Registered Nurse, Ms B

General Practitioner, Dr C

A Rest Home/Hospital

A Report by the

Deputy Health and Disability Commissioner

(Case 06HDC15897)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A (dec)	Consumer
Ms B	Provider/registered nurse
Dr C	Provider/retired general practitioner
Ms D	Caregiver
Ms E	Manager, the rest home/hospital
RN Ms F	Registered nurse
RN Ms G	Registered nurse

Complaint

On 25 October 2006, the Commissioner received a complaint from the manager of a rest home/hospital, Ms E, in relation to the services provided by RN Ms B and Dr C. The following issues were identified for investigation:

- *The appropriateness of care provided by Registered Nurse Ms B to Mr A on 26 August 2006.*
- *The appropriateness of care provided by Dr C to Mr A on 26 August 2006.*

An investigation was commenced on 30 October 2006.

Mr A's family was aware of the complaint and, although they had no concern about the care provided to Mr A, stated that they understood the reason for the investigation.

Information reviewed

Information from:

- Ms B
- Dr C
- Ms D
- The rest home/hospital

Independent expert advice was obtained from general practitioner Dr Ian St George and nursing expert Ms Lesley Spence.

Information gathered during investigation

The rest home/hospital
The rest home/hospital (the rest home) consists of two units, comprising 75 beds in total. Ms E, the Manager, advised that both units provide hospital level care and there is always a minimum of one registered nurse on duty on each unit.

RN Ms B
RN Ms B is a registered psychiatric nurse who commenced employment in October 2004. She stated:

> "I work in the hospital care ward, where I am always the shift leader for my unit, which has 25 residents, and sometimes more often than not I am in charge of the entire facility, which in total is 75 residents.
>
> This involves managing staff as well as the care of patients and any crisis that the residents have.
>
> I am often told to put sub cut [subcutaneous] fluids up overnight, make up Graseby Pumps and administer same; administer medications; dress wounds; give aperients along with enemas; perform rectal assessments; make assessments in crisis situations and manage those situations.
>
> …
>
> When I was employed by [Ms E] I discussed with her my scope of practice and she informed me that I was to be employed within the Dementia Unit and that this was within my scope of practice. However this did not happen and since the beginning of my employment I have been rostered on in [the Hospital care ward]."

Ms E agreed that RN Ms B had often been in charge of the whole facility because of a shortage of registered nurses, and would call the team leaders if advice was required. Ms E could not recall the conversation she had with RN Ms B at her job interview but added:

> "I would not have offered [RN Ms B] a position in the dementia unit because we do not employ RNs there apart from the team leader, and I was not offering her the position of team leader."

In response to the provisional opinion, Ms E stated:

> "When RN [Ms B] was employed at [the rest home/hospital] the process then was for gaining approval from the Ministry of Health for a Psychiatric Nurse to work in a residential facility for older people, which was done. RN [Ms B] had a full and comprehensive orientation given her scope of practice. She did not, at any time, approach me in relation to changing her scope of practice. She is currently undergoing

> the process for changing her scope of practice which I am supporting, but that has happened as a result of my requesting her to do so."

Ms E provided a copy of an unsigned letter to the Ministry of Health (the Ministry) seeking approval to employ RN Ms B. However, Ms E had no record of any response from the Ministry and, when contacted, the Ministry was unable to find any record of any contact from the rest home regarding RN Ms B's employment.

26 August 2006

Mr A was an 87-year-old, terminally ill resident. He resided in the hospital care ward where he required full nursing care. On the evening of 26 August 2006, Mr A's care had been delegated to a caregiver, Ms D. She was supervised by RN Ms B, who was the shift leader for the hospital care ward. Also on duty that evening in other parts of the facility were RN Ms F (working as a caregiver) in the hospital care ward, and two other registered nurses in the other unit. Ms E stated that one of the registered nurses was in charge of the "entire facility", and that "[one] of the conditions of employment of RN [Ms B] to [the facility] was that she must consult with the RN in [the other unit] about anything she is unsure of and needs help with".

RN Ms B said:

> "Often I do not always know if there is a registered nurse in the other ward, as the communication is so poor. I have to give the other ward a call to find out who is on and touch base."

Later, in response to the provisional opinion, RN Ms B stated:

> "[There were no] conditions placed upon me at commencement of employment, I took the initiative and consulted with my colleagues if I was uncertain. Sometimes I was unsure if there was RN coverage in the other unit, so I made it a practice at the beginning of my shift to find out who was where. This is the same situation that exists at present."

In her response to the provisional opinion, Ms E stated:

> "RN [Ms B] always phones the other unit at the start of her shift to find out who is on as part of the condition of her employment as a registered psychiatric nurse. On the evening in question RN [Ms B] would have known there were three other RNs in the building."

At about 8pm on 26 August, Ms D found Mr A in distress, and she informed RN Ms B. RN Ms B stated:

> "I went to [Mr A's] room and assessed that he had stomach pain, was indeed very distressed and crying. He indicated to me that his stomach was very painful. I checked his abdomen, and then asked [Ms D] when he had last had a bowel motion. [She]

> stated that he had not had a bowel motion for several days. I asked [Ms D] to get me a stethoscope to listen for bowel sounds, which were absent. I then performed a [rectal examination] and found that the rectum was very full of faeces."

Ms D said that she and RN Ms B discussed the next step, which would be either to get advice from another RN on duty, or to contact the on-call doctor. However, RN Ms B stated that her options were "limited as I had been told … that we were not to call the doctor after-hours, as this was costly. The other option was to send [Mr A] to [the Public] Hospital." In response to the provisional opinion, RN Ms B stated that in her view sending Mr A to hospital was not an option as it would have caused Mr A distress.

Ms D and RN Ms B recalled that during their discussion they were approached by Dr C, a retired GP whose wife was a resident of the rest home. In contrast, Dr C stated:

> "[RN Ms B] came into my wife's room and during the course of our conversation said that she was worried about [Mr A]. She thought that he might have an abdominal emergency and that she would have to contact the St John Ambulance and send him to the Emergency Department at [the Public] Hospital. … I simply said to [RN Ms B] I'll come down and see if I could help or advise."

