Pegasus Health (Charitable) Limited

A Report by the
Health and Disability Commissioner

(Case 19HDC00866)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This case highlights the importance of considering differential diagnoses, and the impact that cognitive biases and a lack of critical thinking can have on diagnostic decision-making.

2. A woman presented to Pegasus Health with symptoms of a heart attack, and a clinical background that put her in a high-risk category for ischaemic heart disease. However, the focus throughout the five-hour period before her eventual diagnosis was on the possibility that the woman was suffering a reaction to an antibiotic.

Findings

3. The Commissioner considered that both medical and nursing members of staff at Pegasus Health failed to provide services with reasonable care and skill. In particular, the woman was triaged incorrectly, and medical practitioners did not elicit her symptoms appropriately or reconsider the working diagnosis. Furthermore, conversations between nursing and medical staff were not documented, the symptoms were not documented in Pegasus Health's electronic records, and nursing staff did not escalate care to medical practitioners. As such, the Commissioner found Pegasus Health in breach of Right 4(1) of the Code.

Recommendations

4. The Commissioner recommended that Pegasus Health provide a written apology to the woman; provide evidence of all triage nursing staff attendance at the College of Emergency Nurses New Zealand (CENNZ) national triage course; use the anonymised version of this report as a case study for training; and review and update its "Consult Documentation" policy.

5. The Commissioner recommended that the Royal New Zealand College of Urgent Care review the use of the Australasian Triaging Scale in urgent care clinics.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Mr and Mrs B (received 13 May 2019) about the services provided by Pegasus Health (Charitable) Limited. The following issue was identified for investigation:

- *Whether Pegasus Health (Charitable) Limited provided Mrs B with an appropriate standard of care in September 2017.*

7. This report is the opinion of the Commissioner.

8. The parties directly involved in the investigation were:

Mrs B	Consumer/complainant
Mr B	Complainant
Clinic	Provider

9. Further information was received from:

Registered Nurse (RN) A	Registered nurse
Dr C	Urgent care doctor
Dr D	Urgent care doctor
RN E	Registered nurse
RN F	Registered nurse
RN G	Registered nurse
Clinic receptionist	
Dr I	General practitioner (GP)
ACC	
Telehealth service	

10. Internal reviewer Dr H is also mentioned in the report.

11. Independent expert advice was obtained from Dr Stephen Adams, an urgent care specialist (Appendix A) and Ms Fay Tomlin, a nurse practitioner (Appendix B).

12. Attached is the Royal New Zealand College of Urgent Care "Urgent Care Standards" (Appendix C), and extracts from the New Zealand Nursing Council "Code of Conduct" (Appendix D), and the Nursing Council of New Zealand "Competencies for registered nurses" (Appendix E).

Information gathered during investigation

Introduction

13. This complaint concerns the care provided by Pegasus Health (Charitable) Limited (Pegasus Health) to Mrs B, aged in her fifties at the time of events, on 2 September 2017. The report discusses Pegasus Health's management of Mrs B's chest pain symptoms.

Prior visit with Mrs B's GP

14. On 28 August 2017, Mrs B visited her GP, Dr I, for diarrhoea and vomiting. Dr I noted that Mrs B had become unwell overseas around two weeks previously, and had abdominal pain and was unable to eat. Dr I ordered a faeces test, which showed a parasitic infection, and prescribed an antibiotic (metronidazole) on 1 September 2017.

Events on 2 September 2017

Pre-arrival at Pegasus Health

15. On Saturday 2 September 2017, Mr B called Dr I because Mrs B was in pain and had vomited after taking the antibiotic. Mr B did not outline the location of the pain (chest) and Dr I did not ask. Dr I referred Mrs B to Pegasus Health, and called Pegasus Health to inform staff that Mrs B would be arriving.

16. Mr and Mrs B told HDC that on the way to Pegasus Health, Mr B telephoned ahead and said that he thought Mrs B was having a heart attack. Pegasus Health said that when Dr I called, she said that Mrs B had been experiencing ongoing nausea and vomiting after starting the antibiotic. There is a note in Pegasus Health's patient contact notes that Dr I called and spoke to one of the receptionists. It was noted: "[Dr I] patients GP called. She has seen [Mrs B] three times this week."

Arrival/triage at Pegasus Health

17. At about 1.40pm, Mrs B arrived at Pegasus Health. Mr and Mrs B told HDC that they recall being met with a wheelchair at the front door. However, RN A told HDC that Mr and Mrs B approached the reception on foot and appeared to be distressed. HDC was unable to obtain CCTV footage from Pegasus Health owing to the time elapsed (footage remains available for a maximum of six weeks). In response to the provisional opinion, Mr and Mrs B told HDC that they requested CCTV footage and phone records in their first meeting with Pegasus on 17 July 2018.

18. Mrs B was triaged by RN A. RN A was informed that Mrs B was having a reaction to the antibiotic. Mr and Mrs B said that Mrs B reported "horrific chest pains", and they told the nurse that they thought she was having a heart attack and requested an ECG. However, RN A said that at the time of triage, Mrs B's main concern was nausea.

19. RN A allocated Mrs B a triage code of four. RN A documented on the triage form that Mrs B was feeling pain in her arms, chest, and back following "? ingestion of metronidazole". RN A recorded most of Mrs B's vital signs,[1] but not her respiratory rate or pain score. RN A noted Mrs B's vital signs in the electronic clinical notes, but did not include Mrs B's symptoms of pain in the arms, chest, or back. RN A documented that the plan was for Mrs B to be reviewed further by a doctor.

<u>Information from Mr and Mrs B</u>

20. Mr and Mrs B state in their complaint that Mrs B was groaning and grimacing, was in excruciating pain, and was unable to open her eyes or lift her head, and it took all her strength to sit up straight. Mrs B stated that she said, "I think I am having a heart attack — help me," and Mr B also informed the nurse that he thought she was having a heart attack, and they were told to take a seat. After approximately ten minutes, Mr B asked when Mrs B would be seen, and was advised that she would be given a room as Mrs B's dry retching was very loud.

