Registered Nurse, RN D

Registered Nurse, RN C

Medical Centre

A Report by the

Deputy Health and Disability Commissioner

(Case 17HDC00067)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. On 6 January 2017, Ms A presented to a medical centre with shortness of breath and coughing. Ms A is an asthmatic.

2. Ms A reported her symptoms to a medical receptionist, and a triage alert was activated (for Ms A to be seen immediately).

3. Ms A was escorted to a nursing area to wait to be seen. A registered nurse (RN), RN D, noted that Ms A did not appear to be breathless, and concluded that it was safe to continue to provide care to another patient. During this time, Ms A's condition deteriorated, and another patient alerted the nursing staff to Ms A's condition.

4. RN D performed an initial triage assessment and recorded Ms A's vital signs. RN D assigned a Triage Code of 3 (to be seen by a nurse or doctor within 30 minutes).

5. RN C attended the triage cubicle because Ms A was coughing and crying. RN C noted Ms A's triage assessment and instructed RN D to call a doctor immediately. RN C's impression was that Ms A was hyperventilating, and instructed her to breathe into a paper bag.

6. Dr E arrived and established that Ms A was asthmatic, and auscultated her chest. Ms A's partner arrived and advised that Ms A has cough variant asthma, which responds well to Ventolin and Atrovent.

7. Dr E removed the paper bag and instructed the nurse to commence nebulised Ventolin and Atrovent. Prior to the medications being administered, Ms A's partner noticed that the Atrovent had expired, and another ampoule was obtained and administered to Ms A.

Findings

RN D

8. The Deputy Commissioner considered that RN D failed to adhere to the medical centre's Triage Policy, and that the standard of her assessment of Ms A was inadequate. Accordingly, it was found that RN D breached Right 4(1) of the Code.

RN C

9. Adverse comment is made about RN C. Ms A was having an asthma attack and RN C treated her for hyperventilation with a paper bag over her mouth when this was not indicated. This placed Ms A's well-being at risk.

Medical centre

10. Adverse comment is made about the medical centre for its failure to ensure that emergency treatment medication was current, as the subsequent delay placed Ms A's well-being at risk.

Names have been removed (except the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Dr E

11. Adverse comment is made about Dr E for his failure to remove the paper bag over Ms A's mouth prior to auscultating her chest and obtaining her medical history.

Complaint and investigation

12. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided to her by RN D, RN C and the medical centre.[1] The following issues were identified for investigation:

- *Whether RN D provided Ms A with an appropriate standard of care on 6 January 2017.*
- *Whether RN C provided Ms A with an appropriate standard of care on 6 January 2017.*
- *Whether the medical centre provided Ms A with an appropriate standard of care on 6 January 2017.*

13. This report is the opinion of Deputy Commissioner Meenal Duggal, and is made in accordance with the power delegated to her by the Commissioner.

14. The parties directly involved in the investigation were:

Ms A	Consumer
Mr B	Consumer's partner
RN C	Provider/registered nurse
RN D	Provider/registered nurse
Dr E	Provider/general practitioner
Medical centre	Provider/medical practice

Also mentioned in this report:

Dr F	Clinical director

15. Independent expert advice was obtained from a registered nurse, Emma Hickson (Appendix A), and from in-house general practitioner Dr David Maplesden (Appendix B).

[1] The medical centre provides general medicine and urgent clinical care.

Names have been removed (except the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Information gathered during investigation

Introduction

16. Ms A has a history of asthma, and at the time of events was aged 22 years. She was not an enrolled patient with the medical centre, and subsequently the medical centre did not have information regarding her medical history.

17. This report relates to the care provided to Ms A at the medical centre on 6 January 2017 when she presented with a cough and shortness of breath.

Registered nurses

18. RN D commenced employment as a practice nurse[2] at the medical centre in 2016. RN C commenced employment as a practice nurse at the medical centre in 2010.

Attendance at the medical centre

19. On 6 January 2017 at 4.22pm, Ms A sought medical assistance from the medical centre owing to a cough and shortness of breath. Ms A presented alone and she informed a medical receptionist that she was short of breath. Ms A told HDC that she is an asthmatic who presents with cough variant asthma, with continuous coughing but no wheeze or shortness of breath.[3]

20. The medical centre told HDC that the staff did not have Ms A's medical records, and did not recognise her unusual asthma condition. The medical centre considers it unusual that Ms A's history of asthma was not communicated when she first presented.

21. In responding to the provisional opinion, Ms A said that she did not consider it prudent to inform the medical receptionist of her past medical history, as she expected to discuss the information with a nurse.

Medical Centre Triage Policy

22. The medical centre's "Triage Policy" (Version 2009:7) is based on the ACEM[4] Triage Guidelines, and provides for the allocation of a triage code to each presenting patient to ensure prioritisation for treatment according to the urgency of the patient's condition. The triage code sets a maximum time for which a patient should wait before receiving a clinical assessment by a nurse or doctor, and subsequent treatment. The ACEM guidelines set out a series of indicative clinical descriptors to assist in the allocation of code categories. Triage Code 1 (T1) pertains to imminently life-threatening conditions or the need for immediate treatment. A Triage Code 2 (T2) patient requires treatment within 10 minutes, and examples in the Policy include "breathing difficulty, chest pain". Triage Code 3 (T3) pertains to semi-urgent conditions that require treatment within 30 minutes.

[2] The position description states that its practice nurses work within the registered nurse scope of practice (Nursing Council of New Zealand).
[3] Cough variant asthma (also known as "cough predominant asthma") usually presents solely with a cough, without any other symptoms such as dyspnoea (laboured breathing) or wheezing.
[4] Australasian College of Emergency Medicine (ACEM).

Names have been removed (except the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

23. The initial triage assessment is performed by the nurse on duty, who will gather information to determine the clinical urgency and identify immediate care requirements. In the event that the nurse is seeing another patient when an unwell patient arrives and is suffering from shortness of breath, chest pain, bleeding, severe pain, vomiting, or dizziness, or the patient is an irritable or distressed child, the receptionist is required to notify the nurse on duty immediately. A triage alert is to be activated, and triage alert patients should be seen by the registered nurse immediately on arrival.

