Registered Nurse, RN B

Medical Centre

A Report by the

Deputy Health and Disability Commissioner

(Case 17HDC01194)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. On 10 May 2016, Ms A attended a medical centre to request the emergency contraceptive pill (ECP). Ms A was seen by Registered Nurse (RN) RN B.

2. Ms A's recollection of the appointment was very different to that of RN B. Ms A told HDC that she went to the medical centre only for the ECP. RN B recalled that Ms A had various complaints. RN B said that she was concerned that Ms A's symptoms indicated a possible urinary tract infection (UTI) or sexually transmitted infection.

3. RN B told HDC that she gave Ms A one tablet of Postinor (an ECP) and three tablets of trimethoprim, which is used to treat UTIs. RN B said that Ms A took the Postinor tablet in the consultation room, but RN B could not recall whether Ms A also took one of the trimethoprim tablets in the consultation room or took all three tablets home. Ms A recalled being given two tablets to take in the consultation room. At the time, she assumed that the tablets were the ECP.

4. The day after RN B saw Ms A, RN B retrospectively completed the nursing notes, but did not document what medication she gave to Ms A. RN B completed a standing order template for azithromycin, an antibiotic used to treat chlamydia. She did not complete standing order templates for either trimethoprim or Postinor.

5. Ms A returned to the medical centre on 2 June 2016. A pregnancy test undertaken that day revealed that Ms A was pregnant.

Findings

RN B

6. Due to the conflicting accounts from Ms A and RN B, and the incorrect and incomplete clinical notes, the Deputy Commissioner was not able to determine exactly what occurred during Ms A's consultation with RN B. However, the Deputy Commissioner was critical of the lack of clinical documentation, particularly with respect to the recording of the medications dispensed and the failure to adhere to the medical centre's standing order protocol. Consequently, RN B was found to have breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code).

The medical centre

7. In the Deputy Commissioner's view, the errors made by RN B were not a result of a lack of training or a lack of adequate policies or guidelines from the medical centre. The medical centre was therefore found not to have breached the Code.

Recommendations

8. In response to the recommendations in the provisional opinion, RN B provided a written letter of apology to Ms A.

9. It was also recommended that the Nursing Council of New Zealand consider undertaking a review of RN B's competence.

Complaint and investigation

10. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided to her by RN B at the medical centre. The following issues were identified for investigation:

- *Whether RN B provided Ms A with an appropriate standard of care on 10 May 2016.*
- *Whether the medical centre provided Ms A with an appropriate standard of care on 10 May 2016.*

11. This report is the opinion of Deputy Commissioner Kevin Allan, and is made in accordance with the power delegated to him by the Commissioner.

12. The parties directly involved in the investigation were:

Ms A	Complainant/consumer
Ms B	Registered nurse/provider
Medical centre	Provider

Also mentioned in this report:

Dr C	General practitioner

13. Independent expert advice was obtained from RN Vivienne Josephs, and is included as **Appendix A**.

Information gathered during investigation

Consultation on 10 May 2016

14. On 10 May 2016, Ms A attended the medical centre to request the emergency contraceptive pill (ECP) following unprotected sexual intercourse on the morning of 8 May 2016. Ms A was seen at around 4.23pm by RN B.[1]

15. RN B told HDC that Ms A "presented in a somewhat flustered state with various complaints". RN B recalled spending some time trying to clarify with Ms A when the unprotected sexual intercourse occurred, in order to confirm that she was within the 72-hour timeframe suitable to have levonorgestrel,[2] but ultimately this was confirmed.

16. RN B told HDC that she felt that it was a struggle to obtain a clear history from Ms A, as she was distracted and vague. RN B stated:

[1] RN B has been a registered nurse since 2006.
[2] A medication used as an ECP in New Zealand.

> "[Ms A] felt she had had a number of recent illnesses and was concerned that her immunity was low. She also raised [concerns] regarding having difficulty with passing urine and lower pelvic pain."

17. Ms A emphasised to HDC that she went to the medical centre for the ECP, and nothing else. She said that she was not flustered or anxious, as she knew what she was there for, and "it seemed straight forward to [her]".

18. RN B told HDC that she was concerned that Ms A's symptoms raised the possibility of other health issues, such as sexually transmitted disease, pelvic inflammatory disease, or urinary tract infection (UTI). RN B noted that lower pelvic pain and difficulty passing urine can be caused by chlamydia, so she asked Ms A to provide a urine sample in the bathroom next door, and to do a self-swab for chlamydia and gonorrhoea.