[1] Temperature 36.2°C, pulse 66 beats per minute (bpm), oxygen saturation 100%.

Information from RN A

21. RN A told HDC that Mrs B reported that she had pain in her arms, chest, and back, which appeared to be "diffuse[2]". RN A said that chest pain was not the main concern at the time of triage, which is why she allocated Mrs B a triage category of four rather than a three or two. RN A stated:

> "There was no mention by [Mr or Mrs B] that [Mrs B] was having a heart attack at the triage desk, and neither of them requested an ECG at any stage during my interaction with them."

22. RN A said that after she had triaged Mrs B, Mr B approached her saying that Mrs B was feeling worse, with increased nausea and vomiting. RN A stated that she reassessed the situation and asked the team to take Mrs B to a room in the treatment bay and reassess her further. However, this was not documented in the clinical notes. RN A said that she provided the nurse in the treatment bay with a verbal handover.

Information from Pegasus Health about triage

23. Pegasus Health told HDC that it believes that RN A's triage of Mrs B was appropriate given her presentation and the telephone call from her GP. Pegasus Health also said that Mrs B was seen within the triage three timeframe (30 minutes), regardless of being given a triage score of four (timeframe of 60 minutes).[3] Pegasus Health also advised that in this case, "technically with a history of 'chest pain' a patient should be given a [triage score of two/three] using the [Australian Triage Scale (ATS)][4]", but the nurse made a judgement that the chest pain was minor and related to other symptoms of nausea and vomiting, so gave a triage score of four.

Triaging tool

24. Pegasus Health uses the Australasian Triaging Scale (ATS) to triage incoming patients. It said that Pegasus Health is audited against the Urgent Care Standard, which states that they must use an approved system. Pegasus Health said that no concerns were raised by auditors relating to the use of the ATS, and the ATS is the most widely used triage tool.

25. Pegasus Health stated that the ATS is designed and validated for emergency departments. It said that despite much research, it has been unable to identify a triage system designed primarily for urgent care that is well validated. Pegasus Health said that one of the cons of the ATS is that it can give a patient a higher triage code than is appropriate in primary care.

First medical review by Dr D

26. Dr D was the first urgent care doctor to assess Mrs B at this presentation. Dr D told HDC that he became aware that Mrs B was likely to present to Pegasus Health via a verbal handover from the Nursing Team Leader. Dr D said that the verbal handover he received was that Mrs B had been overseas and had returned with gastrointestinal symptoms, and was

[2] Widespread.
[3] Mrs B was triaged on arrival at 1.41pm. A laboratory form from the first medical review was generated at 2.20pm.
[4] A clinical tool used to establish the maximum waiting time for medical assessment and treatment of a patient.

experiencing side effects from metronidazole. He stated: "This verbal handover is not recorded in my notes and I am unsure precisely when it occurred."

27. Pegasus Health said that Dr D reviewed Mrs B at approximately 2.20pm. The time of Dr D's clinical note was not documented. Dr D noted:

> "[S]ignificant nausea/vomiting post first [metronidazole] dose but continued with 2nd dose this morning, now getting tingling and pins and needles in hands and feet,[5] severe back and other muscle group aches and pains, feeling dreadful and miserable."

28. Dr D recorded that Mrs B's past medical history included type 1 diabetes, high cholesterol, and an eye condition resulting from diabetes (diabetic retinopathy), and that Mrs B had no known allergies but "likely ? Metronidazole". That is, Dr D was considering whether Mrs B was having an adverse reaction to the antibiotic.

29. Dr D documented in the clinical notes that his observations were "unremarkable", and that Mrs B had no fever, her chest was clear, and her abdomen was difficult to assess owing to her distress. Dr D recorded his plan to carry out a blood test, start intravenous (IV) fluids, and prescribe medication for nausea and vomiting (ondansetron) and pain (morphine).

Information from Mr and Mrs B

30. In their complaint, Mr and Mrs B said that when Dr D arrived in the room, Mrs B said that she thought she was having a heart attack, and requested an ECG. Additionally, Mr and Mrs B state that Dr D came to the room another time and said there was nothing wrong with Mrs B's blood tests and that she should go home and sleep it off. Mr B told Dr D that Mrs B was "in no fit state to go home", and Dr D said that she could stay until the results of the second blood tests returned.

Information from Dr D

31. Dr D told HDC that he reviewed the available notes prior to assessing Mrs B, which did not include any reference to a request for an ECG. Dr D said that on assessment, Mrs B was definitely feeling discomfort, with abdominal pain and nausea being the main features. He stated that he "was aware that chest pain had been noted on the triage form", but that this was in the context of pain being in many places, which included Mrs B's chest and back. He said that he would have noted what Mrs B reported to him as the main concern.

32. In a later response, Dr D told HDC that to his recollection, at no time during his review did Mrs B complain of chest pain, nor was there evidence of it in the electronic triage notes. He stated:

> "In the clinical context of the available information from the electronic triage notes, the referral letter from the GP and my assessment of the patient, the mention of chest pain on the written triage notes may have been overlooked by myself as I had already read the electronic triage assessment."

[5] Mrs B said that she did not tell Dr D that she had "tingling" or "pins and needles" in her hands or feet.

33. Dr D said that the earlier statement he made (see paragraph 32) detailing his awareness of chest pain related to his knowledge at the time of providing the statement to HDC, rather than at the time of the events. He stated that had he been aware of chest pain at the time of events, there is a strong likelihood that he would have undertaken a more focused history and investigation to rule out a cardiac issue. RN A's handwritten triage description on the paper chart stated that Mrs B had reported pain in her arms, chest, and back. Of note, Dr D signed for Mrs B's medication on the paper chart that stated that she was complaining of chest pain. However, as outlined above, Dr D told HDC that he was unaware of this.

