may have been confusing the fact that [Ms C] had spoken with [Mr B] that morning and therefore was aware of his involvement and concern should have ensured [Ms C] contacted him directly to explain that [Mr A] was absent without leave from the ward.

9. [Ms C] became aware that [Mr A] was missing at 2.00pm. The [local] Police received a fax at 2.51pm notifying them that [Mr A] was AWOL. Was this delay acceptable?

The request for Police assistance details potential for violence: aggression towards others especially family, paranoia, agitation, suicidal.[26] It also details there had been previous AWOL, and there was a history of dangerousness and violence. The delay in notifying the Police given this information is unacceptable.

Are there any aspects of the care provided by [Ms C] and/or CCDHB that you consider warrant additional comment?

The CCDHB [Report on Mr A][27] draws conclusions and makes some recommendations. The introduction of various policies regarding risk management and treatment plans

[23] Supporting Information supplied, Information from [Ms C] p88.
[24] Supporting Information supplied, Information from Capital and Coast District Health Board, including Sentinel Event Investigation Report Recommendations p148–149.
[25] Ibid, p319.
[26] Supporting Information supplied, Information from Capital and Coast District Health Board, including Sentinel Event Investigation Report Recommendations p326.
[27] Ibid p358 [ie, the Sentinel Investigation Report].

(p366) in response to the report is sound. There is however no mention of the development of an auditing system to ensure these policies are part of usual ward practice. It would be usual to ensure a system is developed to incorporate the implementation and use of these policies into the quality improvement and auditing calendar."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

…

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Other relevant standards

Competencies for Entry to the Register of Comprehensive Nurses (amended 8 February 2002):

"**Competencies for the Registered Nurse scope of practice.**

Evidence of safety to practise as a registered nurse is demonstrated when the applicant:

3.0 Professional Judgement

Makes professional judgements that will enhance nursing practice.

4.0 Management of Nursing Care

Manages nursing care in a manner that is responsive to the client's needs and which is supported by nursing knowledge.

5.0 Management of the Environment

Promotes an environment which maximises client safety, independence quality of life and health.

6.0 Legal Responsibility

Practises nursing in accord with relevant legislation and upholds client rights derived from that legislation."

The *National Mental Health Sector Standard* (2001)[28] 16.11 states:

"**16.11** A review of the individual plan shall also be completed when significant changes for the person receiving the service occur.

This shall include and is not limited to ensuring reviews are conducted when the person receiving the service:

(a) Requests a review;
(b) Has a decline in his/her health;
(c) Self-injures or injures another person;
(d) Has a legal status change;
(e) Declines treatment and/or support;
(f) Is exiting the service in an unplanned way."

Opinion: Breach — Ms C

Introduction
Ms C was one of many health professionals involved in Mr A's care during his admission in July. There were serious inadequacies in the way inpatient mental health services were provided by Capital and Coast District Health Board. Those inadequacies have been fully considered by the Coroner and recommendations made as a result. The Coroner did not criticise Ms C's actions and specifically stated that the circumstances in which she was working made it very difficult for her to discharge her professional duties. Nonetheless, in my opinion Ms C failed to provide an appropriate standard of care to Mr A, even allowing for

[28] NZS 8143:2001 National Mental Health Sector Standard, Ministry of Health p 38.

inadequate staffing and the lack of support and supervision. I have concluded that Ms C breached Rights 4(1), 4(2) and 4(5) of the Code, for the reasons set out below.

Beginning of shift

When Ms C commenced her shift at 7.00am Mr A's condition had already been discussed at the morning shift nursing handover. Following handover, she was informed by Ms D of Mr A's change in condition, specifically that he had been quite paranoid and delusional the night before and irritable towards family members.

Despite being aware that there was a heightened air of concern about Mr A, Ms C did not read Mr A's clinical notes or personally speak with him following handover. Instead, Ms C became involved in activities that drew her away from Mr A's care, including performing the drug round with Ms D.

My expert advised that it is accepted practice for the nurse allocated to particular patients to read their clinical notes as well as be involved in the shift handover. This assists the staff to formulate a plan of care for their patients.

