Registered Nurse, RN B

A District Health Board

A Report by the

Health and Disability Commissioner

(Case 12HDC00027)

Table of Contents

Executive summary....................1

Complaint and investigation....................1

Information gathered during investigation....................2

Relevant standards....................14

Opinion: Breach — RN B....................16

Opinion: Other comment — DHB 1....................21

Recommendations....................22

Follow-up actions....................23

Addendum....................23

Appendix A — Independent nursing advice to the Commissioner....................24

Executive summary

1. In April 2011, Ms A (then aged 19 years) was admitted to the mental health inpatient unit at Hospital 1, in City 1. During her admission, she was nursed on a number of occasions by registered nurse (RN) Mr B.

2. In early June 2011, RN B and Ms A began communicating by text. A week later Ms A was discharged from hospital and went to stay with her parents. In the fortnight following her discharge, she met up with RN B on at least two occasions.

3. In mid-June 2011, Ms A returned to City 2, where she had been living prior to her hospital admission. She and RN B maintained regular communication by text. The texts became increasingly personal and sexual in nature. In early July 2011, RN B went to City 2 and stayed with Ms A. The following week, Ms A went back to City 1, and stayed with RN B. There is some disagreement as to when Ms A and RN B first became physically intimate, but they both state that they had sexual intercourse for the first time while Ms A was staying with RN B. This was less than six weeks after Ms A's discharge from hospital.

4. Ms A returned to City 2. The relationship between RN B and Ms A continued via email, Skype, and mobile phone. RN B visited Ms A again in August 2011.

5. In December 2011, Ms A told her key worker in City 2 that her boyfriend had been her nurse when she was in Hospital 1. The matter was reported to DHB 1. RN B was interviewed and admitted that he had been in a sexual relationship with Ms A.

Findings

6. RN B's conduct was sexually exploitative and a breach of Right 2 of the Code of Health and Disability Services Consumers' Rights (the Code).[1] In addition, his relationship with Ms A breached professional boundaries and, accordingly, he breached Right 4(2) of the Code.[2]

7. DHB 1 was not vicariously liable for RN B's breaches of the Code. However, the Commissioner expressed concern that, after RN B disclosed concerns about his own mental well-being, a more formal process was not followed to respond to those concerns.

Complaint and investigation

8. The Commissioner received complaints from the Nursing Council of New Zealand and Mrs C about the services provided to Ms A by RN B.

9. The following issues were identified for investigation:

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[1] Right 2 states: "Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation."
[2] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

- *The appropriateness of the services provided by RN B to Ms A in 2011 and 2012.*
- *The appropriateness of RN B's relationship with Ms A in 2011 and 2012.*
- *The appropriateness of the care provided by DHB 1 to Ms A in 2011.*

10. This report is the opinion of Anthony Hill, Health and Disability Commissioner.

11. The parties directly involved in the investigation were:

Ms A	Consumer
RN B	Registered nurse
Mrs C	Complainant and consumer's mother
DHB 1/Hospital 1	District health board/Provider

Also mentioned in this report:

Mr C	Consumer's father
RN E	Registered nurse
RN D	Associate clinical nurse manager
RN F	Registered nurse
Ms G	RN B's lawyer
DHB 2	District health board

12. Information was reviewed from: Ms A, Mrs C, Mr C, RN B, DHB 1 and DHB 2.

13. Independent expert advice was obtained from a registered nurse, Kathryn Brankin (**Appendix 1**).

Information gathered during investigation

Summary of events

Ms A's admission to Hospital 1

14. Ms A (then aged 19 years) had significant mental health issues, including a history of depression and anxiety with episodes of self-harm and suicidal ideation. In April 2011, she was admitted to the mental health inpatient unit (the inpatient unit) at Hospital 1.

15. Within the inpatient unit, there is a closed ward for patients requiring an enhanced level of safety and secure care, and an open ward. Ms A was initially cared for in the closed ward, where she could be kept under close observation. She later moved to the open ward, but periodically returned to the closed ward at times of crisis or increased distress.

16. Ms A remained in hospital for eight weeks. During her admission, she was nursed on several occasions by RN B, a registered nurse.

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RN B

17. RN B had completed his Bachelor of Nursing less than three years prior, and had completed his first postgraduate year at another DHB's mental health unit. In early 2011, RN B started work on a casual basis at Hospital 1's inpatient unit. Approximately one month later, he formally accepted a permanent position.

18. DHB 1 provided HDC with details of the information given to RN B at the commencement of his employment and during his orientation programme. RN B was provided with a new employee starter pack, which included an Orientation CD. This included information about the Code of Rights, organisational House Rules, and Disciplinary Procedures. DHB 1 advised that all staff are made aware of the policies and procedures that govern their work and care delivery, and that the CD provided the "starting point" for RN B.

19. DHB 1 advised that usual practice is that when orientation has been completed, the orientation documents are filed in the employee's personnel record. However, these documents could not be found in RN B's record. DHB 1 could not explain why this was so, but confirmed that RN B did attend two full orientation days.

20. DHB 1 advised that the Nursing Service runs 14 mandatory registered nurse study days each year, and that it is the individual RN's responsibility to attend one of these study days each year. The study days cover a range of topics, which change from year to year. The 2011 schedule included a session on "Professional Issues", which focused on professional standards and practice, accountability, legislation, and conduct. DHB 1 stated that there was no record of RN B having attended his mandatory study day, but that when the matter giving rise to this complaint came to light, he had been employed for just on one year, so a formal check on his attendance had yet to be made.

21. DHB 1 provided a list of seven courses undertaken by RN B during 2011, none of which appear to have dealt with professional boundaries. DHB 1 advised that had RN B wished, he could have attended a Professional Safety Forum delivered by a professional advisor for the New Zealand Nurses Organisation, in April 2011. However, there is no record that he did so.

22. DHB 1 advised that no other education dealing specifically with professional boundaries is offered unless this is identified as an area of need in an individual employee's education agreement. DHB 1 stated that although its "Intimacy and Sexuality" policy relates particularly to patients, the policy reiterates that staff must abide by the House Rules and any professional Code of Ethics or professional boundaries that may apply.

Contact between Ms A and RN B during inpatient admission

23. Ms A and RN B both recall that they first met shortly after Ms A's admission, while she was in the closed ward.

24. RN B was Ms A's allocated nurse on several occasions. RN B explained that he was involved in Ms A's care on other occasions, for example, if she approached the nursing station in distress, they would go and talk. He also relieved other nurses

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allocated to Ms A, during their meal breaks. RN B and Ms A also referred to other casual, day-to-day contact on the ward — watching television or playing cards, etc. RN B told HDC that, as a nurse, he tried to put himself in the patient environment as much as possible so that he was available for people to talk to him.

Account from Ms A

25. Ms A recalled that while she was in the inpatient unit, RN B was the only person who was nice to her, and who seemed to care. She felt that she had a better relationship with him than she had with the other nurses.

26. Ms A stated that on the second day of her admission, RN B told her he had dreamt about her, that she was meant to be in his life, and that he had had a nightmare that Ms A had killed herself. She recalled that on another occasion when she was in crisis, RN B said: "You can't kill yourself because when you get out we are going to go for coffee." Ms A said she thought he was trying to lighten her mood. She said that later, when she was very distressed and having suicidal thoughts, he said: "What about me, what about our future?"

27. Ms A stated that she was a bit shocked by some of the things RN B said, but she thought he was just being nice. She stated:

> "I began to think that some of the things he said to me were probably beyond the normal nurse/patient relationship and bordered on the unprofessional at times but I thought he was trying to get through to me, to help me so I didn't think too much about it at the time.
>
> …
>
> During my stay in hospital he made many similar comments suggesting that he wanted to be part of my life. Before I was discharged he mentioned several times how he had to keep in touch with me but he had to wait six months or he could get into serious trouble."

Account from RN B

28. RN B (then in his mid-30s) stated that he "attempted to keep everything extremely professional" with Ms A while she was an inpatient. He said he did not develop an inappropriate relationship with Ms A while she was a patient, but that on reflection he could see that "some transference and counter-transference may have taken place while she was an inpatient which blurred the lines of professional detachment".

29. RN B advised HDC that prior to undertaking his nursing training, he was treated for depression. He said that at one stage, he told Ms A about the depression he went through prior to becoming a nurse, "in an attempt to show her that the possibility of achieving your dreams was a reality".

30. RN B explained that he was concerned about the treatment Ms A was receiving. He stated: "I think my dilemma was that she had been admitted for suicidality and had a personality disorder but most of the nurses were looking at the personality disorder and not treating the suicidality which was at times quite significant …"

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31. RN B stated that he and Ms A developed a working therapeutic relationship, and she disclosed a lot of information to him about her life and why she felt suicidal.

Clinical records

32. RN B wrote in Ms A's notes on 12 occasions during the course of her admission. RN B advised HDC that he wrote in Ms A's notes either at the end of a shift if Ms A was one of his allocated patients, or at some other time if he was involved in a significant event involving Ms A.

Account from Mrs C

33. Ms A's mother, Mrs C, also had direct contact with RN B on several occasions during her daughter's admission. She stated that she spoke to RN B frequently, even when he wasn't Ms A's nurse. Mrs C said that she was always glad when she saw RN B's car in the car park, that he was really understanding, that he "clicked" with her daughter, and that her daughter was responsive to him.

