Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 21HDC01302)

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1. This report is the opinion of Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner. The report discusses the care provided to a client by Health New Zealand|Te Whatu Ora (Health NZ).

2. A lawyer raised concerns with HDC about an injury received by the client during a restraint by clinic staff, which caused pain and required surgery.

3. The following issue was identified for investigation:

   - *Whether Health New Zealand|Te Whatu Ora provided the client with an appropriate standard of care on 8 January 2021.*

4. This report sets out the Deputy Commissioner's opinion on the standard of care the client received from Health NZ, and the actions it took in response to the injury.

Background

5. At the time of the events on 8 January 2021, the client (then aged 19 years) resided in a secure unit that provides forensic psychiatric services.[1]

[1] The branch of psychiatry that relates to mental illness and the law.

6. The client was remanded to the clinic in September 2019 for assessment of fitness to stand trial and possible disposition options.[2] Subsequently, the client was found unfit to stand trial and remained at the clinic as a special care recipient[3] under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (the IDCCR Act).[4] The complainant is a lawyer appointed to ensure that the provisions of the IDCCR Act are upheld for the client as a special care recipient.[5] She raised this complaint on the client's behalf.

7. The client has been diagnosed with Fetal Alcohol Spectrum Disorder (FASD)[6] and a mild intellectual disability. The client had no history with mental health services. The client resided in the clinic's forensic psychiatry medium secure unit as there were no suitable beds in Health NZ's Forensic Intellectual Disability Secure Services (FIDSS).

8. Health NZ told HDC that the client's life had been unstable for a significant period and had been complicated by factors including substance abuse, living on the streets, involvement with the police, and a likely history of early trauma. Health NZ stated that while the client did not normally present with physical aggression, the risk of harm to self and others was known to increase when the client was in a vulnerable state.

9. The care plan directed that additional support be put in place when the client is stressed and vulnerable to ensure safety of self and others. This included staff supporting and promoting the client's 'active engagement' to reduce the risk of dysfunctional behaviours such as deliberate self-harm. The client had been encouraged to approach staff if distressed or angry, and staff were told to prompt the client to use coping skills and/or have time out in their room or the library or be given courtyard access for exercise. Health NZ said that the client had told staff that when showing early warning signs of stress or anger, the best thing to do was to provide space and time alone.

How the complaint arose

7 January 2021

10. On the evening of 7 January 2021, the client had a disagreement with another client. The client became angry and agitated and attempted to assault the other client. Health NZ stated that 'although [staff] placed hands on [the client] [as a restraint] and [to] move [the

[2] Disposition is a process for reaching an outcome in cases where a defendant is found unfit to stand trial.
[3] In relation to the client, a person who is liable to be detained in a secure facility by a court order made under section 24(2)(b) of the Criminal Procedure (Mentally Impaired Persons) Act 2003.
[4] The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 established a scheme that authorises the provision of compulsory care and rehabilitation to individuals with an intellectual disability who have been charged with, or convicted of, an imprisonable offence.
[5] The complainant is a district inspector — a lawyer who is appointed by the Minister of Health to protect the rights of people receiving treatment under the IDCCR Act or the Mental Health (Compulsory Assessment and Treatment) Act 1992. District inspectors are independent of the Ministry of Health and health and disability services.
[6] A neurodevelopmental disorder caused by exposure to alcohol before birth. Though the severity of FASD varies, its symptoms are irreversible. Symptoms may include a mix of complex and persistent physical, behavioural, learning, and intellectual problems.

client] to high care,[7] it only required a wrist hold and [the client] went willingly'. The client calmed down quickly in the high-care area of the unit and returned to the ward within 30 minutes.

11. Health NZ said that this incident was 'the most significant stressor … that was a clear precipitant' to the events of the following day, which are the subject of this investigation. The client was also upset that attempts to contact the client's mother by telephone earlier in the day had been unsuccessful.

8 January 2021

12. At midday on 8 January 2021, the client was assessed by the responsible clinician in relation to the incident that occurred the previous evening. The client was observed to be 'sad and irritable'. The client was later documented to have told the primary registered nurse about some self-harm and said that given the means, the self-harm attempted would have been worse. The client was also still angry with another client following an argument the previous day.

13. A decision was made to move the client from the bedroom at the rear of the ward to a bedroom near the staff office, where closer observation was possible. Neither the person/s who made this decision nor the rationale for the decision are documented. Staff made only two entries in the notes that evening, at 7pm and a retrospective entry at 10.31pm. Health NZ acknowledged that documentation that evening was 'minimal' and 'not of the expected standard' and said that it had largely established what happened from interviewing staff and clients.