19. RN B said that she consulted with a general practitioner (GP) at the medical centre, Dr C, while Ms A was providing the samples. RN B recalled going to Dr C's room, and Dr C reviewing Ms A's file on her computer. RN B recalled telling Dr C that Ms A's blood pressure was slightly above normal, and querying whether this could relate to a kidney issue. RN B stated that she and Dr C agreed that Ms A should be treated for a UTI, along with the ECP, and that Dr C gave a verbal order for trimethoprim.[3]

20. Neither Dr C nor the other GP working at the medical centre on 10 May 2016 can recall this discussion occurring. They have both noted to HDC that there are no clinical records to support RN B having discussed Ms A with either of them. When Ms A initially raised concerns, RN B told HDC: "[I recall] [Dr C] stated she did have a memory of a discussion that took place between us on the day the patient originally presented." In response to my provisional opinion, Ms A stated that she did not hear RN B consult with Dr C, and does not recall RN B mentioning that she had done so.

21. RN B told HDC that a pregnancy test was undertaken from Ms A's urine sample, which showed a negative result, while "the urinalysis showed abnormalities". RN B said that she then "obtained Postinor[4] from the cupboard and gave this to [Ms A] with a glass of water in the consultation room". RN B added that it is her usual practice to tell patients to return to the medical centre if they miss a menstrual period. She believes it is likely that she did discuss this with Ms A, given that Ms A had been unclear about the date of her last period.

22. Ms A told HDC that she "was given 2 tablets to take by the nurse". At the time, Ms A understood that the two tablets were the ECP, as that was what she had requested. She said that RN B gave her water to "take one [tablet] then and there".

23. RN B told HDC that she had also obtained a bottle containing three trimethoprim tablets for the suspected UTI. She recalled discussing with Ms A why she was providing her with trimethoprim, and how and when to take it. RN B stated that usually trimethoprim is taken in the evening, and it is her usual practice to give a patient the three tablets of

[3] An antibiotic used mainly in the treatment of bladder infections.
[4] Levonorgestrel.

trimethoprim in a bottle to take away. She said that she "very clearly remembers giving the patient Trimethoprim and explaining a number of times that she would need to take one tablet at night for three nights …".

24. RN B told HDC that she gave Ms A the three tablets of trimethoprim to take home. However, in a later statement to HDC, RN B recalled Ms A being uncertain, and that she (RN B) needed to repeat this advice. RN B told HDC that it is likely that she gave Ms A the first tablet to take whilst still in the clinic, and the remaining two to take home. Contrary to RN B's recollection, Ms A said that she has no issues understanding directions, and she strongly refutes RN B's assertion that she had to repeat instructions to her.

25. RN B did not document the consultation with Ms A contemporaneously on 10 May 2016. RN B told HDC that she believes Ms A was her last patient that day, and that she did not complete the notes at the time as it was late in the evening prior to the clinic closing and she needed to leave. RN B also said that it had been a busy afternoon, and other tasks required her attention.

26. Dr C confirmed to HDC that Ms A was the last patient to be seen by RN B on 10 May 2016.

11 May 2016

27. On the morning of 11 May 2016, RN B completed her nursing notes regarding her consultation with Ms A. RN B recorded the following retrospective notes:

> "1 [Patient] here as concerned regarding a number of issues. Requires morning after pill [unprotected sex] on Sunday morning
>
> 2 last night find it difficult to [pass urine] was sitting on toilet for a number of hours with lower pelvic pain, has been passing urine as normal today, no pain.
>
> Urine dip[5]-ery[6]+++ ubg[7]++.
>
> Sample to lab for MSU[8].
>
> Self swab done for STI[9] check, no symptoms at present.
>
> [Patient] states has also been feeling tired, has had a number of minor illness over the last month, concerned regarding immunity. BP 140/100."

28. RN B did not explicitly state in her notes that she was making retrospective notes, and nor did she document Ms A's weight or BMI, or the discussion she said she had with Dr C. In addition, RN B did not record any medication given to Ms A, or any discussions she may

[5] This refers to a urine dipstick test, which can be used to detect urinary tract infections.
[6] "Ery" stands for "erythrocytes", or red blood cells.
[7] "UBG" stands for "urobilinogen". UBG urine tests are used to identify liver problems such as hepatitis.
[8] Midstream specimen of urine (MSU) is used to test for infection.
[9] Sexually transmitted infection.

have had regarding such medication. RN B also incorrectly recorded the consultation date as 9 May 2016.

29. RN B generated laboratory forms for the MSU and STI screening. Laboratory test results provided to HDC show that both the MSU and urogenital swabs were negative for urinary infection and chlamydia.

30. A standing order template for the provision of azithromycin (an antibiotic used to treat chlamydia) was also completed, but RN B did not complete standing order templates for levonorgestrel or trimethoprim. RN B told HDC that she would not have completed a standing order checklist for trimethoprim, as this was given as a verbal order from Dr C. A standing order is a written instruction issued by a doctor authorising a registered nurse to administer and/or supply specified medicines. Standing order checklists are electronic prompts for registered nurses to check factors relevant to the medication they are administering.