34. Mrs C recalled that quite soon after her daughter had been admitted to the inpatient unit, she was allowed ward leave. Mrs C said that they were sitting together in the car, and her daughter told her that RN B had said he'd had a dream about Ms A. Mrs C said that she thought RN B was being caring and saying things to keep her daughter going. Mrs C felt that anything that helped her daughter was good.

Texting

35. According to Ms A, RN B said that they would have to stay in contact after she was discharged. She stated that a few days or a week before she was discharged, she gave RN B a piece of paper with her mobile number on it. She stated that as soon as she did this, he started to text her, including while he was on the ward. She said that his first texts said things such as "Hope you sleep well" and "Sweet dreams".

36. RN B admitted to communicating with Ms A by text, but said that he was "pretty sure" that Ms A gave him her mobile number in the car park, on the day of her discharge.

37. Ms A's telephone records show that she first received a text from RN B's mobile phone in early June 2011, with two further texts the following day. At this time Ms A was still an inpatient. The texts were sent between nine and ten in the evening, when RN B was on duty.

38. Ms A was on home leave for five days in early June 2011. During this period, she received 37 texts from RN B's mobile phone. Following this home leave, Ms A was formally discharged from hospital. On the day of discharge, she received 23 texts from RN B's mobile phone.

39. RN B was asked to comment on Ms A's telephone records, which showed that there were texts from his mobile phone to Ms A's mobile phone prior to the date of her discharge. RN B reiterated that to the best of his knowledge, Ms A gave him her mobile number in the car park as she was leaving the hospital on the day of her discharge.

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RN E

40. Ms A stated that on one occasion, she was not feeling well and asked her main nurse, RN E, if she could go down to the closed ward. Ms A said that RN E refused her permission because RN B was there. According to Ms A, RN E said: "I don't know what's going on between you two but I don't like it." Ms A said that she was surprised by this, as she did not think anything was going on.

41. When this was put to RN E, she stated that although she does not recall saying this, it was not inconsistent with what she observed, and that she had noticed RN B seemed eager to spend time with the young female patients. RN E said that she had some concerns that RN B might be crossing professional boundaries, although there was nothing concrete to report. She said she talked informally with another senior nurse about this.

42. RN E advised that she was a senior staff nurse with eight years' experience, while RN B was a new graduate with little experience. RN E said that she was able to manage this situation by swapping RN B off duties where he was responsible for patients such as Ms A. RN E was aware that RN B's view on the best way to nurse Ms A differed from the team's view; he was more inclined to spend time with her, rather than "limit-setting".

Initial contact following discharge

43. Following her discharge, Ms A stayed with her parents for six days. During this period, she and RN B were in regular contact by text. They met on two, or possibly three, occasions.

44. According to Ms A, a few days after her discharge RN B suggested in a text that they should meet. They did so, and when Ms A told RN B she was moving to City 2, he said they had to meet again. Ms A recalled that the day before she went to City 2, she and RN B spent the day together. She stated that they went for coffee, to the cinema and to various other local places.

45. According to RN B, he contacted Ms A by text following her discharge, and they arranged to meet for coffee. RN B stated that he was motivated by concern for Ms A's mental state following her discharge.

46. When asked further about what he intended when he met Ms A at this time, and the capacity in which he did so, RN B stated:

> "I think at that stage I was quite unsure about what capacity it was really. I was trying to keep her safe. I didn't want to have the death of a young person on my mind, not that, you know, again upon reflection, not that it would have really been directly my fault, I suppose it's just that rescuer thing, you know you get into that mode and you want to keep everyone safe and you don't want anyone to die."

47. RN B initially stated that he met Ms A for coffee on one other occasion during the week or two following her discharge. He subsequently said that there was possibly a third meeting, and admitted that on one of these occasions, they also went to a movie and to various other local places.

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Further communications by text

48. In mid-June 2011, Ms A returned to City 2, where she had been living prior to her hospital admission. Ms A was referred back to DHB 2's Mental Health Services for ongoing care and treatment.

49. Ms A and RN B maintained regular communication by text. The texts became increasingly personal and sexual in nature. Ms A retained a number of texts she received from RN B. The first few texts retained were sent in mid-June 2011, ten days after Ms A's discharge. They include a text from RN B to Ms A saying: "It was very dificult for me coz of my professional role. Its still difficult now for the same reason but I cant stop how I feel" (sic).

50. Ms A stated that in the course of her communication with RN B at this time, he told her that he had broken up with his partner, and he asked her by text whether that made them — RN B and Ms A — boyfriend and girlfriend. Ms A had, by her own account, very little experience when it came to romantic or sexual relationships.[3]

RN B's visits to Ms A in City 2

51. In early July 2011, RN B went to City 2 to visit Ms A, and he stayed with her. Ms A stated that during this visit, there was some physical intimacy between them, although they did not have sexual intercourse.

52. RN B stated that during his first visit to Ms A in City 2, he stayed in the lounge at the hostel where she was living, and that on this occasion there was no physical intimacy between them. RN B said that by that time, his relationship with Ms A was becoming "a friendship".

53. RN B stated that he visited Ms A in City 2 for a second time, and that it was during this visit that the relationship became "more than a friendship", with some physical intimacy.

54. According to Ms A, RN B visited her a second time in City 2, but this did not occur until after she had been to stay with him (see below). Ms A's account is supported by entries in her clinical records held by DHB 2. There were, for example, contemporaneous entries referring to Ms A's plans for the following weekend, or reports of the previous weekend, which included reference to her "boyfriend". At this time, the clinicians documenting these notes were not aware of RN B's name or his position at Hospital 1.

Ms A's return to City 1

55. In mid-July 2011, Ms A returned to City 1[4] and stayed with RN B. RN B could not recall the date of this visit, but acknowledged that while Ms A was staying with him at his flat they had sexual intercourse for the first time. Ms A also states that it was during this visit that they first had sexual intercourse. This was less than six weeks after her discharge from hospital.

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[3] This is supported by information from Ms A's clinical records, including information recorded prior to these events.

[4] Confirmed by bus company records.

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56. RN B told HDC that he then became "quite fearful" about how far things had gone. He stated:

> "[She] went to her parents, and I tried to distance myself from her from that point. Unfortunately in the back of my mind I had her mental state as a concern so I didn't want to just terminate things and have her feel that she was used and abused because that was not my intention. Around that time in my life I was struggling with keeping my job — I was thinking about quitting my job and moving to [City 2] because I had formed such a relationship with [Ms A]. I believe I was quite unwell at that stage. As I say, there had been a lot going on for me and I was questioning my future really. But following the intimacy I, I think I had a bit of a reality call, and realised just how much damage had been done."

57. Ms A recalled that while she was staying with RN B, he told her that another nurse had seen them together and reported this to his boss. Ms A said that RN B told her he was under investigation. RN B was not under investigation at that time. RN B told HDC that he had told Ms A he was under investigation at work "to try to limit the contact". He stated that, on reflection, he could see how horrible that was and how bad it sounded, but "at the time it made perfect sense".

Continuing relationship

58. Ms A returned to City 2. The relationship between her and RN B continued via text, Skype, Facebook, and telephone.

59. Ms A stated that RN B visited her a second time in City 2, and that the relationship was still sexual at that time. DHB 2's clinical records refer to Ms A having stated that her boyfriend had visited her again in City 2 in August 2011. RN B stated that he visited Ms A because she had been telling him she was suicidal and he felt "duty bound" to visit. RN B told HDC that by this time his relationship with Ms A was colder, and that he was trying to distance himself and trying to "manage the situation".

60. Ms A's mental well-being at this time was still a significant concern. She continued to receive care and treatment from a community mental health team, and also required further inpatient care.

61. Ms A stated that she and RN B sometimes spoke about her treatment. She said that if she told him about a change in her medication, he would know about the medication and talk about it "a bit". RN B stated that if he had any discussions with Ms A in relation to her medication or treatment after the commencement of their sexual relationship, it was to encourage her to continue with these.

62. Conversations between Ms A and RN B via Skype include comments from RN B about Ms A's mental well-being, and specific references to her care and treatment.

63. RN B told Ms A that he had applied for work in City 2. In an email sent to Ms A in early November 2011, RN B asked Ms A if she still wanted him, because if she did not, he would withdraw his job applications in City 2.

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64. In early December 2011, RN B sent a text to Ms A telling her that he was going to be admitted into respite care in another area for a few days. The following day he sent texts saying that he had been sectioned on a five-day assessment.[5] RN B subsequently confirmed to HDC that this information was untrue, and that it was another way of trying to distance himself from Ms A. He stated that he needed time to try to sort out his mental state, and at the time was starting to come to terms with the fact that he had relapsed into a depression.

Subsequent events

65. In mid-December 2011, Ms A told her DHB 2 key worker that her boyfriend had been her nurse when she was an inpatient at Hospital 1. The matter was reported by DHB 2 to DHB 1. RN B was interviewed and admitted that he had been in a sexual relationship with Ms A. He was suspended and then dismissed from his employment, effective early January 2012. The matter was reported to the New Zealand Nursing Council, and the Nursing Council notified HDC. In the meantime, HDC received a complaint from Mrs C.

66. After disclosing her relationship with RN B, Ms A stated:

> "I feel like I have been manipulated and used by someone who pretended to have feelings for me. He knew everything that had happened to me in the past and took advantage of that."