14. In the early evening, the client made further comments to the primary nurse that indicated increased thoughts of suicide. As a result, the client was placed on 'Special Observations', which required the client to remain in sight and sound of a registered nurse or a healthcare assistant. Staff also decided to remove any of the client's belongings that could be used as a means of self-harm. At that point, the client became increasingly angry and was 'verbally aggressive' towards staff.

15. A registered nurse and a healthcare assistant asked the client to walk to the high-care area with them to de-escalate. When the client declined to do so, the two staff attempted to put the client in an escort hold (a type of restraint) to guide the client to the high-care area. The healthcare assistant attempted to take the client's arm, and the client 'hit out at him'. When the registered nurse also tried to take hold of the client's right arm, the client 'hit out' and knocked the nurse against the wall. Both staff then tried to take hold of one of the client's arms, and there was a 'significant struggle' and all three people fell to the floor.

16. The client's recollection of events differs. The client states that the healthcare assistant 'grabbed [me] by the arm and took [me] to the floor, then walked [me] through the main lounge, holding [my] arm behind [me] and twisting it'. Health NZ noted that there were

[7] A safe, quiet, low-stimulus area where clients can receive a high level of care and support and de-escalate with dignity.

some inconsistencies in the client's account of the incident, in that later the client stated that while still on the floor, a second healthcare assistant arrived to walk the client to the high-care area.

17. Ultimately, the client was taken to the high-care area by the original healthcare assistant and the second healthcare assistant (who had taken over from the registered nurse), and seclusion[8] was commenced at 6.30pm. Health NZ said that seclusion must have been initiated by the two healthcare assistants, in breach of its policy and procedure, as they were the only staff present at that point.

18. Health NZ stated that the facility was part of the national 'zero seclusion' project by Te Tāhū Hauora|Health Quality & Safety Commission, and it had been working on several initiatives to eliminate seclusion. Health NZ said that seclusion was very unusual for the client and had happened only once before.

19. When seclusion was officially terminated at 7.30pm (the door was open from 7pm), the on-call doctor assessed the client, who was noted to be calm and apologetic but was reporting pain. A portable X-ray revealed that the client had sustained an injury.

20. The client was transferred to hospital that evening and received treatment. Following further investigations, the client returned to hospital for surgery on 25 January 2021, and recovered well over the following months.

Adverse event report completed by Health NZ

21. On 12 January 2021, the Charge Nurse Manager completed an adverse event triage form in relation to the client's injury three days previously. Further investigation was recommended to learn from the incident, as the injury was recognised to have been sustained during a restraint that should not result in any injury.

22. On 10 October 2022, Health NZ provided HDC with a detailed adverse event report (AER) concerning the injury during a restraint. The AER noted that the client's injury was the first injury to have occurred during a restraint at the facility in six years.

AER findings

23. The AER concluded that 'improved management and care of [the client's] emotional state may have prevented the event from occurring'. The AER set out five key findings:

1. The incident on 7 January 2021 was 'very poorly managed and is likely to have had a direct impact on [the client's] emotional state, as did the decisions to increase monitoring [the next day and] … it appears there was no consideration of the de-escalation strategies … in [the] care plan'.

[8] An environmental form of restraint in which a person is placed alone in a room or area they cannot leave freely.

2. The restraint was 'poorly managed and likely resulted in the fall where [the client] most likely sustained the [injury]'.
3. The seclusion breached policy 'as it was initiated by the two HCAs without RN leadership. Staff handed over to the on-call consultant that it was due to risks to self, which is not an indication for seclusion.'
4. Documentation did not meet the expected standard. Several key decisions and events were not recorded or were recorded only 'at a very superficial level'.
5. There was 'poor consultation, coordination and leadership throughout the event and starting from the previous day. Registered nurses did not routinely take an active lead in directing and overseeing the care of [the client].'

AER recommendations and changes made

24. The AER made recommendations for improvements in six key respects. On 12 October 2023 Health NZ provided HDC with an update on its progress on each of the recommendations. The recommendations and progress update are set out below.

