The Order of St John Central Region Trust Board

Ngati Porou Hauora Charitable Trust

General Practitioner, Dr B

Registered Nurse, RN F

Registered Nurse, RN D

Registered Nurse, RN E

A Report by the

Health and Disability Commissioner

(Case 14HDC01598)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In 2014, in the early hours of the morning, Ms A (aged 18 years) was involved in a single-vehicle car accident with one other occupant. Two The Order of St John Central Region Trust Board ambulances and staff attended the scene. EMT[1] L transported Ms A without assistance, and the other patient was transported by FR[2] O. The ambulances stopped multiple times in transit. Station Manager ILS[3] K met up with the ambulances but did not assess Ms A. Both ambulances stopped in a rural township and met with a further ambulance that had been dispatched from another station. This ambulance took the other patient to a city hospital, and EMT L took Ms A to the rural township's hospital at approximately 4.45am.

2. Ms A was transferred from the ambulance into the hospital on a wheelchair. During the transfer she was unable to weight-bear, was expressing pain, and was reported to be drunk. EMT L stated that during handover she was told that Ms A would not be transferred to the city hospital because she was drunk. RN D performed baseline observations but not neurological observations. Dr B told HDC that she assessed Ms A and recorded that she was inebriated, had no obvious head injury, no tender spine, and was moving her arms and legs freely. Dr B's plan was to "observe and send home when alert". At approximately 6.45am Dr B returned to take a blood sample at the request of the Police. She then examined Ms A's left ear and observed that it was inflamed. At approximately 7.45–8.10am Dr B handed over Ms A to Dr C. Dr B stated that she told Dr C that he needed to assess Ms A, but Dr C said that he was not asked to assess her and was told that she could be sent home once alert. He left the hospital to attend another clinic. During the morning shift the glass on Ms A's back was not fully removed.

3. RN D stated that she attempted, but failed to provide, a handover to RN E at approximately 7.30am. At 8.30am RN E recorded that Ms A was "rousable to illicit pain". She did not conduct observations or commence cooling cares until approximately 1.30pm. Following concerns raised by Ms A's whānau at approximately 1pm, RN E contacted Dr B and Dr C, and requested that they review Ms A. Both doctors returned to the rural hospital and, after assessing Ms A, arranged for an immediate transfer to the city hospital. Blood tests showed no blood alcohol content. Upon arrival at the city hospital, Ms A received a head CT, which showed multiple brain injuries. Ms A was transported to the intensive care unit at a large main centre hospital. Despite surgery and intensive care therapies, Ms A died in the ICU.

Findings

4. The Order of St John Central Region Trust Board breached Right 4(1) by not providing services to Ms A with reasonable care and skill. In particular, it was noted that staff failed to recognise the seriousness of Ms A's condition, failed to have someone in the back of the ambulance to provide reassurance during transportation, the staff manager failed to undertake further assessment of Ms A during transit, Ms A was inappropriately transferred from the ambulance to the rural hospital, paramedic staff failed to provide an adequate handover or a patient report form to hospital staff, staff failed to complete the patient report

[1] Emergency Medical Technician paramedic.
[2] First Responder.
[3] Intermediate Life Support paramedic.

form to an adequate level, and staff failed to advocate on behalf of Ms A for a transfer to the city hospital.

5. Dr B breached Right 4(1) for failing to recognise that Ms A's neurological examination was significantly abnormal, and that her failure to improve over time suggested that alcohol could not be the explanation. Dr B also failed to follow Ngati Porou Hauora Charitable Trust's Admissions policy appropriately. Adverse comment was made regarding the ambiguity in the medical handover between Dr C and Dr B. Dr B breached Right 4(2) for failing to record clearly that an additional clinical note she made was retrospective.

6. Adverse comment was made in respect of Dr C regarding the ambiguity in the medical handover between Dr B and himself, and also regarding his failure to discuss with nursing staff a discharge plan for Ms A.

7. RN D breached Right 4(1) for failing to include neurological observations, namely a GCS and pupillary response assessment, as part of her initial nursing review of Ms A, or assess Ms A's blood glucose level. She also did not conduct further observations, including neurological observations, over the course of her shift, or attend to Ms A's hygiene needs. Adverse comment was also made regarding RN D's failure to ensure that she had communicated salient information and any nursing information to RN E before completing her shift. RN D breached Right 4(2) for failing to clearly record that additional clinical notes she made were retrospective.

8. RN E breached Right 4(1) for failing to conduct nursing assessments and monitor Ms A's vital signs prior to 1.35pm, check her blood glucose level, or conduct an objective neurological assessment. Criticism was also made regarding the way RN E managed Ms A's hygiene, food, and hydration needs and the effectiveness of the cooling cares provided. Adverse comment was made regarding RN E's failure to ensure adequate communication with RN D, and in particular that she received a complete handover from RN D. RN E breached Right 4(2) for failing to clearly record that additional clinical notes she made were retrospective, and for removing original clinical notes from the file.

9. Adverse comment was made regarding RN F's failure to identify clearly that amendments in her clinical notes were made retrospectively, and her failure to raise concerns about another colleague's documentation.

10. Ngati Porou Hauora Charitable Trust breached Right 4(1) by not providing services to Ms A with reasonable care and skill. In particular, it was noted that both medical and nursing staff did not provide an appropriate standard of care. This included the failure of staff to provide Ms A with basic personal cares, including attending to her hygiene needs and ensuring that glass was removed from her back. It was also noted that there was a lack of clinical leadership; that there was poor communication between nursing and medical teams; that staff failed to comply with Ngati Porou Hauora Charitable Trust policies; and that staff failed to document accurately that some clinical notes were made retrospectively.

Recommendations

11. Since the time of these events, The Order of St John Central Region Trust Board has made a number of changes to its practice. It is recommended that The Order of St John Central

Region Trust Board provide HDC with a report confirming the implementation of the recommendations and actions following its internal investigation into these events, and any associated education provided to its paramedic staff in the region.

12. It is recommended that Ngati Porou Hauora Charitable Trust provide HDC with a report confirming the implementation of the recommendations and actions following its internal investigation into these events, undertake an audit of the rural hospital's clinical records and practice management system to ensure that patients have been appropriately assessed and transferred to the city hospital, and meet with all clinical staff to discuss the findings of this report and relevant organisational policies.

13. It is recommended that Dr B undertake an audit of her clinical records of all patients who have been involved in a motor vehicle accident, to demonstrate that she has assessed all patients appropriately. It is also recommended that Dr B arrange for further training with the Medical Council of New Zealand regarding record-keeping, and provide HDC with evidence of the training she has completed since the time of these events regarding triage and the assessment of patients who have been involved in a motor vehicle accident.

14. Since the time of these events, the Medical Council of New Zealand ordered that Dr B undergo a performance assessment. The Council resolved that Dr B met the required standard of competence, but considered that she would benefit from undertaking a 12-month recertification programme.

15. It is recommended that RN D arrange further training with the Nursing Council of New Zealand regarding communication with colleagues and clinical leadership, and attend an accredited emergency medicine triage course.

16. It is recommended that the Nursing Council of New Zealand consider whether a review of RN D's competence is warranted.

17. It is recommended that RN E arrange further training with the Nursing Council of New Zealand regarding clinical leadership, how and when to conduct neurological assessments, and when it is appropriate to assess trauma patients' vital signs and attend to hygiene, nutritional, and hydration needs.

18. It is recommended that the Nursing Council of New Zealand consider whether a review of RN E's competence is warranted.

19. It is recommended that RN F attend a course on communication and when to escalate concerns about the conduct of a colleague.

20. It is recommended that Ngati Porou Hauora Charitable Trust, The Order of St John Central Region Trust Board, Dr B, RN D, and RN E apologise to Ms A's family for their breaches of the Code.

Complaint and investigation

21. The Commissioner received a complaint from Ms A's whānau about the healthcare services provided to her following a motor vehicle accident. The following issues were identified for investigation:

- *Whether The Order of St John Central Region Trust Board provided an appropriate standard of care to Ms A in 2014.*
- *Whether Ngati Porou Hauora Charitable Trust provided an appropriate standard of care to Ms A in 2014.*
- *Whether Dr B provided an appropriate standard of care to Ms A in 2014.*
- *Whether RN F provided an appropriate standard of care to Ms A in 2014.*
- *Whether RN D provided an appropriate standard of care to Ms A in 2014.*
- *Whether RN E provided an appropriate standard of care to Ms A in 2014.*

22. The parties directly involved in the investigation were:

Ms A (dec)	Consumer
Complainants/whānau	
Ngati Porou Hauora Charitable Trust	Hospital/medical centre
Dr B	Rural general practitioner
Dr C	Rural general practitioner
RN D	Registered nurse
RN E	Registered nurse
RN F	Registered nurse
RN G	Registered nurse
EN H	Enrolled nurse
Ms I	Healthcare assistant
Ms J	Healthcare assistant

Chief Executive, Ngati Porou Hauora Charitable Trust
Rural hospital Services Manager, Ngati Porou Hauora Charitable Trust
The Order of St John Central Region Trust Board — Ambulance service provider
Clinical Safety and Risk Manager, St John
Head of Patient Safety and Quality, St John

ILS K	Paramedic
EMT L	Paramedic
EMT N	Paramedic
FR O	Advanced first aider/first responder
EMT P	Paramedic
ILS Q	Paramedic
ICP R	Territory Manager

23. Information was reviewed from:

Medical Council of New Zealand	
Coroner	
New Zealand Police	
Ms S	Volunteer Fire Service
Mr T	Volunteer Fire Service
Ms U	Member of the public
RN V	Member of the public
Mr W	Duty Centre Manager — Clinical Control Services Centre, St John

24. Information obtained from the above sources was used in writing this opinion, including from providers directly and the New Zealand Police (NZ Police).

25. Independent expert advice was obtained from a rural general practitioner, Dr Abi Rayner, in-house nursing expert RN Dawn Carey, and paramedic Geoff Procter.

Information gathered during investigation

Background

26. At the time of these events, Ms A was aged 18 years. This case involves the paramedic, medical, and nursing care provided to Ms A following a motor vehicle accident.

27. The Order of St John Central Region Trust Board (St John) provides ambulance and paramedic services to the area and is responsible for operating three stations. St John is responsible for the volunteer and employed paramedic staff who operated from those stations.

28. Ngati Porou Hauora Charitable Trust (NPHCT) is a healthcare provider that provides general practitioner, nursing, maternity, accident and emergency, mental health, and alcohol and drug addiction services, along with other services in the area. NPHCT provides these services through six regional clinics and the rural hospital. The rural hospital employs two rural general practitioners (GPs) and a number of nursing staff and healthcare assistants. The rural GPs also provide services to the regional clinics.

Ambulance services

29. At approximately 12.15am, a passing motorist discovered Ms A and the driver, who had been involved in a car accident. The motorist pulled the driver out of the car and then drove to a nearby house and asked the occupant, Ms U, if he could use her telephone to call 111. As Ms U did not have a landline or cell phone coverage, she advised the motorist to return to the crash site while she drove and notified police and volunteer fire service staff. After notifying the police and fire service staff, Ms U then drove to the crash site and found that another motorist, a registered nurse (RN), RN V, was on the scene assisting with the care of

Ms A (who was still in the vehicle) and the driver . A short time later, police and volunteer fire service staff arrived at the crash site.

30. At 1.34am, St John's Clinical Control Services Centre (CCSC) was notified of the accident by police. The Location 1 First Responder Unit (Location 1 Ambulance) was dispatched and was crewed by a first responder[4] (FR), FR O. At the time of these events, FR O had worked for St John in a volunteer capacity for a few years. She held a first aid (level three) pre-hospital emergency care qualification.

31. The Location 2 Ambulance 1 was also dispatched and was crewed by an emergency medical technician[5] (EMT), EMT L. EMT L was a paid employee who worked at the Location 2 station. At the time of these events, EMT L was employed as a full-time paramedic at the station and had approximately 20 years' experience with St John. A rescue helicopter was also dispatched with the St John Territory Manager, ICP R (an intensive care paramedic[6] (ICP)) on board. Shortly afterwards, rescue helicopters from two other regions were also dispatched.

32. The Location 1 Ambulance was the first ambulance to arrive at the scene at 2.08am, with Location 2 Ambulance 1 arriving soon after at 2.15am. FR O told HDC:

> "On arrival after parking [the Location 1 Ambulance], [a police officer] spoke to me through [the] driver's window with [an] update of the scene. I grabbed gloves and [a] bag prior to going to see [the] casualties. After tending to [the] [driver] I went to [the] vehicle which was laying passenger side to the ground. I could hear [Ms A] moaning and groaning as I neared the vehicle. I did a secondary survey[7] on her as best I could reaching down as far as her lower back for abnormalities.
>
> I attempted to put [a] stiff neck collar on [Ms A] with the aid of a Fire personnel but this was impossible due to an obstruction we came up against. The firee[8] continued to hold [Ms A's] neck/head whilst the roof of the vehicle was removed. Once this was completed we used [a] spine board from [the Location 1 Ambulance] to remove her from the car all the time her neck/head was being supported by the firee until a collar was put on her neck in [Location 2 Ambulance 1] by ambulance officer [EMT L]."

[4] First responders have undergone a comprehensive first aid course but do not have an authority to practise, and so cannot administer prescription medicines.
[5] Emergency medical technicians have successfully completed the National Diploma in Ambulance. This course takes 6–12 months to complete, and includes core skills, as well as the theory and application of key concepts relating to both medical and traumatic events. Emergency medical technicians have an authority to practise.
[6] Intensive care paramedics are specialists in critical care and clinical judgement, with a proven ability to manage complex patients. They are capable of delivering a wide range of medicines, advanced airway management, and a number of invasive procedures. A minimum of a Bachelor degree is required to achieve this level of skill.
[7] The secondary survey occurs following the primary survey. Although designed predominately for patients suffering from trauma, a secondary survey is required in all patients. The following are assessed: central nervous system, head and face, neck, chest, abdomen and pelvis, extremities, back, and further recordings (ie, a recheck of the patient's vital signs) — *St John Clinical procedures and guidelines 2013–2015.*
[8] Volunteer Fire Service officer.

33. EMT L told HDC that when she arrived at the scene she received a handover from FR O and RN V. EMT L noted that there was "a strong smell of alcohol" from both Ms A and the driver. EMT L further stated:

> "[I] had to wait [until the] roof was cut off before we could get closer to [Ms A]. Prior to that [FR O] and a fire fighter tried to put a collar on her. They couldn't get a collar on her because of the position she was in. When [the] roof [was] off [a] fire fighter went in to hold her head [until] we could get her on [a] spine board and move her. Got her into my ambulance [Location 2 Ambulance 1] and put the collar on her again but she kept pulling it off. Did first[9] and secondary survey on [Ms A] as best as I could as [she] was thrashing around. Also mumbling a lot."

34. Ms S, a Fire Service volunteer, stated that before the car was dismantled by Fire Service staff, Ms A was conscious and talking, "saying that she was sore" and rubbing her stomach. Ms S rubbed Ms A's hand and reassured her and let "her know what [they] were going to do to get her out". Ms S stated that she does not recall seeing a neck brace when she first sat down with Ms A, and does not recall holding Ms A's head "at any stage".

35. RN V stated that just prior to Ms A being removed from the vehicle, he "put a neck brace collar on her and noted that she was lifted onto a backboard stretcher".

36. At 2.43am, EMT L reported to CCSC that Ms A had been triaged as status three,[10] and the other patient as status one.[11]

37. At 2.47am, ICP R told EMT L from the Rescue Helicopter:

> "You are just probably going to need to load [the] patients and start heading towards [the city hospital]. We are possibly not going to be able to make it. I will start trying to send some support up to you by road, but at this stage we are in serious doubt of making it up there."

[9] The primary survey (referred to in the quoted text above as the "first survey") is a rapid assessment of immediate threats to life. The following are assessed: Airway, Breathing, Circulation, Disability (which includes assessing the level of consciousness) and exposure, examination, and environmental control (ie, appropriately expose and examine the patient and keep the patient warm) — *St John Clinical procedures and guidelines 2013–2015.*

[10] Status three patients have been assessed as not having a condition that is likely to be a threat to life (eg, mild respiratory distress, cardiac chest pain relieved by nitrates and oxygen alone, isolated femur fracture). Status two patients have a potential threat to life (eg, moderate respiratory distress, shock responsive to fluid loading, post cardiac arrest but awake, cardiac chest pain unrelieved by nitrates and oxygen alone, an abnormal Glasgow Coma Scale (GCS) score but greater than nine). The Glasgow Coma Scale is a common scoring system used to describe the level of consciousness in a person. The minimum score is 3, which indicates deep coma or a brain-dead state. The maximum is 15, which indicates a fully awake patient. The Patient Report Form for the transfer documented that [Ms A] was triaged as status two. Her vital signs were recorded as follows: respiration rate 22 breaths per minute, heart rate 106 beats per minute, blood pressure 150/100mmHg, Glasgow Coma Scale 5/15, oxygen saturation level 99%, and blood glucose 8.8mmol/L. Definitions of normal observation ranges are detailed below.

[11] Status one patients have an immediate threat to life (eg, an obstructed airway or airway needing intervention to prevent obstruction, severe respiratory distress, shock unresponsive to fluid loading, multisystem trauma with very abnormal vital signs, post cardiac arrest with coma, cardiogenic shock, and coma with a GCS less than or equal to nine).

38. EMT L asked ICP R whether she should "call in" to the rural hospital or head straight to the city hospital. ICP R responded: "At this stage the patients need to come to [the city hospital] so you need to carry straight through." EMT L responded: "Copy that."

39. Due to poor weather conditions, none of the dispatched rescue helicopters were able to reach the scene of the accident. Instead, at 2.49am another ambulance (Location 3 Ambulance) was dispatched from the Location 3 Station and was crewed by an intermediate life support paramedic[12] (ILS), ILS Q, and EMT P. At the time of these events, ILS Q and EMT P were both employed as full-time paramedic staff.

40. At 3.01am, Ms A was transported by EMT L in the Location 2 Ambulance 1, and at 3.02am the other patient was transported by FR O in the Location 1 Ambulance. EMT L told HDC that because each ambulance had only one St John member, Ms U (the member of the public who notified the Police and the Fire Service) was asked to go with FR O "to keep an eye" on the other patient. EMT L also stated that she buckled Ms A onto the ambulance stretcher because "she was thrashing and yelling". RN V and Fire Service and Police personnel remained at the scene.

41. At 3.15am, the CCSC contacted EMT L and requested that she "call in via [the rural hospital] on [her] way to [the city hospital] please". EMT L responded: "Copy that, copy that."

42. At 3.20am, the off-duty Location 2 station Manager, ILS K, was asked to attend. He crewed the Location 2 Ambulance 2 and went to meet EMT L and FR O en route. At the time of these events, ILS K had been an ILS paramedic for 10 years, and with St John for many years.

43. At 3.26am, ICP R and CCSC Duty Manager Mr W contacted ILS K, who was en route to meet the ambulances. ICP R told ILS K: "I would really like to avoid stopping at [the rural hospital], it just delays [the patients] coming here and ED want them here." ILS K responded: "I won't stop at [the rural hospital] anyway I will just go straight past." They agreed that ILS K would contact ICP R if he required ICP support.

First stop after leaving the scene

44. EMT L and FR O made a stop. EMT L conducted an assessment on both Ms A[13] and the other patient. While she was assessing the other patient, she asked FR O to sit with Ms A. FR O told HDC that during this stop Ms A was "moaning and groaning". FR O stated: "I told her [who it was] and she managed to say to me 'I'm sorry […] for being like this' but not in a clear voice."[14] FR O said that Ms A "had no neck brace on at this time but it was near her [and] she was also trying to sit up and get off the stretcher".

[12] Intermediate life support paramedics are able to deliver some medicines specific to patients who require pain relief, are in shock, or who are fitting continuously. Officers at this level have either completed an internal education package, or have completed a Bachelor of Health Science in Paramedicine.
[13] At 3.10am the Patient Report Form (PRF) records a second set of observations for [Ms A] as follows — respiration rate 22 breaths per minute, pulse 102 beats per minute, blood pressure 154/96mmHg, GSC 5/15, oxygen saturations 98%.
[14] EMT L stated that Ms A recognised FR O.

45. Volunteer fire officer Mr T was the officer in charge of the fire staff who attended the accident scene. After leaving the scene, Mr T noticed the parked ambulances and stopped to see if they needed assistance. He observed that EMT L was assessing the other patient, but he could not see Ms A. Mr T stated: "I didn't speak, I pulled up, I did a few hand signals to check all okay, they gave the 'thumbs up', I turned around and went back to our station." EMT L did not request assistance from volunteer fire staff when transporting Ms A.

Second stop after leaving the scene

46. EMT L and FR O met up with ILS K. At 3.42am, FR O contacted CCSC and stated that ILS K had boarded the Location 1 Ambulance that was transporting the other patient, and that they would "continue to meet up with the [Location 3] [Ambulance]".

47. With respect to this stop, EMT L stated:

> "I did a handover[15] to [ILS K] and let him know what was with the patients. As the [other patient] was status 1 and [Ms A] was status 2,[16] [ILS K] jumped on to [the Location 1 Ambulance] with the [other patient] and he travelled with [FR O]. [Ms U] drove the [Location 2 Ambulance 2] that [ILS K] drove up to meet us on. She then drove it to [the turn off]."

48. At 3.48am, CCSC asked FR O if ILS K required ICP R to assist them. At 3.49am, FR O responded: "[ILS K] says he should be able to handle it and he will get in contact should we need [ICP R] to come."

Third stop after leaving the scene

49. Ms U parked the Location 2 Ambulance 2 and got into the front passenger seat of the Location 2 Ambulance 1, in which EMT L was transporting Ms A. Ms U commented:

> "[Ms A] was in the back [of the ambulance] lying down on her back. She did not have a neck brace on and she wasn't strapped to the bed like [the other patient] was … She was flailing her arms about and quietly moaning. I couldn't make out what she was saying. She was holding her hand up covering her eyes, as if to block out the light from inside the ambulance."

50. Ms U further stated that she was worried that Ms A might fall off the stretcher, and remembers EMT L stating: "No she will be fine."

51. EMT L then continued on to meet the Location 3 Ambulance. At 4.12am, EMT P (who was travelling in the Location 3 Ambulance) contacted CCSC to see where the other two ambulances were located, and was informed that they were near the rural hospital township.

[15] At 3.40am, the following observations were recorded on the PRF: respiration rate 22 breaths per minute, pulse 110 beats per minute, blood pressure 146/101mmHg, GCS 5/15, and oxygen saturation 98%. It is not clear whether these observations were communicated to ILS K.

[16] As per footnote 10, status two patients have a potential threat to life. EMT L recorded in the PRF that [Ms A] was a status two patient. However, as per contemporaneous radio recordings, EMT L informed the rural hospital staff that [Ms A] was a status three patient. There is no contemporaneous inter-cad or radio record of EMT L's discussion with ILS K.

Fourth stop after leaving the scene

52. Location 2 Ambulance 1 parked in the immediate vicinity of the Location 1 Ambulance and the Location 3 Ambulance near the entrance to the rural hospital.[17] The other patient was transferred from the Location 1 Ambulance to the Location 3 Ambulance for transportation to the city hospital. With respect to Ms A, EMT L stated:

> "Met up with [the] [Location 3] [Ambulance] in […]. [ILS K] did handover to them for [the other patient]. Officer in [Location 3 Ambulance] said he can only take [one patient] and that I would have to take the other [Ms A]. [Ms A] was agitated and still thrashing around so I decided to take her to [the rural hospital] to see if she could be stabilised for the trip to [the city hospital]."

53. EMT P (Location 3 Ambulance paramedic) commented with respect to the transfer of the other patient:

> "We were dispatched to collect a patient from [the rural hospital]. I cannot recall why but I understand there was [one status one patient] and [one status three patient — Ms A]. We transferred the [status one patient] to our vehicle and discussed not taking [Ms A who was status three] — [as] our [status one patient] needed [ILS Q's] full attention."

54. ILS Q told HDC that he cannot recall any conversations regarding the transfer of Ms A. The other patient was taken to the city hospital in the Location 3 Ambulance.

55. EMT L then drove into the the rural hospital complex, and at 4.35am radioed (which was recorded): "Good morning [the rural hospital] coming to you with a 20ish year old female involved in a single [motor vehicle accident] … [The] patient is status three, vitals are normal range,[18] on your back door now, over."[19] FR O stated that after she and ILS K had finished transferring the other patient to the Location 3 Ambulance, they both went to the rural hospital.

Transfer from Ambulance to the rural hospital

56. RN D stated that the hospital staff who met the Location 2 Ambulance 1 were rural GP Dr B, Healthcare Assistant (HCA) Ms J, and herself. At the time of these events, RN D had been a registered nurse for approximately 15 years and was working in the general ward at the rural hospital.[20] Dr B provided rural GP services to patients at the rural hospital and the regional clinics operated by NPHCT, and had been working in rural medicine for approximately five years.

57. With respect to the transfer, RN D told HDC:

[17] EMT L stated that the ambulances met near the entrance to the rural hospital.
[18] At 4.10am, the following observations were recorded on the PRF: respiration rate 20 breaths per minute, pulse 108 beats per minute, blood pressure 150/90mmHg, GCS 5/15 and oxygen saturation 97%.
[19] Dr B stated that EMT L met the rural hospital staff in the ambulance bay of the hospital.
[20] RN D told HDC that the general ward consists of long-term care, medical, maternity, and accident and emergency patients.

> "[Ms A was] brought into hospital by wheelchair not stretcher. When [Ms A] was transferred from the ambulance stretcher to the wheelchair she was dragged off the stretcher by [EMT L]. [FR O] then helped [EMT L] to put [Ms A] onto the wheelchair. While this was happening [Ms A] swore once or twice and was yelling, screaming and kicking at the ambulance staff."

58. In her nursing notes, RN D recorded that Ms A was "very restless", getting out of the ambulance, was not weight-bearing, and her arms and legs were "swinging around". RN D also documented that Ms A had been incontinent of urine in the ambulance, and that she "appeared to keep rubbing her [left] ear".

59. With respect to the manner of transfer from the ambulance, Dr B told HDC:

> "[EMT L] went to move [Ms A] off the stretcher and at that moment [Ms A] put her feet onto one ambulance stretcher and head and shoulder onto the other stretcher resisting movement as she lay across the ambulance. She was pulled up by ambulance staff to stand and she kicked ambulance staff. She was shouting and swearing at ambulance staff."

60. Ms U stated:

> "[EMT L] picked [Ms A] up from the front of her clothing and hauled her up. [Ms A] was going 'ow, ow, ow' and I could see from her face that she was in a lot of pain. I said to [EMT L] 'why don't you just take her in on the gurney[21]?'. [EMT L] replied 'it's alright, she can go in the wheelchair'. [Ms A] couldn't stand and slumped to the floor of the ambulance, down on her knees as she leant back on the gurney, [EMT L] was trying to hold her up. [FR O] came in and helped pick her up from behind and put her into a wheel chair that the nurses had brought up."

61. FR O told HDC that upon arrival at the rural hospital, she noticed:

> "[Ms A] was still in the [ambulance]. She had her feet on one stretcher with the rest of her body elevated off the ground between the two stretchers and the ambulance. I said to myself 'oh what happened?' My intention was to try and get her onto the stretcher. Someone said: 'bring a wheelchair here'. [EMT L] said to [ILS K] to put the ramp down on the back of the ambulance. Between her and I we put [Ms A] onto a wheelchair on the ambulance ramp."

62. FR O further stated that Ms A "was relaxed to the point like a rag doll" and she did not yell or kick at St John staff.

63. With respect to the transfer, EMT L stated:

> "Above the stretcher in the back of the ambulance is a bar and [Ms A] had pulled herself up with this bar. She was still buckled in around her waist and was now sitting in an awkward position. Because of the way she was positioned we couldn't get her onto a stretcher. We decided to use a wheel chair to get her into the hospital and so [RN

[21] Wheeled stretcher used for transporting patients.

> D] brought a wheel chair to the back of my [ambulance]. In the back of the ambulance then were me and [Ms U].
>
> Although [Ms A] felt heavy it was like she was dead weight but she was still ok to stand [long] enough for us to turn her around and position her for when [RN D] came in with the wheel chair. We sat [Ms A] into the wheelchair and wheeled her into the hospital."

64. EMT L further explained that during the transfer she unbuckled Ms A from the bed before transferring her into the wheelchair. During the transfer, EMT L noted that Ms A was shouting "but not making any words. [She] was not swearing or kicking anyone purposely, was just thrashing around when we transferred her from the ambulance to the wheelchair."

65. RN D told HDC that once Ms A had been put into the wheelchair she was taken into the hospital. RN D stated:

> "[Dr B] instructed that [Ms A] be moved into the old A&E room in order to avoid her waking the other patients who were in the next room to A&E … I can't remember how many patients were in the hospital that night but we had a number who were asleep near by. [Ms A] was transferred from the wheelchair onto the bed by me and one of the ambulance staff. Before we moved her onto the bed we removed her jacket which had glass on it. During the transfer onto the bed she was moving her arms around and crying. [Dr B] instructed that the side rails on the bed be put up and the head of the bed [be] elevated because of her agitation and in order to prevent her from falling."

66. RN D documented in her nursing notes[22] that during the transfer from the wheelchair to the bed, Ms A was not weight-bearing, and her words "appeared to be [too] jumbled to [be] understandable". Ms U stated that following Ms A's transfer onto the hospital bed, "there was heaps of windscreen glass all over the place which fell off her". Ms U said:

> "[Ms A was] in a dazed state and quite still. [FR O] had been and was still trying to talk to [Ms A] and comfort her. [She] could just mumble only, there were no clear words. I couldn't smell any alcohol around [Ms A] at any time."

67. In response to the provisional opinion, RN D also stated that the decision to put Ms A into the old ED room had a significant impact on the care she received, and reinforced "the view that she was a noisy drunk" and that the main concern was to keep her from disturbing other sleeping patients.

Paramedic handover to rural hospital staff

68. EMT L stated that she handed Ms A's care to both RN D and Dr B. EMT L explained that she started to give handover in the ambulance and finished her handover in the hospital treatment room. With respect to what she communicated during the handover, EMT L told HDC:

[22] As discussed in more detail below, RN D's clinical entry was made retrospectively but not marked as such.

> "[I] told [Dr B] [that Ms A was] trapped in vehicle for about 15–20 mins [and] was conscious at all times. [I] had to wait for [the] fire [service] to cut [the car] roof off. [Ms A] was [the] front passenger. [I] told [Dr B] where [Ms A] was in the car. Car on its [left] side."

69. EMT L stated that during her handover Dr B informed her that there was no way Ms A was going to the city hospital "because [the city hospital] would get angry if they sent a drunk girl there". EMT L said that Dr B then spoke to Ms U about Ms A as if she thought Ms U was her mother.

70. Ms U commented:

> "Once [Ms A was] on the bed, [Dr B] walked in. She didn't ask anybody anything. Before checking [Ms A], [Dr B] started mouthing off, she was growling, she said 'we're not here to babysit drunks!' She kept going on and on like that — she said 'she can stay here the night and sleep it off'. She turned to me and said 'you can jolly come back in the morning and take her home!'. She didn't ask who I was or anything. [FR O] said to [Dr B] 'excuse me, this is not her mother'. [Dr B] said 'yes well, like I said we are not here to baby sit drunks, get someone to call her family to come and pick her up'. I did not say anything to [Dr B] as I was too gob-smacked in the way she was reacting to the situation."

