District Health Board
Registered Nurse, RN C

A Report by the
Deputy Health and Disability Commissioner

(Case 19HDC02060)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a particularly vulnerable elderly woman by nursing staff at a district health board. The woman, who was in her early nineties, had recently suffered a stroke. As a result she was unsettled and confused, and found it difficult to follow complex commands. Given the woman's vulnerabilities, the onus was on all the DHB staff who cared for her to ensure that any intervention was carried out with respect, and reasonable care and skill. The actions of both the night shift Clinical Nurse Manager and the hospital system resulted in unnecessary harm and distress to the woman.

2. During the woman's stay in the neurology ward, the Clinical Nurse Manager assisted in trying to stop her from hurting herself, and applied bandaging to her hands and arms. The way in which the woman's hands were bandaged, and the lack of monitoring afterwards, resulted in her right thumb being found in an abnormal position. The bandaging also caused bruising and discolouration to her hands.

3. After the bandaging was applied, the Clinical Nurse Manager failed to monitor, review, and document the care provided. Other nursing staff did not monitor the woman, and the harm was not identified until the following morning.

4. There was also a lost opportunity for nursing staff to communicate with the woman's family in order to de-escalate her unsettled behaviour.

Findings

5. The Deputy Commissioner considered that the Clinical Nurse Manager did not provide services to the woman with reasonable care and skill. The Deputy Commissioner found that the bandaging of the woman's hands and arms caused bruising and constriction, and considered that the Clinical Nurse Manager should have ensured that the woman was monitored and reviewed following the bandaging. Accordingly, the Deputy Commissioner found the Clinical Nurse Manager in breach of Right 4(1) of the Code.

6. The Deputy Commissioner also found the Clinical Nurse Manager in breach of Right 4(4) of the Code, as she did not provide services that minimised potential harm to the woman and optimised her quality of life.

7. The Deputy Commissioner noted that the DHB has a duty of care to patients, and a responsibility to keep them safe whilst in hospital. The Deputy Commissioner did not find the DHB in breach of the Code, but made educative comments about a proactive strategy for behaviour of concern, and the ability of junior staff to raise concerns about care provided by senior staff.

Recommendations

8. The Deputy Commissioner recommended that the Clinical Nurse Manager provide a written apology to the woman's family, and provide evidence of having completed training on the use of restraints and the management of actual or potential aggression.

9. The Deputy Commissioner recommended that the DHB provide an apology to the woman's family, use an anonymised version of this case for wider education of nursing staff, and audit nursing staff awareness of, and compliance with, the DHB's Restraint Minimisation Policy. The Deputy Commissioner also recommended that the DHB provide evidence that the changes made and training provided to nursing staff have been effective, and consider implementation of the recommendations made by HDC's independent nursing advisor.

Complaint and investigation

10. The Health and Disability Commissioner (HDC) received a complaint from Mr B about the services provided to his late mother, Mrs A, by a district health board (DHB) and Registered Nurse (RN) C at a public hospital. The following issues were identified for investigation:

- *The appropriateness of the care provided by the district health board to Mrs A in 2019.*
- *Whether RN C provided Mrs A with an appropriate standard of care in 2019.*

11. This report is the opinion of Deputy Commissioner Rose Wall, and is made in accordance with the power delegated to her by the Commissioner.

12. The parties directly involved in the investigation were:

Mr B	Complainant/consumer's son
DHB	Provider/district health board
RN C	Provider/registered nurse

13. Further information was received from:

RN D	Registered nurse
RN E	Registered nurse
Ms F	Healthcare assistant

14. Independent expert advice was obtained from a registered nurse, Associate Professor Karole Hogarth (Appendix A).

Information gathered during investigation

Introduction

15. This report concerns the appropriateness of the care provided by the DHB and RN C to Mrs A. In the early morning of 1 Month2,[1] crêpe bandages were wrapped around Mrs A's hands and up to her elbows, causing bruising and distress.

Background

16. Mrs A was in her early nineties at the time of these events, and lived with her son, Mr B. Mrs A's medical history included high blood pressure, a heart attack, low sodium, and poor vision.

17. During the late night of 27 Month1, Mrs A was transported by ambulance to the public hospital because of a sudden onset of dry retching, vomiting, and nausea. At 12.13am (28 Month1), Mrs A was admitted to a ward that specialises in neurology care, for further clinical examination. A CT scan of Mrs A's head taken on admission to the Emergency Department showed that she had suffered a stroke[2] earlier that night. The discharge summary from the Emergency Department noted that Mrs A had slurred speech with "some confusion and difficulty following complex commands". It was later documented in the clinical summary for stroke rehabilitation that the stroke had affected Mrs A's communication skills, and that she had significant post-stroke fatigue, which affected her engagement with the rehabilitation team.

18. After further management and observation of Mrs A's condition over the following days, neurosurgery was discussed with Mr B. However, it was felt that any surgical treatment[3] would delay her inevitable decline, and it was noted that Mrs A did not want any invasive procedures performed on her. As a result, a decision was made to provide comfort care[4] for Mrs A during her hospital stay.

Care of Mrs A prior to 1 Month2

19. Mrs A's inpatient data records noted that she required an interpreter (although Mr B told HDC that she could speak and understand English) and hospital-level care (24-hour nursing). As part of the initial assessment of Mrs A, it was observed and documented by a registered nurse in the Behaviour of Concern Pathway (BOCP)[5] that Mrs A had no cognition problems, but displayed the following behaviours of concern at the time of assessment:

[1] Relevant months are referred to as Months 1–2 to protect privacy.
[2] This was diagnosed as a posterior fossa haemorrhagic stroke, which is a life-threatening haemorrhage that affects the structure of the brain, and can cause coma and death.
[3] The surgical treatment would be insertion of an external ventricular drain (EVD). This is a device used to divert fluid from the ventricles of the brain in order to relieve elevated intracranial pressure when the normal flow of cerebrospinal fluid (CSF) inside the brain is obstructed.
[4] "Comfort care" is defined as a patient care plan that is focused on symptom control and pain relief.
[5] The Behaviour of Concern Pathway, as stated within the DHB's policy, is a tool used by experienced nursing staff to understand the causes, and develop strategies and interventions to alleviate distressing symptoms for individuals who display behaviours of concern.

- Interference in treatment
- Lack of co-operation
- Falls risk
- Unable to follow instructions
- Pacing/agitation
- Disorientated/confused

20. The initial assessment also assigned a patient attender for Mrs A, which meant that she was observed constantly (also known as a "CAT A" watch). This involved Mrs A being assessed within arm's reach at all times with full view of her hands and neck area. Furthermore, it was documented that the additional strategies put in place for Mrs A included maintaining a low stimulus room, encouraging family participation, and "orientating at every contact". Mr B advised HDC that no Enduring Power of Attorney (EPOA) had been activated for Mrs A at the time of events, as she was aware of her circumstances (although she may have had diminished awareness due to the stroke).

21. Throughout 28–30 Month1, Mrs A stayed in the ward and received care from numerous nurses. During this period, it was documented in the BOCP notes that Mrs A was "restless", "agitated", and "getting out of bed without assistance". In particular, it was documented that Mrs A was pulling her IV luer and IDC.[6] Although it is unclear whether this behaviour was discussed with senior nursing staff or Mrs A's family at the time, it was documented that a nurse would intervene by redirecting Mrs A's hand away from the luer, or by repositioning her body to make her more comfortable. In the afternoon of 29 Month1, a doctor also helped to settle Mrs A by making her more comfortable.

30 Month1 — observations of Mrs A's condition

22. On 30 Month1, it was documented in the BOCP notes that the behaviours of concern for Mrs A included increased falls risk, restlessness, agitation, and trying to get out of bed without assistance.

