Registered Nurse, RN C

A District Health Board

A Nursing Agency

A Report by the

Deputy Health and Disability Commissioner

(Case 12HDC00953)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of Contents

Executive summary

1. Mrs A, aged 56 years, had been diagnosed with motor neurone disease.[1] She was unable to speak, and communicated via an iPad. Mrs A also had difficulty swallowing, which was documented numerous times in her clinical records, and on the handover note. Her clinical records also noted her preference for intravenous (IV) rather than oral paracetamol.

2. On 19 July 2012, Mrs A was admitted to the public hospital because of a sudden onset of chest pain. Later that day she was transferred to the ward. An agency registered nurse (RN), RN C, was working on the night shift on the ward.

3. Mrs A's clinical notes, including a written handover sheet, noted that she had "MND" (ie, motor neurone disease). RN C did not recognise the abbreviation "MND" and did not take steps to find out what it meant.

4. At 12.30am on 20 July, Mrs A rang the bell because she needed to go to the toilet. RN C assisted Mrs A to the toilet and back to bed. Mrs A asked for pain relief, and RN C offered her paracetamol elixir.

5. Mrs A wrote on her iPad that she required IV paracetamol and could not swallow elixir. RN C administered IV paracetamol.

6. At 4.15am, Mrs A again needed to go to the toilet and was assisted by RN C. As Mrs A was getting out of bed, RN C said to her, "You need to sit up yourself," which Mrs A was unable to do.

7. Mrs A requested more pain relief, and RN C again brought paracetamol elixir. Mrs A indicated that she could not take it, but RN C administered elixir into Mrs A's mouth. During administration of the elixir, Mrs A felt as though she was choking. RN C said, "What's this performance about?" and walked away.

8. Approximately an hour later, RN C returned with IV paracetamol, but did not flush the luer and, after administering the paracetamol, threw the syringe on Mrs A's bed and walked away.

Findings

9. RN C's conduct and manner towards Mrs A were unkind and unprofessional. Her behaviour demonstrated a lack of respect for Mrs A and, as a result, RN C breached Right 1(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[2]

10. RN C should have been aware of Mrs A's diagnosis of motor neurone disease and familiarised herself with Mrs A's needs and preferences in order to provide safe care to her. RN C's failure to take those steps meant that she failed to provide services in a manner consistent with Mrs A's needs and breached Right 4(3) of the Code.[3] In addition, by failing to flush Mrs A's luer prior to administering IV paracetamol at

[1] Motor neurone disease is a neurological condition that causes the progressive degeneration of nerve cells in the brain and spinal cord.
[2] Right 1(1) of the Code states: "Every consumer has the right to be treated with respect."
[3] Right 4(3) of the Code states: "Every consumer has the right to have services provided in a manner consistent with his or her needs."

4.15am on 20 July, RN C failed to provide services with appropriate care and skill and, in doing so, breached Right 4(1) of the Code.[4]

11. In disregarding Mrs A's refusal to take paracetamol elixir, RN C breached Right 7(7) of the Code.[5]

12. RN C will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

13. The Deputy Commissioner found that neither the District Health Board nor the nursing agency breached the Code.

Complaint and investigation

14. The Commissioner received a complaint from Mrs A about the services provided by RN C at a public hospital. The following issues were identified for investigation:

- *Whether RN C provided Mrs A with an appropriate standard of care in July 2012.*
- *Whether the agency provided Mrs A with an appropriate standard of care in July 2012.*
- *Whether the district health board provided Mrs A with an appropriate standard of care in July 2012.*

15. This report is the opinion of Theo Baker, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

16. The parties directly involved in the investigation were:

Mrs A	Consumer/Complainant
Mr B	Consumer's son
RN C	Registered nurse
The agency	A nursing agency
The district health board	Provider

17. Independent expert advice was obtained from the Commissioner's in-house nursing advisor, Registered Nurse Dawn Carey (**Appendix A**).

[4] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[5] Right 7(7) of the Code states: "Every consumer has the right to refuse services and to withdraw consent to services."

Information gathered during investigation

18. On 23 July 2012, Mrs A lodged a complaint via HDC's website. She alleged that during an admission to the hospital, a nurse called RN C had brought her liquid paracetamol (even though her preference for IV pain relief was noted in her records), had been disrespectful, and had forced paracetamol syrup into her mouth, until she choked. Mrs A had been so upset by this that she had texted her family to collect her.

19. Sadly, a short time later, Mrs A passed away.

Mrs A

20. Mrs A, who was aged 56 years at the time of these events, was diagnosed with motor neurone disease in 2011. This affected her mobility and her ability to communicate and swallow, but her mental capacity was unimpaired. She used an iPad to communicate, and had been receiving palliative care due to a progressive decline in her condition.

21. On 2 June 2012, Mrs A was referred to speech therapy because of a recent change in her ability to swallow. The referral form noted: "Frequent coughing/choking during oral intake."

Admission 19 July 2012

22. On 19 July 2012, Mrs A was admitted to the hospital because of a sudden onset of chest pain. Later that day, she was transferred to a general medical ward.

23. In a Patient Admission Questionnaire (completed in consultation with Mrs A by her sister), Mrs A stated that she had pain all over her body, which was related to her motor neurone disease. Two entries in the questionnaire remind the reader that although Mrs A's speech was impaired, she had full understanding. In response to the question asking whether there was anything else she wished to tell staff, the following statement is recorded: "I am human! Direct your questions to me!" A referral to speech therapy, also dated 19 July 2012 and included in the clinical notes, stated: "NBM [nil by mouth] due to swallowing issues."

Administration of medication

24. Mrs A's clinical notes include a handwritten note (attached as **Appendix B**), which her son had prepared on her instructions. It states that Mrs A wished to receive her medications intravenously because of her difficulty swallowing.