Nursing care by RN F

34. Around 2.35pm, RN F[6] and another nurse gave Mrs B IV fluids and her medications for pain and nausea, and took bloods.[7]

35. At 2.45pm, RN F documented in the clinical notes that Mrs B had symptoms of "back/chest pain" but was more comfortable after receiving morphine. RN F noted that she planned to discuss with a doctor that Mrs B's pain score was 8/10. However, there is no documentation of whether this discussion occurred.

36. Dr D said that at around 2.45–3pm, he was told by RN F that Mrs B's nausea and pain had improved somewhat following the morphine. He said that there was no mention of chest pain or a request for an ECG, and stated: "[Mrs B] was however still experiencing pain and a request for further analgesia [pain relief] was made at this time."

37. At 3pm, RN F documented that Mrs B was "still experiencing chest/arm/back pain", her pain score was 8/10, and she was "grimacing in pain and restless on the bed". RN F administered a further dose of morphine, and noted that Mrs B said that the morphine had not helped her pain at all. RN F documented that she intended to discuss a plan with Dr D. However, there is no documentation of whether this discussion occurred. RN F advised HDC that she does not remember what was discussed during her conversation with Dr D.

38. Dr D said that he does not recall any reports about Mrs B being made to him between 3pm and 4pm, other than that Mrs B was still requiring IV pain relief.

39. At 3.26pm, RN F documented that Mrs B still had a pain score of 8/10, was feeling nauseous, and was still restless on her bed, grimacing and panting through pain and nausea. RN F administered a further dose of morphine. She noted that the plan was to continue to monitor Mrs B's pain and blood sugar levels.

[6] In response to the provisional opinion, RN F told HDC that at the time of events, she had only recently graduated as a nurse.

[7] RN F documented that she sent Mrs B's blood tests at this time. However, the blood tests were not picked up by a taxi as expected. This was identified at 4.50pm and a taxi was ordered. Pegasus Health's "Laboratory Services Policy" states that staff should telephone for pick-up after collecting bloods, and specify that the specimens are urgent. The time at which the pick-up is requested, and the time at which the specimen is taken should be documented in the patient notes. The policy states that the nurse assigned to the doctor requesting urgent tests is responsible for ensuring that they are followed up or handed over to the next shift.

Information from Pegasus Health

40. In relation to the absence of documentation regarding whether RN F discussed Mrs B with a doctor, Pegasus Health said that the Urgent Care Documentation Standards (Appendix C) do not require this, and Pegasus Health considers that RN F complied with these standards. Pegasus Health told HDC:

> "[W]hile maintaining a record of discussions between staff can be useful when reviewing a case retrospectively, it is difficult to determine how much additional detail to put into a clinical record at the time."

Handover to Dr C and care by RN F

41. Dr D said that at 4pm, he gave a detailed verbal handover to Dr C, an urgent care doctor who had just started his shift. Dr D recalls telling Dr C that Mrs B's provisional diagnosis was irritation of the digestive tract (gastroenteritis)/dehydration and antibiotic (metronidazole) reaction, and that she had been in distress with her symptoms. Dr C told HDC that he became responsible for Mrs B's care at 4pm and received a verbal handover from Dr D informing him that Mrs B had a two-week history of diarrhoea and had developed nausea and vomiting after taking antibiotics. Dr C said that he was told that they were waiting for Mrs B's blood test results, and that her provisional diagnosis was an adverse drug reaction to the antibiotic, and diarrhoea caused by a bacterial infection of the digestive system. He said that his plan was to review Mrs B with her blood results when they were available. He told HDC:

> "At this time no concerns that [Mrs B] had focal chest pain, that she thought she was having a heart attack, or that she or her husband had requested an ECG were raised with me by [Dr D] or the nursing staff."

42. At 4pm, RN F documented that Mrs B had a score of 8/10 for pain and 10/10 for nausea. RN F noted that she discussed a plan with Dr C, but the content of the conversation was not documented.

43. Dr C told HDC that around 4.25pm, RN F informed him that Mrs B had ongoing pain and nausea, but he was not informed that Mrs B had complained of focal chest pain.[8] He said that he told RN F that Mrs B could have a final dose of morphine and anti-nausea medication,[9] and he would review her as soon as possible.

44. At 4.25pm, RN F documented that Mrs B was still nauseous and in pain, and could not get comfortable. RN F noted that further morphine was administered, and that five minutes after this, Mrs B was still uncomfortable and in pain. RN F documented that the plan was for Mrs B to be reassessed by Dr C. It is not clear whether a request for reassessment was discussed with Dr C, as this was not documented.

[8] Chest pain centred on a specific body system/part.
[9] Cyclizine.

45. RN F told HDC:

> "For the avoidance of doubt, I confirm that [Mrs B] did not at any stage complain to me about focal chest pain, or ask for an ECG. Her complaints to me were of generalised pain … she did not complain of particular pain in her chest. If she had done so, I would have performed an ECG without delay."

Medical review by Dr C

46. At 4.50pm, Dr C reviewed Mrs B and documented that she felt "about the same". Dr C realised that the blood sample had not been sent, so he asked for a taxi to pick it up. Dr C also documented: "If requiring further analgesia will discuss with medics[10]."

47. Dr C told HDC that he considered that Mrs B's physical presentation matched the handover from Dr D, and that her symptoms were nausea and generalised body pains. He stated that neither Mrs nor Mr B raised any concern that Mrs B was experiencing focal chest pain, or that they were concerned about a heart attack or requested an ECG. Dr C said that his plan was to monitor Mrs B until her blood test results were available and would refer her to hospital if her pain did not settle. Dr C said that he informed Mrs B of this. It is documented: "[I]f requiring further analgesia will refer to medics." In response to the provisional opinion, Dr C stated that this meant that he would refer Mrs B to the public hospital, and that at no point in Mrs B's admission did he tell her to go home.