23. At around 3.00pm on the same day, whilst Mrs A was sleeping, her family arrived to visit. There are no documented discussions or a plan for Mrs A's behaviours of concern between the nursing staff and her family during this time. Mr B told HDC that his mother was able to speak to him and the family during the visit.

24. At around 7.00pm, Mrs A was awake and was observed to be pulling her sheets and moving both her hands around with her legs out, and was "agitated". She was repositioned by the nursing staff and was sleeping again by 9.00pm. An internal report recorded the events that followed: "[Mrs A was] very unsettled, restless and agitated, the [healthcare assistant] needed help to change the patient and the [Clinical Nurse Manager] had come to help her."

[6] Her intravenous line and her indwelling urinary catheter (IDC) (a tube inserted into the bladder to drain urine).

Wrapping of Mrs A's hands and arms — early morning of 1 Month2

25. The Clinical Nurse Manager role includes supporting and assisting staff, including in difficult situations.[7] The overnight Clinical Nurse Manager, RN C, told HDC that either she was called to the ward that night, or she visited as part of her rounds. She cannot recall the exact time she visited Mrs A, but said that she bandaged her hands towards the end of the night shift, between 3.50am and 5.30am.

26. A healthcare assistant (HCA), Ms F, was assigned as the night shift patient attender. The patient attender is responsible for providing care to specific patients.

27. RN D was also on duty. She told HDC that she was the only ward nurse[8] assigned to the unit floor during this shift, which she recalled was very busy. It is documented in the clinical notes that RN D attended Mrs A hourly between 12.00am to 6.00am (the last observation being taken at 6.00am). When her shift ended, she was replaced by RN E.

Timing of incident

28. At some point in the early morning of 1 Month2, Mrs A's hands were wrapped separately with bandages and tape. The exact method of bandaging is discussed in more detail below. There is no dispute that the wrapping was undertaken by RN C,[9] and it is accepted that it was done sometime between 3.00am and 5.30am.

Appropriateness of bandaging — justification, method, and tightness

29. RN C told HDC that she was called to assist with Mrs A because other staff had not been able to settle her. RN C said that when she first observed Mrs A, she was partially undressed, in a state of constant motion with her arms "flailing", and she was plucking at her IV cannula (luer) on her left arm. This concerned RN C because she was aware of Mrs A's state of health, which required IV fluids, and her increased risk of bruising or bleeding.[10] RN C said that at the time, she understood that the patient was not able to have sedative medication, so she believed she did not need to contact a doctor for review.

30. RN C explained that Mrs A's cannula "needed to be secured to her arm and her forearms needed to be bandaged to provide a buffer in the event they hit [something]". In response to the provisional opinion, RN C also told HDC that she considered that the catheter in place for Mrs A was at risk of being pulled out. RN C was also concerned that Mrs A would pull off the remainder of her clothing in the shared room, which would be detrimental to her dignity.

31. RN C recalled that when she first bandaged over the cannula with crêpe bandages, she needed to use different variations of bandaging, as Mrs A kept pulling off the bandages.

[7] As per the Nurse Manager Position Description (March 2020).

[8] The DHB provided the nursing roster for 1 Month2, which shows that usually there were two rostered nurses and one HCA assigned on the unit floor. However, RN D cannot recall why the ward was understaffed on the night or whether the other nurse had been assigned to another unit.

[9] The Clinical Nurse Manager is responsible for the safety of day-to-day hospital services, including assisting nursing staff with patients with complex needs.

[10] Stroke patients may be given anticoagulant medication, which increases the risk of bruising or bleeding.

According to RN C, Mrs A began to push up her sleeve, before pushing the bandage down her arm. Subsequently, Mrs A's sleeves were taped to her wrist, but her limbs were still able to move freely to push her hair from her face or to rub her leg.

32. RN C submitted the following to HDC:

> "[When I made the decision to bandage [Mrs A's] hands I was aware that [Mrs A] was not able to perform many activities of daily living, such as brushing her teeth, dressing or brushing her hair. Nor was she able to mobilise or use the toilet by herself (she had a catheter) … [and] bandaging would not prevent the patient [from] doing these activities. In terms of the actions that she could perform herself — such as pushing hair from her face or rubbing her leg — she was still able to do these with the bandages."

33. The DHB told HDC that it is usual nursing practice to secure an IV luer with an adhesive dressing or tape, or at times with a crêpe bandage. According to the DHB, the crêpe bandages were wrapped from Mrs A's hands to above her elbows to help provide protection for the luer and to minimise the risk of Mrs A removing the luer, and to prevent further harm.

34. RN D told HDC that she cannot recall how far up Mrs A's arms the bandages went. However, the clinical notes record that RN D was able to visualise the IV luer, and that there was no issue with the bandages preventing observation.[11] Photographs do not confirm how far up Mrs A's arms the bandages went.

35. Ms F stated:

> "I remember that the senior nurse (who I now know was CNM [RN C]) continued the bandage up the patient's arm and said 'good luck'[12] to the patient. Normally the tape just goes up to the level of the wristwatch, but this time it went all the way up her arms."

36. There is some dispute over the position of Mrs A's thumb, and whether it was taped abnormally. RN C says that she enclosed Mrs A's fingertips and thumbs like a "mitt". RN C told HDC:

> "I was very careful to position her thumbs in their natural positon. I bandaged from the fingertips to the elbow crease. To secure the bandages I taped over the parts that would easily roll and undo (being careful to avoid constriction)."

37. RN C considers that she did not place Mrs A's thumb or fingers in an "abnormal" position. RN C told HDC that she "was simply trying to stop a patient hurting herself". She stated that if Mrs A's hands ended up in an abnormal position, this would have been caused by

[11] The clinical notes documented: "IV luer on L) arm, nil sign of phlebitis."

[12] RN C was given an opportunity to respond to this comment. She cannot recall exactly what she said to Ms F, but stated that if she said "good luck", this would have been directed to Ms F rather than the patient.

Mrs A subsequent to the bandaging. RN C told HDC that she had many years' experience of bandaging in the Emergency Department.

38. RN E, who came on shift at around 7.00am on 1 Month2, took over from RN D and documented in the clinical notes at 9.10am that crêpe bandages had been applied on both of Mrs A's hands. It was observed that Tubigrip had been wrapped tightly on Mrs A's right hand and to her shirt, and, in contrast to RN C's statement, it was documented that Mrs A's thumb was tucked under her palm. Photographic evidence taken by the DHB and provided to HDC (see Appendix C) shows both Mrs A's hands wrapped in bandages with tape applied throughout, with the left thumb protruding but not the right. Ms F observed that both hands were taped separately, but "taped up like boxing gloves".

39. When the bandages were removed, RN E saw marks from the tape and bruising on the hands, with Mrs A's "thumb tucked under into her palm".

40. There is also evidence that the bandages were pulled tightly. The internal report and RN E's documented clinical notes state that Mrs A's hands were observed to be "tightly" wrapped, and the nursing staff found bruising of her hands alongside the purple discolouration and marks of the tape.

41. Mr B told HDC that when he saw his mother, he could still see the deep purple-red bruise marks on the back of her palms and forearms.

42. RN C told HDC that when she wrapped Mrs A's hands, she was very careful to avoid constriction, given her knowledge of Mrs A's health. RN C stated that she did not bandage to cause constriction or bruising. She explained that this could have occurred from Mrs A "pulling the bandages tighter with her teeth or mouth". The DHB concurs with RN C's explanation.

43. RN D accepts that she did not have sufficient time to review the bandages properly, as she needed to attend to other patients during the night. She advised HDC that if she had identified that the bandages were too tight, she would have removed them immediately and informed the Clinical Nurse Manager.

44. RN E's clinical notes at 9.10am document:

> "Both bandages wrapped in layers of tape. [Right] hand was so tightly wrapped that it was purple … marking of tape evident, discolouration, poor capillary refill.[13]"

45. The internal report documented that the bandages were "not suitable on [a] ward setting".

[13] RN E recorded the capillary refill as > 3 seconds. The pulse oximeter measured the SpO_2 (oxygen saturation) on the right hand as 80–88%, whereas the left hand measured 94–95%.