De-escalation

25. The AER recommended that all staff working with the client should be familiar with FASD, managing patients with intellectual disability, and the client's care plan. The AER listed three actions that would be taken to achieve this recommendation:

1. The clinic's forensic psychiatric service would incorporate FASD and Positive Behavioural Support[9] in its yearly education plan as required learning for inpatient staff (as part of orientation and update days).
2. A guideline would be developed for staff in mental health units who are managing care recipients under the IDCCR Act.
3. A patient's care and rehabilitation plan and nursing care plan would be integrated and must be reviewed at weekly clinical meetings with the patient's input.

26. Health NZ said that familiarity with FASD and intellectual disability had been identified as a broader training need across the division of specialist mental health and addiction services. As a result, clinical nurse educators were collaboratively developing a half-day package of training for nursing staff. This training would develop understanding of trauma-informed care, FASD, and common forms of neurodiversity, such as autism spectrum disorder and intellectual disability, and will be included in the 2024 learning framework and offered to inpatient nursing staff quarterly.

27. Health NZ said that it had also developed a guideline for staff in mental health units who are managing recipients of care under the IDDCR Act. The guideline would be implemented to all staff across the service and would make clear that a patient's care and rehabilitation plan and nursing care plan are integrated and should be reviewed at weekly clinical meetings.

[9] Individualised strategies to try to reduce and stop a behaviour or the need for the use of any restrictive practices, whilst helping the person to develop the skills required to avoid using challenging behaviour to have their needs met.

Health NZ said that this was occurring in practice while the guideline was being developed, as the Care Manager attended weekly clinical review meetings and integrated key aspects of clients' care and rehabilitation plan goals into plans for the week ahead.

Restraint

28. All staff involved in the incident with the client were to reattend full calming and restraint training. Health NZ confirmed that six of the eight staff who were working on 8 January 2021 were up to date with their calming and restraint training, and the two remaining staff were booked on courses in October 2023 (it was noted that only three of the eight staff still work in the unit). Health NZ stated that compliance with annual calming and restraint training varies between 76% and 91% across different inpatient units in the service, and it continued to work towards 100% compliance with annual training.

Seclusion

29. All staff involved in the incident should be familiar with the seclusion policy, particularly around the need for registered nurse leadership. The AER stated that this was to be achieved by setting up 'in-service training in areas that use seclusion, to cover purpose, procedures and roles and responsibilities of staff involved in any seclusion event'.

30. Health NZ said that staff in the facility had education sessions with the Clinical Nursing Director and two clinical nurse specialists on 20 March 2022 and 6 July 2022 about the requirements of the seclusion policy. In addition, information and discussion about the seclusion policy is included in the annual calming and restraint training package.

Documentation

31. All clinical documentation was to meet legal and local requirements. Two actions would be taken to achieve this:

1. A workshop would be held for all staff about legal and local requirements for documentation and how to problem-solve barriers to completing documentation.
2. A quarterly documentation audit would be embedded into the routine.

32. Health NZ said that the Clinical Nursing Director met with staff on 20 March 2022 and 6 July 2022 to deliver in-service training, which included discussion of legal and local documentation requirements and specifically covered the documentation of seclusion. In addition, Health NZ said that clinical documentation audits are completed every two months as part of the Specialist Mental Health and Addictions Service audit schedule. The audit had shown that compliance ranged between 90% and 94% for randomly selected audits completed between October 2022 and February 2023.

Nursing co-ordination

33. Shift co-ordination training was to take place to outline the responsibilities for leadership and ensure that shift co-ordinators are not carrying out duties that prevent them from leading the shift, such as special observations.

34. Health NZ said that its Clinical Nurse Educator had developed a training package for shift co-ordinators across the site and it had been trialled and delivered to 10 shift co-ordinators. This shift co-ordination training is part of the nursing learning framework and will be offered quarterly.

Staffing cover model

35. The cover model relating to the staffing of shifts was to be reviewed, with nursing leadership and the Operations Manager to address the skill mix and staffing ratio of unregistered and registered staff. Health NZ said that this revision and reworking of cover models is an 'active project across the site', which is being championed by the Associate Director of Nursing and the Group Manager.

Additional improvements

36. Health NZ stated that it has made significant changes to the way it cares for people with mental illness or intellectual disability who are on remand for criminal offending.

37. In addition, Health NZ said that it had established a monthly meeting led by a group of Pacific staff to review and develop care delivery for people of Pacific descent. The group is represented at the Clinical Governance Meeting and is supplemented by an ongoing needs assessment survey of the needs of Pacific staff, service users, and family.[10]

Notification of HDC investigation

38. On 24 July 2023, I notified Health NZ of HDC's investigation of the complaint. I proposed that HDC find Health NZ in breach of Right 4 of the Code of Health and Disability Services Consumers' Rights (the Code)[11] based on its AER relating to the client's case.

