Prison Service
Registered Nurse, RN A
Registered Nurse, RN B

A Report by the
Deputy Health and Disability Commissioner

(Case 19HDC01130)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided at a prison in May 2019. It highlights the importance of adequate documentation of assessments and care provided to consumers.

2. At around 8pm on 5 May 2019, a man was found unresponsive in his cell. He was assessed by a nurse, and the recorded plan was to refer the man to hospital for follow-up. However, there were omissions in the documentation of the assessment. Prison officers were also asked to continue observations of the man until the transfer to hospital, but records of any observations made could not be located by the prison.

3. At around 9.30pm that day, another nurse reviewed the man. There were further omissions and inaccuracies in the documentation of care provided to the man by the nurse at this time. On 6 May 2019, the man was seen by a GP, who determined that the man's earlier loss of consciousness required further investigations, including a chest X-ray and referral to an ENT specialist.

Findings

4. The Deputy Commissioner found that the nurses both breached Right 4(2) of the Code by failing to comply with the Nursing Council of New Zealand's standard for documentation, and prison service policies for clinical documentation.

5. The Deputy Commissioner criticised the prison service for the multiple omissions in the documentation of the care provided to the man by different staff on different occasions, and for the failure to locate any record of observations made by officers.

Recommendations

6. The Deputy Commissioner made several recommendations, including that the nurses both provide evidence of having undertaken training on documentation, and that they provide a written apology to the man for their respective breaches of the Code.

7. The Deputy Commissioner recommended that the prison service provide evidence that nursing staff have received training on documentation standards and relevant healthcare policies, and that it consider the adequacy of guidance and training currently provided to officers in relation to the observation of patients with health conditions.

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint from Mr C about the services provided to him at a prison. The following issues were identified for investigation:

- *Whether the prison service provided Mr C with an appropriate standard of care in 2019.*
- *Whether RN A provided Mr C with an appropriate standard of care in 2019.*
- *Whether RN B provided Mr C with an appropriate standard of care in 2019.*

9. This report is the opinion of Deputy Commissioner Vanessa Caldwell, and is made in accordance with the power delegated to her by the Commissioner.

10. The parties directly involved in the investigation were:

Mr C	Consumer
Prison service	Provider
RN A	Provider/registered nurse
RN B	Provider/registered nurse

11. Further information was received from Ms D, the Health Centre Manager at the prison.

12. Independent expert advice was obtained from registered nurse (RN) Barb Cornor (Appendix A).

13. The prison service provided HDC with a copy of its relevant policies (summarised in Appendix B) and relevant standards (summarised in Appendix C).

Information gathered during investigation

14. On 9 March 2019, Mr C was received as a prisoner.

15. As part of the admission process, Mr C underwent a health assessment, which identified that he was a smoker, and nicotine replacement therapy was prescribed.

16. The prison service told HDC that between 2 and 8 May 2019, Mr C was transferred to a specialist unit (SU). The prison service said that prisoners in the SU are seen daily by a mental health nurse for a welfare check. This report concerns the care provided to Mr C while in the SU, after an unwitnessed collapse.

5 May 2019

17. On 5 May 2019 (time not recorded), a staff member recorded a file note that Mr C had covered his observation window and the CCTV camera in his cell.

18. At approximately 8.03pm, a duty officer saw through the hatch cell door that Mr C was on the floor with blood dripping from his nose, and that he was unresponsive. The officer triggered a medical Code Blue.[1]

Initial assessment — RN A

19. At approximately 8.05pm, RN A responded to the Code Blue alert and attended to Mr C in his cell. RN B was also on duty and attended. She told HDC that RN A was responsible for assessing Mr C at this time.

20. On arrival, RN A observed through the cell door hatch that Mr C was on the ground lying on his back, and that his chest was rising and falling but he did not respond when called.

21. RN A recorded that it had been 60 minutes since Mr C's previous check by the SU officer, and that Mr C "had liquid on his face & head that had come from his mouth".

22. No description of the liquid was recorded by RN A. He acknowledged to HDC that he should have documented a description of the liquid in the clinical notes, so that this information was clear for subsequent reviews of the notes.

23. RN A, RN B, and the SU officers entered Mr C's cell, and RN A took Mr C's pulse and noted that it was normal.[2] Mr C was placed in the recovery position by the SU officers.

24. At about 8.07pm, Mr C opened his eyes and asked, "What is going on?" He was assisted to his bed, and said that he could not remember anything at all, but he was able to give his name and date of birth.

25. Mr C told HDC that he was bleeding from a lump on his head, and blood was on the ground and on his shirt.

26. In contrast to Mr C's statement, RN A documented: "[N]il head injury noted at the time of assessment." However, there is no documented evidence of what the physical assessment of Mr C's head entailed. RN A told HDC that there was no injury to Mr C's head at the time of his assessment, but he acknowledged that his documentation could have been clearer.

27. A neurological assessment was undertaken by RN A, and it was noted that "once awake [Mr C] was both physically alert and responsive", and that he reported no headache, dizziness, or weakness. The findings were normal with the exception of his eye movements, as Mr C was slow to follow RN A's finger during the assessment. An assessment of Mr C's limbs and balance was not performed owing to concerns about his safety in performing the test on a wet floor .[3]

[1] A clinical emergency.
[2] Mr C's pulse was 88 beats per minute (the normal range is between 60 and 100 beats per minute).
[3] An incident form completed at 4.31pm on 5 May 2019 reports that Mr C threw shower gel on the floor of his cell when he was asked to hand over this item to staff.

28. A respiratory and cardiac assessment was normal, other than Mr C's complaint of left-sided chest pain. A full set of observations was taken, and these were also noted to be normal.[4]

29. RN A's recorded impression was:

> "Found on the ground unresponsive? length of time. ? concussion, ? Neuro deficient — extraocular movement [Mr C] not able to follow writer's finger. ?chest pain below left breast."

30. RN A recorded his plan to refer Mr C to the public hospital for assessment and treatment, and for him to have continuous observations by officers until transfer to hospital, and a GP review the following day.

31. RN A completed an Advice of Prisoner Health Status Form, which directed officers to observe Mr C for symptoms[5] and report to Health Services while waiting for transfer to hospital.

32. RN A also completed an ACC injury claim form[6] and documented a diagnosis of "concussion".

33. RN A documented no further involvement in Mr C's care from this point.

34. The prison service told HDC that officers recorded and filed their observations of Mr C on 5 May 2019, but the records cannot be located.

Second assessment — RN B

35. At 9.30pm, RN B reviewed Mr C in his cell to follow up the medical alert, but incorrectly documented that this visit occurred at "0930hours".

36. RN B told HDC that she cannot recall whether she reviewed RN A's clinical notes prior to her assessment of Mr C at 9.30pm, and stated that there was no access to the Medtech notes[7] while in the SU.

37. During her assessment, RN B documented that Mr C said that he had felt sick and had vomited twice, and had a splitting headache, but no chest pain was reported. She took his observations and these were normal. RN B told HDC that she had spoken to the prison officers and asked for a report on Mr C's condition during the time he was under constant observation, and said that she cannot recall whether the prison officers reported that Mr C had vomited. However, this conversation was not documented. RN B said that her usual practice is to ask the prison officers who are undertaking the observations of a prisoner whether there is anything to report, and to check the record of the observations taken.