24. On seeing a patient who has a triage code of T1 or T2, the nurse will immediately notify — or arrange for the receptionist to immediately notify — the duty doctor, as well as the supervising registered nurse.

25. Each triage code category has a corresponding performance indicator threshold. The medical centre's policy provides that 100% of T1 patients are to be seen by a duty doctor immediately, and 80% of T2 patients are to be seen by a duty doctor within 10 minutes.

Initial triage assessment

26. Owing to Ms A's shortness of breath on presentation, the receptionist activated a triage alert indicating that Ms A should be seen by a registered nurse immediately.

27. The medical centre stated that on arrival, "[Ms A] did not appear to be distressed or coughing a lot, despite the triage alert status," and that had her clinical symptoms of cough variant asthma been evident, and had she appeared distressed, it is likely that she would have been assessed more promptly.

28. Ms A was escorted to the nursing area where she could be seen from the nurses' station.

29. RN D told HDC that the receptionist informed her of the triage alert at 4.25pm. RN D stated:

> "[W]hen I received the handover from the medical receptionist, [Ms A] did not appear as breathless as she became … [S]he did not look like she was experiencing any difficulties … I decided it was safe to continue doing injections [for another patient] before seeing her."

30. RN D said that she proceeded with the other patient's injections and recorded these in the clinical notes, and was unaware that during this time Ms A's condition had deteriorated.

31. Ms A told HDC that she waited for 20–25 minutes to be seen by the nurse, and that during that time several doctors and nurses passed by while her condition deteriorated and she became unable to talk. Ms A said that another patient alerted the nursing staff of her deteriorating condition. The medical centre agrees that nursing staff were alerted by another patient.

32. RN D told HDC that she reviewed Ms A within nine minutes of being informed by the receptionist of Ms A's triage alert status. RN D said that she was alerted to Ms A's

Names have been removed (except the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

shortness of breath when she "looked over and noticed [Ms A] was coughing, crying and finding it hard to breathe". RN D stated: "I stopped what I was doing and hurriedly attended to [Ms A], taking her with the receptionist to the triage room for triaging at 4.35pm."

33. The medical centre told HDC that in the absence of any performance indictor threshold for patients with a triage alert, most patients with a triage alert are seen within a reasonable time if not immediately.

Initial triage assessment — RN D

34. RN D triaged Ms A and recorded:

> "History given by patient; SOB [shortness of breath] and cough. Observations: Triage score 3–30 mins; Pulse: 128; Temp: 37.5; Tympanic; RR: 40; Post-neb. PRF: 370; SA02: 97; Actions Taken: Unable to take weight and pt declined peak flow. PRF: 370."

35. RN D stated that she did not take Ms A's peak exploratory flow rate (PEFR)[5] as part of her triage assessment because this was declined by Ms A.

36. In response to the provisional opinion, Ms A said that she waved away the peak flow device because she was coughing continuously, and therefore was unable to complete the assessment.

37. RN D documented the triage assessment at 4.47pm and assigned Ms A a triage code of 3, indicating that she was to be seen by a nurse or doctor within 30 minutes. RN D said that at the time of recording the triage code, a doctor had reviewed Ms A, and the T3 code was assigned in light of this.

38. The medical centre told HDC that in the absence of a peak flow reading, the triage assessment relied on heart rate and respiratory rate measurements in a patient who was distressed and crying, which can elevate these recordings. The medical centre believes that Ms A's "recordings would be reasonable in a patient complaining of shortness of breath and where there was no known history of asthma". The medical centre considers that Ms A should have been categorised as a Triage Code 2, indicating that she should have been seen within 10 minutes. RN D acknowledged that the triage code should not have taken into account the review by a doctor, and that a T2 code should have been assigned.

RN C's care of Ms A

39. In response to the provisional opinion, RN C told HDC that she was walking past the triage room when she heard Ms A coughing and crying while being assessed by RN D. On arrival at the triage room, RN C asked RN D whether Ms A had been experiencing any wheeze during RN D's examination, and RN D confirmed the absence of any wheeze. RN C said that she asked RN D for Ms A's vital signs, and was told, "Pulse rate 128/min, respiratory rate

[5] The speed and force at which air is expelled from the lungs.

Names have been removed (except the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

40/min, oxygen saturation 97%, temperature 37.5°," and that "Ms A declined [to perform] a peak flow [reading]". RN C instructed RN D to call the doctor immediately while she remained with Ms A.

40. In response to the provisional opinion, RN C stated that Ms A was coughing, distressed and breathing rapidly but did not appear to be struggling for breath. She recalls that Ms A was unable to give any further history. RN C stated:

> "From the vital signs handed over I was concerned about [Ms A's] increased heart rate and respiratory rate. My visual assessment together with the vitals taken by [RN D] contributed to my initial impression that she was hyperventilating.[6]"

41. Ms A told HDC that the nurse pushed a paper bag into her face, and her breathing continued to deteriorate. RN C told HDC that she explained to Ms A how to use a paper bag over her mouth. In response to the provisional opinion, RN C maintains that she explained to Ms A how to use the paper bag before giving it to her.

42. RN C stated:

> "I thought this [paper bag] would help with her rapid breathing and reduce the likelihood that she would become dizzy and faint due to her Tachypnoea[7] before the doctor arrived … Obtaining a paper bag was an interim measure based on my initial impression until the doctor arrived."

43. The medical centre told HDC that it considers that a hyperventilating patient with a clear chest and no sounds on auscultation of the chest could present a picture similar to cough predominant asthma.

44. RN C told HDC that Dr E arrived in the triage room in a matter of minutes, and that she left the triage room, and on leaving heard RN D hand over the vital sign observations to Dr E.

Dr E's assessment and diagnosis of Ms A

45. Dr E reviewed Ms A at 4.40pm, 18 minutes after her presentation to the medical centre.

46. RN D informed Dr E of Ms A's condition and the triage observations taken. Dr E recalls that on arrival he "could see that [Ms A] was coughing while holding a paper bag 15–20 cm away from her face".

47. Dr E told HDC that when he assessed Ms A he did not consider there to be any evidence of audible wheeze or increased work of breathing. He explained to HDC that his "initial working diagnosis" was of hyperventilation.

