NEW ZEALAND HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL
TE RŌPŪ WHAKATIKA KAIMAHI HAUORA

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BEFORE THE HEALTH PRACTITIONERS' DISCIPLINARY TRIBUNAL

HPDT NO	**1202/Nur21/513D**
UNDER	the Health Practitioners Competence Assurance Act 2003 ("the Act")
IN THE MATTER	of a disciplinary charge laid against a health practitioner under Part 4 of the Act.
BETWEEN	**THE DIRECTOR OF PROCEEDINGS designated under the Health and Disability Commissioner Act 1994**
	Applicant
AND	**[A], of [X], registered nurse**
	Practitioner

HEARING held in Wellington on 4 October 2021

TRIBUNAL	Ms T Baker (Chair) Ms C Neilson-Hornblow, Ms L Corlett, Ms H Pocknall, Mr C Nichol, (Members) Ms G Fraser (Executive Officer) Ms J Kennedy (Stenographer)
APPEARANCES	Mr G Robins, Acting Director of Proceedings and Ms D Roche for the Director of Proceedings Ms S Eglinton for the practitioner

PRELIMINARY DECISION OF THE TRIBUNAL ON DISCIPLINARY THRESHOLD

Introduction

[1] A panel of the Tribunal convened on 4 October 2021 to hear a charge of professional misconduct laid by the Acting Director of Proceedings (**the Director**) against the practitioner, [A]. The parties agreed that the conduct amounted to malpractice and/or negligence, and/or conduct likely to bring discredit to the profession,[1] but there was a dispute about whether it met the threshold to warrant a disciplinary sanction.

[2] For the reasons outlined below, the Tribunal has found that the conduct does meet both parts of the test for professional misconduct and will hear further from the parties on the question of penalty. Directions are made at the end of this decision.

The Charge

[3] The Director of Proceedings charged that:

1. On [ ] April 2018, after your patient had kicked and broken a glass panel in a lounge door, you applied unreasonable restraint and/or physical force to your patient when you:
   (i) took hold of the back of his collar with your right hand; and/or
   (ii) pushed him out of the lounge, while still holding him by the back of his collar; and/or
   (iii) pushed him down the corridor towards his bedroom, while still holding him by the back of his collar.

   AND/OR

2. On [ ] April 2018, after your patient had kicked and broken a glass panel in a lounge door, you failed to appropriately manage and/or respond to your patient's behaviour when you:
   (i) failed to use de-escalation techniques in a way that was suitable and/or reasonable in the situation; and/or
   (ii) considered that your patient was in an aggressive state without assessing whether he was in fact in an aggressive state; and/or
   (iii) used restraint and/or physical force that was disproportionate to any risk to the safety of your patient, yourself, other patients and/or other staff members; and/or

[1] The definition of professional misconduct found in section 101 of the Health Practitioners Competence Assurance Act 2003.

(iv) did not consider the option of escorting other patients out of the lounge; and/or

(v) failed to ask available staff members to assist you with:

a. responding to your patient; and/or
b. escorting your patient out of the lounge; and/or
c. escorting other patients out of the lounge.

AND/OR

3. On or immediately after [ ] April 2018, you failed to accurately report the care you provided to your patient, insofar as you omitted from the incident report:

(i) the restraint and/or physical force you used to remove your patient from the lounge; and/or

(ii) your reason for using such measures.

The relevant facts

[4] The evidence before the Tribunal was in the form of an agreed summary of facts, a video of the incident that was the subject of the charge, affidavits from RN Megan Sendall (expert witness for the Director), and statements from RN [A] and RN [E].

[5] The parties also filed an Agreed Bundle of Documents which included notes relating to the resident, and relevant policies and standards. At the hearing RN Sendall, RN [A] and RN [E] were all available for questioning. RN Sendall's experience and expertise in aged care and psychogeriatric services was set out in her affidavit and there was no challenge to her qualification to provide an opinion on the appropriate standards expected of a nurse in RN [A]'s position at the date of this incident.

[6] The following evidence is relevant to the Tribunal's finding of professional misconduct. The Tribunal heard further evidence including about RN [A]'s history and current circumstances, which will be referred to in the final decision.