71. FR O told HDC that she heard EMT L say, "We need to get a patient transfer," and that she remembers Dr B telling EMT L: "No we're not sending [Ms A] to [the city hospital]. She can sleep it off here [and] her family can come and pick her up in the morning."

72. With respect to the handover, RN D stated:

> "On arrival we were told by the ambulance that [Ms A] (the patient) was involved in a [motor vehicle accident] and that she had abrasions on both her legs, she was drunk and had been incontinent of urine. No factual information, verbal or written, such as neuro[logical] observations, details of the accident scene or level of trauma, was handed over. The Ambulance staff were [EMT L], [FR O], [Ms U] (a member of the public) and later [ILS K], as he had been attending to the [other] patient who had been involved in the accident, and who was being transferred by the [Location 3] ambulance. I asked the ambulance officers why [Ms A] did not have a collar in situ and why wasn't she going to be brought into A&E by stretcher? The reply was she was drunk and didn't need them."

73. RN D further stated that the paramedic staff emphasised to her that Ms A was drunk, and her presentation was consistent with someone who was very intoxicated. In particular, RN D told HDC that Ms A was uncoordinated, aggressive, uncooperative and her speech was incoherent and consistent with someone who was heavily intoxicated. In response to the provisional opinion, RN D also stated that ambulance staff told her that Ms A was a status 3 patient with normal vital observations. RN D said that no injury concerns or suggestion of a head injury were reported.

74. In response to the provisional opinion, RN D also told HDC that she remembers Dr B telling paramedic staff that Ms A was not to be sent to the city hospital, and that "she could sleep it off here at the rural hospital". RN D also recalls Dr B speaking to Ms U in a way that "sounded as if she was telling her off and saying she had to get the family up here right away to collect her. At the time I thought it was uncalled for."

75. Ms J stated that EMT L gave a "very brief handover", and her attitude "was not open for [Dr B]".

76. Dr B told HDC that she spoke with ILS K in the ambulance bay, and that he described the accident as involving a car that had slid off the road and rolled onto its side. She further commented:

> "The history was one of low impact, in that there was no history provided of collision with any other vehicle or other obstacles along the road. There was no report from ambulance staff about another person being in the accident or that this person had been transported to [the city hospital] …
>
> I asked about [Ms A's] injuries and [ILS K] replied that [she] had some superficial cuts and an abrasion to the knee, and no other injuries. He commented that she was inebriated. She did not have a cervical collar on at arrival, and no information was given to suggest that there had been an attempt to apply a cervical collar at the scene or on the way to the hospital. The ambulance said she was fine and had no injury concerns. There was no mention of a suspected head injury."

77. ILS K was asked to comment on his recollections of the handover to the rural hospital, including what was discussed regarding the nature of the road incident and Ms A's condition. He replied that he did not have any part in the treatment of Ms A, as he was caring for the other patient and did not witness Ms A's transfer from the ambulance to the wheelchair. In response to the provisional opinion, RN D stated that ILS K came later to the rural hospital and was there only briefly. She did not hear anything he said to Dr B.

PRF and paramedic departure

78. EMT L stated that once she had finished her handover she completed a Patient Report Form (PRF) and left it in the nurses station at the rural hospital, near the computers. However, Dr B and RN D stated that no PRF was handed over by ambulance staff, and that the only information provided was by way of verbal report only. St John told HDC that no PRF was completed at the conclusion of the handover, "despite a statement that this had been done", and noted that the PRF was located at the St John Location 2 station approximately 10 days following the incident.

79. The PRF provided to HDC by St John was recorded as being completed by EMT L, and stated that Ms A was a status two patient. Her chief complaint was recorded as an "[a]brasion to [the left] knee". Under the patient history heading, EMT L recorded:

> "Single [motor vehicle accident]. [Location 2 Ambulance 1] on scene. Also [Location 1 Ambulance]. Unsure if [Ms A] was driver or passenger. Vehicle on its side. [Ms A] still trapped but conscious. Can't get into vehicle to assist [her]. [Ms A] yelling and

> thrashing about. [Ms A] free from vehicle. [Cervical] collar put on but [Ms A] keeps pulling it off. Did primary and secondary survey, only injury is abrasion to [left] knee. [Ms A] mumbling [and] not making sense. Pupils reactive, [Blood pressure] ↑, Pulse ↑. Helicopter was flying but had to turn back [be]cause of bad weather. Transported [Ms A] still thrashing about. Also smelt [alcohol]."

80. The PRF recorded that Ms A's GCS[23] score was 5/15 at 2.40am, 3.10am, 3.40am, and 4.10am. St John's Clinical Safety and Risk Manager told HDC that upon reviewing the description of Ms A's condition in the PRF and statements given by paramedic staff to the police, he believed that "status 2 was correctly assigned", but that "if [Ms A's] [GCS] had really been five she should have been classified as a status one". He further commented that he believed Ms A's GCS was incorrectly recorded, and should have been 11/15. He further explained that a patient who was "mumbling, yelling and thrashing" would have had a GCS of approximately 11.

Rural hospital — 4.45–7.30am

Triage form — version one

81. HDC was supplied with two versions of the rural hospital's "Accident and Emergency Assessment" (triage form) in relation to Ms A. On the first version, RN D noted that Ms A arrived at the hospital at 4.45am via an ambulance. RN D recorded that she was the triage nurse and Dr B was the attending doctor. Under the heading "Patient's Chief Complaint", she stated:

> "[Ms A was] [i]nvolved in a [motor vehicle accident.] Abrasions on both legs, [left] side of face, [right] hand. ~~[Patient] agitated at times rubbing [right] ear~~. [RN D's signature] Error [please] see notes on paper attached."

82. RN D also documented on the triage form the following baseline observations for Ms A:

> "Pulse: 104 beats per minute (bpm),[24] B[lood] P[ressure] 127/73mmHg,[25] R[espiratory] R[ate] 26 breaths per minute,[26] Temp[erature] 39.3[°C].[27] [Oxygen saturation level] 100%[28] [room air]."

Triage form — version two

83. On the second version of the triage form, RN D again recorded that Ms A arrived at 4.45am via an ambulance and that RN D was the triage nurse and Dr B was the attending doctor. The same baseline observations stated in the first version of the form were recorded. Under "Patient's Chief Complaint", RN D recorded:

> "[Ms A was] [i]nvolved in a [motor vehicle accident]. Abrasions on both legs, [left] side of the face, [right] hand. [Please] see attached notes."

[23] See footnote 10.
[24] Normal resting heart rate is between 70 and 100 bpm.
[25] Normal blood pressure is approximately 120/80mmHg.
[26] Normal respiratory rate in adults is approximately 16–20 breaths per minute.
[27] Normal body temperature is between 36.6°C and 37°C when measured orally.
[28] Normal oxygen saturation in an otherwise healthy individual at sea level is over 95%.

84. In different handwriting, directly beneath RN D's entry, it is documented: "[Left] side of head behind [Ms A's] ear — bruised linear. Neck pain." Observations were taken at 2.35pm, 3pm, 3.30pm, and 3.50pm, and the medications administered to Ms A were also recorded in the same handwriting (more detail below).[29]

85. With respect to why there are two triage forms, a deleted entry, and two authors of the second version of the triage form, RN D told HDC:

> "When I wrote my notes on the triage form I wrote brief notes and I wanted to write more. So when I came back in for my [night shift 16 hours later], I added to the form but found that I didn't have enough room because the A&E form had been photocopied and the transfer nurse [RN G], who was taking [Ms A] to the city hospital, had written notes on it. I therefore wrote on some clinical paper and added those notes to my assessment. I crossed out some information that I had previously written on the triage form and added that on the [progress notes] and put 'written in error' so that I could write more information [in the progress notes].[30]"

86. In response to the provisional opinion, RN D added that she thought that it was important to expand on her notes of her presentation between 4.45am–7.00am when she heard that Ms A had not been discharged, had deteriorated, and had a suspected head injury. RN D said that she added "patient agitated at times rubbing her ear" and then thought that she should write more, so crossed it out and added more information on the clinical note paper.

87. RN D did not record that her clinical notes were made retrospectively. Subsequent references in this report to what RN D recorded or documented are taken from the retrospective notes she made following these events.

88. RN D told HDC that during her triage she could not smell any alcohol on Ms A.

Dr B's initial assessment of Ms A

89. An audit of the electronic record provided by the rural hospital shows that Dr B first recorded her initial assessment at 4.55am and added to that record at 6.54am. In particular, Dr B contemporaneously documented her triage review of Ms A as follows:

> "[Motor vehicle accident] — inebriated
> Scratches both thighs abrasions [Left] knee
> Contusion[31] [left] shin

[29] As discussed below, RN F told HDC that she entered vital sign observations onto the "Accident and Emergency Assessment" form at the time they were completed. She stated that her observations were completed at 3pm. RN F said that she handed Ms A over to RN G at 3.30pm, and that RN G recorded her observations on the "Accident and Emergency Assessment" form.

[30] RN D documented in the additional progress notes that [Ms A] had been involved in a motor vehicle accident and brought in by ambulance. RN D noted that [Ms A] had abrasions to both legs, the left side of her face, and her right hand. RN D recorded that [Ms A] was very restless getting out of the ambulance, was not weight bearing, and was swinging her arms about upon being transferred into a wheelchair. RN D stated that [Ms A] was crying, her speech was not understandable, she had been incontinent of urine, and was rubbing her left ear, and that the ambulance officers helped to transfer her onto a bed. The observations recorded on the triage form were repeated in the progress notes, and RN D noted that she checked [Ms A] regularly.

[31] Bruise.

No obvious head (sic)
Responding
No obvious head injury
PERLA[32]
No tender spine
No pelvic injury
Moving legs [and] arms freely

Will observe and send home when alert"

90. Several days later, Dr B added the following to the first line of the consultation note: "[S]een 4.0[0]am [GCS] 14/15." No record was made of the entry having been retrospective. When asked to comment on this amendment, Dr B told HDC that she realised that Ms A's GCS of 14/15 "was omitted from [her notes] and as such [she] inserted [it] in [retrospectively]". An audit of the electronic record provided by the rural hospital showed that Dr B made this entry retrospectively.

91. With respect to her initial review of Ms A, Dr B told HDC:

"Following [Ms A's] arrival at 4.45am and the discussion with ambulance staff, I spent an hour with [Ms A] from 5.00am–6.00am (although my notes say 4.00am it was in fact 5.00am). My examination was influenced by the advice from ambulance staff of a minor accident, minor injuries, and my initial observation of [Ms A] appearing to move quite freely. My examination was carried out in the room where [Ms A] was placed so she could be seen alone; she was shouting loudly and so we placed her away from elderly sleeping patients.

My initial survey on examination noted that she had multiple small superficial lacerations on her anterior thighs.[33] She had three abrasions to her left knee and a contusion on her left shin which was showing as a bruise. [RN D] and I removed the glass which was covering her body. I observed I did not smell alcohol.

[Ms A] had no obvious head injury by way of bleeding, cuts or bruising. There was a tiny cut above her right brow. There were no bruises or abrasions found on her face or head. When I put a torch light on her pupils they reacted and reduced in size equally. She could focus on my finger moving towards her nose. [GCS] was 14; [Ms A] was giving single word responses and appeared to know she was at [the rural hospital]. She did not express confusion when I was with her. She could follow and touch my hand when I moved it in different positions. Her eyes followed me around the room.

She did not express any pain when I examined her. I pressed on the vertebrae on her neck and down her spine and she did not have any pain and did have good touch sensation. Her pelvis showed no pain and she could move her legs with full range of movement. On spinal examination there was no cervical,[34] thoracic[35] or lumbar[36]

[32] "PERLA" means "pupils are equal and reactive to light and accommodation".
[33] The front of her thighs.
[34] The cervical spine relates to the vertebrae in the neck.
[35] The thoracic spine relates to the vertebrae in the upper back.

tenderness, and there was no evidence of a pelvic injury. She was breathing normally and her breath sounds were clear. There was no bruising on her chest although later the bruise from her seat belt showed on her left shoulder.

Chest had equal expansion on both sides with good air entry and no bruising. Her abdomen showed no sign of bruising and no tenderness. She had normal strength and power in her legs and arms. She was moving a lot on the bed, moving her legs and arms freely. Her [blood pressure] was 127/73 [mmHg], pulse 104 [bpm], [oxygen saturation levels] 100%. [Ms A's] temperature was not taken as she was pushing [RN D] off and prevented [RN D] from taking her temperature. [RN D] reported this to me while I was doing my assessment she was in the room when I was checking for injuries. I pointed out [Ms A's] injuries listed them and I asked her if she had noticed any other injuries when she was taking initial observations. I was not immediately concerned as on examination her skin had felt cool to touch and she appeared afebrile.

Following my examination, I discussed with [RN D] and caregiver [Ms J] about [Ms A's] arrival and history up to that point of time and asked that she be kept under observation. By this I expected that observations would be repeated and any change reported. When I wrote that [Ms A] could be discharged when alert, by alert I meant if she was up and walking, and then the nurse would call the doctor to assess for permission to go home, as is routine."

92. With respect to Dr B's review, RN D recorded in the nursing progress notes: "[Seen by] Dr B [Ms A] to be observed and sent home when alert." RN D further explained:

> "Once [Ms A] was transferred to a bed I asked [Dr B] about doing observations and she said just do base line observations not to worry about [neurological] observations. I reported to [Dr B] that the baseline observations were [blood pressure] 127/73 [mmHg], heart rate 104 [bpm], respiratory rate 26 [breaths per minute], temperature 39.5 [°C][37] and oxygen saturations 100% air. [Dr B] said that [Ms A] was drunk and needed to sleep it off and that she would come back [to the hospital] and assess her later. Her discharge instructions were that when [Ms A] was alert and sobered up she could be sent home. She then left the hospital."

93. RN D stated that she did not see Dr B physically examine or assess Ms A. In response to the provisional opinion, RN D said that she disputes that Dr B "did any of the things" referred to in para 91, including an examination of Ms A's head, face, neck, spine, abdomen, legs, and arms. RN D also disputes that Dr B was present when she took Ms A's temperature, and said that Dr B did not ask her if she had noticed any other injuries. RN D also said that it was she and the ambulance officer who removed Ms A's jacket and shook off any remaining glass.

94. RN D's recollection is that once Ms A was placed on the bed, "[Dr B's] sole instruction was that [Ms A] was drunk, needed to sleep it off, and that she would come back and assess her later". RN D stated that Dr B made no mention of conducting any ongoing observations "at

[36] The lumbar spine refers to the vertebrae in the lower back.
[37] The triage forms state that Ms A's temperature was 39.3°C.

all". RN D stated that Dr B left the hospital and went home around 5am and did not return until approximately 6.30am when a police officer arrived (more details below) and RN D telephoned her.

95. Dr B told HDC that she made no comment about Ms A "sleeping off alcohol" or "words to that effect".

Dr B's second assessment of Ms A

96. RN D recorded that at 6.45am a police officer had arrived at the hospital to collect a blood sample from Ms A. Dr B was contacted and came to the hospital to take a blood sample. RN D documented that as Dr B was taking bloods, Ms A "responded by pulling her arm away and crying [she] appeared to be touching her [left] ear and crying. Still not talking just crying and moaning."

97. Dr B stated that Ms A looked at the police officer and consented to the blood test, and looked at her while she took the blood sample. Dr B recollected that Ms A's skin "was cool and she was moving her arms and legs around".

98. Dr B said that she asked the police officer about the accident, and he replied that Ms A had smelt heavily of alcohol, and that she was in the passenger seat with her seatbelt on when found. Dr B said that she asked the police officer about the driver but he did not have any information.

99. RN D initially told HDC that after the blood test had been taken, she "voiced" her concerns that Ms A had been waking up crying and holding the left side of her head by her ear. RN D stated: "I was concerned about this because I thought that she may have more going on, for example a head injury." RN D stated that Dr B "didn't really respond" to her concerns, and said that she would assess Ms A later. RN D stated that she never observed Dr B doing a physical examination of Ms A, and believes that one did not occur.

100. RN D later told HDC that she raised her concern about Ms A putting her hand up to her left ear to Dr B so that she could be reviewed medically. RN D said that she considered that Ms A was intoxicated to a significant level, and she believes that she would have done neurological observations and advised Dr B if she had suspected a head injury at any time during her shift.

101. In response to the provisional opinion, RN D said that her explanations to HDC were not intended to be inconsistent. She stated that upon noticing Ms A touching the left side of her face/ear, she "was wondering if there was something more going on" and that is why she raised it with Dr B to get her medical review. RN D said that Dr B dismissed her concern, and she was not "brave enough" to continue to push the point. RN D further said that her shift was just finishing and she was unable to say anything in handover. RN D also stated that Ms A's presentation was consistent with other patients she had attended to who were heavily intoxicated and "this clouded the situation and [her] judgement".

102. Dr B told HDC that RN D reported that Ms A had been putting her hand up to her left ear but she was not informed of any rise in temperature or pain. As above, RN D stated that she did report Ms A's vitals, including that she had a raised temperature. Dr B also stated that

she would not have seen Ms A's elevated temperature, as she was working on her own clinical notes, and it was not recorded on the triage sheet. RN D states that she did record Ms A's temperature on the triage sheet, and that this was kept in the nurses station by the doctor's desk.

103. Dr B said that she examined Ms A's left tympanic membrane (eardrum), which "was inflamed but not markedly so". Dr B further noted that there was no injury to the left ear or surrounding area, and that the right eardrum was normal. There is no clinical record of this assessment having occurred during Dr B's morning shift.

104. RN D recorded that at 7am she checked Ms A, "who appeared to be sleeping but agitated, moaning and crying at times". RN D told HDC that during the time she was caring for Ms A she noticed that she was irritated and that she would rub the left side of her ear and cry every minute or two.

Rural hospital — 7.30am–3pm

Nursing handover — morning shift

105. The clinical notes indicate that at approximately 7.30am,[38] Team Leader RN E received a handover from Dr B and RN D regarding Ms A. At the time of these events, RN E was the Nurse Team Leader at the rural hospital, and had previous nursing experience in the acute medical ward at the city hospital. With respect to the handover she received, RN E recorded:

> "Post [motor vehicle accident] — nil head injuries, some superficial abrasions and inebriated. Drs instructions are to let [Ms A] sleep and once alert [she] may go home."

106. Dr B told HDC that she was not present at the nursing handover as recorded in RN E's notes, "and the information recorded there did not come from [her]". Dr B stated that she did see RN E in the corridor outside Ms A's room at approximately 7.40am, and "mentioned [Ms A] was under observation following a motor vehicle accident". Dr B told HDC that "this was not given as instructions to [RN E], as her instructions for ongoing care would come from the duty doctor for that day, who was [her] colleague [Dr C]".

107. RN D stated that she was in the nurses' office when Dr B gave a handover to RN E, and heard the instructions that were given. RN D remembers that Dr B stated that Ms A was to be allowed to sleep, that she did not have a head injury, and that when she was "awake and alert she could be sent home". RN D stated that she did not give a handover to RN E, as "every time [she] went to say something [she] got cut off from [Dr B]". RN D further stated that she felt she "couldn't say anything" and left because "it was obvious that [Dr B] wanted to hand the patient over and did not want me to participate".

108. RN E also told HDC: "[Dr B] overruled [RN D] who was unable to give me the information due to [Dr B's] interruptions."

[38] RN D told HDC that the shift handover was at 7am.

Handover to Dr C

109. At the time of these events, Dr C had been practising rural medicine at the rural hospital for approximately four years, and had worked exclusively in rural medicine throughout his training and practice as a general practitioner.

110. Dr B stated that at 7.45am she met with Dr C for a "face-to-face handover" of the patients at the rural hospital who would need an assessment from him during his ward round — "including [Ms A]". Dr B stated that she told Dr C that Ms A had been involved in a car accident as a passenger with a seat-belt on; that the other person in the car had been taken directly to the city hospital; and that she "had been told [Ms A] had a history of inebriation, and she appeared drowsy". Dr B said that she did not inform Dr C of Ms A's temperature as she did not know that a raised temperature had been observed. Dr B said that following this handover she left the hospital to attend another clinic.

111. Dr C told HDC that he arrived at the rural hospital at approximately 8am and Ms A's care was handed over between 8–8.10am. With respect to what was discussed during the handover he received from Dr B, Dr C stated:

> "I was advised by [Dr B] that [Ms A] was to remain under observation only and that she did not require admission. Accordingly, I was not asked to assess [Ms A] (as [Dr B] had already done so) … my understanding was that [Ms A] had been assessed as being inebriated and she reported no other concerns. [Dr B] confirmed her plan was for [Ms A] to be observed and, when alert, to be allowed home."

112. Dr C further stated that he considered that the only pertinent information communicated to him was that Ms A "was inebriated and required rest and would be able to go home". He stated that the magnitude of the motor vehicle accident Ms A was involved in was not communicated to him, nor were the other passenger's (ie, the driver's) significant injuries communicated to him. He further commented that where any passenger in a motor vehicle accident has been seriously injured all occupants need to be transferred to a medical facility capable of taking CT scans, blood analysis, and radiographs.

113. RN E told HDC that she remembers Dr B telling Dr C "that he did not have to worry about the patient ([Ms A]), as she was intoxicated and could go home when she woke up".

114. Dr C stated that after he had discussed the care of the long-term patients at the rural hospital with nursing staff he left for another clinic at approximately 8.30am.

Morning shift care

115. At 7.50am, RN E recorded that Ms A was sleeping and a call bell was "in situ". At 8.30am, RN E checked Ms A again and recorded that she was "rousable to illicit pain, still appears very drowsy". RN E told HDC that she did not think that she should have undertaken a GCS assessment at 8.30am, as "it would not be unreasonable" for someone who had been reported as intoxicated at around 4.35am to "still be sleeping during the morning".

116. At 9.30am, RN E checked Ms A and documented: "[S]till appears to be sleeping, though responds with eyes opening when I say her name. Nil obvious pain observed. Patient sleeping."

117. At 10.15am, RN E received a telephone call on behalf of Ms A's father, and recorded that she informed him that Ms A "would be going home once she was awake and sober". At 10.30am, it is recorded that Ms A's whānau arrived at the hospital, and RN E informed them that Ms A would be discharged when "she was alert enough to go home".

118. At 11.25am, Ms A's condition was recorded as being "unchanged".

119. RN E told HDC that she "anticipated that [Ms A] would wake by lunchtime as her intoxication abated and she became hungry". RN E stated that she did not rouse Ms A to facilitate a planned discharge, as Ms A was in a deep sleep and Dr B had instructed her to let Ms A sleep. RN E told HDC that she did not offer any food or drink to Ms A as she was "concerned that in her altered state of consciousness there was a real risk of aspiration".

120. RN E documented that at 12.15pm Ms A was crying and was told that she had been in an accident, and that once she had settled RN E left her to sleep. RN E told HDC that Ms A was "awake and responsive" at this time, and that she remembers saying to Ms A "that everything would be alright, to have a sleep and then she could go home".

121. RN E recorded at 1.15pm:

> "[Ms A's whānau] expressed concern that [Ms A is] not her usual self in terms of when she is intoxicated. She would usually be awake. [I] advised whānau that I would inform [Dr B] of their concerns."

122. RN E stated that Ms A's whānau told her that they had been informed via social media that "she had not been drinking at all" the previous night, and that "this information rang alarm bells". She said that she informed the whānau that she would contact Dr B and "would do a set of vitals".

123. RN E recorded that at 1.35pm she had contacted Dr B and Dr C about Ms A's condition and informed the whānau "that [Dr B] was on her way". RN E also recorded that she started cooling cares.[39] The following set of observations were also documented:

> "[Blood pressure] 132/79 [mmHg], [heart rate] 103 [bpm], [oxygen saturation level] 99% on air, [respiration rate] 16–18 [breaths per minute], [body temperature] 38.9 [°C] … [GCS] 9/15."

124. RN E told HDC that she did not consider it clinically necessary to take vital observations between 7.30am and 1.35pm as she had been informed by Dr B that Ms A had minor abrasions, no head injury, and was intoxicated. With respect to blood glucose monitoring for hypoglycaemia,[40] RN E stated that she did not do this during the morning as Ms A's presentation was not inconsistent with someone who was intoxicated.

125. RN E said that the cooling cares she conducted consisted of opening the windows in the room and placing a damp cloth on Ms A's forehead. RN E told HDC that she did not see urine on the bedclothes or floor, and did not smell urine in the room.

[39] Cooling cares are steps taken to reduce a patient's temperature.
[40] Deficiency of glucose in the bloodstream.

126. Ms A's friend told HDC that she arrived at the rural hospital at approximately 1.30pm. When she saw Ms A, she noticed that Ms A had no neck brace, no pain medication, and did not appear to be drunk. She said that she told hospital staff that Ms A needed a scan, but was told that "she was just highly intoxicated and needed to sleep it off".

127. RN E recorded that at 2pm Ms A was sleeping and that she informed the whānau that once Ms A had been assessed by a doctor she would "likely be sent to [the city hospital] for investigations".

Telephone calls to Dr B and Dr C

128. RN E told HDC that she telephoned Dr B (at 1.35pm per nursing notes) and voiced concerns about Ms A's vital signs,[41] and informed Dr B that Ms A was tachycardic,[42] febrile,[43] and had a GCS of 9/15, and that Ms A's whānau had stated that she had not been drinking the previous night.

129. Dr B stated that she received a call from RN E at approximately 2pm while she was at the clinic. Dr B said that RN E told her that "the family were concerned that [Ms A] was still drowsy". Dr B stated that she was not informed that Ms A had been assessed as having a GCS of 9/15. Dr B said that in light of the fact that she was 28km away and Dr C was 10km away from the rural hospital, she instructed RN E to take observations and contact Dr C. Dr B stated that as she was worried that Ms A was still drowsy, she decided to rearrange her appointments that day and, approximately 10 minutes later, left the clinic and travelled to the rural hospital. As she left she instructed the receptionist to contact the hospital to let staff know that she was on her way.

130. Dr C remembers being informed by staff at the clinic just after 2pm that ward staff at the rural hospital were trying to contact him. Dr C stated that as he was in the middle of a surgical procedure, he was unable to make immediate contact with RN E. Dr C said that when he contacted her he was informed that Dr B had been notified and was on her way back to the rural hospital. Dr C told RN E that he would also travel back to the hospital. He remembers being surprised that Ms A's condition "appeared to have deteriorated so dramatically in light of the discussion that had taken place at the handover meeting earlier that morning".

Nursing handover — afternoon shift

131. At 2.30pm, RN E recorded that she had handed over the care of Ms A to Dr B and RN F. At the time of these events, RN F had been working at the rural hospital for 10 months, and this was the first nursing position she had held in New Zealand, although she had had previous nursing experience overseas (approximately six years).

132. RN E told HDC that she was part way through handing over Ms A to RN F when Dr B came in and "took control of the situation". RN F told HDC that during this handover RN E advised that Ms A had been involved in a motor vehicle accident, was intoxicated, and had minor lacerations. RN F stated that RN E told her that "the doctor's orders" had been that

[41] The vital signs RN E refers to are stated in paragraph 123.
[42] A fast resting heart rate.
[43] Displaying symptoms of a fever.

Ms A could go home when she was awake. RN F also remembers that RN E told her that Ms A had a GCS of 12/15.

133. RN F said that during the handover, Dr B came in and asked the nursing staff to clean Ms A after observing that she had been incontinent. RN E stated that she was not aware of Ms A's incontinence until Dr B mentioned it at the afternoon handover.

Dr B's third assessment

134. Dr B told HDC that she arrived at the rural hospital at approximately 2.40pm and noted that Dr C had not yet arrived and nursing staff were meeting for the shift handover. Dr B stated that upon entering Ms A's room she observed that Ms A was lying still on the bed with her hands resting on the upper part of her stomach. Dr B said that on examination Ms A opened and closed her eyes on her approach, but was not talking or responding verbally. Dr B further noted:

> "[Ms A] had been incontinent of urine and the sheet was wet and her skin felt hot, and I was immediately concerned about her fever. I checked her skin wounds and her ears. The left tympanic membrane was inflamed and bulged and was significantly worse than on my examination in the early morning. There was tenderness when touched and there appeared to be pain behind the left ear. I commented to [Ms A's] relatives that she would need her clothing changed as she was soaked through and they agreed."

135. Dr B stated that she went to the nursing station and asked RN E, RN F, Enrolled Nurse (EN) EN H and HCA Ms I to start cooling cares. Dr B commented that the nursing staff "appeared surprised" about Ms A's high temperature.

136. Dr B said that she then returned to Ms A's room and noted that:

> "[Ms A's] chest was expanding equally both sides and air entry was good, abdomen soft, pelvis normal, she moved on touching the legs and brought her hand over to where she was touched. [Ms A] was localising touch well. However there was no verbal response. [Ms A] opened her eyes in response to questions. [Her GCS] was 12[/15]."

137. Dr B stated that she then checked the set of observations in the clinical notes ("[Blood pressure] 132/79 [mmHg], pulse 103 [bpm], [oxygen saturation levels] 99% and temperature 38.9 [°C]"[44]) and then went back to the nurses station and repeated her request that Ms A be changed out of her soiled clothing. Dr B recalled that RN E went into Ms A's room following her second request.

Rural hospital — 3pm–4.35pm

138. At 3pm, RN F recorded that she had checked Ms A, given her a sponge bath, changed her clothes, and put on a cervical collar. RN F noted that Ms A cried when turned on her sides, that she was on "continuous cooling cares", and that she was being monitored closely. The following observations were recorded: "[GCS] 9/15, [blood pressure] 124/77 [mmHg]. [Temperature] 38.9 [°C], [pulse] 94 [bpm], [oxygen saturation levels] 99%."

[44] These observations are recorded in the nursing notes as occurring at approximately 1.35pm.

139. RN F told HDC that once she and two healthcare assistants had finished cleaning Ms A and had changed her into a hospital gown, she attached Ms A to a portable observations monitor and set the machine to record her blood pressure, pulse, and oxygen saturations every 30 minutes. RN F said that the only cervical collar she could find in the hospital was a "soft collar", which she put on Ms A. Following her review of Ms A, RN F also made a plan to take neurological observations every 30 minutes. RN F said that she assessed Ms A as having a GCS of 9/15 during her shift.

140. At 3.30pm, RN F recorded that Dr B had sent a fax for an "ambulance/helicopter", and that RN G had arrived at the hospital to be a nurse escort, as a helicopter was unavailable.[45] RN F handed over Ms A to RN G, who inserted an intravenous (IV) line[46] into Ms A's left hand and administered 10mg of metoclopramide.[47] The following observations were also recorded: GCS 9/15, temperature 38.8°C, respiratory rate 20 breaths per minute, blood pressure 120/68mmHg, and pulse 79bpm.

Dr C's assessment

141. Underneath the 3.30pm entry in the nursing notes it is recorded that Dr C had arrived at the hospital. Dr C told HDC that he arrived at the rural hospital at approximately 2.45pm and noted that Dr B had already reviewed Ms A and had started writing up her notes. Dr C stated that Dr B advised him that she had contacted the city hospital, and that a road ambulance had been dispatched because a helicopter was not available.

142. Dr C said that on entering Ms A's room he was met by her whānau and observed that she had a soft collar around her neck and was making incomprehensible sounds. The whānau informed him that she had been unable to talk to them but "had been moaning and not making any sense". Dr C then examined Ms A. He assessed her as having a GCS of 9/15, and noted that she made incomprehensible sounds, and responded to localised painful stimuli. His examination of Ms A's head and neck showed reactive pupils and tenderness of the left temporal area[48] and lower cervical and upper thoracic spine on palpation.[49] Dr C also observed that Ms A had a bruise on her left shoulder, bruises and grazes on her left knee and shin, non-tender abdominal and urogenital[50] systems, and no elicited tenderness on manipulation and rotation of her hips and upper limbs.