Ms C spoke with Mr A's father at approximately 9.00am. During the conversation, she read the notes written the night before by Ms F, including that Mr A had appeared "pre-occupied & overwhelmed with his psychotic beliefs". Ms C did not have an opportunity to complete reading Mr A's notes due to her other tasks. She did, however, inform Ms D about her discussion with Mr B and discuss Mr A's condition with her.

Mr A was Ms C's patient and it was her responsibility to act on changes in his condition. Ms C had spoken to Mr B, read the notes written by Ms F the night before, and knew of the concerns expressed by the afternoon staff. In my view the combination of these concerns should have alerted Ms C to contact a responsible clinician and request that Mr A be reviewed. Although not part of Mr A's treatment team, Ms C was the nurse assigned to care for him that day and the information she held warranted further action on her part. It was not sufficient for Ms C to have a brief discussion with the preoccupied acting nurse co-ordinator. At the very least, she should have followed up with the registrar, Dr G, to confirm that Mr B had spoken to her. (Of course, had Ms C done so, she would have realised that Dr G was not at work that day.)

Mr A's attendance at the day hospital

Ms C spoke to Mr A following her discussion with Mr B. This was the first time she interacted with him since coming on duty at 7am as he had been asleep when she first checked on him. Mr A requested to attend the day hospital, and Ms C encouraged him to do so. It has not been possible to establish when Mr A left the ward or when he arrived at the day hospital. What is clear, however, is that apart from talking to Ms D about Mr A, Ms C did not pass on any concerns about Mr A's apparent decline to day hospital staff. In light of the concerns expressed about Mr A's condition and the absence of a documented risk assessment, a clinical review should have occurred prior to acceding to Mr A's request to attend the day hospital.

Handover of care
According to the DHB, it was the usual custom in the ward for nurses to hand over their patients to a colleague and to inform their senior nurse when they were leaving the ward. Ms C stated that, in practice, nurses told the co-ordinator they were leaving the ward and the co-ordinator took over their patients or allocated them to someone else. Ms C left for ECT training and did not give an individual handover of Mr A's care to Ms D or to a nursing colleague as she did not consider that Mr A had any particular concerns that warranted an individual handover of care.

Even if Mr A had already gone to the day hospital when Ms C left the ward, she should have provided a handover of her patients. She did not do so. It was not sufficient to make a passing comment to Ms D that she was leaving the ward and that Mr A had gone to the day hospital. Ms D assumed that Ms C had taken care of Mr A's monitoring.

My expert identified the confusion about the transfer of Mr A's care prior to Ms C attending ECT training, noting that Ms C assumed Ms D fully understood what attending ECT training meant, both for Ms C and for her patients.

The confusion about the handover of patients was obviously not only Ms C's. However, in light of the information from the DHB that the practice was for nurses to hand over their patients to a colleague, and my expert's comments about what is usual practice, I consider that Ms C omitted to arrange appropriate care of Mr A when she left the ward to attend ECT training.

Return from ECT training
Following her return to the ward at approximately 12.00pm, Ms C proceeded to take blood samples and administer medications, but she did not check her own patients, including Mr A, before doing so.

Although she thought she saw Mr A eating his lunch in the dining room, Ms C did not confirm this. Ms C advised that she was not informed that Mr A had not attended lunch. My expert noted that, in her experience, when returning to duty a nurse receives a verbal handover from the person covering in her absence. In my view, this is sound practice and helps ensure continuity of patient care. I have received no evidence that Ms C sought such a handover from Ms D upon her return to the ward or enquired which nurse her patients had been assigned to, so that she could receive their handover.

In any event, Ms C's omission to appropriately hand over Mr A's care to another nurse while she attended ECT training meant that she could not receive a handover herself on her return to the ward. I acknowledge that Mr A's acute daily unit status was not up-to-date, but Ms C should have been able to account for Mr A's whereabouts at any given time. She had a professional obligation to ensure his safety was maintained.

AWOL

At 2.00pm Ms C became aware that Mr A was AWOL. The Police received a fax from her at 2.51pm informing them of his absence from the ward. My expert advised that Ms C's delay in notifying the Police was unacceptable.

Ms C explained that she attempted to inform the Police of Mr A's being AWOL by telephone, but was put on hold and so sent a fax. It is understandable that there was some delay in initially informing the Police of Mr A's absence, but the Police did not receive the fax until 2.51pm. I consider this delay to be unacceptable.

