

Department of Corrections

**A Report by the
Deputy Health and Disability Commissioner**

(Case 16HDC01922)



Health and Disability Commissioner
Te Toihou Hauora, Hauātanga

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Executive summary

1. This report concerns the care provided by the Department of Corrections (Corrections) at a Corrections Facility (the facility) to a woman with a history of painful medical conditions and mobility issues. The Deputy Health and Disability Commissioner found that Corrections did not provide medical treatment to the woman that was reasonably necessary, and that the standard of health care at the facility was not reasonably equivalent to the standard of health care available to the public. He considered that there was an overarching service failure in this case.
2. Corrections failed to provide the woman with pain medication in accordance with her prescription after her blister packs ran out, and failed to prioritise a consultation with a prescriber. The woman was admitted to hospital with a viral exacerbation of asthma. Multiple significant departures from accepted practice were found with regard to her respiratory care and safe administration of medication.

Findings

3. The Deputy Commissioner found that Corrections breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights for poor planning of the woman's care, for failing to provide her blister-packed medications over four days, for administering paracetamol against recommended practice, for failing to reassess her insulin requirements, and for failing to perform a full respiratory assessment despite her symptoms, physical distress, and previous history of respiratory issues.

Recommendations

4. The Deputy Commissioner recommended that Corrections apologise to the woman, arrange an independent external review of the clinical services at the facility, provide an update to HDC on the efficacy of services changes made at the facility since these events, and develop policies and procedures to guide staff on (a) assessing prisoners who seek health treatment in a timely manner; (b) assessing newly arrived prisoners in a timely manner; and (c) seeking patient clinical notes from a prisoner's previous doctor in a timely manner.

Complaint and investigation

5. The Health and Disability Commissioner (HDC) received a complaint about the services provided to Ms A at the facility. The following issue was identified for investigation:
 - *The appropriateness of the care provided to Ms A by the Department of Corrections from 19 October to 31 December 2016.*

6. This report is the opinion of Deputy Commissioner Kevin Allan, and is made by him under the authority delegated by the Commissioner.

7. The parties directly involved in the investigation were:

Complainant

Department of Corrections

Medical centre

Ms A

Dr B

RN C

RN D

RN F

RN G

RN H

RN I

RN J

Provider

Provider/general practice

Consumer

Provider/general practitioner

Provider/registered nurse

Provider/registered nurse

Provider/registered nurse

Provider/registered nurse

Provider/registered nurse

Provider/registered nurse

Provider/registered nurse

8. Further information from the District Health Board was also reviewed.

9. Independent expert advice was obtained from registered nurse (RN) Barb Cornor (**Appendix A**) and general practitioner (GP) Dr David Maplesden (**Appendix B**).

Information gathered during investigation

Background

10. In May 2014, Ms A, then aged in her early forties, developed empyema¹ and underwent a thoracotomy² and decortication.³ In December 2014, she was admitted to hospital with right-sided pleuritic chest pain at the thoracotomy site.

11. Ms A was remanded to the facility on 27 June 2015. On 28 June 2015, she had chest pain and was coughing up dark green purulent exudate in her phlegm. She was sent to the public hospital for assessment, prescribed antibiotics, and returned to the facility on 29 June 2015. Following a court appearance she was released from prison.

12. On 19 October 2016, Ms A was remanded to the facility. Her next court day was scheduled for three months' time. This opinion considers the healthcare services provided to her at the facility from 19 October 2016 until 31 December 2016.

¹ Empyema is a collection of pus in the space between the lung and the inner surface of the chest wall (pleural space). It is usually caused by an infection that spreads from the lung.

² A surgical incision of the chest wall.

³ Surgical removal of the surface layer of the lung.

The facility's medical service

13. The Health Centre is run by registered nurses, who are on site from 7am until 10pm daily. Outside of these times, a nurse is available on call. At the time of these events, Dr B was contracted to provide general practitioner services to the facility for 16 hours each week, spread over four days.
14. All new arrivals at the facility undergo an initial health assessment (IHA). Following the initial assessment, prisoners can request access to non-urgent health services verbally or by submitting a Health Request Form (also known as a "health chit"). If a prisoner wishes to request an appointment with the health team, they obtain a health chit from the custodial officer, complete the chit, and place it in a locked chit box. Corrections' policy requires health chits to be cleared daily and actioned according to clinical need.
15. The morning shift nurse collects the chits from the locked chit box, triages them, and enters the details into Medtech.⁴ The nurse then creates a clinic appointment for the prisoner. The prisoner is first assessed by a registered nurse to determine whether an appointment with a doctor or other health professional is required. If so, an appointment is made. If a patient is triaged as non-urgent, the patient is required to be seen within seven days.
16. RN F stated that patients in the care unit (prisoners with multiple co-morbidities) are visited by a dedicated registered nurse, as moving the prisoners to and from the medical clinic would require three custodial officers to escort them.
17. RN F stated:

"Due to issues with staff shortages (custodial and nursing), transfers or movements, muster freezes,⁵ security classifications, medical emergencies and custodial incidents, it is very difficult to see all booked patients and, usually, the RN may only get to see a few patients in a day and have to rebook the patients they could not see."
18. RN F stated that this is a cycle that creates delays, risks, and greater workload for the nursing staff, and makes triaging patients difficult because they are not seen on time unless the issue becomes a medical emergency.
19. RN F said that all custodial staff are trained in first aid and have been tasked to dispense paracetamol (Panadol) if requested by prisoners. She stated that custodial staff are briefed on the safe administration of Panadol — to be given as required for pain relief, no more than four hourly, and up to a maximum of 4g daily. The custodial staff complete a Panadol log sheet when they administer Panadol to a prisoner, and the morning nurses collect the Panadol log sheets and then enter the details into the Medtech daily record.

⁴ An electronic medical records system.

⁵ A process to check prisoners, during which they cannot be moved.

Ms A's admission

20. RN G told HDC that on 19 October 2016 she was rostered on duty as the receiving office nurse, so she completed Ms A's Reception Health Triage. RN G said that Ms A was placed in the care unit at the facility because of her co-morbidities and lack of mobility.
21. RN G said that she asked Ms A to sign the "Consent to receive general health and dental services" form. RN G also sought Ms A's consent for Corrections to uplift her medical records from her GP, and asked her to sign the "GP transfer request" form.
22. RN G stated that Ms A discussed her health issues and said that she had brought her medications with her in blister packs.⁶ The Reception Health Triage Form states that Ms A was on the following medications: Losec,⁷ gabapentin,⁸ OxyNorm,⁹ OxyContin,¹⁰ diazepam,¹¹ quinapril,¹² and a Ventolin inhaler for asthma. Ms A was also taking metformin¹³ and Lorstat¹⁴ but this was not documented at that time.
23. Ms A told RN G that she was also on Novomix¹⁵ and Novorapid¹⁶ for diabetes, but had none with her on admission. Ms A said that she had a painful lipoma¹⁷ on her back, and was on the waiting list at the public hospital for surgery. Ms A also stated that she had a prolapsed disc, pain in her lower back and right leg, and numb toes on her right foot. She was able to mobilise with crutches for short distances, but otherwise required a wheelchair. Ms A was morbidly obese, with a body mass index of 53.9.
24. RN G told Ms A that her medical notes would be requested from her current GP, and that the medical officer would be asked to chart her medication once her medical notes had been received.
25. RN G requested Ms A's medical records from the medical centre and booked Ms A for an IHA with a nurse, and for an appointment with the medical officer — both for the following day.
26. RN D told HDC that she saw Ms A on 20 October 2016 for the IHA, which is a questionnaire that covers a general health assessment. RN D said that she asked Ms A the questions and

⁶ Blister packs are prepared by a pharmacist with the medications for each day packed in a tear strip. The medication name and instructions are printed on each pottle.

⁷ Medication used to reduce the amount of acid produced in the stomach.

⁸ An anticonvulsant medication.

⁹ An opioid medication containing oxycodone used to relieve moderate to severe pain.

¹⁰ An opioid medication used to relieve moderate to severe pain. OxyContin is a longer acting preparation of oxycodone than OxyNorm.

¹¹ An anti-anxiety medication.

¹² Medication used to treat high blood pressure, heart failure, and diabetic kidney disease.

¹³ Medication used to treat type 2 diabetes.

¹⁴ Medication used to treat high cholesterol.

¹⁵ A mixture of rapid- and longer-acting insulin used to treat diabetes mellitus.

¹⁶ Rapid-acting insulin.

¹⁷ A lipoma is a knot of fatty tissue that is usually found just below the skin (subcutaneous).

filled in the responses, and then wrote additional comments based on the IHA and Ms A's general presentation during the interview. The comments include the following:

- “Stated that she was in pain — gets anxious”
 - “Palm sized lump on her back was soft and tender to touch”
 - “May need a shower chair as pt [patient] uses crutches/wheelchair to mobilise”
27. RN D said that Ms A told her that she had problems with mobility owing to back pain, and used aids such as crutches and a wheelchair and, at times, needed assistance with activities of daily living (ADLs).
28. RN D said that her role was to complete the IHA questionnaire rather than to assess Ms A, as that would have required a clinical consultation and a formal plan of care. RN D told HDC that when the health team identified that a prisoner had complex health needs, the Health Centre manager or team leader would assign a nurse to initiate a treatment plan. However, she said that she was not asked to prepare a treatment plan for Ms A. RN D said that she spoke to the Health Centre manager to request a shower chair for Ms A, but did not document the conversation.

Medical records and pain medication

29. RN G said that on 20 October 2016, she was asked to call the medical centre because Ms A's medical notes had not arrived. Dr B stated that the nurse told her that they were waiting for the GP notes before Ms A's medications could be prescribed. Dr B said that the blister packs were not mentioned at that time, and that if she had been aware of them she could have charted the medications, because a prison doctor can write a new prescription based on current blister packs.
30. On 20 October 2016, a nurse recorded that she had contacted the medical centre and asked for a list of medications to be faxed through urgently in order for the medical officer to chart insulin for Ms A. The nurse noted that no fax confirmation had been received by 12.30pm that day.
31. The medical centre told HDC that its records show that on 20 October 2016, it received a phone call from RN G, who stated that she required Ms A's medical notes. The medical centre notes state that RN G said that she would send a fax (with the signed transfer request form).
32. On 20 October 2016, RN G recorded that she had called the medical centre requesting Ms A's medical notes, and that the person who replied stated that she had not received any telephone calls or faxes requesting the medical notes. RN G recorded that she sent a fax at 2.50pm requesting the medical notes.
33. A Health Centre administrator recorded on 21 October 2016 that she called the medical centre at 10.45am and left a message on voicemail with regard to Ms A's medical notes. Dr B told HDC that she remembers telephoning the GP clinic several times, and that each time

she was connected to an answerphone. She stated that she and administration staff or nurses made eight attempts to obtain the medical notes.

34. Ms A's blister packs ran out on 22 October 2016. The regular non-packaged medicine administration record shows that Ms A's Oxycodone, OxyNorm, and diazepam ceased on 22 October 2016. However, the regular non-packaged administration record shows that Ms A's other medications (as listed above) were continued. On 23 October 2016, RN C recorded that Ms A became upset when told that her pain relief medications in her blister pack had run out and she was "informed [that the facility had] not received her GP notes therefore [the doctor] was unable to chart her pain relief medications". Ms A said that the lack of medication would cause her to "get the sweats and have to be admitted to hospital".
35. On 24 October 2016, RN C recorded that she had seen Ms A in the care unit at 9am. Ms A told RN C that she had had a fall overnight, and the custodial officers had thrown her onto the bed. Ms A said that she had been unable to void or open her bowels since then, and had no feeling in her lower body. RN C said that at that time she was conducting a medication round, and so she hesitated to enter Ms A's room. However, she did so, to inspect and palpate Ms A's lower limbs quickly. RN C said that she pinched one of Ms A's toes, following which Ms A reacted immediately, which indicated that she did, in fact, have feeling in her toes.
36. RN C recorded: "[P]inch test done on foot — pt [patient] flinched immediately."
37. RN C said that she checked with the custodial staff and was told that the events Ms A had described were very unlikely to have occurred. RN C told HDC that shortly thereafter a custodial staff member told her that Ms A had stood up unaided and gone to the toilet. RN C said that she reassured Ms A that she would be back, and went to complete her medication round. In response to the "information gathered", Ms A said that during this incident she was left on the floor for several hours, lost control of her bowel motions, does not recall the nurse doing a pinch test, and crawled across the floor to get to the toilet.
38. RN C stated that during the medication round, Ms A told her that she was on insulin for her diabetes. RN C said that she spoke to the nurse who had completed the IHA (RN D), and was told that the doctor was aware of the situation, but there was difficulty in obtaining Ms A's GP notes. RN C said that she tested Ms A's blood sugar levels (BSLs) (that day, Ms A's BSL was 7.8mmol/L) and, as they were stable, she was not too concerned.
39. RN C said that when she returned to the care unit later that morning, she saw Ms A in the day room with other prisoners, talking and laughing, with no signs of pain or discomfort. RN C stated that Ms A did not report any concerns, so she saw no need to investigate further.
40. On 25 October 2016, Dr B recorded: "[Medical centre] re [Ms A's] medical notes — left message as they are always busy." Dr B said that she did not receive a reply to the message she had left.