Further information from RN B

67. RN B was asked about his understanding of a registered nurse's conduct in relation to professional boundaries between healthcare providers and patients/ex-patients. He stated:

> "My understanding of the RN's code of conduct in relation to patients is that personal relationships with patients are prohibited however I was unsure of the code as it applied to ex-patients who had left the DHB. Upon reflection following stabilisation of my mental state I can see how this is also inappropriate.
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> …
>
> I believe that the breach of ethics in relation to this event [is] the direct result of my un-wellness and vulnerable state at the time, and my lack of experience as a mental health nurse […] at the time of the incident. I had only been practicing as a registered nurse for [a short time]. I am in no way trying to make an excuse for my actions. I am however outlining the facts that impacted on my ability to maintain a professional relationship with [Ms A]. I regret the events involved in this matter and now that my mental state is settling I am beginning to see how events developed and how long I had been unwell for before seeking help. The events of this incident are totally out of character for me as I strove to maintain very high standards of professionalism within my nursing practice."

[5] Under section 11 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 a person can be detained for up to five days for the purposes of assessment and treatment.

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68. RN B said that he spoke to his colleagues "in a generic sort of way" about the point at which it was all right to have a relationship with a patient, but that he did not get a lot of clear-cut advice. He said that given his mental state at the time, he would probably have heard only the things he wanted to hear anyway.

69. RN B also noted that one of his lecturers had met her husband while her husband was a patient, although RN B did not know whether the lecturer had nursed him directly. He said that he was under the impression that it was "the direct nursing thing that was the problem". RN B agreed that he should have sought further clarification at the time.

70. In mid-January 2012, RN B advised the Nursing Council that he was not actively seeking employment as a registered nurse and would not do so until he had been adequately treated for his depression. RN B's practising certificate expired in March 2012.

Further information from DHB 1

71. DHB 1 advised HDC that it had no record of any concerns regarding RN B's professional conduct with any other patient, nor was it aware of any anecdotal concerns.

Professional supervision

72. DHB 1 advised that whilst professional supervision was an expectation, it was not mandatory. In early April 2011, RN B emailed a nurse director, requesting a list of current clinical supervisors. The nurse director replied two days later with a list of supervisors, and asked RN B to let him know if he had any difficulty contacting or securing a supervisor.

73. RN B told HDC that there was only one person on the list of supervisors he was given with whom he had a rapport. RN B said that he had a couple of informal conversations with that person, but was unable to set up regular supervision with him.

74. In its response to my provisional report, DHB 1 advised that RN B had access to clinical supervision and, as with all staff, he was actively encouraged to attend. He was also able to access a number of senior clinicians for support, which he did.

RN B's well-being

75. RN B stated that during his first postgraduate year, he was well supported with regular clinical supervision, regular rostered shifts, performance reviews, and support for any and all issues that arose. He stated that in contrast, he found the rosters at Hospital 1 hectic and unpredictable. He said that he had been assaulted twice, and felt unsafe because of poor staffing and an inadequate staff skill mix.

76. In its response to my provisional report, DHB 1 advised that during the period of RN B's permanent employment at DHB 1 in 2011, there were five reported incidents that related to short staffing, four of which were due to staff sickness. Of these, one involved a duty on which RN B was rostered. DHB 1 advised that it has one report of an assault on RN B, which occurred during a five person restraint. The report indicates that RN B received minor injuries, he was assessed at the Emergency

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Department, he was able to return to work after the assessment, he declined the offer to go home, and he subsequently stated that he suffered no ill effects.

77. Further, DHB 1 stated that the shifts worked by RN B were consistent with his roster, and the rosters were within the District Health Boards and New Zealand Nursing and Midwifery Multi-Employer Collective Agreement. DHB 1 advised that the rosters were published four weeks in advance, and were neither hectic nor unpredictable. It states that the inpatient unit was very well staffed during the period of RN B's employment.

78. RN B stated that he began turning up for work early, and on at least one occasion he was at work three hours before he was due on duty. He said that the associate clinical nurse manager, RN D, saw him and asked him why he was there, to which he replied that he felt he needed to be around people for his own safety or he would probably kill himself. RN B said that he was offered counselling, but he was reluctant to admit that he had a problem.[6] He stated that RN D may have followed up with him a week later, asking him how he was feeling, but that there was no real discussion around his mental state. RN B said that this was after he had separated from his partner.

79. RN B said that he had also communicated informally with RN F about his mental state, telling Mr RN F that he felt safer at work than at home.

80. According to DHB 1, RN F was the shift co-ordinator on the evening on which RN B divulged his suicidal ideation. RN F recalled that RN B arrived at work 1¼ hours before his duty, and that RN B explained this by saying he felt safer at work.

81. DHB 1 stated that the following day, RN F discussed with RN D what had happened. RN D stated that on the basis of the information from RN F, she made immediate arrangements to meet with RN B informally, for a discussion about what was happening to him. RN D stated that RN B expressed concern about aspects of his personal life, including his difficulty with his relationship, his partner's children, and his siblings. RN D said that RN B admitted to having had fleeting thoughts about hurting himself the previous day, but that he did not currently have any intent, thought, or plan. RN D encouraged RN B to take leave, which he declined to do. They also discussed the Employee Assistance Programme (EAP).

82. RN D stated that a week later she followed up the conversation with RN B, at which time he indicated that he had not used the EAP and was still having ongoing relationship issues. RN D stated that throughout the process it was stressed to him that he was able to take time off to address his issues, and that support was available to him.

Responses to Provisional opinion

83. Relevant information from the responses to my provisional report has been incorporated above. The following comments were also received.

[6] RN B also noted that earlier in the year he had approached RN D following a death in his family, and that she had suggested the Employee Assistance Programme at that time.

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Ms A and Mrs C

84. In response to the "Information gathered" section of my provisional report, Ms A stated:

> "I want to say how much all of this has affected me. [RN B] took advantage of me at my most vulnerable time of my life. In my opinion he played games with my mind and caused me to sink even further into depression. He led me to believe life was not worth living, which led me to seriously attempt to take my own life. I believe he has set my recovery back even further. As my nurse he was supposed to be helping me recover, not causing me to become even more unwell. I fully cooperated with this investigation because I don't want [RN B] to be given the opportunity to do this to another patient."

85. Mrs C stated that she believed RN B was "playing games" with her daughter, and not trying to help her to get well at all. Mrs C considers RN B is not taking responsibility and is using his depression as an excuse for his behaviour.

RN B

86. In response to my provisional findings, RN B's lawyer, Ms G, advised that RN B accepts the finding that he breached Right 4(2) of the Code. However, Ms G submitted that RN B was not in a fit state to perform the functions required of his profession at the time that he was caring for Ms A and after she was discharged. Ms G stated that RN B was not well enough to have acted with the intent of sexually exploiting Ms A and, accordingly, his actions do not amount to a breach of Right 2 of the Code.

87. Ms G also submitted that DHB 1 failed to respond adequately when RN B informed staff of his concerns for his mental health.

88. RN B provided a written apology for forwarding to Ms A.

DHB 1

89. In its response to my provisional findings, DHB 1 commented further on the matter of RN B's disclosure of concerns about his own mental well-being, as follows.

90. When RN B disclosed concerns about his mental state, RN F specifically asked RN B if he was well enough to be at work. RN B replied that he felt better at work and would continue with support from RN F as shift co-ordinator. RN B said that he no longer felt suicidal and confirmed he could guarantee his safety. RN F reported checking on RN B's well-being and mental state again before RN B went home. DHB 1 advised that RN F is a senior registered nurse with many years' experience in acute psychiatry, and

> "… had he thought [RN B] was not safe to be at work in terms of operating within his scope of practice and competency then he would have made contact with the hospital's Duty Nurse Manager and insisted on [RN B] not [remaining] in the workplace".

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91. DHB 1 reiterated that when RN D met with RN B subsequently, he informed her that he had had fleeting thoughts of hurting himself on the aforementioned occasion but did not have any intent, thought or plan to do so then. RN D offered and encouraged RN B to take leave, which he declined to do, stating that work was beneficial to him. The EAP was discussed at length, including what the service offered, the confidentiality and accessibility of the service, and the ability to use this service during work time. RN D said that she paid closer attention to RN B's overall presentation and functioning after this time, and specifically followed up with him a week later. DHB 1 advised that RN D is also a very experienced senior registered nurse with significant experience in acute psychiatry, and had she had concerns that RN B was unable to perform within his scope of practice or to a competent level she would not have hesitated in seeking appropriate avenues to address this. Equally, if she had been concerned about RN B's personal safety she would have sought appropriate intervention.

92. Further, DHB 1 stated:

> "Risk assessment and risk management relation to acute psychiatry is daily core business for both [RN F] and [RN D]. [RN F] and [RN D] remain clear that the level of support and intervention provided at the time was congruent with [RN B's] presentation. [DHB 1] is not aware of any actual self harm or attempts of self harm other than the brief reference made to [RN D] to having fleeting thoughts of hurting himself.
>
> Consideration should be given as to [RN B's] truthfulness and reasons behind this disclosure to his colleagues. It would seem that [RN B] had made numerous fabrications to [Ms A] in what was an obvious attempt to distance himself from the relationship which was a direct result of him knowing and expressing to [Ms A] on at least one occasion what may happen to his employment and registration if caught.
>
> …
>
> Notwithstanding this, [DHB 1] takes the health and wellbeing of its employees seriously and your provisional opinion stands as a good reminder."