Conclusion

There is no doubt that the ward was short-staffed on 7 July, and that the environment in which Mr A received care fell well below what are considered acceptable standards. These systemic issues have been thoroughly canvassed, and relevant recommendations made, by the Coroner. Nonetheless, as the nurse assigned to care for Mr A on 7 July, Ms C's actions warrant particular consideration. My investigation has highlighted some unacceptable practices on the part of Ms C.

Having been informed by Ms D about Mr A's declining mental health, Ms C failed to read Mr A's clinical notes before commencing her ward tasks. She was directly informed by Mr B about his concerns for his son and she spoke with Ms D about this conversation, but she did not document her discussion until after Mr A was found to be missing. This meant that Mr B's new concerns about his son's well-being were not available to staff at the morning meeting. Nor did Ms C seek out a clinician to discuss the fresh concerns. Ms C acceded to Mr A's request to attend the day hospital. Before leaving the ward to attend ECT, Ms C failed to hand over the care of Mr A. On her return from ECT at 12.00pm, she did not locate Mr A and she failed to obtain an update on his condition. When she became aware of Mr A's absence from the ward at 2.00pm, Ms C failed to inform the Police of Mr A's absence within an acceptable timeframe.

Ms C was an experienced nurse who had worked as a mental health nurse for several years. Yet Ms C exhibited poor judgement in her care of Mr A up until the time she reported him AWOL to the Police.

In my opinion Ms C simply failed to appropriately care for Mr A and breached Rights 4(1), 4(2) and 4(5) of the Code.

Opinion: Breach — Capital and Coast District Health Board

Vicarious liability
In addition to any direct liability for a breach of the Code, employers are responsible under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code. Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from doing or omitting to do the things that breached the Code.

Ms C was employed by the DHB. As an employer, the DHB may be vicariously liable for any breaches of the Code by Ms C.

As discussed above, Ms C breached Rights 4(1), 4(2) and 4(5) of the Code. Ms C's failure to provide an appropriate standard of care to Mr A was partly due to her individual clinical practice for which her employer cannot be held responsible. However, the DHB is responsible for the systemic failures that contributed to the poor care Mr A received. This includes the failure to have policies in place to ensure proper handover of patients.

There was a handover policy in place at the time, but it did not cover handover during a shift and therefore did not adequately reflect the reality of staff needing to leave a ward. Ms C's attendance at ECT training was a regular event and, presumably, other nurses were required to attend such training. In the DHB's view, there was an accepted practice of nurses handing over their patients to a colleague, but this was clearly not adequately advised to staff or reflected in the ward's written policy at the time. In my view, the failure to adequately inform staff what was expected contributed to Ms C's and Ms D's confusion when Ms C left to attend ECT training and Ms C's failure to ensure a handover on her return to the ward.

Clearly, Ms C and her colleagues were under pressure at the time as a result of low staff numbers. Ms C was placed in the invidious position of having too many tasks to perform.

In these circumstances, the DHB is vicariously liable for Ms C's breaches of the Code.

Recommendations

- I recommend that Ms C review her practice in light of this report.

- I recommend that the Capital and Coast District Health Board review its mental health services in light of this report and continue to implement the actions identified in respect to the Sentinel Report recommendations and the Coroner's recommendations.

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand.

- A copy of this report, with details identifying the parties removed (other than Capital and Coast District Health Board and Wellington Hospital), will be sent to the Mental Health Commission, the Mental Health Consumers Union, and Te Ao Maramatanga (New Zealand College of Mental Health Nurses) Inc, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names (other than Capital and Coast District Health Board, Wellington Hospital and HDC's independent expert advisor) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix 1

Recommendations from Coroner's report

Overview:
The Mental Health Service accepts the role of the Coroner and welcomes the opportunity provided by the report to once again reflect on the way in which systems operate and to review the changes that have taken place since the death of [Mr A].