Monitoring, review, and documentation of bandaging on Mrs A's hands

46. Ms F (Mrs A's patient attender) told HDC that she was asked by RN D to monitor Mrs A by ensuring that she did not pull out the IV luer.

47. As noted above, RN D reviewed Mrs A every hour between 12am and 6am. RN D told HDC that she was very busy during the night shift, and undertook as much monitoring and documentation as she could manage, as she was the sole nurse on the floor. RN D stated that her normal practice would have been to record in the clinical notes any behaviours of concern from Mrs A.

48. RN D told HDC that she was trying to manage many patients with complex needs[14] during her shift, and no concerns were raised by Ms F regarding the bandages when RN D saw Mrs A at the hourly visit.[15]

49. RN C told HDC that at the time, she understood that Mrs A was under 24-hour watch (CAT A). RN C said that she would have expected the ward nurse (RN D) to monitor Mrs A through the hourly visits. RN C said that she could not review or monitor Mrs A herself, given her other clinical nurse management tasks. However, RN C accepts that she did not document her bandaging of Mrs A's hands at the time, owing to her other nursing tasks,[16] and that she should have done so. RN C also acknowledged that she should have left instructions for the other nursing staff to follow up on Mrs A, and should have documented her interactions, rationale, and monitoring expectations in the clinical notes.

Discovery of Mrs A's bandaging

50. After RN C applied the bandaging, she told Ms F that the purpose of the wrapping was to prevent Mrs A from pulling her clothes and tubes. Ms F told HDC that she did not question the correctness of the wrapping because it was done by a senior nurse, and she felt at the time that she did not need to question the senior nurse's authority.

51. At around 7.00am, the handover nurse for the morning shift, RN E, received handover information from Ms F in Mrs A's room. RN E observed and documented in the clinical notes that Mrs A had "been biting her hands trying to remove bandages". There were traces of blood on her shirt and on the Tubigrip[17] and crêpe bandages.

52. RN E took off the bandages and immediately informed the Acting Charge Nurse (ACN). Photographs were taken of Mrs A's arms and hands (see Appendix C).[18] The doctors and the Nurse Manager were also notified of the incident. When the nurses saw Mrs A's hands,

[14] RN D provided care for a patient with a hyper-acute stroke, a patient who had had a fall (and required thorough assessment), and two other patients on a Behaviour of Concern pathway.
[15] "Intentional Rounding" is a process whereby nurses carry out regular checks on their patients every hour. The purpose is to address issues such as pain and positioning, in order to increase patient safety.
[16] The Clinical Nurse Manager role is generally busy, and requires prioritisation of other clinical and administrative tasks.
[17] Tubigrip is a tubular elastic bandage designed to provide tissue support and compression.
[18] Two photographs were provided to HDC by the DHB (taken in the morning shift). Both show Mrs A's hands wrapped separately by bandages, with tape covering them.

it was recorded in the clinical notes that they could still see "the purple/pink red discolouration".

Subsequent events

53. The internal report documented that the ACN and Nurse Manager met with Mr B and a close family friend to discuss the incident. During the meeting, Mr B was advised of the DHB's complaints process and his right to submit a complaint to the Health and Disability Commissioner.

54. The incident caused distress to Mr B, but he said that he is thankful that the nursing staff were proactive in removing the "restraint" once it was discovered. In the internal report, it was documented that the "restraint" was not consented to by the next of kin, and that Mrs A's family were told that the DHB "never encourage[s] restraint in the ward".

55. Mrs A remained on the ward until 8 Month2, when she was transferred to another team for a trial of intensive stroke rehabilitation. She remained at the public hospital until 24 Month2, when she was discharged to her family doctor. Sadly, Mrs A passed away a few weeks later.

Further information

56. The DHB told HDC that it has a duty of care to patients and a responsibility to keep them safe whilst in hospital. The DHB stated that the incident was treated very seriously, and that the DHB was completely transparent with Mrs A's family. When the bruising was discovered in the morning shift, the family was informed immediately.

57. RN C told HDC that the Clinical Nurse Manager role is incredibly busy, and usually requires careful prioritisation of both clinical and administrative tasks. The role required her to move from one urgent situation to another. Despite the aforementioned explanation, she has reflected carefully on the incident and feels a huge amount of regret for the distress caused to Mrs A and her family, which was never her intention.

58. The DHB's Restraint Minimisation Policy defines a restraint as "the use of any intervention by a service provider that limits a patient's normal freedom of movement". The use of restraints is governed by the Restraint Minimisation Policy, which sets out when and how restraints should be used. In response to the provisional opinion, the DHB told HDC that it has accepted that the bandaging was a form of restraint.

59. However, RN C told HDC that she does not consider the wrapping of Mrs A's hands during the incident to have been a "restraint", as there is a possibility that Mrs A caused the tightening of the bandages when she pulled and bit them. This is despite the internal report, which labelled the wrapping as "restraints".

Responses to provisional opinion

60. Mr B was provided with an opportunity to comment on the "information gathered" section of the provisional decision. He told HDC that he had no further comments to add.

61. RN C was provided with an opportunity to comment on the provisional opinion. Whilst RN C accepted the Deputy Commissioner's provisional opinion and recommendations for the most part, she submitted some factual matters for correction. Accordingly, RN C's submissions have been incorporated into this report as appropriate.

62. RN C told HDC that at the time, it was reasonable for her to assume that the other nursing staff (Ms F and RN D) would have intervened if Mrs A's bandaging was too tight, or would have asked for further assistance, as it was their shared responsibility.

63. Regarding the abnormal positioning of Mrs A's thumb, which was found in the morning, RN C told HDC that she used padding on Mrs A's palms and had carefully placed the thumbs in a neutral position, and therefore the thumbs were not bandaged abnormally to begin with. RN C also submitted that it was reasonable to assume that the other nursing staff would have intervened if the thumbs had ended up in an abnormal position.

64. RN C broadly accepts that there was a lack of monitoring from her after she bandaged Mrs A's hands. However, she told HDC that it was reasonable for her to assume that the other nursing staff would monitor Mrs A, and that as the Clinical Nurse Manager, she was unable to monitor a patient personally on a busy shift, and was there to provide discrete clinical assistance.

65. RN D was provided with an opportunity to comment on the provisional opinion, and advised that she had no further comment to make.

Opinion: General comment

66. Mrs A was a particularly vulnerable consumer at the time of events. She was in her early nineties and had recently suffered a stroke, which meant that she was in physical decline. She had communication issues and required assistance from her family. Given Mrs A's vulnerabilities, the onus was on all the DHB staff who cared for her to ensure that any intervention was carried out with respect, with reasonable care and skill, and with due consideration to her dignity.

67. Below I discuss how the actions of both RN C and the hospital system resulted in harm and distress to Mrs A.

Opinion: RN C — breach

68. RN C was a Clinical Nurse Manager at the DHB at the time of events. She was required to facilitate safe and effective day-to-day hospital services, including assisting nursing staff with patients who had complex needs. There is a reasonable expectation that a senior

nurse would provide safe and effective care. RN C provided care to Mrs A for a brief period of time in the early morning of 1 Month2.

69. First, I acknowledge RN C's detailed recollection of the issues raised about her care, as well as transparency throughout the investigation process. I recognise from RN C's response that the Clinical Nurse Manager role is often challenging and complex. However, this does not mitigate her responsibility to provide services of an appropriate standard.

70. With respect to RN C, my main concern relates to her decision-making on 1 Month2, which affected patient safety. I discuss this below.