41. The medical centre notes state that on 25 October 2016, a telephone call was received from Dr B asking for Ms A's medical records, and Dr B was advised that the fax still had not arrived, and that once it had been received, the notes would be faxed back. The records state that later that day, a fax and the consent form were received from the facility, and the notes were faxed through to the facility, as requested. By then it had been six days since Ms A had been incarcerated. On receipt of the notes, Dr B prescribed Ms A's medications, other than insulin.
42. RN C stated that she was aware that several attempts had been made to obtain the GP notes, and she understood that the normal procedure was to wait until the notes arrived before any medication could be charted. She said:
- "I do not know why [Ms A] had no alternative medications, such as pain relief charted while we waited for her medical notes to come in. The only pain relief available to her at the time was paracetamol and this is provided through custodial staff."
43. RN C said that she updated the custodial staff regarding Ms A's medication running out, and that had Ms A reported concerns to the custodial staff, the concerns would have been documented.

Diabetes management

44. Dr B stated that Ms A arrived at the facility with no insulin, and at that time there was no documentation from her GP to confirm her medications (for example, the insulin doses). Dr B said that while Ms A was off the insulin she was monitored, and it was noticed that her BSLs were very well controlled, and so a decision was made to stop the insulin. Dr B said that Ms A's BSLs varied from 5.0 to 8.1 mmol/L,¹⁸ and that excellent control is considered to be between 4.0 and 8.0 mmol/L. Dr B said that Ms A was on metformin, and that along with a diabetic diet, this was sufficient to maintain her metabolic control.
45. Dr B noted that if Ms A had been administered her usual large dose of insulin and then been locked up for 15 hours, this would have been a risk, because the custodial officers would have had no way of knowing whether she was asleep or in a coma when they carried out the 15-minute observations.
46. Dr B stated that despite Ms A having been documented as an IDDM (insulin-dependent diabetic), she (Dr B) realised that Ms A was an NIDDM (non-insulin-dependent diabetic) because she was able to maintain low BSLs. Dr B said that in prison, Ms A was on a diabetic diet, and that it is not uncommon to stop prescribing NIDDM patients insulin when their circumstances change (ie, when their diet changes). Dr B stated that it was far safer not to give Ms A insulin if her BSLs were to remain on the low side, as there were no nursing staff at the prison overnight, and they were unaware of Ms A's ability to respond and correct hypoglycaemia. Dr B said that the Medtech documentation on 26 and 27 October 2016

¹⁸ Ms A's BSLs were documented as being 5.3 and 5.8 mmol/L on 22 October 2016, 8.3 mmol/L on 23 October 2016, 7.8 mmol/L on 24 October 2016, and 8.6 mmol/L on 25 October 2016.

shows that Ms A was informed that her BSLs were low enough to stop the insulin at that time, and that she agreed to the decision.

47. Dr B stated that if Ms A had been an insulin-dependent diabetic, it would have been critical that she have her insulin, and she would have been put on an emergency protocol (a sliding scale of insulin depending on her BSLs) until her GP notes were received.
48. Dr B said that she never saw Ms A in person during the timeframe of this investigation, as Ms A was housed in the care unit, and was seen by the nurses three times a day and had regular observations performed. Dr B noted that her management of Ms A's diabetes was no different than it would have been with a face-to-face consultation with Ms A.
49. Dr B stated:

“Though not ideal, sometimes in the prison we have to work within time constraints. Another symptom of being pushed for time is that documentation can suffer to a degree but I like to think this is a result of being overloaded, rather than incompetence.”
50. On 26 October 2016, Ms A's BSL was 7.5 mmol/L. On 27 October, her BSL was 9.5 mmol/L. On 29 October it was 12.4 mmol/L, and on 30 October it was 12.9 mmol/L. There is no further record of Ms A's BSL until 17 November 2016, when it was 12.4 mmol/L, and the following day it was 11.2 mmol/L. No further BSLs are recorded. There is no record of any action being taken by clinical staff in relation to the increased BSLs, and no record that the increased BSLs were brought to Dr B's attention.
51. In response to the “information gathered”, Ms A said that she had good diabetes control prior to her admission to the facility, but that she was refused insulin and that she was given a high carbohydrate diet in the facility.

Increasing back pain

52. Ms A was administered OxyNorm from 26 October to 30 October 2016. On 26 October 2016, it is recorded that Ms A was feeling much better because her pain relief medication had been charted.¹⁹
53. RN F stated that from 15 to 20 November 2016 she was working in the care unit in the mornings. She said that she assessed Ms A on 15 November 2016, and at that time she (RN F) did not have any concerns. She recorded, “continue monitoring”, which, she told HDC, was not a reference to monitoring by the health team, but rather to monitoring by the custodial officers. She said that custodial staff would observe Ms A and record her activities while she was in the care unit, until she was cleared to go into the mainstream prison.

¹⁹ The medication charts require completion of the full name and initial of the signatory. However, most either do not contain the full name of the health professional, or the name is illegible.

54. RN F said that she picked up the Panadol logs and entered them into Medtech on those days. She recorded that at 12.37am, 6.44pm, and 9.49pm on 14 November 2016, and at 10.21pm on 15 November 2016, custodial officers administered Ms A Panadol for back pain. The dose of Panadol given is not recorded.
55. RN F stated that on 16 November 2016, she saw Ms A at 9.08am during the medication round, and Ms A said that the pain in her back was getting worse. RN F stated: "Since her presentation was optimal, despite her verbalised report, I did not consider it necessary to complete any further assessment at the time." RN F stated that her clinical judgement was that Ms A was generally fine on 16 November 2016. RN F said that Ms A was independent with her ADLs, had a pleasant mood, and was conversing and even laughing with others. However, RN F booked Ms A for an appointment with the medical officer on 21 November 2016 (the next available date) so that her worsening pain could be reviewed.
56. RN I documented that at 6.52am and 4.30pm on 21 November 2016, and at 7.45pm and 3pm on 22 November 2016, the custodial officers gave Ms A Panadol for back pain, but the dose given was not recorded. However, RN I noted that 1g is the standard dose given to prisoners who ask for Panadol. She told HDC that she was satisfied that the amount and frequency of Ms A's Panadol use on 21 and 22 November 2016 was in order.
57. Dr B stated that she was asked to see Ms A about her painful lipoma, but when she went to the care unit on 25 November 2016 she was unable to, either because Ms A was not present, or there were not three officers available to open the door for her. Dr B said that she believes Ms A was not at the care unit, because she would have attempted to communicate through the window if there were not enough officers to open Ms A's door. Dr B said that Ms A was known to the District Health Board pain clinic, and, according to her notes, Ms A was already meant to have been withdrawn from the opiate medication. Dr B said that therefore it would have been wrong to increase Ms A's OxyNorm or OxyContin, and so she prescribed Ibuprofen,²⁰ as there was no record that Ms A was unable to take it.
58. Dr B stated:
- "In the prison setting, it is simply not possible to discuss the advantages or disadvantages of taking every medication in the same way you might in general practice due to time constraints. In this case, I could not see the patient, I provided an option so she would get some relief ... and I clearly thought this would be better than not charting her anything and then running the risk of not seeing her for days while she was in pain."
59. The clinical records state that on 25 November 2016, Ms A was administered Panadol for back pain at 12.30am, 6.52am, 7.45am, 11.09am, 4.30pm, 6.07pm, and 11.57pm. There is no documented assessment of the effectiveness of the pain relief or follow-up pain assessment. The dose of Panadol given is not recorded.

²⁰ Ibuprofen is used to relieve pain and reduce inflammation.

60. On 30 November 2016, Ms A completed a medical chit that states that on a few occasions she had not been given her metformin or her controlled pain relief on time, that drugs had been charted and given to her without her knowledge, and that she had not been given her insulin medication since she had been in prison and, as a result, her blood sugar results had been high.
61. On 1 December 2016, Ms A refused the ibuprofen, and on 4 December 2016 she complained that she found out that she had been charted ibuprofen only when she developed gastric upset and night sweats. She signed a refusal form for ibuprofen that day.

Breathing difficulties

62. RN H stated that on 12 December 2016, a registered nurse gave Ms A a new inhaler. At handover, RN H was asked to get the old inhaler from Ms A and to give her a spacer²¹ to use with her new inhaler. RN H said that she gave Ms A a spacer and a Corrections spacer handout. As Ms A said that she had already been given education on the use of the spacer, RN H did not provide further education on its use.
63. RN J stated that on 13 December 2016, at approximately 7.30pm, she delivered Ms A's night medication to her cell. RN J said that at that time, Ms A did not show any signs of breathlessness, and was seated in her wheelchair when she presented to her cell door for her medication. RN J said that Ms A was upset because the surgery to remove her lipoma had been cancelled.
64. RN J stated that at approximately 7.50pm, she was contacted and told that Ms A was having problems breathing. RN J said that the process after hours is that master control has to inform the principal corrections officer (PCO), who must give consent for a prisoner's cell to be unlocked and the prisoner moved from her cell to the medical clinic. A corrections officer then escorts the prisoner to the medical clinic.
65. RN J said that she stopped the medication round so that she could attend to Ms A. When Ms A arrived at the medical clinic, she was tearful, had very fast, shallow breathing, and said that she had pain when lying on her right side. Ms A said that the lump on her back hurt and was causing her breathing difficulties. RN J stated that Ms A was not guarding her right side and, when palpated, the reaction was delayed.
66. RN J told HDC:

“I did auscultate [Ms A's] chest and lungs — front, back and sides, but did not document ... I acknowledge that my documentation at the time was not up to standard and I have worked on it and it has improved a lot since then.”

²¹ Spacers are clear plastic tubes with a mouthpiece or mask on one end and a hole for the inhaler at the other. A valve in the spacer mouthpiece opens as the user breathes in, and closes as the user breathes out. A spacer makes a metered dose inhaler easy to use and more effective.

67. RN J said that she gave Ms A salbutamol/Asthalin 2.5ml/5mg via a nebuliser,²² following which Ms A's oxygen saturations seemed normal at 98%, and her peak flow reading²³ was average. RN J said that she telephoned Dr B and informed her of Ms A's condition. Dr B instructed that Ms A was to continue to use her inhaler with the spacer, and was to be put on the list to see Dr B when she was next on duty.
68. RN J stated that Ms A was calm, with no signs of breathlessness, and was speaking in full sentences. She was advised to ask to see the on-call nurse if she had any further concerns and, at approximately 8.45pm, the escort officer and RN J took Ms A back to her cell. RN J then completed the medication round.
69. RN I stated that on 14 December 2016 she was working a morning shift, and at around 10am, during the medication round, she received a medical chit from Ms A requesting an appointment. The chit stated: "Finding it very hard to breathe and lower back pain increasing. Coughing up yellow [phlegm] at my chest & leaves me with a bloody aftertaste in my mouth ..."
70. RN I said that after completing the medication round she triaged the medical chit. At that time she noted that Ms A was already on the 15 December 2016 nurses' clinic list at 12.15pm, and the doctor's clinic list at 2.00pm. RN I documented, "already booked for 2", rather than recording that Ms A was booked to see the doctor at 2.00pm the following day. RN I stated that she did not assess Ms A or have any discussions with her, as she considered that Ms A could wait until the next day to be seen by the nurse and doctor. RN I said that she discussed Ms A at handover with the nurse on the afternoon shift.
71. RN H recorded that when Ms A presented for her medications at 3.30pm on 14 December 2016 she appeared to be very short of breath and wheezy, and had audible dyspnoea (difficulty breathing). Ms A had trouble completing sentences. RN H stated that on auscultation, both Ms A's upper and lower lung fields had crackles and a loud wheeze. Ms A's peak flow reading was 175, but she found it difficult to complete as she kept coughing with the effort and was unable to complete three readings. RN H stated that she assessed Ms A but did not complete palpation and percussion as she "did not have knowledge of what was expected to be palpated for wheezing/crackling lungs. On reflection, [she] could have percussed [Ms A's] lung field."
72. RN H stated that she started Ms A on the antibiotic amoxicillin, as per the Corrections standing order.²⁴ RN H said that between 3.30pm and 8.45pm, Ms A did not inform any

²² A nebuliser is a machine that converts liquid medication into a fine mist, which is breathed in through a mask or mouthpiece so that medication is able to reach the lungs.