48. Dr C said that he did not review Mrs B's clinical notes at 4.50pm because he had received a verbal handover and had reviewed Mrs B's paper chart, which included vital signs and prescribed medications. He had also reviewed Mrs B himself in person. He said that in his experience, any nurse who had concerns about a patient having chest pain would inform him immediately.

49. The front page of the paper chart to which Dr C refers contains the medications he and Dr D prescribed to Mrs B. The top half of the page contains RN A's handwritten triage description, including that Mrs B had reported pain in her arms, chest, and back.

50. In response to the provisional opinion, Dr C told HDC that his first assessment of Mrs B did not cause him to conclude that further cardiac investigations were required at that time.

Nursing care by RN E

51. RN E told HDC that RN F was working until 5pm, and at the end of her shift she handed over her care to the nursing team. The handover provided to all the nurses was to continue monitoring and waiting for blood test results for Mrs B, who had ongoing nausea and chest/back/arm pain. In response to the provisional opinion, RN E explained that he did not think he was Mrs B's primary nurse, and therefore the handover instruction to monitor and wait for the blood test results was to the nursing team as a whole, and not to him individually. RN E stated: "There was no communication of [Mrs B] having a heart attack or that [she] was requesting an ECG by [the] nursing team or medical team."

[10] Other medical practitioners.

52. At 5.37pm, RN E documented that Mrs B was still lying down in bed, and was feeling pain in her arms, chest, and back. RN E documented Mrs B's observations[11] and noted that her pain score still remained 8/10.

53. RN E told HDC that during his assessment, there was no communication of concern from Mrs B about having a heart attack, or a request for an ECG. He said that he noted that Mrs B had had all of the morphine prescribed, so advised Mr and Mrs B that they were awaiting blood test results, and the doctor would then review her in relation to her ongoing symptoms and for further pain relief.

54. RN E said he assumed that the blood test results would not be far away, and that the doctor's review was imminent. He said he also took into account that Mrs B's pain had not increased.

55. RN E said that he did not consider it necessary to talk to the doctor about the fact that all of the prescribed morphine had been administered because usually this is done by the nurse who administered the last dose, and therefore, he thought that the doctor was already aware. In response to the provisional opinion, RN E said that he has learnt that a crucial part of his patient care is to consider how the patient's pain is presenting to him, rather than through the eyes of the previous carers or the care plan. RN E now acknowledges that he should have escalated Mrs B's pain to the doctor rather than relying on others in the nursing team to do so.

56. In response to the provisional opinion, Dr C stated that he received no reports of Mrs B's ongoing pain, and that he was the medical shift leader that day and, as such, he relied on his colleagues to pass on concerns of ongoing pain.

Discovery of heart attack

57. Mr B approached RN G for more nausea medication, so RN G discussed this with Dr C. At 6.35pm, Dr C reviewed Mrs B and documented that she "feels the same, ongoing pain and nausea, feels as if she is having chest pain". Dr C told HDC that during this review, Mrs B reported "focal chest pain". Dr C ordered an ECG. He told HDC that prior to this time, no concerns about focal chest pain had been raised with him. In response to the provisional opinion, Dr C stated that Mrs B's symptoms evolved over time, and he acted immediately, swiftly, and in accordance with standard acute coronary syndrome management when Mrs B informed him that she was having chest pain and symptoms not in keeping with gastroenteritis and a reaction to metronidazole.

58. The ECG indicated that Mrs B was having a heart attack. Dr C called the on-call cardiology registrar at the public hospital, who agreed to Mrs B being reviewed in the Emergency Department (ED). An ambulance was then arranged.

[11] Pulse 72bpm, respiratory rate 18 breaths per minute, BP 140/66mmHg, oxygen saturation 100%, temperature 36.2°C.

59. RN G cared for Mrs B while waiting for the ambulance. RN G documented: "[Patient] reported 9/10 dull chest pain across chest, radiating through to back, into neck, and down arms, as has been experiencing [throughout] day."

60. RN G told HDC:

> "I recall that [Mrs B] reported to me that she was having chest pain, and that she had been experiencing such pain throughout the day, along with full body pain, nausea and fatigue. She rated the chest pain to be 9/10 and described it as a dull pain across her chest that radiated through to her back, into her neck, and down her arms, and that she had been experiencing these symptoms throughout the day."

61. On arrival at the hospital, Mrs B's heart attack was confirmed, and she underwent treatment, including surgery.

Further information

Mr and Mrs B

62. Mr and Mrs B told HDC that this was one of the most traumatic experiences of their lives, and it still affects Mrs B.

63. In their complaint, Mr and Mrs B said that they repeatedly told clinicians at Pegasus Health that Mrs B was experiencing chest pain, advised clinicians that they thought she was having a heart attack, and requested an ECG on multiple occasions (five times) with different staff members.

64. Mr and Mrs B explained that overall, they are very disappointed in their experience with Pegasus Health, and feel that Pegasus Health's lack of care and attention to Mrs B's situation could have cost Mrs B her life.

Verbal transfer of care

65. Pegasus Health told HDC that handover of patients between colleagues is done verbally using the iSoBAR [12] format, and the Urgent Care Standards do not require specific documentation of handover in the iSoBAR format. Pegasus Health said that as a result, it does not expect its staff to document that this format of handover is used, or is available to be used, but does advise staff that they should document the person to whom they have handed over. As noted above, transfer of care between staff occurred by verbal handover. Pegasus Health's staff did not document their use of the iSoBAR tool when handover occurred.

66. Pegasus Health told HDC that during the shift handover, all clinical staff meet and go through a list of patients in the treatment and observation areas, and a verbal handover occurs.