93. In relation to the maintenance of professional boundaries, DHB 1 stated:

> "The maintenance of professional boundaries is a very fundamental professional responsibility for all registered nurses. The degree to which a registered nurse maintains this accountability sits fairly with them as an individual. Notwithstanding this [DHB 1] now provide an online training package which covers the key aspects of professional practice for registered nurses. This includes Professional Boundaries, the Nursing Council New Zealand Code of Conduct, the guideline for Direction and Delegation and Social Media and Nursing. This online training is mandatory for all registered nurses …"

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94. DHB 1 confirmed that a mandatory study day for nurses, which runs throughout the year, specifically addresses professional responsibilities, including inappropriate relationships and professional boundaries.

95. In response to a comment by my expert advisor, Kathryn Brankin, regarding RN B's awareness of his actions, DHB 1 stated:

> "[RN B's] undergraduate training would have involved significant clinical education around the therapeutic relationship, including how to initiate, how to terminate and how to work within the boundaries of the relationship. This would have been reiterated in his New Graduate year. Whilst the DHB respects Ms Brankin's opinion … it cannot accept that [RN B's] 'actions did not indicate he was aware of his behaviours' transgressing the therapeutic relationship to one of 'over involvement with [Ms A] and her life beyond hospital and treatment required'. To the contrary the DHB believes [RN B's] actions were calculated and self-centred as indicated in the information from the [DHB's] investigation."

96. DHB 1 concluded:

> "[DHB 1] strives to protect those patients in our care and take this responsibility very seriously. We are extremely disappointed in [RN B's] actions and are deeply sorry for any distress and/or anguish [RN B's] actions have caused [Ms A] and her family."

Relevant standards

The Nursing Council of New Zealand's Code of Conduct for nurses (November 2010)[7] includes the following:

> "**PRINCIPLE FOUR**
>
> The nurse justifies public trust and confidence
>
> **Criteria**
>
> **The nurse:**
>
> …
>
> 4.3 uses professional knowledge and skills to promote patient/client safety and wellbeing
>
> …
>
> 4.7 respects the trust implicit in the nursing relationship
>
> …
>
> 4.9 acts in ways that contribute to the good standing of the nursing profession.
>
> **Conduct in question**

[7] The Code of Conduct was updated in 2012.

HDC

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Some examples of behaviour that could be considered to be a basis for a finding of professional misconduct or imposing a penalty are listed below:
…

- entering into a sexual or inappropriate intimate relationship with a client or ex-client"

The Nursing Council of New Zealand's Competencies for registered nurses (2007) includes the following:

"**Domain three: Interpersonal relationships**

Competency 3.1

Establishes, maintains and concludes therapeutic interpersonal relationships with client.

Indicator: Initiates, maintains and concludes therapeutic interpersonal interactions with health consumers.

Indicator: Incorporates therapeutic use of self and psychotherapeutic communication skills as the basis for nursing care for health consumers with mental health needs.
…

Indicator: Demonstrates respect, empathy and interest in health consumer.

Indicator: Establishes rapport and trust with the health consumers.

Competency 3.2

Practises nursing in a negotiated partnership with the health consumer where and when possible.

Indicator: Undertakes nursing care that ensures health consumers receive and understand relevant and current information concerning their health care that contributes to informed choice.

Indicator: Implements nursing care in a manner that facilitates the independence, self-esteem and safety of the health consumer and an understanding of therapeutic and partnership principles."

The New Zealand Nurses Organisation Code of Ethics (2010) states:

"Nursing was founded on the moral premise of caring and the belief that nurses have a commitment to do good. Part of society's expectations of nurses is that they are moral agents in their provision of care and that they have a responsibility to conduct themselves ethically in what they do and how they interact with persons receiving care."

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Opinion: Breach — RN B

Introduction

97. At the time of these events, Ms A was a vulnerable young woman with significant mental health issues. She has a history of depression and anxiety, with episodes of self-harm and suicidal ideation. When she was admitted to the inpatient unit at Hospital 1 in April 2011, she was acutely unwell.

98. Under Right 2 of the Code, Ms A had the right to be free from discrimination, coercion, harassment, and sexual, financial, or other exploitation. Under Right 4(2) of the Code, she had the right to have services provided that complied with professional and ethical standards.

99. The nature of RN B's communications with Ms A while she was still an inpatient was inappropriate. He contacted her and met up with her within days of her discharge, and entered into a sexual relationship with her less than six weeks after her discharge from Hospital 1. RN B failed to comply with professional and ethical standards, and his behaviour was sexually exploitative. In my view, his conduct was reprehensible and inexcusable.

Professional relationship

100. When RN B commenced work as a registered nurse at DHB 1 in early 2011, he was still a recent graduate. He had been working in the inpatient unit to which Ms A was admitted for less than three months.

101. There is no question that RN B had a professional relationship with Ms A while she was an inpatient. RN B was Ms A's allocated nurse on a number of occasions, he was involved in her care on the ward at other times, he recorded entries in her clinical records, and he spoke with her mother about her care and treatment.

102. RN B also advised that he discussed with his colleagues the concerns he had regarding Ms A's treatment. I note that RN E recalls that RN B's view on the most appropriate way to nurse Ms A differed from the team's view. However, at no point did RN B document his concerns about Ms A's diagnosis or treatment plan.

Personal relationship

During hospital admission

103. According to Ms A, RN B told her early in her hospital admission that he had dreamt about her. Mrs C confirmed that her daughter told her at the time what RN B had said about his dream.

104. Ms A said that RN B talked about meeting him after her discharge, and about their future together. She said that before she was discharged, he mentioned several times that he had to keep in touch with her, but that he had to wait six months to avoid getting into serious trouble. Ms A said that at the time, she thought that some of his comments were not what she expected from a nurse, but that they were just his way of trying to make her feel better.

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105. RN B submitted that while Ms A was in hospital he attempted to keep his relationship with her “entirely professional”.

106. On balance, I find that it is more likely than not that Ms A’s account of RN B’s comments to her while she was in hospital is correct.

107. Ms A told HDC that RN B sent texts to her up to a week before she was discharged. Contrary to this, RN B told HDC that he thought she gave him her mobile phone number only on the day of her discharge from hospital.

108. Ms A’s account is supported by her telephone records, which show that she received texts from RN B’s mobile number in early June 2011, when she was still an inpatient and when RN B was on duty. She received a further 37 texts from RN B’s mobile phone over five days in early June 2011, while she was on home leave. On the day Ms A was formally discharged from hospital she received 23 texts from RN B’s mobile phone. RN B was provided with a copy of these records, but offered no further explanation.

109. RN B has confirmed that during Ms A’s admission he divulged to her information about his own depression. He stated that this was in an attempt to show her the possibility of dreams becoming a reality. For a nurse to reveal feelings and aspects of his or her personal life to a patient beyond that necessary for the patient’s care is a warning sign that the boundaries of a professional relationship may be being crossed, and that the relationship may be becoming inappropriate. RN B submitted that he divulged information about his history of depression to Ms A for a therapeutic purpose. However, in my view, in the circumstances of this case, the extent of RN B’s communication with Ms A about his personal history of depression went beyond that necessary for her care. It was RN B’s responsibility to ensure that his own personal needs were not influencing his interactions with Ms A.

110. RN B’s communication with Ms A while she was an inpatient was inappropriate. In my view, his conduct at this time was a breach of his professional obligations and effectively laid the foundations for what followed in the period following Ms A’s discharge from Hospital 1.

Following discharge

111. RN B contacted Ms A after her discharge from hospital and suggested they meet. He stated that he was motivated by his concern for her mental state.

112. When RN B was initially asked to provide an account of his contact with Ms A, he stated that he met her two or possibly three times for coffee. He gave a similar account during an interview with HDC staff. RN B initially omitted to mention, but confirmed subsequently, that on one of these occasions they also went to a movie and to various other local places. RN B’s lack of candour is concerning and suggests a lack of credibility.

113. In my view, RN B’s meetings with Ms A at this time were inappropriate. As my expert advisor, RN Kathryn Brankin, states, RN B’s actions “provide evidence that relationship boundaries were blurred. [RN B] continued to see [Ms A] in a way that

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was not underpinned by nursing values, ethics and professional requirements." If RN B was concerned for Ms A's mental state, the appropriate action would have been to report his concerns to his manager, Ms A's key worker, or another colleague.

114. In mid-June 2011, Ms A returned to City 2. She and RN B continued to text one another, with the content becoming increasingly personal and sexual in nature. RN B visited Ms A in City 2 in early July 2011. The following week Ms A returned to City 1 and stayed with RN B at his flat. Ms A and RN B disagree as to when they first became physically intimate, but both state that they had sexual intercourse for the first time while Ms A was staying with RN B. This was less than six weeks after Ms A's discharge from hospital.

115. The personal relationship between RN B and Ms A continued for a further five months, until Ms A disclosed RN B's identity to her DHB 2 key worker. RN B stated that although he understood that personal relationships between nurses and patients are prohibited, he was unsure of the Code of Conduct for nurses as it applied to ex-patients who had left the DHB. He stated that on reflection and following stabilisation of his mental state, he could see that relationships with former patients are also inappropriate.

116. In mid-June 2011, RN B sent a text to Ms A saying that it had been difficult for him while she was an inpatient because of his professional role, and that it is "still difficult now for the same reason but I can't stop how I feel".

117. RN B knew that it was inappropriate for him to enter into a personal relationship with Ms A. Personal relationships between nurses and patients with whom they have previously had a professional relationship are almost always inappropriate. The Nursing Council of New Zealand's Code of Conduct for Nurses (November 2010), which applied at the relevant time, states that entering into a sexual or inappropriate intimate relationship with a client or ex-client is an example of behaviour that could be considered to be a basis for a finding of professional misconduct.