[6] An excessive rate and depth of respiration leading to abnormal loss of carbon dioxide from the blood.
[7] Abnormally rapid rate of breathing.

Names have been removed (except the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

48. Ms A told HDC that Dr E pushed the bag further into her face. Dr E stated that he moved the bag closer to Ms A's face "until [he] had done a more complete assessment and determined that [the paper bag] should be removed". Dr E said that he does not consider that the presence of the bag hindered his ability to obtain a history or examine Ms A.

49. Dr E told HDC that he asked Ms A whether she suffered from anxiety or panic attacks, and she shook her head. When he asked whether she was asthmatic, she nodded yes. Dr E said that he auscultated Ms A's chest, and at that time her partner, Mr B, arrived.

50. Mr B told HDC that on arrival he noted that Ms A was unable to talk, and that Dr E was attempting to obtain a medical history. In response to the provisional opinion, Mr B stated that he observed Dr E for approximately two minutes, and became concerned about the situation. Mr B advised Dr E that Ms A has cough variant asthma and responds well to nebulised bronchodilators.

51. Dr E said that he immediately ceased the paper bag treatment and ordered nebulised Ventolin[8] and Atrovent.[9] He stated that the time elapsed from his arrival into the triage room to the removal of the paper bag was less than one minute.

52. The medical centre told HDC that it was important for Dr E to obtain a thorough medical history because of the diagnostic uncertainty. The medical centre stated that Ms A presented alone and distressed with tachypnoea, dyspnoea,[10] and persistent coughing, but no wheezing or evidence of airway obstruction. It considers that the lack of details and the absence of any records of asthma[11] contributed to the diagnostic uncertainty of Ms A's presentation.

Delay in arranging nebuliser

53. RN D told HDC that Dr E instructed her to administer Ventolin and Atrovent to Ms A via a nebuliser. RN D stated that RN C handed her the medication in the nursing station. RN C said that she did not check the expiry dates of the Ventolin and Atrovent as she assumed that RN D would check the dates prior to administering the medication.

54. RN D stated that prior to commencing her usual checks of the medication, Mr B noted that the Atrovent had expired.[12] RN C stated that RN D returned to the nursing station and informed her about the expired Atrovent. RN C said that she obtained another ampoule of Atrovent, checked the expiry date, and told RN D that she would administer the medication to Ms A.

55. At 4.55pm, RN C recorded in the treatment notes: "5mg vent [Ventolin]/500mcg iprat [ipratropium bromide (Atrovent)] given via [nebuliser] as per Dr's [Dr E's] order."

[8] Medication administered to open up the breathing tubes in the lungs.
[9] Medication administered to open up the breathing tubes in the lungs.
[10] Difficult or laboured breathing.
[11] Ms A was a casual patient, and there were no records on file regarding her asthma.
[12] It had expired in the last week of December 2016.

Names have been removed (except the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

56. The medical centre acknowledged that the Atrovent had expired, and advised that routine monthly checks had not been performed owing to the time of year, ie, after the New Year period. The medical centre stated that its usual nursing practice is to check expiry dates prior to administering medication to patients. The medical centre acknowledged that a delay in obtaining a nebuliser is unacceptable when a patient is short of breath.

57. At 4.53pm, Dr E documented his assessment of Ms A:

> "Asked to see at 4.40pm by the receptionist … Her lungs were clear and remove the paper bag as partner advised she was asthmatic.
>
> OE [on examination] SOB [short of breath], cough, chest clear, unable to do a full examination as cough increasing.
>
> A [airway] — patent, B [breathing] self, C [circulation] 128pm. Vital parameters noted from nurses notes.
>
> Imp [impression] hyperventilation/ ? Asthma attack.
>
> Partner says … usually she was having an asthma attack without (expectorant) wheeze and he treated with nebs and get better.
>
> …
>
> Plan: Advised to start nebs immediately with Ventolin and Atrovent will [review] after nebs."

58. RN C assessed Ms A at 5.09pm, and at 5.20pm Dr E reviewed Ms A and ordered a further 5mg of Ventolin via nebuliser, and 40mg of prednisone.[13]

59. Dr E reviewed Ms A again and noted that her "chest [was] clear" and that she had performed a peak flow reading that was not of concern.[14] Dr E discussed the Ventolin protocol[15] and advised Ms A to visit the Emergency Department if her symptoms worsened.

The medical centre

Position description for practice nurse

60. The position description for a practice nurse at the medical centre states that the purpose of the position is to "maintain and/or improve the health status of patients". Key responsibilities include:

> "• Good waiting room management is applied; patients are triaged appropriate to their needs and patients with emergent health needs are identified.
>
> • Appropriate nursing theory is used as the basis for decision making in the practice setting."

[13] An anti-inflammatory agent.
[14] The peak flow reading was 350.
[15] Appropriate dosage and administration instructions.

Names have been removed (except the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Training

61. Dr F, on behalf of the medical centre, advised that compulsory training occurs as part of nurse induction, and this includes training around triage. He stated that RN C completed her induction training sessions in 2010 and 2013, and that induction training sessions were provided to RN D in 2016. Further, Dr F told HDC that RN D had one-to-one supervision and training on triage from senior staff for six months during her induction programme.

62. Dr F advised that in September 2015, April 2016, and September 2017, RN D and RN C participated in medical emergency training sessions. Dr F said that one of the emergency response drills involved responding to an adult patient with life-threatening asthma.

Changes made since these events

Medical centre — internal review

63. Dr F advised that in February 2017 he completed an internal review of the care provided to Ms A on 6 January 2017, and that the medical centre undertook the following quality improvement measures:

a) Implementation of new Early Warning Score protocols to assist nurses with triaging adults.

b) A review and update of its Triage Policy to ensure that staff excuse themselves when leaving another patient to attend to patients with potentially emergent conditions.

c) An update of Ms A's medical records to reflect her diagnosis of cough predominant asthma.

d) In August and September 2017 it provided RN D with further education in relation to triage skills, and undertook monthly performance appraisals of her triage skills and provided further training and feedback on the same day.

e) It provided RN C with further one-to-one training on triage skills, and in March 2018 she completed a triage module.

f) It shared the learnings from this complaint at the Doctors Peer Review Meeting and at the Nurses Continuing Education Training Day.