[4] Blood pressure, temperature, respiratory rate, and oxygen saturation were all normal.
[5] Unresponsiveness, headache, and a change in mood and behaviour.
[6] ACC 45.
[7] Medtech is an electronic clinical record system used by primary healthcare providers.

38. RN B documented that Mr C was alert, responsive, and interactive, but that he "appear[ed] to be disoriented to time/date".

39. RN B told HDC that when she reviewed Mr C, she may not have been aware of the results of RN A's assessment that Mr C's eye movement was slow and that a mobility test had not been performed. RN B told HDC:

> "If I had been concerned that [Mr C] was looking weak or unsteady in any way that would have prompted me to undertake a mobility assessment. If I was concerned that he was displaying any cognitive deficits I would have undertaken a neurological examination."

40. RN B recorded that her impression was "query gastro bug[8]/reflux".

Management plan for Mr C

41. At 9.45pm, RN B telephoned the Health Centre Manager, Ms D, to update her on Mr C's condition. Ms D recollected that RN B told her that Mr C was "orientated and alert", but did not mention that he was "disorientated to time/date".

42. RN B told HDC that despite the ongoing nausea and the headache, Mr C had improved over the hour, and a decision was made in conjunction with Ms D not to send Mr C to hospital, but to arrange for a medical review by the GP the following day.

43. RN B booked Mr C for a GP appointment the following day as a "must see", and completed a Prison Health Status form requesting that he be under 15-minute observations to monitor for any changes. Mr C was advised to notify the prison officers if his symptoms worsened overnight.

44. RN B told HDC that she accepts that the clinical notes do not reflect that there was a change of impression from concussion to "gastro bug/reflux", and that owing to the passage of time it is very difficult to provide a full response.

45. Ms D told HDC that a Health Centre Manager is always available by telephone to discuss any concerns that a nurse may have about whether hospitalisation is being considered. Ms D said that the decision not to send Mr C to hospital was made by RN A, very soon after his initial assessment of Mr C.

46. In contrast, the prison service told HDC that RN A recommended that Mr C be reviewed in hospital, because at the prison no health services staff are available after 10.00pm. The prison service said that owing to Mr C's rapid improvement, and the level of observation available to him in the SU, it was decided that he no longer required hospital review and that his healthcare needs could be managed in the prison. The prison service stated:

[8] Gastroenteritis — an intestinal infection that can include symptoms of diarrhoea, cramps, nausea, vomiting, and fever.

> "Any decision to conduct a prison escort (including health related prisoner escorts such as hospital visits) must be carefully considered. The potential security and safety risks of removing a prisoner from their custodial environment must be balanced against their health needs."

47. RN B told HDC that her documentation of the second assessment could have been much fuller, and that the reason for the change in management plan and any discussion with the Health Care Manager should have been recorded.

GP review and further care

48. On 6 May 2019, Mr C was seen by a GP, who noted that Mr C's ear, nose, and throat (ENT) and cardiorespiratory examinations were normal. The GP documented that Mr C had reported that on the previous day "he had blood coming down the sides of his mouth". A plan was made for a chest X-ray and then a referral to an ENT specialist.

49. The GP told HDC that he was unable to identify any specific cause for Mr C's unexplained loss of consciousness, and he considered that further investigations were warranted, and this was arranged.

50. The prison service told HDC that following a chest X-ray on 27 June 2019, a referral was made to an ENT specialist at a district health board on the same day. The prison service said that initially Mr C was scheduled to be seen at the DHB on 8 August 2019, but later the referral was declined and Mr C was discharged by the DHB.

Further information

Mr C

51. Mr C told HDC that a nurse revived him and recommended a transfer to hospital owing to the seriousness of his condition. He said that the prison service refused to transfer him to hospital, and the Health Care Manager ignored the nurse's recommendation. Mr C stated that the medical staff did not follow the correct procedure in handling his health concerns, and "[i]t took this life threatening incident to occur to allow [him] to be seen by a doctor the very next day following the [collapse]".

RN A

52. RN A told HDC that the prison service provided him with "little training" on the Medication Management Policy and Health Care Policy. He also said that the training he received was limited in scope to the prison's policy, and that full training on the new national policy was not always provided. RN A stated that training did not always take place, and it was not always accessible due to time constraints.

RN B

53. RN B told HDC that these events occurred on her first shift back at the prison after extended leave, having commenced her employment with the prison in September 2017. RN B said that these events occurred at the end of her shift, and time constraints may have affected the quality of her documentation.

54. RN B stated: "This has been a significant learning experience for me and I have gained valuable knowledge going forward."

Prison service

55. The prison service told HDC that Mr C received health services that were in line with current policies and procedures. The prison service said that on 5 May 2019, two registered nurses covered the afternoon shift (1.30pm–10pm) in accordance with normal staffing levels.

56. The prison service also stated:

> "[The prison's] Health Services are committed to ongoing, continuous improvement. Nurses are supported through ongoing education and training to aid in the delivery of best practice health services at the prison."

Responses to provisional opinion

57. Mr C, the prison service, RN A, and RN B were all given the opportunity to respond to relevant sections of my provisional report. Where appropriate, their comments have been incorporated into this report. In addition, the following responses were received.

58. Mr C told HDC: "I disagree with all of the responses provided by the nurses and [the prison service]." He stated that the prison service, RN A, and RN B "need to be held accountable for their actions so that this doesn't happen again in the future".

59. The prison service told HDC that it accepts the Deputy Commissioner's provisional recommendations.

60. RN A told HDC that he acknowledges that his documentation was inadequate, and he accepts the Deputy Commissioner's provisional findings and recommendations.

61. RN B was contacted multiple times to provide a response but none was forthcoming.

Opinion: RN A — breach

62. On 5 May 2019, RN A attended a medical Code Blue (emergency call) to respond to Mr C, who had been found unresponsive on the floor of his cell. RN A was responsible for the assessment of Mr C's condition and for developing an appropriate management plan to guide staff in their further care of Mr C. While aspects of the assessment were adequate, I am critical that there were omissions in the documentation of the assessment, as set out below.

Assessment of Mr C

63. At 8.05pm on 5 May 2019, RN A reviewed Mr C, who had been unresponsive for an unknown length of time before the nursing staff arrived. RN A assessed Mr C and recorded that he "had liquid on his face & head that had come from his mouth", but he did not identify the

liquid. Mr C told HDC that he had been bleeding, and an officer reported that Mr C had been bleeding from his nose.

64. RN A documented, "[N]il head injury noted at the time of assessment", but there is no evidence of what the head injury assessment entailed.

65. RN A acknowledged that he should have documented a description of the liquid on Mr C's face and head, and that his documentation of the physical assessment of Mr C's head could have been clearer.

66. My independent nursing advisor, RN Barb Cornor, advised that RN A completed a full and comprehensive assessment of a collapsed unresponsive person without a suspected head injury, and that the neurological assessment is well documented.

67. RN Cornor advised that RN A's documentation of "nil head injury noted at the time of assessment" met the minimum requirement of a neurological/head injury assessment.

68. However, RN Cornor advised that the physical assessment for a head injury was not documented adequately. She said that there was no evidence of a physical assessment of Mr C's head, including looking for any lacerations, bruising, or swelling to the face or scalp, to determine whether there had been any trauma to the head. RN Cornor advised that the failure to undertake these assessments represents a severe departure from accepted practice, particularly when the assessment is to determine how the patient became "unresponsive" and to make a differential diagnosis between a head injury and a neurological event.

