Psychiatric Nurse

Public Hospital

A Report by the

Health and Disability Commissioner

Case 02HDC08692

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Dr A	Complainant / Forensic Psychiatrist
Ms B/Staff Nurse B	Provider / Registered Nurse
Ms C	Clinical Director, Nursing, Public Hospital
Mr D	Consumer
Mr E	Chief Executive Officer, Public Hospital
Ms K/Staff Nurse K	Registered Psychiatric Nurse, Public Hospital
Mr L/Staff Nurse L	Registered Psychiatric Nurse, Public Hospital

Independent expert advice was obtained from Peter O'Kane, registered comprehensive nurse.

Complaint

On 1 October 1997 the Commissioner received a complaint about Ms B, forwarded by the Nursing Council of New Zealand. The complainant, Dr A, is a Forensic Psychiatrist and was Acting Director of Area Mental Health Services at the time of these events.

The complaint is that, during the night of 13 to 14 December 1996, while Mr D was in a locked seclusion room, Ms B did not:

- *enter Mr D's room at any time to undertake regular monitoring of Mr D as instructed by medical staff;*
- *observe and report Mr D's deteriorating condition to medical staff.*

An investigation was commenced on 6 November 1997. On 9 May 2001 the Commissioner decided to take no further action on the complaint pending the outcome of the Coroner's inquest. There were extensive delays in completing the inquest, and the Coroner's Findings were not issued until 18 March 2002.

The Commissioner received a request from Dr A to re-open the file on 15 April 2002. On 9 May 2002, the Commissioner advised the parties of his inclination to re-open the file. After careful consideration of responses from Ms B and the Public Hospital, the file was re-opened on 1 July 2002.

Information reviewed

- Complaint letter from Dr A, dated 18 August 1997
- Further correspondence from Dr A
- Response of Ms B dated 19 December 1997
- Response of the Public Hospital dated 4 December 1997
- Medical records relating to Mr D's care, obtained from the Public Hospital
- Internal review of events dated 30 December 1996 carried out by the Assistant Clinical Director of Nursing
- Internal review of events dated 10 January 1997 carried out by Dr H, Psychiatrist
- Recommendations regarding nursing and clinical practices at the Public Hospital's Psychiatric Unit, prepared by Ms C, Clinical Director Nursing
- Coroner's Findings at the Inquest into the death of Mr D, including the appended Report of the Psychiatric Assessor
- Transcripts of evidence heard at inquest (held at Wellington Coronial Office)
- Request to reopen from Dr A, dated 8 April 2002
- Response of the Public Hospital to Dr A's request to re-open, dated 31 May 2002
- Response of Ms B to Dr A's request to reopen, dated 12 June 2002
- Response of the Public Hospital, dated 23 July 2002
- Response of Ms B, dated 25 July 2002
- Medsafe Datasheet on Clopixol
- File note of discussion with Dr David Galletly, Chair of the New Zealand Resuscitation Council, dated 23 September 2002

Information gathered during investigation

Past psychiatric history
Mr D was a 41-year-old man with a mild intellectual handicap, and no significant medical problems. He had a 20-year history of work in the community. Mr D had intermittent contact with the Public Hospital's Psychiatric Unit between 1993 and 1996 with feelings of depression and auditory hallucinations. His episodes of mental illness were brief, and he responded well to moderate doses of oral antipsychotic medication.

Towards the end of 1996 Mr D decided to stop his medication, and his mental state gradually deteriorated. On 7 December 1996, Mr D was seen at the Psychiatric Unit, distressed because he did not have a job. Soon after, he gained part-time employment as a department store Santa for the Christmas season.

11 December 1996
In the early hours of 11 December 1996, Mr D was compulsorily admitted to the Psychiatric Unit under section 11 of the Mental Health (Compulsory Assessment and Treatment) Act 1992, having made a number of phone calls to the police. He presented dressed in pyjamas,

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

holding a large white teddy bear. He had a grandiose delusion that he was Father Christmas, and stated that he was "destined to save all the children of the world". He was irritable, displayed pressure of speech and a labile mood (fluctuating from crying to laughing) and his behaviour was inappropriate.

The admitting psychiatrist assessed Mr D as being hypomanic, and asked for him to be placed in seclusion for destimulation. The seclusion room that Mr D was placed in had an adjoining soft area. At the time of Mr D's admission, there was no means for a patient to call for the attention of nursing staff from the seclusion room.

The responsible clinician assessed Mr D during the day, and made a diagnosis of schizoaffective disorder. He was prescribed thiothixine, an oral antipsychotic. (The thiothixine was stopped the next day.) A house officer physically examined Mr D around noon. He ordered an electrocardiogram, and requested four-hourly checks of pulse and blood pressure. No ECG was ever performed, as an ECG machine was not available on the ward, and Mr D was not fit to travel to the ECG machine. Mr D's blood pressure was noted to be 200/110 during the day, but had dropped to 170/110 by 8pm.

Mr D spent much of the day singing and pacing the soft area adjoining the seclusion room. His mother visited him at 9.00pm, and he went to sleep soon after this visit. The nursing notes state that, during the night, he slept intermittently and had bizarre conversations.

12 December 1996

The nursing notes state that Mr D continued to be elevated in mood and inappropriate in behaviour on 12 December 1996. Nursing staff attempted to reintegrate Mr D into the ward at breakfast time, but this was unsuccessful and Mr D was returned to seclusion at 8.30am. His behaviour at this time included removing his clothes and charging at the exit door. The notes state:

> "Returned to seclusion in soft area for his own safety as in danger of being hit by fellow patients due to inappropriate behaviour / comments."