Issue of restraint

71. Under the Restraint Minimisation Policy, a restraint is defined as "the use of any intervention by a service provider that limits a patient's normal freedom of movement". The Restraint Minimisation Policy also sets out when and how restraints should be used, including that they should be used as a last resort when all other clinical interventions or calming and defusing strategies have failed, where they can be initiated safely, and following a specific risk assessment of the patient's profile.

72. My nursing advisor, RN Karole Hogarth, commented that "[Mrs A's] hands should never have been strapped in this manner in the first instance, whether the bandaging and taping were tight or not as this is a form of restraint". RN Hogarth considers that her colleagues would find that the use of this kind of restraint, and the manner in which it was implemented, do not fit with current nursing practice.

73. RN C told HDC that at the time of the events she did not consider that she was restraining Mrs A. Although the intention was to stop Mrs A from hurting herself by securing her luer and by protecting her arms, on reflection RN C accepts that she did "restrain" Mrs A when she bandaged over her hands. RN C explained that she saw "a significant risk that [Mrs A] would hurt herself". RN C stated that "bandaging the patient's hands was necessary and should have posed less risk of harm than leaving the patient's arms and lines exposed". She accepts that she did not defer to the Restraint Minimisation Policy (see Appendix B).

74. In agreement with RN C, the DHB also told HDC that the application of the crêpe bandages was not to restrain Mrs A, but to protect the luer and to prevent her from trying to remove her lines.

75. In my view, and guided by RN Hogarth's advice, the use of crêpe bandaging on Mrs A's hands and arms did constitute an intervention that limited the patient's normal freedom of movement. The purpose of wrapping Mrs A's hands was clearly to limit her attempts to remove her lines, including her IV luer and catheter tube.

76. Accordingly, I consider the actions undertaken by RN C to be classified as "restraint", as per the Restraint Minimisation Policy.

77. Although I acknowledge RN C's concern that there were few alternative options readily available to her at the time (given that Ms F had been unable to settle Mrs A further and RN D was occupied with other tasks), it concerns me that RN C lacked insight into her actions at the time of the events, and failed to see that her actions had the effect of restraining Mrs A, and therefore required the appropriate process to be followed. I take careful note of the position of my expert on this matter, where she states that her colleagues would find that this kind of restraint, and the manner in which it was implemented, do not to fit with current nursing practice.

78. However, I am pleased that in the response to the provisional opinion, RN C showed further insight into the care she provided to Mrs A, and accepts that she could have done better.

79. Irrespective of RN C's awareness that she was restraining Mrs A, I consider her actions to have been inappropriate, and I have concerns about the method and manner in which RN C bandaged Mrs A's hands. I discuss my concerns below.

Appropriateness of using crêpe bandages and method of bandaging

Use of crêpe bandages

80. In terms of the appropriateness of using crêpe bandages and tape in the circumstances, both RN C and the DHB consider that securing an IV luer with adhesive dressing, tape, and at times with crêpe bandages, was usual nursing practice.

81. My nursing advisor, RN Hogarth, stated that the wrapping of a luer site with a light bandage or Tubigrip can be acceptable to ensure that the luer does not get caught and pulled.

82. In terms of the decision to use crêpe bandages, RN Hogarth advised:

> "Crêpe bandaging needs to be undertaken with care. Bandages that have lost their elasticity or are pulled taut during application are dangerous as they act like rope to inhibit circulation and would be very uncomfortable and could result in loss of distal circulation."

83. RN Hogarth also stated that "the taping of the bandages is excessive, and the type of tape used is not flexible so there would have been no give".

84. I accept RN Hogarth's advice. Whilst I accept that crêpe bandages are used regularly by nursing staff for day-to-day care, in my view the use of crêpe bandages alongside the tape, in Mrs A's circumstances (for the purpose of restricting movement and effectively as a restraint), was inappropriate. Mrs A had already demonstrated that she was likely to resist the bandaging, and had attempted to pull it off. As discussed below, that the bandages would end up too tight is a foreseeable result of using crêpe bandages in this instance.

Tightness of bandaging

85. The tightness with which RN C originally wrapped the bandaging around Mrs A's hands is also unclear.

86. When the bandages and tapes were unwrapped from Mrs A's hands in the morning, it was documented that the bandages were wrapped tightly and had resulted in bruising, poor capillary refill, and discolouration, with the marks of the tape still evident.

87. However, RN C told HDC that she did not bandage or tape Mrs A's hands and arms tightly enough to have caused the bruising. According to both RN C and the DHB, the tightness of the bandaging could have been caused by Mrs A when she tried to pull and bite at the bandaging. RN C told HDC that it would have been reasonable for her to assume at the time that if the bandaging became too tight (owing to pulling), the other nursing staff would have observed Mrs A and, if need be, intervened or sought further assistance.

88. However, RN Hogarth said that the photographs do not show evidence of pulling or stretching, as the bulk of the bandaging remained intact.

89. I am unable to make a finding on how tight the bandaging was originally. However, I am concerned regardless, because even if the bandaging was not too tight in the beginning, I accept RN Hogarth's advice that RN C, as an experienced nurse, should have taken into account Mrs A's agitation and behaviour when making the clinical decision to wrap Mrs A's hands, especially when she knew that Mrs A would continue to interfere with the bandaging, as evident by her many attempts to pull at it.

90. Whilst I acknowledge RN C's statement about the reasonableness of relying on other staff members to intervene (especially given that Mrs A was being monitored by Ms F), in my view and in the context of a busy ward, it was still a foreseeable risk that nobody would intervene. As the person who initiated the restraint, and noting RN C's position as an experienced senior nurse and the Clinical Nurse Manager, RN C retained primary responsibility for ensuring that appropriate monitoring occurred, especially as she had not given specific instructions to the other staff as to how Mrs A should be monitored. In any case, I remain critical that Mrs A was put into a position where she could cause further harm to herself in the first instance.

Positioning of Mrs A's thumb

91. RN E documented that Mrs A's right thumb was tucked under her palm when the bandages were unwrapped in the morning.

92. With respect to the positioning of thumbs, my expert advised:

> "[T]he use of a crêpe bandage to bind a patient's hands with the thumb against the palms is not accepted practice. It is never acceptable to bind a thumb to a palm of a hand in order to prevent a patient pulling at lines, as this is an abnormal position for the thumb to be held in."

93. RN C told HDC that she was careful to position Mrs A's thumbs in their natural position, and noted that she has many years' experience of bandaging in the Emergency Department. RN C stated that the abnormal positioning of Mrs A's right-hand thumb could have been caused subsequently by her pulling and her agitation, and that it was

reasonable for her to assume that the patient attender or registered nurse on duty would continue to observe Mrs A and intervene if need be.

94. I am unable to make a finding whether the abnormal position of Mrs A's thumb was a result of the original bandaging, or her subsequent pulling. However, it was either bandaged incorrectly to start with, or it was bandaged appropriately initially and the bandaging then moved to constrict the thumb as a result of Mrs A pulling, and this was not detected and addressed owing to inadequate monitoring. Either scenario reflects a reduced standard of care from RN C, because the resulting thumb position caused Mrs A further distress.

Lack of consideration of alternative options

95. RN C stated that at the time, she did not consider that her actions constituted a restraint. Even if the bandaging was not a restraint, and the Restraint Minimisation Policy did not apply (which is not my view), it would have been good nursing practice to consider and implement other de-escalation strategies before bandaging Mrs A in this way. I do acknowledge that on the night, RN C was called into an urgent situation, with the healthcare assistant unable to settle Mrs A further. This was not an easy situation to manage, and would have required clinical judgement, and there were limited options to prevent Mrs A from hurting herself.

96. Notwithstanding the mitigating factors stated above, and RN C's statement that there were few options available to her, I remain of the view that other possible interventions were open to RN C at the time. These included contacting Mrs A's family for guidance, or consulting a registrar for advice on dealing with Mrs A's behaviour. Whilst I acknowledge RN C's concerns that she was aware of Mrs A's increased risk of bruising and self-harm, in my view it would have been prudent to seek further help and consider alternatives to the bandaging, given that Mrs A's behaviour was disruptive and was escalating.