67. In response to the provisional opinion, Pegasus Health told HDC that it makes a paper-based iSoBAR handover tool available, and some staff complete the form to refer to during

[12] A clinical handover tool. The acronym "iSoBAR" (identify, situation, observations, background, agreed plan, read back) summarises the components of the tool.

handover or during their shift. The form is a working document, rather than part of the clinical record, and is destroyed securely at the end of the shift. Pegasus Health stated that it expects patient handovers and the content of the handover (done using iSoBAR) to be documented.

Incident review

68. Pegasus Health's audit committee undertook a review of the care provided to Mrs B. Some criticism was made regarding a lack of further assessment in light of the need for ongoing morphine, and also that there was a "possible short" delay in transporting Mrs B's blood test to the laboratory. The audit committee noted that ultimately a definitive diagnosis was made in a person presenting atypically and, whilst any delay is not ideal, the team did well to make the diagnosis and move Mrs B to a place for definitive care.

Acknowledgement

69. In correspondence to Mrs B, Pegasus Health said that it acknowledged the significant pain and discomfort she was in while at Pegasus Health, and the possible delay in her diagnosis. Pegasus Health apologised to Mrs B for her experience and ongoing distress.

Responses to provisional opinion

70. Mrs B, Pegasus Health, Dr D, Dr C, RN E, and RN A were given the opportunity to respond to the relevant sections of the provisional opinion, and their responses have been incorporated into this report where relevant.

71. RN A told HDC that she has reflected on Mrs B's case and she can now see that she could have been more proactive in asking Mrs B her pain score and documenting it appropriately. RN A said that this case has served as a reminder for her to be an advocate for all her patients. She also stated that she should have ensured clear documentation of all of Mrs B's vital signs, including respiration rate and pain score in both the electronic and paper notes, and takes care to do so now. RN A also accepts that she failed to document that Mrs B was being moved to a room in the treatment bay, and the reason for doing so.

72. RN F told HDC that as part of recording the plan, she could have recorded the doctor's plan for Mrs B, and that in future she will ensure that she includes the doctor's response in her notes.

73. RN E told HDC that he has reflected on the care he provided, and provided an apology to Mrs B for not escalating her symptoms to a doctor. He stated that if the same situation arose again, he would escalate his concerns to the wider medical and nursing team.

74. Pegasus Health submitted that the combined impact of the individual failings in Mrs B's care do not amount to an organisational failure of Pegasus Health. It argued that the number of areas identified by the independent advisors, and HDC's provisional opinion, represent a series of individual actions, which does not mean that Pegasus Health failed in its obligations in a systemic manner. Pegasus Health stated that it is difficult to see how it could have prevented the sequence of events and individual actions by the staff involved, and that it took all steps as were reasonably practicable in all the circumstances, and it can have no

direct liability under the Code of Health and Disability Services Consumers' Rights (the Code).

75. Pegasus Health also told HDC that whilst it expects that staff will document discussions, it considers that a balance should be struck between sufficiently detailed records and timely patient care. Pegasus Health further submitted that the Nursing Council's comments on documenting discussions are general guidance, and need to be recognised in the diverse environments in which practitioners work. It argued in favour of the Urgent Care Standards guidance on documentation, and stated that it does not accept that professional standards go so far as to require that all discussions between colleagues are documented.

76. Dr D told HDC that the final diagnosis of an atypical presentation of a heart attack (NSTEMI) is by its very nature very difficult to make, and in the context of the care provided to Mrs B, he does not believe this case is indicative of competence concerns. However, he told HDC that he has reflected on the events of September 2018, and has taken steps to improve his own practice and understanding of cardiac events.

77. Dr C provided an apology to Mrs B for the pain and suffering she experienced. He also told HDC that he accepts that there were communication issues between the nursing and medical staff in this case.

78. Dr C stated that the nature of Mrs B's pain as she described it to him (generalised body pains) at his initial review, along with the preceding history, referral from her GP, Dr D's handover, the confirmed gastrointestinal infection, and nausea and vomiting precipitated by taking metronidazole, represents a far greater diagnostic challenge than HDC's expert advisor, Dr Adams, allowed for in his report.

79. Dr C also stated that he used the term "focal" chest pain in his responses to HDC, to differentiate between Mrs B's symptoms as she described them to him at his initial review — generalised body pains including symptoms in her feet, and not chest pain radiating to the arms, back, or abdomen. Dr C told HDC that his assessment and record of Mrs B's symptoms at all times was sincere and candid.

80. Dr C stated that he was and is aware that patients with diabetes are more likely to have abnormal presentations, but he believes that the symptoms he elicited from Mrs B, along with the preceding history, strongly pointed to the initial diagnosis of gastroenteritis and a reaction to metronidazole.

Opinion: Pegasus Health — breach

81. This report highlights the importance of considering differential diagnoses, and the impact that cognitive biases and a lack of critical thinking can have on diagnostic decision-making.

82. At the outset, it is necessary to acknowledge that in this matter there are some significant discrepancies between what Mr and Mrs B say happened, and the evidence of the health practitioners involved. The evidence has been carefully evaluated to make factual findings. However, there are some instances where it is simply not possible, given the competing evidence, to make such findings to the required standard of proof. In assessing whether or not the standard of care was breached, I have relied on the independent clinical advice provided to me by urgent care specialist Dr Stephen Adams, and Registered Nurse Fay Tomlin.

Triage

Triage score

83. Mrs B presented to Pegasus Health at approximately 1.40pm with pain in her arms, chest, and back. She was assessed by RN A and given a triage code of four. RN A did not document Mrs B's respiratory rate or pain score in the electronic record.

84. There are differing accounts of what was discussed during triage. Mr and Mrs B said that Mrs B reported "horrific" chest pain, told RN A that she thought she was having a heart attack, and requested an ECG. However, RN A said that Mrs B's main concern was nausea, and there was no mention by Mr and Mrs B of Mrs B having a heart attack, and neither of them requested an ECG.

85. My nursing advisor, RN Fay Tomlin, advised that if Mrs B reported "horrific" chest pain and concern that she was having a heart attack, she should have been given a triage code of two (to be seen within 10 minutes), rather than four (to be seen within 60 minutes).