25. Nursing notes taken at 2.30am on 19 July state that Mrs A was able to tolerate tablets orally if crushed with yoghurt. Mrs A's Drug Treatment Sheet had paracetamol charted "po/iv", which allowed for administration of paracetamol orally, in the form of elixir or tablets, or intravenously. At 9pm on 19 July, an RN recorded: "Pt [patient] prefers pain relief prior to meds/oral medication. Give paracetamol IV prior works well with pt."

RN C

26. RN C is a registered nurse. At the time of these events she was working on the general medical ward at the hospital as an employee of an external nursing agency, (the agency). RN C was employed by the agency on 19 September 2011, but had been registered as a nurse since 1982. She had had previous experience working at the hospital and on the general medical ward, but 19 July 2012 was her first time on that ward as an agency nurse.

27. RN C was working on the general medical ward from 11pm on 19 July to 7am on 20 July 2012. She was on the shift with two permanent ward staff. The District Health Board (DHB) told HDC that patient acuity was even across the three nurses, and that RN C had 10 patients. The DHB advised that this was a "usual workload for the ward although, in retrospect, probably more than [RN C] was comfortable with".

28. RN C told HDC that:

> "… because of the high patient loading which would be considered unsafe in some hospitals I have worked (especially for a nurse not familiar with the patients), I had to prioritise what I could. That night I was also responsible for a patient who deteriorated very quickly … this did impact my ability to provide non-critical care to other patients."

29. The DHB stated that RN C received a verbal handover in the nurses' office and a walk around the ward to each bedside, as well as a written handover sheet for Mrs A that recorded "c/pain: Hx MND, Crohn, NSTEMI and impaired swallow". The DHB advised that this means "chest pain with a past history of motor neurone disease, Crohns disease, heart attack and impaired swallow".

30. RN C stated to HDC that she did not recognise the abbreviation "MND", and said:

> "My recent experience had been in hospitals where abbreviations in clinical notes were considered bad practice. This should have alerted me, and on seeing the abbreviation for MND I should have made more enquiries."

31. RN C also told HDC that "at [verbal] handover, no mention was made to me of [Mrs A's] difficulties with swallowing, her need to communicate by [iPad], or particular reference to MND".

32. In response to my provisional opinion, RN C stated that she did not see the handwritten note (**Appendix B**) in Mrs A's clinical records.

Administration of medication

33. During RN C's shift, there were two instances when Mrs A requested pain relief.

12.30am incident

34. At around 12.30am, RN C assisted Mrs A to the toilet. Mrs A told HDC that she then requested pain relief and RN C offered paracetamol elixir. Mrs A stated that she communicated by way of her iPad that she required IV paracetamol, as she could not swallow properly. RN C then administered IV paracetamol.

35. RN C told HDC that at 12.30am she offered Mrs A IV paracetamol on advice from one of the other nurses. RN C stated that she does not recall Mrs A requesting IV paracetamol. In response to my provisional opinion, RN C stated that she did not offer paracetamol elixir to Mrs A at 12.30am.

4.15am incident

36. At around 4.15am, RN C again assisted Mrs A to the toilet.

37. Mrs A stated that RN C said, "You need to sit up yourself," and described RN C's manner during this interaction as "sour", "unprofessional and completely unsupportive". According to the agency, RN C advised that she did not think she was "particularly rude or off hand".[6]

38. Mrs A stated that she asked for pain relief, and RN C again offered paracetamol elixir. Mrs A stated, "I indicated no, I cannot take that," but that RN C then forced the elixir into her mouth until she choked.

39. In contrast, and as noted above, RN C told HDC that she did not recall Mrs A requesting IV administration. RN C stated:

> "It is normal practice in this case to alternate the method of administration […] Following normal protocols I offered the second dose of [paracetamol] orally. [Mrs A] had a small sip and it was obvious from this that she was not able to take the full dose that way. I discontinued the oral administration and discarded the remainder of the dose. I deny that [Mrs A] was 'forced' to take the dose orally."

40. RN C advised HDC that she did not observe Mrs A choking.

41. Mrs A stated that RN C then "said sarcastically, 'What's this performance about?' and walked away". Mrs A said that she was left upset and crying, with paracetamol elixir spilt all over her. She said she eventually managed to get her tissues and clean off some of the elixir.

42. RN C stated to HDC that she did not observe Mrs A upset or crying, and that, had she noted any distress, she would have responded with concern and support, which has always been a foundation of her nursing practice.

43. Mrs A told HDC that approximately an hour later, RN C returned with IV paracetamol. RN C told HDC that she was unable to recall when the subsequent IV administration occurred, but that if there was a delay it was likely because of the need to attend to another patient.

44. Mrs A stated that RN C did not flush the luer,[7] and, after administering the paracetamol, threw the syringe on the bed and "marched away". Mrs A said that this interaction occurred without RN C talking to her or making eye contact. Mrs A stated that eventually she went to sleep and, when she awoke, another nurse was present.

[6] This quote is taken from RN C's interview with the agency. In response to my provisional opinion, RN C said that she would not have used the word "particularly".
[7] Clean the IV line with saline.

The nurse asked why there was a syringe on the bed, and why the empty bottle and line were still attached.[8] Mrs A said that she "just shrugged" and then sent text messages to her sister and son asking them to come to get her out of the ward.

45. In response to my provisional opinion, RN C stated that while she does not specifically recall flushing the luer, "given that [her] professional practice ingrained through a lifetime of nursing would be to do so, it is unlikely that [she] did not do so as a matter of course".

46. Regarding Mrs A's allegations about RN C's manner, RN C provided HDC with the following response:

> "[Mrs A] reported that there were communication difficulties on my part, lack of eye contact, that I was unprofessional. I am sorry [Mrs A] had this impression. It was not my intention at any stage to be unprofessional. Given that it was night, and dark or poor light, direct communication was difficult and perhaps miss-understood [sic]. Some of the comments [Mrs A] attributes to me are simply not in my nature."

47. In response to my provisional opinion, RN C also stated that she denies being unkind, unprofessional or lacking respect for Mrs A, and that she is a caring and compassionate nurse. She stated that:

> "I believe at least part of the reason [Mrs A] perceived me to be 'short' with her had to do with the time constraints imposed on me in dealing with another allocated patient who deteriorated quickly and unexpectedly during the latter part of the shift, which required me to prioritise care."