143. Dr C told HDC that an IV luer had been placed in Ms A's left forearm by nursing staff prior to his arrival, and that he placed a second luer in her right forearm as he expected to intubate her, and "took bloods on this line". Dr C ordered a series of blood tests, including an ethanol level and a "basic metabolic profile test", which included electrolytes,[51] creatinine,[52] and a full blood count.[53] Dr C also made a plan for neurological observations to

[45] RN F also contacted RN G to come in to assist in transporting [Ms A] to the city hospital.
[46] A small plastic tube inserted into a patient's vein using a needle.
[47] A medication commonly used to prevent nausea and vomiting.
[48] The left side of the head.
[49] Examination of the body using the hands.
[50] Relating to the urinary and genital organs.
[51] Salts and minerals found in the blood (eg, sodium, potassium and bicarbonate).
[52] Creatinine levels provide information about kidney function.
[53] To evaluate overall health and detect infection.

be taken every 15 minutes. The results of the blood test for ethanol level confirmed that there was no ethanol (alcohol) in Ms A's blood.

144. Dr C stated that following his assessment he noticed that there were still shards of glass on Ms A, and placed her in a neck collar. Dr C said that he discussed his findings (as outlined above) with Dr B, who was drafting a referral letter. He also stated that he made enquiries with St John's head office regarding a helicopter transfer, to no avail, and contacted the city hospital's Emergency Department (ED) clinical staff to advise them of Ms A's transfer, and "discussed the possibility of intubation[54] should [her] neurological condition deteriorate further". Dr B stated that she also contacted the city hospital's ED clinical staff.

145. At 3.50pm, the following observations were recorded: "[Blood pressure] 122/76 [mmHg], [pulse] 118 [bpm], [oxygen saturation levels] 95%."

146. Dr B wrote the following referral letter[55] to a "house surgeon" at the city hospital:

> "Thank you for seeing [Ms A] who presents with drowsiness not apparently attributed to alcohol.
>
> History leading up to this point of time:
> [Motor Vehicle Accident] approx. 1.0[0]am
> Seen 4.0[0]am
> Brought in by ambulance responding very assertive
> Reported by paramedics as drinking very heavily and inebriated, apparently the passenger in the accident and found approx. an hour after the accident.
>
> Yet moving all limbs and arms freely
> No neck tenderness no spinal tenderness
> Scratches both thighs abrasions [left] knee contusion [left] shin
> Responding verbally to questions single word response
> No obvious head injury No bruising or wounds found
> PERLA [Blood pressure] 127/73 [mmHg] Pulse 104 [bpm]
> Blood alcohol taken for police at 6.15am
>
> 8.30am she was resting and responsive
> Sleeping but due to continued drowsiness and less able to respond and verbalise — doctor was notified at 2pm
>
> 2.30pm she appeared drowsy and not verbally responding
> GCS was 12/15
> [Blood pressure] 132/79 [mmHg]
> [Oxygen saturation levels] 99%
> Pulse 103 [bpm]
> Temp[erature] 38.9[°C] — cooling her down
> PERLA

[54] Insertion of a tube into the windpipe for mechanical ventilation.
[55] Dr B entered the above letter into Ms A's clinical notes approximately three weeks after the accident.

> [3.50]pm GCS 9/15
> Has left middle ear infection [thin membrane[56]] inflamed with effusion bulging ear drum. She is more irritable on movement and cries. She had painful [left] ear.
> ? Differential subdural haematoma[57] and would value CT[58] head scan and management."

147. At 4pm, RN F recorded that an ambulance had arrived, Ms A's cervical collar was changed (to a hard plastic collar), and "bruising behind her left ear [and] dried blood noted in outer ear" was observed. RN F also recorded that Dr C observed redness on Ms A's left shoulder, and that it "look[ed] like a seatbelt mark". Ms A's blood glucose level was recorded as 6.3mmol/L and her GCS as 9/15.

148. RN F recorded that upon transfer from the hospital bed onto an ambulance stretcher she observed "small broken glass, very fine [at] her back", and that she "carefully" removed the glass and noted that Ms A's skin was intact.

149. EMT N told HDC:

> "[Ms A was] [u]nder a blanket and when I removed it to see how we were going to move her, she was in wet clothes and I could smell urine once [the] blanket was lifted … I could see glass shards and said to the [nurse] that we need to clean and dry her up before moving her. Mattress was wet and she felt cold to touch.
>
> We log rolled[59] her as I was still concerned about a possible [cervical spine] injury so we could change her and noticed glass slivers/[s]hards on her back. The [nurse] cleaned as much as she could and we put a gown on [Ms A] and rolled her the other way so I could clean the other side, noticed red back … we did what we could to make [Ms A] comfortable and [give her] some form of dignity. Then we loaded and transported her with [RN G] monitoring her during transport."

Transfer to the city hospital and subsequent care

150. The nursing notes record that Ms A left the rural hospital at 4.35pm with a GCS of 9/15.

151. Upon arrival at the city hospital, Ms A was intubated and received a head CT scan, which showed significant injuries including multiple brain haemorrhages. The scan was discussed with a neurology registrar at the main centre hospital, and a decision was made to observe Ms A in the city hospital overnight. Ms A was transferred to the Intensive Care Unit (ICU). During her stay, Ms A underwent neurosurgery and received brain-orientated intensive care therapies. Sadly, despite interventions, Ms A died.

[56] Thin layer of tissue covering the middle ear.
[57] A collection of blood between the covering of the brain (dura) and the surface of the brain.
[58] Computerised tomography — three-dimensional images of body structures.
[59] Moved without flexing the spinal column.

RN E's and RN F's clinical note-taking

RN F's recollection

152. At the time of Ms A's transfer to the city hospital (approximately 3.45–4pm), the Chief Executive of the rural hospital was on the ward at the rural hospital and asked to see Ms A's clinical notes "to get a clearer picture of what observations had taken place in-between the times of which the Drs' had recorded on the electronic medical notes". RN F stated that she showed the Chief Executive the notes that had been handed over to her earlier in the afternoon at around 2.30pm. RN F recalled that, at that time, the triage form had only a phrase written on it, which stated, "involved in a [motor vehicle accident] abrasions on both legs L/s of face. R/hand," and one set of baseline observations. RN F said that from the morning shift "there was an observation chart with 1 set of observations taken at about [2pm] with a 12/15 [GCS]".

153. RN F stated that she telephoned RN E and asked her to complete her nursing records, and that RN E returned to the hospital at around 5pm to do so. RN F further told HDC:

> "At about [5.30pm] I completed my notes following on chronologically from [RN E]. I had entered my vital sign observations (completed at [3pm]) onto the Accident and Emergency Assessment form at the time they were completed. I had been taking [Ms A's] Glasgow coma scores throughout the shift and had already entered these onto the observation chart I was provided at handover (the chart that had one set of vital signs and neurological observations taken about [2pm]). [RN E] then asked me to re-write my neurological observations onto another observation chart that she provided. This observation chart had observations recorded at 9.30, 11.30, 12.30, [1.30] and [2.30]. I copied my earlier Glasgow coma scores and neurological observations onto this chart."

154. RN F told HDC that the following day she arrived at work and found that RN E was completing another set of notes for Ms A and had also completed a third observation chart. RN F stated:

> "[RN E] informed me that I would need to complete my notes and observations again. I had the previous notes available to me and copied them following on chronologically from [RN E's] second set of notes, making some minor alterations for clarification. I copied my neurological observations and Glasgow Coma scores onto the third observation chart."

RN E's recollection

155. RN E stated that after she had written her nursing notes, and before Ms A was transferred to the city hospital, she saw Dr B's referral letter. RN E said: "I pointed out to [Dr B] that she had recorded the Glasgow Coma Score as 12/15 when it had been 9/15 per my clinical record. Dr B said I needed to change my notes to show that the [GCS] was 12/15." RN E said that she re-wrote her notes to make the change in the GCS.

156. RN E further stated that after leaving the rural hospital at around 3pm:

> "I had felt uncomfortable changing the Glasgow coma score at the time and as time passed I felt less and less comfortable. I decided to ring [Dr C] to discuss this. [Dr C] said that I knew what I had done was wrong and that I knew what I needed to do — I

> knew that I needed to ensure that accurate clinical information was recorded in [Ms A's] notes. I returned to the hospital and removed the clinical note that contained the Glasgow Coma score 12/15 — I re-wrote my notes and included the true GCS of 9/15 …"

157. RN E told HDC that she returned to the rural hospital approximately two and a half hours after her shift:

> "I rewrote clinical notes for observations of [Ms A] and actions taken at 7.30, 7.50, 8.15, 8.30, 9.15, 9.30, 10.15, 10.30, 11.25, 12.15, [1.15], [1.25], [2.00] and, [2.30] … These rewritten notes were identical to the previous notes, apart from me now recording the [Glasgow Coma Score] at [1.25pm] as 9/15, rather than the originally recorded 12/15. I asked RN F to write her own clinical notes again, after my last entry at [2.30pm]."

158. RN E stated that she does not recall asking RN F to re-write her neurological observations (which were recorded on a different sheet from the general clinical notes specified above). RN E also stated that she did not re-write her clinical notes again the following day. She said she believes that RN D re-wrote her clinical notes the following morning "or the [next day] and I think that [RN F] has confused [RN D] [with] me".

Dr B's recollection

159. Dr B told HDC that she did not have any conversation with RN E about changing the GCS record, and did not direct her to change her records.

Further information from St John

Staffing at Location 2 ambulance station

160. St John told HDC that at the time of the incident there were three full-time paid staff at the station, and that they worked on a three-person roster. EMT L and ILS K were two out of those three full-time staff. In addition, casual and volunteer staff also worked at the station.

Training and clinical support provided at the time of events

161. St John advised that the training provided to staff with clinical authority to practise "consisted of mandatory engagement in continued clinical education". However, it noted that "there was minimal" clinical support officer (CSO) availability to the staff in the region in 2014, and a number of reasons were identified as contributing factors, including isolated geography, staff resistance, and financial limitations in funding a full-time CSO position. St John also identified other challenges associated with the operational management team moving staff into higher workload areas on a regular basis.

Root cause analysis report

162. In response to the complaint received by HDC, St John prepared a root cause analysis report of the paramedic care provided to Ms A. The report stated that "a seriously injured patient did not receive appropriate prehospital clinical assessment and care resulting in transportation of that patient to a medical facility unable to provide an appropriate level of ongoing care". The report found that there was inconsistent managerial development, supervisory oversight, and clinical development of staff at the Location 2 station, which

resulted in "significant skill-degradation" and "sub-optimal" clinical competencies, operational capabilities, and role-modelling. It stated:

> "There were many comments made by the people interviewed that depicted a general feeling that isolation, lack of clinical support, performance and communication issues in [the area] have been accepted as 'the norm' despite previous and current managers being made aware of the concerns."

163. The report also found that the "remoteness and isolation" of the area exerts a heavy reliance on the availability of road-based ambulances and managers that "cannot be provided in a timely manner due to the distances involved". The report further found that the accessibility of the rural hospital and belief by local paramedic staff that patients can be managed and discharged into the community from that hospital "creates a higher risk for seriously ill and injured patients because of non-contemporary care and delays [in patients] being transferred out of the area".

164. The report stated that during the course of the internal investigation it was apparent that staff at the communications centres and an operations duty manager overseeing the incident were not aware of the limitations of the rural hospital, and "actively suggested transportation [to the rural hospital] in the first instance".

165. The report was critical of the care provided by EMT L and ILS K (the Station Manager) and recommended that they have their current practise levels evaluated "to ensure patient safety is not compromised". The report also recommended that further clinical and operational/management support be prioritised in the area, that a "pool" vehicle be provided to allow staff to travel to larger centres to attend training and operational shifts, and that Ms A's whānau and all St John staff involved in her care be informed of the findings of the report.

166. Whilst not expressly stated in the report, St John advised HDC that during the course of its internal investigation it identified a number of hierarchical constraints within the area that posed particular challenges for junior staff in challenging the decision-making of senior staff.

167. St John advised HDC that EMT L and ILS K are no longer employed by St John.

Report

168. St John supplied HDC with a report which made a number of recommendations to improve the paramedic services provided in the area, including:

- Staff to receive targeted training focusing on local needs.
- A system to be established for isolated staff to do shifts in urban areas.
- Regular contact with operations managers and a dedicated clinical support officer role for the area to be established.

- Training to be provided to increase understanding when working with allied medical providers (eg, rural GPs under the PRIME[60] programme).

Changes made to practice

169. St John stated that since these events, "there have been significant changes and initiatives implemented", including:

- The development of professional development plans for staff at the Location 2 station, which are supported by face-to-face training, mentored operational shifts, and structured clinical education.
- Four- to six-weekly clinical support workshops, tutorials, and one-on-one training provided to rural paramedic staff, including inter-agency training with fire and medical staff involved in the PRIME programme.
- Rural staff now receive regular shifts at the Location 3 station "for mentoring, increased workloads and clinical exposure", and a "pool" vehicle has now been supplied to allow staff to travel to and from stations.
- The territory manager now visits the Location 2 station on a weekly basis, and the district operations manager visits twice a month.
- Satellite phones have been put into the three ambulances, and fibre internet access has been introduced at the Location 2 station to support remote face-to-face communication via Skype.
- Review of the trial conducted between St John and the NZ Defence Force regarding the provision of operational and PRIME support and clinical development training.
- Review of the technical support currently available to St John with the view to help reduce helicopter mission fail rates in the area.

170. St John also wrote to the district operations manager for the central region to clarify its expectations regarding patient transportation and destination criteria in the area. In summary, it specified that all status one and status two patients shall be transported directly to the city hospital, as well as all patients who clearly require assessment and treatment in hospital. It also specified that patients should be transferred to the medical facility at the rural hospital only if it is reasonably expected that they can be treated by a GP and discharged back into the community. However, St John acknowledged that it may be appropriate to stop at the medical facility for specific support from the medical and nursing staff en route to the city hospital subject to specific requirements.

Comments on culture and policies

171. With respect to FR O, St John stated that her inexperience and lack of clinical authority to practise would not have supported her to identify and manage Ms A without the oversight and direction of EMT L. St John also stated that FR O would not have had "the ability to challenge the decision making of [EMT L] based on a long standing culture of deference to that hierarchy".

[60] The PRIME programme utilises the skills of specially trained rural GPs and/or rural nurses to support the ambulance service in areas where the response time for assistance would otherwise be significant, or where additional medical skills would assist with the patient's condition.

172. With respect to the policies in place at the time of these events, St John stated that "the policies relating to patient handover and land ambulance safe operations in place at the time were sufficient however they were not followed".

NPHCT policies

173. NPHCT's Admission Policy in force at the time of these events provides:

> "• Medical assessment and examination is undertaken by NPHCT GP to determine [the] level of complexity. Low complexity/risk patients are admitted to the Case Mix Ward.
>
> • Medium and high complexity patients requiring further medical/specialist interventions, and/or other services that are not available at our facility are assessed by the [NPHCT] GP for transfer to [the district health board] in consultation with the appropriate consultant and or medical officer on duty.
>
> • Transfer arrangements will be planned in a timely manner …
>
> • The patient receives timely, competent, and appropriate services in order to meet their assessed needs and desired outcomes/goals.
>
> • Patient care is planned, consumer focused, integrated, and promotes continuity of service delivery.
>
> • A discharge plan will be commenced on admission to the NPHCT casemix ward, in consultation with the patient and whānau as appropriate."

174. NPHCT's Continuity of Care Policy in force at the time of these events provides:

> "• A multidisciplinary team approach ensures clear delegation of responsibility for the coordination of care, and that people have access to the appropriate health service provider.
>
> • [NPHCT] ensure that all clinical staff will promote the coordination of patients in their recovery care and treatment …
>
> …
>
> • Comprehensive services are delivered through collaboration and cooperation."

Further information from NPHCT

175. Following notification of the complaints to HDC, NPHCT arranged a hui with Ms A's whānau, and the Chief Executive wrote letters to the whānau expressing her sympathy for their loss.

Reportable Event Investigation Report

176. NPHCT also prepared a "Reportable Event Investigation Report". The key findings of the report included that as a result of poor communication between St John and the rural hospital staff, the hospital team did not understand the context and severity of the motor vehicle accident, and the manner of transfer into the hospital (via wheelchair) reinforced to hospital staff that Ms A was drunk.

177. The report also found that the physical placement of Ms A away from the nurses station "could have reinforced the assessment that the patient was not a high complexity and [this] influenced the level of observation care provided". It stated that poor communication between hospital staff, and the lack of timely documentation contributed to an assessment that Ms A was drunk and should be sent home when alert.

178. The report further found that Ms A was not provided with a basic quality of care, including the fact that she was not provided personal cares, had not been cleaned following her incontinence, glass was removed from her back only later in the day, she was experiencing pain and discomfort, and she was not encouraged to eat or take fluids.

179. The report further stated:

> "[N]o one person in the clinical team took the responsibility for coordination of care on the night and day shift and neither was a second opinion sought. Normal practice was not adhered to i.e. admitting [the] patient to the case mix ward after 4 hours which would have resulted in a further assessment and development of a care plan and discharge plan."

180. The report also stated that medical assessment and examination did not determine a level of complexity for transfer to another facility or admission to the rural hospital.

181. The report made a number of recommendations, including:

- Development of a standardised pathway for the transfer of patients between St John at the rural hospital, and a guideline for internal and external communication.
- Work to strengthen internal and external relationships with other providers (the District Health Board and St John).
- All clinical staff to read and adhere to the documentation policy.
- Key clinical staff to review and update policies relating to continuity of care, assessment, and admissions; and to review the clinical roles and responsibilities for doctors, nurses, and team leaders.
- Clinical staff to receive training on triage and trauma care, assessment, care planning, patient rights, and NPHCT values and code of conduct.
- Accident and emergency cases to be presented during monthly nursing meetings, with doctors to attend these meetings.

182. With respect to its changes to practice, NPHCT told HDC that it has implemented the changes to its policies and processes that were recommended in the Reportable Event Investigation Report.

Further information from Dr B

183. Dr B told HDC that she offers her sincere condolences to Ms A's whānau for their tragic loss, and apologised for the care given to Ms A while she was at the rural hospital. Dr B also stated: "I have taken this case very seriously and I continue to carry it with me."

184. Dr B said that in hindsight she should have noted the details of Ms A's neurological signs that she considered to be normal, and that she "takes care to do so now". Dr B does not

accept that she failed to review and reassess Ms A over time, and states that she reviewed her at 6.30am, and that her condition had not changed, so she set a time for reassessment after handover at 8.30am. Dr B further stated that she asked nursing staff to keep Ms A under observation, and expected that they would repeat observations and report any changes to her. Dr B said that nursing staff did not report to her any rise in Ms A's temperature.

185. Dr B further stated that whilst she accepts that the altered mental state of a patient in the setting of a high impact accident should not be attributed to alcohol, she was not aware of how serious the accident was, and had no knowledge that the other patient had been sent to the city hospital. She stated that she would not have accepted Ms A if the motor vehicle accident had been described as high impact, and would have advised immediate transfer to the city hospital. Dr B told HDC that she conducted her assessment based on the paramedic report that Ms A was a status three patient and intoxicated. Dr B stated that following her assessment she did not find anything inconsistent with intoxication.

Changes to practice

186. With respect to changes to her practice following this incident, Dr B stated that she now obtains a history from as many people as possible, including first responders, ambulance staff, and any other witnesses, and ensures that ambulance reports are obtained and read on arrival. If anything is not covered or is unclear, she will have further discussions with paramedic staff regarding the accident scene and observations and assessment. Dr B told HDC that she has learned that a patient's accident history is vital to decision-making regarding effective and efficient transfer of patients to a hospital.

187. With respect to her interaction with nursing staff, Dr B stated that she now double checks with nursing staff to ensure that they have a good understanding of the patient, the observations required, and the importance of documentation, and that any abnormal recordings are to be reported to a doctor immediately. With respect to her handover to other doctors, Dr B told HDC that she does "not take it as a given that they will reassess a patient", and now makes "a point of being clear on all that needs to be done even where it may seem excessive".

188. Dr B also stated that she ensures that patients with high impact injuries are evacuated to the city hospital "as soon as possible" for further assessment and investigation, and that she types her notes contemporaneously.

189. Since the time of these events, Dr B has undertaken further training in rural medicine, head injuries, and communication with colleagues.

Further information from RN D

190. RN D stated that "in hindsight" she should have attended to Ms A's incontinence when they first placed her on the hospital bed. RN D said: "[I did not do this as] I thought it would be less upsetting for [Ms A] to let her settle for a bit and when she was more sober that I would be able to manage her cares and wash her when she was more cooperative." RN D accepted that "at a minimum" she should have cut off Ms A's clothing.

191. With respect to why she did not test Ms A's blood glucose level, RN D stated that at the time of these events she did not know that blood glucose was a useful indicator in

intoxicated patients. She further stated that blood glucose was not usually taken in baseline observations, "especially when the patient comes in as a category 3 with minor injuries".

192. With respect to why she did not conduct neurological observations, including a Glasgow Coma Score and pupillary response assessment, RN D stated that she received no indication from paramedic staff that Ms A had a potential head injury, and considered her behaviour to be consistent with the metabolising of alcohol. RN D stated that had she thought she was dealing with a suspected head injury, she would have taken neurological observations and advised Dr B of any concerns.

193. RN D told HDC that she should have annotated that her clinical notes were made retrospectively. She further stated:

> "I am very angry with myself for not advocating for [Ms A] more. I should have gotten more evidential facts to support [Ms A] such as neurological observations, [blood glucose levels], done observations more frequently and handed over to [RN E] by pulling [her] aside to give her more information about [Ms A] that the doctor wasn't saying and preventing me from saying. Even staying until the next doctor came on shift and [informing] him of what was going on …
>
> There was a lack of clear understanding of the clinical roles and responsibilities on the day and because of this, opportunities were missed to recognise the seriousness of [Ms A's] injuries."

194. RN D told HDC that she has "learned a lot from this experience" and was willing to undergo further education to improve her nursing knowledge. She also stated that she has since spent a week in the city hospital's ED, which she found to be "very helpful and useful".

Further information from RN E

195. RN E told HDC that prior to these events, it was not her practice to read the clinical notes from the previous shift, as she relied on the information conveyed during the shift handover. RN E stated that she now always reads the notes "because [she] realise[s] how easy it is for something to be missed during the handovers". She has also attended a clinical documentation course, has spent three weeks working in the city hospital's ED, and is due to attend a PRIME training course. RN E stated that when faced with a clinical situation where she thinks there is a patient safety issue, she has "no hesitation" completing an incident form, and encourages other staff members to approach her if they are concerned about a patient's care.

Further information from RN F

196. RN F stated that she accepts that she should have been clear about the time at which her clinical notes were written. She also accepts that she knew that RN E had changed her notes, and she "did not challenge her about this". RN F said that at the time of these events RN E was her clinical team leader, and she did not have the confidence to challenge her, and instead followed RN E's request to rewrite her clinical notes. RN F told HDC: "I realise this was a judgement error on my part and I should have completed an incident report outlining the events that occurred."

197. With respect to changes to practice, RN F stated: "[I have] learned that I need to be an advocate for my patients, judge situations for myself and speak up if I think that something is not right." She told HDC that she has completed a week's work placement in the city hospital's ED, and has registered for a course on documentation.

Responses to provisional opinion

198. The parties were given an opportunity to comment on the relevant sections of the provisional report. These responses have been incorporated into the report where appropriate. Further responses have been outlined below.

Ms A's whānau

199. Members of Ms A's whānau stated that they felt that Ms A should not have been transferred to the rural hospital and treated by Dr B.

Dr B

200. Dr B stated that she considers the finding that she breached the Code to be harsh on the facts. She stated that with the benefit of hindsight, and now having access to further information regarding this case, she could have had a "higher index of suspicion of a brain injury and could have transferred [Ms A] to [the city hospital] earlier". Dr B apologised for not doing so. Dr B also accepts that her retrospective documentation should have been annotated as such.

201. Dr B further stated that having finished her initial assessment at approximately 6am, the two-hour timeframe to have prompted consultation with the city hospital according to the expert advice would have been at approximately 8am — the same time she handed over to Dr C. Dr B stated that during the handover she asked Dr C to reassess Ms A.

202. Dr B stated that since the time of these events, she has received training regarding the triage of patients in car accident scenarios, and primary and secondary survey of patients.

Dr C

203. Dr C said that there was clearly a "poor" handover of Ms A. He further stated that it was assumed that Ms A was inebriated, and that was the information that was communicated to him during handover.

RN E

204. RN E stated that when the overall context of the events in question are considered, and in particular that Dr B was "someone it was very difficult to say no to", the decisions she made in respect of her clinical care of Ms A were reasonable.

205. RN E said that she thought she did everything she could to ensure a proper handover. She reiterated that RN D endeavoured to provide her with the events that had occurred, and that Dr B overruled her, and RN D was unable to convey the information due to Dr B's interruptions. RN E said that receiving a handover from a doctor was unusual for her, and it would be uncommon for nursing staff to take control of a handover being led by a senior doctor such as Dr B. RN E also stated that it was reasonable for her to assume that the handover provided by Dr B was full and accurate, particularly since it was not contradicted

by RN D, and to rely on that handover to determine the appropriate care for Ms A throughout her shift.

206. RN E stated that she accepts that she should have taken and recorded vital signs, but noted that no mention of abnormal vital signs was made during handover, and she believed that all important information had been conveyed during handover, and she did not consider it necessary to read Ms A's clinical notes from the previous shift. RN E said that had she been informed of the initial abnormal signs, her care of Ms A would have been different. RN E acknowledged that this information was available on the triage sheet. She also stated that clear direction from Dr B "strongly influenced" her to leave Ms A to sleep. RN E told HDC that she has now amended her practice to read a patient's clinical notes after a patient has been handed over.

207. RN E stated that her neurological assessment of Ms A "was at all times appropriate". RN E submitted that there is a wide range of causes of altered level of consciousness, including alcohol consumption, and that consciousness can be documented in clinical notes in ways other than a GCS, for example recording that the patient is "alert". RN E said that although she did not conduct a formal neurological assessment or record a GCS, she conducted an appropriate level of assessment given her understanding that Ms A was intoxicated and did not have a head injury. RN E noted that she did document Ms A's consciousness several times during her shift, including that Ms A was rousable but sleepy at 8.30am and opened her eyes at 9.30am. RN E said that as soon as Ms A's whānau told her that they did not think Ms A had been drinking alcohol, she recognised that if Ms A was not intoxicated, there must be another reason for her decreased level of consciousness, which must be identified quickly and acted on appropriately.

208. RN E told HDC that she accepts that her handling of clinical notes was inappropriate, and she should not have removed her original notes from the record. She stated that she felt she had "no choice" but to follow Dr B's instructions to amend the GCS score, and was scared and anxious about what would happen if she refused to do so. RN E stated that she would not have changed the notes had she not felt under pressure to do so. RN E further stated that while she accepts that the method was incorrect, by changing the notes the second time she was attempting to act in accordance with her obligation to keep clear and accurate records.

209. RN E told HDC that she has undertaken further professional development regarding her documentation and how to improve her handling of conflicts and disagreements over the content of clinical notes.

RN D

210. RN D stated that she is sincerely sorry and deeply regrets that she did not help Ms A more during her shift. She accepts HDC's recommendations for further training.

211. RN D said that "the understanding and expectation" at the time of these events was that patients should be transferred to the rural hospital only if it was reasonably expected that they could be treated by a GP and discharged back into the community, and that St John knew that the rural hospital would not accept anything other than status 3 or 4 patients or patients who are to be stabilised briefly for transfer to the city hospital.

212. RN D further commented that minimal resources, unclear processes, and the fact that she felt unable to seek a second opinion or constructively challenge doctors' opinions affected the care she provided to Ms A, and noted that this was acknowledged in the the rural hospital NPHCT report.

213. RN D said that she did not conduct a neurological assessment as part of her initial nursing assessment on the basis of the formal handover from St John, Ms A's presentation, Dr B's view that Ms A was drunk, Dr B's repeated instruction that Ms A was to be left to sleep it off, and because Dr B had specifically told her not to take neurological observations. RN D said that she did not test Ms A's blood glucose levels as "[the rural hospital] did not do blood glucose levels [at that time] and so it did not occur to [her] to do one at that time".

214. RN D stated that she accepts that she should have communicated all salient information to RN E before completing her shift. RN D said that at the time of handover, she did not have the confidence to push her concerns when she felt that they were being dismissed by Dr B. RN D said that she now records any concerns she may have about a patient's care, and ensures that she hands over patients to other nursing staff clearly. RN D stated that the culture at the rural hospital is that nurses' opinions are not respected. However, she said that now, if she is in doubt regarding a patient's care, she will escalate her concerns to management or seek a second opinion.

215. RN D stated that she accepts the criticism and findings made in respect of her documentation. She said that the level of the written documentation she completed was influenced by the direction from Dr B to do only baseline observations, and her instruction that Ms A was to be sent home when sober.

216. RN D told HDC that she has learned a salutary lesson in making it clear when notes are made retrospectively.

RN F

217. RN F stated that she did not wish to comment on the provisional decision.

NPHCT

218. NPHCT stated that it will comply with the recommendations made by HDC. NPHCT said that since the time of these events, periodically it has met with St John (initially monthly, now quarterly) to strengthen the relationship between both organisations. NPHCT has also established a standardised pathway for patient transfer between St John and the rural hospital staff, and provides training to its clinical staff regarding triage and trauma care, assessment, care planning, documentation, and NPHCT's values and code of conduct. NPHCT also stated that a senior nurse has been recruited to provide clinical leadership for patient care, it has implemented and trained staff on a communication tool, and the New Zealand Nurses Organisation continues to provide training.

St John

219. St John stated that it accepts the findings of the provisional decision "without reservation", and also accepts the recommendations made by HDC. St John also stated that it met with its former employees ILS K and EMT L to go over the findings of the provisional decision. St

John said that it has taken its breach of the Code very seriously and has actively reviewed its community focus and service delivery to the area.

Opinion: The Order of St John Central Region Trust Board — breach

220. The Order of St John Central Region Trust Board (St John) provides ambulance and paramedic services in the area. St John had a duty to ensure that Ms A received quality services and continuity of care. In this case, the care provided by St John staff was suboptimal in a number of respects.

Steps taken at the accident scene

221. FR O was the first paramedic staff member to arrive at the scene of the accident, closely followed by EMT L. Volunteer firefighters also attended the scene. FR O said that she conducted as much of a secondary survey on Ms A as possible, reaching down as far as her lower back to check for abnormalities. FR O also attempted to put a neck collar on Ms A, but was unable to do so because of an obstruction in the car.

222. EMT L and FR O stated that upon removal of the car roof, Ms A's head was supported until a spine board was in place and she was moved to EMT K's ambulance. RN V, a passing motorist who had stopped at the scene, stated that he put a neck collar on Ms A before she was removed from the car, and also remembers a backboard stretcher being used. EMT L stated that once Ms A was in the ambulance she put a neck collar on her again, but Ms A kept removing it. EMT L said that she conducted a primary and secondary survey as best she could, and remembers that Ms A was "thrashing around".

223. My expert advisor, paramedic Geoff Procter, stated that the initial attempt to put a collar on Ms A and ensure that her head was stabilised, and the subsequent application of the neck collar (albeit briefly), were adequate and appropriate attempts at stabilising the cervical spine during the extraction process. He further advised that the use of a spine board was consistent with standard practice.