39. I proposed this option as Health NZ accepts that the client was injured during a restraint by clinic staff, that the injury should not have occurred, and that it caused the client pain and required surgery.

40. On 12 October 2023, Health NZ responded to HDC's proposal to agree a breach of the Code. It also provided details of its implementation of the AER recommendations and other relevant improvements. Health NZ stated:

> '[Health NZ] does not contest the breach proposal … [HDC] concluded that [this service] breached patient rights in the care of the client on 8 January 2021. [HDC] acknowledged that the serious incident review … on behalf of [Health NZ] … was an appropriate investigation and [HDC is] now seeking information regarding progress against the review recommendations.
>
> … Given the substantial service improvements that have occurred since the time that the client suffered [the] injury, if the client was admitted to the [facility] in similar

[10] Conducted as part of a postgraduate research project led by a researcher of Pacific descent.
[11] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

circumstances today, [the care would be] qualitatively different from that received in January 2021.'

Responses to provisional opinion

41. The provisional opinion was shared with Health NZ for comment. Health NZ advised that it did not wish to comment on, clarify, or dispute any of the information gathered during the investigation, or the preliminary conclusions, proposed recommendations, or follow-up actions.

42. The sections of the provisional opinion containing the information gathered during the investigation was shared with the complainant for comment. The complainant confirmed that she had consulted with the client, who did not wish to comment.

Opinion: Health NZ — breach

43. Having undertaken a thorough assessment of the information gathered, I am critical that systemic issues culminated in the client being seriously injured during a restraint. Health NZ responded to the incident appropriately with a detailed investigation and recommendations for improvement. However, I am concerned that some of the key improvements were not implemented in a timely manner. I have set out my decision on these matters below.

Care provided to the client — breach

44. I acknowledge the impact of this event on the client. The injury caused significant pain. The client's movement was limited for many weeks, and the client was not discharged from follow-up care until June 2021.

45. I commend Health NZ's prompt decision to investigate the cause of the injury. Health NZ took responsibility for the errors identified in the AER and committed to make changes to policies and processes to prevent a similar incident happening again. It is notable that Health NZ's investigation sought a 'full contextual understanding to ascertain learning and improvement points'. In my view, this holistic approach resulted in a good contextual understanding of all the events that led to the client's injury, including the events of the previous day that had caused vulnerability and feelings of anger.

46. Nonetheless, a serious incident occurred that resulted in a significant injury to a client. As Health NZ stated, its 'approved methods of restraint should not result in any injury'. The AER highlighted the key areas where Health NZ considered that, had failures not occurred, the injury might have been avoided. I am satisfied that Health NZ appropriately identified six broad areas where things went wrong. Nursing leadership, staffing levels/skill mix, and clinical record-keeping are fundamental to the safe operation of services, as are staff training and compliance with de-escalation techniques and methods of restraint, including seclusion.

47. It is clearly problematic that the client was residing on a forensic psychiatric ward, with staff who were trained to care for those with a mental illness. The client was not diagnosed with

a mental illness and should have been placed in a forensic intellectual disability setting, with staff who were trained to care for intellectual disability and FASD. Health NZ acknowledged the issues that arose from the client's placement in the facility, with the AER stating that 'the staff [in the unit] outlined that they have limited orientation, knowledge and understanding of how to work with someone with an intellectual disability and FASD'.

48. This highlights a common theme in complaints, of the difficulties disabled people with co-existing problems face in accessing care. The client was not able to reside in a forensic unit that provided intellectual disability care. Similar difficulties arise for people who are neurodivergent or have an intellectual disability and are in crisis, but do not meet diagnostic criteria for a mental health disorder. Where people with these conditions are placed in an inpatient psychiatric unit due to a lack of disability care options, as the client was, the facilities are not well suited to their needs and can in fact be detrimental to their wellbeing.

49. Ultimately, Health NZ has an organisational responsibility to provide a reasonable standard of care to its clients. That did not occur in this case, as Health NZ failed to employ de-escalation strategies and managed the client's restraint poorly in several respects, to the extent that the client was injured. Seclusion was then initiated by healthcare assistants without the leadership of a registered nurse and in breach of the seclusion policy, and documentation of the events of that evening is minimal. Accordingly, with Health NZ in agreement, I find Health NZ in breach of Right 4(1) of the Code for failing to provide services with reasonable care and skill.