Recommendation	Comment	Action (Person Responsible)	Date
1. That steps be taken immediately to establish strong clinical leadership within the Unit and that a proper system of supervision, clinical oversight and support of nursing staff be laid down and maintained at all times.	There is already a strong clinical leadership structure within the unit, including the roles of Clinical Nurse Specialist [CNS], shift coordinator and Team Leader. Review of the way in which these positions are currently utilised, and another recent incident elsewhere in the Mental Health Service, suggests that there is a strongly held view amongst at least some staff that individual autonomy of practice is paramount and that there is as a consequence less use made of additional resources (such as senior clinicians) to assist with decision making and practice review that would ordinarily be desirable.	Staff will be assisted in recognising the senior clinical resources available to them within their work settings, through • practice memorandum (Clinical Director) • policy/protocol development (Clinical Director) • line management supervision (Clinical Leaders/Team Leaders)	January 05 January 05 Ongoing
The clinical staff member(s) appointed to supervise and support nurses should be freed of other duties and may be designated Charge nurses or nursing coordinators	Additionally, there are presently various levels of experience of registered nursing staff within the unit, with the roles of more senior staff including a role in supervision and oversight within the competencies associated with their level on the nursing career pathway.	Reinforcement of these roles within the context of ongoing discussion with staff and unions regarding the skill mix within the unit (Team Leader, Clinical Leader).	Ongoing

Recommendation	Comment	Action (Person Responsible)	Date
	Over the past 12 months there have been a number of changes of Team Leader and there remains currently an acting Team Leader in this role. We accept the importance of this Team Leader role in particular in providing strong leadership to the unit, and to this end have supported that role with a "Resource Team" to assist with oversight of functions of that role.	The Resource Team continues to meet regularly (fortnightly) to support acting Team Leader. Team Leader interviews have been held and an offer of appointment made. Acceptance pending.	Ongoing February 05
	It is considered that the relocation of the Team Leader and CNS offices away from the ward (to create more client space within the unit) may have [led] to a view that they are less available to assist with leadership roles within the ward. There has been an effort made by these personnel to spend more time within the ward environment.	Continue efforts by Team Leader and CNS to have a high profile and regular physical presence within the ward setting. (Team Leader and CNS) Re-locate Team Leader and CNS offices to the ward setting	Ongoing As soon as practicable, within constraints of space
	There is an established policy regarding professional supervision of staff. Although this policy is directed toward professional practice rather than clinical line management, this assists with matters in relation to practice roles. All registered nurses are expected to have supervision. Adherence to this policy is regularly audited by the Best Practice Group within the ward. (The Best Practice Group was established following the external review of this incident)	Best Practice Group to continue implementation of supervision policy. (Team Leader)	Ongoing
	All staff have annual performance reviews which incorporate attention to practice issues.	Performance reviews to specifically include attention to function within context of a clinical team and the use of the senior clinical	Immediate and ongoing

Recommendation	Comment	Action (Person Responsible)	Date
		resources available within that context. (Service wide issue) (Clinical Leaders)	
2. That special care be taken by the Board to ensure that the Mental Health Services risk management system developed by it be maintained at the level of safety needed to achieve the objective set out in S.3(1)(a) of the New Zealand Public Health and Disability Act 2000, namely "the improvement, promotion and protection of their health" and the attainment of the objective set out in [S].22(1)(a) of that Act, namely the improvement, promotion and protection of the health of people and of communities. The Board should also ensure, in terms of S.3 of the Health and Disability Services (Safety) Act 2001 the safe provision of psychiatric services to the public.	The Mental Health Service accepts fully that it has important obligations with regard to risk assessment and management and, to the fullest extent possible, with regard to safe care of clients of the service.	CCDHB including Mental Health Services have engaged and undertaken accreditation through Quality Health New Zealand. Implementation of recommendations from the survey pertaining to the ward will contribute to the ongoing improvements in standards of care Acting Plan from Quality Health Survey Implementation (Team Leader and Quality Facilitator)	Immediate and ongoing
	Although the Client Pathway has lacked specificity regarding the requirements for review of risk assessment documentation within the inpatient setting, the CNS has been coaching staff in updating risk documentation.	Revised Client Pathway documentation to expressly identify requirements regarding documentation of risk. (Clinical Director) Immediate confirmation of the requirement (memorandum to staff in acute ward) of requirements for update in accord with changes in risk status. (Clinical Director)	June 05 Immediate