Conclusion

97. Whilst I accept that in bandaging Mrs A's hands it was RN C's intention to protect her and to ensure that her treatment was not compromised, she appears to have overlooked the risks and harm that could be caused, and failed to exercise reasonable care and skill in the bandaging process. Accordingly, I am critical of the adoption of this approach without clear consideration of other options.

98. Whilst it is unclear how far the bandaging went up Mrs A's arms, this does not change my conclusions.

Lack of monitoring of Mrs A

99. RN C acknowledges that she did not review or monitor Mrs A after the bandaging because she had expected the ward nurse to monitor her throughout the night, and because of her general busyness with other tasks. RN C did not discuss the bandaging with the ward nurse. She accepts that she should have documented her interactions, rationale, and monitoring expectations in the clinical notes.

100. RN Hogarth advised that bandaging must allow for some skin to be visible to assess for colour, warmth, movement, and sensation. This should be monitored and reviewed at regular intervals, and could have been delegated by RN C to the healthcare assistant. RN Hogarth concluded that there was a lack of monitoring, review, and documentation by RN C to ensure the safety of Mrs A.

101. I agree. It is clear from RN C's acknowledgement and from my expert's advice that there was no further monitoring, review, or documentation by RN C once the bandaging had occurred. There was also no clear delegation of the tasks to the ward nurse, which RN C accepts would have been helpful. RN C submitted that personal monitoring of a patient is not possible for a Clinical Nurse Manager on a busy shift, and that her role is for discrete clinical assistance. However, RN C had initiated this restraint, and, as a senior, experienced clinical nurse manager, she remained responsible for ensuring that Mrs A was monitored appropriately afterwards. As RN C has acknowledged, she left no specific verbal or written instructions regarding monitoring for Mrs A that the other staff could have utilised.

Communication with Mrs A, and family involvement with her care

102. Mrs A had suffered a stroke, which may have affected her ability to communicate. However, it was noted by Mr B that when the family visited during the day, Mrs A was still able to speak and communicate with them. Whilst her communication abilities during the time of events (i.e., the early morning of 1 Month2) is a little unclear, it was noted in the Behaviour of Concern Pathway that Mrs A had "nil cognition problems" after the stroke. Accordingly, whilst Mrs A's family continued to have involvement in her care, in my view Mrs A could still make her own decisions, as it appears that she remained competent.

103. Despite this, there is no evidence of efforts made by the nursing staff to involve Mrs A in her care. Nor was there any contact with Mrs A's family during the night to discuss her care or alternative options other than bandaging her.

104. I also note that communication with the family should have occurred to facilitate the provision of health services that respected Mrs A's social needs, values, and beliefs. Having her family involved to some extent was, in my view, necessary to achieve this.

105. RN C accepted in hindsight that she should have contacted Mrs A's family during the night. RN C explained to HDC that she was reluctant to contact the family in the middle of the night, as she considered that they needed rest and privacy, and she did not consider that Mrs A's agitation was an emergency at the time. However, it was documented in the clinical notes that Mrs A's family was happy to be called at any time for further deterioration.

106. I note that Mrs A was visibly distressed during the night, and I would have expected RN C to have taken steps to understand and address this better prior to applying the bandaging. Mrs A was in an unfamiliar environment being cared for by people unknown to her. I remind RN C of the importance of ensuring a patient-centred approach to care, which includes involving family in care and interventions. RN C appears not to have involved Mrs A in her care, and made the assumption that Mrs A's family did not want to be contacted

throughout the night. RN C was unaware of the documentation that clearly indicated that communication with the family was warranted.

Conclusion

107. In summary, I consider that RN C failed to provide appropriate care to Mrs A for the following reasons:

a) RN C's use of crêpe bandages to bind Mrs A's hands and arms was a restraint, and was implemented inappropriately. This led to Mrs A's thumb being placed in an abnormal position, and to constriction that resulted in bruising and discolouration.

b) After the bandaging, RN C failed to monitor, review, and document the care provided, including the rationale for the bandaging.

c) There was a lack of communication with Mrs A and her family in order to de-escalate behaviour such as biting off the bandage.

108. In my opinion, RN C did not provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[19] When considering the wrapping of Mrs A's hands and arms with crêpe bandages, which caused bruising and constriction, and the lack of monitoring and review of Mrs A following the bandaging, in my opinion RN C also failed to provide services in a manner that minimised potential harm to Mrs A. I therefore find RN C to have breached Right 4(4) of the Code.[20]

Opinion: District health board — adverse comment

109. This opinion concerns the standard of care provided to Mrs A by the DHB during Month1 and Month2. Mrs A was admitted to the Emergency Department and then transferred to a ward that specialises in neurology care, before being diagnosed with a stroke. She received care from numerous clinical and nursing staff.

110. The DHB has a duty of care to patients, and a responsibility to keep them safe whilst in hospital. For vulnerable patients, this includes assessing patients' risks and behaviours that may cause them harm during their stay. Although I do not find the DHB in breach of the Code, as ultimately the wrapping of Mrs A's hands was done by RN C, I set out my broader concerns about the care provided by the DHB below.

Lack of proactive strategy for Mrs A's behaviours of concern

111. Mrs A was on the ward from 28 Month1 until the night of the incident on 1 Month2. It was explicitly observed and documented in the Behaviour of Concern Pathway assessment that

[19] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[20] Right 4(4) states: "Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer."

Mrs A was interfering with her treatment, was unable to follow instructions, was agitated and confused, and was pulling on her lines. Mrs A was assigned a "CAT A" watch to provide 24-hour review, but during the night shift, Ms F was required to escalate Mrs A's care to a senior nurse.

112. My expert nursing advisor, RN Hogarth, advised:

> "[Mrs A's] agitation and attempts to remove lines had been occurring for a number of days prior to this incident. The Behaviour of Concern Pathway is a useful tool and had been used as required in this instance with 24hr review, with [Mrs A] a Cat A watch. There was time to discuss and implement a strategy with strong rationale and talk to the family about how this might be managed rather than being reactive to the situation."

113. I accept RN Hogarth's advice. There were multiple opportunities for the various nursing staff who assessed Mrs A to have proactively prepared a plan to intervene with the identified behaviours of concern, specifically, Mrs A's agitation and pulling at her lines. In my view, nursing staff should have developed a robust plan during the day when Mrs A's family was present, and this should have been documented clearly and communicated to staff, to prevent reactive management of care during a busy night shift.

114. Without an effective strategy to manage Mrs A's behaviour of concern, there was no co-ordination of care between the nursing staff during the day shift and the night shift. This was exemplified by the fact that Ms F was unaware of what to do for Mrs A and had to request help from the Clinical Nurse Manager.

Ability of junior staff to raise concerns about care provided by senior staff

115. When RN C was wrapping Mrs A's hands and arms during the early morning, Ms F was reportedly not present, but returned to find that Mrs A's hands were already covered by bandages and tape. Ms F told HDC that at the time of discovery, she did not question RN C about the correctness of the bandaging because she felt she should not question senior nursing authority. I note that Ms F did not specifically say to HDC that she was troubled by the bandaging when she observed it.

116. RN Hogarth advised:

> "The actions of the CNM put the HCA attender on the night of the 30 [Month1]–1 [Month2] in a difficult position as the decision making was out of their control and they did not feel they could do anything about the actions that had been taken."

117. I agree with RN Hogarth's advice. I remind the DHB of the importance of fostering a workplace culture where all staff feel empowered to advocate for patient safety, particularly where patients are vulnerable and unable to do so for themselves.