224. Mr Proctor advised that a thorough secondary survey would involve the visualisation and palpation of the head, torso, abdomen, and all limbs, to look for any deformity or skin laceration or abrasion. I am unable to make factual findings regarding the precise steps taken by St John paramedic staff in conducting surveys of Ms A, including whether any secondary survey was conducted at all. However, I accept that a primary survey occurred.

Transportation from the accident scene

225. Due to poor weather conditions, rescue helicopters were unable to reach the scene. At approximately 3am, EMT L transported Ms A, and FR O transported the other patient via ambulances. EMT L asked Ms U (a member of the public) to assist FR O. EMT L transported Ms A without assistance. Two other ambulances were also dispatched to meet the ambulances en route.

226. Mr Proctor advised that EMT L should have asked RN V to assist in patient monitoring. Mr Proctor also stated that an acceptable alternative would have been to utilise one of the fire service staff to drive the ambulance whilst EMT L attended to Ms A.

227. Mr Proctor advised that the failure to have someone in the back of the ambulance attempting to encourage Ms A verbally to stay still was a moderate departure from the standard of care. He advised that if a patient was not cooperating and a cervical collar was causing agitation, the collar could be discontinued, but that verbal coaching to encourage the patient to remain still needed to be employed. As outlined above, EMT L stated that once Ms A was in the ambulance, she was moving around and "kept pulling" off the cervical collar. I am concerned that steps were not taken to ensure that a member of the paramedic team was in the back of the ambulance to provide care and assistance to Ms A.

Strapping of Ms A in the ambulance

228. EMT L stated that she buckled Ms A onto the ambulance stretcher before she left the scene. FR O remembers that when she was sitting with Ms A at the first stop, she was trying to sit up and get off the stretcher. Ms U stated that at the third stop after leaving the scene, when she had moved into the Location 2 Ambulance, Ms A was not strapped to the ambulance stretcher as the other patient had been.

229. Mr Proctor advised that if EMT L had attempted to secure Ms A with seatbelts but Ms A kept removing them, the standard of care would be to attempt to calm her with the view to securing the seatbelts. If such attempts were unsuccessful, then transporting Ms A without seatbelts would be within accepted practice. Upon review of the evidence available, I accept that Ms A was strapped at least for periods of her transportation to the rural hospital. However, as stated above, I am concerned that no one was in the back of the ambulance to provide care and assistance to Ms A.

Assessment by ILS K

230. ILS K met the ambulances crewed by EMT L and FR O. EMT L stated that when she met up with ILS K, she informed him that Ms A was status 2 and the other patient was status 1. EMT L stated that ILS K went in the ambulance carrying the other patient. ILS K did not comment to HDC on what occurred during the handover, but did state that he took responsibility for caring for the other patient.

231. Mr Proctor advised that it would be a minor departure if ILS K failed to assess both patients physically before proceeding. Mr Proctor commented that the departure was minor, as it would be reasonable to trust the judgement and verbal handover of EMT L, but prudent to check that both patients were receiving appropriate care. I am concerned that ILS K did not assess Ms A physically before he got into the ambulance carrying the other patient.

Decision to transport to the rural hospital, and recognition of condition

232. At 2.47am, EMT L asked ICP R (senior paramedic and St John Territory Manager) via radio transmission whether she should "call-in" to the rural hospital. ICP R instructed that Ms A should go "straight through" to the city hospital. Contrary to ICP R's instruction, at 3.15am a St John dispatcher contacted EMT L and requested that she "call in" via the rural hospital on her way to the city hospital. At 3.36am, ICP R contacted ILS K and stated: "I would really like to avoid stopping at [the rural hospital], it just delays [the patients] coming

here and [the city hospital] ED want them here." ILS K responded that he would go straight past.

233. The ambulances transporting Ms A and the other patient met the ambulance that had travelled from Location 3 near the entrance of the rural hospital. The other patient was transferred to the Location 3 Ambulance and taken to the city hospital. EMT L stated that she was informed by the Location 3 paramedic staff that she would have to take Ms A to the city hospital herself. EMT L said that as Ms A was still "thrashing around", she decided to take her to the rural hospital to see if she could be stabilised for the trip to the city hospital. EMT L then radioed the rural hospital to tell them that she would be arriving with Ms A. EMT L and Ms U proceeded to the rural hospital, and ILS K and FR O followed her after the other patient had been transferred.

234. EMT L stated that during the handover at the rural hospital, Dr B told her that there was no way Ms A would be taken to the city hospital. FR O told HDC that she remembers EMT L requesting a patient transfer and being told by Dr B that she would not be transferring Ms A to the city hospital. However, I note that EMT L's recorded radio transmission to the rural hospital made no reference to seeking assistance for onwards transfer to the city hospital, and the history she reported was that Ms A was a status three patient and her vitals were within normal range, suggesting a low acuity patient.

235. Mr Proctor advised that if EMT L was seeking assistance from the rural hospital it was reasonable and appropriate to stop temporarily. He noted that a doctor would have been able to provide chemical sedation, which would have assisted in the stabilisation of Ms A's spine and reduction in damage caused by any suspected head injury. However, Mr Proctor advised that it would be a significant departure if EMT L was seeking to hand over Ms A as a patient to the rural hospital and failed to recognise the seriousness of her condition.

236. I accept that EMT L intended to transfer Ms A onwards to the city hospital. However, I also note that EMT L contemporaneously reported to the rural hospital that Ms A was a status three patient and her vitals were within normal range. Accordingly, in combination with her decision to transport Ms A without assistance, I find that it was more likely than not that EMT L failed to recognise the seriousness of Ms A's condition. Notwithstanding this failure, I am concerned that EMT L did not take further steps to advocate for the onwards transfer of Ms A given that she had been instructed to do so.

237. I note that one of the findings of St John's internal investigation was that staff at the communication centres were not aware of the limitations of the rural hospital, and "actively suggested transportation" to the hospital. Following the events of this case, St John wrote to the district operations managers for the central region to clarify that all status one and two patients should be transported directly to the city hospital. St John also stated that patients should be transported to the rural hospital only if it is reasonably expected that they can be treated by a general practitioner and discharged back into the community. I consider this action to be appropriate.

Transfer out of ambulance

238. Upon arrival at the rural hospital, Ms A was transferred from the ambulance into the hospital using a wheelchair rather than a stretcher. The information provided is unclear

regarding Ms A's exact body position prior to, and during, transfer, and her level of cooperation. EMT L told HDC that she found Ms A in the back of the ambulance with a buckle around her waist and sitting in an awkward position, having pulled herself up with a bar above the stretcher. Dr B said that Ms A put her feet onto one ambulance stretcher and head and shoulders onto another stretcher, resisting movement. FR O also said that she saw Ms A in this position when she arrived at the hospital. RN D did not record how Ms A was positioned, but did record that she was restless getting out of the ambulance, and that her arms and legs were swinging around.

239. Dr B and RN D also stated that Ms A was shouting and swearing, and kicked at ambulance staff as she was moved onto the wheelchair. Ms U stated that Ms A was expressing pain verbally as this happened, saying "ow, ow ow", and that it was clear from her face that she was in pain. EMT L said that Ms A was yelling, "but not making any words", and was thrashing about. EMT L said that Ms A did not kick staff deliberately. FR O stated that Ms A did not yell or kick at St John staff.

240. Given the variations in the accounts provided, I am not able to make a finding about Ms A's exact body position prior to (and during) transfer, and her level of cooperation. However, I accept that at some point Ms A moved from a position of lying straight on the ambulance stretcher, and that she was at least restless while being handled, which created some difficulty in transferring her. I also accept that Ms A was making some noises, and I am persuaded by Ms U's comments that they included expressions of pain.

241. Mr Proctor stated that if the patient was being uncooperative with being on the stretcher or attempting to get off the stretcher, the appropriate course of action for EMT L would have been to attempt to calm the patient and return the patient to the stretcher. Mr Proctor further stated that it would have been appropriate for FR O to encourage EMT L to do this or attempt to do it herself. I note that none of the evidence presented to me suggests that such attempts were made, or that FR O encouraged this.

242. Further, although EMT L stated that Ms A was able to stand long enough to be put in the wheelchair, she accepts that Ms A was like a "dead weight". RN D stated that Ms A was "not weight bearing" and was "dragged" off the stretcher; FR O said that Ms A was "relaxed to the point [of being] like a rag doll"; Ms U said that Ms A was "hauled" up by her clothing and "couldn't stand and slumped to the floor"; and Dr B said that Ms A was "pulled up … to stand". Having considered the evidence, I find it more likely than not that, although restless, Ms A was not weight bearing and was unable to mobilise unassisted. There is also consensus between EMT L, RN D, and Ms U that Ms A was brought to her feet to transfer her to a wheelchair. Accordingly, I find that EMT L attempted to lift Ms A to her feet to transfer her to a wheelchair.

243. Mr Proctor stated that if Ms A was unable to mobilise unassisted, and was verbally expressing pain, then moving/lifting Ms A to her feet in light of previous attempts to secure a cervical collar represented a significant departure from the expected standard of care. I accept Mr Proctor's advice and am concerned about the way in which Ms A was transferred from the ambulance. In particular, I am concerned that no attempts were made to calm her and return her to the stretcher, and that attempts then followed to lift her to her feet when she was unable to mobilise unassisted.

Handover to rural hospital staff and PRF

244. EMT L stated that she provided handover to RN D and Dr B. EMT L said that she communicated to Dr B that Ms A had been trapped in a vehicle for 15–20 minutes and had been conscious at all times. EMT L said she also told Dr B that Ms A had been located on the left side of the car. In her radio transmission to the rural hospital, EMT L stated that Ms A was a "20ish year old female" who had been involved in a single motor vehicle accident, was a status three patient, and had vital signs within the normal range.

245. Dr B said that she received handover from ILS K, who told her that Ms A had some superficial cuts, an abrasion on the knee, and no other injuries, and that she was inebriated. ILS K stated that he did not have any part in the treatment of Ms A, including her transfer from the ambulance. RN D stated that FR O and EMT L were present at the time of transfer, and that ILS K arrived later.

246. Upon review of the evidence, including the fact that EMT L was transporting Ms A, I find it more likely than not that EMT L provided handover.

247. Mr Proctor advised that EMT L's handover represented a significant departure from the accepted standard of care. In particular, he noted that there were inconsistencies between the verbal handover and the PRF, including the fact that the rural hospital was told verbally on the radio transmission that Ms A was a status three patient, but was recorded as a status two patient on the PRF. Mr Proctor also stated that there was a failure to emphasise Ms A's persistent altered level of consciousness. I am concerned that neither EMT L nor any other member of St John provided an adequate handover.

248. EMT L stated that once she finished her handover she completed a PRF and left it in the nurses' station at the rural hospital. RN D and Dr B stated that no PRF was handed over by paramedic staff. St John also told HDC that no PRF was completed at the conclusion of the handover, and noted that a PRF was located at the Location 2 station approximately 10 days following the incident. In light of the fact that a PRF was located at the station, I find that a PRF was not supplied to rural hospital staff at the time of these events. Mr Proctor advised that the failure to leave a PRF with rural hospital staff represented a significant departure from the expected standard of care. I am concerned that a PRF was not given to rural hospital staff.

249. Mr Proctor also advised that the PRF failed to communicate the seriousness of Ms A's condition, specifically that she might have a potential head injury.

System/cultural issues at Location 2 station

250. St John's internal report found that there was inconsistent managerial development, supervisory oversight, and clinical development of staff at the Location 2 station, which resulted in "significant skill-degradation" and "sub-optimal" clinical competencies, operational capabilities, and role-modelling. As a result of the interviews conducted, the report found that there was "general feeling that isolation, lack of clinical support, performance and communication issues in [the area] have been accepted as 'the norm' despite previous and current managers being made aware of the concerns". I note that EMT L and ILS K were an integral part of the service provided by the station, as they were two out of only three full-time paid staff at the time of the incident.

251. St John stated that during the course of its internal investigation it identified a number of hierarchical constraints within the area that posed particular challenges for junior staff in challenging the decision-making of senior staff. St John told HDC that it does not believe that FR O would have had the ability to challenge the decision-making of EMT L, based on a long-standing culture of deference to that hierarchy. St John also stated that FR O's inexperience and lack of clinical authority to practise would not have supported her to identify and manage Ms A without the oversight and direction of EMT L.

252. St John told HDC that there was minimal CSO support available to the staff in the region in 2014. It stated that the reasons for the lack of CSO support included staff resistance, financial limitations, and geographic isolation. This is reflected in the findings of St John's internal report, which stated that there was a general feeling of a lack of clinical support, and that performance and communication issues had become accepted as being normal, despite previous and current managers being made aware of the concerns (as stated in para 162 above). I am concerned that there was minimal CSO support available to staff at the time of these events.

253. I note that Mr Proctor advised that the St John policies and procedures current at the time of these events were adequate. However, these policies and procedures were not supported by a culture of performance or compliance. I note that St John has made a number of changes to its practice (as stated in para 169), which include improvements to the training and professional support and managerial oversight of the paramedic staff in the area, as well as the provision of additional resources. I consider these changes to be necessary and appropriate.

Conclusion

254. St John is responsible for the operation of the clinical services it provides, and can be held responsible for any service failures. In my view, it was the responsibility of St John to have adequate systems in place and appropriate oversight of staff, to ensure that Ms A received an acceptable level of care.

255. While I accept that the written policies and procedures in place at the time were adequate, St John has acknowledged in its root cause analysis report that a culture of inadequate clinical support, and suboptimal performance and communication had developed within the Location 2 station. The report noted that there was minimal clinical support officer support available to staff in the region in 2014. St John's internal report also found that there was a general feeling of a lack of clinical support, and that performance and communication issues had been accepted as the norm.

256. I also note St John's finding that FR O, as a less experienced member of staff, would not have had the ability to challenge the decision-making of EMT L, based on a longstanding culture of deference to that hierarchy. As discussed above, this issue is apparent at least with respect to the way in which Ms A was transferred into the hospital. As an organisation, St John is responsible for the culture within the organisation, and for ensuring that staff feel comfortable raising concerns they may have about patient care. If such behaviours are not encouraged, patient care can be compromised.

257. For these reasons, I consider the failures of the clinical staff to be service failures that are directly attributable to St John as a service provider. In my view, St John provided Ms A with suboptimal care as follows:

- Failure to recognise the seriousness of Ms A's condition.
- Failure to have someone in the back of the ambulance to provide verbal reassurance to Ms A and encourage her to stay still during transportation.
- Failure by the staff manager to undertake a further assessment of Ms A upon meeting the ambulances carrying the two patients.
- Inappropriate transfer of Ms A from the ambulance using a wheelchair, including a failure by junior staff to encourage appropriate action.
- Inadequate handover to the rural hospital staff.
- Failure to supply the rural hospital staff with a PRF.
- Failure to complete the PRF form to an adequate level.
- Failure to advocate on behalf of the patient, in particular relating to transfer to the city hospital.

258. St John's failure to provide appropriate clinical and managerial support, development, and oversight at the Location 2 station, and to ensure a supportive and safe organisational culture, meant that Ms A was provided with inadequate care by its staff. I consider that St John did not provide services to Ms A with reasonable care and skill. Accordingly, St John breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[61]

Opinion: Dr B — breach

259. Dr B cared for Ms A between approximately 4.45–8am and 2.30–4.30pm. Dr B told HDC that when Ms A arrived at the rural hospital, she was informed by paramedic staff that Ms A had been involved in a low-impact motor vehicle accident, had superficial cuts and an abrasion to the knee, and was inebriated. EMT L stated that during her handover Dr B informed her that there was no way Ms A was going to the city hospital because "[the city hospital] will get angry if we send a drunk girl down there".

260. Dr B told HDC that she assessed Ms A at approximately 5am. Dr B made an initial entry of her assessment at 4.55am and added further notes to that entry at 6.54am. In particular, Dr B documented that Ms A had been involved in a motor vehicle accident, was inebriated, and

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

had scratches on both thighs, an abrasion on her left knee, a contusion on her left shin, and no obvious head injury. Dr B also recorded that Ms A's spine was not tender, her pupils were equal and reactive to light, that she was "responding", was moving a lot on the bed, moving her legs and arms freely, and had no pelvic injury. Dr B's plan was to "observe and send home when alert". Dr B retrospectively added to this consultation note that Ms A had a GCS of 14/15.

261. Dr B told HDC that she spent about an hour with Ms A, and during this assessment Ms A could focus on her (Dr B's) finger moving towards her nose, and could follow and touch her hand when she moved it in different positions. Dr B said that Ms A was able to give single word responses, did not seem confused, and appeared to know that she was at the rural hospital. Dr B also stated that Ms A's chest had equal expansion on both sides with good air entry and was not bruised. Dr B said that Ms A's temperature was not taken because she pushed RN D off and prevented her from doing so. Dr B observed that she did not smell alcohol.

262. Dr B told HDC that the factors that influenced the care Ms A received were that a low-impact accident was reported, the patient was reportedly intoxicated, and no information was provided or found during her assessment of the patient that contradicted that, Ms A's raised temperature was not reported on by the nurse, and no history was provided regarding the other patient's condition.

263. I note that RN D has told HDC that she did not see Dr B physically examine or assess Ms A following her arrival at the rural hospital, and disputes Dr B's account of the assessment she says she performed. I note that Dr B made a contemporaneous record of an assessment and has provided a detailed statement to HDC regarding that assessment. I also note that NPHCT's internal report recommended that work be undertaken to strengthen internal relationships between providers, and the comments RN D has made about Dr B's attitude when interacting with her. Having considered all of this information, I consider it more likely than not that Dr B did conduct an initial assessment.

264. At approximately 6.45am, RN D recorded that Dr B took a blood sample from Ms A, who responded by pulling her arm away, crying, and touching her left ear. RN D noted that Ms A was "still not talking just crying and moaning". Dr B stated that she examined Ms A's left eardrum, which was inflamed but not markedly so. Dr B told HDC that Ms A's condition had not changed, and so she set the time for reassessment after handover at 8.30am. There is no clinical record of this examination having occurred during Dr B's morning shift. Dr B told HDC that she was unaware of Ms A's elevated temperature (39.5°C). At 7am, RN D recorded that Ms A was sleeping but agitated, and was "moaning and crying at times".

265. I note that RN D has stated that she did report Ms A's temperature to Dr B and recorded it on the triage form. I note the conflicting evidence regarding whether Dr B was aware of Ms A's elevated temperature, but do not consider it is necessary to make a finding in relation to this.

266. At approximately 7.45–8.10am, Dr B handed over Ms A to Dr C. Dr B stated that she told Dr C that Ms A had been in a car accident, had a history of inebriation, appeared drowsy,

and would need an assessment during his ward round that morning. Dr C stated that he was not asked to assess Ms A, and his understanding was that she was inebriated and was to be observed and allowed to go home when alert. Dr C stated that after completing his ward round he left the hospital at approximately 8.30am to attend another clinic. At approximately 2pm, after receiving a telephone call from RN E regarding Ms A's condition, Dr B returned to the rural hospital and assessed Ms A, and worked with Dr C to arrange an urgent transfer to the city hospital.

267. My expert medical advisor, Dr Abi Rayner, stated that Dr B's initial physical assessment of Ms A met minimum standards, noting that the failure of information sharing by paramedics at the time of handover clearly influenced Dr B's assessment and decision not to transfer to the city hospital. However, Dr Rayner stated that Dr B appears to have interpreted abnormal findings as due to alcohol, and further information and assessment did not alter the conclusion. Dr Rayner advised that Ms A's failure to improve in the period between 4.45am and 6.30am suggested that alcohol could not be the explanation for her condition.

268. In particular, in relation to the initial examination, Dr Rayner noted that finding that a previously healthy young woman was able to respond only with single words, was not able to describe the incident, and was "moving a lot in bed" should have been alarming in the setting of a motor vehicle accident. Dr Rayner further advised that Ms A's neurological examination was not normal at any point. Dr Rayner noted that there is no record that Ms A spoke after the initial medical assessment, or that she sat up, moved purposefully, or followed commands after she touched Dr B's finger. Dr Rayner advised that in the setting of an altered level of consciousness, the impact of alcohol or drugs cannot be clearly differentiated from brain injury, and all abnormal behaviour in the setting of an accident should be considered suspicious for a brain injury. She also advised that the finding of an abnormal eardrum in the setting of an injury must be considered a sign of basal skull fracture.

269. Dr Rayner stated that Ms A's initial presentation "should have probably resulted in an immediate transfer to [the city hospital]", and that Ms A's failure to improve over a two-hour period should "certainly" have prompted consultation with the city hospital staff. Dr Rayner said that "even if alcohol was the explanation for [Ms A's] behaviour, one could not be certain without a CT scan". Dr Rayner noted that the rural hospital was a resource-poor environment, and stated that Ms A should have been transferred to a facility equipped to provide further assessment.

270. I note Dr B's submission that because she completed her assessment at approximately 6am, using Dr Rayner's two-hour period, the timeframe to have prompted consultation with the city hospital would have been at approximately 8am, which was at handover to Dr C. Dr B also said that she had set the time for reassessment after handover at 8am, and says that she handed over to Dr C to assess Ms A.

271. Regardless of whether Dr B asked Dr C to assess Ms A after handover, Ms A was still under Dr B's care up to approximately 8am (which was a total of approximately 3 hours and 15 minutes). In any event, Dr Rayner advised that Dr B's failure to recognise that Ms A's neurological examination was significantly abnormal, and that her failure to improve over time (even in the interval from 4.45am to 6.30am) suggested that alcohol could not be the

explanation, represented a significant departure from the accepted standard of care. I accept Dr Rayner's advice and am critical of the clinical care Dr B provided Ms A.

272. I note that the rural hospital's (NPHCT's) Admission Policy required low complexity patients to be admitted to the rural hospital via the Case Mix Ward system. Medium and high complexity patients requiring further medical/specialist interventions were to be transferred to the city hospital. NPHCT's Reportable Event Investigation Report stated that Ms A was not assessed to determine her complexity level, or admitted to the Case Mix Ward system. I am concerned that Dr B did not follow this policy.

273. NPHCT's Reportable Event Investigation Report also stated that no one person in the clinical team took responsibility for the coordination of Ms A's care. I note that there are differing recollections between Dr B and Dr C regarding what was communicated during the morning handover. That is, Dr B stated that she told Dr C that Ms A would need an assessment during his ward round that morning. Dr C stated that he was not asked to assess Ms A, and his understanding was that she was inebriated and was to be observed and allowed to go home when alert. I also note that RN E telephoned Dr B hours after she had handed over Ms A's care to Dr C, to inform Dr B of Ms A's deteriorating condition.

274. At best there was significant ambiguity in the conversation between Dr C and Dr B, and I note that Dr C's actions were consistent with what he says he was told. In particular, he did not assess Ms A and left the hospital shortly thereafter to attend another clinic. I am concerned that there could be such ambiguity in a medical handover.

275. I am critical that Dr B failed to recognise that Ms A's neurological examination was significantly abnormal, and that her failure to improve over time suggested that alcohol could not be the explanation. I am also critical that Dr B did not follow NPHCT's Admission Policy appropriately. Accordingly, I consider that Dr B did not provide services to Ms A with reasonable care and skill, and so breached Right 4(1) of the Code.

Documentation

276. Dr B retrospectively added the text, "seen 4.0[0]am GCS 14/15" to her consultation note. Dr B did not specify that this entry was made retrospectively. When asked to comment on this amendment, Dr B told HDC that she realised that Ms A's GCS of 14/15 "was omitted from [her notes] and as such [she] inserted [it] [later]". An audit of the electronic record shows that Dr B made this entry at 4.04pm on the later date.

277. MCNZ's statement on "The maintenance and retention of patient records" (2008) states that doctors must make records at the same time as the events they are recording "or as soon as possible afterwards". MCNZ's publication *Cole's Medical practice in New Zealand* comments:

> "Sometimes, on reviewing an earlier record entry, a doctor may feel that it is inaccurate, incomplete or potentially misleading. It is appropriate to augment a record in such cases, making it clear when and by whom the augmentation or annotation was added. The earlier entry should never be deleted, obliterated or changed, if only because such amendments might later raise suspicion of covering up an error in treatment or diagnosis."

278. I agree with MCNZ's professional guidelines. Given Ms A's ongoing deterioration and the timing of this amendment, this is a good example of how retrospective amendments to the clinical record, without making it clear that it was retrospective, could raise suspicion. I am very critical that Dr B failed to record clearly that the additional notes she made regarding her assessment of Ms A were retrospective. Accordingly, I consider that Dr B did not provide services to Ms A that complied with professional standards, and so breached Right 4(2) of the Code.[62]

Opinion: Dr C — adverse comment

279. Dr C was responsible for Ms A between approximately 8am–4.30pm.

280. At approximately 7.45–8.10am, Dr B handed over Ms A to Dr C. Dr B stated that she told Dr C that Ms A had been in a car accident, had a history of inebriation, appeared drowsy, and would need an assessment during his ward round that morning. Dr C stated that he was not asked to assess Ms A, and his understanding was that she was inebriated and was to be observed and allowed to go home when alert. He said that the magnitude of the car accident was not communicated to him. Dr C stated that after he had discussed the care of the long-term patients at the rural hospital with nursing staff, he left to attend another clinic at approximately 8.30am.

281. At approximately 2pm, following Ms A's family expressing concerns regarding her condition, and a further nursing assessment, RN E telephoned Dr B regarding Ms A's condition. At Dr B's request, Dr C was subsequently informed of Ms A's condition, and both doctors returned to the rural hospital to assess her. After assessing Ms A, Dr C took immediate steps to arrange for an urgent transfer to the city hospital.

282. My expert advisor, Dr Abi Rayner, stated that if a patient is "being boarded in the ED, with [a] planned discharge and has been assessed by the night doctor, it may be the standard that the day doctor assess the person only if problems are identified". However, Dr Rayner further stated that in a patient who has been reported as normal and stable, it would be a minor failure from expected standards not to discuss with nursing staff a plan for discharging the patient.

283. I note that there are differing recollections between Dr B and Dr C regarding what was communicated during the morning handover, including whether or not Dr C was required to conduct a further assessment. I also note that RN E telephoned Dr B hours after she had handed over Ms A's care to Dr C to inform her of Ms A's deteriorating condition.

284. At best there was significant ambiguity in the conversation between Dr C and Dr B, and I note that Dr C's actions were consistent with what he says he was told. In particular, he did not assess Ms A and left the hospital shortly thereafter to attend another clinic. I am

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

concerned that there could be such ambiguity in a medical handover. I am also concerned that a discussion with nursing staff regarding the discharge plan for Ms A did not occur, and am critical of Dr C for this.

Opinion: RN D — breach

285. RN D cared for Ms A between approximately 4.45–7.30am. RN D told HDC that when Ms A arrived at the rural hospital, she was informed by paramedic staff that Ms A had been in a motor vehicle accident, had abrasions on both her legs, was drunk, and had been incontinent of urine. RN D stated that no factual information, such as neurological observations, details of the accident scene, or the level of trauma was handed over to her.

286. RN D also said that she was told that Ms A was a status three patient, that no suggestion or concerns of a head injury were reported, and that St John knew that the rural hospital would not accept anything other than a status three or four patient or patients who were stabilised briefly for transfer to the city hospital. RN D further stated that from her initial observations of Ms A, she thought that her presentation was consistent with someone who was very intoxicated, but stated that she could not smell any alcohol on her.

287. There are two different versions of the Accident and Emergency Assessment form (triage form), both of which record RN D as being the triage nurse. On both forms under the heading "Patient's Chief Complaint" it is recorded that Ms A had been involved in a motor vehicle accident, and had abrasions on both legs and on the left side of her face and right hand. The primary difference between the forms is that one version contains the text, "Patient agitated at times rubbing [right] ear", which subsequently has been crossed out; the other does not contain that text at all. The same baseline observations are recorded on both versions of the form, and document Ms A's pulse, blood pressure, respiratory rate, temperature, and oxygen saturation levels (the details of which are set out above). Both versions also make reference to further information on attached clinical notes.

288. By way of explanation, RN D told HDC that during her night shift she wrote only brief notes. When she returned to the rural hospital for her next shift (approximately 16 hours after caring for Ms A initially), she added further information to the triage form but found that she did not have sufficient room because the form had been photocopied and another nurse had written on it. RN D stated that she crossed out some information on the triage form and inserted "written in error", and wrote further information in the clinical notes.

289. RN D retrospectively documented in the additional clinical notes that Ms A was very restless when getting out of the ambulance, was not weight-bearing, and was swinging her arms about upon being transferred into a wheelchair. RN D recorded that Ms A was crying, her speech was not understandable, she had been incontinent of urine and was rubbing her left ear, and that the ambulance officers helped to transfer her onto a bed. The observations recorded on the triage form(s) were repeated in the clinical notes, and RN D noted that she checked Ms A regularly.

290. RN D told HDC that once Ms A had been transferred onto a hospital bed she asked Dr B about doing observations, and was told by Dr B to do baseline but not neurological observations. RN D stated that she reported the baseline observations, including temperature, to Dr B. RN D recorded in the notes that Dr B had instructed that Ms A was to be observed and sent home when alert.

291. RN D told HDC that she did not conduct neurological observations as part of her initial nursing assessment on the basis of the verbal handover from St John, Ms A's presentation, Dr B's view that Ms A was drunk, Dr B's repeated instruction that she was to be left to sleep it off, and that Dr B specifically told RN D not to do neurological observations. RN D also said that blood glucose levels were not done at the rural hospital in 2014 and she did not know that it was a useful indicator in intoxicated patients.

292. My in-house expert advisor, RN Dawn Carey, stated that based on Ms A's presentation as recorded by RN D, she was moderately critical that RN D did not assess Ms A's blood glucose level or undertake a neurological assessment, in particular a GCS and pupillary response, as part of her initial nursing assessment.

293. I accept RN Carey's advice that based on Ms A's presentation as recorded by RN D, blood glucose levels and a neurological assessment should have been undertaken as part of her initial nursing assessment. I am critical that RN D did not include these assessments in her initial nursing assessment.

294. RN D retrospectively recorded that at 6.45am a police officer had arrived and that Dr B took bloods, and that Ms A responded by pulling her arm away, crying, and touching her left ear. RN D told HDC that after this blood sample had been taken she voiced concerns to Dr B that Ms A would wake up crying and hold the left side of her head by her ear. RN D initially told HDC that she was concerned "because [she] thought that [Ms A] may have [had] more going on, for example a head injury".

295. RN D later told HDC that she did not conduct neurological observations because she received no indication from paramedic staff that Ms A had a potential head injury, and considered her behaviour to be consistent with the metabolising of alcohol. RN D said that she told Dr B about Ms A raising her hand to her ear so that Dr B could review Ms A. RN D stated that she believes she would have undertaken neurological observations if she had suspected a head injury, and would have advised Dr B.

296. In response to the provisional opinion, RN D stated that she raised the issue of Ms A touching the left side of her face/ear and crying because she "was wondering if there was something more going on" and because at that point, she said, Dr B had not assessed Ms A. RN D also stated that Ms A's presentation was consistent with other patients she had attended to who were heavily intoxicated, and "this clouded the situation and [her] judgement".

297. RN D recorded that at 7am Ms A was sleeping but agitated, and was "moaning and crying at times". RN D told HDC that during the time she was caring for Ms A she noticed that she was irritated and that she would rub the left side of her ear and cry every minute or two.