²³ Peak flow is a measurement of how fast a person can blow air out of the lungs. It shows how wide the airways are at the time of taking the test. A normal rate depends on the person's gender, age, and height. For a woman of this age it varies from 410–450.

²⁴ A written instruction issued by a medical practitioner, dentist, nurse practitioner, or optometrist. It authorises a specified person or class of people (eg, paramedics, registered nurses) who do not have prescribing rights to administer and/or supply specified medicines and some controlled drugs. The intention

custodial officers or health staff that her symptoms were deteriorating, and did not ask to be assessed again.

73. RN H stated that at approximately 8.45pm, she arrived at Ms A's unit with the night medications. When the custodial officers opened the cell door, Ms A was lying flat on her back in her bed and holding/guarding her left lung area. Ms A said that she had 8/10 pain with breathing. RN H told HDC: "On inspection I noted that her whole body was [involuntarily] shaking and she was very diaphoretic."²⁵
74. RN H said that she asked the custodial officers to bring Ms A to the medical clinic for further assessment, but was told that this was not practicable as moving her normally was time consuming, and it would take further time to do so as she was unwell. RN H stated that she then telephoned Dr B, who told her to transport Ms A to hospital via ambulance as an emergency.
75. RN H said that as the computer system was down that night, she was unable to send the health advice, or notify the Health Centre Manager of Ms A's transfer to the public hospital. RN H said that she notified the morning staff the following day, and wrote notes in retrospect at 4.58pm on 15 December 2016.

Public hospital

76. Ms A was admitted to the public hospital on 14 December 2016 and diagnosed with a viral exacerbation of her asthma. She was treated with antibiotics (Augmentin and roxythromycin), a corticosteroid (prednisone), and salbutamol nebulisers. Subsequently she was weaned off salbutamol nebulisers to salbutamol via a spacer.
77. Ms A was discharged on 22 December 2016. The discharge summary notes that she complained of having had saddle anaesthesia²⁶ and urinary and bowel incontinence since a fall onto her back in October 2016. She was reviewed by the orthopaedic service and underwent an MRI scan, which showed no evidence of nerve compression. Creatine kinase (CK)²⁷ and C-reactive protein (CRP)²⁸ tests were repeated, and both were found to be normal.

Corrections policies

78. Corrections' "Medicines Management Policy" (October 2016) states that patients who report having been prescribed medicines prior to coming to prison must be prioritised for a consultation with a prescriber. The registered nurse is responsible for accessing the patient's medical records before the patient is assessed by the prescriber.

is for standing orders to be used to improve patients' timely access to medicines — for example, by authorising a paramedic in an emergency or a registered nurse in a primary healthcare setting.

²⁵ Perspiring.

²⁶ Loss of sensation to the buttocks, perineum, and inner surfaces of the thighs.

²⁷ To detect and monitor muscle damage and help to diagnose conditions associated with muscle damage.

²⁸ To test for inflammation.

79. The “Medicines Management Policy” states: “The patient will receive adequate information to enable them to make an informed decision about the care they receive ... The patient has the right to refuse treatment.”
80. Corrections’ “Health Care Pathway Policy/Procedure” (2008) provides guidance to Health Services staff for the delivery of healthcare services at each stage of imprisonment. This policy states that all prisoners who have needs that are significant and/or complex in nature must have a treatment plan. It states that prisoners who do not need a treatment plan must have a plan of care if they need clinical interventions.
81. The “Health Care Pathway Policy/Procedure” also specifies that health assessments will be clinical assessments that are “appropriate to clinical presentations, according to current good practice, and provided in a timely manner”, and the plan of healthcare interventions should then be matched with the assessed needs.

Further information: Department of Corrections

82. Corrections stated that Corrections officers provide prisoners with Panadol tablets, particularly out of hours when there is no registered nurse on site. Corrections stated that there is no formal medication training or certification of Corrections officers included as part of the Corrections health services’ medicines policy and procedure.
83. Corrections stated that since these events it has made a number of significant changes to the health service, including the following:
- An additional full-time clinical quality assurance advisor has been appointed.
 - A new role of practice leader has been developed.
 - It has been agreed that additional full-time equivalent registered nurses will be employed.
 - Medical officer hours have been increased from 16 to 20 hours per week.
 - A new contract is in place for additional GP support when a facility-contracted medical officer is not on site.
 - A new contract is in place with a local pharmacy for medication to be provided immediately following any external additional GP support.
 - The region has established a regional clinical governance group to provide assurance and oversight of health services across the region.
 - Strengthening of clinical practice continues to occur through regular documentation audits.
 - All standing orders except for those associated with emergencies were withdrawn in May 2017. Standing orders training has been in place since that date.
 - The local operating manual has been reviewed.

- A new local operating manual process for accessing and reviewing GP notes is in place.
 - The healthcare team at the facility has been introduced to the New Zealand Formulary²⁹ and HealthPathways³⁰ and encouraged to use both as a day-to-day clinical resource.
 - Timely responses and plans are in place to address any noted practice deficits as they arise.
 - One of the two regional clinical quality assurance advisors was on site two days a week from October 2017 to January 2018.
 - An external consultant has been employed on a short-term contract to implement a team building programme aimed at strengthening the Health Centre culture.
 - The Health Centre manager has been receiving coaching from an external consultant.
 - The Health Centre manager has been receiving one-on-one leadership support and mentoring from members of the Corrections' leadership team.
84. The facility stated that registered nurses are expected to be able to provide, at a minimum, a competent level of practice.
85. Corrections acknowledged that it did not meet the accepted standard of care in relation to the assessment, management, and, in particular, the documentation of Ms A's respiratory symptoms. It stated that it plans to recommend that all members of the nursing team be required to be certified as competent in respiratory assessment, treatment, and management.
86. Corrections accepted that there was a lack of comprehensive pain assessments, less than adequate documentation in relation to recording the results of pain assessments, and a lack of formally documented plans of care. It also accepted that the Panadol log signing sheet was potentially confusing with regard to the number of doses custodial staff gave the patient. It stated that it is reviewing the Panadol log to include the recording of the number of tablets a patient has received, rather than the dose alone.
87. Corrections accepted that at the time of these events there was a lack of process for obtaining medical notes for newly arrived prisoners, and that regular medications were not being prescribed within an appropriate time frame. It stated that an action plan was developed in May 2017 to improve the processes. The procedure for managing new arrivals was reviewed and updated, training was provided to the health team on the new procedure, and monitoring of compliance was undertaken.

²⁹ The New Zealand Formulary is an independent resource for health professionals, with clinically validated medicines information and guidance on best practice so that safe and effective medicines can be selected for patients.

³⁰ HealthPathways is a web-based information portal that supports primary care clinicians to plan patient care through primary, community, and secondary healthcare systems within the region. It is like a "care map", so that all members of a healthcare team — whether they work in a hospital or the community — can be on the same page when it comes to looking after a particular person.

88. With regard to the management of Ms A's diabetes, Corrections accepted that the communication between the health team and Ms A did not meet the required standard.
89. Corrections accepts that the clinical documentation did not meet the accepted standard, and noted that there was little evidence in the documentation of the evaluation of treatments recommended and/or the interventions undertaken. Corrections stated that it recognises the importance of careful, considered, and accurate documentation, and is committed to high-quality comprehensive communication and documentation of all patient care.
90. Corrections said that a series of documentation audits were undertaken at the facility in 2017, and any registered nurses who did not meet the required standard were provided with coaching plans to help to support their practice.
91. Corrections stated that there are now two new GPs at the facility, and the Health Centre manager has provided orientation to the medical officer role and established clear expectations with regard to documentation. Corrections stated:

“The department acknowledges, recognises and accepts the deficits in health care service delivery at [the facility] at the time of this complaint. Significant efforts have been made throughout 2017 — and will continue in 2018 — to undertake the necessary improvements in clinical practice and to ensure that the health service delivery at [the facility] is both appropriate and meets the standard required. Progress has certainly been made. There remains, however, a need for continued scrutiny. The clinical practice improvements, progress and gains made to date will be maintained and sustained through the continuous quality improvement framework provided by [the facility's] Health Centre Action Plan and supported through monitoring and evaluating assurance processes via the [region's] Clinical Governance Group.”

92. Corrections told HDC that since these events, Ms A has been allocated a primary nurse to oversee and update her comprehensive treatment plan for diabetes management, pain management, and mobility support. It advised that the Health Centre manager followed up with the local DHB for dietician advice and support for Ms A, and that a medical officer is now scheduled to see Ms A on a three-monthly basis for regular assessments of her long-term conditions.

Responses to provisional opinion

93. Ms A, Corrections, and Dr B were given an opportunity to comment on the relevant sections of the provisional opinion. Where appropriate, responses have been incorporated into the report.
94. In response to the “information gathered” section of the provisional opinion, Ms A and her partner reiterated their concerns that Corrections was unable to manage Ms A's medical and disability needs effectively.
95. Dr B had no comments to make on the provisional opinion.

96. Corrections stated that it supports my investigation and provisional opinion. It gave an overview of the programme of work that has been undertaken to improve the service at the facility, which included:
- Nurses at the facility have completed a large number of electronic learning modules.
 - Staff at the facility have engaged in self-audits of clinical notes, standing orders, and medication management.
 - HealthPathways is now linked in the medical notes system for all Corrections Health Services staff to access daily.
 - Recruitment of leadership and oversight positions to better support Health Services. The facility now has two additional nursing staff, and another regional clinical quality assurance advisor has been appointed.
 - Coaching plans and one-on-one sessions have been implemented to strengthen some existing staff's practice.
97. Corrections also provided information to support the implementation of the provisional recommendations. This is outlined further in the recommendations section below.
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Relevant legislation

98. Section 75 of the Corrections Act 2004 states:

“75. Medical treatment and standard of healthcare

- (1) a prisoner is entitled to receive medical treatment that is reasonably necessary
- (2) the standard of healthcare that is available to prisoners in a prison must be reasonably equivalent to the standard of healthcare available to the public.”
-

Relevant standards

99. The Medical Council of New Zealand publication *Good Prescribing Practice* (September 2016) states:

“You should only prescribe medicines or treatment when you have adequately assessed the patient's condition, and/or have adequate knowledge of the patient's condition and are therefore satisfied that the medicines or treatment are in the patient's best interests ...

Ensure that the patient (or other lawful authority) is fully informed and consents to the proposed treatment and that he or she receives appropriate information, in a way they can understand, about the options available; including an assessment of the expected risks, adverse effects, benefits and costs of each option.”

Opinion: Department of Corrections — breach

Introduction

100. Ms A was remanded to the facility on 19 October 2016. Previously she had undergone a thoracotomy. She had a history of chest infections and asthma, and had multiple co-morbidities, including type 2 diabetes, a painful lipoma on her back, a prolapsed disc, pain in her lower back and right leg, and numbness of the toes on her right foot. She was able to mobilise with crutches for short distances, but otherwise required a wheelchair.
101. I have a number of concerns regarding the treatment provided to Ms A while she was incarcerated at the facility, including her initial assessment, care planning, medication management, pain relief, respiratory assessments, and the standard of clinical documentation.
102. A number of failures within the facility led to Ms A receiving treatment that was well below the accepted standard of care. While individuals have a responsibility for the failures that occurred, in this case there was a pattern of failures by multiple providers responsible for Ms A’s care. I consider that such a pattern of failures indicates systemic problems at the facility, for which, ultimately, Corrections is responsible.
103. My expert nursing advisor, RN Barb Cornor, advised that although there are difficulties and barriers when working in a prison:

“[T]his should not concede to any deviance from the legal, professional or ethical requirements and/or conduct of a health professional. The prisoner with health issues remains a person with health issues, whatever their reason for incarceration.”

104. I firmly concur with that view, which is reflected in the law and in Corrections’ policies and procedures.

Care planning and evaluation

105. RN Cornor was critical that Ms A did not have full health assessments. RN Cornor stated these were required, for example, when Ms A arrived at the facility, following the fall on 24 October 2016, following the stopping of her insulin, and when her respiratory condition was deteriorating.
106. Corrections’ “Health Care Pathway Policy/Procedure” states that all prisoners who have needs that are significant and/or complex in nature must have a treatment plan. It states

that prisoners who do not need a treatment plan must have a plan of care if they need clinical interventions.