86. However, RN Tomlin said that if the events occurred as documented, Mrs B's triage score should have been three (to be seen within 30 minutes) rather than four, given her symptoms of persistent vomiting and/or perceived non-cardiac chest pain. RN Tomlin said that this means there was a potential delay in Mrs B being seen. RN Tomlin also noted that there was a lack of clinical detailing by RN A (obtaining Mrs B's pain score and respiratory rate) to support the triage score given to Mrs B.

87. While difficult to reconcile the two differing versions of what occurred, it is clear from the documentation that Mrs B reported nausea and pain in her chest, arms, and back to RN A. Therefore, I do not consider it necessary to make a factual finding about which scenario occurred, as the triaging that occurred by RN A in either scenario represents a departure from accepted practice. I note Pegasus Health's view that the triage score was appropriate, but prefer the evidence of my expert advisor, RN Tomlin (supported by my urgent care specialist, Dr Stephen Adams) that Mrs B's triage score should have been at least three.

Documentation

88. After RN A triaged Mrs B, she entered Mrs B's vital signs into the electronic notes, but did not include Mrs B's symptoms of pain in the arms, chest, or back. Additionally, she did not document that Mrs B was moved to a room in the treatment bay because of increased nausea/vomiting.

89. I note that the Nursing Council of New Zealand competencies (see Appendix D) state that nurses should maintain and document information necessary for continuity of care and recovery, and ensure that documentation is accurate. RN Tomlin considers it a minor departure from the accepted standard of care that RN A did not document the reason for moving Mrs B to the treatment area.

90. As discussed above, when Mrs B was triaged by RN A, her symptoms of chest, arm, and back pain were not entered into the electronic notes. Mrs B's first medical review was with Dr D, who said that the verbal handover he received was that Mrs B had gastrointestinal symptoms, and was experiencing side effects from metronidazole. Dr D told HDC that he was not informed at handover that Mrs B was experiencing chest pain.

91. In a busy urgent care environment where verbal handovers are common but may not always be effective, it is important that written documentation is accurate and complete to supplement a clinician's knowledge of a patient's presentation. Whilst I accept that RN A did record Mrs B's report of chest, arm, and back pain in the handwritten triage notes, it is concerning that a pain score and respiratory rate were not recorded, and that relevant medical history (including the report of chest pain), and the rationale for her being moved into the treatment bay, were not recorded in the electronic record.

First medical review

92. At approximately 2.20pm (about 40 minutes after arrival), Dr D reviewed Mrs B. The handover he received was that Mrs B was experiencing gastrointestinal symptoms (significant nausea and vomiting) and side effects from metronidazole. Dr D noted that Mrs B had a history of type 1 diabetes, high cholesterol, and diabetic retinopathy, and was experiencing "severe back and other muscle group aches and pains".

93. There are differing accounts of what occurred during this consultation. Mr and Mrs B said that Mrs B told Dr D that she thought she was having a heart attack and requested an ECG. Dr D said that Mrs B did not report chest pain, and that he recorded what Mrs B reported to him as the most prominent symptoms (as outlined above in paragraph 92).

94. Dr D stated that he was not aware of chest pain during this consultation.[13] He said that he may have overlooked the mention of chest pain on the written triage note, as he had reviewed the electronic triage assessment (noting that the electronic triage completed by RN A did not include the reported chest, arm, and back pain).

[13] Dr D's initial statement suggested that he was aware of the chest pain from the triage form. He later corrected this stating that the initial statement reflected his understanding from the time of writing the statement, not his understanding at the time of consultation.

95. I acknowledge Mrs B's assertion that she told Dr D that she thought she was having a heart attack and asked Dr D for an ECG. However, there is no reference to a request for ECG in the documentation by Dr D, or indeed by any other health practitioner throughout Mrs B's presentation. I note further that all health practitioners have denied that a request for an ECG was made, as well as the evidence that if an ECG request had been made, this could have been arranged easily. While acknowledging Mrs B's firm and sincere belief that she made this request on several occasions, I am not satisfied with reference to the standard of proof that this request was made. I am, however, satisfied that throughout her attendance at Pegasus Health, Mrs B was suffering from chest pain (as well as other pain). This is recorded clearly from her point of arrival (in the handwritten triage notes), to the eventual diagnosis of heart attack, where the clinical notes record that Mrs B reported dull chest pain at that time radiating through to her back, neck, and down her arms, "as [she had] been experiencing throughout the day".

96. The essential question for this part of Mrs B's care is whether, based on the information available to Dr D, a cardiac cause for her presentation should have been considered as a differential diagnosis.

97. My urgent care advisor, Dr Stephen Adams, agreed that the provisional diagnosis of a reaction to metronidazole was reasonable given the history of nausea and vomiting. However, he also advised that Mrs B's diabetes, high cholesterol,[14] and vascular disease placed her at higher risk of ischaemic heart disease. Dr Adams said that ischaemic heart disease should have been considered, even if it was not included in the differential diagnosis, and noted that individuals with diabetes are more likely to have abnormal presentations. However, Dr Adams also advised that chest pain radiating to the arms, back, or abdomen is not an obscure presentation of myocardial infarction (a heart attack). This advice is consistent with that given by an expert advisor for ACC, who confirmed that Mrs B's diabetes and high cholesterol put her in a group at high risk for a heart attack. Dr D has accepted this.

98. Dr Adams further stated that Dr D's failure to note the presence of chest pain either directly from the patient herself or from the written triage form (which he signed) was a departure from the standard of care.

99. I concur that context is relevant, and accept Dr Adams' advice that it was not unreasonable to pursue the diagnosis of a reaction to the antibiotic. I also note Dr D's response to the expert advice that there was nothing in Mrs B's presentation that was significantly different enough from the provided information to warrant a more wide-ranging differential diagnosis.