[7] The parties agreed that in April 2018 Mr [D] had been a resident of the specialist level two high dependency unit (HDU) at Bupa's [hospital/rest home] since November 2012, and since April 2015 had been the subject of an indefinite compulsory treatment order under the Mental Health (Compulsory Assessment and Treatment) Act 1995 because of chronic schizoaffective disorder and vascular dementia. RN [A] was

employed at [hospital/rest home] as a registered nurse from January 2011 until June 2018.

[8] The practitioner accepted that each of the particulars was established. In particular, it was agreed that at approximately 1:18pm on [ ] April 2018, Mr [D] slowly walked to a set of external glass doors and stopped in front of them. He then began to swing his lower right leg towards the lower glass pane of the left door for around 6 seconds. He kicked the glass pane approximately three times, causing the glass to break.

[9] RN [A] then left the nurse's station and walked towards Mr [D]. As soon as he reached Mr [D], he took hold of the back of Mr [D]'s shirt collar with his right hand and placed his left hand on Mr [D]'s left arm. He then "redirected" Mr [D] away from the doors, causing him to drop the mug he was holding. RN [A] then pushed Mr [D] out of the HDU lounge down the corridor towards his bedroom, while still holding his collar.

[10] RN [A]'s evidence was that as he left the nurse's station, he asked Mr [D] 3 or 4 times to go to his room and at the same time he completed a quick visual inspection of Mr [D]'s legs and feet, which took 1 to 2 seconds. RN [A] told the Tribunal that he asked Mr [D] if he was injured or in pain and that Mr [D] responded, "No, I am fine", or words to that effect. He said Mr [D] then walked a few steps away from the glass and he started to swing his body, which to RN [A] was a warning sign that he was about to become aggressive. He noted that you cannot see this in the video, possibly because it was only a minor movement. RN [A] said that another resident became agitated by clapping his hands and making sarcastic comments, which is a warning sign of that resident becoming aggressive.

[11] Later that day, RN [A] made the following entry into Mr [D]'s progress notes:

> /4/18 14:00 Witnessed [D], without any trigger or provocation, kicking on the glass pane of the exit door. Assessment done, no scratch mark or injury sustained, lucky guy. Redirected to the main room. Broken glass cleared and left-over glass removed from the remaining frame. Space locked with notice board, on maintenance book to have it fixed.

[12] At some point after the incident, RN [A] also completed an incident report, in which he recorded:

> I was in the nursing station when I witnessed said resident who without any provocation, kicked on the glass pane of the exit door with his right foot.
>
> …
>
> Resident assessed, no bruise, no scratch marks and nil injury sustained, very lucky guy. Redirected to his room, Cordon made all over the surrounding area, pieces of glass cleaned and leftover glaas (*sic*) on the remaining frame removed for the safety of staff and residents.

[13] Included in the Agreed Bundle of Documents were the following policies from Bupa:

- *Behaviours that challenge*
- *Restraint*
- *Incident Policy*

[14] The policy entitled *Behaviours that challenge* defines such behaviours as any "… which cause distress or put the resident or others at risk of harm. These behaviours are generally associated with a decline in cognitive capacity and are mostly due to dementia or delirium". Examples are provided. The policy covers ways in which to prevent behaviours that challenge, and notes:

> It is important to recognise that behaviours associated with dementia are not **bad** behaviour on the part of the person – these symptoms are often associated with chemical changes in the brain or by social and environmental triggers – **the behaviours are due to the dementia**.

[15] The policy has a section entitled "Responding to behaviours that challenge, an outburst of behaviour". The key steps are first to remove others from imminent harm, to ensure the dignity of the person displaying the behaviour by moving others out of the area, and then to try to understand what the resident is trying to communicate by the behaviour. The policy stipulated that the main thing is to remain calm, speak in a quiet manner and use the person's name. De-escalation techniques include offering a cup of tea, taking them outside, opening the door and taking them for a walk.