48. The clinical notes include the following record signed by RN C:

> "1145 Nursing notes 2300–0700
> Pt went to toilet on chair
> Pt then requested IV Panadol [paracetamol]
> ─ Same given as per MR4
> Good communication with laptop
> 0530 IV Panadol given x2 per shift Pt up to toilet /w chair"

Reports of incidents

49. Mrs A stated that when the respiratory consultant came to see her in the morning, she told him what had happened.

50. At 11.30am on 20 July 2012, the respiratory consultant recorded that Mrs A had informed him of a "nasty experience with nursing staff overnight".

[8] The DHB advised HDC that the two other nurses on duty in the general medical ward on 19–20 July did not have knowledge of the events in question, and neither "noted any of the events relayed in [Mrs A's] complaint".

51. The Charge Nurse Manager subsequently wrote in the clinical notes[9] that on 20 July 2012, Mrs A "described an incident with nursing staff overnight. [Mrs A] will email me with the detail of incident so I can follow up appropriately". The clinical notes include an email dated 23 July 2012 from Mrs A to the Charge Nurse Manager describing her recollection of events in detail.[10] Mrs A stated in the email that she was reluctant to return to the hospital for fear that the treatment she experienced could escalate.

Discharge

52. Mrs A's Discharge Summary dated 20 July 2012 stated that "unless contraindicated, Mrs A should be admitted under respiratory team 2 in [a different ward] if possible".

Effect of incident

53. In her complaint, Mrs A stated that this incident caused significant pain and ongoing stress for herself and her family. She also stated that following this event she had "flashbacks" because, having motor neurone disease, "a choke could kill [her]".

54. RN C advised HDC that she considers the incident to be "very minor".

RN C's statements to the DHB and the agency

55. Because there is not agreement on the facts, I have considered the consistency of RN C's prior statements in order to assist my evaluation of the evidence.

56. On 31 July 2012, the agency interviewed RN C about the incident.

57. Regarding handover, RN C advised the agency that "there was a report in the back staff room and an end of bed round", and she also "had a handover sheet". The notes from the interview state that RN C "usually puts patient labels and notes on the back of the sheet for her patients as she reads the notes". RN C said that she does not recall when she read Mrs A's notes, "but does not think it was too late in the shift". RN C stated that she does not recall reading about the motor neurone disease, the need for IV paracetamol, or Mrs A's swallowing difficulties.

58. According to the agency, RN C remembered a couple of trips to the toilet overnight, and a "second request" for paracetamol. In contrast to what RN C told HDC, the agency reported that RN C said that she was not sure whether the first or second request was "the one where the ipad was used to note 'IV Panadol'".

59. Similarly, the DHB's report to Mrs A, responding directly to her complaint, noted that RN C "remember[s] [Mrs A] asking for IV Panadol rather than an oral dose using [her] iPad" but that "[RN C] is unclear if this was the first or second dose request".

60. The agency's report stated that, initially, RN C did not recall bringing paracetamol elixir to the bedside, but that she later stated that since IV paracetamol had been given previously, she thought she should vary that with an oral dose.

[9] The note is dated 23 July 2013 and states "written in retrospect".
[10] The description of the incident in that email is identical in all material respects to the complaint submitted to HDC, and has been incorporated into the facts above.

61. In its first response to HDC, the DHB advised that RN C did not recall attempting to administer paracetamol elixir to Mrs A. However, the DHB's direct response to Mrs A noted that RN C recalled assisting Mrs A with a "trial sip" of the elixir, but did not recall Mrs A's choking or her distress. Similarly, the agency reported to HDC that RN C said that she gave Mrs A a "sip" to try, and that Mrs A gave a "small cough". RN C did not recall Mrs A being distressed, and did not realise there was an issue.

62. According to the DHB, RN C stated generally that it was not like her to behave in the way described in Mrs A's complaint, she does not recall the events in the same way as Mrs A, and she "absolutely denies that the events in the complaint occurred as stated".

63. In response to my provisional opinion, RN C stated that she acknowledges that there are some discrepancies between what she told the DHB and the agency, and what she told HDC 10 months later. She advised that it would be unreasonable to expect "exactness of recall over such a period". However, she does not consider that her recollection of the "essential events of the night of 19-20 July 2012" has been affected.

The DHB's investigation

64. On 25 July 2012 the DHB sent Mrs A a letter acknowledging receipt of her complaint and advising that an internal investigation would be commenced. An investigation was duly undertaken, and the outcome of the investigation was sent to Mrs A in a letter dated 15 August 2012.

65. As part of its internal investigation, the DHB spoke to the other ward staff on duty and interviewed RN C. The DHB's investigation concluded that neither of the other nurses on the shift that night noted any concerns or anything unusual. The DHB advised HDC, following discussions with the other nurses, that "[RN C] was reported to be busy with the patients … but appeared to have managed well with her workload and did not ask for help". I note RN C's statement to HDC that because of the high workload, which she said would be considered unsafe in some hospitals, especially for a nurse not familiar with the patients, she had to prioritise where she could, and this did impact on her ability to provide non-critical care to other patients.

66. As a result of the DHB's investigation, the hospital's "safe staffing committee" (the committee) reviewed the standard of support provided to agency staff. The DHB advised that the committee "is a shared team of [New Zealand Nurses Organisation] representatives and [the District Health Board] nursing staff [who discuss] issues related to safe staffing". The committee's review concluded that the measures for providing support to agency nurses at the hospital were adequate.

Subsequent events

67. The DHB advised HDC that, prior to the events complained of, RN C had applied for, and been offered, a permanent position in another department at the hospital.

68. On 6 August 2012, RN C commenced employment at the hospital and remained on supervised orientation for an extended period. RN C ceased working for the hospital

some months later, and is not currently practising nursing. The Nursing Council of New Zealand has undertaken to monitor RN C's practice should she return to nursing.