298. RN Carey advised that over the course of the remainder of RN D's shift, Ms A demonstrated a pattern of behaviour that was not consistent with a patient metabolising alcohol. RN Carey advised that she considers that RN D's failure to respond by undertaking an objective neurological assessment was a mild to moderate departure from accepted nursing standards.

299. While I acknowledge RN D's position that Ms A's presentation was consistent with other patients she had attended to who were heavily intoxicated, and that she considered Ms A's behaviour to be consistent with the metabolising of alcohol, I accept RN Carey's advice that over the remainder of RN D's shift Ms A demonstrated a pattern of behaviour that was not consistent with metabolising alcohol.

300. As above, I also note that RN D has acknowledged to HDC twice that she raised the issue of Ms A touching the left side of her face/ear with Dr B, as she thought that there might be something more going on, and gave the example of a head injury in one of those responses. I am therefore concerned that RN D did not undertake a neurological examination at any point.

301. RN Carey further stated that given that Ms A's observations were all at elevated levels on initial assessment, RN D's failure to institute regular monitoring of Ms A's temperature, heart rate, blood pressure, and respiration rate was a significant departure from accepted nursing standards. I accept RN Carey's advice and am concerned that regular monitoring of this kind was not instituted by RN D.

302. With respect to Ms A's hygiene needs following her incontinence, RN Carey advised that minimum care expectations would have included removing Ms A's soiled clothing and changing her into a hospital gown. RN D told HDC that she did not attend to Ms A's hygiene needs as she thought it would be less upsetting for her to settle for a bit first, and to attend to her needs when she was more sober. However, RN D stated that in hindsight she should have attended to Ms A's hygiene needs when they first placed her in the hospital bed. RN Carey advised that RN D's failure to support Ms A to maintain her hygiene needs represented a mild departure. I am concerned that these steps were not taken initially, and that Ms A's basic comfort and dignity was not maintained.

303. At 7.30am, RN E recorded that she received handover from Dr B and RN D. RN D stated that she did not give handover to RN E, as "every time [RN D] went to say something [she] got cut off from [Dr B]". RN E confirmed RN D's recollection of events. RN D said that at the time of handover, she did not have the confidence to push her concerns when she felt that they were being dismissed by Dr B. Dr B stated that she was not present at the nursing handover.

304. I note that NPHCT's "Continuity of Care" policy stated that there should be clear delegation of responsibility for the coordination of care, that comprehensive services are to be delivered through collaboration and cooperation, and that appropriate communication should take place between providers.

305. RN Carey stated that the participation of medical staff in a nursing handover is not unusual. She further stated that typically the nurse who is completing a shift will ensure that any

outstanding nursing concerns are communicated to the oncoming nurse, and that this is "fundamental" to the safe transfer of a patient's care from one nurse to another. I agree with RN Carey, and consider that it would have been appropriate for RN D to ensure that she had communicated all salient information and any nursing information to RN E before completing her shift, whether or not Dr B was involved in the handover.

306. In summary, I am concerned that RN D did not include neurological observations, namely a GCS and pupillary response assessment, as part of her initial nursing review of Ms A, or assess Ms A's blood glucose level. I am also concerned that RN D did not conduct further observations, including neurological observations, over the course of her shift, or attend to Ms A's hygiene needs.

307. For these reasons, I consider that RN D did not provide services to Ms A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Documentation

308. Noting the time that had passed between documenting the care provided (i.e., 16 hours) and the additional notes that RN D made, RN Carey advised that RN D's failure to identify the additional notes she recorded as being retrospective represented a significant departure from accepted standards. I also note that the Nursing Council of New Zealand's *Code of Conduct* (June 2012) requires nurses to keep clear and accurate records that are clearly and legibly signed, dated, and timed. The Code of Conduct also instructs nurses not to "tamper with original records in any way".

309. I am critical that RN D did not clearly record that the additional notes she made were retrospective. Accordingly, I consider that RN D did not provide services to Ms A that complied with professional standards, and so breached Right 4(2) of the Code.

Opinion: RN E — breach

310. RN E cared for Ms A between approximately 7.30am–2.30pm. RN E recorded that she checked Ms A at 7.50am and 8.30am and noted that she was "rousable to illicit pain" and appeared very drowsy. At 9.30am, RN E documented that Ms A appeared to be sleeping, and responded by opening her eyes when she heard her name. RN E said that she did not observe Ms A in any obvious pain. At 10.30am, RN E advised Ms A's whānau that Ms A would be discharged when she was alert. At 11.25am, RN E recorded Ms A's condition as being unchanged.

311. At 12.15pm, RN E documented that Ms A was crying and was informed that she had been in an accident. Once settled, RN E left Ms A to sleep. At 1.15pm, RN E recorded that Ms A's whānau had expressed concern that she was "not her usual self in terms of when she is intoxicated". At 1.35pm, RN E recorded that she had contacted Dr B and Dr C about Ms A's condition. RN E also recorded Ms A's blood pressure, pulse, oxygen saturation levels, respiration rate, temperature (38.9°C), and GCS. RN E commenced cooling cares by

opening the windows and placing a damp cloth on Ms A's forehead. RN E told HDC that she did not see urine on the bedclothes or floor, and did not smell urine in the room.

312. At 2pm, RN E recorded that Ms A was sleeping and that the whānau had been informed that it was likely she would be sent to the city hospital after she had been assessed by a doctor. At approximately 2.30pm, RN E handed over the care of Ms A to RN F.

313. RN E told HDC that she did not consider it necessary to take vital observations between 7.30am and 1.35pm because she had been informed by Dr B that Ms A had only minor abrasions and no head injury, and was intoxicated. I note that Dr B stated that she was not present during the morning nursing handover, but did have a conversation with RN E in the corridor outside Ms A's room, and said that she was under observation following a motor vehicle accident. RN E said that she did not undertake a GCS assessment at 8.30am because it would not be unreasonable for someone reported as intoxicated at 4.35am to still be sleeping during the morning.

314. Having received RN E's account of handover, RN Carey acknowledged that RN E had limited information available to her, but noted that the triage sheet detailed that Ms A's vital signs were elevated. RN Carey advised that this information should have cued further monitoring. In particular, RN Carey stated that the failure to monitor Ms A's temperature, heart rate, blood pressure, and respiration rate prior to 1.35pm was a significant departure from the accepted standard of care. RN Carey also considered that RN E should have checked Ms A's blood glucose levels for induced hypoglycaemia.

315. RN Carey stated that over the course of the morning shift, Ms A demonstrated a pattern of behaviour that was not consistent with a patient metabolising alcohol. RN Carey noted in particular that Ms A was rousable to pain at 8.30am, and did not appear to have communicated in words or sentences, or to have moved. RN Carey considered that such behaviour "should have cued an objective neurological assessment", and advised that the failure to conduct such an assessment represented a moderate to significant departure from the accepted standards of nursing care.

316. I acknowledge RN E's submission in response of the provisional opinion that it was reasonable to believe that she had received a full and accurate handover from Dr B, particularly since it was not contradicted by RN D, and to rely on that handover to determine the appropriate care for Ms A. I also acknowledge RN E's submission that no mention of abnormal vital signs was made during handover, and that Dr B's direction to let the patient sleep strongly influenced her to leave Ms A to sleep undisturbed. RN E also submitted that she did not consider there to be any need to read Ms A's clinical notes from the previous shift.

317. However, I note that RN E told HDC that during handover Dr B overruled RN D, and she was unable to provide her information "due to [Dr B's] interruptions". I further note that RN E has acknowledged that the earlier vital sign observations were available on the triage form. As stated above, RN Carey has advised that these vital signs should have cued further monitoring.

318. I also acknowledge RN E's submission in response to the provisional opinion that, although she did not conduct a formal neurological assessment or record a GCS, documenting Ms A's level of consciousness several times during the morning (eg, noting that she was "rousable but sleepy") was the appropriate level of assessment given her understanding that Ms A was intoxicated and did not have a head injury. However, as stated above, RN Carey has advised that over the course of the morning shift Ms A demonstrated a pattern of behaviour that was not consistent with a patient metabolising alcohol, and that this should have cued an objective neurological assessment.

319. I accept RN Carey's advice. I am very critical that RN E did not monitor Ms A's vital signs up to 1.35pm and, having regard to her presentation, did not undertake any neurological assessment up to that point.

320. RN Carey was also mildly critical of the failure to provide Ms A with appropriate hygiene needs, and questioned the effectiveness of the steps RN E took when initiating cooling cares, which she said would normally involve removing a patient's clothing and sponging the patient with tepid water at a minimum. RN Carey also expressed concern about the management of Ms A's nutritional and hydration needs. RN Carey considered that the assessment RN E conducted at 1.35pm, and the steps she took to notify Dr B and Dr C of her findings, were appropriate.

321. I note that NPHCT's Continuity of Care policy stated that there should be clear delegation of responsibility for the coordination of care, that comprehensive services are delivered through collaboration and cooperation, and that appropriate communication should take place between providers. I refer to the discussion above regarding RN E's submission about this handover. I remain concerned that RN E did not ensure adequate communication with RN D and, in particular, that she received a complete handover from RN D, as set out in the policy, whether or not Dr B was involved.

322. In summary, I am critical that during her shift RN E failed to conduct nursing assessments and monitor Ms A's vital signs prior to 1.35pm. I am also critical that RN E did not check Ms A's blood glucose level or conduct an objective neurological assessment. I am concerned about the way RN E managed Ms A's hygiene, food, and hydration needs, and the effectiveness of her cooling cares.

323. Overall, I consider that RN E did not provide services to Ms A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Documentation

324. RN E stated that before Ms A was transferred to the city hospital she saw Dr B's referral letter, which specified a GCS of 12. RN E said that she told Dr B that she had recorded a GCS of 9 in her nursing notes, and that Dr B asked her to change her notes to show that the GCS was 12. RN E told HDC that she re-wrote her notes to make this change. Dr B told HDC that she did not have any conversation with RN E about changing the GCS record, and did not direct her to change her records.

325. RN E said that after leaving the hospital after her shift, she felt uncomfortable about having changed the GCS score. She discussed the matter with Dr C, and then returned to the rural

hospital and removed the page in the progress notes that contained the GCS of 12, and re-wrote her entries in the progress notes to specify a GCS of 9. RN E also stated that she asked RN F to re-write her own entries in the progress notes again, after her (RN E's) last entry at 2.30pm. RN E did not annotate which notes were made retrospectively. RN F told HDC that she re-wrote her entries in the observation chart (as distinct from the progress notes) upon RN E's request, and that she was not asked to rewrite her entries in the progress notes at this time. RN F stated that the following day she arrived at work and found RN E completing another set of progress notes and an observation chart for Ms A. RN F told HDC that on RN E's request she copied her previous clinical notes from RN E's second set of progress notes, making some minor alterations for clarification. RN F also stated that she copied her neurological observations and GCS scores onto a third observation chart.

326. RN E does not recall asking RN F to re-write her neurological observations onto another chart, and told HDC that she did not re-write her notes again.

327. Although there is some conflict between what RN E and RN F have told HDC, RN E does not dispute that she removed some original progress notes, re-wrote her entries into the progress notes, and then instructed RN F to re-write hers.

328. I therefore find that RN E removed and re-wrote clinical notes and instructed RN F to do the same. I am severely critical that she did so.

329. RN Carey stated that RN E should have documented the circumstances that led her to record a GCS of 12 rather than 9, and should not have removed the original clinical notes from Ms A's file. RN Carey stated that she considered the nursing documentation to be a departure from accepted practice, and was severely critical of retrospective additions to clinical nursing notes being presented as otherwise.

330. I note that the Nursing Council of New Zealand's *Code of Conduct* (June 2012) requires nurses to keep clear and accurate records that are clearly and legibly signed, dated, and timed. The Code of Conduct also instructs nurses not to "tamper with original records in any way".

331. I acknowledge RN E's submission that while she accepts that the method was incorrect, by changing the notes the second time she was attempting to act in accordance with her obligation to keep clear and accurate records.

332. I am critical that RN E did not clearly record that the additional notes she made regarding the care she provided to Ms A were retrospective, and consider that RN E should have documented the circumstances that led her to modify her nursing records. I am also extremely critical that, in addition, she removed the original clinical notes from the file.

333. Accordingly, I consider that RN E did not provide services to Ms A that complied with professional standards, and so breached Right 4(2) of the Code.

Opinion: RN F — adverse comment

334. RN F provided care to Ms A between approximately 2.30–4.35pm. RN F told HDC that during her shift she telephoned RN E and asked her to complete her nursing records, and that RN E returned to the rural hospital at approximately 5.30pm. RN F stated that upon RN E's request, she re-wrote the neurological observations she had recorded during her shift onto another observation chart that RN E had given her.

335. RN F stated that the following day she arrived at work and found RN E completing another set of notes and observation charts for Ms A. RN F told HDC that on RN E's request she copied her previous clinical notes to follow on from RN E's second set of notes, making some minor alterations for clarification. RN F also stated that she copied her neurological observations and GCS scores onto a third observation chart.

336. RN E told HDC that she returned to the rural hospital at approximately 5.30pm and re-wrote her clinical notes and observations, and asked RN F to write her own clinical notes again after her (RN E's) last entry at 2.30pm. RN E does not recall asking RN F to re-write her neurological observations onto another chart, and told HDC that she did not re-write her notes again the following day.

337. RN F told HDC that she accepts that she should have been clear about the time at which her clinical notes were written. She also accepts that she knew that RN E had changed her notes, and did not "challenge her about this". RN F stated that she did not have the confidence to challenge RN E, because RN E was her team leader at the time of these events.

338. Although there is some conflict between what RN E and RN F have told HDC, I find that upon instruction from RN E, RN F re-wrote her clinical notes and failed to record that they were written retrospectively, as she has accepted.

339. RN Carey advised me that the clinical care RN F provided to Ms A was consistent with accepted standards. However, RN Carey stated that she considers the nursing documentation to be a departure from accepted practice, and is severely critical of retrospective additions to clinical nursing notes being presented as otherwise.

340. I note that the Nursing Council of New Zealand's *Code of Conduct* (June 2012) requires nurses to keep clear and accurate records that are clearly and legibly signed, dated, and timed.

341. I consider that RN F's clinical note-taking clearly breached the accepted standard of nursing documentation. In particular, I am critical that RN F failed to identify clearly that the amendments to her clinical notes were made retrospectively. In addition, I do not consider that the fact that RN F was asked to re-write her clinical notes by her senior excuses her actions, and am critical that she did not raise any concerns with RN E or management. However, I do consider the fact that RN F copied her previous entries into the progress notes, and made only minor alterations for clarification, to be a mitigating factor.

Opinion: Ngati Porou Hauora Charitable Trust — breach

Introduction

342. During Ms A's stay at the rural hospital, the care she received from a number of clinicians was suboptimal. Individual NPHCT clinicians who provided services to Ms A hold a degree of responsibility for the suboptimal care at various times. However, group providers are responsible for the operation of the clinical services they provide, and can be held responsible for any service-level failures.

343. NPHCT has an organisational duty to ensure that services are provided with reasonable care and skill. This includes a responsibility to facilitate continuity of care and compliance with its policies and procedures.

Clinical care

344. Ms A presented to the rural hospital after having been involved in a motor vehicle accident. RN D conducted baseline observations but did not include neurological observations in her initial nursing assessment or test Ms A's blood glucose level. RN D also did not conduct further observations or attend to Ms A's hygiene needs over the course of her shift. RN D told HDC that the paramedic staff emphasised to her that Ms A was drunk, and her presentation was consistent with someone who was very intoxicated.

345. Dr B told HDC that she assessed Ms A at approximately 5am and documented that she was inebriated, had scratches on both thighs, had an abrasion and a contusion on her left leg, and had no obvious head injury. Dr B made a plan to "observe and send home when alert". At approximately 6.45am, Dr B took a blood sample from Ms A and examined her left ear, which Dr B said was inflamed but not markedly so. At approximately 7.45–8.10am, Dr B handed over Ms A's care to Dr C. During the morning shift the glass on Ms A's back was not fully removed.

346. RN E cared for Ms A between 7.30am and 2.30pm. RN E stated that she did not receive a handover from RN D. RN E did not conduct nursing assessments or monitor Ms A's vital signs prior to 1.35pm. RN E also did not check Ms A's blood glucose level, conduct a neurological assessment, or manage Ms A's hygiene needs appropriately. RN E told HDC that she considered Ms A's behaviour was not inconsistent with someone who was intoxicated.

347. NPHCT's Reportable Event Investigation Report found that Ms A was not provided with a basic quality of care, including the fact that she was not provided with personal cares, had not been cleaned following her incontinence, and glass was removed from her back only later in the day. The report further stated that the placement of Ms A away from the nurses station could have influenced the level of observation provided.

348. My expert nursing advisor, RN Dawn Carey, stated that there were a number of departures from the accepted standard of care regarding the services nursing staff provided to Ms A. RN Carey's criticisms include the lack of nursing assessments conducted, the failure to conduct neurological observations prior to 1.35pm or check Ms A's blood glucose level, and the failure to attend to her hygiene, nutritional, and hydration needs.

349. My expert medical advisor, Dr Abi Rayner, was also critical of the medical care provided to Ms A. Dr Rayner stated that there was a failure to recognise that Ms A's neurological examination was significantly abnormal, and that her failure to improve over time suggested that alcohol could not be the explanation. Dr Rayner noted that in the setting of an altered level of consciousness, the impact of alcohol or drugs cannot be clearly differentiated from a brain injury. In a resource-poor environment like the rural hospital, Dr Rayner stated that Ms A should have been transported to a facility equipped to provide further assessment such as a CT scan.

350. I am concerned at the multiple and serious clinical failings of both NPHCT's medical and nursing staff when providing care to Ms A. I agree with NPHCT's finding that Ms A was not provided with a basic quality of care, and am critical that there was a significant delay in removing glass shards from her back. I am particularly concerned about the apparent reliance placed on incorrect information conveyed that Ms A was inebriated, and the impact this assumption had on the care that she received.

Communication between NPHCT staff

351. RN D stated that she did not hand over Ms A to RN E at the conclusion of her shift because of being interrupted by Dr B. Dr B stated that she was not present during the morning nursing handover, but did have a conversation with RN E in the corridor outside Ms A's room. RN E told HDC that she was unaware of Ms A's incontinence until Dr B mentioned it during the nursing afternoon shift handover.

352. With respect to the medical handover for the morning shift, Dr B stated that she told Dr C that Ms A had been in a car accident as a passenger with a seatbelt on, had a history of inebriation, appeared drowsy, and would need an assessment during his ward round that morning. Dr C stated that he was not asked to assess Ms A, and his understanding was that she was to be observed by nursing staff and sent home when alert.

353. RN Carey advised me that typically a nurse completing a shift would ensure that any outstanding nursing concerns were communicated to the oncoming nurse, and that this is "fundamental" to the safe transfer of a patient's care from one nurse to another. Dr Rayner considers that there was a lack of clear communication during the nursing and medical morning handovers. I also note that NPHCT's Reportable Event Investigation Report found that poor communication between hospital staff contributed to an assessment that Ms A was intoxicated and should be sent home when alert.

354. In my view, there was suboptimal communication between the NPHCT nursing team and the medical staff responsible for caring for Ms A, which resulted in missed opportunities for Ms A to receive further medical and nursing assessment.

Clinical leadership

355. As stated above, both Dr B and Dr C had different understandings as to whether Ms A required further assessment before being sent home. At approximately 1.35pm, RN E telephoned Dr B to inform her about Ms A's condition. I note that Ms A's care had been handed over to Dr C earlier that morning. At Dr B's request, Dr C was subsequently informed of Ms A's condition, and both doctors returned to the rural hospital to assess her.

356. NPHCT's Reportable Event Investigation Report stated that no one person in the clinical team took responsibility for the coordination of Ms A's care. Upon review of the evidence, I am concerned that there was ambiguity over which clinician was in charge of Ms A's care. Ensuring that the clinical team (both nursing and medical) is clear about who is responsible for the care of a patient is fundamental to good coordination of care and clinical leadership.

Staff compliance with NPHCT policies

357. Both RN Carey and Dr Rayner advised me that NPHCT's Admissions Policy and continuity of care policy were appropriate, but were not followed by nursing and medical teams.

358. The Admissions Policy stated that low complexity patients were to be admitted to the rural hospital via the Case Mix Ward system. Medium and high complexity patients requiring further medical/specialist interventions and/or services not available at the rural hospital were to be transferred to the city hospital. Dr B did not assess Ms A to determine her complexity level or admit her to the Case Mix Ward system, and I note that NPHCT's Reportable Event Investigation Report stated that "normal practice was not adhered to". I am critical that the Admissions Policy was not followed.

359. The Continuity of Care policy stated that there should be clear delegation of responsibility for the coordination of care, that comprehensive services are delivered through collaboration and cooperation, and that appropriate communication takes place between providers. As stated above, I note that Dr C and Dr B have different recollections about what was communicated during the medical handover. I also note that RN D stated that she did not provide handover to RN E. In addition, whilst Ms A's care had been handed over to Dr C at approximately 7.45–8.10am, RN E first contacted Dr B regarding Ms A's condition later that day. I am concerned that there was poor communication between medical and nursing teams and ambiguity regarding who was responsible for the coordination of Ms A's care. I consider that such matters reflected consistent non-compliance with NPHCT's Continuity of Care policy.

360. I am critical that multiple members of NPHCT's clinical team failed to follow its policies. I consider that such failures point to an organisational culture of non-compliance.

Documentation

361. RN E removed original contemporaneous documentation from the clinical record, and RN D, RN E, and RN F all recorded clinical notes retrospectively but did not document that those notes were retrospective. RN F also told HDC that she was aware that RN E had changed her notes, but did not have the confidence to challenge her because she was her team leader.

362. RN Carey was critical that RN D, RN E, and RN F all failed to identify that notes they recorded were retrospective, and considers such a practice to be a departure from the accepted standards of nursing care. RN Carey also said that RN E should not have removed original clinical notes from the file. I also note that Dr B inserted a GCS score into her consultation note on a later date, and failed to record that this addition was made retrospectively.

363. The importance of good record-keeping cannot be overstated. It is the primary tool for continuity of care, and a tool for managing patients. If clinical notes are supplemented at a later time, it is important that they are annotated as such, to make it clear what information was recorded and available on the clinical record at any particular time, and to avoid raising suspicion of covering up an error in treatment or diagnosis.

364. I am critical that multiple members of NPHCT's nursing and medical teams considered it acceptable to make additional notes without clearly recording that the notes were written retrospectively, and that original contemporary documentation was removed from the clinical record. I am also concerned that RN F did not feel comfortable discussing her concerns about the situation with her team leader. Such actions point to concerning attitudes and patterns of behaviour by staff at the rural hospital in terms of accurate record-keeping.

Conclusion

365. Group providers are responsible for the operation of the clinical services they provide, and can be held responsible for any service failures. NPHCT has a responsibility for the actions of its staff, and an organisational duty to facilitate good continuity of care. This includes ensuring that all staff work together, communicate effectively, and comply with organisational policies and procedures. While the individual clinicians who provided services to Ms A hold a degree of responsibility for the suboptimal care at various times, I consider the failures of the clinical staff to be service failures that are also directly attributable to NPHCT as a service provider. In my view, the care provided by NPHCT to Ms A was suboptimal in the following ways:

- The nursing and medical teams did not provide an appropriate standard of care. This included the failure of staff to provide Ms A with basic personal cares, including attending to her hygiene needs and ensuring that glass was removed from her back.
- There was a lack of clinical leadership demonstrated in relation to Ms A's care.
- There was poor communication between the nursing and medical teams.
- Staff failed to comply with NPHCT policies.
- Staff failed to document accurately that some clinical notes were made retrospectively.

366. These failures resulted in Ms A not being assessed and monitored appropriately, or transferred to the city hospital in a timely manner. Accordingly, I consider that Ngati Porou Hauora Charitable Trust failed to provide services to Ms A with reasonable care and skill, and breached Right 4(1) of the Code.

Recommendations

367. I recommend that The Order of St John Central Region Trust Board provide a written apology to Ms A's whānau for its breach of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A's whānau.

368. Since the time of these events, The Order of St John Central Region Trust Board has made a number of changes to its practice. I recommend that St John provide HDC with a report confirming the implementation of the recommendations and actions following its investigation into these events, and any associated education provided to paramedic staff in the region. The update is to be sent to HDC within six months of the date of this report.

369. I recommend that NPHCT:

1) Provide a written apology to Ms A's whānau for its breach of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A's whānau.

2) Provide HDC with a report confirming the implementation of the recommendations and actions following its investigation into these events, and any associated documentation. This report is to include:

   (i) The steps taken to strengthen internal and external relationships with other providers.

   (ii) An update on the training provided to clinical staff in relation to triage and trauma care, assessment, care planning, documentation, and NPHCT values and code of conduct.

   (iii) An update on the standardised pathway for the transfer of patients between St John and the rural hospital staff.

   NPHCT is to provide an update to HDC within six months of the date of this report.

3) Undertake an audit of the rural hospital's clinical records and practice management system for a two-month period to ensure that:

   (i) All patients who present to the Accident and Emergency Department have been assessed appropriately and either transferred to the city hospital or have been admitted to the rural hospital in accordance with the Admissions Policy.

   (ii) All patient presentations to the Accident and Emergency Department have been documented appropriately and additional notes have been marked as having been recorded retrospectively.

   NPHCT is to provide evidence of the audit and its outcome to HDC within six months of the date of this report.

4) Meet with all clinical staff (including healthcare assistants, nurses, and doctors) to discuss the findings of this report and NPHCT's new Admissions, Continuity of Care, and Communication and Participation policies. NPHCT is to provide HDC with minutes of the meeting within six months of the date of this report.

370. I recommend that Dr B provide a written apology to Ms A's whānau for her breach of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A's whānau.

371. Since the time of these events, Dr B has received training on diagnosis and management of patients with a head injury, triage of patients in car accident scenarios, primary and secondary survey of patients, and communication with colleagues. I recommend that Dr B also undertake the following actions:

1) Undertake an audit of her clinical records for three months from the date of this report, to demonstrate that she has appropriately assessed all patients who have been involved in a motor vehicle accident and complied with NPHCT's Admissions Policy.

2) Arrange for further training with the Medical Council of New Zealand regarding record-keeping.

3) Provide evidence to demonstrate the successful completion of the training received following the time of these events.

Dr B is to provide HDC with evidence of the audit and training within six months of the date of this report.

372. Since the time of these events, the Medical Council of New Zealand ordered that Dr B undergo a performance assessment. The Council resolved that Dr B met the required standard of competence for a doctor registered in a vocational scope of general practice but considered that she would benefit from undertaking a 12-month recertification programme to ensure that she maintains the required standard of competence. This programme is due to commence shortly.

373. I recommend that RN D provide a written apology to Ms A's whānau for her breach of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A's whānau.

374. Since the time of these events, RN D has received training on documentation, and has spent time in the city hospital's Emergency Department. I recommend that RN D also arrange for further training with the Nursing Council of New Zealand regarding:

1) An accredited emergency medicine triage course. The course should include training on when and how to conduct neurological assessments, when to assess trauma patient vital signs, and when to attend to hygiene.

2) Communication with colleagues, including how to conduct patient handovers and advocate for a patient.

3) Clinical leadership.

RN D is to provide HDC with evidence of the training within six months of the date of this report.

375. I recommend that the Nursing Council of New Zealand consider whether a review of RN D's competence is warranted.

376. I recommend that RN E provide a written apology to Ms A's whānau for her breach of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A's whānau.

377. Since the time of these events, RN E has received training on documentation, has spent time in the city hospital's Emergency Department, and has attended a clinical training course related to motor vehicle accidents and serious trauma. I recommend that RN E also arrange for further training with the Nursing Council of New Zealand regarding:

1) How and when to conduct neurological assessments.
2) When it is appropriate to assess trauma patients' vital signs, conduct neurological assessment, and attend to hygiene, nutritional, and hydration needs.
3) Clinical leadership.

RN E is to provide HDC with evidence of the training within six months from the date of this report.

378. I recommend that the Nursing Council of New Zealand consider whether a review of RN E's competence is warranted.

379. Since the time of these events, RN F has received training on documentation and has spent time in the city hospital's Emergency Department. I recommend that RN F also attend a course on communication and when to escalate concerns about the conduct of a colleague. RN F is to provide evidence of this training within six months of the date of this report.

Follow-up actions

380. The Order of St John Central Region Trust Board and Ngati Porou Hauora Charitable Trust 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.

381. A copy of this report will be sent to the Coroner.

382. A copy of this report with details identifying the parties removed, except The Order of St John Central Region Trust Board, Ngati Porou Hauora Charitable Trust, and the experts who advised on this case, will be sent to the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners, and they will be advised of Dr B's name.

383. A copy of this report with details identifying the parties removed, except The Order of St John Central Region Trust Board, Ngati Porou Hauora Charitable Trust, and the experts

who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN D's, RN E's, and RN F's name.

384. A copy of this report with details identifying the parties removed, except The Order of St John Central Region Trust Board, Ngati Porou Hauora Charitable Trust, and the experts who advised on this case, will be sent to the District Health Board, and it will be advised of RN D's, RN E's, RN F's, and Dr B's name.

385. A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the Health Quality & Safety Commission.

386. A copy of this report with details identifying the parties removed, except The Order of St John Central Region Trust Board, Ngati Porou Hauora Charitable Trust, and the experts who advised on this case will placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

387. The Director of Proceedings decided not to take proceedings.

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Appendix A: Independent paramedic advice to the Commissioner

The following expert advice was obtained from paramedic Geoff Procter:

"**Statement**

This statement is to confirm that I have read, understood, agreed to and followed the guidelines for independent advisors to the Health and Disability Commissioner. Additionally I have no known conflict of interest with any of the individuals involved in the investigation.

Personal Qualifications

I currently hold a Bachelor of Health Sciences in Paramedicine, and have been a practising paramedic since 2007 with Wellington Free Ambulance. I currently hold an authority to practise at Paramedic level. Additionally my current role, which I have held for four years, is as Field Operations Manager for Blue Shift.

Instructions from the Commissioner

Below are the instructions received from the Commissioner verbatim:

I would be grateful if you limited your advice to the paramedic services provided and addressed the following points in your report:

1. *The adequacy and appropriateness of the paramedic services provided by [EMT L] including (but not limited to):*
    a) *The removal of [Ms A] from the car wreck and the secondary survey conducted.*
    b) *The monitoring of [Ms A], including the decision to transport her without another emergency services staff member present.*
    c) *Whether a C-Spine immobilisation or other relevant equipment/techniques should have been employed when transporting [Ms A].*
    d) *The frequency and nature of observations and clinical assessments conducted en route to [the rural hospital].*
    e) *The decision to transport [Ms A] to [the rural hospital].*
    f) *The manner of transfer of [Ms A] from the ambulance into [the rural hospital]. Please provide advice if the Commissioner accepts the following alternative scenarios:*

        Scenario One: [Ms A] was yelling, screaming and kicking at the ambulance staff (per [RN D's] and [Dr B's] account).

        Scenario Two: [Ms A] was unable to mobilise unassisted and was verbally expressing pain (per civilian [Ms U's] and [FR O's] account).

        Scenario Three: [Ms A] was able to pull herself up off the ambulance bed (per [EMT L's] account).

    g) *The appropriateness of the handover provided to medical/nursing staff. Please provide advice if the Commissioner accepts the following alternative scenarios:*

Scenario One: [EMT L] provided handover to medical and nursing staff (per [EMT L's] account).