[16] Bupa's Restraint policy includes the following:

> **Restraint**
>
> - The use of any intervention that limits a resident/client's normal freedom of movement – (eg it is preventing someone from going somewhere)

- It is only used when clinically indicated and when all other alternatives have been tried
- The least restrictive method must be used – and for the least amount of time with the least amount of force
- Restraint is used as a last resort to maintain the safety of the resident/client, staff and others

[17] The policy is quite extensive and much of it is on the assessment of residents by a registered nurse and consultation with family and whanau on the use of restraint to assist or support a resident, for example for reduction of falls. The approved methods of restraint are lap belts, T belts, Tabletop chairs, Fall out chairs, Bed rails, Bean bags and secure access into the unit via key pads. Even under the heading "Emergency Restraint", the policy seems to envisage the use of restraint over a period of time, rather than as a means to remove someone from a situation. There is no reference to the use of physical handling to remove a resident either for the wellbeing of themselves or others. Nowhere in the documents before the Tribunal was any evidence of approved methods or training to physically restrain residents in those limited circumstances, once de-escalation had been attempted.

[18] The *Incident Policy* includes the incident management process and requirements for reporting.

[19] The evidence of the Director's expert witness, RN Megan Sendall, also emphasised the need to remove others if there is a risk of harm, and to use similar de-escalation techniques. In her opinion the policies align with accepted professional nursing standards.

[20] RN Sendall noted that Mr [D] was recorded in the Bupa documentation as having a history of aggressive behaviour and being unpredictable. She noted that in the industry, these are more commonly referred to as symptoms rather than behaviours. A person may hit a glass wall because of a change in perception, rather than a sign of aggression.

[21] RN Sendall accepted that removal of Mr [D] from the lounge was one option available to RN [A], but only if a thorough assessment of the situation had first been carried out and it is apparent that other de-escalation techniques are not possible. RN Sendall said that if it was thought the resident should be removed, it should be done in an appropriate, respectful and reasonable manner, and it is very rarely appropriate to use force; there must be a real and live risk to physical safety of the resident, other staff

and/or residents that outweighs the obligation to consider non-forceful de-escalation techniques.

Grounds for discipline

[22] The grounds on which a health practitioner may be disciplined are set out in section 100 of the Act. The relevant provisions are:

> **Grounds on which health practitioner may be disciplined**
>
> (1) The Tribunal may make any 1 or more of the orders authorised by section 101 if, after conducting a hearing on a charge laid under section 91 against a health practitioner, it makes 1 or more findings that—
>
> (a) the practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, amounts to malpractice or negligence in relation to the scope of practice in respect of which the practitioner was registered at the time that the conduct occurred; or
>
> (b) the practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, has brought or was likely to bring discredit to the profession that the health practitioner practised at the time that the conduct occurred; or

[23] "Malpractice" has been accepted as meaning "the immoral or illegal or unethical conduct or neglect of professional duty. Any incidence of improper professional misconduct".[2].

[24] The Tribunal has adopted the test for bringing, or likely to bring "discredit to the practitioner's profession" from the High Court decision on appeal from the Nursing Council. The Tribunal must ask itself:[3]

> … whether reasonable members of the public, informed and with knowledge of all the factual circumstances, could reasonably conclude that the reputation and good standing of the [profession] was lowered by the behaviour of the [practitioner] concerned.

[25] Determining professional misconduct is approached in two steps. This has been expressed:

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[2] Collins English Dictionary 2nd Edition. Definition consistently accepted Tribunal decisions.

[3] *Collie v Nursing Council of New Zealand* [2001] NZAR 74 (HC) at [28]

(a) The first step involves an objective analysis of whether or not the health practitioner's acts or omissions in relation to their practice can reasonably be regarded by the Tribunal as constituting malpractice and/or negligence and/or conduct having brought or likely to bring discredit to the profession;

(b) The second step in assessing professional misconduct requires the Tribunal to be satisfied that the practitioner's acts or omissions require a disciplinary sanction In *F v Medical Practitioners Disciplinary Tribunal*[4] the Court of Appeal said:

> In cases of both professional misconduct and conduct unbecoming it will be necessary to decide if there has been a departure from acceptable standards and then to decide whether the departure is significant enough to warrant sanction.

[26] The High Court endorsed the earlier statement of Elias J in *B v Medical Council* that "the threshold is inevitably one of degree". This was further discussed in *Martin v Director of Proceedings* where the High Court said:[5]

> … While the criteria of "significant enough to warrant sanction" connotes a notable departure from acceptable standards, it does not carry any implication as to the degree of seriousness. Given the wide range of conduct that might attract sanction, from relatively low-level misconduct to misconduct of the most reprehensible kind, the threshold should not be regarded as unduly high. It is certainly a threshold to be reached with care, having regard to both the purpose of the HPCAA and the implications for the practitioner, but the measure of seriousness beyond the mere fact that the conduct warrants sanction is a matter to be reflected in penalty. The degree of seriousness does not form part of the Tribunal's enquiry at the second stage of the two-step process.