31. RN B told HDC that she cannot clearly state why she completed the standing order template for azithromycin. However, she thinks that she would have gone to complete the standing order for levonorgestrel, and then incorrectly entered the template for azithromycin, as she had given Ms A a self-swab for chlamydia. RN B said that she did not give Ms A azithromycin during the consultation on 10 May 2016.

32. The medical centre told HDC that it reviewed the clinical notes entered into the system around 10 May 2016, and confirmed that the notes for Ms A were not inadvertently entered into another patient's notes.

Consultation on 2 June 2016

33. On 2 June 2016, Ms A returned to the medical centre for a medical certificate. She was seen by the practice nurse. During this consultation, Ms A queried why she had been given two pills when she asked for the ECP at her consultation on 10 May 2016, as she had taken the ECP previously and it had been only one tablet.

34. Dr C told HDC that following Ms A's query:

> "[The practice nurse] reviewed the notes and became aware of the discrepancy between the documented clinical indications for treatment (dysuria[10] and unprotected intercourse), and what had been documented as given (azithromycin) … [The nurse] then obtained a urine sample and performed a pregnancy test that was positive."

35. Dr C told HDC that after it had been established that Ms A was pregnant, she was asked to join the consultation with Ms A to discuss the situation and options regarding the pregnancy. However, according to Dr C, "[Ms A] was understandably upset, very anxious, and preferred to leave and return to [the medical centre] when she felt ready to discuss the situation."

[10] Painful urination.

36. Later that day, Dr C requested that RN B review her notes and provide her recollection of the consultation. RN B told Dr C that Ms A had "requested ECP treatment and was treated with levonorgestrel [Postinor]". RN B also recalled treating Ms A with trimethoprim for her UTI symptoms. In relation to her retrospective notes, RN B told Dr C that she entered the treatment for azithromycin in error, and she believes her notes "do not reflect the treatment provided".

37. RN B told HDC that after being informed that Ms A had raised concerns, she instantly remembered her consultation with Ms A, which RN B described as "a difficult and disjointed consultation due to the history giving and [Ms A's] distracted presentation". RN B stated that she very clearly remembers handing Ms A medication to take away, and explaining how it should be taken multiple times because Ms A appeared muddled.

Subsequent events

38. The medical centre investigated these events. On 8 June 2016, Ms A was contacted by the medical centre to discuss the situation. Dr C told HDC that Ms A told the medical centre at that time that she recalled being given two tablets on one card and none to take home (although, as noted above, Ms A told HDC that she took one tablet "then and there" at her consultation with RN B).

39. On 28 July 2016, Dr C and the medical centre's nurse leader met with Ms A to discuss the discrepancy between the clinical record, Ms A's recollection, and RN B's recollection. Dr C told HDC that they also discussed Ms A's date of conception, as a scan on 15 June 2016 had determined the date of conception to be 15 May 2016 (five days after her consultation with RN B). Dr C noted that Ms A replied that her midwife disagreed with these dates, and that Ms A "was inclined to believe her midwife's advice that conception was earlier because of the 'medical mishap' that she felt she experienced at [the medical centre]".

40. Dr C told HDC that after the 28 July meeting, the medical centre provided RN B with an interim plan that focussed on education and supervision. Dr C also told HDC that the medical centre investigated Ms A's concerns immediately but, "given the disparity between [Ms A's] recollection and that of [RN B], [the medical centre was] unable to conclude that either recall was more accurate than the other".

Medical centre standing orders

41. The medical centre has standing orders for azithromycin, levonorgestrel, and trimethoprim. RN B was authorised to use these.

Azithromycin standing order

42. The standing order protocol for azithromycin stated that the dose was two 500mg tablets, and that the nurse was required to observe the treatment being taken. The standing order checklist for azithromycin completed by RN B required RN B to confirm, among other things, that Ms A had a positive chlamydia result, did not have abdominal pain, a fever, or

cardiac arrhythmia,[11] that a urine hCG[12] test had been carried out, and that she had discussed the impact of sexually transmitted infections with Ms A.

43. RN B's clinical notes (as outlined above) noted only that a urine sample had been sent to the laboratory, and that a self-swab for STIs had been taken.

Postinor standing order

44. At the time of events, the medical centre's standing order protocol for Postinor stated that the dose was one tablet of levonorgestrel,[13] and that the nurse was required to observe the treatment being taken. The standing order checklist also required, among other things, informed consent from the patient, a negative pregnancy test, and confirmation that unprotected sexual intercourse had taken place within 72 hours. The practice nurse was also required to explain to the patient how ECP works and its failure rate,[14] which increases in time after the unprotected sexual intercourse.

45. RN B did not complete the standing order checklist for Postinor, and did not document having undertaken any of the required assessments or discussions.