69. RN Cornor also advised that no description of the liquid noted on Mr C's face, head, and mouth was provided. RN Cornor advised that the liquid should have been identified, as this was relevant to the assessment, provisional diagnosis, and physical resuscitation. RN Cornor considers that the failure to identify the liquid represents a moderate departure from the accepted standard of care.

70. The prison service policies (Appendix B) indicate that documentation in a clinical emergency response should include all clinical information and actions taken. The Nursing Council of New Zealand (NCNZ) Code of Conduct for Nurses (2012) states that nurses should keep clear and accurate records of any discussions and assessments made (Appendix C). The guidance states that this includes clear and accurate records of assessments. RN A failed to document important details, including a description of the liquid noted on Mr C's face, and did not record a comprehensive physical assessment. In doing so, RN A failed to comply with the prison service's policy for documentation and the NCNZ standard for documentation.

71. I accept that RN A undertook an assessment of Mr C for a neurological/head injury, but I am concerned that without sufficient detail in the documentation I cannot determine the adequacy of the assessment. RN A should have documented a visual assessment of Mr C's face and head, and identified the liquid around his mouth. I am critical that this did not occur.

72. By failing to document a comprehensive assessment for a head injury, and the liquid noted on Mr C's face, RN A failed to comply with the NCNZ standard for documentation, and the prison service policies for clinical documentation. Accordingly, I find that RN A failed to provide services in accordance with professional and other relevant standards, and, as such, breached Right 4(2)[9] of the Code.

Opinion: RN B — breach

73. On 5 May 2019, RN B attended to Mr C on two occasions. On the second occasion, she was responsible for reviewing Mr C's condition and the management plan in place from the previous review. I am critical that there were omissions and inaccuracies in the documentation, as set out below.

Documentation

74. The Nursing Council of New Zealand (NCNZ) Code of Conduct for Nurses (2012) states that nurses should keep clear and accurate records of discussions and assessments made. In addition, nurses should ensure that entries in a patient's clinical records are clearly and legibly signed, dated, and timed (see Appendix C). The prison service's Health Care Policy (Appendix B) also provides the standard for documentation, and requires that documentation is dated, accurate, and relevant.

Impression (provisional diagnosis)

75. RN B reviewed Mr C and noted that he had reported having vomited on two occasions, but this was not sighted. RN B documented that Mr C was alert, responsive, and interactive, but that he appeared to be disoriented to time and date. She recorded her impression of "? gastro bug/reflux", but this was not consistent with the initial impression recorded by RN A of "?concussion, ?neuro deficient, ?chest pain".

76. RN B accepts that the clinical notes do not reflect the change of impression, but said that she consulted with Ms D, and reviewed Mr C before forming an assessment. However, I note that this is not supported by Ms D's account that RN B told her that Mr C was orientated and alert, but not that he was disorientated to time and date.

77. RN Cornor advised that RN B's impression is quite different from the initial impression documented, and, as the reason for this change is not recorded, the impression is difficult for her to understand. RN Cornor considers that the failure to provide any evidence to reflect the change of impression represents a severe departure from accepted standards.

78. I agree with RN Cornor. I would have expected RN B to have documented clearly any discussion with senior staff, and any advice provided. I am concerned that the evidence for RN B's provisional diagnosis is not clear, particularly when it reflects such a change from RN

[9] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

A's initial impression. RN B's failure to record clear reasons for her change in diagnosis make it difficult to assess Mr C's clinical situation.

Other documentation errors

79. RN B accepts that on 5 May 2019, she did not document that she had spoken to the prison officers and asked for a report on Mr C's condition during the time he was under constant supervision, and she cannot recall whether the prison officers reported that Mr C had vomited. However, she said that her usual practice is to ask the prison officers undertaking the observations of a prisoner whether there is anything to report, and to check the record of observations taken. RN B submitted that these events occurred at the end of her shift, and that this may have affected the standard of her documentation.

80. RN Cornor was critical that RN B failed to document her request to the prison officers for a report on Mr C's condition during the hour of "constant observation", and did not clarify whether they had observed Mr C vomiting. RN Cornor advised that this represents a severe departure from accepted practice.

81. While I am open to the possibility that RN B had a discussion with the prison officers about Mr C's condition during the period of observation, I am critical that this discussion was not documented clearly.

82. RN B documented in the clinical notes of 5 May 2019 that she reviewed Mr C at "0930" hours, when it was 9.30pm. In addition, she recorded that Mr C was alert, responsive, and interactive, but that he "appear[ed] to be disoriented to time/date". RN Cornor advised that the documentation should reflect whether Mr C was disorientated or not, and that the term "appears" lacks clarity about Mr C's presentation.

83. At 9.30pm, RN B reviewed Mr C and documented the management plan, but did not document the reason to depart from the plan to transfer Mr C to hospital. RN B told HDC that on review, Mr C's condition had improved, and the decision not to send him to hospital was made in consultation with Ms D via a telephone call at 9.45pm. However, neither the reasons for the change in plan nor the telephone consultation with Ms D were documented in Mr C's clinical records.

84. RN Cornor advised that the improvement in Mr C's health status, and the fact that he could be observed overnight, was a good rationale for not sending Mr C to hospital. However, RN Cornor advised that the failure to document the rationale for the decision to change the plan represents a severe departure from accepted practice.

Conclusion

85. I accept RN Cornor's advice. There were multiple documentation errors by RN B in this case. RN B did not document the evidence for her impression of Mr C's condition, which was a vast change from the initial impression recorded by RN A. Further, RN B documented an incorrect time for her review on 5 May 2019, and did not record clearly whether Mr C was disorientated, or note any discussions had with officers about Mr C's condition, and the reasons for the change in Mr C's management plan. Accordingly, RN B failed to comply with the NCNZ standard for documentation, and the prison service's Health Care Policy for clinical

documentation. Accordingly, I find that RN B failed to provide services in accordance with professional and other relevant standards, and, as such, breached Right 4(2)[10] of the Code.

Assessment 5 May 2019 — adverse comment

86. At 8.05pm on 5 May 2019, RN A performed an initial assessment of Mr C, and noted an abnormality in his eye movement. A mobility assessment was not performed because the wet floor raised safety concerns. RN B was in attendance for this assessment.

87. RN B reviewed Mr C again at 9.30pm in accordance with his management plan, but she did not assess his mobility or review his eye movements.

88. RN B told HDC that she cannot recall whether she reviewed RN A's clinical notes prior to her assessment of Mr C at 9.30pm, and said that there was no access to the Medtech notes in the SU. RN B stated that she may not have been aware that in the previous assessment Mr C's eye movement had been slow and that an assessment of his mobility had not been performed. She said that when she reviewed Mr C she would have completed these assessments if warranted.

89. My independent nursing advisor, RN Cornor, advised that the failure to review Mr C's eye movement and assess his mobility represents a moderate departure from the accepted standard of care.