Submissions

[27] It was the second step in assessing professional misconduct that was in issue in the present case.

[28] Both counsel referred to various High Court authorities which discuss the relevant principles in assessing disciplinary threshold.

[29] The essence of the submissions for the Director was that the conduct in question was sufficiently serious to warrant a disciplinary sanction. In particular:

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[4] *B v Medical Council* HC Auckland, HC11/96, 8 July 1996, noted at 2005 3 NZLR 810

[5] *Martin v Director of Proceedings* [2010] NZAR 333

(a) The conduct was deliberate, rather than mere carelessness or an inadvertent error.

(b) No attempt was made to resolve the situation in a more suitable fashion.

(c) The force used was wholly disproportionate to the actions of Mr [D].

(d) It was contrary to the professional standards expected of nurses, the expectations of his employer and the expectations of other competent and responsible practitioners.

(e) The conduct risked causing injury to Mr [D] or others.

(f) The reporting displays sparse resemblance to the events.

(g) RN [A] has displayed little insight into his actions.

[30] Mr Robins added:

(a) As noted above, in *Martin v Director of Proceedings*, the threshold is not "unduly high".

(b) Subjective factors or personal circumstances of the practitioner at the relevant time may be taken into account when considering penalty but are not relevant to the Tribunal's decision about disciplinary threshold.[6]

(c) In identifying threshold, the assessment is one of degree.

(d) In any event this was serious misconduct.

(e) A finding of professional misconduct is necessary to hold RN [A] to account and to maintain professional standards.

[31] Ms Eglinton referred us to several cases, noting the second stage of the test has recently been considered in *A Professional Conduct Committee of the Pharmacy Council v A, B, C and E* [2021] NZHC 949 where the High Court upheld a decision of the Tribunal who had found negligence but not that the conduct warranted a disciplinary sanction. The Tribunal noted that the negligence established against the four practitioners was not in the same category as previous cases cited.

[6] Mr Robins referred to *Gabb* 1138/Den20/479P as authority for this proposition

[32] On the basis of statements in *Johns v Director of Proceedings* [2010] NZHC 2843, and *Dr E v Director of Proceedings*, Ms Eglinton submitted that the gravity and seriousness of the conduct, and subjective and personal factors should be considered in deciding whether the threshold test is met.

[33] In the present case Ms Eglinton submitted:

(a) There is no evidence that Mr [D] sustained any injury either physical or emotional, from being redirected to his room.

(b) The time it took for Mr [D] to be redirected was very short.

(c) Mr [D] was taken to his bedroom which was the safest place for him as he could be at peace.

(d) RN [A] has worked as a nurse for 30 years without incident except for this one occasion.

(e) He reasonably considered at the time that he needed to remove Mr [D] from the area because there was glass everywhere and Mr [D] had bare feet.

(f) The behaviour of another resident was becoming heightened and RN [A] considered that an urgent response was required.

(g) While he did not consider other de-escalation techniques, it is clear that removal of Mr [D] from the lounge was the most appropriate de-escalation technique, albeit not in the manner it was carried out.

(h) RN [A] realised he had behaved inappropriately and has since discussed the situation with his current employer and has undertaken significant professional development, both of his own doing and at the request of the Health and Disability Commissioner.

(i) As a result of this reflection, growth and development, it is clear that any required period of rehabilitation has now been completed and RN [A] has become an even better nurse. He has taken on more responsibility in his new role and has been an exemplary nurse, providing safe and sympathetic nursing care.

(j) RN [A] has willingly co-operated with the investigation by his ex-employer and the Health and Disability Commissioner and this proceeding with the Director of Proceedings.

Discussion

[34] The Tribunal's process for making findings of professional misconduct and reaching a decision about the imposition of a penalty involves several steps. When a practitioner admits the conduct and recognises their wrongdoing, it may seem somewhat arduous, but the Tribunal must always be mindful of its role in setting standards for the profession, and the precedent that may be set by its decision. The Tribunal must be satisfied:

(a) Do the established facts support the allegations in the charge? Where the allegations are denied, the onus is on the prosecutor to prove the charge. Even where the facts are agreed, there must still be sufficient evidence to support each allegation.