100. I do not, however, accept that submission as an answer to the concerns raised by Dr Adams. That Mrs B was experiencing chest pain could, and in my view should, have been elicited from her. She had reported it both before and after her consultation with Dr D, and noting Mrs B's evidence in her complaint, I consider it more likely than not that she or her husband would have described the chest pain if asked about it (as she did to RN G when asked later

[14] Fat in the blood.

in the day). It was also information available to Dr D on the written triage form — which he clearly viewed as he charted medication on it (although he apparently overlooked the mention of chest pain). Moreover, it is relevant that Mrs B was at increased risk for a heart attack (a fact known at the time), and was experiencing symptoms that were not obscure for the possibility of heart attack (nausea, back, and neck pain). Given the whole context, a cardiac cause for Mrs B's presentation should have been considered. This may have prompted further questioning of Mrs B, an earlier ECG, and possibly earlier diagnosis and treatment. In reaching this conclusion, I note Dr D's response that he was not aware of the chest pain — which calls into question not just the extent to which this symptom should have been elicited by him, but the effectiveness of the communication between nursing staff (who were aware of the chest pain) and the doctors. This is addressed further below.

Nursing care

101. Between 2.45pm and 5pm, while under the care of RN F, Mrs B consistently reported high levels of pain that did not decrease with IV morphine. RN F documented on each occasion that either further analgesia was provided to Mrs B, or that she planned to report it to the doctor. However, on the occasions where RN F documented that she planned to discuss Mrs B's pain levels with the doctor, the outcome of the conversation that occurred was not documented.

102. Pegasus Health told HDC that it considers that overall the clinical records completed by nursing staff are of an accepted standard, and the Urgent Care Standards do not require such discussions to be documented. However, I note that the Nursing Council of New Zealand's Code of Conduct states that nurses should keep clear and accurate records of the discussions they have. Additionally, the Nursing Council of New Zealand competencies for registered nurses state that nurses should maintain and document information necessary for the continuity of care and recovery.

103. I acknowledge Pegasus Health's view. However, I note that the Urgent Care Standards state that medical records should be documented with sufficient information to describe the consultation, and should meet current best practice and legislative requirements. The Nursing Council's Code of Conduct does not outline best practice, but rather the lower threshold of accepted practice. I consider that registered nurses employed by Pegasus Health must at a minimum comply with the above accepted standards, as set out by the Nursing Council of New Zealand.

104. In response to my provisional opinion, Pegasus Health clarified that whilst it expects staff to document discussions, a balance must be struck between sufficiently detailed records and timely patient care. It also continued to argue in favour of the Urgent Care Standards guidance on documentation, and stated that it does not accept that professional standards go so far as to require that all discussions between colleagues are documented. I have carefully considered Pegasus Health's submissions on documentation, and maintain the view that the comments in the Nursing Council Code of Conduct regarding documentation reflect the accepted standard nurses are required to follow. I have also obtained expert advice from my nursing advisor, RN Tomlin, who has confirmed that nursing discussions with the medical team about Mrs B's care should have been documented.

105. More specifically, RN Tomlin advised that if RN F updated clinicians when she documented that she planned to, then this is consistent with accepted practice. However, RN Tomlin noted that RN F should have documented the doctor's response to her updates. RN Tomlin considers that this omission constitutes a moderate departure from the required standard of documentation.

106. Based on the statements provided, I accept that RN F did update Dr D and Dr C as documented, but the exact content of those conversations is unknown. RN F did document the presence of chest pain in the electronic observation notes, but it is not apparent on the evidence that this was conveyed to the doctors (and both deny being aware of the chest pain (until reported to Dr C at 6.35pm)). I accept RN Tomlin's advice that the discussion should have been documented. I remind RN F of her professional obligation to record adequate documentation to ensure continuity of care for consumers.

107. It is particularly concerning to me that Pegasus Health considers that clinical discussions between a nurse and doctor do not need to be documented, in spite of the Nursing Council's Code of Conduct and expert nursing advice to the contrary. Documentation is important to promote continuity of care, to guide clinical decision-making, and to enable the early detection of changes in a patient's condition. While individual practitioners hold some accountability for the failure to comply with accepted standards, in my view they were not supported in their role by the expectations of Pegasus Health. I note further that the inadequacies in the documentation during Mrs B's presentation not only potentially impacted the care she received, but has impeded the investigation into the issue of whether there was adequate communication and coordination between nursing and medical staff.

Subsequent medical reviews

108. Dr D handed over care to Dr C at 4pm. Dr D advised Dr C that Mrs B had gastrointestinal symptoms and was having a reaction to metronidazole. Dr C said that he was not made aware of "focal" chest pain at this time. Dr C reviewed Mrs B at 4.50pm and said that again he was not made aware of "focal" chest pain. Dr C told HDC that he used the term "focal" to differentiate between Mrs B's symptoms as she described them at his initial review — i.e., that of generalised body pains including symptoms in her feet, not chest pain radiating to the arms, back, or abdomen.

109. Dr C further stated that he did not review Mrs B's clinical notes during his review at this time because he had received a verbal handover and had reviewed Mrs B's paper chart, which included vital signs and prescribed medication. I note that the "paper chart" to which Dr C refers also included the handwritten triage notes that detailed that Mrs B had chest pain. Dr C prescribed medication on the same page on which the chest pain was recorded, and this medication was dispensed at 4.25pm.

110. Dr Adams considers Dr C's failure to ascertain that Mrs B was experiencing chest pain from the clinical documentation to be a mild to moderate departure from accepted practice. Speaking generally, he also noted and disagreed with the use of the term "focal" to describe chest pain. Dr Adams advised that cardiac pain is known to radiate from the "focal" position

in the chest to adjacent areas — in particular, the arm, neck, back, and abdomen. Again, such radiation of pain is not an obscure presentation of heart attack.