RN D

64. RN D advised that she has enrolled in an education course to assist with her triage skills. RN D said that she has reflected on this incident, and told HDC:

> "I now prioritise triage alert patients as soon as I am alerted. If there is a triage alert and I am with another patient, I would explain that I need to urgently attend to another patient … I am now in the habit of checking the register of clinic medications every month."

RN C

65. RN C advised that she is undertaking training in triage module 2013. RN C told HDC that she is now more aware of the condition of cough variant asthma.

Names have been removed (except the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

66. She said that in a similar situation, if she was immediately concerned about the deterioration of a patient she would call a doctor straight away. She stated:

> "I would usually obtain vital signs before calling the doctor (as had been done) but if the condition appears serious then I believe the priority is for the doctor to be called before further assessment is undertaken."

Dr E

67. Dr E acknowledged the concerns raised by my expert advisor, Dr Maplesden, about the risks of CO_2 retention and the dangers of this in conditions such as asthma. Dr E told HDC that he has read about cough predominant asthma, and that in future he would immediately remove a paper bag from a patient until he was confident that there was no other explanation for the patient's hyperventilation, aside from hyperventilation syndrome.

Responses to provisional opinion

68. Ms A, RN D, RN C, and the medical centre were provided with relevant parts of my provisional opinion, and their responses have been incorporated into the report where appropriate. In addition, I note the following:

Medical centre

69. The medical centre stated that it had no further comment to make in response to the provisional opinion. Dr E had advised that he had no further comments.

70. The medical centre also stated that it agreed with the findings and conclusions reached in the provisional opinion in respect of RN D.

71. The medical centre also advised that it has ensured that all nursing staff have received recent training in the Adult Early Warning Score protocols and would be confident to teach this guideline to staff.

Opinion: RN D — breach

72. RN D was the triage nurse responsible for triage assessment at the medical centre on 6 January 2017. At that time she had completed the medical centre triage training and six months of supervision and training on triage.

Triage response

73. The medical centre's Triage Policy provides that patients with a triage alert code "should be seen by a registered nurse immediately on arrival".

74. My expert advisor, registered nurse Emma Hickson, advised:

Names have been removed (except the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

> "The standard of care as per [the medical centre's] triage policy and other policies are to immediately see/assess any patient with triage alert status. In this case, there was a moderate departure from [the] triage policy which resulted in a delay for [Ms A] to be assessed. Such a delay, undermined the well-being for this patient and was an avoidable added moderate risk."

75. I accept this advice. RN D was the duty nurse at the medical centre, and she was aware that Ms A had a triage alert owing to her "shortness of breath". RN D failed to adhere to the Triage Policy when she failed to assess Ms A immediately following notification of her triage alert status. I am concerned that RN D relied on a visual check of Ms A to determine her condition, and concluded that it was safe to continue to immunise another patient. I do not consider that a visual check of Ms A was sufficient to form an appropriate assessment of her condition. Subsequently, Ms A's condition deteriorated while she was waiting to be seen, and RN D was not alert to this. RN D should have excused herself from the patient she was immunising and attended to Ms A to assess her condition in person, as required by the Triage Policy.

76. I note that there are different accounts regarding the time Ms A waited to be seen by RN D. Ms A believes she waited for 20–25 minutes. However, RN D refutes this and states that she reviewed Ms A within nine minutes of being informed of her triage alert code. I note that RN D's clinical notes were recorded retrospectively, and it is not possible to confirm the precise time at which Ms A was seen by RN D. Nevertheless, I am highly concerned that Ms A's condition deteriorated while she was waiting to be seen by RN D, and that another patient alerted staff to Ms A's condition. Overall, I am of the view that the delay in RN D's assessment of Ms A did not meet the required standard in these circumstances.

Initial triage assessment

77. The Triage Policy states that the purpose of a triage assessment is "to determine who needs to be seen immediately and who is safe to wait and for how long".

78. Ms Hickson advised:

> "The standard of care for initial assessment of such a patient would normally include a thorough assessment including a suite of vital signs, history taking and spending time with the patient assessing their status. A peak expiratory flow rate [PEFR] would normally be part of that accepted practice, but even without a PERF being performed, with a more thorough assessment, a level 2 categorisation may have resulted. Therefore, without completion of a thorough assessment, in my opinion, it was not appropriate to give [Ms A] a level 3 rather than a level 2 categorisation."

79. Ms Hickson advised that this amounts to a moderate departure from the accepted standard of care.

80. I accept that advice. RN D noted that Ms A was coughing, crying, and struggling to breathe, and in the absence of a peak flow reading assigned a T3 code (ie, semi-urgent and to be

Names have been removed (except the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

seen within 30 minutes). I am critical that RN D failed to perform a more comprehensive assessment and evaluation of Ms A's condition. Relevant details, including Ms A's history of asthma, were not obtained. RN D was not alert to Ms A's actual condition, and failed to identify the urgency for her to be reviewed by a doctor. RN D told HDC that she assigned a T3 code because at the time of documenting the triage assessment Dr E had reviewed Ms A. I note that RN D acknowledges that her triage assessment should not have taken into account the review by a doctor. In these circumstances, RN D should have performed a thorough assessment and assigned Ms A a T2 code (to be reviewed within 10 minutes). In my opinion, RN D's triage assessment was suboptimal.

Expired Atrovent

81. Ms Hickson advised that when it was noticed by Ms A's partner that the Atropine RN D had been handed had expired, RN D had yet to perform a final check of the drug prior to administering it. Ms Hickson said that the standard of care was acceptable, as the expired Atrovent was not administered to Ms A. I accept that advice.

Conclusion

82. RN D failed to adhere to the Triage Policy which required her to assess Ms A immediately. As a result, RN D did not triage Ms A accurately and was not alert to her deteriorating condition. Overall the deficiencies in RN D's care represent two moderate departures from the expected standard of care and I consider these to be serious. In my view, RN D failed to provide services to Ms A with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[16]

83. I acknowledge that RN D has undertaken further training with regard to triage skills and nursing assessments. I consider this to be appropriate in the circumstances.