118. I commend RN E for her swift and appropriate actions upon discovering Mrs A's bandaging.

Changes made since complaint

119. Following the events, the DHB conducted an internal review with the nursing staff involved, and had follow-up discussion with Mrs A's family. The DHB told HDC that as a result of Mr B's complaint, it has implemented the following changes:

- It has made improvements in the configuration of the stroke ward. There is also a dedicated room to care for vulnerable patients safely. The patients can be visualised at all times, and the room is set up to provide a low stimulus environment. The configuration of the new unit is expected to prevent staff from being isolated, particularly during the night shifts.
- It has staffed the stroke ward with a dedicated registered nurse who is supported by an enrolled nurse or a healthcare assistant at all times.
- It has strengthened the senior nursing leadership model on the stroke and rehabilitation ward. Clinical charge nurses will now be involved in the management of patients who are exhibiting behaviours of concern.
- It has required all staff involved in the stroke ward to undertake patient-focused sessions.
- It has required all staff to complete the restraining training model.
- It has enabled healthcare assistants to receive the DHB study days, which cover care of the vulnerable patient, behaviours of concern, documentation, calming, and de-escalation.
- It has required nursing staff to undertake the bedside handover training module. The training involves the nurse who is caring for the patient handing over to the receiving nurse at the patient's bedside.
- It has implemented tools that are utilised to measure patient acuity levels and available nursing resource in wards, in order to ensure safe staffing levels.
- The DHB incorporated the support of vulnerable patients as part of nursing education, including what nurses should do if they feel that a vulnerable patient's safety is not being addressed adequately.
- Clinical nurse managers receive training for documentation of interventions put in place for a patient, and requirements to review those interventions and to increase accountability for the interventions implemented.

120. RN C told HDC that as a result of the incident, she has implemented the following changes:

- She has reflected carefully on the incident, including learning to contact the family member before acting, and asking for assistance with de-escalation in any future similar incidents.
- She will involve the ward nurse in her decision-making process in any future similar incidents.

- She will contact the doctor to discuss patient care in any future similar incidents.
- She will document her interactions and leave instructions for other nursing staff for follow-up in any future similar incidents.
- She now carries a notebook to make notes, and as a reminder to do so.
- She has refreshed herself with the Restraint Minimisation Policy, and has completed the most recent online restraint training module.
- She has completed a Clinical Nurse Manager course on "management of actual or potential aggression", which covers aspects of restraint.

Recommendations

121. I acknowledge that in response to the events, both RN C and the DHB implemented the changes described above. In addition, I recommend that RN C:

a) Provide a written apology to Mrs A's family, including details of the changes she has made in response to the event. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to the family.

b) Provide evidence and a short written report to HDC confirming her completion of the most recent online restraint training module and the Clinical Nurse Manager course on "management of actual or potential aggression". The report should be sent to HDC within six weeks of the date of this report.

122. I recommend that the DHB:

a) Use an anonymised version of this case for the wider education of nursing staff who provide care to elderly patients with high needs and communication difficulties. In particular, focus should be given to the breaches of the Code identified, having pro-active planning with the patient's family, and the de-escalation principles from the Restraint Minimisation Policy to which nurses should adhere.

b) Undertake a survey of a small random sample of nursing staff from the neurology ward to determine the awareness of, and compliance with, the DHB's Restraint Minimisation Policy. The outcome of the audit is to be provided to HDC within three months of the date of this report.

c) Provide evidence to HDC that the changes made and training provided to nursing staff since the events have been effective and have been complied with. This is to be provided to HDC within three months of the date of this report.

d) Review and consider the implementation of the recommendations made by HDC's independent nursing advisor in her report. This includes:

   i. The types of restraint in the restraint classification tool; and

ii. Evidence of the implementation or decision not to implement the recommendations.

The above consideration is to be provided to HDC within three months of the date of this report.

e) If not already completed, provide a written apology to Mrs A's family detailing the changes the DHB has made in response to the events. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to the family.

Follow-up actions

123. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Nursing Council of New Zealand and the Ministry of Health. The Nursing Council of New Zealand will be advised of RN C's name in covering correspondence.

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

Appendix A: Independent advice to Commissioner

The following expert advice was obtained from Associate Professor Karole Hogarth:

"Thank you for the request to provide clinical advice regarding the care of [Mrs A] by [the DHB] on 30th Month1.

In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

1. I registered as a nurse in 1989.Upon registration I was appointed to a new graduate position at Waikato Hospital and worked in orthopaedics, surgical and post-natal wards for the first year. I then received a permanent position in the burns and plastics unit at Waikato Hospital. Following 2 years' experience in this environment I moved to Saudi Arabia in 1992 working as an RN in the Burn Unit in Dhahran. Upon completion of my contract I moved to England and worked as an RN for an agency providing nursing care in hospitals and community settings. I then moved into a permanent night shift position at BUPA Hull and East Riding, a private hospital in a small community in 1995. On return to New Zealand in 1998 I attended the University of Otago undertaking a combined degree in Zoology and Anatomy completing First Class honours in both in 2001. I worked as an RN in Dunedin at Redroofs Rest home as an RN and casual as a RN at Dunedin Public Hospital during this time. Following the completion of my undergraduate degree I was invited to enroll in a PhD which I did following a further year of travel where I worked as an RN for the Australia blood service in Sydney. While undertaking my PhD in 2004 I was appointed to an academic role 2 days a week at Otago Polytechnic teaching anatomy to Occupational Therapy students. I then expanded my teaching into Bioscience for Nursing and Midwifery students. My PhD research looked at the role of oxytocin in the development and progression of prostate diseases which I completed in the Anatomy Department at the University of Otago in 2009. I was then offered a full-time position in the School of Nursing at Otago Polytechnic teaching sciences. My current role is Associate Professor and Head of Nursing. I am also a Justice of the Peace for New Zealand having completed the requirements for this role in 2016 and reaccreditation in 2018.

2. The Commissioner has requested that I review the documentation provided and advise whether I consider the care provided to [Mrs A] by [the DHB] was reasonable in the circumstances and why. With particular comment on:

    1. The appropriateness/adequacy of [the DHB's] 'Restraint minimisation and safe practice for patients' policy.
    2. Whether the use of crêpe bandages for restraint was appropriate in the circumstances, and if so, whether the tightness of the bandages was appropriate in the circumstances.

3. For each question I am asked to advise:

   a. What is the standard of care/accepted practice?
   b. If there has there been a departure from the standard of care or accepted practice how significant a departure do you consider this to be?
   c. How would it be viewed by your peers?
   d. Recommendations for improvement that may help to prevent a similar occurrence in the future.

4. In preparing this report I have reviewed the documentation on file:

   1. Complaint form dated 31st [Month2].
   2. [The DHB's] response dated 19th December 2019.
   3. Clinical records from [the DHB] covering the period 27th [Month1] to 1st [Month2].
   4. [The DHB's] 'Restraint minimisation and safe practice for patients' policy.

5. Background

[Mrs A], [in her nineties], was admitted to [the public hospital] on 27th [Month1] having suffered a stroke. Her family were distressed to find that on the night of 30th [Month1], [Mrs A's] wrists had been bound tightly by nursing staff as a form of restraint, resulting in deep bruising on her hands and arms.

My comments are confined to the care provided by [the DHB].

6. The appropriateness/adequacy of [the DHB's] 'Restraint minimisation and safe practice for patients' policy.

a. What is the standard of care/accepted practice?

The [DHB] Restraint Minimisation and Safe Practice Policy for Patients is a largely comprehensive policy which covers the use of restraint in a clinical setting. There are clear standards around the decision making and the rationale for the implementation of enablers to ensure patient and staff safety and welfare.