Previous complaints

69. The DHB and the agency were aware of some concerns about RN C's practice prior to July 2012. In May 2012, the DHB was notified of an incident where, during one shift at the DHB, RN C had failed to complete postoperative observations appropriately, had made three near-miss IV medication errors, and had refused to go to work in another ward. The complaint was referred to the agency as RN C's employer at that time.

70. The agency provided HDC with documentation showing that each of these incidents was discussed with RN C. RN C was told to review various policies, and to remember to ask for help if she felt she needed it. No other follow-up action was taken.

Opinion: Breach — RN C

Introduction

71. Mrs A was a vulnerable patient. She had been diagnosed with motor neurone disease and had been affected to the extent that she had limited mobility and was unable to speak, and communicated by way of her iPad. However, she was still fully able to understand her circumstances and what was said to her. She expressed her feelings as, "I am human! Direct your questions to me!" When admitted to the hospital, she advised that she had pain all over her body because of the motor neurone disease, and was concerned about choking because of her swallowing difficulties.

72. Mrs A had the right to expect that she would be treated with respect, and that the staff providing care to her would respect her wishes with regard to her treatment. Staff needed to ensure they were sufficiently informed to be in a position to provide Mrs A with safe care.

Factual findings

73. I have considered the statements Mrs A and RN C have made to HDC. There are a number of discrepancies in their accounts of events. In my view, the following factual findings are material to my consideration:

- whether or not Mrs A requested IV paracetamol at 12.30am;
- whether or not Mrs A refused paracetamol elixir at 4.15am;
- what happened when RN C administered the paracetamol elixir at 4.15am; and
- whether or not RN C's manner was unprofessional.

74. My consideration of the evidence in regard to each of these issues is set out below.

12.30am incident

75. I am satisfied that at around 12.30am, Mrs A requested pain relief from RN C.

76. Mrs A's evidence is that she requested IV paracetamol on her iPad the first time it was administered.

77. RN C stated to HDC that at 12.30am, she offered Mrs A IV paracetamol on advice from one of the other nurses. RN C stated that she does not recall Mrs A requesting IV paracetamol. However, RN C advised the DHB and the agency that she does recall at least one occasion when Mrs A requested IV paracetamol on her iPad, but that she cannot recall whether it was the first or second time paracetamol was administered. In addition, RN C documented in Mrs A's clinical records that Mrs A requested IV paracetamol.

78. In light of RN C's inconsistent evidence on this point, I accept that at 12.30am, Mrs A advised RN C via her iPad that she required IV paracetamol, as she could not swallow the paracetamol elixir. RN C then administered IV paracetamol in accordance with that request.

4.15am incident

79. Mrs A told HDC that at 4.15am, RN C assisted her to go to the toilet. Mrs A stated that she then requested pain relief, and RN C again offered paracetamol elixir. RN C told HDC that "following normal protocols [she] offered the second dose of [paracetamol] orally".

80. I therefore consider it to be evident that around 4.15am, Mrs A again requested pain relief, and RN C again offered paracetamol elixir.

81. Mrs A told HDC that, when RN C offered her the elixir at 4.15am, "I indicated no, I cannot take that." As stated above, RN C told HDC that she does not recall Mrs A requesting IV paracetamol.

82. I consider it to be more likely than not that at 4.15am, before RN C administered the elixir, Mrs A again indicated to RN C that she could not take the elixir. I make this finding on the following basis:

- Mrs A stated that at 4.15am, she indicated to RN C that she could not take the paracetamol elixir.
- RN C has provided unclear accounts about whether Mrs A requested IV paracetamol at 12.30am or 4.15am (she told the DHB and the agency that she recalled one occasion but was not sure whether it was at 12.30am or 4.15am) or at all (she told HDC that she does not recall Mrs A requesting IV paracetamol).
- Mrs A's preference for IV administration was clearly and repeatedly recorded in her records.
- Mrs A had previously refused oral paracetamol at 12.30am.

83. RN C then administered the elixir to Mrs A.

Administration of elixir

84. Mrs A said that she "choked" during the administration of the elixir. RN C advised HDC and the DHB that she did not observe Mrs A "choking". RN C advised the agency that Mrs A "coughed" when the elixir was administered.

85. I note the advice of my nursing advisor, RN Dawn Carey, that although Mrs A's reaction to the administration of the elixir was technically a cough, her ability to cough was reduced because of the motor neurone disease, and therefore a sustained coughing episode would have made her feel as though she was choking.

86. In my view, it is immaterial whether Mrs A's reaction to the administration of the elixir is described as a "choke" or a "cough"; it is evident that Mrs A had difficulty swallowing the elixir and felt as though she was choking.

RN C's manner

87. Mrs A also raised concerns about RN C's conduct and manner. Mrs A stated that at around 4.15am RN C told her that she needed to sit up by herself. Mrs A described RN C's manner as "sour", "unprofessional and completely unsupportive". Mrs A also said that, when she choked, RN C "said sarcastically, 'What's this performance about?' and walked away". Approximately one hour later, RN C administered the IV paracetamol. Mrs A stated that RN C did not speak or make eye contact during the IV administration, and subsequently did not flush the luer, and left the used syringe on the bed. Mrs A further stated that, later in the morning, she sent text messages to her sister and son asking them to come to get her out of the ward.

88. Although I have been unable to question Mrs A further about her statement to HDC, I have no reason to doubt her reliability. She made the statement only four days after the events, and there is no question about her mental capacity.

89. In response to the allegations about her conduct and manner, RN C stated that:

- she does not think she was "particularly rude or off hand";
- it is not like her to behave in the way Mrs A described;
- she does not recall the events in the same way as Mrs A;
- it was not her intention at any stage to be unprofessional;
- it was dark, meaning that direct communication was difficult and perhaps misunderstood;
- some of the comments Mrs A has attributed to her are not in her nature; and
- she absolutely denies that the events in the complaint occurred as Mrs A has stated.