Following this incident, a decision was made to administer 100mg of zuclopenthixol acetate acuphase (Clopixol Acuphase), and this was given at 11.30am. Zuclopenthixol acuphase is an antipsychotic medication with sedative effects. It has significant side effects, including marked drowsiness, and should always be used with caution. Zuclopenthixol acuphase was a new drug for the staff at the Psychiatric Unit, having first been introduced one month prior to Mr D's death.

The Medsafe Datasheet for zuclopenthixol acuphase states:

> "Severe adverse reactions requiring immediate medical attention may occur and are difficult to predict. Therefore, the evaluation of tolerance and response, and establishment of adequate maintenance therapy require careful stabilisation of each patient under continuous, close medical observation and supervision."

In the late afternoon, a second attempt to take Mr D out of seclusion was not successful due to his inappropriate behaviour.

At 5.00pm the house officer reviewed Mr D again, and requested four-hourly blood pressures and pulse recordings to continue. The doctors' orders state "check BP 4 hourly", while the nursing notes state that blood pressure was only to be checked four hourly until stable. There appears to have been some miscommunication between the house officer and nursing staff on this point. Mr D's blood pressure was taken three times during the day with readings between 170/100 and 180/110. He was given a single dose of bendrofluazide, a blood pressure medication, at 6.40pm.

By 6.45pm Mr D appeared subdued with no bizarre speech. Mr D slept soundly from 10.15pm onwards, apart from one trip to the toilet at 3.45am.

13 December

Dr I saw Mr D at 8.20am on 13 December 1996, and found him to be snoring loudly and sleeping soundly. Mr D remained in seclusion and slept almost the whole day, with a brief period awake for breakfast. At one point he was seen clapping and sitting on his bed. Nursing notes record that he was "too drowsy for lunch".

Mr D was given benztropine 2mg at 9.45am and 7.00pm for side effects (including excessive salivation) of the zuclopenthixol acuphase given the day before. Mr D's blood pressure was recorded as being 120/64 at 10am and 110/64 in the afternoon, with an irregular pulse.

Ms K nursed Mr D on the afternoon shift. She recorded that Mr D was "asleep and snoring loudly at each nursing check". He was unable to be transported to the ECG machine because he was too sedated. At 6pm, Ms K noted: "Difficult to waken for evening meal, once mobile Mr D did not open eyes." Because of her concern about Mr D's poor oral intake and level of sedation, Ms K entered the seclusion room hourly to assess Mr D's condition, in addition to the required fifteen-minute observations. At 8pm, Ms K noted: "Unable to wake for fluids, BP taken satis (satisfactory), needing full assistance to attend to ADLs (activities of daily living), as very sedated. Frequent turns as breathing quite strained when laying flat, resps regular, nursed under seclusion order."

At the inquest, Ms K recalled the afternoon of 13 December 1996 as follows:

> "I monitored him during the shift and from the records of the previous shifts I could see that he was still showing side effects of sedation from the Clopixol. As part of my care of Mr D he was checked every 15 minutes as required. I also turned him regularly at least hourly. I also remember another access period where he was physically toileted by myself and others. He didn't drink much either and he was accessed for this as well. From my notes I've documented my concerns about Mr D breathing difficulties. I didn't feel that this required medical intervention just close and constant nursing attention like I'd given throughout my shift … By turning the client I mean the physical turning over or around of the person's whole body. Mr D was a big

man and if he was turned from his side to his back I could manage alone. However, from his back to his side required two people."

At the inquest, Ms K was also cross-examined by the psychiatric assessor:

"Psychiatric assessor:	In reply to one of the previous questions you said that on your shift of the 13th you couldn't accurately assess Mr D through the window
Ms K:	Yes
Psychiatric assessor:	Why was that?
Ms K:	In terms of assessing, he was a big man and I couldn't even with the lights on, I couldn't see whether his chest was rising and falling, that was my observation."

At 11pm Ms K handed over Mr D's nursing care to Ms B. Ms K's written summary for Mr D for the period 16:00 to midnight stated: "Food/fluid intake: Sedative effects inhibit food intake. Urine/bowel output/personal care and hygiene: Requires assistance with same. Care/interventions other than seclusion: Full nursing cares required. Concerns now: Full nursing cares required." At the inquest, Ms K acknowledged that she had been satisfied with Mr D's blood pressure.

At the inquest, Ms K stated: "I recall that I verbally expressed the concerns that I'd written in my notes to the night shift nurse Ms B … I have no doubt that Ms B was fully aware of the concerns I had regarding Mr D's condition."

Ms B, in her response of 25 July 2002, submitted that she found nothing in the notes which suggested to her that it was necessary that Mr D be physically accessed for care.

Night of 13/14 December

In an interview with the Assistant Clinical Director of Nursing of the Hospital, Ms B stated she came on duty at 10.45pm and was told in the verbal handover by Ms K that Mr D was "In seclusion this duty, watch his breathing, he is snoring. He is turning on his side with the assistance of staff, do 15 min obs."

Ms B believed that she could adequately monitor Mr D's physical condition without entering the room, and she restricted her nursing care to observation through the seclusion room window. She did not attempt to enter Mr D's room at all, although she was aware that other people were available to assist her if this was needed.

The seclusion form specifically required documentation of the patient's position if asleep. On earlier night shifts, other nurses had written comments such as "asleep R side" "asleep snoring" "asleep on back" "appears to be stirring" and so on. In contrast, Ms B's 15-minute observations are restricted to a single word "asleep" repeated over and over. The box

"colour/breathing checked" was ticked at every observation. Her hourly summaries state only "appeared asleep". The writing on the seclusion form is remarkably uniform, suggesting that multiple entries may have been completed at once. Ms B's nursing notes for the shift recorded: "… nursed in seclusion on 15/60 obs. Appeared to sleep on all rounds. Breathing has been satisfactory."