107. The “Health Care Pathway Policy/Procedure” also specifies that health assessments will be clinical assessments that are “appropriate to clinical presentations, according to current good practice, and provided in a timely manner”, and the plan of healthcare interventions should then be matched with the assessed needs.
108. RN Cornor noted that there is no evidence that proposed treatment plans were discussed with Ms A in order for her to make informed decisions. For example, RN Cornor considered that a treatment plan should have been detailed to observe Ms A’s blood sugar levels more regularly in the first week, or until they were stable, to document the treatment required if there were side effects, and to prioritise discussion about lifestyle factors.
109. RN Cornor said that there was limited evaluation of the effectiveness of Ms A’s response to the prescribed treatments, interventions, and health education. RN Cornor advised that the clinical staff should have developed plans with Ms A, including for ceasing insulin, indications for deterioration of any of her health conditions, mobility, and lifestyle changes for her type 2 diabetes. RN Cornor said that the plans of care for Ms A were limited, and documented in response to an incident, or not documented at all.
110. When Ms A’s condition deteriorated, the nurses contacted Dr B on 13 and 15 December 2016. However, there was no formal plan of care documented following the calls, and no follow-up by Dr B.
111. I accept RN Cornor’s advice and consider that the planning of Ms A’s care was very poor. In my view, Ms A had complex needs that required clear treatment planning in accordance with the “Health Care Pathway Policy/Procedure”. As there were a number of staff providing services to Ms A, effective planning was essential in order to achieve continuity of care.

Medication management

Prescribed medications

112. Ms A brought her blister-packed medications with her to the facility, and these were used until 22 October 2016. Thereafter, she was without her diazepam and her pain relief medications until 25 October 2016, during which period the facility attempted to obtain her GP notes and medication list. On 25 October 2016, the facility received Ms A’s GP notes, and Dr B then prescribed Ms A’s medications, other than insulin.
113. Dr B stated that the nurse told her that they were waiting for the GP notes to arrive before Ms A’s medications could be prescribed, and did not mention the blister packs. Dr B said that if she had been aware of the blister packs she could have charted the medications, because a prison doctor can write a new prescription based on current blister packs. This was a missed opportunity to provide Ms A with the pain relief medication she required. Ms A was also not prioritised for a consultation with a prescriber, as required by the

Corrections “Medicines Management Policy”. I consider this was a further missed opportunity for Corrections to provide Ms A with the pain relief medication she required.

114. RN Cornor advised that Ms A was at risk of withdrawal symptoms resulting from not taking the narcotics she was prescribed regularly, and would have experienced increased pain because she was not taking her usual pain relief medication. RN Cornor noted that the lack of pain relief and any possible withdrawal effects were not factored into Ms A’s care or treatment during this period. RN Cornor advised that Ms A was put at high risk during the period she did not receive her usual prescribed medications.
115. My expert clinical advisor, GP Dr David Maplesden, advised that the nature and dosages of the medication that Ms A brought with her to prison suggest that it would have been clinically unwise and possibly harmful to stop them suddenly (particularly the opiates).
116. Ms A was understandably upset when she was told that her pain relief medications had run out and the doctor was unable to chart her any pain relief because the facility had not received her GP notes.
117. With regard to Ms A not being provided pain relief once her blister packs ran out, RN Cornor advised:

“This is not an acceptable practice and should be reported for any patients taking any type of medication and specifically if there is no alternative medication offered during that period.”
118. RN Cornor considered that the delivery and adequacy of pain relief for Ms A was a departure from accepted practice, and stated that if there is concern about the administration of a medicine, the nurse should take action to prevent potential harm to the patient, and report it as soon as possible to the prescriber, line manager, or employer. She noted that although the GP is responsible for prescribing appropriate medications for the patient, it is also the responsibility of the nurse to ensure that the medications meet the needs of the patient.
119. It appears that the delay was a consequence of the medical centre not receiving the required faxed documentation. Although attempts were made to obtain Ms A’s GP records, I consider it was unsatisfactory for her to have been without her OxyContin, OxyNorm, and diazepam during this period. In my view, the nurses failed to advocate on behalf of Ms A adequately, and should have realised that her medications could have been charted from the blister pack.

Panadol

120. RN Cornor advised that internationally it is recommended that Panadol be taken only 4–6 hourly, and the maximum amount for adults is 1g per dose and 4g per day, as higher doses can cause liver damage. However, on 14 November 2016, custodial officers administered Ms A Panadol for back pain at 6.44pm and 9.49pm, and again on 25 November 2016 at 12.30am, 6.52am, 7.45am, 11.09am, 4.30pm, 6.07pm, and 11.57pm. While the dose of

Panadol given was not recorded, I note RN I's explanation that 1g is the standard dose given to prisoners who request Panadol. I accept this explanation, and am critical that potentially Ms A received 7g of Panadol within a 24-hour period — a significantly higher maximum daily dose than the recommended 4g. RN Cornor advised:

“That several and excessive doses of Panadol provided by custody to the patient over several days has not been raised, nor assessed by any clinical staff is a significant departure from the standard of accepted practice.”

121. I agree. I am also critical that Ms A's ongoing pain was not followed up with an assessment of the effectiveness of the Panadol to relieve the type of pain Ms A was experiencing, and that the dose of Panadol given was not documented in Ms A's records.

Diabetes management

122. Ms A arrived at the facility with no insulin. Dr B decided not to prescribe Ms A further insulin on the basis that metformin and a diabetic diet were sufficient to maintain her metabolic control. Dr B noted that the Medtech documentation on 26 and 27 October 2016 shows that Ms A was informed that her BSLs were low enough to stop the insulin at that time, and that she agreed to the decision. Dr B stated that excellent control is considered when the BSLs are maintained between 4.0 and 8.0 mmol/L.
123. However, between 29 October and 17 November 2016, Ms A's BSLs were taken four times, and ranged between 11.2 mmol/L and 12.4 mmol/L. These readings were higher than her initial BSL readings from 22 to 27 October 2016, which ranged from 5.3 mmol/L to 9.5 mmol/L. There is no record of any action being taken by clinical staff in relation to the increased BSLs, and no record that the increased BSLs were brought to Dr B's attention. In these circumstances, I am critical that no action was taken by clinical staff to reassess Ms A's insulin requirements in light of her increased BSLs after 27 October 2016.

Respiratory assessments

124. No baseline peak flow was taken at the time Ms A arrived at the facility for comparison by clinical staff when she became unwell. On 12 December 2016, she was given a new inhaler and a spacer, but there was no confirmation or assessment of her current need for salbutamol.
125. RN Cornor advised that Ms A should have had regular assessments of her respiratory rate, pulse rate, temperature, breath sounds, effort with breathing, ability to speak, and any follow-up to ensure the effectiveness of the medications, and that failing to do so would not be accepted practice. RN Cornor stated that the assessment of Ms A's condition was not adequate, and that this was a significant departure from accepted practice.
126. On 13 December 2016, at approximately 7.50pm, Ms A began having problems breathing. RN J telephoned Dr B and informed her of Ms A's condition. Dr B instructed that Ms A was to continue to use her inhaler with the spacer, and was to be put on the list to see Dr B

when she was next on duty. Ms A was booked to see Dr B two days later. However, there was no assessment of whether the spacer was being used correctly.

127. RN Cornor advised that Ms A's medical history included her previous respiratory condition, which indicated that immediate assessment and intervention was required if she had respiratory signs or symptoms. However, there was no care plan to inform staff about this. Despite her concerning symptoms on the previous evening, there is no record of Ms A being assessed on the morning of 14 December 2016.
128. Ms A requested an appointment via a health chit at 10am on 14 December 2016, because she was finding it hard to breathe, was coughing up yellow phlegm, and had severe pain in her back. RN I triaged the medical chit and noted that Ms A was already on the nurses' clinic list at 12.15pm on 15 December 2016, and on the doctor's list at 2pm that day. RN I documented, "already booked for 2", but did not assess Ms A, as she considered that Ms A could wait until the following day to be seen by the nurse and the doctor.
129. RN H recorded that when Ms A presented for her medications at 3.30pm on 14 December 2016 she appeared to be very short of breath and wheezy, and had audible breathlessness and difficulty completing sentences. On auscultation, both of Ms A's upper and lower lung fields had crackles and a loud wheeze. She was administered antibiotics.
130. I am concerned that it was not appreciated by Health Centre staff that Ms A's condition was deteriorating until she came to the medical centre at 3.30pm for her medications, despite having put in a health chit at 10am advising of her breathing difficulties. RN Cornor advised that the delay in assessment of Ms A's condition "is a significant departure from accepted practice or standard of care for a patient presenting with a respiratory illness". I accept this advice.
131. At approximately 8.45pm, RN H found Ms A lying flat on her back in her bed holding/guarding her left lung area. Ms A had 8/10 pain with breathing, her body was shaking, and she was very diaphoretic. There is no further documented assessment of Ms A's condition at that time.
132. RN H said that she assessed Ms A but did not complete percussion and palpation as she did not know what was expected to be palpated for wheezing/crackling lungs. RN Cornor stated that a full respiratory assessment would include an initial assessment, history taking, inspection, palpation, percussion, auscultation, and further investigations as necessary. She said that the initial assessment should include the respiratory rate, rhythm, depth, effort, accessory muscle use, chest expansion, and sounds.
133. I am critical that a full respiratory assessment was not performed on 14 December 2016, particularly in light of Ms A's previous history of respiratory issues.

Conclusions

134. Ms A was unwell and suffering from painful conditions. A person being held in custody does not have the same choices or ability to access health services as a person living in the

community. People in custody do not have direct access to over-the-counter medications or to a GP, and are entirely reliant on prison staff to assess, evaluate, monitor, and treat them appropriately.

135. In my view, medication management at the facility was inadequate. By failing to provide Ms A with medication in accordance with her prescription after the blister packs ran out, and prioritise a consultation with a prescriber, Corrections staff failed to ensure that she was provided with care of an acceptable standard. In my view, ultimately Corrections was responsible for the medication management shortcomings of its staff, which indicate a suboptimal culture towards medication management within the health service. It is particularly concerning that Ms A was left in pain.
136. Ms A's clinical management while she was a prisoner at the facility was seriously inadequate, and there were multiple significant departures from accepted practice with regard to safe medication administration and Ms A's respiratory care.
137. It is clear to me that Corrections did not provide medical treatment that was "reasonably necessary", and that the standard of health care at the facility was not "reasonably equivalent" to the standard of health care available to the public. Given the factors outlined above, I consider that there was an overarching service failure in this case. I also consider that the number of failings in the care provided to Ms A is indicative of an environment that did not support its nursing staff adequately to do what was required of them.
138. I am of the view that Corrections failed in its responsibility to ensure that Ms A received services of an appropriate standard for the following reasons:
- The planning of Ms A's care was very poor and, at times, non-existent.
 - Ms A went without her blister-packed medications from 22 to 25 October 2016, and was not prioritised for a consultation with a prescriber in line with Corrections' "Medicines Management Policy".
 - Ms A was administered Panadol against recommended practice.
 - No action was taken by Corrections staff to reassess Ms A's insulin requirements in light of her increased BSLs after 27 October 2016.
 - A full respiratory assessment was not performed on 14 December 2016 despite Ms A's symptoms, her physical distress at the time, and her previous history of respiratory issues.
139. Accordingly, I find that Corrections breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).³¹

³¹ Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

Record-keeping

140. RN Cornor advised that the documentation of assessments, treatments, and outcomes was poor. She stated that there is no consistency of staff documenting the time of their clinical entries, and the records are very difficult to follow. She said that in the majority of the clinical documentation there is a lack of documentation of signs and symptoms, a shared plan of care, decisions made, or care delivered. She stated: “[A]ny other health professionals working within this environment could not follow a plan of care and be [assured that] the patient remains safe in the health status.”
141. RN Cornor was also critical that although the medication charts require completion of the full name and initial of the signatory, the majority either do not contain the full name of the health professional or are illegible.
142. RN Cornor noted that statements such as “continue to monitor” do not give any indication of a plan of care or what is to be monitored, and therefore cannot be measured for outcomes.
143. Ms A arrived at the facility with no insulin, and Dr B decided not to administer insulin. On 26 October, a nurse documented that Dr B had requested that the decision not to prescribe insulin be discussed with Ms A. Dr B did not document the rationale for her decision, or a plan of care/treatment if there were untoward effects. RN Cornor said that the staff did not document the advice given to Ms A, including the side effects to look out for and other methods of reducing her insulin needs, such as diet and exercise.
144. Ms A received multiple doses of Panadol from custodial staff. While the timing of the doses was transcribed into Ms A’s clinical notes, the doses given were not recorded on 14, 15, 21, 22, and 25 November 2016. This is clearly information that should be documented in the clinical records.
145. Overall, the documentation is very poor. Corrections accepted that the clinical documentation did not meet the accepted standard, and noted that there was little evidence in the documentation of the evaluation of treatments recommended and/or the interventions undertaken.
146. This Office has continually stressed the importance of clear and accurate documentation. As set out in the Health and Disability Services (Core) Standards, consumer information must be accurately recorded, current, and accessible when required. In my view, the documentation in this case was suboptimal, and created real risk that the quality and continuity of Ms A’s care would be compromised. The poor documentation contributed to the poor quality of care. Accordingly, I find that Corrections breached Right 4(2) of the Code.³²

³² Right 4(2) states: “Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.”