Recommendation	Comment	Action (Person Responsible)	Date
	A working party has been reviewing the approach to individual clinical risk assessment and management. A pilot training session in a more comprehensive approach to risk assessment and management was held in early December 2004. A plan is being developed to implement this training more widely across the service, commencing early 2005.	Implementation plan for training in revised risk management process and documentation to be agreed at February meeting of the [Safety and Quality] Committee (Clinical Director).	February 05
	Attention has been paid to the processes of incident reporting and review with more widespread use of summary information within service divisions and teams to assist with system improvement.	Weekly summary incident reports to continue to be provided to Clinical Leaders for discussion within service groups regarding trends and analysis. (Coordinator, Clinical Practice Group) Monthly incident reports to be tabled at the [Safety and Quality] Committee monthly. (Clinical Director)	Ongoing February 05
	An audit plan has been developed which identifies annual audit of compliance with client pathway documentation across the service as a whole. More frequent audits currently occur within inpatient settings. Within the acute ward, the CNS is now conducting these audits monthly, including attention to the quality of the documentation and the content of the plans.	Monthly audits of risk assessment and compliance with other aspects of client pathway to be summarised in monthly reports. (Clinical Leader)	Immediate
3. That the Board lay down and maintain a safe and proper system of ensuring that patients who are the subject of continued detention, in terms of S.30 of the	Although the Mental Health Act provides the authority to detain people, this must be balanced against the need for inpatient settings to maintain a therapeutic focus. There is a balance that must be realised between an environment in which		

Recommendation	Comment	Action (Person Responsible)	Date
Mental Health (Compulsory Assessment and Treatment) Act 1992, are prevented from absenting themselves from its hospital premises without leave.	detention containment [is] paramount and one in which people feel comfortable [and] do not experience the setting as inhospitable. There are clear requirements of the National Mental Health Standards that services operate without unreasonable restriction of people who use those services.		
	Although the Mental Health Service accepts that it must exercise care in preventing people from leaving if they should be within the hospital, it does not believe that it should create an environment that attempts to guarantee that people who are determined to leave will be unable to do so. In trying to address this balance, the following methods are applied. The Intensive Care Unit is generally locked, although provision does exist for this area to be unlocked should the mix of clients within the unit allow such to occur safely. Egress from the ICU, should it be unlocked, is through the "open" ward. Uncontrolled external doorways form the open ward access enclosed courtyards. A fence has been built around the day hospital courtyard and trees (that assisted some clients to absent themselves from the ward courtyard) have been removed. These courtyards are not designed to be "escape-	Design of a facility to replace the current ward will address matters of security, to assist with minimising the risk of people absenting themselves without authority. (Clinical Director) Attention to risk of unauthorised absence will be highlighted specifically within revised risk assessment processes and risk statements within Client Pathway (Clinical Director)	Ongoing within planning for a new facility June 05

Recommendation	Comment	Action (Person Responsible)	Date
	proof". There is no intention to make them such, but care is taken with observation of people within these areas and to reduce the risk of unwanted absences. The only exit door from the unit is ordinarily unlocked during daytime hours and access to and egress from the ward is now controlled. These doors can be locked should the need arise to prevent unauthorised exit.		
	The CNS now reviews all AWOL incident reports to ascertain whether further changes are made to physical of functional aspects of the unit to reduce future AWOL incidents.	AWOL incident summary information (numbers and key aspects of analysis) to be identified specifically within monthly report. (Clinical Leader) AWOL incidents will be reviewed in the [acute inpatient psychiatric unit] Best Practice group	Immediate and ongoing Immediate and ongoing
4. That the Board ensures that every [in]patient has assigned to him or her an identified primary nurse with whom such patient can establish a therapeutic relationship and whose function is, inter alia, to coordinate assessment, treatment and management	Although the Coroner has used the term "primary nurse", it is not clear how the Coroner viewed this role applying. This is a matter with which all inpatient settings struggle in light of the changing patterns of staffing resulting from shift work and rosters.		
	The Mental Health Service accepts however that there is a need for continuity of information and for consistency of approach to care, and that where possible staff who have had some prior involvement with a client should be allocated	Emphasise the importance to allocation processes to the shift coordinator, in accord with the policy on Primary Nursing. (Team Leader, Clinical Nurse Specialist)	Immediate and ongoing