Ms B did not document any attempts to rouse Mr D, or any change in his position. Ms B advised "… the patient had had little sleep and considering his mental state and that he was in no way in distress, I made the decision to let him rest and not attempt to enter the room".

From 8.00pm on 13 December 1996 to 8.30am on 14 December no vital signs were checked. Ms B stated that she did not do any blood pressure readings because the notes stated that four-hourly blood pressures only needed to be done until stable, and she considered that the readings had been stable.

The Assistant Clinical Director made the following record of her interview with Ms B on 24 December 1996: "as there were no concerns she did not go into the room all night. All observations were done through the window. Ms B could hear Mr D breathing and these were deep and regular and stated that Mr D was stirring and rolling over. Handover was given to the AM staff at 0700 hours. As best as Ms B could recall the report was: 'there were concerns regarding Mr D's breathing and he was checked throughout the night through the window. Generally a settled night. [Another patient] was unsettled early in the night but had settled by 2400 hours. Mr D was settled and sleeping all night.'"

In her response to the Commissioner on 19 December 1997, Ms B made the following statement:

> "During my 15 minute observations I at several times turned on the light to the seclusion room, this is standard practice for me to do to get a better look at the patient. During these times I disturbed the patients sleep by accident. I spoke to him and encouraged him to lie back down and get some sleep."

At the inquest Ms B stated:

> "I do recall that on three occasions I saw Mr D react by sitting up when I switched on the light to his room, I switched the light on and off because I didn't need for him to wake fully but it was a check. His night light in the room wasn't on, the other checks I made with a torch. I also recall Mr D was snoring."

The following cross-examination took place during the inquest:

> "Ms B: I turned on the light a number of times into Mr D's room as I also did into the other gentleman's room. I generally just do that and I noted he woke up on those occasions and he rolled over but in regard to the breathing I could see his chest rising and falling, the blanket moving up and down that was on top of him.

Counsel: You appreciate your evidence in that regard differs from Ms K who was saying that she couldn't see breathing through the window, she wasn't able to observe it?

Ms B: Yes I do …

Counsel: Is it the position that if you were not able to get sufficient information for the quarter hourly checks by observing through the window, you would feel it necessary to access the room?

Ms B: Yes I may.

Counsel: Do I therefore assume that throughout the shift you were able to have sufficient information by observing though the window, not to enter for that reason?

Ms B: Yes …

Psychiatric Assessor: You state in your evidence that you observed him moving throughout the night, can you explain why you didn't document that in either your quarter hourly or hourly observations overnight in seclusion?

Ms B: No I can't I'm sorry."

Morning of 14 December

Mr L was the registered nurse on duty the morning of 14 December 1996. In an interview on 21 December 1996, he reported that Ms B stated in the nursing handover that Mr D had "slept well and hasn't moved all night".

At 8am, a fourth period of seclusion was authorised, on the grounds that Mr D "requires destimulation, in danger of abuse from fellow patients".

At 8am and 8.15am Mr D was seen lying on his left side and appeared asleep. At the inquest, Mr L stated that he believed he could see that Mr D was breathing from the seclusion room window, but could not assess Mr D's colour as he was covered by a blanket and was six to eight feet from the door. At 8.40am, a nurse entered the seclusion room to give Mr D his breakfast. Mr D was found to be lying on his left side with no blood pressure or pulse. His skin was cyanosed [blue] and clammy to touch. Mr L noted a "groan" response to a painful stimulus. (Pressure to the sternum, a classic painful stimulus, can elicit a groan-like sound in a deceased person as air is forced out of the lungs.)

Staff initiated cardiopulmonary resuscitation, and called the Crisis Resuscitation Team, who took some 10 minutes to reach the scene. The Team attempted to resuscitate Mr D with defibrillation and adrenaline. Their efforts were unsuccessful and he was pronounced dead at 9am on 14 December 1996.

Post mortem examination

The Pathologist carried out a portmortem examination on Mr D's body. He found:

> "The sequence of events, in my opinion, were the onset of circulatory collapse and hypoxia due to the acute onset of congestive heart failure, aggravated by the usual mild hypotensive and sedative effects of the normal dose of Clopixol. This was exacerbated by the gradual onset of hypostasis and early pneumonia, with an increasing degree of hypoxia, leading finally to circulatory collapse and cardiovascular failure.
>
> **Cause of death:**
>
> Circulatory collapse and cardiopulmonary failure due to:
>
> Cardiomegaly with acute and chronic congestive cardiac failure complicated by hypostasis and early pneumonia, being exaggerated effects resulting from a usual dose of Clopixol."

At the inquest the Pathologist stated that the hypostasis and early pneumonia suggested that Mr D's death was almost certainly a gradual event. The following cross-examination took place:

> "The Pathologist: By and large patients are not allowed to be still – not still enough to get pneumonia and there is usually a reason for it. Now I don't work in the place so I am not aware of the circumstances. Old people who die of varying diseases, if they are still long enough they do get pneumonia, we know that and you expect to find that …
>
> Psychiatric Assessor: You are talking about a condition where someone does not change their body position and that allows these changes in the lungs to then occur?
>
> The Pathologist: That is correct
>
> Psychiatric Assessor: That compromises their breathing although it didn't lead in this case to death.
>
> The Pathologist: Right
>
> Psychiatric Assessor: But it is suggestive that either someone was either too asleep or perhaps too sedated to perhaps be able to move themselves as one might normally do in sleep?
>
> The Pathologist: That is correct.

Psychiatric Assessor: What then if he had been observed throughout a 12 hour period prior to his death, moving on a number of occasions?