118. This Office has considered the issue in the past, and a previous report stated:[8]

> "Mr U's actions in establishing this relationship with Ms A and involving her in deception were exploitative and potentially very dangerous to her well-being. He failed to maintain professional boundaries in his dealings with her and abused a position of trust."

119. Similarly, the Health Practitioners Disciplinary Tribunal found that "it [was] clearly a significant breach of [the nurse's] nursing obligations to form a relationship with a patient while she was an inpatient in the ward where he worked and to form a sexual relationship with her such a short time after she left hospital after a lengthy period of being an inpatient".[9] The Health Practitioners Disciplinary Tribunal has also found that text messaging with a vulnerable mental health patient "blurred the boundary

[8] Opinion 08HDC18422 (14 May 2008), page 14.
[9] Decision 459/Nur12/202P (12 June 2012), at paragraph 35.

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between the therapeutic and professional relationship on the one hand and some personal relationship on the other".[10]

120. At the time of these events, RN B clearly knew that he had breached professional standards by entering into a personal relationship with Ms A. In addition, in my view, the text messaging engaged in by RN B was unethical and inappropriate.

121. In this case, the inequality of the relationship was accentuated by the fact that Ms A was emotionally vulnerable and had placed her trust in RN B. It is a responsibility of a registered nurse to maintain professional boundaries and ethical standards and, in my view, once RN B was aware of the relationship developing, he should have sought peer support.

122. Factors of particular relevance when considering the appropriateness of the relationship that developed between RN B and Ms A are as follows:

- Ms A required intensive inpatient psychiatric care for more than two months.
- The professional relationship developed because Ms A was mentally unwell and in a state of significant distress, such that she needed inpatient psychiatric care.
- Ms A's mental and emotional well-being both while she was an inpatient and following her discharge meant that she was highly vulnerable. I note also that Ms A was 19 years old at this time and, by her own account, inexperienced when it came to romantic or sexual relationships. RN B was in his mid-thirties.
- RN B had access to highly personal, sensitive information about Ms A, through his direct contact with her on the ward, liaison with colleagues and family, and her clinical records.

123. The time that had elapsed between Ms A's discharge from hospital and the commencement of the sexual relationship — less than six weeks — is also relevant.

124. This matter has been highlighted in previous reports from this Office. In 06HDC06218, HDC's expert advisor, registered psychiatric nurse Clarissa Broderick, stated:

> "[The] nurse has the responsibility to recognise the significant power imbalance that exists within the therapeutic relationship. The dynamics of a relationship that involves disclosure on the client's part, and empathy and understanding from the nurse, can arouse strong emotions for the client and feelings of dependence. To take advantage of these emotions, to form a 'friendship', intentionally or not, is unethical and exploitative …
>
> Nurses know it is not acceptable to accept invitations to meet socially with clients or ex-clients, nor is it acceptable to exchange phone numbers. It is a breach of the Nursing Council of New Zealand's Code of Conduct, and a significant departure from what would be considered acceptable."

[10] Decision 432/Nur11/192P (19 January 2012), at paragraph 72.

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125. RN B stated that very soon after he had had sexual intercourse with Ms A, he became fearful of how far things had gone, and tried to distance himself from her. This included telling her that he was under investigation at work, although this was not true.

126. However, RN B also visited Ms A again in August 2011, when they again had sexual intercourse. RN B told Ms A that he was applying for jobs in City 2 so that they could be together. In November 2011, he asked Ms A whether she still wanted him because if she didn't he would withdraw his job applications. The following month, RN B lied to Ms A again, telling her that he had been sectioned.[11] RN B stated that this was a further attempt to put some distance between himself and Ms A.

127. I am concerned by RN B's conduct over this period. Ms A was under the care of DHB 2's mental health services and she remained highly vulnerable. Principle 4 of the Nurse's Code of Conduct requires the nurse to use professional knowledge and skills to promote patient/client safety and well-being, and to act in a way that contributes to the good standing of the nursing profession. The Nursing Council's Competencies for registered nurses requires the nurse to maintain and conclude therapeutic relationships with clients. The New Zealand Nurses Organisation Code of Ethics states that nurses have a responsibility to conduct themselves ethically in what they do and how they interact with persons receiving care. RN B's behaviour was contrary to these standards.

128. I have considered RN B's submission that his breach of ethics in relation to this event was the direct result of his unwellness and vulnerability at the time, and his lack of experience as a mental health nurse. I have also considered Ms G's submission that RN B was not well enough to have acted with the intent of sexually exploiting Ms A and therefore should not be found in breach of Right 2 of the Code. I disagree.

129. I find that RN B had the intention to enter, and did enter, the relationship which, in these circumstances, was by its nature sexually exploitative.

130. I do not accept that RN B's depression or personal stress, or his relative inexperience as a nurse, mitigate his responsibility to maintain appropriate professional boundaries, nor do they change my finding in relation to sexual exploitation. A nurse must be responsible for ensuring he or she is able to practise safely and, in the event that his or her ability to do so may be compromised, for seeking appropriate support and guidance. RN B had been offered leave and had been informed about the EAP, but it appears that he did not avail himself of either opportunity to address his personal circumstances.

Conclusion

131. I find that RN B breached professional and ethical boundaries by having an inappropriate personal and sexual relationship with Ms A. The foundations of the sexual relationship that commenced following Ms A's discharge from DHB 1's inpatient unit were established while she was still an inpatient, and included

[11] The term "sectioned" usually refers to being sectioned under the Mental Health (Compulsory Assessment and Treatment) Act (see footnote 9).

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inappropriate text messaging. In my view, RN B's behaviour towards Ms A was selfish, and had no regard for her vulnerabilities or the significance of his actions in forming a relationship with her. RN B failed to comply with professional and ethical standards and, accordingly, breached Right 4(2) of the Code. His conduct was sexually exploitative and, accordingly, also a breach of Right 2 of the Code.

Opinion: Other comment — DHB 1

132. DHB 1 had an obligation to provide Ms A with appropriate and safe care. As RN B's employer at the time of these events, DHB 1 is vicariously liable for RN B's breaches of the Code unless it can show that it took reasonable steps to prevent those breaches from occurring.

133. Information provided to RN B as part of his orientation included the Code of Rights, House Rules, and Disciplinary Procedures. The principles of DHB 1's Intimacy and Sexuality policy reiterate that staff must abide by the House Rules and any professional Code of Ethics or professional boundaries that may apply.

134. DHB 1 has confirmed that RN B attended two full orientation days, although the orientation documents that should have been filed in his employee record were not found. There were two training sessions that RN B could have attended during his employment with DHB 1 that dealt with professional boundaries, although there is no evidence that RN B attended these.

135. However, I accept that RN B was bound by the Nursing Council of New Zealand's Code of Conduct for nurses and its competencies for registered nurses, and DHB 1 had a reasonable expectation that RN B would comply with those in respect of his obligation to maintain professional boundaries with the patients under his care.

136. Ms G submitted that DHB 1 failed to adequately respond when RN B informed staff of his concerns for his mental health. It is evident from the information provided by DHB 1 that the DHB, including RN F and RN D, did respond to RN B's concerns about his mental health and, having done so, did not consider that they had reason to believe RN B was unable to perform the functions required for the practice of his profession. RN F and RN D confirmed that they were clear that the level of support and intervention provided at the time was congruent with RN B's presentation.

137. In addition, it appears that DHB 1 acted promptly and appropriately when it was advised by DHB 2 of the information disclosed by Ms A.

138. Taking all of these factors into account, in my opinion, DHB 1 is not vicariously liable for RN B's breaches of the Code.

139. Nevertheless, I consider the following points are worthy of note:

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- Ms Brankin comments that the DHB she works for provides all registered nurses with a one-hour training session on professional boundaries. This covers the importance of the therapeutic relationship in meeting the needs of the client, the role of boundaries in protecting the therapeutic relationship, and the role of the nurse in ensuring professional boundaries are maintained. DHB 1 has confirmed that it has a mandatory training day for nurses which includes professional responsibilities and covers inappropriate relationships and professional boundaries. However, there is no evidence that RN B attended such training.

- RN E had observed that RN B seemed "eager" to spend time with young female patients, and she was concerned that he may have been crossing professional boundaries. She did not consider that there was anything concrete to report, but she did speak informally with another senior nurse and made a point of swapping RN B off duties where he was responsible for patients such as Ms A. I agree with Ms Brankin's comments on this matter:

  > "Challenging staff's therapeutic relationships with clients in a safe manner may need to be addressed and on-going education around this may be beneficial for [DHB 1] staff. Open discussions around professional boundaries should be encouraged in a neutral manner."

- Ms Brankin also raises concerns about the support provided to RN B after he disclosed his own suicidal ideation. There are some discrepancies in the accounts provided by DHB 1 and RN B as to what occurred at this time. I share Ms Brankin's concern that following RN B's disclosure, a more formal process was not followed. However, I accept DHB 1's submission that at the relevant time, neither the DHB nor its staff considered that there was reason to believe RN B's mental well-being was such that he was unable to perform the functions required for the practice of his profession.

Recommendations

- RN B has provided a written apology for forwarding to Ms A, in accordance with a recommendation in my provisional report.

140. I recommend that DHB 1

- review the effectiveness of the online training for professional practice and report to HDC within three months of the date of this opinion on the outcome of the review; and
- consider whether regular upskilling on professional boundaries following completion of the online training for professional practice is required, and report to HDC within three months of the date of this opinion on the outcome of its consideration.