Trimethoprim standing order

46. The standing order protocol for trimethoprim stated that the dose was for one 300mg tablet once daily, for three days. The standing order checklist also required, among other things, confirmation that the patient was experiencing frequent or painful urination, had a negative pregnancy test, and had a temperature of less than 38°C. The practice nurse was also required to give the patient advice regarding the signs of worsening infection.

47. RN B did not complete the standing order checklist for the use of trimethoprim. However, she did document that Ms A was experiencing difficulty urinating, that the urine dipstick test was positive for blood and urobilinogen, and that she would send an MSU sample to the laboratory.

Further information

RN B

48. RN B acknowledged to HDC that she undoubtedly should have completed the standing order checklist for Postinor when Ms A was present or when she left the room. According to RN B, this oversight reflects poor practice on her part, but she stated that it was not her normal practice.

49. RN B accepts that there was a significant lapse in the standard of her documentation, and that she did not pay sufficient attention when filling out the standing order. She stated

[11] An irregular heartbeat.
[12] Human chorionic gonadotropin — a hormone that is produced by a pregnant woman's placenta. A urine hCG test is a pregnancy test.
[13] The medical centre told HDC that it updated its standing order protocol for Postinor on or around 27 March 2017 to reflect that women with a BMI of 25 or more are provided with a two-tablet dose of levonorgestrel.
[14] According to the Medsafe Datasheet on Postinor-1 (levonorgestrel), dated 23 June 2017, the medication prevents 85% of pregnancies.

that her clinical records should have reflected the administration of the Postinor and trimethoprim, her discussion with Dr C, and her safety-netting advice in respect of the Postinor. RN B believes she gave the safety-netting advice verbally.

50. RN B said that following Ms A's concerns being raised, the Clinical Leader at the medical centre reviewed her use of Postinor standing orders during 2015 and 2016, and found no errors. Further, RN B's use of Postinor was monitored for three months, and no issues were identified.

51. RN B told HDC that she undertook training in August 2016 regarding the management of difficult patient consultations. This included training on difficult history-taking, and how best to manage this. RN B said that she has also engaged in a monthly reflection with a senior nurse practitioner regarding patient engagement, and has attended training on documentation with a New Zealand Nurses Organisation nursing advisor. RN B now ensures that her patient consultations are never written in retrospect.

The medical centre

52. The medical centre told HDC that it had in place appropriate policies for the accurate application of standing orders. Further, the medical centre's standing order checklists are used to ensure that the prerequisite conditions are present and required tests undertaken prior to issuing medication. Before the medical centre staff are authorised to use standing orders, they must go through formal training and sign-off. The medical centre added that standing orders and their accompanying policies are held on the medical centre's server, and are available to staff at all times.

53. The medical centre acknowledged that RN B did not ensure that appropriate conditions were met and/or documented for the application of standing orders for any of the three possible medications provided to Ms A.

54. The medical centre stated that having reviewed its computer systems, it does not think that the clinic was running late on 10 May 2016. The medical centre told HDC that it "has taken the matters raised by [Ms A] and the actions of [RN B] seriously". The medical centre said that it has made changes to its policies and procedures to lessen the risk of a similar occurrence in the future. The changes include:

- Ensuring that all staff are aware that notes should be made contemporaneously at all times and, when this is not possible, staff have been advised to complete the notes in retrospect, clearly identified as such and without date changes.

- Reviewing the standard of clinical notes and adopting a standard approach to documentation to support accuracy and completeness.

- Amending the standing order for Postinor to recommend the use of two tablets for patients with a BMI of over 25.

- Monthly auditing of the use of standing orders.

Relevant standards

55. The New Zealand Nurses Organisation (NZNO) Guidelines for Nurses on the Administration of Medicines[15] (NZNO Medicines Guidelines) states:

> "• Guideline 11.2: nurses must give medicines in accordance with the relevant standing order and must follow local workplace policies and guidelines on the use of standing orders."

56. The NZNO Standards of Professional Nursing Practice[16] (NZNO Standards of Practice) states that nurses must:

> "• Guideline Standard 1.4: provide documentation that meets legal requirements, is consistent, effective, timely, accurate and appropriate."

57. The Nursing Council of New Zealand (Nursing Council) Code of Conduct for Nurses[17] (Nursing Code of Conduct) states that nurses must:

> "• Guideline Standard 4.8: Keep clear and accurate records."

58. The Nursing Council Competencies for Registered Nurses[18] (Nursing Council Competencies) include the following:

> "• Guideline Competency 1.1: Demonstrates knowledge of, and accesses, policies and procedural guidelines that have implications for practice."
>
> "• Guideline Competency 2.1: Administers medications according to authorised prescription, established policy and guidelines."
>
> "• Guideline Competency 2.3: Maintains clear, concise, timely, accurate and current health consumer records. Demonstrates computer skills necessary to record, enter, store, retrieve and organise data essential for care delivery."
>
> "• Guideline Competency 2.4: Makes appropriate professional judgement regarding the extent to which the health consumer is capable of participating in decisions relating to his/her care."
>
> "• Guideline Competency 2.9: updates knowledge related to the administration of interventions, treatments medications and best practice guidelines within area of practice."