90. I find RN C's above statements, which do not directly respond to Mrs A's specific allegations, unconvincing. As outlined above, RN C has been inconsistent in respect of many issues. Overall, I do not find her evidence reliable. I therefore find it more likely than not that RN C's manner and conduct were as Mrs A described.

Respect

91. The Patient Admission Questionnaire dated 19 July includes the statement: "I am human! Direct your questions to me!" The note that Mrs A had attached to her clinical records (see **Appendix B**) stated: "I have trouble talking although I can understand everything. I have an iPad to communicate with you, please be patient with me while I type. Please be AWARE my left side is extremely painful please be gentle when moving me etc."

92. It is clear from the records that Mrs A felt that because of her inability to speak, she was at risk of being treated with a lack of respect. In addition to their obligations under the Code, registered nurses must treat health consumers with kindness, and use their expertise and influence to promote the health and welfare of vulnerable health consumers.[11]

93. As stated above, I accept Mrs A's account of RN C's conduct and manner. I find that RN C's conduct was both unkind and unprofessional. Mrs A was entitled to be treated with respect and, accordingly, I find that RN C breached Right 1(1) of the Code.

94. I note that RN C has stated that she regrets and is sorry for any actions of hers that may have contributed to the distress Mrs A suffered.

Standard of care

95. At the time of these events, RN C was working on the general medical ward at the hospital as an agency nurse. RN C was obliged to provide services to Mrs A with reasonable care and skill.[12] This required RN C to use appropriate care and skill when assessing Mrs A's needs, and to take steps to ensure that her care did not harm Mrs A.[13]

96. RN C received a verbal handover in the nurses' office and a walk-around to each bedside, as well as being provided with a written handover sheet that recorded "c/pain: Hx MND, Crohn, NSTEMI and impaired swallow". The DHB advised that this means "chest pain with a past history of motor neurone disease, Crohns disease, heart attack and impaired swallow". I note RN Carey's advice that a printed handover sheet stating the patient's admitting diagnosis, followed by a walk-around handover, are part of an adequate and safe transfer from one registered nurse to another.

97. The administration of paracetamol elixir was not contraindicated for Mrs A. Paracetamol was charted for Mrs A to be taken either intravenously or orally. However, Mrs A's preference for pain relief to be administered intravenously was clearly expressed in her records. Her clinical notes refer repeatedly to her diagnosis of motor neurone disease and her difficulty with swallowing. Attached to her notes was a handwritten instruction (see **Appendix B**), which stated that Mrs A had motor neurone disease, and that she had difficulty swallowing and required her medication intravenously. RN C was obligated to ask for and respect Mrs A's views and decisions about her health, and respond to her concerns and preferences where practicable.[14] As RN Carey advised, Mrs A's indicated preference should have been respected.

98. On 31 July 2012, RN C advised her employer, the agency, that she "usually puts patient labels and notes on the back of the sheet for her patients as she reads the notes". She stated that she did not recall when she read Mrs A's notes, "but did not

[11] Nursing Council of New Zealand, "Code of Conduct for Nurses" (June 2012), Standards 1.1 and 3.8.
[12] Code of Health and Disability Services Consumers' Rights, Right 4(1).
[13] See also Nursing Council of New Zealand, "Code of Conduct for Nurses" (June 2012), Standards 4.1 and 1.10.
[14] See Nursing Council of New Zealand, "Code of Conduct for Nurses" (June 2012), Standards 1.3, 3.2 and 3.3.

think it was too late in the shift". RN C stated that she did not recall reading about motor neurone disease or Mrs A's need for IV paracetamol, or that Mrs A had any swallowing difficulties. I do not find this account credible in light of the number of times Mrs A's impaired ability to swallow was mentioned in her records, including the handover sheet.

99. RN C claimed that she did not recognise "MND" on the handover sheet as meaning "motor neurone disease", and does not recall being told of Mrs A's diagnosis. I note RN Carey's advice that "MND" is an accepted clinical abbreviation, but that it was reasonable that RN C might not have recalled its meaning. However, all registered nurses must keep their professional knowledge and skills up to date, and ask for advice and assistance from colleagues, especially where care may be compromised by a lack of knowledge or skill.[15] RN Carey advised:

> "[L]egislation and professional standards require registered nurses to identify and resolve any deficits of clinical knowledge. Whilst I can appreciate there are circumstances where this may be difficult to do, this is the required level of accountability. In my opinion, the failure of [RN C] to communicate her lack of knowledge about the abbreviation MND signifies a moderate departure from the expected standard of nursing practice."

100. Given that RN C has acknowledged that she read the notes, I find that she should have been aware of Mrs A's diagnosis of motor neurone disease, and should have familiarised herself with Mrs A's needs and preferences in order to provide safe care to her. RN C's failure to take those steps meant that she failed to provide services to Mrs A in a manner consistent with her needs, and breached Right 4(3) of the Code.

101. Mrs A stated that, prior to administering IV paracetamol at 4.15am, RN C did not flush the luer.

102. In response to my provisional opinion, RN C stated that while she does not specifically remember flushing the luer, it is "unlikely that [she] did not do so".

103. RN Carey advised that flushing the luer is required to ensure that it remains in the correct position, to clear administered medications, and to create a flush lock.[16] RN Carey considers that a failure to flush the luer before and/or after administering IV medication is a moderate departure from expected standards of practice.

104. As stated above, I find it more likely than not that RN C's conduct was as Mrs A described. Accordingly, I am of the view that RN C did not flush the luer. I consider that, in failing to flush the luer, RN C did not provide services to Mrs A with reasonable care and skill and, therefore, breached Right 4(1) of the Code.

[15] See Nursing Council of New Zealand, "Code of Conduct for Nurses" (June 2012), Standards 4.3 and 4.5.
[16] A flush lock helps to keep the luer or catheter patent for subsequent medications/fluids.