Recommendation	Comment	Action (Person Responsible)	Date
	regularly to the care of that client. A policy exists (and is in operation within The Acute Adult Inpatient Unit) in relation to Primary Nursing. This policy was issued in July 2004. The policy notes the role supporting the continuity and effectiveness of nursing care and the promotion of active multidisciplinary team involvement and emphasises these aspects of practice and coordination of staffing. The shift coordinator has a key role in allocation of staff in accord with this policy. The CNS is taking an active role in assisting with such allocation matters. Each client does have an allocated named lead nurse each shift. This allocated nurse is identified to the nurses and to clients each shift.		
5. That steps be taken immediately to ensure that Mental Health Services risk assessment and risk management plans be updated immediately the nature and degree of patient risk changes so that the existence of such new and/or increased risk and plan for management thereof is made known to all persons for whom such knowledge is material for the purposes of assessment, treatment, management and care.	Established requirements of the Client Pathway include risk assessment determinations incorporating past behaviour and current presentation into account as well as reports from other people. Instructions on completion of risk documentation also include matters being identified in such a manner as to be available to clinicians who may not be ordinarily or otherwise aware of such matters (including where the specific element should be recorded and where more detailed information may be found). Client Pathway instructions in relation to Risk	See above (recommendation 2)	

Recommendation	Comment	Action (Person Responsible)	Date
	Assessment and Management do not clearly in themselves identify the frequency with which risk assessments should be conducted. The Daily Status Review for inpatients however notes that risk assessment information must be updated daily. This expectation is supported by the policy statement – [the acute inpatient psychiatric unit] Daily Review Meetings (July 2004).		
	The centrality of adequate handover of information across shifts is highlighted in the policy "Handover of Nursing Responsibility – [the acute inpatient psychiatric unit]" (July 2004). This policy makes specific reference to information in regard to serious or adverse events, current mental state and observation status.	The importance of this aspect of care has been highlighted to staff. New staff are oriented to this requirement. Their shift coordinator will continue to monitor that staff pass on key information regarding and responsibility for their clients should they have to leave the ward.	ongoing
6. That psychiatric unit staffing numbers be increased immediately to such a level as will ensure that the workload of staff members is at all times of manageable proportions and does not pose a risk to patient safety AND that the Board give immediate attention to the steps needing to be taken to improve working conditions in its psychiatric unit and to lift morale.	The Coroner appears to have focussed solely on numbers of registered nursing staff within the unit. The Mental Health Service does not accept that the current nursing establishment for the unit is insufficient for the designated occupancy of the unit. Rather, the Service believes that the focus must be on the range of skills available within the unit and the effective application of these skills. From early 2004 there have been regular (weekly and fortnightly) meetings of staff, Union representatives, senior nursing personnel and managers to address a range of matters in relation to staffing and other aspects of concern in the IAU. These continue.	A discharge coordinator position is now being piloted. Early signs are that this is having a positive effect, freeing nurses up from some of the time consuming administrative processes involved with client discharge, allowing nurses to concentrate on other aspects of nursing roles.	Current
	Staff levels and staff mix remains under discussion. There remains concern regarding the vacancies in the regular nursing positions and in	Continue work with Unions and staff in defining roles and responsibilities. Monthly	Ongoing

Recommendation	Comment	Action (Person Responsible)	Date
	the cost of running current rosters. There has been however, and remains so, the provision to bring on additional staff to cover particular needs (such as close observation and high levels of acuity) in addition to established numbers of rostered staff.	liaison meetings continue. Establish an External benchmark with acute units to provide best practice for skill mix development.	March 05
	An OT position has been developed. A policy to assist with defining the responsibilities of registered and non-registered staff has been developed (Client Care Responsibilities for registered Nurses and Non-Registered Staff – issued March 2002). The [acute inpatient psychiatric unit] Shift Coordination Policy (July 2004) emphasises the role of the coordinator in changing deployment of staff and in maintaining a safe and appropriate case-mix for staff. Practice aspects important to consider even in the face of full staff levels and agreed mix of roles and responsibilities have been addressed. The importance of handing over responsibility for one's immediate clients when leaving the ward has been emphasised in development of a policy on nursing handover.	The [acute inpatient psychiatric unit] Best Practice group will consider these matters and develop an action plan to assist with defining roles and responsibilities across the staff groups. (Clinical Leader)	
7. That in planning, structuring and staffing the Psychiatric Unit of the Regional Hospital about to be constructed the Board take into account and implement best international principles and practices for the delivery of	Planning for a replacement Mental Health IAU has not specifically been within the scope of the New Regional Hospital development. A commitment has been made to replace the current facility and planning has commenced to assist with determining some aspects of the service that will	Project plan to be developed for replacement facility (Business Manager)	August 05