Opinion: Dr B — adverse comment

147. Dr B prescribed medication for Ms A despite never having assessed her. The Medical Council of New Zealand publication *Good Prescribing Practice* (September 2016) states:

“You should only prescribe medicines or treatment when you have adequately assessed the patient’s condition, and/or have adequate knowledge of the patient’s condition and are therefore satisfied that the medicines or treatment are in the patient’s best interests ...”

148. In my view, Dr B had limited knowledge of Ms A’s complex medical conditions and should have reviewed her in person. I note that Corrections’ “Medicines Management Policy” states that patients who report having been prescribed medicines before coming to prison must be prioritised for a consultation with a prescriber. However, even when Ms A’s condition deteriorated, she was not seen by Dr B. I note, however, that Dr B did recommend that Ms A be sent to hospital on the evening of 14 December 2016, and this occurred.

149. Ms A brought in a small supply of her own labelled medication, which lasted from 19 to 22 October 2016. However, she was without her OxyContin, OxyNorm, and diazepam from 23 to 25 October 2016 while awaiting receipt of her medical file. Dr Maplesden advised that the nature and dosages of the medication she brought in with her suggested that it would be clinically unwise and possibly harmful to stop them suddenly (particularly her opiates). He said: “I am concerned that the request for prescribing information was not elevated (eg, GP speaking directly to GP) to ensure there was continuity of care.” While I acknowledge this advice, I do appreciate that Dr B made attempts to contact Ms A’s GP practice.

150. On 25 November 2016, Dr B prescribed Ms A ibuprofen without seeing her and without gaining her consent for this medication. The Medical Council of New Zealand publication *Good Prescribing Practice* (September 2016) states:

“Ensure that the patient (or other lawful authority) is fully informed and consents to the proposed treatment and that he or she receives appropriate information, in a way they can understand, about the options available; including an assessment of the expected risks, adverse effects, benefits and costs of each option.”

151. Dr Maplesden said that it is difficult to determine from Dr B’s notes the precise indication for this prescribing. Dr B stated:

“In the prison setting, it is simply not possible to discuss the advantages or disadvantages of taking every medication in the same way you might in general practice due to time constraints. In this case, I could not see the patient, I provided an option so she would get some relief ... and I clearly thought this would be better than not charting her anything and then running the risk of not seeing her for days while she was in pain.”

152. I note that Corrections' "Medicine Management Policy" states: "The patient will receive adequate information to enable them to make an informed choice ... The patient has the right to refuse treatment." While I note Dr B's rationale for prescribing ibuprofen, I am concerned that Ms A was charted medication without her knowledge or consent.

Recommendations

153. After taking account of the actions Corrections has already undertaken, in the provisional opinion I recommended that Corrections carry out the following actions. Corrections' responses to each provisional recommendation are set out below:

- a) Provide a written apology to Ms A.
 - Corrections provided an apology, which has been forwarded to Ms A. This recommendation has now been met.
- b) Arrange for an independent external review of the clinical services provided at the facility to advise on whether or not they meet the requirements of Section 75 of the Corrections Act 2004 and, specifically, whether the health service has sufficient clinical capacity. The review should incorporate medical, nursing, consumer advocate, and Māori and other relevant cultural expertise. A report with the results of the review and any actions taken or agreed as a result of it should be provided to HDC.
 - Corrections advised that in April 2019, an independent review was undertaken of the health service. A copy of the review was provided to HDC. Fortnightly meetings have been established to ensure that all identified actions are being implemented and evaluated in line with section 75 of the Corrections Act 2004. In July 2019, Corrections also achieved further accreditation by the Royal New Zealand College of General Practitioners.

I recommend that within six months of the date of this opinion, Corrections provide HDC with an update on the implementation of the recommendations from the review.

- c) Provide an update on the efficacy of the changes made to the health service.
 - Corrections advised that in addition to the programme of work undertaken at the facility (detailed above), a documentation template has improved structure and clarity of nurse documentation and assessment. It also noted that following the independent review, a number of actions were initiated to improve health services at the facility. I am satisfied that this recommendation has now been met.

- d) Develop a policy to ensure that the assessment of prisoners who seek health treatment is completed in a timely manner and in accordance with the prisoner's signs and symptoms.
- Corrections provided a copy of its new Health Care Pathway policy (implemented April 2019), which documents the process for health assessments from initial reception into Corrections, and the ongoing assessment process. The policy specifies timeframes in which prisoners are to be seen, and outlines the process for triaging prisoners' requests for healthcare assistance. I am satisfied that this recommendation has now been met.
- e) Develop a policy to require that assessment of newly arrived prisoners by medical officers is conducted within a specified timeframe of arrival, and that documentation by medical officers accurately describes the rationale for any change of treatment, and records that the informed consent of the prisoner has been obtained.
- Corrections provided HDC with a copy of its Health Care Pathway policy and Informed Consent policy, which detail these requirements. I am satisfied that this recommendation has now been met.
- f) Develop a process for the provision of patients' clinical notes from previous GPs in a timely manner, to ensure that no prisoner is put at risk of not receiving health needs, including that when faxes are used, a receipt from the fax machine is retained to indicate that the fax has been sent/received.
- Corrections confirmed that the Health Care Pathway policy outlines this process, which is now undertaken via an electronic process called GP2GP. Corrections stated that faxes are no longer used to request prisoner health records, and that the facility has access to TestSafe, which provides key medical information, including medication prescriptions and laboratory results. I am satisfied that this recommendation has now been met.

Follow-up actions

154. The Department of Corrections 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. Corrections stated that it will cooperate fully with the Director of Proceedings, with a view to agreeing on an appropriate outcome that adequately acknowledges its breach of the Code.
155. A copy of this report with details identifying the parties removed, except the experts who advised on this case and the Department of Corrections, will be sent to the Office of the Ombudsman and the Nursing Council of New Zealand, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

156. The Director of Proceedings filed proceedings by consent against Corrections in the Human Rights Review Tribunal. The Tribunal issued a declaration that Corrections breached Right 4(1) of the Code by failing to provide services to Ms A with reasonable care and skill, and Right 4(2) of the Code by failing to provide services to Ms A that complied with legal, professional, ethical and other relevant standards.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Barb Cornor (Registered Nurse, Masters Nursing, NZ Nursing Council 051169):

“This complaint concerns the health care of prisoner [Ms A]. [Ms A] is [in her forties] and was admitted to [the facility] on October 19, 2016.

Her past medical history includes previous empyema, thoracotomy and decortication in May 2014, increased BMI, type 2 diabetes and on insulin, hypotension and chronic back pain due to a discectomy at 8 years old. Due to this pain [Ms A] uses a wheelchair and crutches outside of the wheelchair for mobility. This information is recorded by the writer from a Discharge Summary dated 2015, included in the documentation received.

The third party complaint concerned pain management and it is alleged [Ms A] was refused a doctor. Particular concern related to 13–15 December 2016, when [Ms A] presented with breathing difficulties. It is claimed the nurse refused to listen to her chest despite her concerns due to her ongoing chest condition making her prone to pneumonia.

I (the writer) have been requested to review the documentation provided and advise whether I considered the care provided to [Ms A] by [the facility] reasonable in the circumstances, and why?

I am particularly asked to comment on the following:

The adequacy and appropriateness of the respiratory assessment on 14th December 2016

WHAT IS THE STANDARD OF PRACTICE/ACCEPTED PRACTICE?

The ability to carry out and document a full respiratory assessment include: an initial assessment, history taking, inspection, palpation, percussion, auscultation and further investigations as necessary. A prompt initial assessment allows immediate evaluation of severity of illness and appropriate treatment measures may warrant instigation at this point.

The initial assessment should include Respiratory rate, rhythm, depth, effort, accessory muscle use, chest expansion and sounds.

Clinical examination of the patient follows and advanced nurses may also continue with inspection, palpation, percussion and auscultation. Inspection is a comprehensive visual assessment, while palpation involves using touch to gather information. The next stages are percussion and auscultation. While percussion is striking the chest to determine the state of underlying tissues, auscultation entails listening to and interpreting sound transmission through the chest wall via a stethoscope.

All objective and subjective data collected from the assessment is then documented.

[The facility's] practice

It is the writer's opinion, the respiratory assessment, follow-up or plan of care was not the accepted standard of care or accepted practice for this patient. Documentation, as from the 12 December where [Ms A] provided an empty inhaler in exchange for a full inhaler, and the following day reported respiratory signs and symptoms to the clinical team, there was a respiratory ailment beginning. Her medical history provides a full report of her previous respiratory conditions which would provide the evidence of the need to prioritise immediate assessment and intervention for any respiratory signs or symptoms. There is no care plan evident in the documentation to provide this communication to all staff.

The assessment of her current condition is not adequate and this **significant departure from practice** has resulted in a seriously deteriorated health condition requiring hospitalisation. The lack of regular assessment and clinical intervention e.g. Respiratory rate, pulse rate, temperature, breath sounds, effort with breathing, ability to speak, and any follow-up to ensure effectiveness of medications and/or [Ms A's] condition **would not be an accepted practice by my peers**. A peak flow was attempted on three occasions without success, is recorded on two occasions but there is no documented evidence of a baseline peak flow for [Ms A] which may have been taken on arrival at [the facility] to provide the opportunity for clinical staff to compare it to when the patient went from well to unwell.

On 14th December 2017, it is documented by [provider], a medical chit was received requesting an appointment for 'finding it hard to breath[e] and lower back pain is increasing. Coughing up yellow flem (sic) at my chest & leaves me with a bloody after taste in my mouth. Excessive pain from the lump on my spine and feeling tired and weak.' Followed by 'Already booked for 2'. There is no time of entry nor does '2' have any indication if this is a time or something else.

On the same date there is an entry documented by [provider] which states 'presented to medical for 1530 medications'. [Provider] documents a full and complete respiratory assessment following 'appeared to be very SOB, wheezy'.

The 'Action' then followed with a recorded peak flow, a temperature, description of both lung fields and facial and body sweating. Antibiotics were commenced immediately and were 'charted further Amoxil 500TDS 7/7'. No further actions were documented.

15th December 2017, no time indicated, notes were documented by [provider] 'in retrospect for 15/12/16', stating 'on medication round patient had deteriorated to the point was weak holding L) lateral lung was in 8/10 pain, involuntary shaking, very diaphoretic'. There is no further documented assessment of the patient.

[Provider] documents he/she phoned the MO for advice and was advised to send the patient to hospital for assessment. [Provider] documents 'phoned mane staff to verbally handover'.

The writer can only assume the patient was sent to hospital as there are no further entries in Medtech to indicate admission until 20th December when [provider] documented a phone call at 1130hrs made to [the public hospital] for an update on [Ms A's] condition.

Days previous

- 12 December, 2017 [Ms A] returned a 'Ventolin' inhaler and was given a spacer 'as per Best Practice for use of Ventolin'. There is no confirmation or assessment documented of the current need for the Ventolin or if [Ms A] knew or required education, how to use the spacer.
- 13 December, 2017 at 2000hrs [Ms A] 'came to High medical with difficulty breathing'. [Ms A] stated she had pain and difficulty lying on her right side, and had been given a 'Respigen inh' last night with a spacer, which she had used 4 times (no documented times) between 1630–2000hrs. There is no evidence the spacer was being used correctly. O₂ sats and Peak Flow were recorded and the MO phoned for advice. The MO has advised to continue with the inhaler and spacer and review for nurse 'tomorrow' and booked for MO Thursday (2 days later).

There is no follow-up by a nurse documented the following morning. There is no documentation to suggest [Ms A] was followed up for an assessment, there is no evidence of an appointment at '2' and it is not until she came to 'medical' at 1530 'for her medications' was it determined her condition was deteriorating. **This is a significant departure from accepted practice or standard of care for a patient presenting with a respiratory illness.**

Whether there should be concern about the nursing management of [Ms A's] pain WHAT IS THE STANDARD OF CARE/ACCEPTED PRACTICE?