Responses to provisional opinion

59. The parties were all given the opportunity to respond to relevant sections of my provisional opinion.

[15] Published in May 2012.
[16] Published in July 2012.
[17] Published in June 2012.
[18] December 2007.

60. RN B provided a letter of apology as per a recommendation in the provisional opinion. She had no further comment to make in response to the opinion.

61. The medical centre agreed with the findings. It stated that this has been a serious matter, and that it has reflected on the complaint.

62. Ms A responded, and her comments have been added to the report where relevant.

Opinion: RN B — breach

63. The differences between Ms A's and RN B's accounts of Ms A's consultation on 10 May 2016, and of the medications that were given and/or not given to Ms A, are concerning. They also highlight the importance of clear, accurate, and, ideally, contemporaneous clinical documentation.

64. Ms A went to the medical centre for the ECP, and said that she had no other symptoms. She told HDC that she was given two tablets, which she understood at the time to be the ECP.

65. In contrast, RN B states that she gave Ms A one Postinor tablet (ECP) in the clinic and a course of trimethoprim (being three tablets for three nights) to treat a possible urinary tract infection. No standing order checklists were completed for Postinor or trimethoprim. RN B's consultation notes do not record her giving either of these medications, or any safety-netting advice, to Ms A. The consultation notes also do not record RN B giving Ms A azithromycin, yet RN B completed a standing order checklist for azithromycin. I am unable to conclude what occurred during the consultation on 10 May 2016.

66. My nursing expert advisor, RN Vivienne Josephs, advised that if I accept RN B's account as being correct, and Ms A did receive Postinor and trimethoprim, the lack of documentation of these medications being dispensed and of advice being given, combined with RN B's failure to complete the standing order checklists for those medications as per protocol, would be considered a moderate departure from the following accepted nursing standards:

- Nursing Council Competencies 1.1, 2.1, and 2.3;
- NZNO Standards of Practice Standard 1.4; and
- Nursing Code of Conduct Standard 4.8.

67. RN Josephs questioned why RN B completed a standing order checklist for azithromycin. RN Josephs noted that the checklist required a positive chlamydia result, a negative urine hCG test, and discussions with the patient regarding STIs, none of which were documented as having taken place. RN Josephs considers that "these questions should have highlighted to [RN B] that she was in the wrong drop down option" if azithromycin was not the medication she had administered. I agree.

68. Alternatively, RN Josephs advised that if I accept that Ms A did not receive Postinor or trimethoprim but instead received azithromycin, and if the azithromycin standing order checklist was completed without the criteria being correctly checked (which appears to have been the case), then this would be considered a very significant departure from the following further accepted nursing standards (in addition to those listed above):

- Nursing Council Competencies 2.4 and 2.9; and
- NZNO Medicines Guidelines 10.2.

69. Due to the conflicting accounts from Ms A and RN B, and the incorrect and incomplete clinical notes, I am not able to determine exactly what occurred during Ms A's consultation with RN B. I note that the fact that Ms A became pregnant does not unequivocally prove that she was not given ECP; as noted earlier, Postinor prevents approximately 85% of expected pregnancies, and its efficacy decreases with time following the unprotected sexual intercourse. Furthermore, a scan on 15 June 2016 appears to indicate that the date of conception was 15 May 2016 (five days after Ms A's consultation with RN B) (although I note that Ms A disagrees with these dates).

70. Regardless, there are many issues of concern with RN B's clinical documentation. While RN B did record that the urine dipstick was positive for blood and urobilinogen, RN Josephs advised that "there was no reference to a positive or negative result for nitrates or leucocytes which are also indicative of a urinary infection". RN B's clinical assessment did not identify the "many issues" she said Ms A presented with, and there is no record of a urine hCG test or Ms A's weight and BMI.

71. Further, as noted by RN Josephs, the recording of the provision of azithromycin was not simply a one-word entry, but required confirmation of a number of matters, including positive chlamydia testing (which was incorrect). There is no reference to the medications RN B claims she provided under standing orders, which should have involved contemporaneous completion of the relevant standing order templates. There is no reference to the discussion RN B said she undertook with the GP regarding RN B's blood pressure. There is also no documentation of any medication being given to Ms A at the clinic or to take home.

72. I accept RN Josephs' advice that the lack of clinical documentation, particularly with respect to the recording of the medications dispensed and the adherence to the standing order protocol, raises significant cause for concern. Irrespective of whether or not the correct medication was supplied to Ms A, in my view the combination of documentation deficiencies described is unacceptable.