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Follow-up actions

- RN B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Nursing Council of New Zealand, and the Council will be advised of RN B's name.

- RN B will be referred to the Nursing Council of New Zealand with a recommendation that in the event that RN B reapplies for a practising certificate, Council assess the appropriateness of RN B returning to nursing. In the event that RN B does return to nursing, I recommend that Council determine any necessary conditions on his practice, supervision and monitoring, and training needs, and advise HDC accordingly.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to DHB Shared Services, the New Zealand Nurses Organisation, and the New Zealand College of Mental Health Nurses, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

- The Director of Proceedings laid a charge before the Health Practitioners Disciplinary Tribunal. Professional misconduct was made out and RN B's registration was cancelled.

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Appendix A — Independent nursing advice to the Commissioner

The following expert advice was obtained from registered nurse Kathryn Brankin:

> "My name is Kathryn Brankin. I am a Registered Nurse who works for the Canterbury District Health Board in the intensive care unit of the acute mental health inpatient services, which caters for the Canterbury population, ages between 18–65 years. We do cater for clients older than this if they have an active psychiatric illness which is not aged related and is still being treated by an adult outpatient team.
>
> My training consists of general and obstetric hospital based training in the late 1970's which was then followed in 1983 by a two year bridging course in mental health nursing at Sunnyside hospital, this is now known as Hillmorton Hospital in Christchurch.
>
> My experience has included working for an NGO as a team leader, providing supported accommodation and recovery care for level two and level three clients. I have held various staffing roles, as a Registered Nurse within the Canterbury District Health Board mental health services. Since 2002 I have worked in a 28 bed, open acute inpatient unit. My position is a staff nurse working rostered shifts, as well as relieving the Charge Nurse Manager and Clinical Nurse Specialists as required. My continual practical nursing experience has spanned from 1977–2012. From 1983 I have specialised in mental health nursing practice.
>
> I have read and agreed to the Health and Disability Guidelines for Independent Advisors. Expert advice required is divided into two sections:
>
> Section One
>
> - To comment generally on the standard of care provided by [RN B] to [Ms A].
> - To comment on professional standards which apply in this case and whether these standards were met.
> - Comments on the relevance of the issues [RN B] has referred to in explaining his relationship with [Ms A], including: his concern about [Ms A's] treatment in hospital; his own mental well-being; his personal stress; and his lack of experience as a mental health nurse.
>
> Section Two
>
> - Under this section, as requested, comments will be made regarding Policies and Guidelines of [DHB 1]. Specifically, policies relating to Professional Boundaries.
> - Comments or concerns in relation to [RN B's] induction/orientation within [DHB 1].
> - Support or supervision offered to [RN B] by [DHB 1].
> - Comments in regards to [DHB 1] actions after receiving advice about the personal relationship between [RN B] and [Ms A].
> - Additional comments regarding care provided by [DHB 1].

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Section One

- To comment generally on the standard of care provided by [RN B] to [Ms A].

From the documentation I have received [Ms A's] notes contain 12 dates with notes authored by [RN B]. On […] May 2011 there appear to be two notes entered for the time on these days he nursed [Ms A]. [RN B's] notes contain direct quotes from interactions he had with [Ms A]. These quotes appear to express her belief system and are descriptive of [Ms A's] distress and her inability to self-nurture or sit comfortably with her emotions. There is no written documentation of any discussions which occurred between [RN B] and [Ms A's] mother. [RN B's] letter to the Health and Disability Commission[er] indicate there had been conversations between himself and [Ms A's] mother. There is also no written documentation of his professional concerns about [Ms A's] diagnosis or treatment plan.

[RN B's] nursing progress note dated […] May 2011 documents a situation where [Ms A] was in the toilet and a female HCA would be outside the door to ensure [Ms A's] safety, and [Ms A] was also informed the toilet would be entered by a staff member. One female Registered Nurse and [RN B] did enter the toilet after overriding the lock. These nursing interventions appear to show [RN B] acknowledging gender safety issues at this specific time.

- To comment on professional standards which apply in this case and whether these standards were met.

The following advice has been provided after reviewing the information supplied by the Health and Disability Commissioner, the Nursing Council Code of Conduct, (2010 & 2008), New Zealand Nurses Organisation's Code of Ethics (2010) (revised 1995, 2001, last reviewed 2010), and the Nursing Council Guidelines for Professional Boundaries (2012). The New Zealand Nurses Organisation Code of Ethics (2010) was relevant to [RN B] as a practising nurse, who was a member of this union.

The NZNO Code of Ethics (2010) states that the code 'has been written for nurses to use both as a basis to explore the ethical beliefs of New Zealand nurses, and as a guide to explore the detail of individual situations arising in nursing practice' (p.8). The NZNO also state within the underlying philosophy that 'nursing was founded on the moral premise of caring and the belief that nurses have a commitment to do good. Part of society's expectations of nurses is that they are moral agents in their provision of care and that they have a responsibility to conduct themselves ethically in what they do and how they interact with persons receiving care'. (p. 9).

[RN B's] nursing practice (explicitly relating to care of [Ms A]) and relationship with [Ms A] can be assessed against the underlying values of the NZNO Code of Ethics (2010).

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- Autonomy: It appears [RN B] has failed to recognise that [Ms A's] autonomy may have been limited due to the power imbalance which exists between nurse and client and her vulnerable mental health and personality state.
- Beneficence: This value refers to the nurse performing actions which lead to an outcome that is regarded as worthwhile. [RN B's] actions towards [Ms A] have not ended when she was discharged from the service he worked for. [Ms A] alleges that [RN B] had asked her to stay alive as they planned to have a coffee on her discharge. [RN B] has confirmed he did meet with [Ms A] for coffee on discharge. These actions provide evidence that relationship boundaries were blurred. [RN B] continued to see [Ms A] in a manner which was not underpinned by nursing values, ethics and professional requirements. It could be suggested [RN B] has struggled with ensuring his actions were safe and were of benefit to [Ms A's] health.
- Non Maleficence: It is clear that [RN B's] actions have diverted from this value. It may not have been his intention to have this happen. [RN B] clearly harmed this client, in the context of engaging in a sexual relationship and shifting the nurse–client relationship outside the physical care environment.
- Justice: [RN B] initially provided nursing care which was relevant to [Ms A's] needs, however a clear transgression occurred when the relationship changed from nurse–client and intimacy (initially not sexual) occurred.
- Confidentiality: Due to the privileged position of being a nurse, [RN B] had access to all of [Ms A's] mental health notes. To my knowledge the breaking of confidentiality was not present in this case.
- Veracity: Truthfulness towards the client, colleagues and the organisation was not upheld. [RN B] did not openly communicate with his colleagues or the organisation about the relationship and activities within the relationship with [Ms A]. On-going text messaging and appearing to try and disengage from the relationship after a few months, by saying he was under mental health care are examples of a lapse of truthfulness. Vagueness of dates and actions may also indicate complete truth has not been disclosed.
- Fidelity: There has been a clear transgression from this value within the case. There is no documentation about his debate about [Ms A's] needs/diagnosis and challenging the therapeutic team's approach. Therapeutic relationships with clients are built on trust; it appears [RN B] has misused the trust of the nurse–client relationship.
- Being Professional: This value includes providing sound judgement and practising within relevant codes and laws, providing nursing practice which meets standards developed by the profession. [RN B's] intimate and sexual relationship with [Ms A] clearly demonstrates behaviours which seriously transgressed from these values.

[RN B's] practice would have been guided by the New Zealand Code of Conduct (2010) as this was the current release at the time of the complaint. It is likely during [RN B's] Registered Nursing training he received formal education on the Nursing Council Code of Conduct (2008) edition. From review of both of these documents there have been no significant changes between the 2008 and 2010 editions.

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- o <u>Principle One: The nurse complies with legislative requirements</u>
  Prior to the complaint, [RN B] adhered to the criteria of principle one. (His Depression that had been treated prior to entering nursing, would not be a condition entered on the register).
- o <u>Principle Two: The nurse acts ethically and maintains standards of practice</u>

2.1 The nurse is guided by a recognised professional code of ethics applied to nursing: As outlined above [RN B's] nursing practice and actions failed to maintain ethical standards expected of a Registered Nurse.

2.2 Uses knowledge and skills for the benefit of patients, client and community: [RN B's] notes demonstrate that [RN B] spent time talking with [Ms A] whilst she was an inpatient, which would have allowed for the establishment of rapport and a therapeutic relationship. [Ms A] was able to be guided by [RN B] to utilise medication to manage anxiety and he implemented increased checks on [Ms A] when he felt her safety was compromised. These actions demonstrate some level of skill use which had a positive outcome for [Ms A]. However his knowledge of the patient and skills in maintaining a relationship with her outside of the hospital environment are actions which do not reflect adherence to the Code of Conduct.

2.3–2.6 These pertain to professional standards and ensuring these are maintained. [RN B] did not adhere to professional standards. Despite the 2012 Professional Boundaries and Code of Conduct not being published at the time of the incident, these documents clarify how standards of practice lapsed.

- 2.7 Maintains and updates professional knowledge and skills in area of practice: There are documented records which indicate [RN B] attended in-services provided. There is no clear evidence of any further study or resources [RN B] may have utilised to update professional knowledge and skills (for example NZNO and NCNZ website).