Recommendation	Comment	Action (Person Responsible)	Date
psychiatric services of the kind intended to be delivered by such new unit.	be provided within a hospital-based facility.		
	A more comprehensive process of planning the range of mental health services across the district, including the nature and extent of community-based acute treatment services, has also commenced with a timeframe for completion of this wider process and development of a plan by August–September 2005. These planning processes will encompass not just location and quantity of services but also the nature of the services provided, systems of care, relationships between sector groups, etc.	Steering Committee established. Consultation process to commence early 2005. (MHS Portfolio Manager, Funding and Planning)	ongoing

Recommendation	Comment	Action (Person Responsible)	Date
8. That steps be taken to ensure that at every daily team meeting, and at every weekly multi-disciplinary meeting, at least one nurse with personal knowledge of the history, diagnosis and treatment of each patient falling for assessment and at least one registered medical practitioner being a registrar in psychiatry or vocationally registered psychiatrist; that the daily assessment and treatment plan be recorded in each patient's clinical notes; and that the Inpatient Acute Unit Daily Status Plan be completed each day. Level 3 of the Daily Status Plan category "observation" requires to be redefined so as to fix the periodicity of the documented observations required to be carried out.	The policy statement "[the acute inpatient psychiatric unit] Daily Review Meetings" (July 2004) sets out the expectation that these meetings are attended by members of the multidisciplinary team involved in the care of the clients. Ordinarily medical staff attend during the week — but if circumstances preclude this, and at weekends, the shift coordinator (who also attends) has the responsibility for ensuring that consultation with medical staff (including on-call staff at weekends) occurs. It is not practicable for on-call medical staff at weekends to attend these daily meetings in light of the other demands upon their time and their own limited direct contribution due to their own unfamiliarity with the particular needs of each client.		
	It is not clear what the Coroner means by reference to "the daily assessment and treatment plan". The Service accepts however that it is important for matters of clinical significance to be updated on a daily basis at least. Current practice has involved record being made of some aspects of plans and decisions being recorded in a handover document rather than in the relevant clinical file. The Service accepts that there should be a record in the relevant clinical file of matters of significance.	Clinical Nurse Specialist to discuss with Best Practice Group to identify proper processes for ensuring capture of relevant information in client records as well as convenient vehicle for transfer of information to staff not present at daily meeting. (Clinical Nurse Specialist)	Immediate and ongoing

Recommendation	Comment	Action (Person Responsible)	Date
	Registrars have been reminded that they must see all newly admitted clients over weekends, and nursing staff have been reminded to ensure that they contact on-call medical staff for this purpose. Registrars have confirmed that this occurs.	Registrar orientation material to include reference to this requirement (Clinical Director)	February 05
	The observation policy (issue date July 2004) expressly states that nurses should know the whereabouts of clients under this level of observation at all times and should sight them at least each 30 minutes, engaging with them as necessary.	Ongoing education and upskilling with policies and policy review. This is currently auditable and is regularly spot checked by CNS. (Clinical Nurse Specialist)	Immediate and ongoing
9. That all Mental Health Services professionals be reminded of the National Mental Health Standards indicating a duty on the part of such professionals to involve carers, family and whanau in the provision of Mental Health Services and of the need for consultation in relation to the nature and extent of the risks flowing from a patient's condition and the safe management of those risks AND that there be made available to Psychiatric Unit staff at all times suitable facilities for interviewing carers, family and whanau in private with a view to accurate and complete note-taking.	Staff in general are aware of the importance of involving families in care. Reminding them of this is unlikely to be helpful. Of more value are ongoing actions to assist with the practical application of this standard.	Ensure copies of National Mental Health Standards are available in workplaces. Ensure copies of Ministry of Health document on involving families is available in workplaces, and draw to staff attention (Team Leaders) Ensure family participation is covered within orientation programme for new staff (Professional Advisor – Nursing)	Immediate Immediate February 05