Opinion: RN C — adverse comment

84. RN C heard Ms A coughing and crying and attended the triage room to support RN D. RN C noted RN D's triage assessment and history that Ms A was unable to perform a peak flow assessment. She noted Ms A was coughing, distressed and breathing rapidly, but did not appear to be struggling for breath. Ms A at this point was unable to give any further history. RN C instructed RN D to alert the doctor immediately while she remained with Ms A. RN C's impression was of hyperventilation and she gave Ms A a paper bag to place over her mouth.

85. Ms Hickson advised me that "the standard of care when treating hyperventilation is reliant on the correct diagnosis through thorough assessment". Ms Hickson stated that further assessment would have included repeating vital sign recordings, obtaining a peak flow assessment and obtaining further history. Ms Hickson noted that further assessments were attempted and a doctor was expected imminently.

[16] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

Names have been removed (except the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

86. Ms Hickson advised that Ms A was having an asthma attack, and treating her for hyperventilation with a paper bag over the mouth was not indicated. Ms Hickson advised that this placed Ms A's well-being at risk of potential harm and considers that this represents a moderate departure from the standard of care.

87. I note that RN C's impression of hyperventilation was informed by Ms A's history, triage assessment and observation of her condition. I also note that RN C instructed another RN to call a doctor immediately and commenced the paper bag treatment as an interim measure until a doctor arrived. However, I am critical that RN C commenced paper bag treatment for hyperventilation in a patient having an asthma attack. I am critical that this occurred and placed Ms A's well-being at risk. I note that RN C is now more aware of the condition of cough variant asthma and I consider this appropriate.

88. Ms A told HDC that RN C pushed the paper bag into her face. RN C refutes this, and advised that she gave the paper bag to Ms A to place over her mouth. On the information available to me, I cannot make a finding on this issue.

Expired Atrovent

89. RN Hickson advised that when it was noticed by Ms A's partner that the Atrovent RN C supplied to RN D had expired, RN D had yet to perform a final check of the drug prior to administering it. RN Hickson said that the standard of care was acceptable, as the expired Atrovent was not administered to Ms A. I accept that advice, and note that when the expired Atrovent was noticed, RN C obtained another ampoule and checked the expiry date prior to administering it to Ms A.

Opinion: Dr E — adverse comment

90. My expert advisor, Dr Maplesden, advised:

> "I would be mildly critical of [Dr E's] failure to remove the paper bag while further assessing the patient IF the initial triage readings were available to him (given the O_2 saturation was reassuring, there were no obvious signs of wheeze and no obvious increased work of breathing and with the elevated pulse and respiratory rate being consistent with anxiety)."

91. I accept that advice. I am satisfied that Dr E was informed of the initial triage readings when he commenced his review of Ms A while the paper bag was in place, and that Dr E established that there were no obvious signs of wheeze or respiratory obstruction. However, I am critical that he failed to remove the paper bag before attempting to auscultate Ms A's chest and obtain her history. I acknowledge that Dr E has advised that in the future, he would immediately remove the paper bag until confident of there being no other explanation for a patient's hyperventilation aside from hyperventilation syndrome.

Names have been removed (except the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

92. I acknowledge that once he was informed that Ms A had cough variant asthma, Dr E took appropriate steps and promptly organised nebuliser therapy and provided appropriate safety-netting advice consistent with accepted practice.

93. I note that prior to this case, Dr E had had no experience with cough variant asthma. Dr Maplesden agrees with Dr E that there is limited information available in the medical literature on this type of asthma, and that the condition is not widely known in primary care. I accept that this unusual form of asthma contributed to Dr E's diagnostic uncertainty of Ms A's presentation.

94. Ms A complained that Dr E pushed the paper bag into her face. However, Dr E states that he did not push the paper bag against her face but tried to move it closer. On the information available to me, I cannot make a finding on this issue.

Opinion: Medical centre — adverse comment

95. As a healthcare provider, the medical centre is responsible for providing services in accordance with the Code. In this case, I consider that the errors that occurred did not indicate broader systems or organisational issues at the clinic. Therefore, I consider that the medical centre did not breach the Code directly.

96. In addition to any direct liability for a breach of the Code, under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority may be vicariously liable for acts or omissions of its employees. A defence is available to the employing authority under section 72(5), if it can prove that it took such steps as were reasonably practicable to prevent the acts or omissions.

RN D

97. At the time of these events, the medical centre had a Triage Policy that provided guidelines for triaging patients.

98. Dr F, on behalf of the medical centre, advised that at the time of these events, the medical centre had provided compulsory training as part of nurse induction. Following RN D's appointment, she was provided with one-to-one supervision in triage training for six months. Further, nurses were required to participate in medical emergency simulations, and RN D has participated in these sessions.

99. I note that the information provided by the medical centre regarding the triage training for RN D is consistent with RN D's statement.

100. Individual clinicians need to be competent in the clinical management of patients. I consider that the medical centre was entitled to rely on RN D to follow the Triage Policy and to assess Ms A immediately once notified of her triage alert status, and to perform a

Names have been removed (except the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

thorough triage assessment and assign a triage code accordingly. I am satisfied that the medical centre provided appropriate training to RN D, and accordingly took such steps as were reasonably practicable to prevent her actions. Accordingly, I do not find the medical centre vicariously liable for RN D's breach of the Code.

Expired Atrovent — adverse comment

101. The medical centre acknowledged that the Atrovent first selected had expired, and told HDC that the usual monthly checks had not been performed because of the time of year (Ms A presented to the medical centre on 6 January 2017, and the Atrovent had expired in the last week of December 2016). The medical centre advised that usual nursing practice is to check expiry dates prior to administering medication to patients. However, I am critical of the medical centre's failure to ensure that the emergency treatment medication was current, as the subsequent delay in administration placed Ms A at greater risk.

102. I agree with the medical centre that a delay in obtaining a nebuliser medication is unacceptable when a patient is short of breath. I note that in light of Ms A's case, the medical centre undertook an internal review and has implemented numerous quality improvement initiatives to improve its service. I consider these actions to be appropriate.