90. I agree with RN Cornor. It was RN B's responsibility to familiarise herself with the clinical notes from the initial assessment, and I also note that she was present when this assessment was performed. Had RN B reviewed Mr C's clinical notes, she may have noticed that a mobility assessment had not been performed, and that an abnormality in Mr C's eye movement had been identified. This may have prompted RN B to undertake these assessments herself. The second review was an opportunity to complete a full assessment of Mr C's condition, and I am critical that RN B did not complete the necessary assessments.

[10] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

Opinion: Prison service — adverse comment

91. The prison service has a responsibility to operate its health service in a manner that provides consumers with services of an appropriate standard. The standard of health care that is available to prisoners in a prison must be reasonably equivalent to the standard of health care available to the public.[11] In this case, while I have some concerns about the care provided to Mr C, as outlined below, I do not consider that the prison service breached the Code.

Documentation

92. At the time of events, the Health Services Local Operating Manual provided that staff document all clinical information and actions in the patient's electronic clinical record.[12] In addition, the "Health Care Pathway Policy" noted that documentation should be timely, clear, factual, relevant, accurate, and dated.

93. As stated in the "information gathered" section of the report above, there were multiple omissions in the documentation of the assessments of Mr C undertaken by staff on 5 May 2019.

94. I am particularly concerned about the lack of documented decision-making about changes to Mr C's management plan. RN A reviewed Mr C and documented the plan to refer him to hospital for further assessment and treatment. Subsequently, RN B reviewed Mr C and documented that his further care would be managed by the prison, but she did not document the reasons for the change of plan.

95. RN B told HDC that on review, Mr C's condition had improved, and the decision not to send him to hospital was made in consultation with Ms D. However, this discussion was not documented.

96. Ms D told HDC that RN A made the decision not to send Mr C to hospital very soon after RN A's initial assessment of Mr C, but this was not documented.

97. The prison service told HDC that owing to Mr C's rapid improvement and the level of observation available to him in the SU, it was decided that he no longer required hospital review, and that his healthcare needs could be managed in the prison. The prison service emphasised that a decision to transfer to hospital is a carefully considered one, and balanced against the safety risks and health needs of the prisoner. The prison service also told HDC that Mr C received health services that were in line with current policies and procedures.

[11] The Corrections Act 2004, section 75(2) states that "a prisoner is entitled to receive medical treatment that is reasonably necessary" and that the "standard of health care that is available to prisoners in a prison must be reasonably equivalent to the standard of health care available to the public".
[12] Medtech.

98. RN Cornor advised:

> "Treatment of any severe health event in a prison cannot be deferred due to potential safety risks, but as suggested by [the prison service], they must be balanced against the prisoner's health needs. [Mr C's] health event was well assessed. The improvement in his health status within the hour, and the fact that he could be observed overnight is good rationale for not sending [Mr C] to hospital."

99. However, RN Cornor advised that the decision not to transfer to hospital was not recorded adequately by staff. RN Cornor advised that it appears that process was followed in accordance with the prison service's Health Care Policy (Appendix B), but that not all documentation requirements were met.

100. I am critical of the multiple omissions in the documentation, and that staff did not adhere to the documentation requirements of the prison service's policies. Documentation should be accurate and comprehensive to ensure that staff are in possession of all relevant information following handovers. Further, it is important that documentation clearly demonstrates the reasoning for any changes in the management of a patient's condition. In my view, the multiple omissions by staff suggests a culture of poor documentation at the prison.

101. I also note that RN A stated that the prison service provided him with "little training" on the new Medication Management Policy and the Health Care Policy. He said that training was limited in scope to the prison's policy, and that full training on new national policy was not always provided. RN A said that training did not always take place, and that it was not always accessible due to time constraints.

102. Despite these criticisms, I acknowledge RN Cornor's view that the prison service's Health Care Policy is "an excellent example of policy and has extensive information to meet the health teams' needs with the outcome to provide standard of health care that is reasonably equivalent to that available to the general public". RN Cornor stated that the prison service should be commended on its progress.

103. I also acknowledge the substantial changes made by the prison service since these events to improve the training provided to staff, which I consider will improve the standard of documentation completed by staff. I encourage the prison service to continue its work in this area, and ensure that staff have the training and tools necessary for accurate and complete documentation.

Record-keeping

104. On 5 May 2019, RN A requested that officers observe Mr C for symptoms, and report any concerns to Health Services while waiting for transfer to hospital. HDC requested a copy of the record of observations taken by officers, but this was not provided. The prison service told HDC that on 5 May 2019, officers recorded their observations and these were filed, but the records cannot be located.

105. It is the responsibility of the prison service to retain copies of relevant health records and have adequate systems in place to facilitate this. I am concerned that the prison service was unable to locate a copy of the observations filed by officers on 5 May 2019, and consider that this reflects poorly on the prison service's record-keeping systems.

Conclusion

106. I am concerned that there are multiple omissions in the documentation of the care provided to Mr C by different staff on different occasions. I am also concerned that the prison service was unable to locate a copy of the observations filed by the prison officers on 5 May 2019, and consider that this reflects poorly on the prison service's record-keeping systems at the time of events. While in my view these aspects of Mr C's care could have been improved, I note that the prison service has made a number of changes as a result of these events, as set out below. Notwithstanding such changes, I remind the prison service of the importance of accurate, contemporaneous documentation of the clinical care it provides to prisoners.

Other comment — observations by officers

107. On 5 May 2019, officers were given instructions by RN A to observe Mr C for symptoms, including unresponsiveness, headache, and a change in mood and behaviour, and to report to Health Services while Mr C was waiting for transfer to hospital. Subsequently, officers were asked to update RN B on Mr C's condition while he was under observation.

108. I acknowledge RN Cornor's comments that the observation instructions provided to the prison officers were "clear and concise". However, RN Cornor also noted that there is no evidence that RN B queried, or the prison officers reported, what they had observed.

109. Where it is the prison service's practice to require officers to observe, report on, and escalate concerns about a patient's health condition, I encourage the prison service to ensure that officers are provided with adequate guidance about what they are observing, escalation instructions, and appropriate safety-netting advice. It is also important that observation instructions and reports are documented adequately. I have made a recommendation to this effect for the prison service's consideration.

Changes made since events

110. RN A told HDC that he now ensures that his clinical documentation is clear for everyone to read and understand his assessment. He said that he ensures that documentation of his assessment and findings of a head injury includes any trauma, laceration, or any other injury to the patient's head or face.

111. RN B told HDC that she ensures that her documentation is as full as possible, and she is more mindful of including her rationale and thoughts in any documentation.

112. The prison service told HDC that since the time of these events, a new team at the National Office was established to support health services within its facilities, and the current

specialist unit at the prison provides better facilities for the assessment, treatment, and observation of prisoners.

113. The prison service stated that nursing staff at the prison have received training on the Medicines Management Policy and the Health Care Policy, and that these policies include guidance on documentation following assessment. In response to the provisional opinion, the prison service further stated that currently these policies are under review at a national level, and that associated learning modules are also being developed. The prison service stated:

> "These modules will reflect any policy updates and set out best practice. It is expected that all [prison] health services staff will complete these modules, along with a new module on documentation, due for release by the end of December 2022. While most of our nurses have completed training in relation to the Medicines Management Policy and the Health Care Policy previously, delivering these modules will provide a central and up-to-date register of training completed for both new and long-serving staff."