The obvious benefit of administering analgesics (pain relief) is the relief of suffering. Health carers may not understand the severity of their patients' pain, whether because of cultural differences, lack of empathy, or simply not believing some patients' pain reports and these factors have led to a higher incidence of unrelieved pain in minority groups.

Successfully navigating these concerns requires establishing a strong and trusting relationship with the patient, exploring alternative treatment modalities, and communicating clearly with the patient about risks associated with continuing these medications. The health carer should obtain and review old records to identify the original rationale for instituting the medications, and to clarify any previous dosage changes.

It is recognized that controlled substances including opioid (OxyNorm, OxyContin) analgesics may be essential in the treatment of acute pain due to trauma or surgery. Use for chronic pain carries significant risk and the risks of chronic opioid use need to be weighed against limited benefits. Practitioners should always consider the many facets of pain and strongly consider an interdisciplinary or multidisciplinary approach to management of pain, (acute, episodic or chronic). Health carers should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not the same as addiction.

The patient must provide informed consent and be actively engaged in the stopping of medications and/or weaning process. If this is too challenging, the medical officer should revisit the concerns regularly over time, attempting to make the regimen as appropriate as possible.

It is internationally recommended Panadol should be taken 4–6 hourly. The times documented in [Ms A's] notes indicate this is not the case and there is only just over an hour between two of the doses. There is no dosage documented for the 7 incidents of provision, so it is difficult to tell how many milligrams of Panadol the patient received on this date. The maximum amount for adults is 1 gram (1000 mg) per dose and 4 grams (4000 mg) per day and using more paracetamol could cause liver damage.

[The facility's] Practice

[Ms A] arrived at [the facility] on 19 October, 2016. At that time all medications are documented on the Reception Health Triage Form which were 'blister packed'. Each blister pack is dispensed by a pharmacist according to the patient's individual prescription received from their General Practitioner (GP). Every patient can be assured and trust that their medication dosage is accurately and correctly dispensed. The medication for each day is packed in a tear strip, has the medication name printed on each pottle, with clear and easy to read instructions.

20 October, 2016 [Ms A] Initial Health Assessment (IHA) was completed by [provider]. As part of this assessment it is documented [Ms A] 'stated she was in pain — gets anxious' but there is no assessment of type, situation, severity of the pain or the anxiety she has stated she had. [Provider] also documents the 'palm size lump' on her back was 'soft and tender to touch'. It is stated [Ms A] 'may need a shower chair as pt uses crutches/wheelchair to mobilise' but no reason is included in the assessment why and what is affected to reduce her mobility. There is also no documentation to support that [Ms A] was assessed and/or provided with a shower chair until January 2017, following a fall on 29 December, 2016. There is no formal documented Plan of Care included in the documentation. The writer presumes the statement, 'continue to monitor' is the plan of care, although there is no information provided as what is to be 'monitored'.

Over the five days from arrival at [the facility], 20/21/25 October, it is documented '[the medical centre]' was contacted eight times to request the GP notes and

medication list. GP notes are requested for all prisoners, to support the clinical team in the latest health information and current medications.

23 October, 2016 at 1040 hrs it is documented 'Pt upset when told her pain relief medications had run out from her blister pack'. [Ms A] was informed the doctor was unable to chart her pain relief medications as they had not received her GP notes. [Provider] later spoke to the patient — 'calmed down but still upset and says she will get the sweats and will have to be admitted to hospital'. That she may go through some withdrawal of the narcotics she was prescribed regularly was correct, but there was also the increased pain she was going to experience by not taking that regular pain relief. No pain relief, nor any possible withdrawal effects was not factored in to [Ms A's] care or treatment during this period. No pain relief was prescribed for that time period, neither any medications to support the withdrawal of narcotics. Custodial staff were 'updated regarding the situation'. Why they needed updating, what information they were given and what they were advised is not documented. Interestingly the narcotics were discontinued when they 'ran out', but it appears other medications e.g Metformin were continued.

24th October, 2016 [Ms A] was seen in the 'care unit' after she reported she had a fall overnight. Signs and symptoms reported by [Ms A] were documented. The only assessment documented was a 'pinch test' which the patient 'reacted to'. There is no further assessment of the mode or mechanism of the fall or injury/ies documented in the patient's notes, except 'nil signs of pain or discomfort noted' was documented later that morning. It is unclear whether that observation was made by [provider] or was reported by the patient.

25th October, 2016 the GP notes were received by [the facility], medications were prescribed by the prison MO and all medications including pain relief but excluding Insulin were commenced.

26th October, 2016 [Ms A] 'stated she is feeling better now that she has got all her pain relief charted' and is reported as up and about in her wheelchair and seen cleaning her cell.

It is documented by [provider] on November 14th, 2016 [Ms A] was given Panadol (no dosage) at '0037, 1844hrs and 2149 for back pain' by CO's (the writer assumes this is custodial officers). There is no follow-up documentation of a clinical assessment of the type, area or timeframe of the pain, nor if the Panadol had been effective.

16th November it is documented 'pt stated that the pain on her back is getting worse, mentions that it is a lipoma'. There is no documented assessment of the pain although [provider] continued to document at 0908hrs 'Pt currently on long acting and short acting pain relief', and 'Nil obvious pain during medication rounds' and suggested 'continue monitoring'. [Ms A] raised concerns the following day and was 'reassured she was booked for MO already'.

22nd November it is documented [Ms A] 'wants to be seen by Dentist for loose front upper tooth'. She was advised 'she is already on the dentist list'. No assessment is documented, nor follow-up or dental appointment. On 26 December, 2016 when [Ms A] was in the clinic 'to assist with nebulising Ventolin as per doctors orders' she again 'advised of an extremely wobbly upper central tooth which is very painful'. [Provider] examined the tooth and booked [Ms A] 'for the dentist clinic on 29/12/17'.

November 25th [Ms A] was unable to see (reason not documented) the doctor who documents 'listed because of lump on her back', 'I see she has a lipoma and is awaiting excision' and 'has plenty of analgesia charted' although the doctor prescribed 'Brufen' (anti-inflammatory pain relief).

On this day also, it is documented [Ms A] was given Panadol (no dosage) for back pain at 0300hrs, 0652hrs, 0745, 1109, 1630hrs, 1807hrs and 2357. This is a high dose of Panadol but there is no documented follow up of pain assessment or effectiveness of pain relief made by any clinician on that date. [Provider] documents at 1200hrs on this date, 'nil concerns from patient or unit staff'. The writer is very concerned about the dose of Panadol provided and that there is no follow-up or assessment of the pain completed in that time. Panadol continued to be provided 25/26 and 29 November with no follow up.

That several and excessive doses of Panadol provided by custody to the patient over several days has not been raised, nor assessed by any clinical staff is a significant departure from the standard of accepted practice. Any ongoing pain requiring pain relief should be followed up especially with an assessment, then effectiveness for the pain type. Had this occurred the pain could be defined and other alternatives for pain relief could/have not been offered.

The writer also thinks the delivery and adequacy of pain relief for [Ms A] during the period to the end of November is a departure from accepted practice and the patient's rights. This would not be an accepted practice by my peers. Her medications, which included pain relief, were discontinued due to the blister packs 'running out' 22–26 October. As previously described, blister packs clearly document the name of the medication, the time they should be taken as prescribed by the GP. The writer questions why a prescription and/or medication chart could not have been provided by the medical officer, for this patient, using this resource or some other pain relief, other than Panadol could not be prescribed or doctor to doctor telephone handover from the General Practice to confirm the prescription.

Other medications provided are signed for on a 'signing sheet' which looks to be provided by the pharmacy providing those medicines. Signing sheets were provided to the writer who has found it very difficult to determine the provision of some medicines as they do not match the instructions at the top of the sheet. E.g. 'Signing sheet printed on 29/11/2016 states Oxycodone HCL 40mg CR. Take ONE tablet TWICE daily. Swallow whole, do not crush or chew'. Medication is only signed for once per

day at breakfast on Week 1 and Week 4 but they both contain the same date. This may have a simple explanation but the writer is unable to understand and would suggest this be reviewed by health staff at [the facility]. This reads like a significant departure from the accepted practice and any 'outside' health carer coming in to the prison to work would be confused and the writer identifies a high risk.

Whether there was appropriate liaison with the medical officer within a timely fashion?

WHAT IS THE STANDARD OF CARE/ACCEPTED PRACTICE?

If there is concern in the administration of a medicine, the Registered Nurse must take any action to prevent any potential harm to the patient, and report it as soon as possible to the prescriber, the line manager or employer (according to local workplace policy). The General Practitioner is responsible for prescribing appropriate medications for the patient and also it is the responsibility of the nurse to ensure the medications meet the needs of that patient.

[The facility's] Practice

It is documented that [Ms A] cannot be provided pain relief because her blister packs had 'run out'. This is not an acceptable practice and should be reported for any patients taking any type of medication and specifically if there is no alternative medication offered during that period.

The writer finds it very difficult to understand how all clinical staff have accepted (although did continue to attempt to get the patient's notes from the Health Centre) this practice as normal. All health carers should understand how the patient has been put at high risk during the period of not receiving regularly prescribed medications.

25th October [provider] (Dr) documents the notes have been received and prescribes the medications.

27th October [provider] documents meds are charted and [Ms A] is 'happy with that' and is 'happy with the plan'. There is no indication the patient has actually been seen by the Dr.

4 November [provider] notes [Ms A] is requesting 'cream'. No assessment is included. The writer queries if the patient was seen.

25th November [provider] was 'unable to see [Ms A] when visited'.

26th December seen by [Dr B] and a respiratory assessment and treatment carried out.

It is difficult to determine if [Ms A] had had a medical assessment since arrival in [the facility]. The writer queries this as MO entries do not provide evidence of actually seeing the patient. This is not accepted practice in general practice facilities especially of new patients, and the writer queries is there a process/timeframe for medical assessment on arrival, especially those arrivals with an extensive health history.

There is evidence in the documentation that the Medical Officer has been called when [Ms A's] condition has deteriorated and advice has been provided by telephone and recorded by the nurse. **Having a doctor on call is appropriate practice** and occurs in health facilities where there is no 24 hour medical, on site cover. **What is not accepted practice is that there is no formal plan of care documented** following these calls, except within the nurse's documentation at the time, nor is there any follow-up of the medical officer following up one of the calls, but a hospital admission followed the second call.

Whether the management of [Ms A's] diabetes was appropriate in the circumstances?

WHAT IS THE STANDARD OF CARE/ACCEPTED PRACTICE?

There is increasing evidence that an individual and patient centred approach to the management of type 2 diabetes [sic]. Patients will respond differently to advice from health professionals depending on their age, economic situation, ethnicity and level of health literacy. Cultural competency, which is essentially respectful and effective communication, is just as important as clinical and ethical competency in a healthcare interaction. Type 2 diabetes is a progressive disease which requires lifestyle measures, monitoring and medicines to increase in intensity as cell failure progresses. Most people with type 2 diabetes require regular and intensive management to achieve individualised HbA1c targets.

Healthcare professionals must be both understanding and understandable, and this is essential in managing patients with diabetes to achieve successful health outcomes. Some people with type 2 diabetes may be able to manage their diabetes through diet and exercise, or by taking tablet medication. Insulin is eventually required for many people with type 2 diabetes and early initiation can be appropriate. After ten years, 50% of people with type 2 diabetes will require insulin. Early initiation may reduce cell damage and is thought to slow disease progression. Early initiation of insulin should be strongly considered for people with type 2 diabetes who have significant hyperglycaemia.

The Practice at [the facility]

It is documented on arrival at [the facility], [Ms A] is a diabetic on insulin morning and night but has 'none on her at the moment' and [Ms A] stated 'that she has 48u-novomix in the morning and 38u novomix at night'. Insulin cannot be blister packed. [Ms A] was informed and consented to her GP notes being requested so that 'her meds and insulin' could be 'charted by our MO.' It is also documented on Initial Health Assessment, 'has IDDM but nil insulin brought in with patient'. This is an incorrect diagnosis as IDDM (Insulin Dependent Diabetes Mellitus) is treated differently and has serious consequences if insulin is not available.

Metformin HCl 500mg three times daily was in the blister pack. This medicine also controls type 2 diabetes by lowering blood glucose levels. This tablet works by making

body cells and muscles more sensitive to the action of insulin. It does not make the pancreas make more insulin and means if people are only taking Metformin (and not insulin) they are not at risk of having low blood glucose levels. It should only be taken with food because if taken on an empty stomach it can cause nausea.