The Pathologist: It is very unlikely, but I think it's probably not impossible … I would find it difficult to believe but not impossible, I couldn't categorically say that that is not true."

Similarly, the Senior Police Medical Officer stated at the inquest:

"I must be somewhat critical of the apparent method of observation of a person in this position as very obviously a patient could significantly deteriorate without this form of observation in any way detecting it. I find it difficult to believe that Mr D suddenly deteriorated, and that almost certainly this was a gradual event."

Coroner's Findings
The Coroner's Findings were that:

"Deceased, [Mr D] died on 14 December 1996 at the [Public Hospital Psychiatric Unit] during a period of immobility while in seclusion in terms of the Mental Health Act 1992 extending from some time after he was last turned at about 9.45pm on 13 December 1996 to 8.15am on 14 December 1996 as the result of circulatory collapse and cardiopulmonary failure due to cardiomegaly with acute and chronic congestive cardiac failure complicated by hypostasis and early pneumonia, possibly associated with a usual dose of zuclopenthixol acetate."

Report of Psychiatric assessor
The following comments on cause of death, nursing care and seclusion were made by the psychiatric assessor, and appended to the Coroner's Findings:

"*CAUSE OF DEATH*

The Pathologist indicated that his findings substantiated the Senior Police Medical Officer's assertion that Mr D had a gradual rather than sudden deterioration. The finding of hypostasis and early pneumonia is significant as was described during the inquest as they indicate that this patient in all likelihood had been lying still for a period of time prior to his death. He noted that these changes occurred at different rates in different people and when questioned said it was very unlikely but probably not impossible that the patient may have moved over a period of hours prior to his death.

There is an uncertain association between sudden or unexpected death and the use of antipsychotic agents. It is difficult to establish through research but it is likely that there is a small excess of deaths caused by antipsychotic agents that produce unexpected or sudden deaths and Mr D may well come into this category. There is good evidence that many antipsychotics alter the conduction of electrical impulses through the heart and therefore may predispose such people to arrhythmia. Further a

number of the antipsychotic medications including zuclopenthixol acetate have a blood pressure lowering effect and other effects on the heart. Therefore, the zuclopenthixol acetate may have contributed to the death both through its sedative effects and its effects on the circulatory system …

NURSING CARE

The nursing notes contain reasonable and appropriate documentation that provides useful descriptions of his mental state. As I would expect the nursing entries over night are briefer than those for the morning and afternoon shifts. Overall the quality of the nurses' progress notes are adequate.

There does appear to be some variation in the level of nursing care that was provided to this man, particularly in the 24 hours prior to his death. This relates particularly to the different approaches taken by Ms K on her afternoon shift of the 13th of December 1996 and Ms B on her shift over night. Ms K was accessing the seclusion room on her own. She noted that Mr D appeared to be very sedated. She commented that he was requiring frequent turns. She elaborated on this in the evidence that she gave to court. She reasonably indicated that she was aware of the risk of sedation of the zuclopenthixol acetate and that she was therefore very conscious of monitoring Mr D's condition closely. She further noted the concern she had about his eating, drinking, comfort and blood pressure as well as his psychiatric state. She had concerns about Mr D still being in seclusion.

A significant issue relates to the taking of blood pressure. As we have heard in evidence at the inquest, blood pressure was requested to be taken four hourly. There is a note in the nurse's progress notes that indicates that the blood pressure was to be taken until stable. This was written by the nursing staff on the 12th of December 1996 who attended Mr D in conjunction with the house surgeon. It is difficult to determine whether this was the house surgeon's request or whether it represents a form of miscommunication.

The nurses discontinued four hourly blood pressure recordings. Several reasons were advanced for this. Blood pressure was noted as being stable and therefore, there was no need for further blood pressure recordings. Further it was also noted by Staff Nurse B that it is not usual clinical practice to take blood pressures overnight. The blood pressure recordings were not taken four-hourly consistently and they were not recorded in the one form provided. There is a lack of clarity as to whether the blood pressure recording should have been taken four-hourly until told to stop by a member of medical staff or whether the blood pressure recordings should have been taken four-hourly until a stable and normal blood pressure was reached. If the latter were the case then a well-trained nurse would have the requisite skill to make the decision as to when the blood pressure had stabilised.

Staff Nurse K indicated that she identified that Mr D was unusually sedated and modified her nursing care in relation to this finding. By contrast Staff Nurse B sought to promote sleep overnight and not intrude on Mr D in the seclusion room. Her evidence was that she was able to observe him adequately through the window and she used techniques such as rattling the key in the lock and flicking the light on and off to assess whether he was rousable. Such techniques are recognised as acceptable nursing practice, particularly in seclusion. There is also the issue of the balance between promoting sleep overnight and the requirement that one enter the seclusion room to check on the patient. This highlights one of the problems of seclusion policies and one of the difficulties in maintaining someone in seclusion for long periods. Staff Nurse B gave evidence that it is not practice to enter a seclusion room where a person is asleep unless there is a requirement to do so. However, this man had been identified by the nurse previously responsible for his care as being heavily sedated. She had noted that he was having difficulties breathing. She had further identified that he had to be turned hourly and she was confident in accessing the room on her own. Staff Nurse B gave evidence that she would have read the patient's clinical notes. She should therefore have been aware when she took over care of him that Mr D had effectively been asleep for 24 hours and of Ms K's concerns.

There is by implication the possibility that if Staff Nurse B had been regularly entering Mr D's room over the night prior to his death, his moribund state may have been detected earlier and the death may have been avoided. She gave evidence that she regularly noted throughout the night that Mr D was moving and changing position while he slept. Given the evidence of the Pathologist, this seems improbable.