RN Ms B disputed Dr C's recollection, and said:

> "I walked into [Dr C] as I exited [Mr A's] room, and as an aside asked him … if he knew 'what bowel sounds were like'. I did not give him any information regarding [Mr A]; his response was 'I will take a look' and proceeded into [Mr A's] room. Both [Ms D] and I followed [Dr C] into the room."

Dr C assessed Mr A and concluded that his symptoms "were in all probability due to a faecal impaction". Ms D recalled that it was decided to give a Fleet enema,[1] and she went to another part of the facility to obtain one. While she was away, Dr C decided to perform a manual evacuation. When Ms D returned with the enema, the procedure had commenced. RN Ms B stated:

> "The procedure immediately relieved [Mr A's] pain and discomfort. … I documented in [Mr A's] notes that he had been in pain, was crying and very distressed, and the reason for his current state, this included that he was impacted, and required a manual evacuation. … I did not write an incident report as I did not feel it was necessary. However, hindsight is wonderful. I should have documented the process."

RN Ms B said, "Manual evacuations are a commonly occurring practice at … [the rest home/hospital], and continue to this day."

Ms E stated:

[1] Fleet phosphate enema: prescribed for the treatment of constipation.

> "[The rest home/hospital] does not have a policy on the manual evacuation of bowels as it is not a procedure that is considered safe practice for registered nurses."

In response to the provisional opinion, Ms E explained:

> "[The rest home/hospital] does not have a policy on manual evacuation of bowels as it has been considered by the Better Practice Group, who represents our seven homes, that it is not a procedure that nurses should be performing. However, I have read the Royal College of Nursing guidelines for nurses on digital rectal examination [DRE] and manual removal of faeces, which I will refer to the Better Practice Group for their consideration."

Ms E pointed out that the guidelines suggest that appropriately qualified nurses can carry out these procedures, but that this must be in the context of employers offering training and instruction, and having policies and procedures in place. She advised that the rest home/hospital did not meet those criteria and therefore neither procedure (digital rectal examination and manual bowel evacuation) should be performed by nurses in its facilities. She said:

> "The Better Practice Group has been advised to revisit their stance on DRE and manual removal of faeces as a result of this enquiry."

Ms E denied RN Ms B's suggestion that registered nurses were not allowed to contact the on-call doctor after hours because of cost. She provided the minutes of a staff meeting held on 27 July 2006 which stated:

> "Guidelines re: ringing after hours [doctor] …
> Ensure registered nurse has assessed person, full set of observations are taken [and] discuss with Registered Nurse in facility.
> Phone advice available from Emergency Department."

In response to the provisional opinion, Ms E said:

> "During all discussions that have been held with registered nurses about calling the after hours doctor, they have never been told not to call the after hours doctors because of the cost. Our responsibility is to ensure optimum care for all residents which means access to a medical practitioner when necessary … ."

RN Ms B stated that there was a memo, "instructing Registered Nurses not to call after hours medical cover as this was too costly", but that this memo has subsequently "disappeared".

RN Ms F, who was on duty on the evening of 26 August, and who has since left the rest home/hospital, was contacted during the investigation. RN Ms F stated that she does not

recall a memo that stated that registered nurses were not allowed to contact out of hours medical staff.

RN Ms B was not present at the meeting on 27 July, but Ms E stated that the minutes were "posted on the staff notice board, and all staff are expected to read them". RN Ms B agreed in her response to the provisional that she "read the minutes in the instances that [she did] not go to a meeting".

Subsequent events
On the day after the incident, RN Ms G received a handover from RN Ms B. RN Ms G later said:

> "RN [Ms B] informed me that I would be cross with her because she had used retired GP [Dr C] to examine [Mr A] and he had performed a manual removal of faeces on [Mr A]. I cannot remember my response but feel it was non-committal as other afternoon staff were present in the office at the time.
>
> The following morning 28 August 2006 I checked the documentation in [Mr A's] chart and found details missing i.e. no reference to [Ms B] consulting a doctor on the afternoon of the 26 August 2006. I then verbally informed [the] team leader of the situation. No incident form was completed."

RN Ms B denied this. In response to the provisional opinion she said:

> "The conversation that supposedly occurred with RN [Ms G] the next day is incorrect. I did not have a conversation with [her] until several weeks later when she told me that she had been to see management with regard to the incident and informed them of what had occurred."

Mr A died peacefully a short time later.

The rest home instigated an internal investigation. A meeting was held on 31 August involving Ms E, two other members of management, RN Ms B, her support person, and her New Zealand Nurses Organisation representative.

In a letter to RN Ms B dated 1 September, Ms E stated:

> "Thank you for meeting with me yesterday.
>
> During that meeting you admitted making a gross error in professional judgement and, were it not for your past good record and the regret that you showed, I would have terminated your services.
>
> Instead I have decided to give you a final warning. This letter therefore serves to warn you that, if in the future you fail to follow policy in the application of nursing procedure,

or fail to seek assistance from another registered nurse when you are at all uncertain about procedures, disciplinary action will be taken against you, and that there will be a likelihood of dismissal."

Independent advice to Commissioner

Medical advice

The following expert advice was obtained from general practitioner Dr Ian St George.

"Ref: [Mr A], 06/15897

I respond to your letter of 13 December 2006 seeking advice in relation to [Ms E's] complaints against [Dr C]. I am asked to provide independent expert advice about whether [Dr C] provided an appropriate standard of care to [Mr A].

Background

[Mr A] was a resident of [a rest home] and was terminally ill, requiring full nursing care.

On 26 August 2006, [Dr C] (who is a retired GP, and no longer has a practising certificate) was visiting his wife, who was a resident of [the rest home].

Following a discussion with the registered nurse on duty, [Ms B], [Dr C] became aware that [Mr A] was in discomfort. [Dr C] performed an examination. Having found [Mr A] faecally impacted, he performed a manual evacuation.

Complaint

The appropriateness of the care provided by [Dr C] to [Mr A] on 26 August 2006.

Expert advice required

1. Please comment generally on the care provided by [Dr C] to [Mr A].
2. Was it appropriate for [Dr C] to become involved in [Mr A's] care? Please give reasons for your view.
3. Was there any professional requirement of [Dr C] to provide care to [Mr A]? Please give reasons for your view.
4. Please comment on the care provided by [Dr C] to [Mr A], in the context where [Dr C] did not hold an Annual Practicing Certificate at the time.