73. Overall, by failing to maintain accurate documentation and comply with the medical centre's standing order protocols, I find that RN B failed to provide services in accordance with professional standards and, as such, breached Right 4(2) of the Code.[19]

[19] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

Opinion: Medical centre — no breach

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

75. RN B registered as a nurse in 2006, and had worked at the medical centre since 2012. At the time of the events, the medical centre had standing orders for Postinor, trimethoprim, and azithromycin, all of which RN B was authorised to use. The medical centre told HDC that nurses had to be formally trained before using the standing orders, and that it also provided standing order checklists, which, if completed correctly, ensured that the prerequisite conditions were present and the required tests undertaken prior to the relevant medication being provided to a patient. The medical centre also advised that its standing orders and the accompanying policies are available to staff at all times.

76. In my view, the errors in this case were not a result of a lack of training or a lack of adequate policies or guidelines. While the medical centre has improved its policies and practices to help to ensure that the events do not happen again, I consider that the medical centre's standing orders and checklists in place at the time of these events were robust.

77. The medical centre was entitled to rely on RN B, an experienced registered nurse, to provide an appropriate standard of care and adhere to the protocols in place. RN B has accepted that there was a significant lapse in the standard of her documentation on this occasion, and that she did not pay sufficient attention when filling out the standing order template. Accordingly, I consider that the medical centre did not breach the Code.

Recommendations

78. In response to the recommendations in the provisional opinion, RN B provided a written letter of apology to Ms A. This has been forwarded to Ms A.

79. I recommend that the Nursing Council of New Zealand consider whether a review of RN B's competence is warranted, and report back to HDC on the outcome of that consideration.

Follow-up actions

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

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

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Vivienne Josephs:

"Thank you for the request that I provide clinical advice in relation to the complaint from [Ms A] about the care provided by [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.

1. Documents reviewed

- Clinical consultation records dated 9 May 2016 and 2 June 2016
- Response from [Dr C] dated 10 January 2018
- Response from [medical centre GP] dated 10 January 2018
- Results of urogenital swab and Mid Stream Urine dated 10 May 2016
- Clinical Advice
- Complaint and responses from [Ms A]
- Letter from [the medical centre] dated 26 January 2018
- Statement form [RN B] dated 26 July 2017
- Response from [the medical centre] dated 17 October 2017
- [Medical centre] Standing Orders for Azithromycin, Trimethoprim and Postinor

2. Complaint

[Ms A] attended [the medical centre] on 10 May 2016 to request the morning after pill following unprotected sex on 8 May 2016. She states she was given two tablets to take by [RN B]. She adds that she only went to the clinic for the Emergency Contraceptive pill (ECP — Postinor) and had no other symptoms or infection. On a subsequent visit to the clinic on 2 June 2016, she questioned why she had been given two pills for the morning after pill as she had taken this before and remembers previously only receiving one tablet. A pregnancy test was done which was positive. Her complaint relates to her concerns that she was not given the ECP, became pregnant and that, since the birth of her child, she has suffered and continues to suffer from significant emotional and financial stress.

3. Review of clinical records

There appears to be differing dates entered in [the medical centre's] records for the dates of [Ms A's] consultation. The screenshot of [Ms A's] consultation states she was seen at 4.23pm on 9 May 2016 and clinical notes appear to have been entered at 4.48pm on 10 May 2016 and then updated at 8.30 am and 8.52 am on 11 May 2016. [The medical centre's] letter of 26 January 2018 confirms that [Ms A] was seen on 10 May 2016 and includes a list of patients seen between 10 May 2016 and 11 May 2016. [Ms A's] name appears between the two dates. Since the results of [Ms A's] swab and urine tests were recorded at 10 May 2016, it would appear that she was seen on that day.

[RN B's] notes for the consultation of 10 May 2016 document that (i) *pt here as concerned regarding a number of issues. Requires morning after pill UPS* (unprotected sex*) on Sunday morning and (ii) last night find it difficult to PU was sitting on toilet for a number of hours with lower pelvic pain, has been passing urine as normal today, no pain. Urine dip-ery+++ ubg++. Sample to lab for MSU. Self swab done for STI check, no symptoms at present.*

Pt states has also been feeling tired, has had a number of minor illness over the last month, concerned regarding immunity. BP 140/100.

The checklist for the standing order for Azithromycin was ticked as having been completed.