In summarising, my opinion would be that the level of documentation contained in the nursing staff progress notes is appropriate. Staff Nurse K held an appropriate degree of concern for Mr D's clinical state, recognised that he was heavily sedated and modified her nursing practice of him accordingly. There remains the question as to whether she should have contacted medical staff given her concerns about Mr D's condition. Staff Nurse B acted to promote sleep during her period on the final night shift. In doing so her nursing practice differed significantly from Staff Nurse K. She chose not to enter the room and it was her opinion that she could adequately monitor Mr D's physical condition without doing so. Her evidence that she was able to determine that Mr D had moved during the night is at odds with the evidence given by the pathologist.

SECLUSION

The fact that Mr D was in seclusion at the time of his death is of concern. Patients under the Mental Health Act detained in compulsory fashion in hospital, particularly those in seclusion are vulnerable and therefore particular care is to be taken with their management …

The evidence given is that it is likely that Mr D's deterioration prior to his death was gradual rather than sudden and probably occurred over a number of hours. Further at the time he was heavily sedated from zuclopenthixol acetate. Being in seclusion receiving 15-minute observations means that any deterioration in his physical state should have been recognised more quickly because of the requirement of increased observations. Therefore, a critical area of the circumstances in relation to this man's death is the level of observations that he actually received during his time in seclusion. We have heard evidence from one nurse that she was not satisfied of her ability to observe Mr D without entering the room for 15-minute checks. Particularly she felt that she could not check his respiratory rate or if he was breathing without entering the room. By contrast other nurses have given evidence that they could perform this task satisfactorily through the window. Staff Nurse L on his own admission was unable to accurately assess colour unless he entered the room and failed to do so. His evidence was that Mr D was covered with a blanket and he could not see if he was cyanosed.

One of the crucial matters with regard to this man's seclusion is the limited documentation over the final period from 22:45 on the 13th through to 08:00 on the 14th of December 1996. Other than noting that Mr D was asleep or appears asleep, Staff Nurse B has made no comment overnight with regard to Mr D on the seclusion record. The nursing notes overnight document that he appeared to sleep and his breathing had been satisfactory. There is therefore no way of corroborating her assertion that she noticed him moving regularly throughout the night. Further, although she appears to have signed the summary for hours spent in seclusion between 34:00 and 08:00 she has made no entries into the summary. This is in marked contrast to documentation in the seclusion logs for the previous two days. Further there are no comments written for the box for activity, behaviour or position in sleep for 07:30 or 07:45. In the log for the 14th of December 1996 (commencing 08:00) there is no indication that the breathing and colour have been checked. Nor is there any indication that this had been done for 07:30 or 07:45 on the morning of the 14th of December.

In summarising I believe there is apparent variance between the seclusion policy of the Hospital and the procedural guidelines. There is a tension between the requirement for promoting sleep and the need for satisfactory assessment of the patient highlighted by this variance.

Staff Nurse K used her clinical judgement to enter the room on her own given that she had recognised that Mr D's mental state had significantly altered. Staff Nurse B's decision not to enter the room overnight on the final night was consistent with the procedural guidelines policy but not with the appended seclusion procedure. She did not appear to take cognisance of the concerns and changes in Mr D's clinical state that had been recognised by Staff Nurse K or to have appreciated that this man had already been asleep for a 24 hour period at the time therefore the issue of sleep promotion was less significant. The documentation for this final period is limited and

there are significant omissions that raise the issue of how adequately observed Mr D was over this period. By Staff Nurse L's own admission he was unable to adequately assess colour without entering the room at the times at which he made checks on Mr D in the hour and a half prior to Mr D's arrest and death. There is also the matter of the evidence given by a Police Constable that the seclusion record for the 13th of December, ie exhibit 34, was being altered by a member of staff subsequent to the death on the unit."

Relevant standards

The Hospital Seclusion Policy, current at December 1996, stated:

10 OBSERVATIONS

10.1 Observations of the patient in seclusion **must** be a minimum of every 15 minutes regardless of the time of day. It must include the patient's physical condition eg colour, breathing, position, activity and behaviour.

…

10.2 At least once every two hours, an attempt should be made to enter the seclusion room to assess the patient's physical and mental status except when the patient is asleep or this is contra-indicated clinically. In this situation, the reason for this decision must be clearly documented.

10.3 The number of staff present for assessment and all other procedures will depend on the patient's activity level at the time, unit policy and documented instruction by the Responsible Clinician, Case Manager or CNL [Clinical nurse leader].

11.1 All required documentation must be completed promptly for each patient in seclusion.

The Ministry of Heath Guidelines on Seclusion (June 1995) stated:

"**Observations and Care During Seclusion**

Anyone in seclusion needs increased levels of care, not decreased levels

Seclusion procedures should be the same regardless of whether it is day or night.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Close observation and monitoring is required …

Continous – 15 minute observations

Observation should be continuous or as frequent as possible. The longest interval between observations should be 15 minutes. (The interval should vary within the 15 minutes.)

The **minimum** observations within the 15-minute interval include:

- Colour and breathing
- Position, activity and breathing

Two hourly observations

An attempt should be made **at least** every two hours to enter the room, unless there are documented reasons not to do so.

Unless the patient is asleep, an assessment of the mental state should be made at this time. Further assessment of physical state should be carried out as clinically indicated.

Safety precautions should be taken when entering the room. This should be detailed in local protocols."

Appended to the Hospital Seclusion policy document was a procedure for seclusion (signed by the Unit Manager). Clause 5 of this document required an entry attempt every hour to ensure safety and hydration.