Scenario Two: [ILS K] was present at the time of transfer and provided handover to [Dr B] (per [Dr B's] account).

h) The adequacy of the patient report form (PRF).
i) The appropriateness of [EMT L's] actions if the Commissioner accepts the following alternative scenarios:

Scenario One: She left the PRF in the nurses station (per [EMT L's] account).

Scenario Two: She did not complete a PRF or supply it to nursing/medical staff before leaving [the rural hospital] (per [Dr B's] account/ St John RCA findings).

j) Any other matter you consider clinically relevant to comment on.

2. The adequacy and appropriateness of the paramedic services provided by [FR O] including (but not limited to):

a) the preliminary assessment, secondary survey and removal of [Ms A] from the car wreck.
b) the monitoring of [Ms A] during [the first stop].
c) the manual transfer of [Ms A] from the ambulance into [the rural hospital]. Please provide advice for the scenarios listed in question 1(f) above.

3. The adequacy and appropriateness of the paramedic services provided by [Location 2] station Manager [ILS K] including (but not limited to):

a) the support, guidance, and supervision he provided to [FR O] and [EMT L]:
(i) during the transportation of [Ms A].
(ii) during the handover of [Ms A] to [the rural hospital] staff.
b) The decision not to request the support of [ICP R] to assist when transporting [Ms A] and the [other] passenger.

When responding to question 3(ii) please provide your advice if the Commissioner accepts the following alternative scenarios:

Scenario One: [ILS K] did provide handover to [the rural hospital] (per [Dr B's] account).

Scenario Two: [ILS K] was present at some point during [Ms A's] transfer to [the rural hospital], but did not provide handover to medical/nursing staff.

4. The appropriateness of the services provided by [ILS Q] and [EMT P] including their decision not to transport [Ms A] to [the city hospital].
5. The adequacy and appropriateness of the services provided by clinical control centre staff, including (but not limited to) Duty Centre Manager [Mr W], and

[Territory Manager]. When responding to this question please include comment on:

a) the decision made regarding how to transport [Ms A] from the accident site and which paramedic person[ne]l to dispatch.
b) directions and/or support provided to paramedic staff transporting [Ms A].
c) in light of [ICP R's] advice, whether a direction should have been made to transport [Ms A] to [the city hospital] and not [the rural hospital] (see page 23 and 24 of the CCC transcript).

6. *The adequacy and appropriateness of the services provided by Territory Manager [ICP R].*
7. *The adequacy and appropriateness of the services provided by [EMT N] when transferring [Ms A] to [the city hospital].*
8. *The adequacy of the relevant policies and procedures in place at St John at the time of the events complained of [2014]).*
9. *The adequacy of the relevant policies and procedures currently in place at St John, including the 'Patient handover' and 'Land Ambulance Safe Operation' policies.*
10. *Any other aspects of the care provided to [Ms A] that you consider warrants such comment, including further changes that you consider may be appropriate.*

For each issue listed above, it would be helpful if you would advise:

A. what the standard of care/accepted practice is;
B. if there has been a departure from the standard of care or accepted practice, how significant a departure you consider it is (i.e. mild, moderate or severe); and
C. how the care provided would be viewed by your peers.

Facts and Assumptions

All advice I have formed has been based solely on the material provided by the Health and Disability Commissioner. I have not seen fit to source any further external input to this advice. As such, I have formed my advice on the assumption that all information provided is a full and accurate representation of the course of events, and the accounts of the individuals involved.

Advice and Reasoning

As requested by the Health and Disability Commissioner I have formed my advice below:

1. *The adequacy and appropriateness of the paramedic services provided by [EMT L] including (but not limited to):*

a) The removal of [Ms A] from the car wreck and the secondary survey conducted.

If the accounts of [FR O] and [EMT L] are accurate then the initial attempt to put the collar on, the stabilisation of the head and the subsequent (albeit briefly) successful application of the collar would have been an adequate and

appropriate attempt at stabilising the patient's cervical spine during the extraction process.

If the account of volunteer firefighter [Ms S] is accurate in that she doesn't recall stabilising the head, or a collar being present prior to extraction, then the failure to attempt to stabilise the cervical collar prior to and during extraction would have been inadequate, and would have been a significant departure from the expected standards, and viewed poorly by peers.

There is no mention of how the extraction occurred; standard practice would be via use of a Kendrick Extraction Device (KED) if available, or the insertion of a spine board behind the patient whilst still seated, and the gentle coordinated vertical sliding of the patient until they were able to be secured to the spine board. Given the apparent significance of the impact, failure to perform one of these procedures during extraction would be considered a significant departure from expected standards and viewed poorly by peers.

St John (pg. 109 of the Comprehensive Clinical Procedures and Guidelines) rely on the National Emergency X-Radiography Utilisation Study (NEXUS) criteria to determine if a cervical spine can be clinically cleared or needs to be immobilised:

'If the patient had a mechanism of injury that could injure the cervical spine and any of the following signs or symptoms, they should have their cervical spine immobilised:

a) Tenderness at the posterior midline of the cervical spine ***or***
b) Focal neurological deficit ***or***
c) A decreased level of alertness ***or***
d) Evidence of intoxication ***or***
e) Clinically apparent pain or other factors that might distract the patient from the pain of a cervical spine injury'

In this case, the patient required cervical immobilisation.

There is little detail about the depth of the secondary survey conducted, either from the accounts of any person on scene, the patient report form or the St John RCA conducted. The Patient Report Form (PRF) states that a secondary survey was conducted, and an abrasion of the left knee was found. A knee abrasion would be found in a thorough secondary survey, although it is noted the patient was wearing shorts.

A thorough secondary survey would involve the visualisation and palpation of the head, torso, abdomen and all limbs to look for any deformity or any skin laceration or abrasion. Failure to do this, particularly in light of the altered level of consciousness and the mechanism of injury, would be considered a significant departure from the expected standards of care and would be viewed poorly by peers. There is no evidence in the information presented of the

secondary survey not having been conducted, and no mention in the hospital notes of any injuries being missed.

b) The monitoring of [Ms A], including the decision to transport her without another emergency services staff member present.

The crewing arrangements for the transport of both patients appear to be poor, whilst recognising that remote single crewing is a very difficult situation to be in. [EMT L] appears to have assessed the [other] patient as sicker than [Ms A], however has then herself transported [Ms A]. It would be a moderate departure from the expected standards of care to transport the sicker patient in the lower qualified vehicle, which would be viewed poorly by some peers. No mention is made of why this occurred.

It would be expected that, particularly seeing as it was offered, the services of [RN V] be utilised to assist in patient monitoring whilst transporting. It is likely the registered nurse would be able to provide a higher level of assessment and intervention than either of the two ambulance staff on scene. An acceptable alternative would have been to utilise one of the fire service staff to drive an ambulance, whilst [EMT L] attended to the patient.

c) Whether a C-Spine immobilisation or other relevant equipment/ techniques should have been employed when transporting [Ms A].

As discussed, the patient met the criteria for cervical spine immobilisation, so it was appropriate to attempt to immobilise the patient's cervical spine during transportation. It appears from all accounts this attempt was made, however the patient continually pulled the cervical collar off. It is accepted practice that if the patient is uncooperative, and the application of the collar is causing agitation that the use of the collar be discontinued, and verbal coaching to encourage the patient to remain as still as possible be employed.

There is no mention of whether verbal coaching was used in an attempt to calm and stabilise that patient, however given that there was nobody in the back of the ambulance with the patient for the majority of the transportation, this seems unlikely. Failure to have somebody in the back attempting to verbally encourage the patient to stay still, and to reassure them, particularly in light of the answer to question b) above, would be seen as a moderate departure from the expected standards of care and be viewed poorly by some peers.

d) The frequency and nature of observations and clinical assessments conducted en route to [the rural hospital].

The PRF shows that clinical observations are being conducted on the patient roughly every 30 minutes and no significant change is being experienced.

As mentioned in the answer to question b), departure from expected standards has already occurred by not having somebody in the back of the ambulance monitoring the patient when it was available.

Given that this departure has already occurred, and now being in the situation that [EMT L] is transporting the patient single crewed; pulling over every 30 minutes to reassess the clinical vital signs every 30 minutes is adequate although, given that the GCS is only recorded as five, more frequent clinical vital signs would be preferred so that any deterioration could be rapidly picked up.

It is worth noting that during this transportation, [EMT L] would still have been able to actively monitor the patient through looking in the rear view mirror, and listening to the patient, but that this monitoring would have been less desirable than someone's full attention in the back of the ambulance.

e) The decision to transport [Ms A] to [the rural hospital].

[EMT L] was initially advised, via the communications centre, that the Duty Executive would like them to call via [the rural hospital]. She was subsequently advised by Territory Manager (TM) [ICP R] via radio to avoid [the rural hospital].

The patient has then been transported to [the rural hospital] with the subsequently stated intent to 'see if she could be stabilised for the trip to [the city hospital]' ([EMT L's] statement). It is unclear if the intent is to only seek stabilisation from [the rural hospital] rather than complete handover was communicated to [the rural hospital]. The radio call the [Location 2 Ambulance] 1 made to [the rural hospital] (CCC Transcript [number]) suggested a low acuity patient and no mention was made of them seeking assistance only.

A doctor would be able to provide a higher level of care than either [EMT L] or [ILS K], particularly in regards to chemical sedation. Given the agitated presentation of the patient at the time, chemical sedation would have been of benefit to the patient to allow the stabilisation of the cervical spine, and the reduction in damage caused by any suspected head injury.

If [EMT L] was seeking assistance from [the rural hospital], it was reasonable and appropriate to temporarily stop at [the rural hospital].

If [EMT L] was seeking to hand over the patient to [the rural hospital], and had failed to recognise the potential seriousness of the patient's condition, it would be reasonable to and appropriate to hand over to [the rural hospital]. In this case, the failure to recognise the potential seriousness of the patient's condition would be a significant departure from the expected standards of care, viewed poorly by peers, particularly considering her assessment on the PRF as a status two with a GCS of five.

If [EMT L] was seeking to hand over the patient to [the rural hospital], and had recognised the potential seriousness of the patient's condition, it would be considered a significant departure from the expected standards of care viewed poorly by peers. In this case it should be clear from both her knowledge of the

hospital, and her conversations with [ICP R], that [the rural hospital] would not have the facilities to appropriately assess and care for the patient.

f) The manner of transfer of [Ms A] from the ambulance into [the rural hospital]. Please provide advice if the Commissioner accepts the following alternative scenarios:

Scenario One: [Ms A] was yelling, screaming and kicking at the ambulance staff (per [RN D's] and [Dr B's] account).

If the patient was being uncooperative with being on the stretcher, it would be appropriate for [EMT L] to first attempt to calm the patient and return her to the stretcher given her previous suspicions of a potential cervical spine injury.

Failure to first attempt to calm the patient and return her to the stretcher would be seen as a minor departure from the expected standards of care and would be viewed poorly by some peers, but understood by others, as the patient was increasingly difficult to manage at this point.

If the patient was being uncooperative with being on the stretcher, despite the paramedics' best efforts to keep her on there, it would be appropriate to utilise the next best method, minimising her movement as much as possible by using the wheelchair. If this was the case, there would be no departure from the expected standards of care by [EMT L].

Scenario Two: [Ms A] was unable to mobilise unassisted and was verbally expressing pain (per civilian [Ms U's] and [FR O's] account).

It would be inappropriate for [EMT L] to attempt to move or lift the patient to her feet, particularly in light of her previous attempts to secure a cervical collar. This would be seen as a significant departure from the expected standards of care, and be viewed poorly by peers.

Scenario Three: [Ms A] was able to pull herself up off the ambulance bed (per [EMT L's] account).

If the patient was attempting to get off the stretcher, it would be appropriate for [EMT L] to first attempt to return the patient to the stretcher given her previous suspicions of a potential cervical spine injury.

Failure to first attempt to calm the patient and return her to the stretcher would be seen as a minor departure from the expected standards of care and would be viewed poorly by some peers, but understood by others, as the patient was increasingly difficult to manage at this point.

If the patient was being uncooperative with being on the stretcher, despite the paramedics' best efforts to keep her on there, it would be appropriate to utilise the next best method, minimising her movement as much as possible by using the wheelchair. If this was the case, there would be no departure from the expected standards of care by [EMT L].

g) The appropriateness of the handover provided to medical/nursing staff. Please provide advice if the Commissioner accepts the following alternative scenarios:

Scenario One: [EMT L] provided handover to medical and nursing staff (per [EMT L's] account).

On the PRF, [EMT L] has stated 'unsure if pt was driver or passenger' however in her interview with [St John] she indicates that she told [Dr B] that 'pt was front passenger'.

If [EMT L's] account of the handover is accurate, the handover constitutes a significant departure from the expected standards of care and would be viewed poorly by peers, specifically:

- Stating the patient was status three on the radio transmission, when the patient is recorded as status two on the PRF.
- Failure to emphasise the patient's persistent altered level of consciousness.
- Inconsistencies between verbal handover (patient was front passenger) and PRF (unsure if pt was driver or passenger).

Scenario Two: [ILS K] was present at the time of transfer and provided handover to [Dr B] (per [Dr B's] account).

If [Dr B's] account is accurate, the handover provided by [ILS K] is a significant departure from the expected standards of care and would be viewed poorly by peers. Specifically:

- Inaccurate communication that the patient was status three.
- Failure to emphasise significance of impact and mechanism of injury.
- Failure to communicate the presence of a second person in the vehicle, and their level of injury.
- Failure to communicate persistent altered level of consciousness.
- Failure to communicate attempts to immobilise the cervical spine of the patient.

h) The adequacy of the patient report form (PRF)

The PRF fails to communicate the seriousness of the patient's condition, specifically the potential head injury.

If [EMT L] suspects a head injury but has failed to communicate this on the PRF, then the adequacy of the PRF constitutes a significant departure from the expected standards of care which would be viewed poorly by peers.

If [EMT L] does not suspect a head injury, but believes the patient was status two, with a GCS of five and a chief complaint of abrasion as stated, then the PRF is an adequate and accurate reflection of her observations. If this is the case, the departure from expected standards of care is in the assessment and understanding of the patient's conditions, not in the PRF itself.

i) The appropriateness of [EMT L's] actions if the Commissioner accepts the following alternative scenarios:

Scenario One: She left the PRF in the nurses station (per [EMT L's] account).

This would be appropriate and constitutes expected standards of care.

Scenario Two: She did not complete a PRF or supply it to nursing/medical staff before leaving [the rural hospital] (per [Dr B's] account/ St John RCA findings).

Failing to leave a PRF with [the rural hospital] would constitute a significant departure from the expected standards of care, and would be viewed poorly by peers, particularly in light of the seriousness of the crash and the mechanism of injury.

j) Any other matter you consider clinically relevant to comment on.

[Ms U] indicates that she felt uncomfortable that the patient was not seat belted in. It would be inappropriate and below the expected standard of care if [EMT L] had not attempted to secure the patient using seatbelts.

If [EMT L] did not attempt to apply the seatbelts, this would be a moderate departure from the expected standards, viewed poorly by some peers.

If [EMT L] had attempted to secure the patient with seatbelts (there are usually multiple on a stretcher) but the patient had been agitated to the extent that she kept removing them, then it would be appropriate for [EMT L] to attempt to calm the patient with reassurance to allow her to secure the seat belts. If in this scenario, [EMT L] failed to attempt to calm the patient in order to secure the seatbelts, it would be considered a minor departure from the expected standard of care, viewed poorly by some peers.

If [EMT L] unsuccessfully attempted to calm the patient in order to apply the seatbelts, but had to resort to the patient being unseatbelted in order to commence transport of the patient, there would be no departure from the expected standards of care.

2. The adequacy and appropriateness of the paramedic services provided by [FR O] including (but not limited to):

a) the preliminary assessment, secondary survey and removal of [Ms A] from the car wreck.

As with question 1. a), if the accounts of [FR O] and [EMT L] are accurate in that an attempt was made to protect and stabilise the cervical spine then the paramedic services provided by [FR O] are appropriate and expected standards of care.

If the account of volunteer firefighter [Ms S] is accurate in that she doesn't recall stabilising the head, or a collar being present prior to extraction, then the failure to attempt to stabilise the cervical collar prior to and during extraction

then the paramedic services provided by [FR O] would have been inadequate, and would have been a significant departure from the expected standards of care, which would be viewed poorly by peers.

b) the monitoring of [Ms A] during [the first stop].

If [FR O], upon seeing that the patient 'had no neck brace on … but it was near her' (St John #3, [FR O] personal statement), was aware that an attempt had been made to use the collar, but that the patient was not cooperating, then the standard of care by [FR O] was appropriate.

If [FR O], upon seeing the lack of neck brace, was not aware that an attempt had been made to use the collar, it would be expected standards of care for her to raise this with [EMT L] to ensure the patient got the care necessary. If she failed to do this it would be considered a minor departure from the expected standards of care, viewed poorly by some peers, but understood by others. This is due to the qualification and experience difference between the two staff, and the fact that [EMT L] had spent more time with the patient than [FR O].

c) the manual transfer of [Ms A] from the ambulance into [the rural hospital]. Please provide advice for the scenarios listed in question 1(f) above.

Scenario One: [Ms A] was yelling, screaming and kicking at the ambulance staff (per [RN D's] and [Dr B's] account).

If the patient was being uncooperative with being on the stretcher and [EMT L] failed to first attempt to calm the patient and return her to the stretcher, it would be appropriate for [FR O] to encourage [EMT L] to do this, or attempt to do it herself.

Failure to encourage [EMT L] to attempt to return the patient to the stretcher, or to attempt it herself would be seen as a minor departure from the expected standards of care, viewed poorly by a few peers, but understood by most. This is due to the qualification and experience difference between the two staff, and the fact that [EMT L] had spent more time with the patient than [FR O].

If the patient was being uncooperative with being on the stretcher, despite the paramedics' best efforts to keep her on there, it would be appropriate to utilise the next best method, minimising her movement as much as possible by using the wheelchair.

Scenario Two: [Ms A] was unable to mobilise unassisted and was verbally expressing pain (per civilian [Ms U's] and [FR O's] account).

It would be inappropriate for [EMT L] to attempt to move or lift the patient to her feet, particularly in light of her previous attempts to secure a cervical collar. If [FR O] saw this occurring, it would be expected standards of care that she would encourage [EMT L] to utilise the stretcher instead of lifting the patient.

If [FR O] failed to do this, again it would be considered a minor departure from the expected standards of care, viewed poorly by a few peers, but understood by most. This is due to the qualification and experience difference between the two staff, and the fact that [EMT L] had spent more time with the patient than [FR O].

Scenario Three: [Ms A] was able to pull herself up off the ambulance bed (per [EMT L's] account).

If the patient was attempting to get off the stretcher and [EMT L] failed to first attempt to return the patient to the stretcher, it would be appropriate for [FR O] to encourage [EMT L] to do this, or attempt to do it herself.

Failure to encourage [EMT L] to attempt to return the patient to the stretcher, or to attempt it herself would be seen as a minor departure from the expected standards of care, viewed poorly by a few peers, but understood by most. This is due to the qualification and experience difference between the two staff, and the fact that [EMT L] had spent more time with the patient than [FR O].

If the patient was being uncooperative with being on the stretcher, despite the paramedics' best efforts to keep her on there, it would be appropriate to utilise the next best method, minimising her movement as much as possible by using the wheelchair. If this was the case, there would be no departure from the expected standards of care by [FR O].

3. *The adequacy and appropriateness of the paramedic services provided by [Location 2] station Manager [ILS K] including (but not limited to):*

   a) *the support, guidance, and supervision he provided to [FR O] and [EMT L]:*

      (i) *during the transportation of [Ms A]*.

      From the statement by [FR O] and [EMT L], it appears [ILS K] has taken a verbal handover from [EMT L] on both patients before getting on board [the Location 1 ambulance] with [FR O].

      Given the significance of the mechanism of injury and the status of the female patient being communicated as status two, it would be appropriate for [ILS K] to physically assess both patients before proceeding, to ensure that appropriate care was being taken of both.

      If [ILS K] failed to physically assess both patients before proceeding, this would be considered a minor departure from expected standards of care, viewed poorly by some peers, but understood by others. The significance of departure is minor because it would be reasonable for [ILS K] to trust the judgement and verbal handover of [EMT L], however prudent to double check regardless.

(ii) during the handover of [Ms A] to [the rural hospital] staff.

Scenario One: [ILS K] did provide handover to [the rural hospital] (per [Dr B's] account).

If [Dr B's] account is accurate, the handover provided by [ILS K] is a significant departure from the expected standards of care and would be viewed poorly by peers. Specifically:

- Inaccurate communication that the patient was status three.
- Failure to emphasise significance of impact and mechanism of injury.
- Failure to communicate the presence of a second person in the vehicle, and their level of injury.
- Failure to communicate persistent altered level of consciousness.
- Failure to communicate attempts to immobilise the cervical spine of the patient.

Scenario Two: [ILS K] was present at some point during [Ms A's] transfer to [the rural hospital], but did not provide handover to medical/nursing staff.

If [ILS K] was not present for all of the transfer it would be unreasonable to expect him to be aware of all of the handover content, and therefore there would be no departure from the expected standards of care by [ILS K] for the handover.

If [ILS K] was present during the start of the transfer of the patient and saw that the patient was about to be moved to be transferred in a wheelchair instead of the stretcher, it would be expected standards of care that he would attempt to ensure the patient was transferred on the stretcher.

Failure to do this would be seen as a minor departure from the expected standards of care, viewed poorly by some peers, but understood by others. This is because his role as a station manager and ILS qualification increases his responsibility in ensuring adequate patient care, but it is recognised that he has had little to do with the patient up to this point and would be unaware of any discussions had prior to his arrival.

If the patient was being uncooperative with being on the stretcher, despite the paramedics' best efforts to keep her on there, it would be appropriate to utilise the next best method, minimising her movement as much as possible by using the wheelchair. If this was the case, there would be no departure from the expected standards of care by [ILS K].

b) The decision not to request the support of [ICP R] to assist when transporting [Ms A] and the [other] passenger.

No information is supplied regarding the condition of the [other] patient to determine whether [ILS K] should have called for [ICP R] in regards to the [other patient], however the decision not to have [ICP R] attend for the [other

patient] appears to be supported by the similar decisions by [the Location 2 ambulance] once the [other] patient was on board with them.

If [ILS K] was aware of the potential significance of [Ms A's] injuries and intended to bypass [the rural hospital] and head straight to [the city hospital], it would be appropriate to seek an ICP resource to assist in case sedation or airway assistance was required. Failure to call for an ICP in this case would be seen as a minor departure from the expected standards of care, viewed poorly by some, but understood by others. This is because at the time the patient was not requiring intervention that [ILS K] could not provide, but may have required it later on.

If [ILS K] was not aware of the potential significance of [Ms A's] injuries and intended for her to be handed over to [the rural hospital] as a low acuity patient, then there was no departure from the expected standards of care in not calling for ICP backup for [Ms A].

4. *The appropriateness of the services provided by [ILS Q] and [EMT P] including their decision not to transport [Ms A] to [the city hospital]*.

There does not appear to be any departure from the expected standards of care by [ILS Q] and [EMT P], particularly considering they were leaving [Ms A] in the care of an equally qualified crew, with equal ability to transport [Ms A].

It would be potentially inappropriate for them to have taken both patients considering the status of both, and the alternate resources available.

5. *The adequacy and appropriateness of the services provided by clinical control centre staff, including (but not limited to) Duty Centre Manager [Mr W], and [Territory Manager]. When responding to this question please include comment on:*

a) the decision made regarding how to transport [Ms A] from the accident site and which paramedic personnel to dispatch.

All actions by [the] clinical control centre ([CCC]) staff and [Territory Manager] appear to be appropriate in that they have exhausted multiple avenues to get more qualified staff to the scene, or to meet the patients during transport.

b) directions and/or support provided to paramedic staff transporting [Ms A].

All directions provided to ambulance staff appear to be appropriate, however it is worth noting the conflicting information that was provided, initially to go to [the rural hospital], and then to not go to [the rural hospital].

These decisions appear to be made with the best knowledge available at the time, and revised once more knowledge from [ICP R] was available.

This conflict should have no influence on patient outcome as the final conversation between [ICP R] and [ILS K] clearly shows that [ILS K's] intention was to follow [ICP R's] advice to avoid [the rural hospital] (CCC Transcript [number]).

It is not clear whether [ILS K] believed the advice applied to both patients, or only to the more serious status one patient, however from the earlier conversation between [EMT L] and [ICP R], it is clear the intention for both patients is to go through to [the city hospital] (CCC Transcript, [number]).

c) in light of [ICP R's] advice, whether a direction should have been made to transport [Ms A] to [the city hospital] and not [the rural hospital] (see page 23 and 24 of the CCC transcript).

It is appropriate for the [CCC] to have not made any further directions to the crew regarding destination. It is the responsibility of the crew to determine the most appropriate location to transport their patient to, and it was reasonable for the [CCC] to trust that the conversation between [ICP R] and [ILS K] (CCC 214) was sufficient.

6. The adequacy and appropriateness of the services provided by Territory Manager [ICP R].

The services provided by [ICP R] appear adequate and appropriate. He has made multiple attempts to get to the scene, and has liaised with both the [CCC] and with staff on scene to help plan and determine the best destination for both patients.

He has additionally offered multiple times to respond via road if his skillset is required.

7. The adequacy and appropriateness of the services provided by [EMT N] when transferring [Ms A] to [the city hospital].

The services provided by [EMT N] appear adequate and appropriate, and it appears she has done what she can to maintain the stability of the cervical spine, and the comfort and dignity of the patient.

8. The adequacy of the relevant policies and procedures in place at St John at the time of the events complained of [2014].

Both the Patient Handover Policy and the Land Ambulance Safe Operations Policy supplied appear adequate. The minor changes between the Land Ambulance Safe Operations Policy Issue 3 and Issue 4 don't appear to be relevant to the current case.

The Land Ambulance Safe Operations Policy (both old and new) state that the 'carriage of persons not associated with the patient requires approval from the District Operations Manager (DOM) or Territory Manager.' This appears to apply to [Ms U], and could be potentially restrictive given the difficulty faced with communication in a remote region. Whilst it appears to have had no impact on the

current case, it would be worth considering whether wording should be revised to reflect the intent behind the clause, or guidelines implemented to provide guidance to staff when isolated.

9. *The adequacy of the relevant policies and procedures currently in place at St John, including the 'Patient handover' and 'Land Ambulance Safe Operation' policies.*

   The new Patient Handover Policy has an added section about handovers between ambulances which the previous one did not. Whilst this new section would have applied to the handover between [the Location 1 and 3 amulances], in that the policy would now be for the staff to move vehicles rather than the patient, it does not appear to be of any significance to the outcome of the patient. The policy appears adequate in its current format.

10. *Any other aspects of the care provided to [Ms A] that you consider warrants such comment, including further changes that you consider may be appropriate.*

    None.

Literature and Materials Used

The literature and materials relied on are restricted to the documentation provided by the Health and Disability Commissioner, and my knowledge of the ambulance sector. These materials were sufficient in this case to form advice on the reasonableness of the ambulance responses for [Ms A].

Examinations, Tests and Investigations Relied On

There were no further examinations, tests or investigations relied on or necessary for my advice on this investigation."

Appendix B: Independent nursing advice to the Commissioner

The following expert advice was obtained from internal advisor RN Dawn Carey:

Report One

"1. Thank you for the request that I provide clinical advice in relation to the complaint from the whānau of [Ms A]. The complaint concerns the care provided by [the rural hospital] following [Ms A] being involved in a road traffic crash (RTC) [in 2014]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following documentation on file: complaint and correspondence from the whānau of [Ms A]; response from Ngati Porou Haurora Charitable Trust (NPHCT) to [Ms A's father]; clinical notes for [Ms A's] period of monitoring at [the rural hospital]; responses from St John including the Patient Report Form (PRF) for [Ms A].

3. I have been asked to review the nursing care provided to [Ms A] at [the rural hospital] and to advise specifically on the following:
   i. The adequacy of the initial nursing assessment, specifically whether:
      a. A Glasgow Coma Scale (GCS) score should have been mentioned in the initial assessment.
      b. Whether adequate neurological observations were undertaken.
   ii. Noting that there is no 'vital observations' and GCS score recorded in the nursing notes between 7.30am and 1.35pm, please comment on whether the nursing cares throughout this time, and overall at [the rural hospital], were adequate.
   iii. Should nursing staff have undertaken a different course of action, when informed at 13.15, that this was not her usual presentation of intoxication?
   iv. Do you believe that nurses on duty, adequately advocated for their patient?
   v. Please comment on the standard of the nursing documentation.

4. Summary of events
   [Ms A] and another person were involved in a single vehicle crash at approximately 1am. Multiple St John crews including a rescue helicopter attended the scene, however due to poor weather the helicopter could not land. Extricating [Ms A] from the crashed vehicle took some time. During this time she was reported as being conscious, yelling and thrashing. Her documented assessed level of consciousness (GCS) was 5/15 and she was noted to smell of alcohol.

   At approximately 3.14am an ambulance left the scene transferring [Ms A] to [the rural hospital] arriving at 4.37am. At [the rural hospital] she was assessed by the attending medical officer as having no acute injuries. A plan was made to observe her and send her home once alert. Approximately 9 hours later [Ms A] was assessed as having a reduced level of consciousness and plans were made to transfer her to [the city hospital]. Upon arrival at [the city hospital] she was intubated and underwent CT

scanning. This showed multiple and significant injuries and [Ms A] was transferred to [the main centre hospital]. […]

At [the main centre hospital] [Ms A] underwent neurosurgery and had brain orientated intensive care therapies. Despite these interventions she died [in the ICU].

5. The NPHCT Chief Executive's response to [Ms A's father] refers to an internal investigation being initiated to review the care provided to his daughter at [the rural hospital]. This has not been forwarded for review. The response also reports that [Ms A] was transferred to [the rural hospital] by St John ambulance as a Status 3 patient and that the verbal handover from St John reported that she was drunk with the severity of her injuries not conveyed to the clinical team at [the rural hospital]. The initial assessment by the [the rural hospital] medical officer was that she showed signs/actions mimicking inebriation, had scratches and abrasions but no obvious signs of more acute injuries. As time went on nursing staff determined that there was a deterioration in [Ms A's] condition and reassessment by medical staff was arranged. This was undertaken at 2.15pm and following this [Ms A] was transferred to [the city hospital]. NPHCT explain that [the rural hospital] cannot transfer patients directly to [the main centre hospital].