2.8 Not applicable in this case

2.9 Accurately maintains required records related to nursing practice: From documentation provided (progress notes) these suggest an accurate assessment of [Ms A] and her mental state, by [RN B], but need to be read in context with the rest of the Multidisciplinary notes. There is no documentation that [Ms A] had given [RN B] her cell phone number and conversations [RN B] reports he had with [Ms A's] mother have not been documented in progress notes.

- o <u>Principle Three: The nurse respects the rights of patients/clients</u>

3.1 Acknowledges and allows for the individuality of people: [RN B] appears to have acknowledged the individuality of [Ms A].

3.2 Provides information to enable the patient/client to exercise informed choice and consent to the delivery of professional nursing care: I would question the reason [RN B] divulged his own past mental health history to [Ms A] and what impact this information had on the building of rapport and impact on free consent to make informed choice.

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3.3 Respects any privileged access, conferred by professional status, to patient's/client's information and their possessions, residences and workplaces.

Because [RN B] was in the position of a trusted health professional [and] went on to establish a non-nursing related relationship with [Ms A] he was able to gain access to her within her private life. [RN B] also had a sound understanding of the current family dynamics and how these impacted on [Ms A's] and her mother's wellbeing and vulnerability.

3.4 Safeguards confidentiality and privacy of information obtained within the professional relationship. [Ms A] alleged that [RN B] divulged personal information about his work colleagues to [Ms A]. [Information redacted that is not relevant to this case.] If this statement is true, [RN B] has seriously transgressed from these criteria. To my knowledge [RN B] did not break confidentiality in relation to information about [Ms A].

3.5 Helps patients/clients understand their rights and acknowledge their responsibilities related to the delivery of professional nursing: Although it is clear patient rights may not have been upheld, it is not clear if [RN B] ever discussed patient rights and professional nursing expectation with [Ms A]. If he had done this, a sexual relationship may not have occurred as [RN B] would have had to explain to [Ms A] where their therapeutic relationship ended, why it ended and put measures in place for this to occur. [RN B] had stated in his interview with the HDC that he was unsure if it was OK to have a relationship with an 'ex-patient'. He made mention of a nursing tutor who had divulged an intimate relationship with a previous patient.

3.6 Is aware of and guided by codes of rights and responsibilities for patients/ clients and health care providers in area of practice: As has already been established [RN B] did not ensure nursing practice undertaken was guided by relevant codes of rights and responsibilities.

3.7 Practises in a manner that is culturally safe: In theory this is for the client to judge, but as she has supported this complaint laid by her mother, it would suggest that [Ms A] does not feel she was nursed with regard to her cultural identity. The nurse having an understanding of how their own cultural history, attitude and life experiences impacts on nurse–client relationships is essential. (Power imbalances can occur without this understanding and self analysis.)

3.8 Practises in compliance with the Treaty of Waitangi: The Treaty of Waitangi can be understood in nursing within the three principles: partnership, protection and participation. Partnership refers to the nurse ensuring the client is able to actively participate in their health care and make informed decisions. [RN B's] notes reflect some elements of positive partnership building in the initial stages of [Ms A's] stay on the ward. Protection refers to protecting the client, their health and their wellbeing. [RN B's] actions have not protected the client (socialising with [Ms A] outside of the hospital, regardless of inpatient status, sending text messages to [Ms A] and going to [City 2] to see [Ms A] and furthering their

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relationship), [Ms A's] health and wellbeing are likely to be negatively impacted on now and in the foreseeable future.

o <u>Principle Four: The nurse justifies public trust and confidence</u>
4.1: Provides valid identification about his/her professional qualifications and right to practise: Prior to this incident there were no known concerns related to [RN B's] right to practise as a Registered Nurse.

4.2 Offers or provides professional nursing partnerships: In this incident [RN B] was a paid employee of [DHB 1], however he continued a relationship with [Ms A] which was outside a professional nursing partnership.

4.3 Uses professional knowledge and skills to promote patient safety and wellbeing: Initially when [RN B] was working with [Ms A] he implemented interventions which suggested he was using professional knowledge and skills to maintain her safety. Examples of these interventions include spending time allowing [Ms A] to vent her feeling, utilising PRN medication and utilising a female HCA to access a bathroom when he was concerned about [Ms A's] safety. However as the relationship developed outside the realm of nurse–client [RN B's] boundaries appeared to have blurred. [RN B's] contact with [Ms A] via text messages and emails show his concern for her mental health and his making of suggestions to help her, being based on his nursing knowledge and previous knowledge he gained whilst working as a nurse with her. This became a point of conflict when he suggested he would have to refer her to the crisis team.

4.4 Reports to an appropriate person or authority, any limitation in professional expertise or personal health status or circumstances that could jeopardise patient/client safety: It is well documented throughout this report how this point of conduct has not been met by [RN B].

4.5 States any relevant, conscientious objection that could impact on her/his scope of practice: There does not appear to be any relevance of this point for the purpose of this report.

4.6 Takes care that a professional act or any omission does not have an adverse effect on the safety or wellbeing of patients/clients: It is well established throughout this report that [RN B's] actions have had an adverse effect on the safety and wellbeing of [Ms A].

4.7 Respects the trust implicit in the professional nursing relationship: It is clear that the trust implicit with the nurse–client relationship (and colleagues) has been broken.

4.8 Claims benefits or remuneration only as and when appropriate for services appropriate: Not applicable in this case.

4.9 Acts in ways that contribute to the good standing of the nursing profession: [RN B's] actions have a great potential to bring the nursing profession into disrepute. Society holds nurses in high regard and with this comes a heightened

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level of trust from members of the public at times when they are at their most vulnerable due to compromised health.

It is clear from reviewing this case in line with the Nursing Council's Guidelines for Professional Boundaries (2012) that [RN B's] actions did not indicate he was aware that his behaviours towards [Ms A] had transgressed from a therapeutic relationship into over involvement with [Ms A] and her life beyond hospital and treatment required. It is important to acknowledge at the time [RN B] was practising as a Registered Nurse and working with [Ms A] the Guidelines for Professional Boundaries was not available for nurses to view. The Nursing Council Guidelines for Professional Boundaries were developed after rigorous research and consultation with nurses and it became clear more explicit information was required for nurses to refer to, to assist in ensuring professional boundaries in relationships with clients could be maintained. The context in which care takes place can potentially change or compromise the nurse's ability to maintain firm boundaries within the nurse–client relationship. For example working in a smaller DHB or a rural setting often means dual relationships can exist.

The Nursing Council Guidelines for Professional Boundaries (2012) documents signs of over involvement in a nurse–health consumer relationship. [RN B's] actions as will be outlined demonstrate a clear transgression from his role as health professional within [Ms A's] life.

The following are indicators of over involvement in a nurse–health consumer relationship.

<u>The nurse reveals feelings and aspects of his/her personal life to the health consumer beyond that necessary for care.</u>

- [RN B] disclosed to [Ms A] that he had experienced Depression in the past, it is not clear if this was necessary for [Ms A's] care.
- In a written statement provided by [Ms A] (P. 281), [RN B] allegedly stated to [Ms A] 'You can't kill yourself, when you get out of here we are going out for coffee'. [Ms A] also mentions in this statement that [RN B] had said to her 'What about me, what about our future?' A text message sent by [RN B] to [Ms A] on […] June 2011 states, 'I hope not, I have really deep feelings for you' (SMS No. 7). These statements reflect that the nurse has become emotionally close to the health consumer or has regarded the health consumer as someone special. The [telephone company's] SMS record indicates contact via SMS between [RN B] and [Ms A] whilst she was still an inpatient.

<u>The nurse attempts to see the health consumer outside the clinical setting or outside normal working hours or after the professional relationship has ceased.</u>

- The documentation I have received indicates [RN B] met with [Ms A] for coffee after she was discharged from hospital.

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<u>The nurse frequently thinks of the health consumer when away from work</u>

- The provided script of SMS messages indicates [RN B] was thinking of and attempting to interact with [Ms A] outside the clinical setting and when she was no longer a client of the service he worked for. These messages became sexually explicit indicating a clear transgression from a professional relationship to one where [RN B] had sexual thoughts about the client. Within the SMS's [RN B] is clearly describing his sexual fantasies towards [Ms A] (examples, SMS's […] July 2011, No. 24, No 65–72). From the SMS record from [the telephone company], I assume that the first number of the month indicates the month instead of the day […].

<u>The nurse receives gifts or continues contact with a former health consumer after the care episode or therapeutic relationship has concluded.</u>

- It has been clearly established that contact with [Ms A] continued after the care episode. The most concerning contact between [RN B] and [Ms A] is the confirmed sexual physical contact. Discrepancies of account relating to time and place exists, however both confirm sexual intercourse was part of their relationship. The themes of power imbalance are clearly evident within the relationship between [Ms A] and [RN B]. [Ms A] is a vulnerable young woman with a complex emotional reaction to her perceived world. Vulnerability is enhanced due to social isolation from peers and constantly changing family dynamics. The diagnosis of a Borderline Personality Disorder also places [Ms A] at increased risk of engaging in inappropriate or harmful relationships due to view of the world and limited experiences.
- In relation to the act of [RN B] texting [Ms A] whilst she was still an inpatient I would consider this act to be highly unprofessional and unnecessary in relation to the care she required whilst an inpatient. Principle 7.13 of the Nurses Code of Conduct highlights the inappropriateness of texting, as well as the content of the texts.