Recommendations

103. In accordance with recommendations made in my provisional opinion, the medical centre provided this Office with an audit compliance of the monthly checks of medication, and with evidence that all nursing staff have been trained in the Early Warning Score protocols.

104. In accordance with the recommendation made in my provisional opinion, RN D has provided this Office with a written apology for the deficiencies identified in the care she provided.

Follow-up actions

105. A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN D's name.

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

Names have been removed (except the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A: Independent nursing advice to the Commissioner

The following expert advice was obtained from Registered Nurse Emma Hickson:

"Report for the Health and Disability Commissioner

June 2017

I have been asked to provide an opinion to the Commissioner on case number **C17HDC00067**, and I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I am currently a Registered Nurse in the role of Director of Nursing, Primary and Community, for Capital and Coast DHB. I have previous qualifications and practice experience as a Registered Nurse, Registered Midwife, District Nurse, Nurse Prescriber, Nurse Educator/Lecturer, Nurse Manager and have a Masters (Applied) in Nursing.

I am providing advice and opinion on the care provided by [RN D] and [RN C] at [the medical centre] to [Ms A] on 6th January 2017, if that care was reasonable in the circumstances and why.

Brief factual summary
On 6th January 2017, [Ms A] presented to [the medical centre] with a cough and shortness of breath (she is an asthmatic who presents with cough variant asthma). She told the receptionist she was short of breath, and was advised that she would be seen by a nurse shortly. 20–25 minutes later, her breathing deteriorated to the point where she could not speak and a person in the waiting room ran to get nursing assistance. During this period, she was passed by several doctors and nurses, and no nursing observations were taken. She was then given a paper bag to breathe into before the GP, [Dr E], arrived. He asked if she was asthmatic, to which she nodded, before maintaining paper bag therapy and recording nursing observations.

[Ms A's partner] then arrived and informed [Dr E] that she usually benefitted from nebulised bronchodilator therapy. When [Ms A's] partner checked the medications, the ipratropium was expired. [Ms A] was eventually administered the nebuliser (two sessions) and improved.

The decision by [RN D] to depart from [the] triage policy by deferring formal triage assessment of [Ms A] following notification of her 'triage alert' status by the receptionist.

- The standard of care as per [the medical centre's] triage policy and other policies is to immediately see/assess any patient with triage alert status.
- In this case, there was a moderate departure from [the medical centre's] triage policy which resulted in a delay for the patient to be assessed.

Names have been removed (except the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- Such a delay, undermined the well-being for this patient and was an avoidable added moderate risk.

The standard of triage assessment and categorisation by [RN D], particularly taking into account the failure to establish a history of asthma, and [RN D's] comment that because PEFR could not be performed, it was appropriate to give [Ms A] a level 3 rather than a level 2 categorisation (noting that [Ms A] was unable to talk).

- The standard of care for initial assessment of such a patient would normally include a thorough assessment including a suite of vital signs, history taking and spending time with the patient assessing their status. A peak expiratory flow rate would normally be part of that accepted practice, but even without a PEFR being performed, with a more thorough assessment, a level 2 categorisation may have resulted. Therefore, without completion of a thorough assessment, in my opinion, it was not appropriate to give [Ms A] a level 3 rather than level 2 categorisation.
- The standard of triage assessment appears to be a moderate departure from accepted or normal practice as relevant information was not gathered and as a consequence the nurse was not alerted to the actual condition of the patient.
- Such an assessment with omissions relevant to the well being of the patient would be avoided by Registered Nurses.

[RN C's] actions in assuming [Ms A] was hyperventilating and treating this with a paper bag over the mouth in the two possible scenarios: (a) that [RN D] had completed her triage recordings and these were available to [RN C].

- The standard of care when treating hyperventilation is reliant on the correct diagnosis through thorough assessment which was not adequately achieved.
- I would suggest that there was a departure from the appropriate standard of care for [RN C] to treat this patient with a paper bag over the mouth as there was not adequate information gained in the assessment process to rule out other causes of breathlessness additional to hyperventilation. The resultant care was a significant/severe departure from accepted practice.
- This practice would be viewed as a risk to the patient.

or (b) that [RN D] had yet to complete any triage recordings.

- The standard of care when treating hyperventilation is reliant on the correct diagnosis through thorough assessment which, if [RN D] was yet to complete, would be a deviation from an acceptable standard of care.
- Again, I would suggest that there was a departure from the appropriate standard of care for [RN C] to treat this patient with a paper bag over the mouth, as if there was no assessment information gained to rule out other causes of breathlessness, the resultant care was a significant/severe departure from accepted practice.
- This practice would be viewed as a risk to the patient.

Names have been removed (except the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The failure of [RN C] to check the expiry date of the drugs being administered to [Ms A], and the apparent failure of [the medical centre's] procedures for ensuring all drugs in the emergency treatment are current.

- The standard of accepted practice is to check the expiry date prior to administration of a drug. I am unclear from the statements that the drug was being administered when [Mr B] noticed the expiry date had passed. On occasion, the final checks for safe drug administration can occur just prior to administration at the bedside. Therefore, the standard of care in this situation could be acceptable, if the drug was not yet being administered and if the nurse was planning to complete further checks.
- I think that as long as the drug had not been administered, there was potential for the final check to occur which indicates there may not have been a departure from acceptable practice.
- As long as the drug had not started to be administered, I would view this practice as acceptable, as long as a final check was planned to be made prior to administration.
- It is routine standard of practice for emergency drugs to be regularly checked in health care delivery settings.
- The failure of [the medical centre] to not follow their own procedure of checking their emergency drugs date of expiry placed the patient and health professionals under additional moderate risk and stress and caused a further delay of treatment.
- Such an omission leaves patients and health professionals at greater risk when dealing with an acute health situation and would be viewed as detrimental by health professionals.

List all sources of information reviewed

The information reviewed to enable my opinion was:

- HDC website complaint dated […]
- Letter from [RN D] dated 2nd March 2017
- Letter from [RN C] dated 2nd March 2017
- [The medical centre's] response letter dated 10th February 2017
- Letter from [Dr F] dated 27th January 2017
- Clinical notes for [Ms A] for 6th January 2017
- [The medical centre's] Triage Policy
- [DHB] Health Pathway — Acute Asthma in Adults
- [DHB] — Policy Triage of patients presenting to [Accident and Medical]

Additional comments

I believe the record keeping of the nurses was low in terms of content and detail. For example, there is no mention in the records of [Ms A's] ability/inability to speak in partial or full sentences.