(b) Do the proven acts or omissions amount to negligence, malpractice or conduct likely to bring discredit to the profession?

(c) Is the conduct sufficiently serious to warrant a disciplinary sanction?

(d) What penalty, if any, should be imposed?

[35] Charges of professional misconduct cover a range of acts or omissions. Each charge of professional misconduct laid requires the Tribunal to make an evaluative judgment of the facts, based on the evidence and submissions and its own expertise and experience. This differs from criminal charges in New Zealand, where various statutes including the Crimes Act 1961 define the elements of each offence and prescribe the maximum penalty that the court may impose in each instance.

[36] There are various codes of conduct and standards that apply to health practitioners, including the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. The second limb of the test for professional misconduct recognises that not every breach warrants a disciplinary response from a practitioner's professional or disciplinary body. Although in earlier Tribunal decisions, that second limb has often referred to warranting a disciplinary

sanction "for the purposes of protecting the public and/or maintaining professional standards and/or punishing the practitioner," the High Court has tended to express it as simply being sufficiently serious to warrant a disciplinary sanction.[7]

[37] In Dr U 699/Med14/298P this Tribunal said:

> The second stage in the process is then to consider whether those acts or omissions are sufficient to warrant disciplinary sanction whether for maintaining standards, protection of the public or (to the extent that is relevant) punishment of the practitioner. The Tribunal does not consider that of itself punishment is an objective to be considered; punishment may be an inevitable consequence, but it may also be a way in which standards can be maintained and the public protected for the future.

[38] This is consistent with the Court of Appeal's acceptance that the purpose of disciplinary proceedings is not to punish the practitioner.[8]

[39] There are two submissions on behalf of the practitioner that need to be addressed. In brief at the second step:

(a) Should the Tribunal engage in determinations of seriousness?

(b) Should the Tribunal take into account subjective factors?

[40] Although in Martin, Courtney J said, "The degree of seriousness does not form part of the Tribunal's enquiry at the second stage of the two-step process"[9] this sentence should be read in the context of the entire paragraph. There must be an element of consideration of the seriousness of the conduct in order to decide whether the Director of Proceedings or Professional Conduct Committee has established that the conduct is sufficiently serious to warrant a sanction.

[41] This is a hurdle that the prosecutor's case must get clear, but once over, comparisons and determination of degree of seriousness are factors to consider in deciding penalty.

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[7] *Martin v Director of Proceedings*, above note 5

[8] *Complaints Assessment Committee v Medical Practitioners Disciplinary Tribunal* [2006] NZSC 48; [2006] 3 NZLR 577*; Z v Complaints Assessment Committee* [2007] NZCA 91; [2008] 1 NZLR 65

[9] See paragraph 26 above

[42] In fact, the Tribunal should be careful when imposing a penalty that the features of the case that have been relied on in that second step to reach that disciplinary threshold are not then simply replicated as "aggravating features" at penalty. The aggravating factors may need to be something more.

[43] Turning to the subjective factors: *McKenzie v MPDT & Anor* [2004] NZAR 47 was an appeal under the Medical Practitioners Act 1995. The High Court held that "subjective considerations" or "personal circumstances" of the practitioner are not to be taken into account as part of the threshold question. Venning J said:[10]

> In summary, the test for whether a disciplinary finding is merited is a two-stage test based on first, an objective assessment of whether the practitioner departed from acceptable professional standards and secondly, whether the departure was significant enough to attract sanction for the purposes of protection the public. However, even at the stage it is not for the Disciplinary Tribunal or the Court to become engaged in a consideration of or to take into account subjective considerations of the personal circumstances or knowledge of particular practitioner. The purpose of the disciplinary procedure is the protection of the public by the maintenance of professional standards. That object could not be met if in every case the Tribunal and the Court was required to take into account subjective considerations relating to the practitioner.

[44] In *Dr E v Director of Proceeding*s CIV-20070485-2735, Young J proposed that "there may be personal circumstances which substantially affect the seriousness of the particular negligence or malpractice which are therefore relevant to the decision as to whether a disciplinary sanction is required." The High Court did not find that the subjective factors were relevant to the Tribunal's decision, and so this proposition was perhaps speculative.