I have assessed whether the doctors' actions were reasonable in the circumstances by the standards of the profession, as far as they have been stated or previously judged, at the time of the incidents. I state here I have no personal, financial or professional connection with any party that could bias my assessment.

The essence of this case is the doctor's duty to attend in an emergency. I will refer repeatedly to the Medical Council's 2006 statement *A doctor's duty to help in a medical emergency* which I append. [Appendix 1]

Please comment generally on the care provided by [Dr C] to [Mr A].
[Dr C's] clinical care was exemplary. He diagnosed faecal impaction, and performed a manual disimpaction without delay, with evident relief to the patient.

Was it appropriate for [Dr C] to become involved in [Mr A's] care? Please give reasons for your view.
[Dr C] had a duty as a medical practitioner to respond to what was presented to him as a medical emergency during the evening of 26 August 2006. The nurse's contemporary record stated '[Mr A] in pain and whimpering'. [Dr C] wrote 'She ([Ms B]) thought that he might have an abdominal emergency and that she would have to contact the St John Ambulance and send him to the Emergency Department … [Mr A] groaning and calling out …'.

If asked to attend a medical emergency as defined in this statement, a doctor must respond. This is both an ethical and legal obligation. Rarely there will be times when attending a medical emergency is impossible or unsafe for the doctor or patient. If a doctor chooses not to attend he or she may be required to defend that decision in the event of a charge of professional misconduct or criminal prosecution.

Paragraph 2 of the Medical Council statement is clear that an emergency exists if the caller says it does.

'… case law indicates that an emergency exists if the caller says it does until the doctor has had an opportunity to assess the situation and determine whether a 'medical emergency' exists.'

Paragraph 4 states the penalties if a doctor does not attend.

'A doctor is at risk of being professionally or criminally responsible if he or she fails to render prompt and appropriate medical care to any person (whether the patient is a current patient or not), in a medical emergency. A doctor who chooses not to attend must have good reason and be able to defend this position at a later time.'

Paragraphs 12–14 quote Right 7 (4) and clause 3 of the HDC Code, listing circumstances when the doctor may provide services without obtaining informed consent; these apply here.

12. Right 7(4) of HDC Code states that if the patient is not competent to make an informed choice and give informed consent, and no person entitled to give consent on behalf of the patient is available, a doctor may provide services without obtaining the informed consent of the patient when:
(a) it is in the best interests of the patient; and
(b) reasonable steps have been taken to ascertain the views of the patient; and

either
(c) the provider believes, on reasonable grounds, that the provision of the service is consistent with the informed choice that the patient would have made if he or she were competent; or
(d) if the patient's views have not been ascertained, the provider takes into account the views of other suitable people who are interested in the welfare of the patient and available to advise the provider.

13. Clause 3 of the HDC Code states that a provider is not in breach of the Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties of the Code. It also states 'the circumstances' means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.

14. Therefore a doctor may not need to obtain consent before providing emergency services. This would be one example of a situation where Clause 3 of the HDC Code would apply. However, only necessary treatments should be provided. Where time is of the essence and delay to obtain consent would be considered unreasonable or further threaten the patient's well-being, a doctor may take action without actively seeking the patient's consent. As with any other health service, a competent patient has the right to decline treatment, even in an emergency.

Was there any professional requirement of [Dr C] to provide care to [Mr A]? Please give reasons for your view.

Yes. As a medical practitioner [Dr C] had a duty to attend and render appropriate care. [Ms E's] contention that the matter was serious because 'importantly, the procedure was an extremely intimate one' is simply wrong.

Please comment on the care provided by [Dr C] to [Mr A], in the context where [Dr C] did not hold an Annual Practicing Certificate at the time.

[Dr C] is a medical practitioner, and he had an ethical duty to attend; that is not affected by his registration status.

Paragraph 16 of the Council's statement makes that clear.

I am deeply concerned that the manager of a rest home should have got this so wrong, and suggest systems failure is illustrated by this case.

Chronic constipation is common in the sedentary elderly, especially the demented, as recognised by the [rest home/hospital] nursing policies. It was mentioned several times in [Mr A's] records. One result of chronic constipation is faecal impaction, a state of (eventually) obstruction of the bowel that can be intensely uncomfortable for the patient. It can quite properly be seen as a medical emergency.

[Ms E] stated (email to you undated), 'We do not have a policy for phoning doctors after hours'. Further (letter to Ms Lamb of 16 November), 'We do not have a policy for manual bowel evacuation' and the 'Better Practice Group will discuss the merits of adding into Policy … that manual bowel evacuations are not performed in Presbyterian Support (Otago) Homes'.

[Ms B] stated (5 December letter to Ms Lamb), 'we were not allowed to contact the doctor out of hours, as this was costly. The other option was to send [Mr A] to [the Public] Hospital. I was reluctant to do this for the following reasons [she listed them]'.

I am astonished and dismayed if all this is true.

Any rest home should have policies that include after hours access to general practice care, and that care should include the ability to perform the simple procedure of manual disimpaction when that is necessary: it is misuse of the ambulance and emergency department to use them for this purpose.

Nurse [Ms B] may have been in breach of (apparently inadequate) rest home policy in asking [Dr C] to assist, but to characterise her actions as 'a gross error in professional judgement' is to misunderstand the nature of professionalism.

[Dr C] performed a 'good Samaritan' act in a perceived medical emergency. He acted professionally and entirely properly.

Nursing advice

Ms Lesley Spence provided the following expert nursing advice:

"I am a registered general and obstetric nurse (1963) and hold an Advanced Diploma of Nursing (1981, Distinction) specializing in medical nursing.

Following graduation I worked in an acute medical surgical hospital becoming a staff nurse in a medical ward and prior to being promoted to a nurse tutor position was Sister-in-Charge of Christchurch Hospital on night duty (600 patients).

I taught General Nursing for 3 years (1966–1969) and then had a period raising a family during which time I worked part-time in a hospital for the Aged.

In 1975, I was invited to teach in the then quite new Comprehensive Nursing programme at Christchurch Polytechnic where I was employed for 18 years.