6. Review of clinical records
   i. St John PRF reports [Ms A's] clinical observations from 2.40am–4.10am as respirations 20–22, pulse 102–108, blood pressure (BP) systolic ranging 146–154mmHg diastolic 90–101mmHg, GCS 5 (E1, V2, M2), oxygen saturations 97–99%, blood glucose 8.8mmols/L. Other commentary *collar put on but pt keeps pulling it off*, completing a primary and secondary survey which revealed *only injury is abrasion to L knee, pt mumbling and not making sense. PEARL* (pupils equal and reactive to light) *… pt still thrashing about. Also smelt of ETOH.* The patient status is recorded as 2 for both *at scene* and *ED.*
   Comment: The GCS breakdown as documented on the PRF means that [Ms A] was not opening her eyes at all including when spoken to or when pain was applied, her vocalisations were incomprehensible sounds, and that her movements were extensor posturing. I note the response from St John Clinical Safety and Risk manager — dated 19 March 2015 — offers that the documented GCS is erroneous and calculates 11/15 as more likely. I would agree that a consistent motor score of 2 is at odds with the other reportage that [Ms A] removed her cervical collar, which would indicate more purposeful movement at some stage prehospital. I would recommend that the care provided by St John is reviewed by a suitable peer.

   ii. Triage nurse reports [Ms A] arriving at [the rural hospital] at approximately 4.45am. Baseline observations include an elevated temperature 39.3°C and elevated respiration rate 26. *Involved in MVA. Abrasions on both legs, L)side of face, R)hand.*

   iii. A direction to refer to further nursing notes timed at 6am report *Pt very restless getting out of ambulance, lifted into wheelchair arms and legs swinging around … not* weight *bearing … Pt appeared to keep rubbing L) ear and appeared to be sore … Pt incontinent of urine in ambulance.*

iv. At 6.45am evidential bloods were taken from [Ms A] at the request of the Police. Nursing documentation reports … *bloods taken … pt responding by pulling arm away and crying appeared to be touching her left ear and crying. Still not talking just crying and moaning.* An end of shift note reports *… appeared to be sleeping but agitated moaning and crying at times.*

v. 7.30am: *Pt handover from [Dr B] and RN … Dr's instructions are to let pt sleep and once alert may go home.*

vi. At 8.30am [Ms A] is reported as *rousable to … pain. Still* appears *very drowsy …* At 9.30am … *still appears to be sleeping, though responds with eyes opening when I say her name, ø obvious pain observed …* At 1.15pm concerns from [Ms A's] whānau that *pt not her usual self in terms of when she is intoxicated …* are reported. A GCS 9/15 is documented — E2 (to pain), V2 (incomprehensible sounds), M5 (localises to pain). *Pupillary* assessment is 5mm PEARL. Pulse, BP, respiration rate, oxygen saturations and temperature are also checked. In response to elevated temperature — 38.9°C cooling cares are initiated. Contemporaneous nursing documentation reports informing the two medical officers that [Ms A's] GCS was 9 and that [Dr B] would come and assess.

vii. Nursing staff repeated GCS assessment at 3pm and continued assessments at 30 minute intervals following this. The assessed GCS score remained 9/15 consistently. Assessment of other vital sign observations were also commenced at regular intervals and a cervical collar was placed on [Ms A]. At 4.35pm she was transferred to an ambulance for transportation to [the city hospital].

7. Clinical advice

i. The adequacy of the initial nursing assessment, specifically whether:

a. A GCS score should have been mentioned in the initial assessment.

Baseline vital signs — temperature, blood pressure, respiration rate and oxygen saturation — are recorded by [RN D] as part of the initial assessment of [Ms A]. In my opinion, GCS assessment should also have been undertaken and documented by [RN D].

b. Whether adequate neurological observations were undertaken.

No. In my experience the St John PRF accompanies the patient and becomes part of the clinical handover and the patient's clinical file. I am critical that a patient who was assessed as having a significantly altered level of consciousness — GCS 5 — by the transporting St John officer would not undergo further assessment by the receiving RN. Within the relevant guidelines and literature caution is advised when assessing the neurological status of patients who are presumed to have alcohol onboard[1]. In my opinion, it is expected that inhospital assessment builds on the prehospital assessment findings. There is the benefit of 'fresh eyes' and the further passage of time

[1] New Zealand Guidelines Group (NZGG), *Traumatic Brain Injury: Diagnosis, acute management and rehabilitation*. (Wellington: ACC, 2007).
National Institute for Health and Care Excellence (NICE), *Head injury: Triage, assessment investigation and early management of head injury in children, young people and adults.* (London: NICE, 2014).
Stuke, L., Diaz-Arrastia, R., Gentilello, L. M., Shafi, S. Effect of alcohol on Glasgow Coma Scale in Head-Injured Patients. *Annals of Surgery, 245*. 651–655, (Philadelphia: Lippincott Williams & Williams Inc., 2007).

adds to the clinical picture. As a RN peer I also consider that nurses are accountable and responsible for providing care consistent with their education, scope of practice, competencies and standards[2]. I do not accept that being told that [Ms A] was intoxicated precluded the need for nursing assessment and monitoring at [the rural hospital].

ii. Noting that there is no 'vital observations' and GCS score recorded in the nursing notes between 7.30am and 1.35pm, please comment on whether the nursing cares throughout this time, and overall at [the rural hospital], were adequate.

After the baseline set of vital signs recorded by [RN D], there are no further vital signs recorded until 1.35pm and I am critical of this. [RN D] provided care to [Ms A] from approximately 4.45am–7am before handing over care to another nurse, whose name and designation I cannot decipher. The vital signs that were taken upon arrival showed [Ms A] to have a temperature and respiration rate that are quite elevated and a pulse rate that is slightly elevated. In my opinion these should have cued further monitoring, a consideration of why they may be elevated plus consideration of appropriate treatment options. I also note commentary by [RN D] that indicates that pain may have been an issue but there is no evidence of objective assessment of these signs. If the initial assessment was that [Ms A's] presentation was consistent with intoxication to the point of significant impairment I would also expect that blood glucose monitoring for hypoglycaemia be commenced. I note that prior to 4pm, [Ms A's] blood glucose level was not checked at [the rural hospital].

In my opinion, the nursing assessment and monitoring of [Ms A's] vital signs upon arrival at [the rural hospital] until 1.35pm was inadequate and a departure from the accepted standards of nursing care[3].

iii. Should nursing staff have undertaken a different course of action, when informed at 1.15pm, that this was not her usual presentation of intoxication?

In my opinion, the actions in response to notification were appropriate — a comprehensive assessment was completed and the concerns plus assessment findings were escalated to the duty medical officers.

iv. Do you believe that nurses on duty, adequately advocated for their patient?

In my opinion, there was a failure of adequate assessment and monitoring of [Ms A's] vital signs which in part prevented nursing staff from being an effective advocate for her. I am concerned about the instruction — *let pt sleep* — given as part of the nursing handover at 7.30am. In my opinion, this supported the lack of ongoing assessment by the nursing staff and missed opportunities for earlier intervention. Considering that at this stage [Ms A] was six hours post crash/alcohol consumption, the continuation of impairment — apparent from documentation such as *rousable to pain* — without comprehensive assessment is

[2] Nursing Council of New Zealand (NCNZ), *Code of conduct for nurses.* (Wellington: NCNZ, 2012).
[3] Nursing Council of New Zealand (NCNZ), *Code of conduct for nurses.* (Wellington: NCNZ, 2012).

concerning. Once adequate and comprehensive assessment was undertaken at 1.35pm, I am of the opinion that the nurse in question was a suitable advocate.

v. Please comment on the standard of the nursing documentation.
In my opinion the nursing documentation is consistent with accepted standards.

vi. Other comments
I consider that the nursing care departed from the accepted standards and that the departures could be significant in relation to inadequate assessment and monitoring. I would recommend that individual responses are obtained from the nurses involved in providing care over the course of the three duties [Ms A] was at [the rural hospital].

Dawn Carey (RN PG Dip)
Nursing Advisor
Health and Disability Commissioner
Auckland"

Report Two

"1. Thank you for the request that I provide further clinical advice in relation to the complaint from the whānau of [Ms A]. The complaint concerns the care provided by [the rural hospital] following [Ms A] being involved in a road traffic crash (RTC) [in 2014]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. My advice is focussed on the nursing care provided to [Ms A]. This advice is to be read in conjunction with my previous offered advice on this case.

2. I have reviewed the following information: clinical advice dated 30 March 2015; additional responses from Ngati Porou Hauora Charitable Trust (NPHCT) dated 25 June 2015 including statements from nursing staff and health care assistants, response dated 2 July 2015 including relevant policies and reportable event investigation report (REIR) dated 24 June 2015; statement from [RN F] dated 25 June 2015.

3. As part of this advice, I have been asked to review the provider's statements and consider the following questions:

   i. The adequacy and appropriateness of the services provided by individual nurses responsible for caring for [Ms A], including (but not limited to):
      a) Initial nursing assessment;
      b) Periodic observations and assessments conducted;
      c) Steps taken to maintain [Ms A's] hygiene.

   ii. The adequacy and appropriateness of [Ms A's] nursing records. Where appropriate, please comment on the actions of individual nurses who documented [Ms A's] care, including the appropriateness of any revision and amendment of contemporaneous records.

iii. The adequacy and appropriateness of policies in place [at the time], insofar as they are relevant to the nursing staff of [the rural hospital].

iv. Any other matters considered relevant.

4. NPHCT

I have reviewed the Admission policy and Continuity of care policy that were in place [at the time] and consider that they are appropriate. Unfortunately, these policies were not followed and [Ms A] did not receive the level of care detailed by these policies. In my opinion, the failure to follow the NPHCT policies applies to both medical and nursing staff.

I have also reviewed the Raising concerns about patient safety policy that was in place [at the time]. I consider that this policy is consistent with the expectations of Nursing Council of New Zealand[4].

5. [4.45am–7.30am RN D]

The response from [RN D] reports that the verbal handover from St John identified [Ms A] as a 'status 3' patient who had been involved in a road traffic crash, was inebriated, had minor lacerations to both her legs and had been incontinent of urine. She reports that no factual information, verbal or written, concerning [Ms A's] vital signs/neurological status or accident details were handed over by St John staff. I note that this is consistent with the NPHCT REIR finding that the St John Patient Report Form was not given to [rural hospital] staff. [RN D] reports that in response to her querying St John staff as to why [Ms A] did not have a cervical collar on and why a stretcher was not being used to transfer her to the A&E, she was told that [Ms A] was drunk and did not need them. She also reports that when she assisted in transferring [Ms A] from the wheelchair to the A&E bed she noticed that she was not weight bearing … *My triage assessment of [Ms A] was that she had abrasions on both legs, the left side of her face and an abrasion on her right hand. When I asked [Ms A] questions I found her to be agitated and hard to understand. When I was observing [Ms A] during the two and a quarter hours that I cared for her, I noticed she was irritated and that she would rub the left side of her head and cry, then she would rest a minute or two, and then do it again. [Ms A] had been incontinent of urine. I could not smell any alcohol on her …*

Following [Dr B's] taking of evidential blood at approximately 6.30am, [RN D] reports voicing concerns about [Ms A] waking up crying and rubbing the left side of her head and … *[Dr B] didn't really respond to that and only said she would assess [Ms A] later …* [RN D] also reports being unable to participate in the morning handover of [Ms A] to the next duty RN … *The handover about [Ms A] was given by [Dr B] … I did not give any handover about [Ms A] because every time I went to say anything I got cut off from [Dr B]. Normally in handover the nurse gives handover but on occasion the Doctor will give handover …*

[4] Nursing Council of New Zealand (NCNZ), *Code of conduct for nurses* (Wellington, NCNZ, 2012).

The response from [RN D] reports that she wrote her clinical notes — timed as 6am — when she returned to shift 16 hours later.

Comments

i. In my opinion a neurological — Glasgow Coma Scale and pupillary response — assessment should have been undertaken as part of initial nursing assessment of [Ms A]. As a pattern of 'irritable' behaviour became apparent, I am critical that this did not result in a nursing assessment of [Ms A's] neurological status.

ii. I am also critical of the lack of ongoing monitoring of the vital signs that were checked as part of [RN D's] initial assessment. As noted in my previous advice, [Ms A's] temperature, heart rate and respiration rate were all elevated on initial assessment. I consider that at a minimum, subsequent actions should have included notifying the doctor of elevated vital signs and instituting ongoing monitoring at intervals not greater than hourly. I note that the REIR presents that [RN D] did inform [Dr B] of [Ms A's] vital signs.

iii. As noted previously, as the initial assessment was that [Ms A's] presentation was consistent with intoxication to the point of significant impairment, I consider that her blood glucose level should have been checked.

iv. [RN D's] response does not report why no attempts were made to address [Ms A's] hygiene needs post her noted incontinence. In my opinion, minimum care expectations would include that [Ms A's] soiled clothing should have been removed and a hospital gown placed on her.

v. Medical staff participating in nursing handover is not unusual. However, typically, the RN finishing duty would ensure that any outstanding nursing concerns were communicated to the oncoming RN. I consider this fundamental to safe transfer of care from one RN to another and necessary as nurses are cognisant of nursing standards and professional responsibilities.

vi. I disagree with the practice of presenting retrospective clinical documentation as otherwise.

6. [7am–3pm Team Leader RN E]

The response from [RN E] details that [Dr B] led the handover for [Ms A] … *[RN D] told me the patient had been involved in a motor vehicle accident and endeavoured to provide me with the events that occurred. [Dr B] overruled [RN D] who was unable to give me the information due to [Dr B's] interruptions. [Dr B] informed me that [Ms A] had no head injuries some superficial abrasions and that she was inebriated … She stated that I was not to disturb her but to leave her to sleep and that once alert she would be able to go home*

[RN E's] response details regular checks on [Ms A] reporting that *at lunchtime she was awake and responsive.* At approximately 1pm [RN E] reports completing a vital sign check including GCS and pupillary response in response to concerns from [Ms A's] visiting whānau members. Following this [RN E] reports contacting [Dr B] via telephone and notifying her that [Ms A] had an elevated heart rate and temperature and a GCS 9/15.

[RN E] reports not completing her clinical notes during her shift *... but were completed at approximately two and a half hours after handover ...* She reports being instructed to amend the documented GCS — 9/15 to 12/15 by [Dr B] and complying with this. After reflecting on this action she contacted [Dr C] and notified him of the amendment. [RN E] reports *... On returning to the hospital I removed the clinical note on which I had written GCS 12 and re-entered my original finding of GCS 9.*

Comments

i. While I acknowledge that [RN E] was limited in the information available to her, I note that the triage sheet details [Ms A's] vital signs and that these were elevated. I consider that this information should have cued further monitoring by [RN E]. For the purpose of clarification, if no vital sign history was available to [RN E], I would still be critical of the failure to undertake an assessment of the patient's vital signs. I also consider that based on the reported handover, [RN E] should have checked [Ms A's] blood glucose level for alcohol induced hypoglycaemia.

ii. The reportage of [Ms A] being rousable to pain at 8.30am is concerning and should have cued a formal GCS assessment by [RN E]. At this stage the patient had been at [the rural hospital] for approximately 4 hours.

iii. The response does not report [Ms A] as ever communicating in words or sentences or moving. Such interactions would be expected in a normally fit and healthy young woman even one who had allegedly consumed a significant amount of alcohol.

iv. The submitted clinical notes have entries by [RN E] timed as 07.30, 07.50, 08.15, 08.30, 09.15, 09.30, 10.15, 10.30, 11.25, 12.15, 13.15, 13.35, 14.00, 14.30. [RN E's] response is not clear as to whether all of these entries were written upon return to [the rural hospital] later that day. I note that the response from [RN F] reports this to be the case.

v. While I do not condone [RN E] amending her assessment (GCS) finding, she reports feeling pressurised to do so. Obviously the initial amendment is a departure from professional nursing standards but I am more critical of the subsequent amendments. In my opinion, after her conversation with [Dr C], [RN E] should have documented the circumstances that led her to document GCS 12 rather than 9 and not have removed the original clinical notes from [Ms A's] file. I would recommend that [Dr C's] recollection of this conversation is sought.

vi. The response does not report knowledge of [Ms A's] incontinence or consideration of her nutritional/hydration needs. In my experience when nursing a patient admitted because of drug/alcohol impairment, it is customary for the RN to rouse them and to focus them on completing the actions that support their discharge and to do so promptly. In my experience, nurses are generally keen to progress patients identified 'for discharge later' as it reduces the ongoing nursing workload.

7. [3pm — RN F]

The response from [RN F] details that during the nursing handover from [RN E], [Dr B] *... after seeing the patient was incontinent and soaked with urine and asked us to clean her ...* [RN F] reports commencing vital sign assessment, including neurological at 30 minute intervals. While the ongoing assessments of [Ms A] were carried out by

[RN F], the Enrolled Nurse was allocated to remain with the patient. [Ms A] is reported as being consistently GCS 9/15 during [RN F's] shift.

[RN F] reports the CEO coming to the nurses' station and being shown [Ms A's] clinical notes. These notes are reported as consisting of the A&E assessment form which had brief documentation under 'chief complaint' and one set of observations completed by the triage/night shift RN. [RN F] reports her recollection that … *From the morning shift there was an observation chart with 1 set of observations taken at about 14.00 with a 12/15 GCS.* The response reports [RN E] being contacted and asked to return to complete her nursing notes which she did at approximately 5pm. After [RN E] completed her clinical notes documentation, [RN F] reports adding her notes and referring to the entries that she had contemporaneously completed on the A&E form and observation chart *... [RN E] then asked me to rewrite my neurological observations onto another observation chart that she had provided. This observation chart had observations recorded at 09.30, 11.30, 12.30, 13.30 and 14.30 ...* [RN F] reports complying with this request. [RN F] reports arriving at work the next day and finding [RN E] completing another set of notes and observation chart for [Ms A] … *She informed me that I would need to complete my notes and observations again. I had the previous notes available to me and copied them chronologically from [RN E's] second set of notes, making some minor alterations for clarification. I copied my neurological observations and Glasgow Coma Scores onto the third observation chart. This observation chart has one set of observations at 13.35 and then my neurological observations starting at 15.00.*

Comments

i. I agree that [Ms A] required regular RN assessment and monitoring. I consider the monitoring and supervision over the course of the afternoon shift to be consistent with accepted nursing standards.

ii. [RN F's] entries in [Ms A's] clinical notes give the impression that she made three separate entries at 3pm, 3.30pm and 4pm. Her response details that these entries were in fact completed at approximately 5.30pm. In my experience, retrospective documentation is very typical in nursing practice and for a variety of reasons. With appropriate identification, I do not consider such documentation practice to be inconsistent with professional or health standards but I strongly disagree with entries made retrospectively being presented as otherwise.

iii. I have concerns with [RN F's] compliance with [RN E's] requests to rewrite her documentation. I also have concerns that [RN F] witnessed a RN falsify notes and supported such falsification.

8. Clinical advice

Registered nurses are accountable for ensuring that all health services that they provide are consistent with their education and assessed competence, meet legislative requirements, and are supported by appropriate standards. Following a review of the additional information, I consider that the nursing care provided to [Ms A] departed from accepted standards[5] with some departures being significant.

[5] New Zealand Standards (NZS) *8134.1.3:2008 Health and disability services (core) standards* (Wellington: NZS, 2008).Nursing Council of New Zealand (NZNC), *Code of conduct for nurses* (Wellington: NCNZ, 2012).

While I do not accept that being told that [Ms A] was intoxicated and to let her sleep precluded the need for nursing assessment and monitoring, I am concerned that two registered nurses, perceived it as appropriate to follow this instruction. I am also concerned by the reportage of nursing participation in handover being prevented and nurses being asked to alter and redo their clinical documentation. In my opinion, the inadequate monitoring of [Ms A's] vital signs including neurological observations contributed to ineffective interdisciplinary communication and negatively affected the nurses' ability to be an effective patient advocate. I am also critical of the nurses' failure to consider [Ms A's] comfort or dignity after it was noted that she had been incontinent of urine.

Following a review of the additional information, I wish to amend my previous advice concerning the standard of nursing documentation. When I formed the view that it was consistent with accepted standards, I was unaware that it had been completed retrospectively and after [Ms A] had been referred and accepted for urgent transfer to [the city hospital]. I now consider that the contemporaneous nursing documentation departed from accepted practice and am severely critical of retrospective additions to clinical nursing notes being presented as otherwise.

[RN D] — Based on [Ms A's] presentation I am moderately critical that [RN D] did not assess [Ms A's] blood glucose level, GCS and pupillary response as part of her initial nursing assessment. This criticism would be slightly mitigated if [RN D] has not completed an accredited triage course. Over the course of the rest of [RN D's] shift, [Ms A] demonstrated a pattern of behaviour that was not consistent with a patient metabolising alcohol. I am critical that [RN D] did not respond to this by undertaking an objective neurological assessment. The report that [RN D] relayed her concerns to [Dr B] mitigates my criticism somewhat although I still consider it to be a mild–moderate departure from nursing standards. I consider [RN D's] failure to institute regular monitoring of [Ms A's] temperature, heart rate, blood pressure and respiration rate to be a significant departure from the accepted standards of nursing care.

I am also critical of [RN D's] failure to support [Ms A] to maintain her hygiene needs post incontinence. Due to the relatively short length of time [RN D] was the nurse caring for [Ms A], I consider this to be a mild departure from accepted standards.

In my opinion, [RN D's] documentation of clinical notes without identifying them as retrospective — completed approximately sixteen hours later — is a significant departure from accepted standards.

[RN E] — In my opinion, [Ms A] required nursing assessment and monitoring of vital signs over the course of [RN E's] shift. This was not done and I am critical of this. I consider the failure to monitor [Ms A's] temperature, heart rate, blood pressure and respiration rate prior to 1.35pm, to be a significant departure from the accepted standards of nursing care. I consider that the assessment at 1.35pm and action of notifying [Dr B] and [Dr C] of the findings to be appropriate.

Over the course of the morning shift, [Ms A] demonstrated a pattern of behaviour that was not consistent with a patient metabolising alcohol and which should have cued an

objective neurological assessment. I am critical that this did not occur and consider it to be a moderate–significant departure from accepted standards of nursing care.

I am also critical that [RN E] did not consider [Ms A's] hygiene needs, nutritional needs or hydration needs. I consider that it would be difficult to initiate 'cooling cares' without realising that the patient had been incontinent. Therefore, I consider the failure to provide appropriate hygiene care at approximately 1.35pm to be a significant departure from nursing standards.

I am unsure as to what documentation, if any, was made during [RN E's] morning shift. I strongly disagree with retrospective documentation that is presented as otherwise and consider it to be a departure from accepted standards. If one set of vital signs observations was the only documentation completed by [RN E] during her shift, I would consider it to be a significant departure from accepted clinical documentation standards.

[RN F] — In my opinion, the clinical care that was provided by [RN F] was consistent with accepted standards.

While I am conscious that [RN F] only gained New Zealand registration in 2013, I have significant concerns about her knowledge and understanding of her professional responsibilities and accountability as a RN in New Zealand. In relation to the standard of clinical documentation, I consider [RN F's] presentation of retrospective notes as otherwise to be a departure from accepted nursing standards. I consider that the documentation alterations that she made [the following day] to be more worrisome, and a significant departure from accepted standards.

Dawn Carey (RN PG Dip)
Nursing Advisor
Health and Disability Commissioner
Auckland"

Report Three

"1. Thank you for the request that I provide additional clinical advice on this case. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. My advice is focussed on the nursing care provided to [Ms A]. This advice should be read in conjunction with my previous offered advice on this case.

2. I have reviewed the following documentation available on file: response from [RN E] dated 11 April 2016; response from [RN F] (undated) supplied to the Commissioner on 11 March 2016; response from [RN D] dated 21 April 2016; response from Ngati Porou Hauora Charitable Trust (NPHCT) dated 5 April 2016 and 12 April 2016; my previous clinical advice dated 30 March 2015 and 29 January 2016.

3. [RN D] — [RN D] reports learning from this experience and making changes to her nursing practice. She also reports being willing to undertake additional education to further improve her knowledge and practice. Following a review of [RN D's] additional

response I have found no cause to amend my criticisms or the level of departures previously identified.

4. [RN E] — [RN E] reports learning from this experience and making changes to her nursing practice. She also reports completing a clinical documentation course and being enrolled in a Primary Response in Medical Emergency course.

   [RN E's] response presents a significant difference in the practice of 'cooling cares' from my own. She explains that the 'cooling cares' that she instituted in response to [Ms A's] temperature of 38.9^{o}C, was limited to opening windows and placing a damp cloth on [Ms A's] forehead. In my experience, 'cooling cares' involve, at a minimum, the removal of a patient's clothing and sponging them with tepid water. While I question the effectiveness of [RN E's] actions to manage [Ms A's] elevated temperature, I accept that the steps she took would not necessarily have made her aware that [Ms A] had been incontinent. Following a review of [RN E's] additional response, I now consider that the failure to provide appropriate hygiene care was a mild departure from accepted nursing standards. Other than this, I have found no cause to amend my criticisms or the level of departures from accepted nursing practice previously identified.

5. [RN F] — [RN F] reports learning from this experience and making changes to her nursing practice. She also reports completing relevant education courses and now being more aware of professional expectations of a RN in New Zealand.

   [RN F's] response reports that her compliance with [RN E's] request to amend the clinical notes was influenced by [RN E's] position as a senior nurse. It is also reported that [RN E] had been an allocated mentor during [RN F's] orientation period at [the rural hospital]. While this does not detract from the level of departure previously identified, I consider that it does offer some understanding as to why [RN F] did what she did.

Dawn Carey (RN PG Dip)
Nursing Advisor
Health and Disability Commissioner
Auckland"

Appendix C: Independent medical advice to the Commissioner

The following expert advice was obtained from rural general practitioner Dr Abi Rayner:

Report One

"I have been asked to provide an opinion to the Commissioner on case number 14/01598, and I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I am Vocationally Registered in Rural Hospital Medicine and have worked in the emergency rooms of Grey Base Hospital, Buller Hospital, and Thames Hospital. I have worked in a variety of rural GP practices and have completed the PRIME Course and have a current certificate in ATLS. My CV is attached as Appendix II.

I have been asked to provide an opinion regarding the care provided to [Ms A] by [Dr B], [Dr C] and Ngati Porou Hauora Trust medical facility in [the rural hospital] [in 2014].

Specific issues to be addressed are:

A. [Dr B]: The appropriateness of the care provided by [Dr B] to [Ms A] including, but not limited to:

1. The adequacy of [Dr B's] initial assessment of [Ms A] on her arrival to [the rural hospital] with respect to different versions of events.
2. The adequacy of [Dr B's] instructions to nursing and support staff.
3. Whether appropriate tests and/or observations were carried out for [Ms A].
4. The timeliness of [Ms A's] referral to [the city hospital].
5. The adequacy of the care provided with specific regard to alternative scenarios.

B. [Dr C]: The appropriateness of the care provided by [Dr C] to [Ms A] including, but not limited to:

1. [Dr C's] decision not to assess [Ms A] when he was at [the rural hospital] [in the morning].
2. [Dr C's] actions when contacted by [the rural hospital] staff about [Ms A's] deteriorating condition.
3. [Dr C's] actions on his return to [the rural hospital] [in the afternoon].

C. [The rural hospital]: with respect to the appropriateness of relevant policies in place at the time of these events.

Sources of information reviewed are documented in attached Appendix I.

Not available for review is [Dr C's] initial correspondence.

In addition I reviewed

1. NZ guidelines group/ACC publication 'Traumatic Brain Injury: Diagnosis, Acute management and Rehabilitation' published July 2006.
2. MCNZ Good Medical Practice https://www.mcnz.org.nz/news-and-publications/

3. Rael T. Lange PhD, BC, Grant L. Iverson, Jeffrey R. Brubacher & Michael D. Franzen (2010) Effect of blood alcohol level on Glasgow Coma Scale scores following traumatic brain injury, Brain Injury, 24:7–8, 919–927
4. Jeffrey J. Bazarian, Melissa A. Eirich & Steven D. Salhanick (2003) The relationship between pre-hospital and emergency department Glasgow coma scale scores, Brain Injury, 17:7, 553–560

Brief clinical summary: [Ms A], an [18yo] was involved in a single vehicle, [motor vehicle accident]. The first ambulance dispatch was at 0139 after an uninvolved driver came upon the car on its side an unknown time after the accident. He awakened a neighbour ([Ms U]) who drove to police and fire service to seek help and then returned to the scene. When she returned a nurse was present at the scene[6] and had removed the driver from the vehicle but was unable to access [Ms A]. The first ambulance (unit 1, [Location 1]) arrived at 0208, crewed by Ambulance Officer [FR O]. She attempted to do a primary and secondary survey and place a cervical collar on her but they were unable to reach her to put it on. The second ambulance (unit 2) arrived at 0210, crewed by [EMT L]. She reported on the PRF that 'Single MVA [Location 2 ambulances] on scene. Also [Location 1] first response. Unsure if pt was driver or passenger. Vehicle on its side. Pt still trapped but is conscious. Can't get into vehicle to assist pt. Pt yelling and thrashing about.' Other documents suggest [Ms A] was a restrained passenger, trapped in the vehicle rolled onto its left side and inaccessible to first responders until the roof of the car is removed by firemen, after an estimated hour. After she was accessible to ambulance staff, she was removed from the car on a spine board with her head stabilised and was placed in Unit 2. At this point, she moves all extremities but is crying and moaning with incomprehensible speech. She is agitated and uncooperative, removing the cervical collar and thrashing about when extracted. There are only minor abrasions visible. [EMT L] documents on the PRF that 'collar put on but pt keeps pulling it off. Did primary/secondary survey, only injury is abrasion to L knee. Pt mumbling not making sense. Pupils reactive BP [arrow up], Pulse [arrow up]. Helicopter was flying but had to turn back cause of bad weather. Transported; Pt still thrashing about. Also smelt ETOH.' They leave the scene at 0314, transported in the ambulance, with [EMT L] and no one in the back. They [stopped] to recheck Vital signs (obs documented at 0340 and 0410) and [FR O] reports that '[Ms A] was sitting up, her arms and legs were moving. She didn't have the collar on, but it was near her. She looked at me. I said to her: "Its […] here." She was moaning and crying and said: "[…], I'm sorry for being like this" not in a clear voice though.' [Vital Signs (VS)]VS recorded en route report her GCS as 5/15 but this is not consistent with the written descriptions. Shortly thereafter, a third ambulance (unit 3) met them, crewed by [ILS K], and he assumed care of the other patient. [Ms U] (who had been in unit 1 with the other patient) then drove unit 3 to [the crossroads] and then joined [EMT L], riding in the front seat of the ambulance transporting [Ms A]. [Location 3] Amulance met them at or near the entrance to the hospital and took the other patient, but felt they could not take both.

Upon arrival at the hospital, the handover is given by the Paramedic, not the ambulance driver. She is no longer secured to the stretcher and is either on the floor or partly across both stretchers and remains poorly cooperative as they try to get her out, opting for a wheelchair. There is conflicting reports regarding whether she was kicking the ambulance staff. She is unable to stand. She is moved to A&E and helped onto a bed. The handover

[6] According to neighbour, Ms U

continues in A&E, the doctor and an RN are present. There is conflicting report regarding the details in the handover and whether the ambulance run sheet was provided. The ambulance run sheet reports 'smelt alcohol', but it is uncertain whether this was available for review at the time.

Initial Obs are done with an elevated heart rate, respiratory rate and a fever recorded. There is conflicting reports regarding whether this was recorded contemporaneously and whether it was communicated to the doctor.

[Dr B] examined the patient and considers her inebriated with no evidence of a head injury. She later records a GCS of 14/15.

She is in a side room in A&E. There are no VS or contemporaneous recordings during the night shift.

There is conflicting information regarding nursing handover at the beginning of day shift.

Hospital records document admission at 0712.

[Dr B] was seen leaving [Ms A's] room at the end of her shift and reports reassessment regarding her ear about that time.

There is conflicting information regarding Dr handover at 0810+/-.

There are no contemporaneous VS recorded during day shift. She did not touch her breakfast; notes suggest she could be awakened.

Her family arrived about 0930 or 1000. They were concerned by her lack of responsiveness and mentioned it to a [hospital staff member] but it is unclear whether she discussed their concerns with staff. They expressed their concerns at 1300 to [RN E] the Clinical team leader and day shift nurse that day and she took vital signs and contacted [Dr B] at 1330 and then [Dr C], both of whom were in remote clinics.

She was still in clothes from the time of the accident; some had been cut and was incontinent on several occasions.