[45] In any event, the Tribunal accepts this argument is no longer live. In *Cole v PCC* [2017] NZHC 1178, Gendall J in addressing an argument that Young J's observations should be adopted, said:

> [128] As I see it, however, the law in this area is now settled. The approach of Venning J in *McKenzie* has clearly been preferred after the Court of Appeal in *F v Medical Practitioners Disciplinary Tribunal* approved this approach and confirmed it as part of the two-stage process. As recently as 2010, Courtney J in *Martin v Director of Proceedings*

[10] at paragraph 71

also applied the two-stage test set out in *McKenzie*, acknowledging that was the approach confirmed by the Court of Appeal. (Footnotes omitted)

[46] The subjective factors are therefore not relevant in our determination of professional misconduct but may be considered at the penalty stage.

Findings

[47] The established facts support the allegations in particular one: RN [A] applied unreasonable restraint and used physical force.

[48] The intentional application of force on an individual is an assault, and a conviction for assault may be punishable by imprisonment.[11] Under section 48 of the Crimes Act 1961, there is a justification in using a degree of force in defence of oneself or another. The force may only be that which is reasonable in the circumstances as the perpetrator believes them to be. Restraint involves the intentional application of force.

[49] Institutions such as psychiatric units and aged care residences have policies on the use of restraint and management of behaviours, as was the case here. If any person-on-person restraint is to be used, it is only where de-escalation techniques have not been successful and/or are not appropriate because harm to the patient, other patients or staff is imminent and unavoidable. Only approved restraint techniques can be used. RN [A] described the training he has since received in restraint. In answer to questions from the Tribunal, RN [A] advised that one appropriate form is for two staff members to escort a patient, one on each side, holding the patient's arm.

[50] The Tribunal does not accept RN [A]'s evidence that Mr [D] started to swing his body. In our view of the video, RN [A] walked briskly in a determined manner to Mr [D] and grabbed him. It was very abrupt. The way in which Mr [D] was leaning back into RN [A] with his legs bent indicated there was some resistance as Mr [D] was pushed out from view.

[51] The Tribunal is not persuaded on the evidence presented that any restraint was required. Moreover, the way in which RN [A] removed Mr [D] by grabbing his clothing at the back, holding an arm and pushing him out of the room is not an approved form of

[11] See sections 2 and 196 of the Crimes Act 1961 and sections 2 and 9 Summary Offences Act 1981

restraint. It was an unreasonable use of physical force and a clear departure from accepted standards for any nurse and amounts to negligence of a significant degree.

[52] The Tribunal also finds that the conduct amounts to malpractice. It is neither professional nor ethical to treat a patient in the way RN [A] treated Mr [D]. In our view, any visitor to the residence would have been horrified to see a patient being handled in that way and the conduct undoubtedly brings discredit to the nursing profession.

[53] This type of behaviour is a serious matter and the Tribunal has no hesitation in finding that it warrants a disciplinary sanction. It would be difficult to think of a case of malpractice that did not meet the second part of the test for professional misconduct.

[54] The second particular concerns the practitioner's acts and omissions before and during the incident.

[55] We agree that RN [A] failed to use de-escalation techniques in a way that was suitable and/or reasonable in the situation (particular 2(i)). RN [A] walked briskly towards Mr [D]. According to the timing on the video, at 1.18.45s, Mr [D] had finished kicking the window and was standing with both feet on the ground, and RN [A] then started to walk out of the station and towards Mr [D]. At 1.18.50s, RN [A] is standing beside and to the back of Mr [D], with his right knee bent in a lunge and his right hand above Mr [D]'s head and by 1.18.51s he has grabbed Mr [D]'s clothing. If RN [A] was saying anything intended to calm Mr [D], his actions were not consistent with his words. We find that failure to use appropriate de-escalation techniques fell well below acceptable standards and amounts to negligence.

[56] Particular 2(ii) alleges that RN [A] considered that Mr [D] was in an aggressive state, without assessing whether or not he was in an aggressive state. A practitioner's thoughts may be evidenced by his or her conduct, but it is the conduct, that is an act or omission that is the subject of a disciplinary charge. Mr Robins confirmed that the essence of particular 2(ii) is the failure to undertake the assessment of Mr [D]'s state, rather than the conclusion that was reached. Again, this is a matter of negligence.