- <u>Comments on the relevance of the issues [RN B] has referred to in explaining his relationship with [Ms A], including: his concern about [Ms A's] treatment in hospital; his own mental well-being; his personal stress; and his lack of experience as a mental health nurse.</u>

- In relation to [RN B's] concerns about [Ms A's] treatment whilst an inpatient, HDC documentation reports [RN B] had conversations with [Ms A's] mother in regards to treatment and concerns about the accuracy of the diagnosis [Ms A] had been given. From the progress notes I have been provided with, [RN B] has not documented any conversations had with [Mrs C] and the concerns she had in regards to her daughter. Not documenting concerns raised by family means concerns raised by the family have not been responded to in an appropriate manner. Omitting this information from notes prevents an accurate record of care and assessments to take place and prevents open and thorough communication with the treatment team.

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- o In relation to [RN B's] own mental wellbeing and personal stress, these factors may have had an impact on [RN B's] day to day functioning, ability to provide quality care, and ensuring a work–life balance, in the context of significant personal stress. I have reviewed a roster of [RN B's] and there appears to be inconsistent days off with limited regular two consecutive days off. This factor significantly impacts on achieving work–life balance. Consistently turning up to work very early could also have been an indicator there were some significant issues going on for [RN B]. Constant changing of shift is likely to have also impacted on sleep quality, energy levels and overall wellbeing. [RN B] acknowledges he had limited social supports because of a recent move and relationship break down. As [RN B] had a previous diagnosis of Depression and had been successfully treated, it is likely that he had skills to deal with early warning signs of decompensating mood and had been offered support through the EAP programme, but declined this. This is unfortunate due to the outcomes which have occurred for all parties.
- o In relation to his lack of experience as a mental health nurse, [RN B] is a new practitioner within the mental health setting, initially graduating and working in […]. [RN B] reported receiving regular supervision whilst he was a staff member in […]. He reports finding this useful for professional development. In his first year of work as a Registered Nurse, working in mental health, [RN B] entered into a New Graduate Training Programme in […]. This programme included regular supervision sessions and boundary training. (P. 87, […] April 2012, [the] CEO Response to Health and Disability Commissioner Questions). [RN B's] clinical nursing practice has all been within the mental health setting. He has mentioned in documentation provided by the HDC that mental health was not his first choice of work setting. Documentation from [DHB 1] indicates [RN B] completed [DHB 1] induction programme in 2011.
- o [RN B] reported being concerned about the treatment of [Ms A]. He was a beginning practitioner and did not seek advice from senior colleagues in relation to his concerns. Seeking advice from senior colleagues would have been appropriate intervention to ensure [RN B] safely worked within his scope of practice. The importance of this is highlighted due to the fact [RN B] was not receiving supervision and was caring for a client whose symptoms and behaviours are often challenging, requiring a consistent multidisciplinary approach.

<u>Section Two</u>

- <u>Under this section, as requested, comments will be made in regards to Policies and Guidelines of [DHB 1]. Specifically, policies relating to Professional Boundaries.</u>

The copy of the Code of Conduct I have received is dated [mid-] July 2011. Within the recent release of this document [DHB 1] appear to be working towards a vision of the importance of health and safety in the working environment. However due to the release date, I am unclear if this document was given to [RN B] (during induction, [early…] 2011) and if it was, if the contents of both documents are the same. I am unclear as to if [DHB 1] had a formal Code of Conduct prior to the 2011 document.

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The [DHB 1] 'House Rules' indicate 'Improper Conduct'. [RN B] has breached these house rules, particularly in relation to House Rule G 'Improper Conduct of a Serious Nature in Official Capacity, or while acting in a private capacity of conduct unbecoming an employee of the organisation'.

- Comments or concerns in relation to [RN B's] induction/orientation within [DHB 1].

From the information provided [RN B] undertook two full orientation days [in early] 2011. His attendance was verified by [the Clinical Nurse Manager].

[The Clinical Nurse Manager] stated that [RN B] received the following, mental health addiction services orientation timetable, house rules, module two 'Mental Health Inpatient Nurses', and Mental Health and Addiction Generic Orientation. However other than the confirmed two orientation days [in early] 2011, there is no record of completion of any of the above orientation. [RN B] also received a New Employee starter pack and orientation CD, which provides information about quality, risk, code of rights and human resources.

Further to this it is confirmed that [RN B] completed the following, [DHB 1] Health Sector Orientation Programme, Calming and Restraint Training, Mental Health Inpatient Service In-Service, Section 111 of the Mental Health Act, The National Medication Chart, Smoke Free education and preceptor study days. The hours and explicit content of these courses is not known.

It is not clear from the information provided whether [RN B] received any on-going professional education in relation to professional boundaries with consumers. From my experience Registered Nurses within the Canterbury District Health Board receive a one hour session about professional boundaries. This session is provided by a Nurse Consultant and is provided to all Registered Nurses across the CDHB. The purpose of this education session is to provide information about Professional Boundaries with clients. This session covers the importance of a therapeutic relationship meeting the needs of the client, the role of boundaries in protecting the therapeutic relationship, and the role of the nurse to ensure professional boundaries remain. (Wijnveld, 2011).

From the information provided I find it difficult to assess whether the orientation package supplied would have assisted [RN B] to feel comfortable and well equipped to being in his new position. However, nursing standards make it clear that nurses should always seek support if they require additional assistance to perform their role safely.

- Support or supervision offered to [RN B] by [DHB 1].

[RN B] was unable to successfully engage with his chosen supervisor in a formal arrangement. My concern was [RN B] was coming to work early and when asked why by a colleague, [RN B] disclosed that he felt safer at work because he was suicidal. An informal discussion was held between [RN D] and [RN B] to discuss his expression of suicidal ideation to his colleague the evening before. During this meeting [RN B] admitted to having fleeting thoughts of hurting himself, but no

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plan or intent. There is no clarity of whether this was self-harm or suicidal behaviour. [RN B] declined to take leave at the time of this meeting, EAP was offered, I am unsure if he engaged with this service. (Refer to Chief Executive Reply to HDC, 17th May 2012). [RN B] was instructed to attend the services of EAP. There is no written evidence that he followed these instructions. [RN B] was instructed to attend the EAP services by the DHB, as evidenced in the letter [late] December 2011. He was also suspended on full pay at the time of this meeting, pending complaint investigation.

My concern is that there was no formality to this meeting and given the potential risk factors to clients, other colleagues and [RN B] the situation required exploring with an outline of current issues and conclusions to be made around [RN B's] ability to function with the scope of practice of a Registered Nurse at this time (?practising under disability). I believe [RN F] as shift co-ordinator had attempted to formalise these concerns by passing these onto the Clinical Nurse Manager. Again support with the supervision environment may have been an effective intervention. Encouragement to seek mental health support from [RN B's] GP may have also been appropriate as he was expressing internal distress with potential risk to self.

Principle four of the Code of Conduct for Nurses (2010) states maintaining public trust and confidence in the nursing profession is vital. Within the context of [DHB 1's] inaction towards [RN B] I would struggle to see how the DHB has maintained principle eight and ensure there is support for staff members. (Who is caring for the carers?).

As part of any new Registered Nurse's employment alignment with a more experienced nurse peer may enhance safe practice and allow the new practitioner a safe and stable person to access when needing support with clinical decision making.

- Additional Comment

The age disparity between [RN B] and [Ms A], approximately 15 years, needs to be considered due to the life-world experiences of [RN B] compared to [Ms A] and noted in her psychologist's review was [Ms A's] maturity age was younger than her chronological age. This factor enhances the abuse of trust within the nurse–client professional relationship. (Code of Conduct 2010, Principle two and three).

- Comments in regards to [DHB 1] actions after receiving advice about the personal relationship between [RN B] and [Ms A].

[DHB 1] appeared to have acted in a timely manner once the situation was disclosed by [DHB 2]. Public safety was maintained as [RN B] was suspended on full pay until further information about the incident was gathered. […] [RN B] was advised to seek union and legal representation due to the seriousness of the allegations.

- Additional comments regarding care provided by [DHB 1]

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[Ms A's] diagnosis of Borderline Personality Disorder, and the complex situation surrounding her emotional processing, would be best served by having a core team of nurses working with her to ensure a consistent, structured treatment focus.

Within the HDC provided documentation, Key Nurse [RN E] had adjusted the roster to ensure [RN B] did not work on a day to day basis with 'young, vulnerable women'. [RN E] had noticed [RN B] appeared to have an inclination to work with this client group and she had some concerns around this. [RN E] had discussed this with [a senior colleague]. Challenging staff's therapeutic relationships with clients in a safe manner may need to be addressed and on-going education around this may be beneficial for [DHB 1] staff. Open discussions around professional boundaries should be encouraged in a neutral manner.

In conclusion I would consider [RN B's] conduct with severe disapproval. With the clarity of hindsight and reading the notes there appeared to be a theme of [RN B] aiming to have his needs met within the therapeutic relationship. It appears that [Ms A's] level of vulnerability, in the context of social isolation and personality pathology, allowed [RN B] to engage in an inappropriate relationship. By attempting to disengage from the relationship via text messaging, stating he had been placed under the Mental Health Act reinforces the severity of the misconduct which has taken place. [Information redacted that is not relevant to this case.] [I]n this case there is a clear need for on-going staff support in terms of professional development and ensuring not only client but staff health and wellbeing. There is no documentation to indicate [RN B] was receiving supervision or support in his practice prior to his suspension.

[Information redacted that is not relevant to this case.]

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