Some parts of the policy had been implemented in this case of [Mrs A] including:

- Patient attender
- Use of the Behaviour of Concern Pathway

It is clear in the policy that there are a number of steps that must be undertaken in the assessment for the need for restraint/enablers that were not considered in the case of [Mrs A] …

- Reasonable force …
- Assessments for use of restraint — documentation on the attendant plan …
- Considerations before restraint is applied …
- Monitoring …

- Communication with the patient and family/whānau …

[The] Restraint classification tool also outlines what is required once a restraint/enabler is in use:

- Assessment and monitoring
- Ensure correct application
- Check for skin integrity
- Appropriate planning and preparation
- Under direction of the responsible clinician

The CNM in this case did not follow the policy in the first instance. Being the only RN on duty is not outlined in [the DHB's] policy (… Situations where restraints may be appropriate) as one of the situations in which restraint may be considered. A patient attender was already in one on one care and could have been better utilised to settle the patient. There then followed a number of transgressions from the policy as detailed in 7 below.

b. *If there has there been a departure from the standard of care or accepted practice how significant a departure do you consider this to be?*

From the information provided I would consider that there is no departure from accepted practice and that the [DHB's] Restraint Minimisation and Safe Practice Policy for Patients policy is fit for purpose. Some suggestions have been made that may clarify and strengthen the policy.

c. *How would it be viewed by your peers?*

I believe that my colleagues in practice and education would find the Restraint Minimisation and Safe Practice Policy for Patients fits with national guidelines and that with minor adjustments provides the standards that are acceptable when as in this case patient safety and ongoing treatment are at risk. [Mrs A] was in a very vulnerable position with both cerebral and language barriers that meant she was unable to be fully involved in decision making about her own health and this policy gives guidance and practice standards to advocate for her safety and care.

d. *Recommendations for improvement that may help to prevent a similar occurrence in the future.*

There are some areas that could be strengthened:

i. … Legal and ethical considerations [are] brief. I think that this could be expanded to address factors such as accountability, consent (where appropriate from family) or what the law allows in regard to restraint in the healthcare setting. This is because this policy is not only used by the regulated workforce but also unregulated such as HCAs, orderlies etc. They may not necessarily have the background or context regarding the use of restraint or know what their

responsibilities are in circumstances where this is employed. There needs to be clarity around this rather than just the list of Legislation …

ii. Some clarity about the types of restraint in [the] Restraint classification tool.

For example — 'Physical/mechanical restraint = wrist restraint (2 point) for an extremely restless patient who requires essential treatment such as pulling out tubes/lines which are essential for treatment.'

What does a 2 point restraint entail? — examples needed for staff

iii. Some in service training in a multidisciplinary setting about how to implement safe restraint/enablers with clear guidelines around reporting, monitoring, reassessment, documentation and timing of restraint implementation.

7. Whether the use of crêpe bandages for restraint was appropriate in the circumstances, and if so, whether the tightness of the bandages was appropriate in the circumstances.

a. What is the standard of care/accepted practice?

i. Whether the use of crêpe bandages for restraint was appropriate in the circumstances

The wrapping of a luer site with a light bandage or Tubigrip is acceptable to ensure that it does not get caught and pulled, the pinning of a catheter to clothing or taping to a leg is acceptable with undergarments that inhibit being able to grab the tubing is acceptable. The accepted standard of care would also include discussions with the patient (if able), the team and the family to determine the best course of action to keep [Mrs A] safe during the periods that she was most agitated. This needed to be in conjunction with the restraint minimisation policy.

Crêpe bandaging needs to be undertaken with care. Bandages that have lost their elasticity or are pulled taut during application are dangerous as they act like rope to inhibit circulation and would be very uncomfortable and could result in loss of distal circulation.

The use of a crêpe bandage to bind a patient's hands with the thumb against the palms is not accepted practice. It is never acceptable to bind a thumb to a palm of a hand in order to prevent a patient pulling at lines, as this is an abnormal position for the thumb to be held in. Binding in this manner is not stated as a method of 'enabling' in [the DHB's] policy.

The protocol for application of restraint was not followed as per [the DHB's] policy with the main concern being consent from family with EPOA, no involvement of a physician or other senior staff member to discuss the rationale, method, timing, review and monitoring. There is no evidence of cultural and language considerations being addressed in the decision to restrain in this manner.

ii. Whether the tightness of the bandages was appropriate in the circumstances

The bandages on [Mrs A's] hands and arms appear to have been applied very tightly; this included wrapping with tape (? type) over the bandages presumably to prevent removal with teeth as indicated in the nursing notes. This is evidenced by the presence of bruising to hands and wrists as noted by the family and documented in the nursing and medical notes. *Nursing notes 30 [Month1]–1 [Month2] 0350 by [HCA F] — CNM applied crêpe bandages to both arms as fiddling constantly and attempting to pull out IDC.*

It is indicated that [Mrs A] was found by morning shift with binding, from the description I think that this continued from the hands up the arm to include the shirt. *Nursing notes 30 [Month1]–1 [Month2] by [RN E] — staff with 'both hands wrapped, with thumb tucked against palm' … 'bandages wrapped with layers of tape, R) hand so tightly wrapped that it was purple with tape marks evident, discoloured with poor capillary refill'.*

Bandaging must allow for some skin to be visible to assess for colour, warmth, movement, sensation. This should be monitored and reviewed at regular intervals, and this could have been delegated by the CNM to the HCA on night attender duty but should have been reviewed by an RN at least hourly and documented.

Another point to note is that [Mrs A's] agitation and attempts to remove lines had been occurring for a number of days prior to this incident. The Behaviour of Concern Pathway is a useful tool and had been used as required in this instance with 24hr review, with [Mrs A] a Cat A watch. There was time to discuss and implement a strategy with strong rationale and talk to the family about how this might be managed rather than being reactive to the situation. The actions of the CNM put the HCA attender on the night of the 30 [Month1]–1 [Month2] in a difficult position as the decision making was out of their control and they did not feel they could do anything about the actions that had been taken.

b. If there has there been a departure from the standard of care or accepted practice how significant a departure do you consider this to be?

From the information supplied I would consider that there is significant departure from accepted practice and care of [Mrs A].

The main departures from accepted practice were:

- the decision to bind a patient's hands without deferral to [the DHB's] Restraint Minimisation policy
- the method of bandaging ie crêpe bandages, hands and up arms, thumb in
- tightness of the bandaging including taping
- the positioning of the thumb in an abnormal position against the palm
- the lack of monitoring and review to ensure the safety of the patient
- lack of documentation by the RN in question

- lack of communication with the family including consent

This is not consistent with [the DHB's] Restraint Minimisation policy or with accepted nursing practice.

c. *How would it be viewed by your peers?*

I believe that my colleagues in practice and education would find the use of this kind of restraint and the manner in which it was implemented does not fit with current nursing practice.

d. *Recommendations for improvement that may help to prevent a similar occurrence in the future.*

As in 6 above the provision for in service on the implementation of [the DHB's] policy and application of restraint would be useful for all staff.

Poor staffing levels are a constant threat to patient safety and staff decision making can be impacted especially on night shift when fatigue is also an issue. Ensuring support and adequate staffing is essential to prevent reoccurrence. Pathways to call for assistance and advice must be easily accessible and potential issues recognised early.