114. Professional supervision has been introduced for all Health Services staff at the prison.

115. A schedule of training on Health Services policies was introduced following the recruitment of a large number of staff in the Health Services team, including training on documentation standards.

Recommendations

116. I recommend that RN A:

a) Provide evidence to HDC of having undertaken training on documentation. This is to be provided within four months of the date of this report.

b) Provide a written apology to Mr C for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr C.

117. I recommend that RN B:

a) Provide evidence to HDC of having undertaken training in assessment on a collapse situation, and documentation. This is to be provided within four months of the date of this report.

b) Provide a written apology to Mr C for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr C.

118. I recommend that the prison service undertake the following, and report back to HDC within nine months of the date of this report:

a) Provide evidence that nursing staff at the prison have received training on the prison service Medicines Management Policy and Health Care Policy, including documentation following an assessment.

b) Provide evidence that nursing staff at the prison have received training on documentation standards.

119. In my provisional opinion I recommended that the prison service consider the guidance and training currently provided to officers in relation to the observation of patients with health conditions, and for it to notify HDC of the outcome of that consideration. In response to my provisional recommendation, the prison service stated it will be reviewing the way in which health-specific information is communicated from health staff to custodial staff, as well as its processes to ensure health staff provide the appropriate level of information to support custodial staff observing patients. The prison service further stated that its Health Quality and Practice team is currently working alongside the team who deliver the custodial officer induction and training programme, and that part of this training will include how to respond to unwell people in prison, escalation pathways, and communication. I look forward to receiving an update on the above actions within nine months of the date of this report.

Follow-up actions

120. 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 it will be advised of RN A's and RN B's name in covering correspondence.

121. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Office of the Ombudsman and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from RN Barb Cornor on 24 March 2020:

> "On 5th May 2019, [Mr C] advises that he was found unconscious inside his prison cell bleeding from his mouth and coughing a substantial amount of blood. He says that a nurse revived him and made recommendations that he be taken to the hospital given the seriousness of his condition. [Mr C] advises that [the prison service] refused to take him to the hospital and that the prison health services manager ignored the nurse's recommendations. He feels staff did not follow procedure in handling his health concerns. [Mr C] was allowed to be seen by a doctor the following day. He is unhappy that it took a life-threatening situation for him to be seen by a doctor following the incident.
>
> **Please advise whether you consider the care provided met accepted standards in all the circumstances and explain your rationale.**
>
> [Mr C] arrived at [the prison] in March 2019. A health assessment was completed which identified current smoking status and provided NRT. The mental health status following Mental Health Screening Tool determined a referral was not required and [Mr C] was triaged as priority 3 in accordance with 'Reception Health Screen Indicators' as part of the 'Health Care Policy': 'non-urgent assessment required within 30 days Low health need — generally well, health literate, confident and able to request access to health services more urgently if required.' 'Clinical indicators, include but not limited to: Low health need identified Non-urgent health conditions, require universal screening or prevention interventions e.g. immunization Minor symptoms of a low risk nature If on medication and seen GP within one-month patient may need to see Medical Officer or nurse practitioner but will require a script confirmed and charted. This is at the discretion of the M.O. Transferred patients on medication and who have not seen a M.O. for six months require booked appointment with MO.' 'Initial Health Assessment to be completed within **30 days. NB** may be seen more urgently at the discretion of the HCM.' A 'Health Request Form' dated 19 March, was received on March 22. [Mr C] stated he had 'MRI scan previously arranged. I was released from prison need to do that MRI scan please as previously planned regarding internal bleeding' and that he had these symptoms '2 years'. An appointment was booked with a nurse for March 27. The physical assessment and patient concerns were completed and documented by a nurse. The plan of care also reflected the patient symptoms and what [Mr C] should look out for: 'report straight away and save sputum showing blood Not to strain when doing motion as it can cause bleeding'. The nurse took bloods for a number of tests and on review of the patient's file read (although no date is documented) 'he was to have an MRI but is no longer required; however booked for gp to review bleeding'. On 1 April, a nurse gave [Mr C] his blood test results. These were discussed and a Cardio-vascular Risk Assessment (CVRA) completed and was revealed as a low risk. The nurse discussed lifestyle factors and the kitchen was advised of a diet recommendation. Due to time constraints an appointment on 10 April was postponed until 17 April. It is documented by a nurse 'care/help refused by patient — Refused to see Doctor' and that [Mr C] had

refused to sign the form acknowledging the refusal of the appointment. 18 April, a Health Request Form was received by a nurse, dated 15 April from [Mr C], requesting reading glasses urgently. Although there is no evidence of previous requests, [Mr C] states he has 'been asking and waiting for over 2 months now'. He was advised by [the prison] health unit there were no glasses available and 'if urgent that he could ask someone from his family to bring him reading glasses'. A fasting blood (morning blood test taken prior to eating) was arranged for 30 April, although it is documented [Mr C] did not know why he was there. He 'verbalised he had been waiting to see a doctor for a month', to which the nurse responded, he had declined to attend his appointment on 17 April. At this, [Mr C] became 'aggressive' and said he would 'make a complaint' and 'everyone who is working in [the prison] health unit are liars'. During this appointment also, the process for a prisoner to request a special diet was advised to [Mr C] by the nurse, following his request for a vegetarian diet. The Health Centre Manager received a complaint on May 2 via the 'complaints advisor'. [Mr C] claimed his refusal to attend the GP appointment on April 17 was untrue and 'he has tried to submit PC01s and health chits but they have not been entered'. The Health Centre Manager replied with a diarised account of health requests and appointments and advised the 'complaints advisor' [Mr C] could access his own medical file to see all 'health chits' are recorded there. Although there is no evidence in his clinical documentation of a process or why, on the 3rd May a 'welfare check' in 'SU' was conducted by a nurse because it was reported [Mr C] 'had TOSH (thoughts of self-harm) but had no intention of harming himself'. He said 'he did not feel safe in [specific] units' and 'could guarantee his safety in another unit but will self-harm if he was placed in previous stated units'. The nurse explained the health staff do 'not have any way to help him with these legal issues' and the patient replied, 'that these issues are affecting his mental health in a negative way'. The nurse's plan 'made officers aware of request not to go back to [the specified units]' and for health staff to 'follow up daily during stay in SU'. 5th May at 2005hrs (8.05pm) a 'Medical Code Blue — SU' was called. [Mr C] was seen by officers on the ground in his cell and not responding. Two nurses arrived and saw [Mr C's] observation window was covered which required them to view him through the 'hatch'. When they entered the cell, they also noted the observation camera to be covered. Custody officers advised the patient had been seen 60 minutes prior. The nursing documentation indicates [Mr C] was lying on his back on the floor and that he was breathing. 'Liquid' was noted on his face and head 'that had come from his mouth' there is no description of this 'liquid' as water, blood or vomitus which is a moderate departure from required standards. The liquid should have been identified as this would add to the assessment and assist to identify the impression of the illness. Also, if any type of physical resuscitation was required, identification of the fluid is important for the resuscitator to be aware of prior to commencement.