Refusal of consent

105. Every consumer has the right to refuse consent to the provision of services. As noted above, I accept that during the first incident shortly after 12.30am on 20 July 2012, when RN C offered paracetamol elixir to Mrs A, Mrs A communicated through her iPad that she required IV paracetamol as she could not swallow properly. I consider that this constitutes Mrs A refusing consent to the administration of paracetamol elixir. On this occasion, RN C complied with Mrs A's refusal, and administered the paracetamol intravenously.

106. However, shortly after 4.15am, RN C again offered paracetamol elixir to Mrs A. As noted above, I accept that before the elixir was administered, Mrs A again indicated to RN C that she could not take paracetamol elixir. Once again, I consider that this constitutes Mrs A refusing consent to the administration of paracetamol elixir. Despite that refusal of consent, RN C administered the elixir into Mrs A's mouth, leading Mrs A to cough or choke.

107. Having considered all of the circumstances, including that Mrs A's preference for IV paracetamol was recorded in her notes and that she had refused paracetamol elixir at 12.30am, I find that Mrs A's refusal of consent to the administration of paracetamol elixir at 4.15am was sufficiently clear.

108. However, in the event that RN C did not consider Mrs A's consent or refusal of consent sufficiently clear, I would have expected her to take additional steps to clarify the issue.

109. The consent process for the administration of paracetamol is, in many cases, a simple process because the patient can say "yes" or "no" to the administration. In Mrs A's case, her ability to communicate her consent or refusal of consent verbally was significantly impaired. As the Nursing Council of New Zealand Standards state, registered nurses need to meet health consumers' language and communication needs where reasonably practicable.[17] I consider that, given Mrs A's physical impairment and difficulty in communicating, it was especially important for RN C to take adequate steps to ensure that she had Mrs A's consent to administer the medication.

110. I consider that Mrs A had the right to refuse the administration of paracetamol elixir. I find that she did indicate a clear refusal at 4.15am. This refusal was disregarded by RN C at around 4.15am on 20 July when she administered paracetamol elixir without Mrs A's consent. Accordingly, I find that RN C breached Right 7(7) of the Code.

Adverse comment

Clinical record

111. RN C noted in the clinical record: "0530 IV Panadol given x2 per shift." She did not record that she administered Mrs A paracetamol elixir.

[17] Nursing Council of New Zealand, "Code of Conduct for Nurses" (June 2012), Standard 3.4.

112. Professional standards require nurses to keep clear and accurate records.[18] In my view, by not including her administration of paracetamol elixir, and that Mrs A could not swallow it, RN C's clinical record of the care she provided Mrs A was incomplete.

Other comments

Patient acuity

113. In her response to Mrs A's complaint, RN C stated that she was working as an agency nurse in a ward in which she had been allocated 10 patients, and that during that night she was responsible for a patient who deteriorated quickly and became acutely unwell. The DHB stated that this was a "usual workload for the ward although, in retrospect, probably more than [RN C] was comfortable with".

114. In my view, although RN C may have been busy, this does not excuse her failings in this case. She has acknowledged that she read the handover sheet indicating that Mrs A had swallowing difficulties, and that during the shift she read Mrs A's notes. Accordingly, I do not consider that the workload was a factor in RN C's breaches of the Code.

Opinion: No Breach — The Nursing Agency

115. RN C had been employed by the agency since 19 September 2011. The agency advised HDC that it had no knowledge of any health concerns regarding RN C at the relevant time.

116. However, in May 2012 the DHB had referred to the agency a concern relating to RN C's conduct regarding a shift during which she failed to complete postoperative observations appropriately and, on three occasions during the shift, had near-miss errors when administering IV medication.

117. The agency discussed each incident with RN C, and told her to review policies and to ask for help if she felt she needed it. No other follow-up action was taken.

118. RN C was an experienced nurse. When the agency received the complaints relating to the incidents that occurred during the single shift in May, it followed up the complaints with RN C. In my view, the agency took reasonable action in response to the concerns raised in May 2012. I therefore do not consider there to be any evidence to support a finding that the agency is vicariously liable for RN C's breaches of the Code, or that it breached the Code directly.

Opinion: No Breach — The District Health Board

119. Although RN C was an agency nurse, she had had previous experience working at the hospital and on the general medical ward.

[18] Nursing Council of New Zealand, "Code of Conduct for Nurses" (June 2012), Standard 4.8.

120. RN C received a verbal handover in the nurses' office and a walk around the ward to each bedside, as well as a written handover sheet that recorded: "c/pain: Hx MND, Crohn, NSTEMI and impaired swallow". The DHB investigation found that appropriate handover had been given, including a printed handover sheet, bedside handover and clear instructions in the medical record, where the abbreviations used in the handover sheet appear in full. I note that my nursing advisor agrees that these steps are "part of an adequate and safe transfer of care from one RN to another".

121. Although RN C had a busy workload on the shift concerned, I accept that the workload was not unreasonable. In these circumstances, I do not consider that the DHB is vicariously liable for RN C's breaches of the Code, or that it breached the Code directly.

Recommendations

122. In accordance with the recommendation made in my provisional opinion, RN C has provided a written apology to Mrs A's family.

123. Should RN C wish to return to practice as a nurse, I recommend that the Nursing Council of New Zealand assess her suitability to return to nursing, including a competence review if appropriate, and report the outcome to HDC.

124. I further recommend that should RN C return to practice, she undertake a communication course, particularly focused on communication with patients with impairments.

Follow-up actions

125.
- RN C will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- 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 C's name.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Motor Neurone Disease Association and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings decided not to issue a proceeding.

Appendix A — Independent in-house nursing advice to the Commissioner

The following expert advice was obtained from HDC's in-house nursing advisor, RN Dawn Carey:

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Mr B] about the care provided to his late mother, [Mrs A] whilst she was an in patient at [the hospital]. I note that this complaint was initially made by [Mrs A]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the information on file; complaint from [Mrs A], response and clinical notes from [the DHB].