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The following further advice was obtained from Associate Professor Hogarth:

> "I have been asked to provide further comment on the above case following responses from [RN C] and [the DHB].
>
> With particular comment on:
>
> **[The DHB]**
>
> Please review [the DHB's] response and advise whether any of the additional information submitted would cause me to change my advice in any way. If it does please advise what has changed and the reasons why.
>
> **[RN C]**
>
> 1. Please review [RN C's] response and advise whether any additional information submitted would cause me to change my advice in any way. If it does, please advise what has changed and the reasons why.
> 2. If not addressed above please comment on the following:
>
>   a. [RN C] denies putting [Mrs A's] thumb(s) in an abnormal position: and
>
>   b. [RN C] denies bandaging/taping tightly as to cause bruising or constriction (please provide advice for the alternative).
>
> **[DHB]**
>
> On review of the reply from [the DHB] I am satisfied that there are appropriate policies and procedures in place that provide guidance for staff to maintain patient safety.
>
> One area that I was not originally asked to comment on was staffing on the shift in question. This was highlighted by the staff on the ward and by [RN C] and **may** have contributed to this incident though this should not be used as an excuse for below standard patient care. The impact of short staffing and the busyness that this creates for staff can impact decision making as staff attempt to ensure all care for their patients. This can be exacerbated by shiftwork and tiredness. There is no easy solution and a review of staffing and the tools used to measure need … may be useful.
>
> **[RN C]**
>
> In her response [RN C] gives an account of the workload that may occur for a CNM on any given shift, and I agree that there is a huge level of responsibility. I have put this information aside as this is not about how busy any given shift is but the safety and welfare of patients, the assessment of a patient and decision making of an experienced staff member and the adherence to the policies of [the DHB] in this instance.

1. It is evident in the pictures of the bandaging of [Mrs A's] right hand that her thumb is wrapped in the bandage against her hand. This is not a normal position. I reiterate my response from my original review that [Mrs A's] hands should not have been bound in this way as it is a form of restraint and did not abide by [the DHB's] 'Restraint minimisation and safe practice for patients' policy.

2. [RN C] states that she did not bandage or tape tightly [Mrs A's] hands and that the bandages must have tightened due to the patient pulling at them with her teeth. She also states that she did not see the bandaging as a form of restraint at that time.

I do not see any evidence in the photographs of this except on the fingers where there may be some blood. The bulk of the bandaging over the mid hand is intact with no evidence of pulling or stretching. As an experienced registered nurse, [RN C] as part of her assessment of the patient, should have taken the patient's agitation and behaviour into account when making the clinical decision to strap [Mrs A's] hands, especially a patient that was likely to interfere with the bandaging. Therefore, the bruising and constriction were a foreseeable outcome of bandaging. The taping of the bandages is excessive, and the type of tape used is not flexible so there would have been no give.

[Mrs A's] hands should never have been strapped in this manner in the first instance whether the bandaging and taping were tight or not as this is a form of restraint. It does not meet [the DHB's] 'Restraint minimisation and safe practice for patients' policy or meet the accepted standard of care of an agitated confused patient for whom English was not a first language. There was no discussion with the family in regard to using any type of restraint under the policy and the staff on the morning shift were obviously concerned enough to take photographs and complete an incident report in which 'restraint' is the cause for concern.

Staffing is a perpetual issue in nursing but should not be used as an excuse for below standard provision of care to patients. This incident occurred at ~0500hrs nearly at the morning shift. It is noted that the staff on the ward had not requested assistance with this particular patient as she had a Category A watch so was well cared for though still restless, this was the point of the watch as per the notes.

For both 1 and 2 above:

These are significant departures from accepted practice as per my original advice.

I believe that my colleagues in practice and education would find the use of this kind of restraint and the manner in which it was implemented does not fit with current nursing practice.

Therefore, I reiterate my advice from my review of this case as submitted on the 18th September 2020."

Appendix B: The DHB's "Restraint Minimisation" policy

Under the Restraint Minimisation Policy, a restraint is defined as:

> "[T]he use of any intervention by a service provider that limits a patient's normal freedom of movement."

The Restraint Minimisation Policy also sets out a number of steps and rationale to be undertaken for the need for restraint. The category for physical/mechanical restraint sets out a wrist restraint should be used only "for an extremely restless patient who requires essential treatment" and "the patient [is] at risk of pulling out tubes/lines which are essential for treatment".

The Restraint Minimisation Policy also emphasises that patient safety and de-escalation principles need to be considered with the approved restraint to be applied only as a "last resort" after alternative interventions have been considered or attempted and determined inadequate. As such, the level of force of the restraint must "always be reasonable in the circumstances with regard to [the patient's] age and clinical condition".

The clinicians applying the restraint are also required to adhere to the following considerations before restraint is applied:

> "Key principles that underpin interaction with patient and restraint episodes or consideration of restraint:
>
> - Respect: All actions should demonstrate respect for the person and others.
> - Dignity: All actions should maintain the dignity of the person where possible.
> - De-escalation: Emphasis should be on de-escalation to minimise the need for restraint wherever possible.
> - Engagement: Where possible, engage the patient and the family/whānau and obtain cultural advice so that the situation can be calmed and de-escalated.
> - Safety: Restraint is only used where there is a safety risk to the patient or others, or compromises the therapeutic environment. Restraint should never be used to inflict pain or to deprive the patient's rights as a mean of diversion, distraction or punishment.
> - Last resort: Restraint is only used when necessary and after all less restrictive interventions have been considered or trialed and found to be inadequate.
>
> …
>
> **Considerations before restraint is applied**
>
> Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. Where there is a legal duty of care justification (see legislation), and all

other clinical interventions or calming and defusing strategies have failed the decision to approve restraint for a patient should be made:

- Only as a last resort to maintain the safety of patients, service providers or others;
- Following appropriate planning and preparation;
- By the most appropriate health professional;
- When the environment is appropriate and safe for successful initiation;
- When adequate resources are assembled to ensure safe initiation;
- Only under the direction of the responsible clinician.

… **Assessment for restraint use**

In assessing whether the restraint will be used consideration of the following factors should occur:

- Any risks related to the use of restraint including patient response to previous restraint events.
- Any underlying causes for the relevant behaviour or condition if known.
- Existing advance directives the patient may have made in relation to restraint.
- Any gender and cultural considerations.
- Desired outcome of using restraints and the detailed criteria for ending restraint.
- Possible alternative interventions/strategies.

Patient with a history of aggression or self-harm must have their history documented in their assessment documentation. Assessment of risk associated with behaviour disturbance is undertaken by nursing or medical staff members documented. A plan of care is to be developed. Staff members should refer to the Restraint Management Tool … to ensure the appropriate assessment has been completed.

…

Application of restraint

Only [the DHB] approved restraint techniques will be utilised. The principle of least restrictive practice will apply. There are potential risks associated with the use of physical restraint. These include: psychosocial injury; soft tissue injury; articular or bony injury; respiratory compromise; and cardiovascular compromise. Prolonged physical restraint increases the risk of restraint-related death.

… **Monitoring of personal restraint**

- The restraint initiator is responsible for monitoring the patient during the time of restraint in order to ensure the safety of the patient. The restraint initiator must be a health professional who is trained in de-escalation and restraint.

- It is essential that the patient's airway is not obstructed at any time, and that only authorised holds and positioning are used to minimize the potential for physical and psychological harm/injury.
- When the patient is restrained, checks must be made to ensure that no pressure is applied to the head, neck, chest, lower back or abdomen.
- The restraint initiator can delegate another health professional to continually monitor the patient for: level of consciousness, clear airway, breathing, skin colour and limb positioning.
- Verbal de-escalation should continue throughout restraint.
- Wherever a personal restraint exceeds 10 minutes all reasonable actions to end the restraint and seek an alternative non-physical intervention must be considered.
- A clinician, (nursing or medical) must remain throughout the full length of a restraint.
- During this process, acknowledgement and management of any patient distress should be addressed.
- The above monitoring must be recorded in the individual's Restraint Monitoring Form (CR8803 — see clinical forms), and in their clinical record.

…

Restraint classification tool/Assessment and Monitoring

- Ensure correct application.
- Check for skin integrity.
- Ongoing communication with the patient, family/whānau.
- Complete Behaviour of Concern Pathway (BOCP) if required.

Documentation is also required under the Restraint Minimisation Policy[1].”

[1] A physical/mechanical restraint requires the following documentation; BOCP (if required), CR8803 Restraint Monitoring form, clinical record, (Neuroservices) restraint monitoring care plan for (CR4514) and Wrist.

Appendix C: Images of Mrs A's hands on 1 Month2