Custody staff placed him in the recovery position, his pulse was 'strong and steady' at '88'. After '2 minutes' [Mr C] opened his eyes and asked, 'what is going on'. He was 'helped to sit up and sit on his bed' stating 'he did not remember anything at all' and could give his 'name and DOB but could not remember anything else'. Without knowing how long [Mr C] had been 'unresponsive' prior to nursing staff arriving, two minutes is considered a rapid recovery, unless he had been unresponsive for 60 minutes since last

being seen. This will remain unknown as [Mr C] has no recollection of this episode and there is no evidence from custody due to the cell window and observation camera being covered. There is no evidence of a physical assessment of [Mr C's] head which would determine if there had been any trauma/head injury e.g. lacerations, bruising or swelling to face or scalp. This is a severe departure from accepted practice particularly when the assessment is to determine how the patient became 'unresponsive' and to make a differential diagnosis between head injury or neurological event. A full and comprehensive assessment was completed by the nurse in accordance with a collapsed unresponsive person, without a suspected head injury and is well documented.

'**Neuro' (neurological) assessment** was well documented 'once awake the pt was both mentally and physically alert and responsive'. The one abnormality noted was 'Extraoccular movement — slow to follow writer's finger during the assessment'. The extraocular muscles are the six muscles that control movement of the eye and one muscle that controls eyelid elevation. The action of the six muscles for eye movement depend on the position of the eye at the time of muscle contraction. Limited eye movement may be a factor that negatively affects functional recovery after a mild head injury. 'Pupils were equal and reactive to light (PEARL)'. When a patient's eyes are examined a torch is shone in their eyes. Their pupils should react to the light by shrinking. If they don't react or react unequally there is likely to be a problem causing the brain to not function correctly. There was no headache, dizziness or weakness described by [Mr C]. These symptoms may be indicative of brain trauma. This reviewer queries the cause of the 'wet floor', but due to this, [Mr C's] gait, romber and pronator drift were unable to be reviewed. This would require having him stand and walk across the cell to assess all limbs were functioning and his balance was normal. The wet floor would have provided a safety issue should [Mr C] have attempted to walk on it.

Respiratory assessment documents no sign of chest deformities and apart from a wheeze in both upper lung fields no further abnormal breath sounds were heard. Respiratory rate was 18 which is within normal limits. Often in situations of stress and/or respiratory or brain injuries, respiratory rates increase significantly. Oxygen saturation was 98% and within normal limits indicating effective breathing and oxygen being supplied to the peripherals (outer limbs, fingers and toes) and brain.

Cardiac assessment documents 'patient stated that he was having chest pain and attempted to guard the lower part of the left chest area. However Pt would then move his hands from the chest area and not complained of any pain'. Chest pain described by a person having a cardiac event is not a pain that would normally be guarded on examination. Cardiac pain would be described as pressure, fullness, burning, crushing or tightness in the chest and may radiate down the arm, up the neck, jaw or shoulders. [Mr C] did not describe any further chest pain. He had good radial (wrist) and pedal (feet) pulses and although his feet were 'slightly cold' his hands were warm to touch. All this reflects good peripheral blood flow. Signs of severe shock result in reduced or no peripheral pulses due to the blood supply being prioritised to the brain and other major internal organs. Normal heart sounds were heard, and his pulse was documented at 67 which is slow but within normal limits. Again, during signs of distress or injury the

pulse rate will rise significantly. Although his blood pressure was slightly above normal limits it is not of concern considering the unknown circumstances of [Mr C's] 'collapse' and associated distress, of which this is an indication. The impression (provisional diagnosis) was documented as '?concussion, ?neuro deficient, ?chest pain'. The circumstances of the collapse and the following assessment make it difficult to form an impression and the reviewer considers ?neuro deficient is appropriate. [Mr C] had chest pain, so this is not a query and that chest pain was not ongoing. As there is no physical evidence documented of a head injury it is difficult for the reviewer to determine the appropriateness of ?concussion. It is acceptable for the nurse to have documented 'collapse ?cause'. The documented plan was to refer to hospital for further assessment and treatment, place the patient on constant observations until transfer and book for a GP clinical review. A clear and concise 'Advice of Prisoner Health Status Form' was provided to custody to advise 'what to look for' with [Mr C] 'until he is taken to the public hospital for further review and treatment'. These were for constant observations and report if he 'becomes unresponsive again, complaining of ongoing headaches, change in mood and behaviour'. At '0930hrs' (this reviewer presumes this as 9.30pm and should have been documented as 2130hrs) the patient was followed up 'medical code — SU'. NZNO documentation guidelines state all documentation 'should be accurately dated, timed and signed'. [Mr C] reported he felt sick and had 'vomited twice since being moved', he had a 'splitting headache' and no chest pain. A severe departure from accepted practice is that there is no evidence the nurse asked, nor that the custody officers reported on his condition and/or progress during the hour of 'constant observation', particularly, had they observed the vomiting as [Mr C] described. [Mr C] was 'cooperative, alert, responsive and interactive', although 'appears to be disorientated to time/date'. 'Appears' does not describe whether [Mr C] was or was not disorientated to time/date. Documentation should reflect he is either disorientated or not. There are days when this reviewer doesn't remember the date or time and is not disorientated or appearing to be. Observations recorded at the second assessment remain stable and within normal limits. A second full body assessment has not been completed and as the first didn't identify any major abnormalities this does not depart from accepted practice, although a moderate departure of accepted practice is that there was no review of the abnormality, extraocular eye movement or a mobility assessment which was not done due to a 'wet floor' in the first assessment. The nurse gave the impression of 'query gastro bug/reflux' following the second assessment. Two vomits (not sighted) but reported by [Mr C] and nausea can also relate to a head injury but the previous impression has been withdrawn. 'Gastro bug/reflex' is quite a variation from the original impression of '?concussion, ?neuro deficient, ?chest pain' and as there has been no reason for the change of impression, it is difficult for this reviewer to understand. Although not included in the nurse's documentation, this reviewer has noted an ACC form was completed on May 5th with the 'Diagnosis' of 'Concussion'. It is difficult to determine who has completed this form. The nurse documenter provides no evidence to reflect the change of impression for a possible cause of the collapse which is a severe departure of accepted practice. Also, there is a severe departure from accepted documentation made by the documenting nurse who has not included the reason the change of plan was made.

NZNO Guideline: Documentation, 2017, states — 'Documenting all relevant information ensures others know what you observed and what nursing interventions you took. Documentation must show evidence of clinical judgement and escalation/referral as appropriate and documenting evaluation of the care provided.' 'Documentation should also include care that could not be given and the reason why, so that it does not get overlooked.' 'Health professionals are advised to document steps/care intentionally not taken and the rationale for the decision'. The nurse followed up on the patient status with a phone call to the Health Care Manager at 2145hrs. This reviewer presumes the Health Care Manager was supporting the nurse in the progress and decision making. If so, this is to be commended. The following morning during a mental health check [Mr C] said he was not in any distress and offered information about the 'collapse' he had had the previous night. He was seen by a General Practitioner, 6th May. [Mr C] discussed his health episode of the previous night and stated he had 'blood coming down the sides of his mouth' and also, he has 'shown officers and nurses his blood stained vomitus and phlegm at various times but apparently not taken seriously'. The plan of care on 'admission' to [the prison] in March 2019 acknowledged [Mr C's] symptoms and what [Mr C] should look out for. He was to 'report straight away and save sputum showing blood and not to strain when doing motion as it can cause bleeding'. Although [Mr C] states he has shown officers and nurses there has been no documentation of this by health staff. This discrepancy makes it impossible for any conclusions to be determined. On reviewing [Mr C's] previous health history, the GP reported this problem as being investigated since 2017 and that [Mr C] had not attended an MRI booked in March 2018. A previous biopsy of [Mr C's] tonsils had shown no abnormalities. The GP's observations were documented and within normal limits. The GP's plan was for a chest x-ray to be done and a possible follow up with Ear, Nose and Throat consultant and then the possibility of an MRI. This would be normal practice within any General Practice throughout New Zealand. The GP reports via [the prison service] he was 'unable to identify any specific cause for [Mr C's] reported unexplained loss of consciousness' nor was he able 'to identify any precipitating or predisposing factors.'