Names have been removed (except the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

> There is no comment in the information from [the medical centre] that less experienced nurses will get support from more experienced colleagues during such situations if they were to happen again. It is good to know that [the medical centre] will feature this case example in peer review sessions in the future.
>
> Emma Hickson"

Further advice from Ms Hickson was obtained on 9 October 2018:

> "1. [RN D] (1). — no comment
> 2. [RN D] 6/12/18 — no comment
> 3. [RN C] 29/3/18 — I would maintain that a thorough history and thorough clinical assessment as per early warning score process would be required prior to treating hyperventilation.
> 4. [RN C] 22/6/18 — no comment
> 5. [Medical centre] response 22/3/18 — support quality improvement actions taken
> 6. Early Warning Score [medical centre] — support introduction
> 7. [Medical centre] response 11/9/17 — support the educational opportunities provided to staff.
>
> Emma Hickson"

Further advice from RN Hickson was obtained on 13 April 2019:

> "The following is my response to review additional information and correspondence related to ref: HDC 17/00067 — [Ms A].
>
> …
>
> With the additional information, my advice would be that [RN C's] overall care was a moderate departure from the appropriate standard of care. To specifically respond to the points in the letter dated 13th March 2019 …
>
> [Regarding the further assessment that was required to rule out other causes of breathlessness in the circumstances that (a) [Ms A] had declined to perform a peak flow; (b) [Ms A] was distressed and unable to give further history; and (c) that the doctor had been summonsed and was expected imminently:]
>
> - Further assessment would have included repeating vital sign recordings, obtaining a peak flow and obtaining further history. The additional information indicates that further assessments had been attempted and that the doctor was expected imminently.

Names have been removed (except the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

[Concerning the departure of care regarding [RN C's] awareness of the triage recordings:]

- With additional information, I feel able to judge that [RN C's] departure from expected standard of care was moderate rather than significant/severe.

  …

  The departure from the appropriate standard of care to be significant/severe is an opinion based on the potential harm it could have caused the patient. Considering the additional information supplied, I would now judge the departure to be moderate.

[Regarding the risk of offering a paper bag to the patient to breathe into:]

- The risk was that the treatment was not indicated for this patient with an asthma attack rather than hyperventilation.

…

In this response, my assessment of significant/severe departure in standard of care and accepted practice has been changed to moderate due to the additional information supplied.

Emma [Hickson]"

Names have been removed (except the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix B: Independent advice to the Commissioner

The following expert advice was obtained from Dr David Maplesden:

"13 March 2017

1. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms A] about the care provided to her by nursing and medical staff of [the medical centre]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. I have reviewed the information on file: complaint from [Ms A]; response from clinical director of [the medical centre]; statement from [RN D]; statement from [RN C]; [the medical centre's] triage policy; [the medical centre's] clinical notes.

2. [Ms A] states she attended [the medical centre] at around 1600hrs on 6 January 2017 with cough and shortness of breath. She states: *I am an asthmatic who presents with continuous coughing and very low tidal volume (cough variant asthma).* She notified the receptionist of her symptom of shortness of breath and was advised she would be seen by a nurse shortly. [Ms A] has the following concerns regarding her subsequent treatment:

(i) She was not seen by a nurse for 20–25 minutes. Her condition deteriorated over this period and she was passed by several doctors and nurses who showed no concern. Eventually she could not speak and a fellow patient sought assistance.

(ii) A nurse then saw [Ms A] and without obtaining a history of observations she forced [Ms A] to breathe into a paper bag as treatment for assumed hyperventilation.

(iii) [Dr E] then attended [Ms A] and asked if she was asthmatic. She was unable to speak but nodded yes. [Dr E] maintained the paper bag therapy and nursing observations were then recorded.

(iv) [Ms A's partner] then arrived and conveyed [Ms A's] history of asthma and his concern at her current management. He notified staff that [Ms A] usually benefitted from nebulised bronchodilator in this situation.

(v) There was a delay in organising the nebuliser during which time [Dr E] attempted to obtain further history from [Ms A] despite the fact she was unable to speak. When [Ms A's] partner checked the medications the ipratropium was expired.

(vi) [Ms A] was eventually administered the nebuliser (two sessions) and improved and was discharged on her usual Symbicort inhaler with additional prednisone and salbutamol.

3. Clinical notes

(i) [RN D's] notes are:

Presenting complaints: *History given by: patient; SOB and cough.*
Observations: Triage score 3 — 30mins; *Pulse (Heart Rate): 128; Temp: 37.5; Tympanic; RR: 40; Post-neb. PFR: 370; SAO2: 97;* ***Action Taken:*** *unable to take weight and pt declined peak flow*

(ii) [Dr E's] notes are:

asked to see at 440pm by the receptionist as she was having breathing problem
already nurse giving a paper bag for breathing when I was reaching the patient. her lungs were clear and remove the paperbag as partner advised she was asthmatic.
OE SOB, cough, chest clear, unable to do full examination as cough increasing
A — patent , B self, C 128 pm
vital parameters noted from nurses notes
imp hyperventilating/ ? asthma attack
partner says … usually she was having a asthma attack without exp wheeze and he treated with nebs and get better
Hx from the partner
asthma
thyroid problem
anxiety on SSRI
NKDA
Plan: advised to start nebs immediately with ventolin and atrovent — will r/w after nebs
520pm — r/v: lot better, still cough, chest clear.
Plan: happy to go through another round of ventolin nebs
prednisone stat (40mg) and r/w afterwards
PF meter reading, r/v
R/w after 2nd neb, lot better, Chest Clear, PF 350
Plan: happy to go, ventolin protocol discussed
Advised to go to ED if symptoms persist or worsen later or overnight or to come back in the morning if symptoms are not improving

(iii) [RN C's] notes are:

500mg vent/500mcg iprat given via neb as per Dr's order
5.09pm post neb vitals: resp — 24, O2 sat — 100%, HR—104,PF—350, advised to see Dr again for review
5.26pm 40mg prednisone PO and 5mg vent given via neb as per Dr's order

4. The sequence of events obtained from the various provider responses appears to be as follows: [Ms A] presented to [the medical centre] at 1622hrs on 6 January 2017 and was given a triage alert by the receptionist because of her complaint of shortness of breath (see section 6) and was escorted to the nursing area. She was able to speak at this stage. [RN D] was notified of the triage alert and 'eyeballed' [Ms A] (but did not speak with her) before proceeding with immunizing her current patient. When staff were alerted to [Ms A's] deterioration, according to [Dr F's] response [RN D] attended

immediately and *recalls arriving to triage [Ms A] at the same time as [Dr E] arrived and that [RN C] was also present and had placed the paper bag over [Ms A's] mouth.* This is slightly different to [RN C's] statement which states she *had noted* [RN D's] observations] *before placing a paper bag over [Ms A's] mouth.* Triage notes were made by [RN D] at 1647hrs — records indicate [Ms A] was seen by clinical staff 18 minutes after her arrival. Treatment notes were made by [RN C] at 1655hrs following first administration of the nebulizer. It is confirmed the ipratropium nebule about to be administered had just expired (expiry last week of December 2016). [RN C] states she did not check the expiry date as she assumed the regular (monthly) medication checks would have been undertaken. She indicates [Ms A's] partner identified the expired nebule before [RN D] (who was setting up the nebulizer) had a chance to check it.

5. [Dr F] has responded on behalf of [Dr E]. He states: *[Dr E's] initial impression, in the absence of wheeze and a prolonged expiratory phase on auscultation, was of hyperventilation. It was only when [Ms A's partner] informed [Dr E] of [Ms A's] history that the paper bag was removed and nebulized bronchodilators given.* He notes no collateral history was available initially as [Ms A] had not previously attended the clinic (I note this differs from [Ms A's] recollection of events regarding her affirming (by nodding) [Dr E's] query about a history of asthma). [Dr F] notes that [Ms A] *presented distressed with tachypnea, dyspnoea and with persistent coughing, but no wheezing or evidence of airway obstruction.* He notes there is limited information available in the medical literature on [Ms A's] diagnosis of a cough variant asthma condition, and this condition is not widely known in primary care (and I support this statement).

6. [Ms A] had a triage alert placed on her file following her report to the receptionist that she was experiencing shortness of breath. The [medical centre's] Triage Policy states: *Triage Alert (TA) patients should be seen by a registered nurse immediately on arrival to determine their Triage Code/Score as per the Australasian College of Emergency medicine (ACEM) guidelines.* Since [Ms A's] complaint, this section has been added to as: *If they are with another patient, they should excuse themselves citing the need to attend to a possible emergency and then determine the acuity of the emergent patient's condition.*

7. I have some concerns regarding [Ms A's] nursing management and recommend you obtain expert nursing advice for general comment on [Ms A's] management but to include comment on the following areas:

(i) the decision by [RN D] to depart from [the medical centre's] triage policy by deferring formal triage assessment of [Ms A] following notification of her 'triage alert' status by the receptionist

(ii) the standard of triage assessment and categorization by [RN D], particularly taking into account the failure to establish a history of asthma, and [RN D's] comment that because a PEFR could not be obtained it was appropriate to give [RN D] a level 3 rather than level 2 categorisation (noting [Ms A] was apparently unable to talk).

(iii) [RN C's] actions in assuming [Ms A] was hyperventilating and treating this with a paper bag over the mouth in the two possible scenarios: that [RN D] had completed her triage recordings and these were available to [RN C], or that [RN D] had yet to complete any triage recordings.

(iv) the failure by [RN C] to check the expiry date of drugs being administered to [Ms A], and an apparent failure of [the medical centre] procedures for ensuring all drugs in the emergency treatment area are current.

8. I would have some concerns about [Ms A's] initial management by [Dr E] if he recommended continuing application of the paper bag to [Ms A's] mouth without obtaining further medical history or assessment findings to help decide whether or not it was appropriate treatment. Rebreathing into a paper bag can be used to help build up the pCO_2 but this should only be used where the diagnosis is certain, as it may be dangerous if there is physical disease such as asthma. I would be mildly to moderately critical of [Dr E's] management if he did not recommend removing the paper bag while he attempted to obtain further medical history, and while he examined [Ms A's] respiratory system. I would be somewhat more critical if [Ms A] had been demonstrating signs of increased work of breathing (audible wheeze, prolonged expiration, tracheal tug and use of accessory muscles) but this was evidently not the case, and I note her oxygen saturations were within the normal range. If [Dr E] advised removal of the paper bag while he assessed [Ms A] and attempted to gain further medical history, I would not be particularly critical of his overall management of her. He rapidly established there was no obvious wheeze or signs of respiratory obstruction and promptly organised nebuliser therapy once he became aware of [Ms A's] history of an unusual asthma variant which generally responded to inhaled bronchodilators. Subsequent management, including provision of appropriate 'safety-netting' advice was consistent with accepted practice."

Further advice was received on 6 April 2018:

"I have reviewed the response from [Dr E] dated 7 March 2018. A. I would be MILDLY critical of his failure to remove the paper bag while further assessing the patient IF the initial triage readings were available to him (given the O2 saturation was reassuring, there was no obvious wheeze and no obvious increased work of breathing and with the elevated pulse and respiratory rate being consistent with anxiety). However, the patient had affirmed she had a history of asthma, and the absence of obvious wheeze can be a bad prognostic sign in an asthma attack (would be associated with decreased O2 sats if significant) — hence the mild departure. B. However, if the triage readings were NOT available to [Dr E] at this time (ie he was basing the decision to leave the paper bag in place just on the general observation of no audible external wheeze and no increased work of breathing) I would be MILDLY TO MODERATELY critical of his management in not removing the paper bag before further assessing the patient, particularly once she affirmed she had a history of asthma. I think in this context (without the added reassurance of normal oxygen saturations and only mildly reduced peak flow readings) it was unsafe for the paper bag to be retained until a complete set of observations was available."