Independent advice to Commissioner

The original nursing advisor on this file premised her report on the assumption that Mr D sat up three times during the night, and that he required sleep and rest. For the reasons set out above, I am now satisfied that Mr D was unable to sit up in the early hours of 14 December 1996, and that he had already been sleeping for most of the 24-hour period prior to Ms B beginning her shift.

Accordingly, I sought further expert advice from an independent nurse advisor. Peter O'Kane provided the following expert advice:

"My name is Peter O'Kane. I am a Registered Comprehensive Nurse. At the time of this incident I was employed as a Nurse Consultant, Mental Health, Elderly and Disabilities Services, Capital Coast Health Care Limited.

In writing this advice I have reviewed copies of the following documents:

(A) Dr A's letter of 8 April 2002;

(B) Clinical records and seclusion records of Mr D;

(C) Seclusion forms the Hospital and Ministry of Health;

(D) Coroners Findings;

(E) Clopixol Data Sheet;

(F) Correspondence with Ms B; and

(G) Correspondence with the Hospital.

The Commissioner requested advice on five questions. In answering these, there is some repetition.

Was Ms B's documentation of the standard expected of a reasonable and competent Mental Health Nurse?

It is my opinion that Ms B's documentation, specifically her 'seclusion documentation' was not of the expected standard of a reasonable and competent mental health nurse.

On the seclusion document it states: 'Activity/Behaviour or position if asleep'. Ms B has written the word 'asleep' continuously for her shift 13/14 December. There is no reference to body position.

Ms B advised in the interview with the Assistant Clinical Director of Nursing: 'Mr D was stirring and rolling over'. This was not documented. In response to the Commissioner, she stated 'I spoke to him and encouraged him to lie back down and get some sleep'. This was not documented anywhere.

If Mr D had turned at his own volition, one might have expected some reference to activity by Ms B, given that on the previous shift he had required assistance.

I also note the uniformity with regard to the writing in the seclusion form; this creates the impression there may have been multiple recordings at the same time. If this were the case it would be unacceptable practice. It is understandable that at times the nurse

would not be able to immediately write on the seclusion document. However, multiple recordings should be in exceptional circumstances.

Given Mr D's clinical condition and Ms K's handover, was Ms B's observation of Mr D's condition of the standard expected of a reasonable and competent mental health nurse?

The following aspects of the situation appear significant and would influence the parameters of practice of a nurse in Ms B's position:

(1) Per Psychiatric Assessor's report; '[Mr D] was a man with a mild intellectual disability … the presence of intellectual disability modifies the presentation, prognosis and course of psychiatric disorder … presentations are more likely to be atypical or unusual';

(2) Reference in the clinical notes that Mr D was 'returned to seclusion in soft area *for his own safety* as in danger of being hit by fellow patients due to inappropriate behaviour/comments';

(3) Mr D had received clopixol acuphase, a powerful antipsychotic which had only recently commenced being used in the Unit; and

(4) The handover by Ms K from the afternoon shift.

Given the level of care Mr D had required during the previous shift, one might have expected both nurses to have gone in and physically checked on Mr D prior to or after the verbal handover. Given his intellectual disability, if such a check took place, there would have been an opportunity for Ms K to introduce Ms B as Mr D's nurse for the night shift if Mr D was awake.

The fact that Mr D required physical assistance turning, by nursing staff on the previous shift, should have alerted a competent nurse to the likely needs of the patient during the shift.

Given that Ms B had decided to continue with seclusion, it is questionable whether the level of observation was of an appropriate standard. In my view, a competent mental health nurse would have erred on the side of risking waking the patient and entered the room to do more thorough observations.

Given that Mr D had been having difficulty taking fluids, per pm nursing notes, good practice would also have the nurse place some fluids in his room, informing the patient of the position of the cups of water. The nurse would then check on the contents of the cups whenever entering the room to check on the patient.

Given the conflicting seclusion policies in place at the time, would a reasonable and competent mental health nurse have been expected to enter Mr D's room at any time during the night?

Despite the conflicting policies, it is my opinion that a reasonable and competent nurse would have entered Mr D's room to check on him, for the following reasons:

(1) The handover received from the pm staff Ms K which indicated Mr D had required assistance with turning; and

(2) The fact that Mr D was placed in seclusion because he was at risk from other patients (not that his behaviours posed a risk/threat to others), coupled with the fact that Ms K had felt safe entering the room by herself and turning Mr D indicates that any risk of violence was particularly low.

On entering the room a nurse would initially check on colour and breathing. A decision would then be made whether to check the pulse if indicated by the first assessment. Detection of any abnormal pulse indicator would alert a competent nurse to the need to wake the patient to undertake full observations, including blood pressure.

In her letter 19/12/97 Ms B writes 'If however, the patient had *awoken*, and required me to enter the room, I would have reassessed the situation and then may have chosen to enter'. In her response to the Commissioner on 19/12/97 Ms B stated 'I spoke to him and encouraged him to lie back down'. At the inquest Ms B stated 'on three occasions I saw Mr D react by sitting up'.

I believe it would be remiss of me not to state that there did appear to be some inconsistencies in Ms B's responses throughout the documentation I reviewed. If, in fact, Mr D did sit up then, whilst perhaps not fully awake, he was awake. During these episodes, given the previous outlined points, I believe a reasonable and competent nurse would have made the decision to enter the room, speak with patient and carry out a more thorough assessment.

Given his level of sedation over the previous 24-hour period and poor fluid/food consumption, a competent nurse would have utilized this opportunity to assess whether the patient required hydration or toileting.

Whilst there is conflict between the policies, they are guidelines; one would expect a competent nurse to have as their primary concern the needs of the patient. Again in this situation I would note Mr D's dual diagnosis, the reason for seclusion, and the fact that he had already been resting for a considerable period post the administration of the clopixol acuphase.