Recommendation	Comment	Action (Person Responsible)	Date
	Selected staff from across the Mental Health Service have attended workshops on Family Participation, with a view to these staff acting as resources to other staff within their workplaces to assist in practical elements of involving families in assessment and treatment. Additionally discussion took place in the latter part of 2004 with […] that has resulted in a proposal for further training sessions for teams in 2005, with a view to effective engagement of and communication with families in the process of providing care.	Confirm arrangements for training sessions with […] (Clinical Director) Include Family Participation in core competencies updates for staff (CPAG)	March 05 March 05
	Despite the comment in the Coroners report that appears to suggest he has accepted that there is a "culture" within the ward of not recording information while talking with clients or families, practice varies widely on the basis of personal preference and comfort rather than explicit expectation. Staff have access to space in which to write notes should they wish to do so outside of the context of the conversation with client and/or family. Staff are aware of the need for privacy and confidentiality and for caution in where conversations take place and can and do access various private areas for discussions with clients and families. The Service has put some priority on trying to ensure that private space is available for clients and for staff to interview clients and families, within the constraints of the current facility and occupancy. As occupancy levels have declined, additional quiet spaces have been created.	Design of new facility to ensure adequate attention to privacy and interview requirements (Clinical Director)	Ongoing in context of design phase of project

Recommendation	Comment	Action (Person Responsible)	Date
10. That standard channels of communication and information be established and carers, family and whanau informed in order that information may be passed safely between those persons and Board staff. Transmission of information outside designated and approved channels should be discouraged. Consideration should be given to the sharing of information by e-mail facility under safe and approved conditions.	A policy on e-mail use was developed in the wake of the review that highlighted some gaps in systems to ensure that e-mail messages were received and actioned. The client and family information brochure updated to emphasise that urgent clinical information should not be transmitted by e-mail. Review of the handling of e-mail communication in light of this recommendation reveals that there remains some uncertainty regarding the extent of implementation of the policy although the message in the information brochure is clear.	The policy on e-mail communication with the ward (rather than with identified individuals) will be reviewed to more clearly define responsibility for receipt and response. (Clinical Director) The requirements of the revised policy will be clearly identified to relevant staff (Clinical Leader)	Immediate January 05
11. That steps be taken to draw to the attention of all health professionals working in Mental Health Services, both medically and non-medically qualified, the need for proper note-taking, including the making of a proper record of all personal [sic; Coroner's recommendation: professional] communications.	The Service does not accept that all personal communications must be documented. In order to maintain a reasonable balance of time spent in documenting information against time spent with families and clients in actual delivery of care, staff must exercise judgement as to whether further information received verbally is relevant to the care of a client and whether new information is provided in that exchange. Staff must synthesise and interpret information, recording significant information relevant to the clinical care. All information provided to the service in writing however is filed within the clinical record.	Professional Advisors will be notified of the ongoing need for particular attention to standards of documentation within their usual meetings with their professional groups and in performance reviews. (Clinical Director) Ongoing attention will be given in planning a new facility to the requirements for adequate space for staff to record information in a professional manner. (Clinical Director)	Immediate

Recommendation	Comment	Action (Person Responsible)	Date
	Staff working in health services are generally aware of the need for adequate documentation and further identifying this alone is unlikely to change practice. The Client Pathway already establishes clear standards. Other CCDHB policy statements identify documentation requirements. It may be useful however to review how maintenance of core competencies is managed within the regular cycle of training and staff development activity within the service.	Professional Advisors Group to consider training in core competencies, including documentation, and develop action plan (Coordinator – Professional Advisors Group) Attention will be paid in orientation of new staff to the requirements for adequate documentation. (Professional Advisor – Nursing)	April 05 February 05
	Within the ward, the Clinical Nurse Specialist is regularly reviewing the standard of written notes and is providing coaching and feedback to staff in relation to acceptable standards.	The brochure providing guidance for nurses in record keeping will be redistributed to staff (Clinical Nurse Specialist)	February 05
	Audit of adherence to Client Pathway requirements is a regular part of the cycle of audit activity defined by the Service quality plan.	Audit frequency will be reviewed with Quality Facilitator when new appointment is made to that post (Clinical Director)	February 05