On 20th October it is documented the 'MO advised once confirmation comes through to chart and order insulin as per records'. A phone call on this date is documented from [Ms A's] 'caregiver and partner' who was advised 'medication will be recharted by our MO today' after asking if she needed to bring in the insulin pen or prescription because 'she is on novamix bd'. This person was advised not to bring in the insulin or prescription.

22 October, [Ms A] advised health staff she was diabetic and should be on insulin. Blood sugar levels were documented at 0900hrs 5.8 and 1300hrs 5.5 (within normal limits). There is no documentation of any discussion held with the patient as to what effect this may have on her, the use of Metformin or what signs and symptoms she should be looking out for deterioration of the condition.

There is evidence of metformin being given and are timed at 0900, 1300 and 1530 hours by most signatories. The writer questions, does the patient take them at this time or hold on to them until meal time when she has a full stomach? There is no evidence of missed doses of Metformin in the Signing Sheets.

Following arrival at [the facility] with no insulin, the Doctor has made the decision not to administer the insulin. 26 October, 2016, six days after arrival, documentation by [a nurse] reflects they have been asked by the MO to discuss her not having insulin with [Ms A]. [Provider] documents 'is happy to have BSL (blood sugar levels) checked every second day' and 'Pt agreed not to have her insulin but will have BSL checked every second day'. The nurse informed the MO.

That the MO has not documented the rationale for their decision or a plan of care/treatment if there are untoward effects is a departure from the accepted standard of care. There is no indication in the documentation of what [Ms A] was advised, including side effects to look for and other methods of reducing her insulin need e.g. diet, exercise. Blood sugar levels continued daily or twice daily until 30th October and once more following that.

30 November, it is documented by [provider], a medical chit was received which included 'I haven't had my insulin since I've been here and my sugar results are high'. A diabetic profile was completed including blood tests on 1 December, 2016 and results discussed with [Ms A] on Dec 4 by [provider], who also at this stage, discussed 'lifestyle factors diet/exercise'. This is five weeks following arrival at [the facility].

Diabetes NZ suggests a care plan is useful for diabetics when several people are involved in the care or there are ongoing health issues. This ensures everyone is on the 'same page' as to what matters and what's planned together with the health team

to improve health or wellbeing. The plan is developed with the patient and provides written information about what to do when things go wrong or symptoms occur, for knowing what to watch out for early warning signs and what to do at an early stage to prevent the need to go to hospital. There is no indication if this occurred and to the writer there is no indication of [Ms A's] knowledge level or participation in this process.

The writer cannot provide an opinion on the practice of ceasing of insulin for [Ms A's] diabetes as there is no documentation to support the reasoning behind this but it is a significant departure from accepted practice that the patient was not informed, nor her consent received prior to stopping the insulin.

As with any situation of change in health procedures, medications or treatments a treatment plan should have been detailed to observe blood sugar levels more regularly in the first week or until they were stable, what treatment to conduct if there were side effects and discussion about her lifestyle been priority.

It is not indicated if blood glucose testing was done by the nurse or patient, nor whether [Ms A] needed to seek help with managing those blood glucose levels, and if not, would she be taught to do this as part of the plan.

Were custodial officers made aware of the possible side effects, what to look out for and a plan for them if so?

Clinical Documentation

WHAT IS THE STANDARD OF CARE/ACCEPTED PRACTICE?

Clinical documentation is a legal record of patient care. It is essential for good clinical communication and a core requirement of the Nursing Council of New Zealand (NCNZ) competencies for scope of practice. Good documentation helps to protect the welfare of patients by promoting:

- High standards of clinical care
- Continuity of care
- Better communication and dissemination of information between members of the multidisciplinary care team
- An accurate account of treatment, care planning and delivery
- The ability to detect problems, such as changes in the patient's/client's condition, at an early stage (Collins, Cato et al. 2013).

When documenting in the clinical record, it is important to remember many people are required to read the notes that are written. All health professionals who are involved in the planning, implementation and evaluation of care — from the time of admission through to discharge must complete documentation to meet the needs of all health professionals. External bodies in the case of an investigation e.g. NCNZ, MCNZ, Accident Compensation Corporation (ACC), Health and Disability Commissioner

(HDC), Health Practitioners Disciplinary Tribunal (HDPT) or the Coroner are also required to read the written notes.

Documenting all relevant information ensures others know what the health professional observed and what clinical interventions were taken and what the result was. Documentation must show evidence of clinical judgement and escalation/referral as appropriate and evaluation of the care provided. There is an old saying which remains relevant to this day — *If care is not recorded, then it is assumed the care was not given*. In the review of this case, it appears to the writer a lot of evidence is missing.

Documentation should also include care that could not be given and the reason why, so that it does not get overlooked. When addressing ethical dilemmas in care delivery, health professionals are advised to document steps/care intentionally not taken and the rationale for the decision e.g. it may further endanger the safety of the individual etc.

Documentation Frameworks for Nurses

There are many different documentation frameworks to guide nursing documentation in use across New Zealand (NZ). Four commonly used documentation methods in NZ — SBARR, Focus charting, SOAP/SOAPIER and Narrative documentation are described below.

SBARR

The SBARR is a communication framework used to create a structured and standardised communication format between health care workers. It is particularly useful for reporting changes in a patient's status and/or deterioration between health care services or shifts.

S = Situation — what is going on with the client/patient (Chest pain, nausea, etc ...)

B = Background — patient's presenting complaint, relevant past medical history and brief summary of background

A = Assessment — Vital signs, any outside normal parameters, your clinical impression, severity of client/patient and clinical concerns

R = Recommendation — suggestions of what action is to be taken, how urgent and when action needs to be taken.

R = Review — what has been the effect of the action/intervention.

(Institute for Healthcare Improvement, 2016)

Focus Charting

Focus charting identifies specific concerns determined during the assessment e.g. a focus may reflect:

- A patient's concern, such as shortness of breath.
- A change in a patient's condition, such as shortness of breath and wheeze.
- A significant event in the patient's care, such as transfer to hospital.

The patient care is then organised under the headings of:

- **Data:** Subjective/objective information as supporting evidence of the patient status.
- **Action:** Completed or planned clinical interventions based on the assessment of the patient's status.
- **Response:** Evaluation of the impact of the interventions.

Flow sheets and checklists are frequently used as an adjunct to document routine and ongoing assessments and observations such as personal care, vital signs, intake and output, etc. Information recorded on flow sheets or checklists does not then need to be repeated in the progress notes (College of Registered Nurses of British Columbia, 2013). However, they still are part of the client's clinical record and should be kept with all clinical notes.

SOAP / SOAP I E (R) Charting

SOAP/ SOAP I E (R) charting is a problem-oriented approach which includes the following:

- **S** = subjective data (e.g. how does the patient feel?)
- **O** = objective data (e.g. results of the physical exam, relevant vital signs)
- **A** = assessment (e.g. what is the patient status?)
- **P** = plan (e.g. does the plan stay the same? is a change needed?)
- **I** = intervention (e.g. what occurred? what did the clinician do?)
- **E** = evaluation (e.g. what is the patient outcome following the intervention?)
- **R** = revision (e.g. what changes are needed to the care plan?)

Similar to focus charting, flow sheets and checklists are frequently used as an adjunct to document routine and ongoing assessments and observations (College of Registered Nurses of British Columbia, 2013).

Documentation

Documenting for individual patient's documentation should:

- Be factual, objective, consistent and accurate.
- Be written as soon as possible after an event has occurred, providing current information on the care and condition of the patient including standard care and out of the ordinary care.
- Be written clearly.
- Be written in a manner that any alterations or additions are dated, timed and signed so the original entry can still be read clearly.
- Be accurately dated and timed.

- Avoid inclusion of abbreviations, jargon, meaningless phrases, irrelevant speculation and offensive subjective statements.
- Be readable on any photocopies — ideally written in black ink.
- Have a unique identifier on both sides of every page (NHI, Date of Birth)

In addition, records should:

- Identify problems that have arisen and the action taken to rectify them.
- Provide clear evidence of the care planned, the decisions made, the care delivered and the information shared, with rationale for the nursing action and/or inaction.
- Cross reference vital observations, fluid balance charts etc. rather than repeating the information already available in the client's/patient's notes.

Documentation by nursing staff and medical officer for assessments, treatment and outcomes for [Ms A] is poor. Although dated electronically, there is no consistency of all staff documenting the time of their clinical entries. As it has been very difficult for the writer to follow, I can only imagine how it must be for consistent communication of an effective plan of care between nursing and medical staff. **Documentation which reflects signs and symptoms, a shared plan of care, decisions made or care delivered is lacking in the majority of clinical documentation. Any other health professionals working within this environment could not follow a plan of care and be ensured the patient remains safe in the health status.**

Medication charts provided contain an area of signing register which indicates the 'full name' and 'initial' of the signatory be provided. The majority of these do not contain a full name of the health professional and/or are indecipherable which does not reflect legislative requirements.

'Patient Medical History' contains outbox documents and under the title 'Doctor Legend' are the codes for the staff using Medtech. Unfortunately, it does not indicate the position of that person in the health clinic except two [provider] and [provider] as a Dr (the same Dr). The writer presumes the others are nursing staff but cannot confirm this as the health team may consist of other health professionals who use Medtech also.

Nursing Council of New Zealand, Competencies for Registered Nurses

STANDARDS OF CARE/ ACCEPTED PRACTICE

Departures identified

Competencies for registered nurses Domain two: Management of nursing care Competency 2.2 states 'undertakes a comprehensive and accurate nursing assessment of health consumers in a variety of settings' and the indicators include 'undertakes assessment in an organised and systemic way' and 'applies relevant research to underpin nursing assessment'. This is not consistently reflected in the nursing documentation of [Ms A's] health care. Full health assessments are not documented which leaves the writer to assume, they are not done. Examples of this are on arrival

at [the facility], following a fall, the stopping of insulin and when [Ms A's] respiratory condition was deteriorating.

Competency 2.3 is not met as discussed prior, where clear, concise, timely, accurate and current health consumer records within a legal and ethical framework is not seen consistently.

Competency 2.4 states 'ensure the health consumer has adequate explanation of the effects, consequences and alternatives of proposed treatment options'. The writer does not believe proposed treatment plans were discussed at all, or if they were, in a timely manner which would allow informed decisions to be made by [Ms A].

The professional/ethical issue related to the stopping of her regular pain relief due to the 'blister pack running out', was not discussed in full with [Ms A], neither was an alternative plan of care offered to her. Again the writer's opinion is that this may be seen as normal practice. All health staff have an obligation to raise concerns about issues or risks with colleagues or other members of the team and escalate them to a higher level if the issue is not resolved (Code of Conduct for Nurses, 2012).

There is limited evidence of evaluation of the effectiveness of [Ms A's] response to prescribed treatments, interventions and health education. Competency 3.2 indicator states, to contribute to informed choice, nurses should ensure health consumers receive and understand relevant and current information concerning their health care. This is not reflected in [Ms A's] clinical documentation.

Indications for 'collaboration and participation with colleagues and/or members of the health care team' include plans of care being developed with team members and the patient. Once developed these should be maintained and information shared to ensure continuity of care (competency 4.1). Plans of care for [Ms A] are limited, or documented on a duty in response to an incident or not at all. Plans should have been developed by the clinical staff and [Ms A] to demonstrate for example, ceasing insulin process, indications for deterioration of any of her health conditions, mobility, and lifestyle changes for type 2 diabetes etc. There is no indication about what information has been shared with custodial officers to ensure [Ms A's] health status is maintained. Statements like 'continue to monitor' do not give any indication of a plan of care or what is to be 'monitored' therefore cannot be measured for outcomes which ensure the patient remains clinically well.

A number of nursing staff do not meet these requirements. Performance reviews and management plans would be commenced in other health facilities.

Recommendations:

- Formal review and improvement in all health documentation, including forms within [the facility] with the outcome to ensure all documents reflect the health assessment, treatment, outcomes and informed consent for all seeking health

treatment. A Quality Improvement project will provide the framework for this change.

- Training for all clinicians of a consistent framework for documentation.
- Regular audit of compliance of all health professionals with documentation requirements.
- Update and training on assessment guidelines and tools for specific conditions.
- Assessment of persons seeking health treatment is completed in a timely manner and in accordance with the signs and symptoms.
- GP assessment of newly arrived prisoners is conducted within a specified timeframe of arrival.
- GP documentation accurately describes rationale for change of treatment and identifies informed consent for this.
- Update/training for nursing staff on Nursing Council requirements and competencies and regular audit through appraisal or performance Development are conducted.
- Performance reviews and performance management plans are commenced for all nursing staff to provide consistency of practice within the nursing team.
- Ensure a process is developed for the provision of patients' clinical notes from previous GPs in a timely manner to ensure no prisoner is put at risk of not receiving health needs.