During these years, I taught most comprehensive nursing courses but in the latter 5 years, I had the responsibility for Post graduate short courses which included courses in Gerontology (care of the Aged). It was the relevance of this knowledge that in 1996 led me to accept the offer of a nurse manager's position in a large modern rest home caring for approximately 80 seniors. There I began to apply my learning to practice — I found it rewarding to be able to teach Registered Nurses and caregiving staff and see the

benefits of their knowledge conveyed to the residents. I also developed skills in management which assisted in meeting the challenges of running a rest home.

From this rest home I was invited by new employers to develop a 60 bed rest home, Middlepark Senior Care Centre, from the building plans up — this gave me the opportunity to modify design, plan appropriate furniture, furnishing and equipment, write the policies and procedures, employ, orientate and educate the staff and develop trusting relationships with the residents.

While challenging, this project was enormously satisfying as I was able to implement the nursing philosophies I believed in.

Since then a further 2 rest homes, The Oaks Senior Care Centre (150 residents) and Palm Grove Senior Care Centre (118 residents) have been built to include long-term hospitals. Palm Grove was opened in December 2003.

My role has changed to Principal Nurse Manager with oversight of the 3 centres.

I am a member of:

- New Zealand Nurses Organisation
- New Zealand Association of Gerontology
- Healthcare Providers NZ (& Canterbury Branch committee member)
- New Zealand Retirement Villages Association

I have recently facilitated a group of nurse managers to meet regularly in order to seek solutions to the serious shortage of registered nurses and caregivers in Canterbury.

I act as an advisor for:

- The Otago University — Christchurch School of Medicine Post Graduate Courses
- Christchurch Polytechnic Institute of Technology Post Graduate Courses for Nurses
- Health & Disability Commissioner
- Health Education Trust with input into the Aged Care Education courses for caregivers

I regularly attend conference and courses associated with the care of seniors in rest home and continuing care facilities.

Palm Grove Senior Care Centre has been chosen by the Ministry of Health to provide education for Bachelor of Nursing students, Nurse Assistants and the competency Assessment programme for Registered Nurses who wish to return to the workforce.

[At this point Ms Spence states the background to the matter, which has been stated earlier. She also sets out the questions she has been asked, which she repeats in her report.]

1. Comment on the care provided to [Mr A] by R.N. [Ms B]

[Ms B] is a Registered Psychiatric Nurse (1988) with significant experience in psychiatric nursing. She was employed by [the] rest home in [2004].

She was told on appointment that she could work within her scope of practice in the dementia unit, however this did not happen and she has worked consistently in [the hospital unit], a hospital ward as Shift Leader for 25 long term hospital residents. She states she can be in charge of the whole facility (75 residents) during her afternoon shifts.

On 26th August, [Mr A's] care had been delegated to a care worker, [Ms D], and [Ms B] was in a supervisory role. The care worker approached [Ms B] stating that [Mr A] was in a lot of pain. [Mr A], at this stage, was not eating or drinking and was considered to be dying. [Ms B] checked him and found him distressed, crying and complaining of stomach pain. She checked his abdomen, listened for bowel sounds and then asked the care worker when he had last had a bowel motion. This was found to be several days ago. [Ms B] then did a rectal examination and found [Mr A's] rectum full of faeces which appeared to be causing the pain.

She states then in her report that she had 3 options:

1. To call the After Hours Doctor but was reluctant to do so because staff were told it was too costly.
2. To send [Mr A] to hospital which would have been extremely stressful for him as she considered him to be dying. She also considered that fecal impaction should be able to be dealt with in a long term care hospital.
3. To telephone another R.N. on duty which she was reluctant to do as there would be a time delay /or not a supportive response/ and she was also not sure if other R.N.s were on duty.

She was considering these options when she noticed [Dr C] coming up the corridor and it seemed at the time a good solution to ask him for advice.

She talked to [Dr C] about [Mr A's] pain and he willingly offered to help.

Her description of [Dr C's] actions was that he gave [Mr A] his own careful assessment and finding [Mr A's] bowel full of faeces, then went on to perform a manual evacuation. He did not stop to discuss this with [Ms B] (R.N.).

His actions quickly relieved [Mr A's] discomfort and pain.

Although very sick [Mr A] was informed about what was happening and care worker [Ms D] also confirms this. R.N. [Ms B] documented the actions taken, including the evacuation of [Mr A's] bowel — the Microlax given, Panadol administered, fluids and

personal care. She also contacted the family to advise them of their father's frail condition and they visited.

She did not record that [Dr C] had performed the evacuation — nor did she tell the family.

She also did not ask the advice of the other 2 nurses on duty whom she claims didn't know were there, as she said the only way of finding this out was to ring the wards when she came on duty.

[Dr C's] report of this incident is that R.N. [Ms B] came into his wife's room and in the course of conversation said she was worried about [Mr A], she thought he had an abdominal emergency and she would have to send him to the Emergency Department of [the Public] Hospital.

[Dr C] had heard [Mr A] groaning and crying out — he simply said to RN [Ms B] 'I'll come and see if I can help or advise'. (RN [Ms B] knew of his medical background as he had been visiting his wife for 6 weeks.)

He examined [Mr A] noting how unwell he was and concluded that his symptoms were in probability due to faecal impaction which he easily removed. In a short time [Mr A's] pain and distress was gone and he went to sleep. On his way home 20 minutes later, [Dr C] checked [Mr A] and he was sleeping peacefully.

Of note is Ms D, care worker's comment that [Dr C] offered to help and [Ms B] (R.N.) did not ask him to.

[Ms C] also states that she and RN [Ms B] were considering whether to ask another R.N. on duty to help when [Dr C] came up to them.

Advice Required:

1. RN [Ms B's] care of [Mr A]

I consider the personal care of this seriously ill man demonstrates kindness, appropriate care and compassion from the staff concerned, RN [Ms B], Careworker [Ms D] and [Dr C] — a compassionate Doctor distressed at another resident's pain and discomfort.

Of course when it is viewed from a professional standards point of view there are significant issues to address;

- A retired Doctor with no practicing certificate should not provide medical care to another resident in his wife's rest home.
- The R.N., although understandably seeking a quick solution to her resident's pain and distress should have found more appropriate and professionally acceptable advice and support.