The reviewer concludes — It did not take a 'life-threatening event' for [Mr C] to be seen by a doctor. He had refused a previous appointment with the doctor. It is noted he had had previous health assessments as documented by nurses and his 'request for health care forms' had all been acknowledged in accordance with policy. It is documented in [Mr C's] plan of care on arrival at [the prison] he was requested by clinical staff to report any blood in his sputum. Although [Mr C] states he did not know that and that he had reported to officers and nurses, there is no evidence of this. Observations immediately following the collapse were completed and a treatment plan (to transfer to hospital) was implemented. [Mr C's] observations were continued by custody for an hour. Although [Mr C] stated he had vomited, there is no evidence provided by the custody or health staff. [Mr C] was seen and a nursing assessment reflected good recovery an hour following his collapse. There is no rationale documented for the decision to change the treatment plan, nor for the change of impression for a possible diagnosis. A further plan was implemented for [Mr C] to be continued on 15-minute observations overnight by custody staff. The custodial team had clear written instructions as per policy of what

they were to observe. A GP appointment was made for the following morning as a 'must see'. [Mr C] was 'happy with the discussion' of the plan. As part of his care plan he was advised to keep his fluid intake up and rest, to notify staff of any worsening symptoms and to save his vomit for health staff to observe. The progress and process of health care for [Mr C] in [the prison] has been what the reviewer would expect of any person in the health arena. Unfortunately, there has not been full compliance by the patient throughout his health journey. The conclusions made following [Mr C's] collapse provide good rationale by the reviewer for not transferring [Mr C] to hospital. Unfortunately, these are not reflected in the nurse documentation, as the reason for the changed treatment plan. Treatment of any severe health event in a prison cannot be deferred due to potential safety risks, but as suggested by [the prison service], they must be balanced against the prisoner's health needs. [Mr C's] health event was well assessed. The improvement in his health status within the hour, and the fact that he could be observed overnight is good rationale for not sending [Mr C] to hospital. [The prison service's] 'Health Care Policy' is an excellent example of policy and has extensive information to meet the health teams' needs with the outcome to provide standard of health care that is reasonably equivalent to that available to the general public. [The prison service] should be commended on their progress. Recommendations for improvement would only be around documentation. The reviewer understands the extra work stress created in a 'collapse' situation that occurs out of a health facility where required resources are not immediately at hand. It appears to the reviewer, process has been followed according to policy, but not all documentation requirements are met. This is often caused by the busyness created by the event and the time management of completing everything to policy. The immediate assessment of [Mr C] is documented fairly well, although as previously stated, no visual assessment of face and head are included. The provision of documented rationale for change is a must for future documentation. 'If it's not documented, it's not done'.

Barb Cornor "

RN Cornor provided the following further advice:

"You requested expert advice following my review of the x10 documents you enclosed, and for me to advise whether this amends my initial conclusions and advice. All documents included have been read and reviewed.

Background

On 5th May 2019, [Mr C] advises that he was found unconscious inside his prison cell bleeding from his mouth and coughing a substantial amount of blood. He says that a nurse revived him and made recommendations that he be taken to the hospital given the seriousness of his condition. [Mr C] advises that [the prison service] refused to take him to the hospital and that [the] health services manager ignored the nurse's recommendations. He feels staff did not follow procedure in handling his health concerns. [Mr C] was allowed to be seen by a doctor the following day. He is unhappy that it took a life-threatening situation (his perception) for him to be seen by a doctor following the incident.

As the reviewer I concluded —

- It did not take a 'life-threatening event' for [Mr C] to be seen by a doctor. He had refused a previous appointment with the doctor. It is noted he had had previous health assessments as documented by nurses and his 'request for health care forms' had all been acknowledged in accordance with policy.
- It is documented in [Mr C's] plan of care on arrival at [the prison] he was requested by clinical staff to report any blood in his sputum. Although [Mr C] states he did not know that and that he had reported to officers and nurses, there is no evidence of this.
- Observations immediately following the collapse were completed and a treatment plan (to transfer to hospital) was implemented.
- [Mr C's] observations were continued by custody for an hour. Although [Mr C] stated he had vomited, there is no evidence provided by the custody or health staff.
- [Mr C] was seen, and a nursing assessment reflected good recovery an hour following his collapse.
- There is no rationale documented for the decision to change the treatment plan, nor for the change of impression for a possible diagnosis.
- A further plan was implemented for [Mr C] to be continued on 15-minute observations overnight by custody staff.
- The custodial team had clear written instructions as per policy of what they were to observe.
- A GP appointment was made for the following morning as a 'must see'.
- [Mr C] was 'happy with the discussion' of the plan.
- As part of his care plan, he was advised to keep his fluid intake up and rest, to notify staff of any worsening symptoms and to save any vomit for health staff to check.

The recommendations for improvement I made was around the lack of documentation particularly around the 'collapse' situation. The two staff involved have provided some information (Documents 3 and 4) but are not clear on remembering the event. All processes have been followed in accordance with the health policies provided, but not all documentation requirements are met. In fact, I commended [the prison service's] 'Health Care Policy' as an excellent example of policy and its extensive information which met the health teams' needs and to provide a standard of health care that is reasonably equivalent to that available to the general population.

Review of further information:

[The prison service] advises [the prison] Health Centre Manager has reported there is training occurring for approximately 15 to 30 minutes, two to three times a week and includes documentation standards which will be aided by the use of case studies to support learning. Further to this, [the prison] Health Centre Manager has introduced Professional Supervision that is being attended by all [Health Services staff at the prison]. This focuses on the use of case studies to improve nursing proficiency across a range of clinical subjects with an emphasis on documentation included. Nurses are

supported through ongoing education and training to aid in the delivery of best practice health services at [the prison]. This should improve documentation and have all staff aware of their requirements although one RN stated 'this style of training does not always work well due to time [constraints] and training is not taking place' when the health unit is busy.

Emergency Response 2.5 Policy determines the health staff's responsibility in responding to emergency calls and is read in conjunction with the Clinical Emergency Policies & Procedures found in the Health Services Manual on Cornett.

The policy states:

- 'Health Services staff to take control of the health management of the prisoner after the prison officers secure the scene.
  - Take appropriate baseline observations
  - Take appropriate serial observations. Note time taken and record observations for further reference.
  - Apply clinically appropriate interventions using current best practice guidelines.
  - Facilitate and/or implement any on-going clinical interventions the prisoner may require.
  - Document all clinical information and actions in the prisoner's electronic clinical file. You may also document any clinical interventions on the Emergency Health Care Clinical Record (ECR) in the Outbox tab in Medtech and if away from the Health Unit — use the handover form inside the emergency bag and transfer information to the ECR in outbox at the earliest convenience.
  - Each health staff member will document in Medtech what their part of the response was'.