References:

BPAC NZ, Managing patients with type 2 diabetes from lifestyle to insulin (December 2015)

Nursing Council of New Zealand, Code of Conduct for Nurses (2012)

Nursing Council of New Zealand, Competencies for registered nurses (2007)

NZNO Practice Quality: An NZNO e-book New Zealand Nurses Organisation PO Box 2128, Wellington 6140. www.nzno.org.nz

NZNO Practice Publication Label: Guideline: Documentation, 2017 New Zealand Nurses Organisation PO Box 2128, Wellington 6140. www.nzno.org.nz Page 3 of 12

Paracetamol: Uses, Dosage, Side Effects. <https://www.drugs.com/>

The following further advice was received from RN Cornor:

"I have received further documents since the provision of my initial advice. I am asked to review the documentation and advise whether it caused me to amend the conclusions drawn in my initial advice, or make any additional comments. I have enclosed the separate addendum and have considered the following:

Review of further documentation received:

- A number of nurses and the doctor described the difficulties and barriers when working in a prison. I have six years' previous experience as a health manager with the Corrections Department and was involved in the development of Corrections health policy and procedure. I am fully aware and acknowledge the role requirements and the difficulty and/or barriers some prisoners or processes within the prison, can present. All areas of health employment present with their own barriers, differences and issues. This should not concede to any deviance from the legal, professional or ethical requirements and/or conduct of a health professional. The prisoner with health issues remains a person with health issues, whatever their reason for incarceration.
- Reading the statements written by the RNs involved and the Doctor provides an improved understanding of the process of care. A number of nurses described their shifts, role requirements and barriers to care. Some of those statements specific to the care of [Ms A], if in an abridged form, had been included in her documentation, may have enhanced the restricted and scanty patient management information, plans and outcomes.
- After reading [Dr B's] statement, this too provided a clearer understanding and reasoning for the diabetes and pain management of [Ms A]. [Dr B] described the rationale behind the decisions he/she made therefore, a shorter version of the statement in the patient notes would have improved the documentation in the patient's clinical record, heightened the knowledge of all staff concerned, and provided the appropriate information for a plan of care to be developed for all health staff to share and work to objectives.
- It is acknowledged after reading the RN's and doctor's statements, the writer was not looking for an individual to be held responsible for the outcomes in this situation. 'If it's not documented in the patient record, it's not been done' an old health saying which fits significantly in this situation. Both [Dr B] and a number of Registered Nurses in their statements, have suggested their documentation could have improved or assessment was done but not documented. Effective and well informed patient outcomes occur when there is consistency in practice, all staff are providing the right information and following the same processes and ultimately, working at a competent level or above, within their role and all its requirements.
- It appears there are differing reports of the request for Medical Notes from [the medical centre]. Understandably and according to policy [the medical centre] requires signed consent from the patient before releasing their clinical documents to any other person or facility. [The medical centre] indicate[s] they did not receive the faxed consent (signed 19 October) until October 25th and responded immediately. [The facility] report[s] it was sent on the 20th October. A suggestion

for ensuring this does not occur again and all faxes are received is to request a receipt from the fax machine to indicate it has been sent/received.

Appropriateness of changes?

[The Director of Offender Health] states in her document (February, 2018) received by the HDC Commissioner on behalf of the Department of Corrections, she is 'advised (by [the facility]) that a number of significant changes to the health service provided at [the facility] have occurred during 2017' and 'largely related to strengthening clinical practice and building capacity within the health care team'. The changes are reflected in the time-lined plan for improvement in the Health Unit at [the facility] I received. The plan includes mentoring and/or 1:1 support for leadership positions, induction of the Clinical Quality Assurance position, a new role of Practice Leader has been developed and new Senior Advisor position has commenced. Recruitment of additional and vacant Registered Nurse FTE positions and supervision to nurses undergoing performance management continues and meetings have taken place to provide nurses with 'clear messages given on expected behaviour'. Medical hours have increased by 4 hours per week, with additional GP support contracted through a local community practice.

The Practice Improvement Plan includes improved communication and review of health performance by the health leaders, Practice Leader responsible for performance of documentation and assessment of all RNs and 'training assistance', 'trending issues/areas for development' and confirming all nurses attend all training sessions. The establishment of regular Clinical Governance meetings will also provide clinical support for and to the team. Training and education must continue to be provided regularly, and tertiary studies encouraged/supported on an on-going basis.

Training, with specific objectives for the programme documented, has been provided. This training covers Policy and Procedures, from how and where to access them, through to the specific policies and pathways (Medicines, Assessment and Documentation), to legislative requirements of Health and Corrections. Again this training must continue to be provided.

An external consultant was employed to implement a team building programme aimed at strengthening the health centre culture and to coach the Health Centre Manager. The Health Centre Manager is also receiving one on one leadership and mentoring from [the region's] Leadership team with the focus on supporting the nursing teams.

The review of policies and procedures has been conducted, audit processes are underway which will provide a continued framework for all health staff to be working within. Staff have been provided with the education and training on these policies and how to access them all.

A new 'Process for New Arrivals & Requesting & Receiving GP notes' draft document was received and reviewed. There is no date included on this document but it reflects changes for prisoners arriving at the prison to ensure and check for timely health care interventions. The appointment booking system is improved to ensure no prisoner is overlooked. This policy requires a final document and a date as soon as possible.

At no time was the competency of the Medical Officer questioned in my initial response. The rationale for decisions of change of treatment and/or process for [Ms A] was questioned. The statement made by [Dr B] (November, 2017) to the Deputy Health & Disability Commissioner provides the rationale and as documented prior, if this had been included in the patient's notes could have made a difference.

The remedial actions implemented following recommendation are a credit to [the facility] and the Corrections Department. I would expect following the changes there is a continuing positive culture within the Health Unit due to the improved performance and outcomes for all staff and the patient involved. It now becomes the responsibility of the leadership/management team and the Regional Health Leaders to ensure the implemented changes continue at the highest level and that these are audited and reported on a regular basis. This process will reflect the improvements are continued as business as usual, and staff morale and professional practice will continue at that higher level.

The treatment plan provided for [Ms A], December, 2017, is intensive and comprehensive and is undoubtedly of expected standard and accepted practice.

Positive feedback must go to the staff of [the facility] for the implementation of the intensive process of change they undertook and the improvement thus far.

1. The adequacy of the policies and procedures that were in place at the time of these events?

Health Services 'Medicines Policy and Procedures'

- This was provided to me and dated for review in 2016, therefore, current in the time period of this complaint. This policy describes full medicine management and covers the national Corrections Department Health Facilities. This policy is currently under review and a draft policy was also received.
- Unfortunately, the Standing Orders being used at the time of the complaint were all dated December, 2015. According to policy these must be reviewed annually and therefore, were a year overdue. There was no evidence of a medical officer or dentist signature on the documents but I would suggest/assume the hardcopy with the evidence of those would be available at [the facility]?
- The Medication policy also states in 'Custody Issued OTC Procedures, Custodial Staff to document on the Over the Counter Medication Log Sheet the date, time, patients name, dose or number of tablets and the reason for OTC medication'.

These requirements were not all indicated in the documentation provided by the nursing staff. Eg Panadol given (no dosage documented).

Health Services ‘Health Care Pathway Policy/Procedure’

- The purpose of this procedure, issued in 2008, and reviewed in October 2015, is to support Health Services staff to provide efficient and effective health care interventions according to the clinical needs of individual patients. It also provides guidance for the delivery of health care at each stage of imprisonment.
- It also states a ‘health plan of care is developed for patients who do not need a Treatment Plan’ and describes the needs in that plan and the interventions should reflect the specific needs of the patient, including health promotion and education.
- All prisoners who have health needs that are significant and/or complex in nature (see definition 5.10 in this document) must have a Treatment Plan.
- Patients who don’t need a Treatment Plan must have a plan of care (see definition 5.8 in this document) if they need clinical interventions (of which [Ms A] required many).
- This Policy states
 - ‘Treatment plans or plans of care will be reviewed within an appropriate time frame.
 - All clinical interventions in a treatment plan or a plan of care will be based on current practice standards.
 - Any standardised treatment plan must be able to be personalised and varied according to individual patient’s health needs.
 - Health services staff carrying out clinical interventions for a patient must create the treatment plan or plan of care for that patient.
 - The health services staff member who starts the treatment plan is responsible for ensuring the treatment plan is completed.
 - Any prisoner with “significant and/or complex needs” eg “acute diseases, conditions or injuries that place the patient at significant risk (including mental illness)” treatment plan must cover these.
 - Health assessments will provide clinical assessments that are appropriate to clinical presentations, according to current good practice and provided in a timely manner. The plan of health care interventions should then be matched with assessed needs.’
- Current industry guidelines and standards was (and continues to be) provided in the latest dated and best practice policies available through the Corrections Department intranet (Corrnet). These are found under the Health Services Manual

as Ministry of Health NZ, Medsafe, New Zealand Guidelines Group and Cochrane Library with direct access to the websites provided.

There is no doubt the policies and procedures were in place and up to date in [the facility] at the time of the reported events (with the exception of the Standing Orders). It appears in some statements made by nursing staff and the clinical documentation of assessment and processes, that there is inconsistency of knowledge in health standards including best practice and policy requirements, corrections procedures and health requirements in the Corrections arena.

Policy also states 'each year, three areas of this (Medication Policy) will be audited and patients files will be reviewed against this by Clinical Quality Assurance Advisors' and 'each year the Managers Regional Health will ensure that all local administrative procedures related to this policy are working efficiently and effectively'. This does not appear to have been completed and there also appears to have been a lack of auditing or leadership in the processes, policies or compliance of all staff (both Health and Corrections staff). Auditing and effective leadership would have reflected the lack or limited knowledge and skills and lack or limited compliance with processes within Corrections Department or Health regulations at a much earlier stage and perhaps have prevented this process of events.

2. Any additional recommendations for service improvements at [the facility]

- One comment made by [Dr B] was 'people logging in to Medtech or writing under someone else's log-in code' was occurring at [the facility]. Clinical staff should only be inputting in Medtech under their own code only and not inputting into anybody else's. It is like someone writing under someone else's signature which is not legal practice. This practice needs to stop immediately and every clinical member of the health team must have their own Medtech log-in."

Appendix B: Independent advice to the Commissioner

The following expert advice was obtained from Dr David Maplesden:

“(i) [Ms A] brought in a small supply of her own labelled medication which evidently lasted from 15–22 October 2016 but she was without this medication from 22–25 October 2016 while awaiting receipt of her medical file. The nature and dosages of the medication she brought in with her suggested it would be clinically unwise and possibly harmful to suddenly stop them (particularly her opiates). While notes suggest some effort was made to obtain the medical file from [her home town], and delays in receiving the file appear to have been outside the control of [the facility], I am concerned that the request for prescribing information was not elevated (eg GP speaking directly to GP) to ensure there was continuity of care.

(ii) On 25 November 2016 [Dr B] prescribed [Ms A] ibuprofen (Brufen) without seeing her and without gaining her consent for this medication. It is difficult to determine from [Dr B’s] notes that day the precise indication for this prescribing. [Ms A] noted on 30 November and 4 December 2016 that she was unhappy taking medication that had been charted without her knowledge, and felt it had caused her side effects. The Medical Council of New Zealand state in their 2016 publication ‘Good Prescribing Practice’: *Ensure that the patient (or other lawful authority) is fully informed and consents to the proposed treatment and that he or she receives appropriate information, in a way they can understand, about the options available; including an assessment of the expected risks, adverse effects, benefits and costs of each option.* Compliance with this recommendation is not evident from the information provided.

(iii) I am somewhat concerned at the assessment undertaken on [Ms A] by [provider] on 14 December 2016. [Ms A] had a complex respiratory history including asthma and empyema requiring decortication. She was experiencing significant respiratory symptoms that likely represented a lower respiratory tract infection/bronchopneumonia. There was no record of respiratory rate or blood pressure (part of the CRB-65 community acquired pneumonia assessment tool), and no record of pulse or oxygen saturations. I believe that given the clinical scenario recorded by [the provider], and noting [Ms A’s] previous respiratory history, at the very least opinion should have been sought from the MO immediately following the assessment. I presume the Amoxil was administered under standing orders and this was the appropriate antibiotic treatment, but the main concern was whether the severity of [Ms A’s] condition warranted immediate hospital admission (eg CRB-65 score of 1 or 2, and/or O2 sats <92%) and I do not think the assessment was adequate in this regard.

I suggest this brief advice is provided to [the facility] for their further comment in the first instance and a decision is then made regarding further action required.”