[The practice nurse] saw [Ms A] on 2 June 2016 for renewal *of MSD r/t depression* and documented that [Ms A] had questioned why she had been given 2 tablets for the morning after pill at her last visit as she had had this before and it was only one tablet. After reviewing the notes and screening, the RN documented that it *'seems as though pt was given Azithromycin instead of Postinor'.* Further clinical notes document her LMP mid April and, a positive HCG. Her weight, height and BMI were also recorded. Notes continue that 'a*dvised [Dr C] and she came into the room to talk to [Ms A] who is very upset'.*

4. Provider response(s)

[RN B]

[RN B's] response of 26 July 2016 states that [Ms A] arrived in an anxious state with various complaints. The date of consultation was not stated in her response but in an email sent to [Dr C] on 2 June 2016, [RN B] confirmed she saw [Ms A] as her last patient on 10 May 2016. She knew [Ms A] from previous consultations and states that her presentation was not dissimilar. [Ms A] was complaining of symptoms that [RN B] attributed to a possible UTI (urinary tract infection) and was also requesting the ECP. [RN B] states that it was difficult to obtain a clear history of events and symptoms due to [Ms A's] anxiety. She added that [Ms A's] account of the dates of events and presenting symptoms and their duration changed during the consultation. Urine testing showed a negative pregnancy test (this was not documented in the clinical notes) and 'urine abnormalities' and [Ms A's] blood pressure was raised. [RN B] states that she discussed [Ms A's] blood pressure with the GP (name not provided) and they agreed that they would treat [Ms A] for a UTI along with the ECP. [RN B] remembers giving [Ms A] Trimethoprim stating that she explained 'a number of times' that she would need to take one tablet at night for three nights. [RN B] stated that [Ms A] seemed confused about this. [RN B] stated that she believed that she also gave her one Postinor tablet.

[RN B] further documented that she was unable to write her notes till the following morning as the clinic was running late. She added that this wasn't her usual practice. She retrospectively entered her consultation notes on the 11 May 2016. She stated

that she incorrectly entered that she had given Azithromycin which she states she had not given. She states that she accidently entered 1gm of Azithromycin using the standard order template drop down screening tool instead of Postinor.

She stated that on 2 June 2016 [Ms A] returned to the clinic and told the practice nurse whom she was seeing that she ([RN B]) had given her two tablets and that she had not been given Trimethoprim. [RN B] states that she has a clear memory of giving [RN B] Trimethoprim because of the need for frequent explanation of how to take them. She states that she believes she gave [Ms A] Postinor in the clinic and three 300mg tablets of Trimethoprim to take away.

[Ms A's] response

In her response to [RN B], [Ms A] states that she went to the clinic only for the ECP with no other symptoms or infection. She states she was not flustered or anxious. She stated that she did not require any repetitive clarification. She confirms that she was given two tablets — one which she took in the clinic and the other to take home. During her next visit to the clinic, she stated she saw another nurse who checked her notes and *confirmed that I was never given the ECP and suggested I do a pregnancy test.*

[The medical centre's] response

The clinic confirms that [RN B] did not complete a screening template for either Trimethoprim or Postinor. The only screening template completed was for Azithromycin. [The medical centre] also confirmed that [RN B] had authority to use Standard Order dispensing and that there was no mix up in the clinical notes with another patient. They also confirm that [Ms A] was seen on 10 May 2016 and notes entered retrospectively on 11 May 2016. The date 9 May 2016 was entered incorrectly.

5. Clinical advice

[Ms A] and [RN B] have differing accounts of the consultation at [the medical centre] on 10 May 2016 and of the medications that were given and/or not given to [Ms A]. The lack of clinical documentation including a record of medications dispensed and adherence to the requirements of Standing Order protocol raises significant cause for concern.

There was no documentation of Trimethoprim and Postinor being given to [Ms A] and no standing order checklist templates completed for these medications. There was no documentation of any discussions with [Ms A] or any reference to 'safety netting' around those medications.

A standing order checklist template was completed for Azithromycin which [RN B] states was in error and was not given to [Ms A]. This checklist required the ticking of criteria which was not documented in the clinical notes and included a positive chlamydia screen and the performing of a urine pregnancy test. These questions

should have highlighted to [RN B] that she was in the wrong drop down option if Azithromycin was not the medication she was planning to administer. There is no documentation in the clinical notes of any medication being given to [Ms A], either given in the clinic or to take home.

[RN B's] clinical assessment did not identify a summary of the 'many issues' that [Ms A] is documented as having presented with and there is no recording of her last LMP, a urine HCG test or her weight. The urine dipstick was positive for blood and urobilinogen but there was no reference to a positive or negative result for nitrates or leucocytes which are also indicative of a urinary infection.[1] It is not documented that a UTI was suspected although a MSU was appropriately sent to the lab based on [Ms A's] complaint of pelvic pain. There is no reference to why the urogenital swabs were taken if there was no suspicion of an STI. The clinical note stated that the patient requires the morning after pill but there is no further documentation that it was administered.

[RN B's] reasoning in her statement that she '*discussed the consultation with the GP who was in the clinic as I wanted to highlight that her blood pressure was slightly high and wondered if this would relate to her urine symptoms/urinalysis and due to the difficulties in getting a clear history*' is not clear. If [RN B] did discuss [Ms A's] consultation with the GP at the clinic, it is unclear from [RN B's] statement exactly what the focus of that discussion was. I note that there was no reference to this discussion in the clinical notes and neither GP recalls this conversation.