- Her discussion with [Ms D] about calling the other R.N. on duty would have been the correct one although I understand her unwillingness to ask for help when it had not been willingly given before.
- She was also being permitted to practise outside her scope of practice and although she had mentioned this to management in July, no action had been taken.
- I agree with her decision not to send a dying resident to the Emergency Department but again she would have been wiser to have asked for the professional support from another R.N. before taking the course of action she did.
- She did not ask [Dr C] to help although she did choose to discuss [Mr A's] pain with him when the opportunity arose — while this may be seen as an invasion of privacy it must also be remembered that [Dr C] could clearly hear [Mr A's] distress and knew the residents on [the] Ward well.
- I believe RN [Ms B] working outside of her scope of practice realized the need for more professional advice — it was freely offered and finding a way to relieve her resident's pain, she was grateful to accept it.
- While [Dr C] was retired he had significant experience — 50 years practice and the skills of these years are not readily forgotten. A manual evacuation requires gentleness rather than a high degree of skill and the ease with which he performed it recognized his competence.
- The outcome of RN [Ms B] and [Dr C's] actions demonstrated compassion for a dying man's needs.
- [Ms B's] errors of judgment lie in
    a) Using the skills of a visitor (albeit a well qualified retired Doctor) to treat [Mr A].
    b) Not seeking professional help from other nurses on duty or the After Hours service.
    c) Not recording accurately the actions which were taken to relieve [Mr A's] pain.
    d) Not working within her scope of practice

2. Please comment on RN [Ms B's] decision not to discuss [Mr A's] condition with a colleague.

- [Ms B] gives several reasons for this — one nurse was working as a care worker and correctly stated she did not want to be involved in professional decisions.
- The nurse working in [the other unit], she felt was busy and would not be able to come down immediately. She discovered some weeks later that there was also a nurse in [another] that might, she also stated that unless she rang around when she arrived on duty she would not know if there were other nurses available for support.
- Because her contact with [Dr C] occurred immediately on walking out of [Mr A's] room and his assistance led to a positive outcome for [Mr A], RN [Ms B] felt no need for further advice.

3. Comment on RN [Ms B's] decision to involve [Dr C] in [Mr A's] care

- RN [Ms B] was very concerned about [Mr A's] pain and distress and as stated in 1. She was considering several options of help available when [Dr C] appeared and offered help and advice willingly to her. While choosing this option was ethically and professionally incorrect I suspect her overriding concern for her resident clouded her professional judgment and a serious error was made.

4. Comment on [Ms D's] statement that was witnessed RN [Ms B] performing a manual evacuation.

- RN [Ms B] states that she did not perform a manual evacuation but did a rectal examination to determine if [Mr A] had faecal impaction. I believe that this is what the care worker [Ms D] observed.

5. Comment on the standard of RN [Ms B's] documentation for 26th August 2006.

- Of note is care worker [Ms D's] comment that she had not completed [Mr A's] documentation as she was late off duty so she asked RN [Ms B] to do so. It appears that care workers at [the rest home/hospital] often (?) routinely write lifestyle/progress notes. This was difficult to determine as the designation of writers was not always recorded and much of the writing in the lifestyle/progress notes was difficult to decipher.
- RN [Ms B] did write the notes for [Mr A] on the night of 26th August 2006 — they were clearly stated and easy to read. She commented on his pain and distress, the administration of Panadol (pain relief) — his personal care, the fluids he drank — his chestiness and that she contacted his family about his condition. She gave a comprehensive overview of the treatment of his faecal impaction but did not report that [Dr C], (a visitor to the ward) advised and assisted her with this.
- Her written report was of a good standard, however the omission of [Dr C's] involvement was a serious error because it appears that she had considered at this time, that her professional judgment would be challenged and she may have been concerned about the outcome for her if other professional staff knew.

Any other comment

I have concerns about the following:

1. RN [Ms B's] scope of practice — why RN [Ms B] is practising as an R.N. in a gerontological hospital which is outside her scope of practice as a registered psychiatric nurse.
- She states that she was appointed to work in the dementia unit but has not been given a position there.
- [Ms E], Manager, states on page 000017 that [an R.N. working in the Unit], had responsibility for supervising RN [Ms B] on the evening of 26th November 2006.

She also states that she would not actively go to the [other unit] and supervise unless requested to do so.

Is this sufficient support for a nurse working outside her scope of practice?

Also RN [Ms B] did not appear to know that she had this support. From her statement it appears she felt she was unsupported and was sometimes the only R.N. for 75 residents.

I am very aware of the shortage of suitable R.N.s in New Zealand at present but putting an inappropriately qualified nurse into a busy and challenging ward for older people without qualified supervision is hazardous.

2. Delay in advising relatives of [Mr A].

- This incident occurred on 26th August 2006 and [Mr A's] family were not notified until September.

When RN [Ms B] discovered from a Nursing Council Senior Advisor in July 2006 that she was working outside her scope of practice, she advised [Ms E]. Again nothing was done to change the practice area she was working in.

3. [Dr C's lawyer] requests that a solution can be found where [Dr C] can be comfortable visiting [the rest home/hospital] to see his seriously ill wife.

As a nurse I cannot make a professional comment on [Dr C's] actions in carrying out a clinical assessment and procedure for [Mr A] who was not his patient.

I can however acknowledge that his actions were compassionate and a good Samaritan act.

I suspect he, like RN [Ms B], placed the importance of dealing with the pain and suffering of a resident in his wife's rest home before considering the professional ethics of the situation.

No harm was done to [Mr A] — in fact he was made comfortable and able to sleep. It is unlikely that the level of skill required to deal with [Mr A's] condition was at risk from the work of a retired non certified but very experienced G.P.

He has categorically stated that he will never assist in such circumstances again. It is to be hoped that he can be treated courteously and with kindness when he visits his wife at [the] rest home should any actions arise from his professional/ethical misconduct.

4. No complaint from family

- [Ms E] states she has explained the circumstances to one of [Mr A's] daughter's but does not comment on her response. I note the daughter has not validated the complaint or asked for more information. [Ms E] did apologise for her staff's actions.

When I asked for more information about the family's position I was advised by a Health & Disability Investigator that the family have not formally complained about the incident and have not indicated a desire to do so.