The Hospital seclusion policy Section 10.2 had two exceptions: 'when the patient is asleep or this is contra-indicated clinically'. In this specific situation, I believe a competent nurse would have recognised the previously mentioned concerns, which would indicate a requirement to attempt to enter the room *at least* every two hours.

It is also important to note that Ms B stated that additional staff were available if needed.

If Mr D's room had been entered during the night, is it likely that a reasonable and competent mental health nurse would have observed his deteriorating condition?

Yes, it is likely. By simply being in closer physical proximity one is able to undertake a better assessment of the individual, rather than standing at a window looking into the room at a patient.
This failure to enter would appear to fall below the standard of care expected from a reasonable and competent mental health nurse.

If Mr D's deteriorating condition had been observed, what actions would a reasonable and competent mental health nurse have taken?

A competent nurse would have:

- taken the appropriate steps required to end seclusion;
- maintained regular recordings, temperature, pulse, blood pressure, skin;
- repositioned the patient so they weren't immobile/in the same position;
- offered hydration; and
- sought medical assistance if there was poor response to these interventions.

Additional comments

It is clear from the documentation that by the time Ms B began her shift, Mr D was no longer presenting with the behaviours that had resulted in the instigation of seclusion. In my view a competent nurse would have questioned the need for seclusion, and taken the appropriate steps to commence reintegration.

As well as giving easier access to Mr D and facilitating closer physical assessments, stopping seclusion would be 'least restrictive practice'. The Ministry of Health guidelines state, 'seclusion procedures should be the same regardless of whether it is day or night'. Seclusion should be stopped once it is no longer clinically indicated, not continued because it may be expedient to keep the person in seclusion.

Please contact me if you require any clarification.

Yours sincerely

Peter O'Kane"

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4

Right to Services of an Appropriate Standard

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

Opinion: Breach – Ms B

Right 4(1)
Mr D, a 41-year-old man with a mild intellectual handicap, was compulsorily admitted to hospital, sedated, and locked alone in a seclusion room for an extended period of time. The clinical record documented earlier concern about Mr D's blood pressure and previous sensitivity to psychiatric medications. The nurse going off duty gave Ms B a written and verbal handover that Mr D was heavily sedated, that his breathing was strained when lying flat, and that he needed nursing assistance to turn.

It is hard to imagine a scenario where a patient could be more vulnerable, or owed a greater duty of care. In my opinion, Ms B failed to provide Mr D with the appropriate standard of care.

I accept that there was some inconsistency between the Hospital's seclusion policy, the appended protocol, and the Ministry of Health Guideline. The Hospital, and not Ms B, was responsible for that inconsistency. I also accept Ms B's submission that at times there can be a tension between the need to carry out observations and the need to promote sleep and destimulation.

However, I cannot accept Ms B's submission that on the night of 13/14 December 1996, there was "no real cause for concern", and no need to enter Mr D's room. Mr D's

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intellectual disability meant that there was an increased chance of an atypical presentation and prognosis. He had been heavily sedated with medication that was relatively new to the unit. Ms B was aware that Mr D had required nursing assistance to turn on the previous shift, had a poor intake of fluids, and had strained breathing when lying flat. Ms B was also aware that Mr D had been asleep for most of the preceding 24 hours.

My opinion, guided by the comments of my expert advisor, is that on the night of 13/14 December 1996 Ms B's assessment of where the balance between rest and observation should lie fell below the standard expected of a reasonable and competent nurse.

As Commissioner, it is not possible for me to know or determine exactly what took place on the night in question. However, I accept the Coroner's Findings that Mr D's death followed a period of immobility. The pathologist's findings of hypostasis and early pneumonia indicate that Mr D had *almost certainly* been lying still for some hours before his death. In the light of this information, I am satisfied that had Ms B regularly monitored Mr D's condition during the early hours of the morning, it is likely that she would have been alerted to his deteriorating state of health.

I do not accept Dr A's submission that Ms B was specifically obliged to check Mr D's blood pressure every four hours. The nursing notes recorded that blood pressure should be checked every 4 hours until stable, and Ms B was not to know that this may have represented a miscommunication of the house officer's instructions.

However, as an absolute minimum, Ms B was obliged to regularly carry out a meaningful assessment of Mr D's colour, breathing, position, activity and behaviour (as required by each of the relevant policies in place at the time). Careful and accurate observation was particularly important for this patient, in the light of Ms K's concerning handover. At the inquest, Mr L and Ms K stated that they felt unable to accurately assess Mr D's condition without entering the room. Ms B has variously stated that she was satisfied that she could adequately assess Mr D through the window, that he needed to rest, and that by failing to enter the room she was simply acting in accordance with her employer's guidelines.

I support the comment of my expert advisor that, given Mr D's history and the concerning handover, "a competent mental health nurse would have erred on the side of risking waking the patient and entered the room to do more thorough observations" *at least* once every two hours. Further, if Mr D did in fact sit up at any time during the night, then I agree with my expert advisor that "Given his level of sedation over the previous 24 hour period and poor fluid/food consumption, a competent nurse would have utilized this opportunity to assess whether the patient required hydration or toileting." Ms B has stated that she was aware that she could call on other staff if required.

In relation to Ms B's comments that Mr D needed to rest, I note that when Ms B started her shift, Mr D had already been asleep for much of the previous 24 hours. Further, he had been identified as being heavily sedated, having difficulty breathing, and needing nursing

assistance to turn. What Mr D needed was not sleep, but close observation of his physical condition and recognition of his deteriorating medical condition.