The requirements of this policy cannot be determined to have been met because there is no documentation provided. As my previous review says, the immediate assessment of [Mr C] is documented fairly well, although, no visual assessment of face and head are included. The reason for the rationale for changing the care plan is also not included and is a must for future documentation because 'If it's not documented, it's not done'.

The HCM at [the prison] has reviewed [Mr C's] medical notes. She notes he was seen, during a previous period of imprisonment, on 26 January 2019. During this assessment with a nurse regarding coughing up blood, he was asked to save the sample and show the nurse. There is no documentation to reflect that this had happened, and he was subsequently released. When [Mr C] was seen by the nurse on 27 March 2019, he was again asked to save any samples to show the nurse and he was booked for further review by a doctor which he subsequently declined to attend (17 April 2019). There is no documentation to evidence that [Mr C] presented health staff with a sample of his blood-stained vomitus or phlegm and no staff currently employed have any recollection of him presenting to them with a sample.

Since the time of [Mr C's] complaint, a new team at [the] National Office has been established to support health services within [the prison service's] facilities.

Gaps in processes identified at the time of the first review have now been rectified and audits following this implementation provide evidence monthly that this is happening e.g., [the prison] health cancellation is one of those. As with any audit, trends are identified and provide areas for change and improvement.

Minimal standards of the RNs' documentation and the inability of those two Registered Nurses to remember the event clearly does not change my findings, nor recommendations from my first review. Both nurses have agreed with my review and recommendations and have undertaken training to improve their standards of documentation. [The prison] [has] also provided training and Professional Supervision to improve all nursing standards and in particular documentation.

One RN states, 'I should have documented the fluid more clearly so that anyone that was to read my clinical notes later would be able to understand the type of fluid that I had seen during the event' and 'did not completely describe the head assessment that I had completed'. It is also stated, 'I had written 'Nil head injury noted at the time of the consultation' which is a minimal requirement of a neurological/head injury assessment.

[Mr C] reports he was bleeding, that 'there was blood all over the floor and his shirt'. Unfortunately, the only document I have seen to state there was any blood, was that from an officer's incident report stating blood was dripping from [Mr C's] nose.

[Mr C] was seen the following morning by a nurse with 'no report of further symptoms'. It is reassuring to read his condition was much improved.

Summary:

[RN A]

[RN A's] response admits his documentation was not up to standard, particularly around his physical assessment. [RN A] recognises how he should have documented by providing a statement on what he would report in the future. 'Pt does not appear to have any trauma, lactation or any other injuries to the head/face.' This does not change my initial advice. [RN A] does not record a neurological assessment to determine [Mr C's] level of consciousness.

[RN B]

Does not have a clear recollection of what occurred and accepts that he/she did not document in the notes that he/she had spoken to the custody officer for a report on [Mr C's] condition. She states 'I can confirm that it was always my practice to ask the custody officer present who was undertaking the observations whether there was anything to report'.

He/she states '[RN A] had requested that he be under constant observation and to check for whether he had become unresponsive, was complaining of ongoing headaches, change in mood and behaviour'. [RN A] has not documented this.

[RN B] describes 'usual practice' but couldn't remember the 'CO reporting [Mr C] vomiting'. [Mr C] reported he had vomited x2 and [RN B] had recorded that in his progress notes. That [RN B] documented that, provides legitimate evidence of the vomiting.

The review of the further documents provided to me by the Health & Disability Commissioner does not change my original findings or offer any further recommendations from my first review. The statement provided which suggests 'usual practice' cannot be used in evidence. 'If it's not documented, it's not done'.

I have reviewed the further information and am happy the recommendations I made in the original review were accepted and changes implemented. [Mr C] can be assured, as the reviewer, I have not taken sides, nor pulled the wool over anybody's eyes to cover up for the staff. This is an unbiased report.

Barb Cornor."

Appendix B: Prison Service Policies

The Health Services Local Operating Manual states:

"2.5 Emergency Response

…

- Health Services staff to take control of the health management of the prisoner after the prison officers secure the scene.
- Take appropriate baseline observations
- Take appropriate serial observations. Note time taken and record observations for further reference.
- Apply clinically appropriate interventions using current best practice guidelines.
- Facilitate and/or implement any on-going clinical interventions the prisoner may require.

…

Document all clinical information and actions in the prisoner's electronic clinical file.

- You may also document any clinical interventions on the Emergency Health Care Clinical Record (ECR) in the Outbox tab in Medtech and if away from the Health Unit — use the handover form inside the emergency bag and transfer information to the ECR in outbox at the earliest convenience."

The "Health Care Policy" states:

"23. Clinical emergency management

Clinical emergency

23.1 A serious or life threatening health event involving any person on site at a prison, and which requires an emergency response and treatment from Health Services staff.

…

Clinical emergency management policy

…

23.5 Health staff will attend and respond to a clinical emergency once custodial staff have established the safety of the scene.

…

23.10 Registered nurses, nurse practitioners and medical officers will follow the best practice guidelines in health pathways for assessment and treatment when responding to clinical emergencies

…

23.17 The registered nurse, nurse practitioner and/or medical officer are responsible for documenting the care and treatment provided during the clinical emergency in the daily record in the patient's electronic health record. Medicines administered during the emergency must be documented in the patient's medicines administration record.

23.18 The registered nurse is responsible for completing an Advice of Prisoner Health Status Form and/or an alert in IOMS to advise custody staff of any health implications from a clinical emergency.

…

23.22 Following a clinical emergency the registered nurse(s) on site will record any equipment or medicines issued and will advise the HCM as part of the review of the clinical incident.

…

Clinical emergency training policy

23.27 Health Services staff will receive training to prepare them to respond to clinical emergencies.

…

27 Clinical documentation

Standard

27.1 Documentation of health care in [the prison service] meets professional and legal standards.

…

27.9 Electronic documentation will meet the standard when it:

- is timely — this means any episode of care will be documented at the time the care is provided
- is clear, concise and free of jargon
- is factual, relevant, accurate and current
- is dated (day/month/year), and with the time recorded using 24 hr clock
- clearly identifies the health practitioner who is recording the information
- uses only approved abbreviations and symbols.

Training Module — Clinical Documentation

27.17 Newly employed nurses and Health Care Assistants will complete a documentation standards training module as part of their orientation programme.

27.18 Once completed the training module must be signed HCM or their delegate (usually the preceptor or team leader).

27.19 A record of the completed and signed training module will be kept in the employee's personnel file held by the Health Centre Manager."

Appendix C: Relevant standards

The Nursing Council of New Zealand publication *Code of Conduct for Nurses* (June 2012) states:

"Principle 4

Maintain health consumer trust by providing safe and competent care

Standards

…

4.8 Keep clear and accurate records (see Guidance: Documentation)

…

Guidance: Documentation

- Keep clear and accurate records of the discussions you have, the assessments you make, the care and medicines you give, and how effective these have been.
- Complete records as soon as possible after an event has occurred.
- Do not tamper with original records in any way.
- Ensure any entries you make in health consumers' records are clearly and legibly signed, dated and timed.
- Ensure any entries you make in health consumers' electronic records are clearly attributable to you.
- Ensure all records are kept securely."