5. Manual Evacuation of Bowels

- While [the rest home] does not support R.N.s to carry out this procedure, it is very commonly carried out in long term hospitals and in the community by Registered Nurses and even educated care workers.
- It is an important procedure for people with limited muscle control e.g. those with paraplegia or with neuro-muscular disorders. Some frail elderly even with a good diet and laxative management may also have difficulty in evacuation of their bowels.

Summary

I believe RN [Ms B's] actions did not meet professional standards and would be viewed by her peers with moderate disapproval.

The issue is however primarily a professional/ethical one and although RN [Ms B's] actions were unprofessional, the outcome for the resident was to free him of pain and discomfort in his last days of life.

I also note that she is still currently practising outside her scope of practice despite bringing this to the attention of her employer. [Ms E] has arranged supervision and ensured RN [Ms B] has updated her knowledge of the Policies and Procedures at [the rest home/hospital].

RN [Ms B] is making concerted attempts to increase her scope of practice and could be supported to achieve this goal.

I believe the investigation into the actions of these two professional people will certainly have challenged and extended their understanding of professional/ethical issues.

Lesley Spence"

Response to provisional opinion

RN Ms B
Ms B stated:

> "Although the actions of [Dr C] were in the best interests of [Mr A], they were not necessarily approved of by me. I knew that what [Dr C] was doing and my allowing this to occur was wrong. However, I could not bring myself to ask [Dr C] to stop what he was doing and seek input from my colleagues. I am not too sure whether I was pleased that [Mr A] was receiving some relief, or whether I was intimidated by the status of the Doctor. In the Psychiatric arena, doctors are more like colleagues, and the relationship is more informal, but I found in the medical system doctors were treated differently by the nurses.
>
> …
>
> I concur with the statement made by Lesley Spence with regard to the level of supervision I receive. Although I am working outside my practice currently I do not have the level of supervision and support that is required for me to perform the tasks in the environment that I most need.
>
> …
>
> Finally, I would like to add that I am exceptionally regretful of this one and only error, and given the same circumstances I would be more vigilant and assertive."

The rest home
Manager Ms E stated:

> "[W]hile any enquiry in relation to a nurse's practice and a home's competency is not welcome, I have and will continue to take advantage of what I have learned during this process."

Code of Health and Disability Services Consumers' Rights

The following rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

Right 4

Right to Services of an Appropriate Standard

...

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

...

(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Other relevant standards

Nursing Council of New Zealand Code of Conduct for Nurses (August 2005):

PRINCIPLE ONE

The nurse complies with legislated requirements

Criteria

…

The nurse:

1.3 practices within her/his scope of practice and any conditions entered on the register.

PRINCIPLE THREE

The nurse respects the rights of patients/clients

Criteria

The nurse:

…

3.4 safeguards confidentiality and privacy of information obtained within the professional relationship.

Nursing Council of New Zealand Competencies for the registered nurse scope of practice (June 2005):

…

Competency 2.3

Ensures documentation is accurate and maintains confidentiality of information.

Opinion

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

Opinion: No Breach — Dr C

A complaint had been made relating to care provided by Dr C to Mr A, in the circumstances where Dr C was no longer a registered medical practitioner, and there was no relationship (professional or personal) between Dr C and Mr A. Accordingly, it was appropriate to formally investigate the care provided by Dr C and the circumstances under which it was provided.

However, having reviewed the available information and been advised by my independent expert, Dr Ian St George, that Dr C acted "professionally and entirely properly", I am satisfied that Dr C did not breach the Code.

As Dr St George has identified, the issue here is the doctor's duty to attend in an emergency. In this case, Dr C was retired and no longer held a current practising certificate. However, it is clear he still had a duty to respond to a situation presented as a potential medical emergency. Furthermore, I am advised, and accept, that his clinical care was exemplary. While it was not ideal for a retired doctor to be called on to administer medical

treatment during a visit to a rest home on personal business, these circumstances were outside Dr C's control. He simply responded as a 'good Samaritan', and is to be commended for this.

Opinion: Breach — Registered nurse Ms B

According to Rights 4(2) and 4(5) of the Code of Health and Disability Services Consumers' Rights, Mr A had the right to have services provided that complied with professional standards, and to have co-operation among providers to ensure quality of care.

For the reasons set out below, RN Ms B breached Rights 4(2) and 4(5) of the Code. While RN Ms B clearly had good intentions and was concerned for her patient, the errors she made were serious. She failed to consult appropriate persons regarding the care of Mr A and also breached professional standards of patient privacy by discussing aspects of Mr A's care with Dr C. Of additional concern is the fact that she did not accurately record the incident in Mr A's medical chart, or promptly inform the family.

Management of care

RN Ms B correctly diagnosed that Mr A was suffering from faecal impaction, necessitating timely action. However, she was required to manage Mr A's treatment and care in accordance with correct procedures. In my view, RN Ms B should have discussed Mr A's condition with one of the three other registered nurses on duty. RN Ms B said that she did not, because one of the RNs was working as a caregiver, and she did not have time to consult with the other two because her "contact with [Dr C] occurred immediately on walking out of [Mr A's] room".

RN Ms B also stated that she had been told by Ms E, the manager, that she was not allowed to contact the out-of-hours doctor "as it was costly". She said that there was a memo to this effect which subsequently disappeared. However, RN Ms F (who was on duty on 26 August 2006, but no longer works at the rest home/hospital) stated that she was not aware of such a memo.

Ms E denied giving such instructions, and she supplied minutes of the staff meeting where after-hours medical cover was discussed. RN Ms B was not at the meeting but was expected to have read the minutes on the staff noticeboard. In isolation, the minutes still leave some ambiguity about the use of after-hours doctors, and Ms E has confirmed that there was no formal policy. Accordingly, I accept that Ms B may not have been clear on the availability of this option. However, I do not accept her reasons for not discussing Mr A's condition with her registered nurse colleagues. I note in support of my view that Ms D, the caregiver working with RN Ms B, stated that she and RN Ms B discussed the option of contacting the other registered nurses for advice. Furthermore, RN Ms B confirmed in her

response to the provisional opinion that she always contacted the other parts of the facility at the start of a shift to find out which other RNs were on duty. I also note Dr C's recall that it was RN Ms B who came to him for advice while he was in his wife's room. Although RN Ms B would have had to seek assistance from registered nurses in other parts of the rest home/hospital, I believe that there was enough time for her to make a telephone call to obtain that advice.