3. **Background and complaint** [removed for brevity]

4. **Response from [the DHB]** [removed for brevity]

5. **Review of clinical records and comments**
The relevant [hospital] Drug Treatment Sheet (DTS) for [Mrs A] has paracetamol prescribed *po/iv*. This allows the RN to administer paracetamol elixir, tablets or the intravenous preparation. Unless contraindicated by the patient's clinical status prescribing different routes for medications is common and accepted prescribing practice. Upon presentation to [hospital] [Mrs A] was tolerating tablets orally once they were administered with yoghurt. This is also confirmed by […] nursing documentation; *'… pt has taken meds with yoghurt. Swallow with some difficulty … SLT r/v awaited …'* In my opinion, [Mrs A's] DTS is completed appropriately and is of the required standard. I consider the decision to offer [Mrs A] paracetamol elixir on 19 July 2012 at 11.30pm to meet the expected standard of nursing practice.

The [hospital] 24 hour care plan (CP) was reviewed three times during [Mrs A's] admission. The third entry is signed by [RN C] on 20 July 2012, who identified that [Mrs A] had special dietary needs and required *puree & G1 thickened fluids.* As there is no time recorded I cannot determine when [RN C] made this entry. I do view this entry as indicative of [RN C] being aware of [Mrs A's] swallowing difficulties.

I note that the nursing entry on 19 July 2012 at 9.20pm reports *'… Pt. prefers pain relief prior to meals/oral medication. Give paracetamol IV prior works well with pt…'*. Whilst it is common and good clinical practice for a RN to read the notes of the patients that they are allocated, this activity is completely dependent on the clinical workload. Whilst most RNs' verbal handover reiterates their documentation, there is no evidence that [Mrs A's] swallowing difficulties, pain management regime or diagnosis was handed over to [RN C].

I do agree with [the DHB's] findings that a printed handover sheet stating the patient's admitting diagnosis followed by a walk-round handover is part of an adequate and safe transfer of care from one RN to another. Whilst 'MND' is an accepted clinical abbreviation it is reasonable that [RN C] may not have come across it before or may have just forgotten its meaning. However, legislation and professional standards require registered nurses to identify and resolve any deficits of clinical knowledge. Whilst I can appreciate there are circumstances where this may be difficult to do, this is the required level of accountability. In my opinion, the failure of [RN C] to communicate her lack of knowledge about the abbreviation MND signifies a moderate departure from the expected standard of nursing practice.

Amongst other indicators, NCNZ competencies require that registered nurses have therapeutic relationships with their patients, work in partnership with them, and demonstrate empathy and respect towards them.[19] Within the context of this complaint it would have meant that [RN C] would have familiarised herself with [Mrs A's] needs and diagnosis following their first interaction. [Mrs A] managed to communicate a preference for IV paracetamol during this interaction and a cursory look at the previous RN's documentation would have supported the administration of IV paracetamol. Even allowing for a lack of time to seek clarification of [Mrs A's] diagnosis, her communicated preference should have been respected.

The events concerning the forced administration of paracetamol elixir to [Mrs A] are disputed by [RN C]. The other two RNs on shift report that they were not aware of any difficulties eventuating. However, based on [Mrs A's] timely notification of the complaint, — immediately to her family, attending physician and the ward CNM — her insistence that she be discharged from [the hospital] and not admitted to the general medical ward again, and the concerns of the internal investigating team, it seems plausible that the interaction between [RN C] and [Mrs A] was at the minimum, non-therapeutic and left [Mrs A] feeling vulnerable and upset. As a RN peer I consider the care provided to [Mrs A] to be a departure from the expected standards of nursing practice[20, 21].

6. **Additional comments**
   [Information redacted that is not relevant to the Deputy Commissioner's decision.]

7. **Conclusions**
   - In my opinion, [Mrs A's] medication chart was completed appropriately.

[19] Nursing Council of New Zealand (NCNZ), *Competencies for registered nurses* (Wellington: NCNZ, 2007).
[20] Nursing Council of New Zealand (NCNZ), *Competencies for registered nurses* (Wellington: NCNZ, 2007).
[21] Standards New Zealand (NZS), *8132:2008 Health and disability (general) services standards* (Wellington: NZS, 2008).

- I consider [RN C's] decision to offer [Mrs A] paracetamol elixir on 19 July 2012 at 11.30pm to meet the expected standard of nursing practice.
- In my opinion, the failure of [RN C] to communicate her lack of knowledge about the abbreviation MND significantly affected her ability to provide safe nursing care and was a moderate departure from the expected standard of nursing practice.
- As a RN peer I consider the decision to offer [Mrs A] paracetamol elixir between 4.15am–5.30am on 20 July 2012 to be a departure from the expected standard of nursing care. In my opinion, the nursing care provided to [Mrs A] by [RN C] was sub optimal and not in keeping with expected competencies and standards[22,23]. Overall this was a moderate departure.
- I would recommend that [the DHB] liaise with their external employee providers to ensure that there are strategies to manage the risks of stress, compassion fatigue and burnout."

Further advice

RN Carey provided the following further advice on 29 November 2013:

"The 'flushing' of peripheral intravenous luers/catheters are required for three reasons: to ensure that the catheter remains in the correct position (in the vein), to clear administered medications, and to create a 'flush lock', which helps keep the catheter patent for subsequent medications/fluids.

An example of a generic 'pre' medication flush is the IV competent RN administering 5 millilitres (mls) of NaCl 0.9% checking for pain, swelling or leakage. This assessment plus a visual check of the patient's peripheral IV site and surrounding skin is the only way that the RN can determine that the catheter is in the patient's vein and the catheter is suitable for the administration of the medication/fluid. Some fluids or medications are extremely irritant and can cause tissue damage if infused in non patent catheter hence the importance of this check.

The 'post' medication flush is again with a suitable crystalloid solution and volume. This flush ensures that any residual medication is flushed from the catheter and leaves the catheter patent for next use.

In my opinion, the failure to flush pre/post intravenous medication would be a moderate departure from the expected standards.

The website below is the policy from Intravenous Nursing NZ, which would inform most IV policies. It is the 2012 version so valid for this case. Also the practice of flushing peripheral catheters has been relatively unchanged in the last 10+ years.