As for Ms B's submission that she was simply acting in accordance with her employer's guidelines, I agree with the comment of my expert advisor that guidelines are just that, and that consideration of the patient's best interests should be the nurse's first concern. Guidelines and protocols are not a substitute for professional, clinical judgement, and need to be interpreted in the light of relevant circumstances. A nurse faced with apparently inappropriate or contradictory guidelines or protocols should seek guidance from a senior member of the team rather than risk compromising patient safety by rigidly following a document.

Ms B has stated that her notes were not good, and I agree. Ms B did not document Mr D's position in bed, any movements he may have made, nor his response to any efforts to rouse him. Her clinical notes merely state that Mr D was "asleep" at every 15-minute observation. (At this point it is worth noting the police examiner's comment at the inquest: "People who die look as though they are asleep.") Ms B also failed to complete an eight-hourly summary for the shift, as required. Given Ms K's expression of concern about Mr D's level of sedation, it would have been particularly important to document any significant changes in position.

I am satisfied that Ms B did not adequately observe Mr D's physical condition during the night of 13 and 14 December 1996. Adequate observations may well have alerted Ms B to his deteriorating health, allowing her to seek potentially life-saving medical assistance. In my opinion, Ms B breached Right 4(1) of the Code by failing to provide services with reasonable care and skill.

Opinion: No further action – "the Public Hospital"

It is important to recognise that Ms B was acting within a flawed system. As is the case in many adverse events, the actions of a number of individuals converged and interacted with significant system weakness to contribute to Mr D's death.

In retrospect, it seems apparent that Mr D should not have been in seclusion the night of 13/14 December 1996. Other issues of particular concern were the inconsistency between various seclusion policies, the paucity of new drug education, the lack of an ECG machine on the ward, the confusing clinical record format, and the delay in the arrival of the resuscitation team.

In response to the internal inquiry and inquest recommendations, the Public Hospital has taken the following actions:

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- Reviewed the seclusion policy and brought it in line with the Ministry of Health guideline on Restraint Minimisation and the National Mental Health Standards.
- Improved education on new drugs through close liaison between clinicians and the pharmacy department, formal education, case reviews and supervision.
- Instituted clinical supervision for all levels of staff.
- Provided an ECG machine for the hospital's Psychiatric Unit.
- Introduced individualised care plans and continuous progress notes where clinicians consecutively document their observations and record any doctors' orders.
- Changed the process for summonsing a resuscitation team to ensure a prompt response (calls are now attended by St John's ambulance service).
- Met with Mr D's mother to apologise and discuss the above changes.

I am satisfied that the Public Hospital has responded appropriately to this incident, and has minimised the chance of harm to future patients in similar circumstances.

In view of the actions already taken, and the length of time that has elapsed since the incident occurred, I have decided to take no further action in relation to any potential direct or vicarious liability on the part of the Public Hospital.

Other comment:

Doctors' orders
I note Dr A's concerns about the need for clear communication of doctors' orders. I agree that each hospital needs a reliable procedure for communicating instructions, including doctors' orders, between different staff members and different shifts. Such instructions should be clearly written and appropriately flagged in the clinical record, as well as being handed over verbally where appropriate.

If clinical staff consider a particular instruction to be clinically inappropriate, this concern should be discussed with the person who made the instruction or an appropriate senior staff member and the outcome of such discussion clearly documented. Where instructions appear ambiguous, clinical staff have a responsibility to take all reasonable steps to clarify the meaning of the instruction.

Adrenaline contraindicated in zuclopenthixol-induced hypotension
I also note Dr A's concerns about the use of adrenaline in a patient who had received zuclopenthixol. Medsafe advises that Zuclopenthixol-induced hypotension should *not* be treated with adrenaline, as further lowering of the blood pressure may result. Severe

hypotension due to zuclopenthixol overdose should be treated with noradrenaline instead of adrenaline.

In this case, the resuscitation team was faced with a situation of asystolic cardiac arrest, not a situation of hypotension. Dr Galletly, Chair of the New Zealand Resuscitation Council, advised me that the use of adrenaline according to the standard New Zealand cardiac arrest algorithm is appropriate even where a patient has received zuclopenthixol. However, in non-arrest situations, medical practitioners should follow the Medsafe recommendation to use noradrenaline rather than adrenaline for severe zuclopenthixol-induced hypotension, if noradrenaline is available.

Use of seclusion
I share my expert advisor's concerns at the apparently inappropriate use of seclusion at the time of this incident. It appears that, collectively, the staff caring for Mr D failed to review the need for seclusion in a critical and timely manner.

I endorse Mr O'Kane's statement that seclusion should be stopped once it is no longer clinically indicated, and not continued because it may be expedient to keep the person in seclusion. This incident is a tragic reminder of the vulnerability of patients who have been sedated or held in seclusion, and the importance of careful and safe practice when caring for such patients.

Actions

Since the time of this incident, Ms B has taken the following actions:

- Acknowledged that her note-taking was not good;
- Attended a debriefing meeting and undertaken counselling; and
- Moved from employment in an acute inpatient unit to community work.

I recommend that Ms B:

- Review her practice in the light of this report.

Ms B has informed me that she does not intend to work in an inpatient unit again. Should Ms B wish to resume employment in an acute inpatient setting at any stage, I recommend that she should initially practise under appropriate clinical supervision.

Further actions

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

- A copy of this report, with identifying features removed, will be sent to the Mental Health Commission, the Ministry of Health, the Royal Australian and New Zealand College of Psychiatrists, the Chair of the Chief Medical Advisors Group, and the Chair of the New Zealand Resuscitation Council, and a copy will be placed on the Health and Disability Commissioner's website, www.hdc.org.nz, for educational purposes.