AER recommendations — adverse comment

50. An adverse event investigation should recommend specific actions to be taken to mitigate the risk of a similar event happening again. As explained above, Health NZ conducted a detailed investigation of the circumstances that led to the injury, and identified the key areas where improvements were needed, and I commend them for doing so in such a comprehensive and patient-centred manner.

51. As the identified failings were at a systemic level, it is reasonable that Health NZ's recommendations were also systemic in nature, focusing on training, upskilling, and staffing matters. The recommendations correspond with the identified gaps in staff knowledge of intellectual disability, non-compliance with clinic policies, poor record-keeping, and lapses in nursing leadership, and are suitable to remedy them.

52. Recommendations from an adverse event investigation must be implemented in a timely manner to ensure that the event is unlikely to happen again. Health NZ updated HDC about its progress towards implementing the recommendations in October 2023, which was one year after the recommendations were made and two and a half years since the events.

53. It is evident that suitable training was carried out to improve the knowledge of staff regarding the clinic's seclusion policy and the accepted clinical record-keeping standard. I note that seclusion is now part of the clinic's annual calming and restraint staff training. Likewise, the clinic's documentation is audited regularly and has shown a high level of compliance since the record-keeping training was delivered. Health NZ advised that the shift

co-ordination training was also delivered to 10 shift co-ordinators, although it is unclear whether those 10 staff comprise all the clinic's shift co-ordinators.

54. Health NZ's other recommendations towards improving de-escalation, use of restraint, and the clinic's staffing cover model are not as well progressed. Health NZ did not meet its own implementation targets in this respect, as the latest target date for the staff guideline on IDCCR recipients' care was 30 June 2023.

55. It is troubling that staff had not received planned training on FASD and positive behavioural support or the guidance for providing care to IDCCR recipients by October 2023. Two of the staff who were involved in the events were not up to date with annual calming and restraint training at that time, and Health NZ's data shows that nearly a quarter of staff in one inpatient unit were non-compliant with this training.

56. I am also concerned that the staffing cover model review had not yet finalised the appropriate balance between patient demand and staff capacity. An undated Health NZ briefing paper about the cover model review confirmed that it was an active and much-needed project, as it noted that 'the existing nursing cover models have not evolved to accommodate the changes required to deliver contemporary forensic models of care, which now encompasses least restrictive practices and a move away from containment to care and therapy'.

57. The recommendations made in Health NZ's AER were appropriate to mitigate the risk of a patient receiving an injury during a restraint, as the client did. However, it was important for Health NZ to implement the recommendations in a timely manner. I am critical that several key recommendations were not implemented by October 2023 given that Health NZ had recognised that those actions were needed to remedy systemic issues affecting the care provided in the clinic.

Recommendations

58. Considering the actions that Health NZ has already taken in response to the events, I recommend that Health NZ:

a) Provide a written apology to the client that reflects on the deficiencies identified in this report. The apology should be sent to HDC, for forwarding to the complainant (on behalf of the client), within three weeks of the date of this report.

b) In terms of the planned half-day package of staff training regarding trauma-informed care, FASD, and common forms of neurodiversity, confirm:

   i. whether this training has been implemented, and if so, when;

   ii. what the training includes (please provide a copy of the training outline);

   iii. which staff the training will be offered to (the AER recommendation stated that it would be for all inpatient staff, while the progress update said that it would be offered to inpatient nursing staff);

iv. whether the training will be mandatory; and

v. whether the training will be one-off or an annual requirement.

c) In terms of the guideline for staff in mental health units who are managing recipients of care under the IDDCR Act, confirm that this guideline has been approved and implemented and provide information (such as audit results or similar) about the impact of the guideline on the clinic's service.

d) In terms of the AER recommendation that all staff involved in the incident with the client attend full calming and restraint training, confirm that all eight staff are now up to date with this training.

e) Confirm that the clinic's nursing shift co-ordinators have attended, and are up to date with, shift co-ordination training.

f) Confirm that the revised staffing cover model has been approved and implemented and provide information (such as audit results or similar) about the impact of the revised cover model on the clinic's service.

59. Health NZ's responses to points b) to f) should be sent to HDC within two months of the date of this report.

Follow-up actions

60. A copy of this report with details identifying the parties removed will be sent to Health New Zealand|Te Whatu Ora, Whaikaha|Ministry of Disabled People, and Te Tāhū Hauora|Health Quality & Safety Commission and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.