The family reported that in the early afternoon, a 'new nurse' came on duty, (this corresponds to the report from [RN F]) and initiated care including changing her clothing and bedding and removing shards of glass.

[Dr B] arrived and performed further assessment with impression that she had an ear infection (worse than her prior assessment) and a head injury (GCS12/15) and she arranged transfer. [Dr C arrived], assessed [Ms A], concurred with recommendation for urgent transfer, started a second IV and drew bloods. He considered her GCS 9/15.

When she was being prepared for transfer there were still shards of glass on her back.

She was transferred to [the city hospital] via ambulance with observations by RN accompanying her and remained stable, arriving at 1813.

Areas of uncertainty or discrepancy in reports:

1. The nature and mechanism of the accident
2. The time of the accident
3. Whether [Ms A] was secured to the stretcher
4. Reported status of [Ms A] during transfer.

5. The position of [Ms A] upon arrival to the ambulance bay (with subsequent transfer to wheelchair).
6. The details of the handover regarding accident scene, other victim, status of [Ms A] during the time at the scene. In addition, [Dr B] describes the handover as being from [ILS K] but [EMT L] describes her handover and [ILS K] states 'I did not have any part in the treatment of [Ms A].'
7. Whether the PRF was available for review.
8. Whether the ambulance staff reported that alcohol was considered a factor in the condition of [Ms A]
9. Whether [Ms A] kicked and swore at ambulance staff
10. When the temperature was taken and recorded and whether this was communicated to [Dr B].
11. When the observation that [Ms A] was unable to stand was documented and whether this was communicated to [Dr B].
12. When the observation that [Ms A] was 'rubbing L) ear and appears to be sore' was made and communicated to [Dr B].
13. Details of [Dr B's] initial assessment not recorded in the clinical notes
14. Details of [Dr B's] instructions to nursing staff at the time of admission to [rural hospital]. Details of who was present and what was said at the handover during change of shift [in the morning]
15. Details of [Dr B's] handover to [Dr C]
16. Admission status of [Ms A] at the time of the handover of [Dr B] to [Dr C].
17. Status of [Ms A] at 'lunch time'.
18. Details of discussion between nursing and family during day shift.
19. Timeline of physician assessments and nursing interventions during the time period of 1330 and transfer.

Answers to Questions

[Dr B]
1A scenario 1. Was [Dr B's] initial assessment as recorded in the consultation note [at 0654] adequate?

[Dr B's] documentation is below the standard of care.

The standard of care for all trauma is a primary survey (which is checking for immediate problems to airway, breathing, and circulation) followed by a detailed secondary survey checking for injuries.

Guidelines for the management of traumatic brain injury were published in July 2006 by the NZ guideline group and disseminated to GPs. [Dr B's] note documents that she was specifically concerned about the possibility of head injury. In order to exclude a significant head injury, there must be a baseline evaluation to which further observations can be compared.

There is no record of [Ms A] providing a history. She noted monosyllabic responses and considered her behaviour irritable and agitated, yet failed to document a detailed neurologic assessment, only stating 'No obvious head injury.' She recorded a GCS of 14/15. This is not normal. She attributed her altered mental status was due to alcohol, although she stated that she did not smell alcohol. It is generally accepted that alcohol will depress GCS (although this may not be true).

Assuming that she understood the accident was of a minor nature and that she interpreted her findings as normal, the failure of documentation would be a minor departure from the standard of care. However, the findings were not normal, and this should have prompted early reassessment and/or obtaining additional information. The failure to review and reconsider her diagnosis over time represents a serious departure from accepted practice. This does not infer that this failure influenced the outcome.

1A scenario 2. Was [Dr B's] initial assessment as reported in the interview dated 14/7/15 adequate?

[Dr B] notes her initial assessment was influenced by her understanding of the nature of the accident.

> 'My initial survey on examination noted that she had multiple small superficial lacerations on her anterior thighs. She had three abrasions to her left knee and a contusion on her left shin which was showing as a bruise. [RN D] and I removed the glass which was covering her body.
>
> I observed that I did not smell alcohol.
>
> [Ms A] had no obvious head injury by way of bleeding cuts or bruising. There was a tiny cut above her right brow. There were no bruises or abrasions found on her face or head. When I put a torch light on her pupils they reacted and reduced in size equally. She could focus on my finger moving toward her nose. GCS was 14; [Ms A] was giving single word responses and appeared to know she was at [the rural hospital]. She did not express confusion when I was with her. She could follow and touch my hand when I moved it in different positions. Her eyes followed me around the room.
>
> She did not express any pain when I examined her.
>
> I pressed on the vertebrae on her neck and down her spine and she did not have any pain, and have good touch sensation.
>
> Her pelvis showed no pain and she could move her legs with full range of movement. On spinal examination there was no cervical, thoracic or lumbar tenderness, and there was no evidence of a pelvic injury. She was breathing normally and her breath sounds were clear. There was no bruising on her chest although later the bruise from her seat belt showed on her left shoulder.
>
> Chest had equal expansion on both sides with good air entry and no bruising.
>
> Her abdomen showed no sign of bruising and no tenseness.
>
> She had normal strength and power in her legs and arms.
>
> She was moving a lot on the bed, moving her legs and arms freely.
>
> Her BP was 127/73, pulse 104, O2 sats 100%. [Ms A's] temperature was not taken as she was pushing the nurse off and prevented [RN D] from taking her temperature. [RN D] reported this to me while I was doing my assessment she was in the room when I was checking for injuries. I pointed out [Ms A's] injuries, listed them and I asked if she had noticed any other injuries when she was taking initial observations. I was not immediately concerned as on examination her skin felt cool to touch and she appeared afebrile.'

She reports she later examined her ears and considered that her left tympanic membrane 'was inflamed but not markedly so.'

The NZ guidelines for assessment of suspected traumatic brain injury advises the following history: age, mechanism of injury, vomiting since injury, presence of headache, presence of seizures since injury, presence of anterograde amnesia since the injury or retrograde amnesia of greater than 30 minutes before the injury, GCS on admission and at 2hrs post injury, evidence of suspected skull fracture, signs of basal skull fracture, evidence of trauma above the clavicles, evidence of drug or alcohol intoxication. It specifically states that 'Signs of possible traumatic brain injury should not be attributed to alcohol intoxication when assessing people with traumatic brain injury.'

This assessment notes that [Ms A's] responses were 'single words' and does not address whether she recalled the details of the accident and subsequent transport, whether she was oriented in time, and whether she was able to walk.

The physical assessment as described appears to meet the minimum standards. However, the finding of a previously healthy young woman who is now able to respond only with single words, not able to describe the accident, is agitated and irritable, 'moving a lot in bed' should have been alarming in the setting of a motor vehicle accident. The finding of an abnormal ear drum in the setting of injury must be considered a sign of basal skull fracture.

NZ guidelines recommend a CT for adults with a GCS of 13–14 at 2 hrs after injury. Research literature considers in serial observation in hospital an acceptable alternative.

[Dr B] appears to have interpreted the abnormal findings as due to alcohol and further information and subsequent assessments did not alter the conclusion. The failure to reconsider her diagnosis over time represents a serious departure from accepted practice. This does not infer that this failure influenced the outcome.

2. Were Dr instructions to the nursing and support staff adequate?

It is not clear what the nature and extent of [Dr B's] instructions were. There was clearly a breakdown in communication between members of the team that resulted in failure to provide adequate observations and care.

3. Whether appropriate tests and/or observations were carried out for [Ms A]

No, she should have had serial observations, including neurologic observations with prompt notification of the doctor if there was any deterioration. The presence of a fever should have prompted further investigation into possible causes including unrecognised injuries.

I recognise that a blood alcohol would not have been available, nor would a CT scan without transfer.

4. The timeliness of [Ms A's] referral to [the city hospital]

The referral was delayed due to the assumption that [Ms A's] behaviour was the result of alcohol. The findings of altered mental status at the time of initial presentation should probably have resulted in immediate transfer to [the city hospital], but certainly failure to improve over a 2 hour period should have prompted consultation. Even if alcohol was the explanation for her behaviour, one could not be certain without a CT scan. This does not infer that this failure influenced the outcome.

5B scenario 1. The appropriateness of [Dr B's] care if the ambulance staff stated that [Ms A] was intoxicated.

Altered mental status in the setting of accident should not be attributed to alcohol and mandates reassessment or further investigation.

5B scenario 2. The appropriateness of [Dr B's] care if the ambulance staff did not state that [Ms A] was intoxicated.

Altered mental status in the setting of accident should not be attributed to alcohol and mandates serial observation or further investigation.

5C scenario 1. The appropriateness of [Dr B's] care if St John's had reported a high speed crash.

The mechanism of injury should have prompted immediate referral to [the city hospital].

5C scenario 2. The appropriateness of [Dr B's] care if St John's had reported a low impact crash.

The finding of altered mental status should have prompted serial assessments with referral if there was no improvement over a 2 hr period or any deterioration. An alternative would be immediate referral to [the city hospital] since she could not be adequately evaluated.

5D scenario 1 The appropriateness of [Dr B's] care if [Ms A] kicked and swore at St John's staff.

If this behaviour was witnessed and she was not able to be calmed down and provide a history and explain the behaviour then she should have been referred to [the city hospital] with concern about both possible brain injury and substance misuse. Neither problem could be adequately addressed at [the rural hospital].

5 D scenario 2. The appropriateness of [Dr B's] care if [Ms A] was not kicking and swearing at St John's staff.

If [Ms A] had an altered mental status and/or an abnormal neurologic exam and failed to become normal in 2 hours, she should have been referred to [the city hospital] for further assessment.

[Dr C]

1. [Dr C's] decision not to assess [Ms A] when he was at [the rural hospital] [in the morning].

The details of the handover between [Dr B] and [Dr C] are not known.

If a person is being boarded in the ED, with planned discharge and has been assessed by the night doctor, it may be the standard that the day doctor assesses the person only if problems are identified.

A morning handover that family is expected to take someone home may not trigger assessment unless problems are identified.

It is not clear what instructions the nursing staff were operating under or whether the nursing staff felt empowered to make a decision regarding discharge.

More often, if discharge is dependent on achieving certain goals (in this case, when she was awake and alert) then the day doctor may assess the person prior to discharge or may discuss this with nursing staff. In this case since he was going to a remote clinic for the day and apparently discharge around noon was anticipated, discussion with nursing staff regarding the plan would be expected.

The departure from acceptable standards must be interpreted within the framework of [Dr C's] understanding of the situation, details of which cannot be known.

If the person is admitted and he is assuming care, then his decision was in error. In a patient whom he assumed was normal and stable, it would be considered a minor failure. If it was communicated to him by nursing staff or handover doctor that there were concerns, then it would be considered a significant departure from acceptable standards.

[Dr C's] statement suggests that [Ms A] was not admitted (although documents available state admission time of 0712.

2. [Dr C's] actions when contacted by [rural hospital] staff about [Ms A's] deteriorating condition

[Dr C] responded to the telephone call by the nursing staff by returning to [the rural hospital] to assist in the assessment of [Ms A]. This appears appropriate.

3. [Dr C's] actions on his return to [the rural hospital] [in the afternoon].

He performed a limited assessment, started an IV and drew blood for basic laboratory and spoke to the family. He considered possible need for airway support and contacted [the communication centre] regarding the urgency of the situation. This appears appropriate.

[Rural hospital]
Discussion regarding the hospital is limited to discussion regarding relevant policies.

There is no policy or protocol for transfer of patient from St John to [the rural hospital] A&E.

The admission policy appears appropriate but it does not appear to have been followed in regard to communication between charge nurse and Doctor on duty.

The Reportable Event Investigation Report concludes that further assessment would have been triggered had [Ms A] been admitted to CaseMix, since this would have included a falls risk assessment. If the admission document was the trigger for reassessment, it appears that the policy was not followed.

The continuity of care policy appears appropriate but does not appear to have been followed.

The Second opinion: Raising concerns about patient safety Policy is reviewed and appears appropriate and consistent with MCNZ Good Medical Practice. There is no evidence of contemporaneous concern of the care rendered."

Report Two

"I have been asked to review the responses of [Dr B] and [Dr C] and provide further expert advice regarding case number 14/01598, involving [Ms A] (specific questions detailed below). I have reread and agree to follow the Commissioner's Guidelines for Independent Advisors.

I am Vocationally Registered in Rural Hospital Medicine and have worked in the emergency rooms of Grey Base Hospital, Buller Hospital, and Thames Hospital. I have worked in a variety of rural GP practices and have completed the PRIME Course. (Updated CV attached separately).

I have reviewed the documents provided as well as my initial independent Advisor Report.

These include:

1. [Dr B's] response dated 14/07/2015
2. [Dr B's] response dated 14/04/2016 (partially redacted)
3. [Dr C's] response dated 13/08/2015
4. [Dr C's] response dated 25/01/2016
5. [RN E's] response dated 08/06/2015
6. [RN E's] response dated 11/04/2016
7. [RN F's] response dated 15/06/2015
8. [RN F's] response dated 11/03/2016 with enclosures
9. [RN D's] response dated 08/06/2015
10. [RN D's] response dated 20/04/2016
11. [The rural hospital's] response dated 09/01/2015 with clinical records
12. [The rural hospital's] response dated 02/07/2015 with reportable event report and relevant policies & procedures
13. [The rural hospital's] response dated 05/04/2016 with electronic audit trail
14. [The rural hospital's] response dated 12/04/2016 with updated P&P

HDC questions which [Dr B] responds to in her response dated 14/04/2016

Brief Clinical Summary (copied from original report and updated with information provided):

[In 2014], [Ms A], an [18yo] was involved in a single vehicle, [motor vehicle accident]. The first ambulance dispatch was at 0139 after an uninvolved driver came upon the car on its side an unknown time after the accident. He awakened a neighbour ([Ms U]) who drove to police and fire service to seek help and then returned to the scene. When she returned, a nurse was present at the scene[7] and had removed the driver from the vehicle but was unable to access [Ms A]. The first ambulance (unit 1, [Location 1]) arrived at 0208, crewed by Ambulance Officer [FR O]. She attempted to do a primary and secondary survey and place a cervical collar on [Ms A] but was unable to reach her to put it on. The second ambulance (unit 2) arrived at 0210, crewed by [EMT L]. She reported on the PRF that 'Single MVA [Location 2 ambulances] on scene. Also, [Location 1] first response. Unsure if patient was driver or passenger. Vehicle on its side. Pt still trapped but is conscious. Can't get into vehicle to assist pt. Pt yelling and thrashing about.' Other documents suggest [Ms A] was a restrained passenger, trapped in the vehicle rolled onto its left side and inaccessible to first responders until the roof of the car was removed by firemen, an estimated hour after the first ambulance arrived. After she was accessible to ambulance staff, she was removed from the car on a spine board with her head stabilized and was placed in unit 2. At that point, she was able to move all extremities but was crying and moaning with incomprehensible

[7] According to neighbour, Ms U

speech. She was agitated and uncooperative: removing the cervical collar and thrashing about when extracted. Only minor abrasions were visible. [EMT L] documents on the PRF that 'collar put on but pt keeps pulling it off. Did primary/secondary survey, only injury is abrasion to L knee. Pt mumbling not making sense. Pupils reactive BP [arrow up], Pulse [arrow up]. Helicopter was flying but had to turn back cause of bad weather. Transported; Pt still thrashing about. Also smelt ETOH.' They left the scene at 0314 with [EMT L] driving, [FR O] in the front, and [Ms A] in the back. They [stopped] to recheck vital signs (documented at 0340 and 0410) and [FR O] reports that '[Ms A] was sitting up, her arms and legs were moving. She didn't have the collar on, but it was near her. She looked at me. I said to her: "It's […] here." She was moaning and crying and said: "[…], I'm sorry for being like this" not in a clear voice though.' VS recorded en route report her GCS as 5/15 but this is not consistent with the written descriptions. Shortly thereafter, a third ambulance (unit 3) met them, crewed by [ILS K], and he assumed care of the other patient. [Ms U] (who had been in unit 1 with the other patient) then drove unit 3 to [the crossroads] and then joined [EMT L], riding in the front seat of the ambulance transporting [Ms A]. [Location 3] Ambulance 1 met them at or near the entrance to the hospital and took the other patient, but felt they could not take both.

There are discrepancies upon arrival at the hospital, regarding both who provided the handover and the content provided. [Ms A] was no longer secured to the stretcher and was either on the floor or partly across both stretchers and remained uncooperative as they tried to get her out. They opted to use a wheelchair to transport her. There are conflicting reports as to whether she was kicking the ambulance staff. She was unable to stand. Due to her agitation, she was moved to a side room in A&E and helped onto a bed. The handover continued in A&E, [Dr B] and an RN were present. There are conflicting reports regarding the details of the handover and whether the ambulance run sheet (PRF) was provided. Initial observations record an elevated heart rate, respiratory rate and a fever. It has been confirmed that the elevated temperature was recorded at the time of the initial assessment, it is not clear whether it was communicated verbally to the doctor. Her jacket was removed due to shards of glass in her clothes.

The doctor examined the patient and considered her inebriated with no evidence of a head injury. She later records a GCS of 14/15 (this has now been identified as occurring [retrospectively]).

There were no further vital signs or contemporaneous recordings during the night shift after the initial set taken at the time of presentation.

There is conflicting information regarding who provided the nursing handover at the beginning of day shift.

Hospital records document admission at 0712, apparently reflecting only the admission to ED, not to the hospital itself.

[Dr C] reported that [Dr B] was leaving [Ms A's] room just prior to the doctor handover that morning at approximately 0810.

There is conflicting information regarding the content of doctor handover.

There were no contemporaneous VS recorded during day shift until 1335. [Ms A] did not touch her breakfast. Notes suggest that she could be awakened.

Her family arrived about 0930 or 1000. They were concerned by her lack of responsiveness and mentioned it to [a hospital staff member]. [The staff member] mentioned their concerns at 1330 to [the CEO] who went to the ward at 1410 but reports that [Ms A] was 'being attended by staff members in A&E' and she 'returned to [her] office.'

The first record of family concern expressed to [RN E] was at 1315. She obtained VS at 1335 noting fever of 38.9 and GCS of 9. She contacted [Dr B] and [Dr C], both of whom were in remote clinics. [Dr B] arrived about 1430–1440.

[Ms A] was still in clothes from the time of the accident, though some had been cut. She was noted to be incontinent by the family.

The family reported that a 'new nurse' came on duty (this corresponds to the report from [RN F]) and initiated care, including changing her clothing and bedding.

[Dr B] arrived] and performed further assessment with impression that she had an ear infection ('worse than before?') and a head injury (GCS of 12/15) and she arranged transfer. [Dr C arrived], assessed [Ms A], concurred with [Dr B's] recommendation for urgent transfer, started a second IV and drew blood. He considered her GCS 9/15.

When she was being prepared for transfer there were still shards of glass in her clothing and on her.

She was transferred to [the city hospital] via ambulance with observations by RN accompanying her and remained stable GCS of 9–10, arriving at 1813.

Additional information provided in subsequent documents:

There is a report of contact from [communications] to the RN on night duty requesting a Prime Trained doctor. She notified Doctor On Call (presumably [Dr B]) who 'had to remain On Call in the hospital'. It is not clear whether, upon her arrival, hospital staff recognized that [Ms A] had been in the same accident as the other patient. The time of the accident was added to MedTech later, but was apparently included in the transfer letter on the day of the accident.

There has been clarification with regard to timeliness of charting.

Advice Requested

1. *[Dr B] and [Dr C] have reviewed your expert advice report and provided a response. Please review their responses, and if appropriate, provide further expert advice.*

   [Dr B] is absolutely correct that my opinion was written with the 'benefit of hindsight and knowing what ultimately occurred in this case.' However, the advice is provided on the basis of information known to [Dr B] at the time and within accepted practice at the time of the event.

   I note that she saw [Ms A] on several occasions, one at the initial presentation at 0445, at 0630 (with additional notes documented) and perhaps just prior to her handover to [Dr C] ([Dr C] reports [Dr B] was 'just exiting the observation room' as he came into the hospital). She reports that in the second letter (14/04/16) that at 0630 [Ms A's] 'condition had not changed. There certainly was no evidence of any deterioration. I had therefore set the time for reassessment after handover at 0800.' Later in the second

report [Dr B] noted 'I wanted her to remain for observation and further assessment by [Dr C] following handover later that morning.'

[Dr C] reports that he understood from the handover that the patient was stable and did not understand that he was expected to reassess the patient.

[Dr B] in her initial response dated 14/07/15 reports the following regarding her handover to [Dr C] 'I advised that she had been involved in a car accident as a passenger with a seat belt on; that the other person in the car had been taken directly to [the city hospital].' [RN D] on 24/06/2015 states [regarding the initial handover] 'later [ILS K] (Paramedic), as he had been attending to the other patient who had been involved in the accident, and who was being transferred to [Location 3] ambulance.' [Dr B's] second report dated 14/04/2016 states 'There was no report from the ambulance staff regarding the other person …'

The failure of information sharing at the time of the handover clearly influenced [Dr B's] assessment and decision not to transfer [Ms A]. However, she failed to recognize that her neurological exam was significantly abnormal and her failure to improve (even in the interval from 0445 to 0630) suggested that EtOH could not be the explanation.

This may be a knowledge deficit or the result of failing to alter her impression as a result of new information ('cognitive flexibility'), perhaps aggravated by fatigue.

This represents a significant departure from the standard of care.

In my initial report, I noted that [Dr C's] initial correspondence was not available for review. He has included a copy with his second correspondence which is a duplicate of that provided previously. This misunderstanding arose from the initial sentence in his report 'Thank you for your correspondence dated July 28, 2015 received by email in which you have requested ***<u>further</u>*** information …' (emphasis added). There are no documents detailing what previous information was provided, suggesting it may have been a verbal communication.

He has provided responses to those items in my report identified as 'Areas of uncertainty or discrepancy in reports' and I acknowledge errors in enumeration. However, these are areas of conflicting recollections and/or reports rather than matters of clear fact. I do note that his second report is entirely consistent with his prior report. Specifically, it is worth noting that 'There is conflicting information regarding Dr's handover at 0810 +/-' refers to the specific issue of whether [Dr B] expected or assumed or communicated the need for reassessment by [Dr C]. A clear understanding of this would allow better characterization of whether the standard of care was followed.

2. *Ngati Parou Hauora Charitable Trust ([the rural hospital]) provided an audit trail of the changes which were made to the electronic medical notes. They show that on […][8] [Dr B] made an entry at 4:55am recording her initial assessment and then added to*

[8] Document notes 2016 but clearly refers to 2014.

that assessment at 0654am. [Several days later], [Dr B] added again to the entry stating 'see4.0[0]am GCS 14/15'. Please comment on the appropriateness of [Dr B's] clinical record keeping, including but not limited to the additions she has made to her clinical notes for [the day of the accident][9].

Certainly, additional notes can be added during the period of observation in the emergency room. Often these notes are in haste so that amplification or additional details such as those added at 0654 are appropriate. However, looking at the screen shots it appears that the Temperature of 39.3 was documented in a manner that would have been evident to [Dr B] at that time. The additional notes [at 5:06pm] are under [Dr C's] name, later changed to [Dr B]. [Dr B's] second statement acknowledges that she added information regarding the GCS [on admission] and information from her referral letter to the notes [retrospectively]. Coles Medical Practice in New Zealand[10] states 'Sometimes, on reviewing an earlier record entry, a doctor may feel that it is inaccurate, incomplete or potentially misleading. It is appropriate to augment a record in such cases, making it clear when and by whom the augmentation or annotation was added. The earlier entry should never be deleted, obliterated or changed, if only because such amendments might later raise suspicion of covering up an error in treatment or diagnosis.'

This represents a significant departure from the standard of care.

3. *[RN E] has stated that [Dr B] directed her to change her nursing records which recorded a GCS of 9 to GCS of 12. [Dr B] stated that she did not do so. Please comment on the appropriateness of [Dr B's] actions if [Dr B's] account is accepted or if [RN E's] account is accepted.*

   a. *If [Dr B] did not tell [RN E] to change the record*: Since GCS reflects the observation of the person assessing, it is not uncommon to have disparity. If [RN E] assumed that [Dr B] was providing her opinion (rather than a directive), then [RN E] may have changed the record to reflect that, deferring to [Dr B's] greater expertise. Since the record reflects the impression of the individual, a better answer is to document the specific observations that make up the score, for instance, noting variation in observation (e.g. 'eyes stayed closed when I spoke to her').
   b. *If [Dr B] did direct [RN E] to change the record:* [Dr B] may have been correcting what she considered an error on the part of [RN E] or wanted the disparity to be identified. It is not unusual to discuss GCS findings and arrive at a consensus but to recommend an alteration in the clinical record would be a significant departure from the standard of care.

4. *Please review the changes [the rural hospital] has implemented following this complaint, including the updated policies.*
   I think the policies are appropriate. I do not think the outcome was due to a policy failure. I particularly think the upskilling and professional development of the staff is to be applauded.

[9] *Ibid.*
[10] Coles Medical Practice in New Zealand, Ed. Ian St George, Pub. MCNZ, 2013.

I think a structured handover would be helpful for the physicians ideally with either the SBARR or SHIFT format and preferably written.

I note that there are ongoing plans to 'improve relationships and trust between ward staff …' Specific training in 'dealing with difficult people' may be helpful as well as having an anonymous, non-judgmental method for complaints about staff behaviour.

5. *Please comment on any other matter you consider relevant*:
   a. In the setting of altered level of consciousness, the impact of alcohol or drugs cannot be clearly differentiated from brain injury. All abnormal behaviour in the setting of accident should be considered suspicious for brain injury. The frequency of presentations with altered sensorium is high in all of New Zealand and, particularly with a history of possible injury, poses a real problem for providers. This is compounded by the logistics of trying to transfer patients to referral centers who may only be drunk or under the influence of other substances, including the reluctance of referral centers to accept these patients.

      There is no substitute for serial assessments including neurologic observations in the rural setting. Access to a method of measuring blood alcohol and close monitoring can avoid some of the dangers. Use of drugs to counteract the effects of benzodiazepines and opioids can be helpful in the setting of suspected other substance use.

      At no point was [Ms A's] neurologic exam normal. She lay quietly in bed, sleeping or moaning occasionally and touching her ear. There is no record that she spoke after the initial assessment at 0445 or 0630. There is no record that she sat up, moved purposefully, or followed commands after she touched [Dr B's] fingers.
      The report at the scene was consistent with a maximum GCS of 11 (assuming eyes open spontaneously, incomprehensible sounds, localizes pain). The [ambulance attendant] reports a single phrase '[…] I'm sorry for being like this' but not in a clear voice which could be interpreted as a maximum GCS of 12. PRF (not available at the time of admission to [the rural hospital]) reports a GCS of 5 which has not been clarified in available records but may mean 10/15.

      If the time of the accident was known, then altered mental status should never have been attributed to alcohol.

      The following timeline is constructed from records provided:

      0445 — She was clearly agitated on transfer from the stretcher, 'shouting, kicking' and had been incontinent of urine, did not weight bear on transfer. [Dr B] noted she was 'difficult to assess.' There is no evidence that she was capable of providing a history. She later recorded her GCS as 14/15 but contemporary notes reported monosyllabic responses and that 'she appeared to know she was in [the rural] hospital' although without clarification. [RN D] describes her as 'uncoordinated, aggressive, speech incoherent.' It appears likely her behaviour during attempt at taking her temperature was in response to pain in the ear.

      0630 — [Dr B] records that she was moving her arms and legs around, 'looked at the policeman and nodded with consent' and watched while her blood was being

taken. [RN D] reports she was pulling her arm away and crying during phlebotomy.

0830 — [RN E] notes she was 'rousable to illicit [sic] pain, appeared drowsy.'

0920 — Sleeping opened eyes to voice; no obvious pain.

Lunch — [RN E] notes 'awake and responsive.' However, during this period her family was consistently concerned by her behaviour and did not mention any lucid period in documents reviewed for my initial report. Hospital CEO reports advised by an employee of the hospital and family member of [Ms A] that family report their relative 'not talking, crying (soft, high pitched) intermittently and that they had noticed an interning of her arms across her chest towards the midline' (sometime prior to 1300). This sounds like a GCS of 6–9 depending on whether she was opening her eyes.

1335 [RN E] reports GCS 9.

1440 — [Dr B] records her 'eyes opened on approach, not talking, ear sore with pain.' This would likely correspond to a GCS of 9 (eye opening to speech, verbal — none, and localizes pain) but details regarding the recorded GCS of 12 are not available.

1545 — [Dr C] initial assessment considered GCS of 11 (specifics not noted), later revised to 9.

The majority of the observations (while limited in scope) are more consistent with a GCS of 9–11 (based on eye opening to speech (3) or to pain (2), verbal response incomprehensible sounds (2) or inappropriate words (3), and motor response withdraws from pain (4) or localizes pain (5)). It is not clear that [Ms A] significantly declined during her time in [the rural hospital] or simply never improved.

b. There is consistent evidence of poor communication between providers that resulted in many lost opportunities and reduced standard of care. Lack of clear communication is evident in the initial handover by ambulance staff, the plan of care in the ED, the nursing handover at change of shift (night to AM), and the doctor handover at about 0810. In addition, the families' information from friends and their concern regarding [Ms A's] status were not communicated to the RNs in a timely fashion.

c. The fatal outcome is likely the result of her injuries rather than the delay in recognition."

Report Three

"I agree to follow the Commissioner's Guidelines for Independent Advisors.

I am Vocationally Registered in Rural Hospital Medicine and have worked in the emergency rooms of Grey Base Hospital, Buller Hospital, and Thames Hospital. I have worked in a variety of rural GP practices and have completed the PRIME Course.

I feel that the clinical record should be viewed as the primary means of communicating between physicians and other health care providers with particular attention to both positive and negative findings and conclusions, including areas of concern and plan.

My further comments assume that [Dr B] had neither the St Johns PRF nor a comprehensive handover describing the scene of the accident.

[Dr B] twice noted 'No evidence of head injury' but did not document how she reached this conclusion. This suggests that she recognized head injury was a possibility and evaluated [Ms A] specifically to determine whether she had signs or symptoms of a head injury and concluded that she did not. Assessment for possible head injury should include some documentation of neurologic function.

GCS is a convenient tool for initial management decisions, recognizing decline during serial evaluations and communicating to other providers. However, any evaluation for head injury should at least include whether the person is awake and alert, able to communicate, recalls the event, moves coordinately and follows commands.

It appears that either [Dr B's] evaluation was inadequate or she failed to recognize significant findings and failed to reevaluate the patient.

It could be argued that there were a number of signs to suggest a potentially significant head injury: abrasions on her face, an abnormal ear exam (probably haemotympanum, a classic sign of basilar skull fracture) and inability to weight bear on transfer.

I am surprised that [Ms A] failed to respond with pain to the spinal examination (this with the benefit of hindsight) and saddened that the examination did not result in the removal of her wet clothes and the slivers of glass noted just prior to transfer.

In any case, the fact that she lay still and moaning, and failed to improve over several hours should have raised an alarm.

Indeed, in the setting of trauma and altered level of consciousness, it is virtually impossible to confidently exclude head injury. In a resource poor environment, like [the rural hospital], this effectively renders the patient unevaluable and mandates transport to a facility equipped to provide further assessment.

Nor am I sanguine about a temperature of 39.3. In my view, recognizing a fever mandates further investigation. If seen today, [Ms A] would meet 'sepsis criteria' that would initiate a cascade of rapid evaluation and treatment. I am uncertain whether the current protocols were in place [at the time].

I stand by my conclusions that [Dr B's] care represents a significant departure from the standard of care in a rural hospital environment."