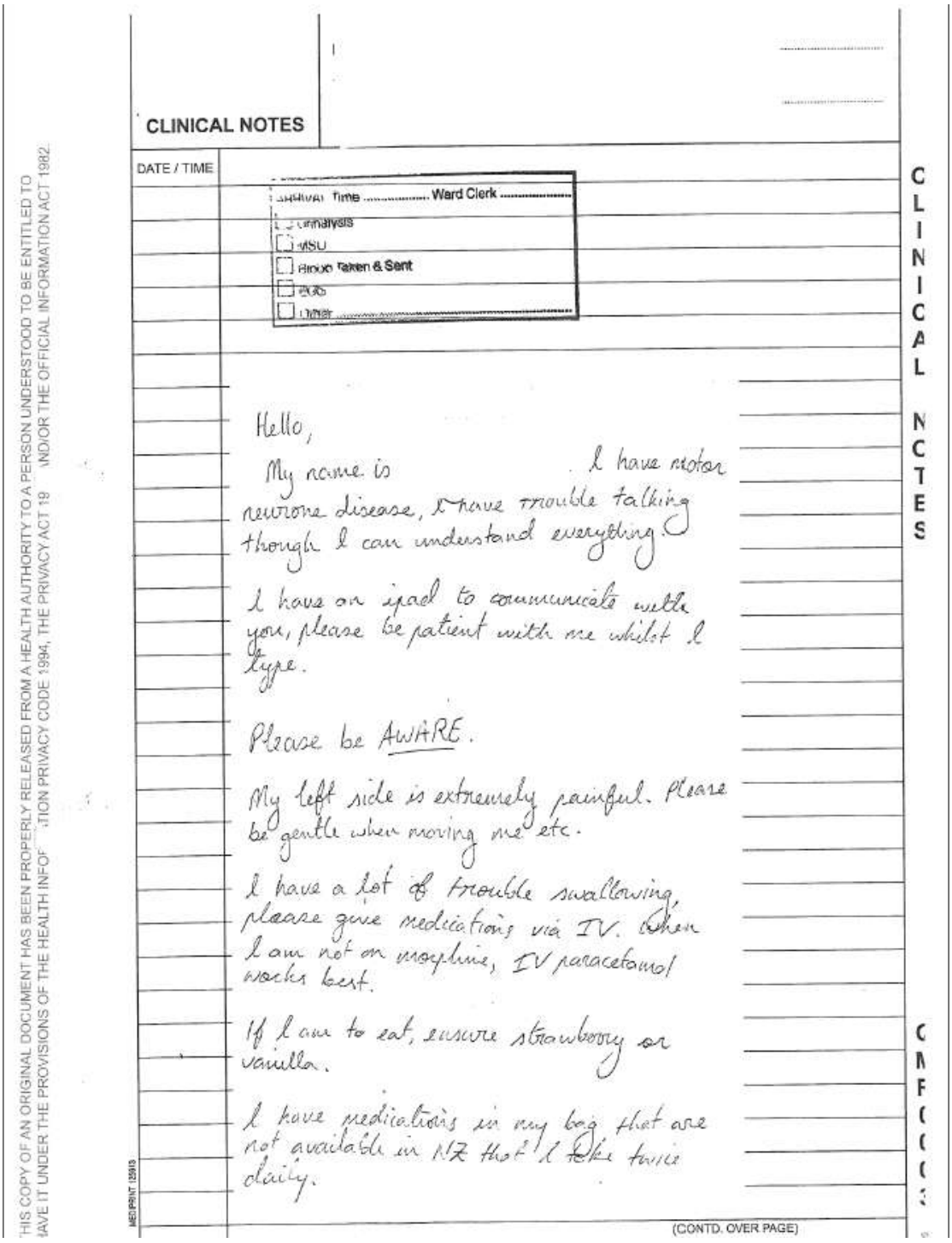
[22] Nursing Council of New Zealand (NCNZ), *Competencies for registered nurses* (Wellington: NCNZ, 2007).
[23] Standards New Zealand (NZS), *8132:2008 Health and disability (general) services standards* (Wellington: NZS, 2008).

http://www.ivnnz.co.nz/files/file/7672/IVNNZ_Inc_Provisional_Infusion_Therapy_Standards_of_Practice_March_2012.pdf

Patients with MND suffer significantly more with coughing and choking due to the progressive degenerative disease process. Coughing is a protective function of the larynx and respiratory system, which helps clear the airway of any foreign material and secretions. Choking is a feeling of suffocation or strangulation, which may result from foreign material being in the airway and obstructing it. The obstruction means that there is an inability to draw breath.

So technically, [Mrs A] had a coughing episode. However, a sustained one in a patient with MND will make them feel as if they are choking, as their capacity to cough effectively is reduced."

Appendix B — Handwritten note in Mrs A's clinical records



CLINICAL NOTES

DATE / TIME

Arrival Time ..... Ward Clerk .....
Dialysis
MSU
Blood Taken & Sent
ECG
Other .....

Hello,

My name is . I have motor neurone disease, I have trouble talking though I can understand everything.

I have an ipad to communicate with you, please be patient with me whilst I type.

Please be AWARE.

My left side is extremely painful. Please be gentle when moving me etc.

I have a lot of trouble swallowing, please give medications via IV. When I am not on morphine, IV paracetamol works best.

If I am to eat, ensure strawberry or vanilla.

I have medications in my bag that are not available in NZ that I take twice daily.

(CONTD. OVER PAGE)

CLINICAL NOTES

THIS COPY OF AN ORIGINAL DOCUMENT HAS BEEN PROPERLY RELEASED FROM A HEALTH AUTHORITY TO A PERSON UNDERSTOOD TO BE ENTITLED TO HAVE IT UNDER THE PROVISIONS OF THE HEALTH INFOR TION PRIVACY CODE 1994, THE PRIVACY ACT 19 ND/OR THE OFFICIAL INFORMATION ACT 1982.

MED PRINT 13913

Names have been removed (except the expert 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.