I have questions as to why the Azithromycin screening template was completed considering the tick boxes required positive chlamydia results, a negative urine HCG and a discussion with the patient around STIs — none of which were documented as having taken place. There is no clinical documentation that an STI was suspected although urogenital swabs were taken. [Ms A] states that she came to the clinic only for the ECP and had no other symptoms. I note that both the MSU and the urogenital swabs are clear for urinary infection and chlamydia.

There is no explanation given by [RN B] as to why the Standing order screening templates for Trimethoprim and Postinor were not completed if those medications had been given. There was no retrospective completion of those screening templates and no incident forms completed. [RN B's] statement makes no apology for the incomplete documentation and there is no retrospective documentation in the clinical notes that trimethoprim and Postinor were given.

According to Med safe sheets and [the medical centre's] Standing Order protocol, the ECP is a one tablet dose (current guidelines are now for two tablets if a patient has a BMI>25). Trimethoprim is one tablet for three nights and Azithromycin is two tablets taken together. [Ms A] states she was given one tablet in the clinic and one to take

[1] https://bpac.org.nz/bt/2013/june/urine-tests.aspx

home. [RN B] believes she gave [Ms A] one Postinor tablet in the clinic and a course of Trimethroprim (3 tablets for 3 nights) to take home.

[The medical centre's] standing order for Trimethoprim requires the inclusion of urinary frequency or dysuria which was appropriately documented and exclusions of a temperature >38 and pregnancy. Advice must also be given regarding worsening infection. There is no documentation of this.

[The medical centre's] standing order for the ECP (Postinor, Levonorgestrel) requires consent from the patient and an exclusion of pregnancy with the requirement to always do a urine HCG. In the version finalised [after these events], it states that two Postinor-1 tablets to be taken stat if BMI>25.

[Ms A's] weight and BMI are not recorded. Patients must also receive advice about how the medication works the need for an HCG if the next period is late or light and the failure rate. Although I note that [Ms A] had received the ECP before, this information should be reiterated with each new dispensing. There was no documentation of this in the clinical notes however [RN B's] later statement stated that a urine HCG had been done.

Whilst it is best practice to document clinical notes at the time of consultation or nursing activity, this is often not possible in a busy clinical context and retrospective entry is not uncommon. I would not consider the retrospective entries in the clinical notes as a departure from practice.

Conclusion

If [RN B's] account is correct and [Ms A] did receive the ECP and a prophylactic course of Trimethoprim, the lack of documentation of these medications being dispensed, advice given and standing order template for the provision of those medications not being completed as per clinic protocol would be considered a moderate departure from the following accepted nursing standards:

Competencies for Registered Nurses[2]

Competency 1.1 Demonstrates knowledge of and accesses policies and procedural guidelines that have implications for practice

Competency 2.1 Administers medications according to authorised prescription, established policy and guidelines

Competency 2.3 Ensures documentation is accurate. Maintains clear, concise, timely, accurate and current health consumer records. Demonstrates computer skills necessary to record, enter, store, retrieve and organise data essential for care delivery.

[2] Nursing Council of New Zealand. (2007). *Competencies for registered nurses.* Wellington

Standards for Professional Nursing Practice[3]

1.4: Provide documentation that meets legal requirements, is consistent, effective, timely, accurate and appropriate

Standards for Code of Conduct for Nurses

4.8 Keep clear and accurate records

If [Ms A's] account is correct and she did not receive the ECP or trimethoprim but received Azithromycin and if the Azithromycin screening template was completed without the criteria being correctly checked, this would be considered a very significant departure from the following additional (to above) standards of accepted nursing practice:

Competencies for Registered Nurses[4]

Competency 1.1: Uses professional standards of practice

Competency 2.4: Makes appropriate professional judgement regarding the extent to which the health consumer is capable of participating in decisions relating to his/her care

Competency 2.9: updates knowledge related to the administration of interventions, treatments medications and best practice guidelines within area of practice

Guidelines for Nurses on Administration of Medicines[5]

11.2 Standing Orders: Give the medicines in accordance with the standing order. Nurses must follow local workplace policies and guidelines on the use of standing orders.

Standards for Code of Conduct for Nurses

Standard 3.1: Explain and share information with health consumers that they want and/or need. Give health consumers information that is honest and accurate in a way they can understand and invite questions.

Standard 4.1: Use appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care.

Standard 4.8: Deliver care based on best available evidence and best practice.

Standard 7.1: Be open and honest in your interactions with health consumers.

Viv Josephs, RN, BHSc, PGCert (Nursing)
Nursing Advisor"

[3] New Zealand Nurses Organisation. .*Standards of professional Nursing Practice:* March 2012
[4] Nursing Council of New Zealand. (2007). *Competencies for registered nurses.* Wellington
[5] New Zealand Nurses Organisation (2014) *Guidelines for Nurses on Administration of medicines*