Documentation
When she recorded the care provided on 26 August, RN Ms B failed to note that Dr C was involved. This is inadequate. Notwithstanding the fact that she should not have involved Dr C at all unless there was no other option, having done so, a complete record should have been made of the event. I concur with the view of Ms Lesley Spence, my independent nursing expert, that this was a "serious error". It suggests that RN Ms B knew that involving Dr C may be regarded as inappropriate.

Privacy of information
RN Ms B involved Dr C in Mr A's care, and, albeit with the best of intentions, breached Mr A's privacy by providing Dr C with personal information about Mr A to which Dr C, a retired GP visiting another patient, was not entitled.

Summary
I have no doubt that by involving Dr C, RN Ms B had her patient's comfort at heart, but I endorse Ms Spence's comment:

> "While choosing this option was ethically and professionally incorrect I suspect her overriding concern for her resident clouded her professional judgment and a serious error was made."

However good the intentions, a registered nurse must provide care in line with professional standards.

By failing to discuss Mr A's predicament with the other registered nurses on duty, RN Ms B failed to co-operate with her colleagues to ensure quality and continuity of services to her patient, and therefore breached Right 4(5) of the Code. By failing to document Dr C's involvement in Mr A's care and safeguard the privacy of Mr A's information, RN Ms B also failed to comply with professional standards, and breached Right 4(2) of the Code.

Opinion: Breach — The rest home

Vicarious liability
In addition to any direct liability for a breach of the Code, an employing authority may be vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for any breach of the Code by an employee. Section 72(5) affords a defence for an employing authority if it took such steps as reasonably practicable to prevent the act or omission in question.

RN Ms B is a registered psychiatric nurse. She said that, prior to the events of 26 August 2006, she had raised her concerns with her managers that she was working outside her scope of practice. The rest home disagreed, saying that RN Ms B had never raised this concern. However, my expert, Ms Spence, confirmed that RN Ms B was indeed working outside her scope of practice as a registered psychiatric nurse. Ms Spence added:

> "I am very aware of the shortage of suitable [registered nurses] in New Zealand at present but putting an inappropriately qualified nurse into a busy and challenging ward for older people without qualified supervision is hazardous."

Ms E stated that RN Ms B was supervised by a registered nurse working in another unit on the evening of 26 August. However, it was up to RN Ms B to consult her as necessary. Ms E also confirmed that RN Ms B had often been in charge of the whole facility because of a shortage of registered nurses.

While I accept that the shortage of registered nurses creates staffing difficulties, it is clear that RN Ms B was working outside her scope of practice, and she was inadequately supervised. Accordingly, the rest home is vicariously liable for RN Ms B's breach of the Code. I intend to send a copy of my final report to the District Health Board, and the Ministry of Health, to bring to their attention my concern about RN Ms B's supervision.

Other comment
RN Ms B and Ms E have given conflicting accounts about whether registered nurses had been told not to contact doctors after hours. What is apparent is that although there were guidelines, in the absence of a formal policy, there was a lack of clarity about this option.

In relation to the need to contact external medical staff, Dr St George advised:

> "Any rest home should have policies that include after hours access to general practice care, and that care should include the ability to perform the simple procedure of manual disimpaction when that is necessary: it is misuse of the ambulance and emergency department to use them for this purpose."

In the rest home's response to the provisional opinion, Ms E enclosed a copy of a policy for contacting medical staff out of hours. Dated March 2007, it clearly outlines the procedure to

be followed, including notifying the family without delay. In my view, the introduction of such a policy was overdue as the lack of clarity in this area may have contributed to RN Ms B's errors, and there was an unacceptable delay in informing the family.

Recommendations

RN Ms B
I note that RN Ms B has reacquainted herself with nursing care practices at the rest home, has accepted mentoring and supervision, and is currently undertaking study to change the scope of her registration.

The rest home
The rest home should review the supervision of RN Ms B and report by **30 May 2007** on what changes have been made to ensure she is supported in her role while she works towards changing her scope of practice.

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand and the Medical Council of New Zealand.

- A copy of this report with details identifying the parties removed, except the name of the rest home, will be sent to the rest home owner, the District Health Board, and the Ministry of Health.

- A copy of this report, with details identifying the parties removed, will be sent to HealthCare Providers New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix 1

Medical Council of New Zealand
A doctor's duty to help in a medical emergency

If asked to attend a medical emergency as defined in this statement, a doctor must respond. This is both an ethical and legal obligation. Rarely there will be times when attending a medical emergency is impossible or unsafe for the doctor or patient. If a doctor chooses not to attend he or she may be required to defend that decision in the event of a charge of professional misconduct or criminal prosecution.

Definition of a 'medical emergency'

1. The Medical Council has adopted the definition of a medical emergency by S Miles[i] as:

> *"a sudden, unforeseen injury, illness or complication, demanding immediate or early professional care to save life or prevent gross disability, pain or distress. The immediate responsibility of the doctor faced with, or called to an emergency is to apply his knowledge and skill to the saving of life and relief of suffering and to establish the most favourable conditions for his patient's ultimate recovery. This is the basic philosophy of medicine...."*.

2. Further to this definition, case law indicates that an emergency exists if the caller says it does until the doctor has had an opportunity to assess the situation and determine whether a 'medical emergency' exists.[ii] The assessment may take place over the phone but the doctor must be confident that the information provided by the caller (who may not be the patient) provides sufficient detail for an accurate assessment.

3. The definition does not include a "state of emergency", although during a state of emergency a doctor may be confronted by individual medical emergencies.

Every doctor must attend

4. A doctor is at risk of being professionally or criminally responsible if he or she fails to render prompt and appropriate medical care to any person (whether the patient is a current patient or not), in a medical emergency. A doctor who chooses not to attend must have good reason and be able to defend this position at a later time.[iii]

5. Council acknowledges there are situations where a doctor can, may or should not attend a medical emergency. For example:

- if he or she is already attending another emergency;
- if it is more appropriate for an emergency service to attend (i.e. ambulance or rescue helicopter);
- the geographical location of the doctor is such that another doctor or medical service can attend more promptly;

if he or she is off duty at the time of the call and has been drinking alcohol or taken medication or other substances to a level that may adversely influence the doctor's level of competence;
if attending the emergency places the personal safety of the doctor at risk;

any other situation (including excessive fatigue) where a doctor believes that his or her level of competence or health may compromise his or her ability to provide the appropriate level of care necessary to deal with the medical emergency situation.