[57] The Tribunal considers that particular 2(iii) overlaps considerably and is probably subsumed by particular 1. The conduct described in particulars 1(i), (ii) and (iii) is clearly disproportionate to the risk to the safety of anyone. Had RN [A] used an approved form of restraint, then there may have been reason to consider whether it was

disproportionate to the risk to the safety of anyone. The factual allegations in particular 2(ii) are established, but we do not make a separate finding of professional misconduct for this conduct, given our findings under particular 1.

[58] Again, with particular 2(iv), the Tribunal is reluctant to make findings of professional misconduct for a practitioner's thoughts. In addition, the Tribunal considers that had RN [A] taken the time to assess whether Mr [D] was in a state that meant there was a risk of harm to anyone, de-escalation and redirection of Mr [D] using words would have been the best option to start with. Had that not been successful, and if a risk of harm to others was imminent, proper use of restraint of the patient might have been more expedient, depending on the mobility of the other residents. For those two reasons, we therefore do not uphold particular 2(iv) as professional misconduct.

[59] The Tribunal agrees that as the senior co-ordinator on the unit, RN [A] should have communicated with the available staff and delegated some tasks. He failed to ask them to assist him with responding to Mr [D], escorting him or others out of the lounge. We find that was negligent.

[60] In summary, the first part of the test for professional misconduct is met for particulars 2(i), (ii) and (v) because the conduct did not meet the standard expected of a reasonable nurse, but had RN [A] not then grabbed Mr [D] and pushed him out of the room in the manner described in Particular 1, the failings are not sufficiently serious to warrant a disciplinary sanction. When considered in conjunction with particular 1, the disciplinary threshold is met.

[61] The third particular of the charge also meets the disciplinary threshold. Any use of restraint must be properly recorded and monitored. In no place did RN [A] record that he had physically removed Mr [D]. To record that he had "redirected" Mr [D] is disingenuous and misleading, as it would give most readers the impression that he had used words to encourage Mr [D] to leave the scene, rather than grabbing him and pushing him. Under cross-examination, RN [A] was asked about other entries where it was recorded that Mr [D] had been "redirected". He said those did not involve the same degree of force as used in the present case.

[62] The Tribunal finds that RN [A]'s failure to accurately record that he had used physical force or restraint and his reasons for doing so was negligent. It was a significant

departure from accepted standards. Accurate documentation is a cornerstone of clinical practice. In this instance we find that this was not simply an omission of a clinical measurement or observation. RN [A] mentioned the incident but did not mention any use of physical force, restraint or manoeuvring. It was a misleading entry and we find it amounts to malpractice.

[63] In many instances one documentation omission error on its own may not be sufficiently serious to warrant referral to the Tribunal. However, in this instance, the requirements for reporting are part of a regime designed to protect consumers of health and disability services from abuse. Restraint is used as a last resort on people who are very vulnerable. Documentation of restraint is required for transparency as well as to accurately record the interventions and responses that have been used and reflect on their efficacy. The Tribunal finds that a failure to document the use of restraint or physical force in accordance with professional standards is a serious departure from accepted practice and warrants a disciplinary sanction.

Directions

[64] The Tribunal will now hear further from the parties on the question of penalty. It is at this stage that the practitioner's insight, rehabilitation and other factors will be considered.

[65] The parties were no doubt prepared to address the penalty at the hearing. They will be given an opportunity to review their submissions.

[66] If either party wishes to be heard in person, they should advise the Executive Officer by 17 November 2021 and a hearing by AVL can be arranged.

[67] Otherwise, the Tribunal will consider penalty on the papers, and the parties will comply with the following directions.

(a) Director of Proceedings is to file submissions on penalty, including costs by 24 November 2021.

(b) The practitioner is to file submissions on penalty by 24 November 2021.

(c) If the practitioner seeks permanent name suppression, any application and supporting evidence must be filed by 24 November 2021.

(d) The practitioner and Director may each respond to the other by 1 December 2021 and have a final right of reply by 8 December.

[68] The Tribunal will then deliberate and issue a final decision.

DATED at Wellington this 8th day of October 2021

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T Baker
Chair
Health Practitioners Disciplinary Tribunal