6. In all these situations a doctor still has a duty of care to the patient. If unable to attend a medical emergency the doctor has a duty to make reasonable effort to assist the caller to locate alternative care to ensure that the patient receives appropriate care from another health professional (another practitioner, hospital or ambulance). Failure to attend a medical emergency because it is inconvenient is unacceptable and may result in disciplinary and possibly criminal prosecution. For this reason Council recommends that a doctor keeps a written record of his or her reasons for not attending, in case this decision is queried at a later date.

Competence

7. Council acknowledges that there are different levels and areas of competence and a doctor may not have the necessary skills to assist with anything more than basic first aid in a medical emergency. It is the doctor who is best able to determine whether his or her competence is sufficient to provide medical care in an emergency. Council endorses Miles, who states:

"The ethical responsibility of the medical practitioner in an emergency is clear. He offers a service within his proper professional competence. He will supplement, within his ability, the expertise of other professionals involved. If he has no appropriate skills he will present himself as a citizen with some knowledge of emergency first aid. Nothing less would be acceptable." (Miles 1981)[iv].

8. If a doctor does not have the necessary skills the doctor should present him or herself as an individual with some level of medical knowledge and assist where possible.

The legal position

9. The Code Health and Disability Services Consumers' Rights (HDC Code) states under Right 4(2) that every consumer has the right to have services provided in a manner that comply with legal, professional, ethical and other relevant standards.

10. Under sections 151 and 160 of the Crimes Act 1961, everyone who has charge of any other person by reason of sickness (which may include a doctor asked to look after a person in a medical emergency), has a legal duty to provide the necessaries of life to that person[v]. If that person's life is endangered, or health is permanently impaired as a result of a doctor's failure

to fulfil this duty, and there is no lawful excuse, a doctor may be criminally liable and subject to imprisonment for a term not exceeding seven years.

11. Failure to fulfil this duty must involve a major departure from the standard of care expected of a reasonable person. Instant decisions may have to be taken in an emergency, and that is a factor when deciding whether there has been a failure to meet the appropriate professional standard.[vi]

Informed consent and emergencies

12. Right 7(4) of HDC Code states that if the patient is not competent to make an informed choice and give informed consent, and no person entitled to give consent on behalf of the patient is available, a doctor may provide services without obtaining the informed consent of the patient when:

(a) it is in the best interests of the patient; and

(b) reasonable steps have been taken to ascertain the views of the patient; and either

(c) the provider believes, on reasonable grounds, that the provision of the service is consistent with the informed choice that the patient would have made if he or she were competent; or

(d) if the patient's views have not been ascertained, the provider takes into account the views of other suitable people who are interested in the welfare of the patient and available to advise the provider.

13. Clause 3 of the HDC Code states that a provider is not in breach of the Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties of the Code. It also states 'the circumstances' means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.

14. Therefore a doctor may not need to obtain consent before providing emergency services. This would be one example of a situation where Clause 3 of the HDC Code would apply. However, only necessary treatments should be provided. Where time is of the essence and delay to obtain consent would be considered unreasonable or further threaten the patient's well-being, a doctor may take action without actively seeking the patient's consent. As with any other health service, a competent patient has the right to decline treatment, even in an emergency.

The ethical position

15. The New Zealand Medical Association's Code of Ethics takes the position that a doctor cannot refuse to care for a patient in an emergency.

16. Section 8(3) of the Health Practitioners Competence Assurance Act 2003 allows a qualified doctor, who is not registered, to render medical or surgical aid to any person in an emergency.

Teamwork

17. There is a professional duty to work with other people in the health service, and recognise the professional competencies or particular skills of other practitioners. At times it may be more appropriate for a non-medical

practitioner, including ambulance staff, to provide the patient's care in an emergency situation, with assistance from a doctor.

Approved by Council August 2006
This statement is scheduled for review by August 2011. Legislative changes may make the statement obsolete before this review date.

Notes and References:

[i] Miles S. *In* Duncan AS, Dunstan GR, Welboum RB (eds). *Dictionary of medical ethics.* Second edition. Darton, Longman & Todd, London. 1981. 155-156. **Mid City Tower, 139-143 Willis Street, P O Box 11-649, Wellington, New Zealand**

[ii] CAC v Dr J P de la Porte. Decision of the Medical Practitioners Disciplinary Tribunal dated 10 June 1999

[iii] A recent opinion from the Health and Disability Commissioner found the medical practitioner did not breach the Code when he was unavailable to attend an emergency. When the person called the medical practitioner the phone was answered by an answerphone explaining the medical practitioner was off duty and that in an emergency the caller should dial 111 or attend the closest hospital. The HDC accepted that the medical practitioner had worked long hours that day and been on–call for the 3 prior nights. The medical practitioner was exhausted and therefore it would have been unsafe to expect the medical practitioner to practise in this state. An anonymised version of the Commissioner's letter outlining the case is available from Council's office on request.

[iv] Miles S. *In* Duncan AS, Dunstan GR, Welboum RB (eds). *Dictionary of medical ethics*. Second edition. Darton, Longman & Todd, London. 1981. 155-156.

[v] According to Adams (Robertson et al, *Adams on Criminal Law*, Wellington, Brookers 1992) the necessaries of life include food, clothing, shelter and medical attention. Legal commentary believes this section could be invoked if a medical practitioner neglected (to a high degree) to supply essential medication or systems necessary to support a patient's life.
Auckland Area Health Board v A-G [1993] 1 NZLR 235. The answer as to whether a ventilator was to be construed as a necessary of life depended upon the facts. Where a patient was surviving only by virtue of mechanical means and was beyond recovery, the provision of a ventilator could not properly be construed as a necessary of life. There was "lawful excuse" to discontinue ventilation when there was no medical justification for continuing that form of medical assistance. It was not unlawful to discontinue if the discontinuance accorded with good medical practice.

[vi] A v M B Bottrill [2002] UKPC 44. Exemplary damages may be granted in the case where the level of negligence is so high that it amounts to an outrageous and flagrant disregard for the patient's safety, meriting condemnation and punishment.