111. It is also not clear on the evidence whether Dr C knew of the chest pain from the nursing handover. RN F does not recall the detail of this conversation. Dr C has said that no *focal* chest pain was communicated (my emphasis).

112. As for Dr D, in my view, Dr C could, and should, have elicited either from the clinical notes or from Mrs B herself that she was experiencing chest pain. The same context applies — that Mrs B was at high risk for ischaemic heart disease — and I refer to my earlier reasoning in paragraph 100. This represents another missed opportunity to undertake further questioning, perform an ECG, possibly obtain an earlier diagnosis, and expedite Mrs B's transfer to hospital.

Pain management

Medical

113. Mrs B experienced high levels of pain throughout her presentation to Pegasus Health, and notwithstanding multiple administrations of IV morphine, her pain levels did not decrease. Despite being put on notice of this pain by RN F, Dr D did not undertake a further assessment of Mrs B.

114. Pegasus Health's incident review identified that further assessment should have occurred in light of Mrs B's ongoing need for morphine.

115. I agree. I consider this to be another instance of a lack of critical thinking by Dr D. Dr D should have undertaken a further review to consider the cause of Mrs B's pain, and should have reassessed his initial diagnosis and the need for further investigations.

Nursing

116. RN F handed over care to the nursing team at 5pm. At 5.37pm, RN E documented that Mrs B was experiencing pain in her arms, chest, and back. Mrs B's pain score was 8/10. However, no further action was taken by RN E. RN E advised HDC that he did not consider it necessary to inform the doctor, as he was under the impression that the blood test results would be available imminently, and the medical review would occur shortly thereafter.

117. RN Tomlin advised that Mrs B had received four doses of morphine between 2.45pm and 3.36pm, so RN E should have been concerned that Mrs B's pain score was 8/10 and no further pain relief had been charted. RN Tomlin said that documenting a pain score of 8/10 and not taking any action on it is a moderate departure from accepted practice.

118. I accept RN Tomlin's advice, and consider that RN E should have escalated this matter to Dr C to consider whether any further treatment was necessary. As a result, Mrs B continued to experience high levels of pain without medical input.

Handover documentation

119. Pegasus Health advised that the handover of patients is done verbally using the iSoBAR tool, and it does not expect its staff to document that iSoBAR is used, but does advise staff that

they should document the person to whom they have handed over. Pegasus Health's staff did not document their use of iSoBAR when handover of Mrs B's care occurred. Pegasus Health told HDC that it makes a paper-based iSoBAR available, and some staff members complete the form during handover or during their shift. Pegasus Health also stated that it expects that handover, and the content of that handover (done using iSoBAR) to be documented.

120. Pegasus Health's "Observation, Monitoring, Extended Treatment" policy states that both doctors and nurses should use iSoBAR when handing over patients, and a specific form was developed to assist with this to ensure accurate transfer of care. The policy further states that "in the near future this process will use an electronic handover tool".

121. RN Tomlin advised HDC that the iSoBAR tool has been common practice for over a decade, and is used to standardise communication and improve clinical handover.

122. I agree with RN Tomlin and with Pegasus Health's expectation that its staff should document that handover has occurred, and the content of those handovers, which should be done using iSoBAR. I remind Pegasus Health and its staff of the importance of doing so.

Conclusion

123. In summary, Mrs B presented to Pegasus Health with symptoms of a heart attack — chest, back, and neck pain and nausea, with a clinical background that put her in a high-risk category for ischaemic heart disease. The clinical focus throughout the five-hour period before eventual diagnosis was on the possibility that Mrs B was suffering a reaction to an antibiotic.

124. Of particular concern to me is that between 1.40–6.35pm Mrs B's chest pain was known to the nursing staff, but apparently not to the two doctors who reviewed her. This raises questions not just about the quality of the medical reviews, but the standard of communication between the nursing and medical staff.

125. The clinical advice received has identified departures from the standard of care for individual clinicians, involving multiple staff. In response to my provisional opinion, Pegasus Health submitted that the combined impact of the individual failings in Mrs B's care do not amount to an organisational failure of Pegasus Health. I disagree. I have carefully considered whether individuals should be held to account, but conclude that because of the various issues throughout the presentation involving multiple providers, these are failings for which ultimately Pegasus Health is responsible. That is, Pegasus Health has a responsibility through both its staff and its processes to provide a reasonable standard of care to consumers. Pegasus Health should also have a system that supports good clinical decision-making, and communication and cooperation between the different individual health providers.

126. Throughout Mrs B's presentation to Pegasus Health, multiple staff demonstrated a lack of effective communication, both written and verbal. Pegasus Health's expectations concerning verbal and written communication did not support staff to comply with the relevant standards and policies. There were several occasions on which staff failed to recognise the significance of Mrs B's chest pain, and there were repeated omissions to act

on ongoing pain. Overall, the deficiencies that have been identified in the care provided to Mrs B provide an impression of poor teamwork and a lack of critical thinking amongst multiple staff.

127. Specifically I consider that Pegasus Health failed to provide services to Mrs B with reasonable care and skill for the following reasons:

- Mrs B was triaged incorrectly by RN A.
- RN A failed to enter into the electronic notes that Mrs B was reporting chest, arm, and back pain, and she did not document the reasons for Mrs B's move from the waiting room to the treatment area for increased nausea/vomiting.
- Dr D failed to elicit Mrs B's chest pain either from her or the clinical record during the first medical review — a significant symptom in the context of her risk for ischaemic heart disease, and the signs and symptoms with which she was presenting.
- RN F did not document the outcomes of her discussions with the medical team.
- During his first medical review, Dr C failed to elicit the presence of chest pain, either from Mrs B or the clinical record.
- Mrs B had a high level of pain that was not resolving adequately with IV morphine, but this did not prompt Dr D to reconsider the working diagnosis of gastroenteritis and a reaction to metronidazole.
- RN E failed to escalate care to Dr C when Mrs B reported high levels of pain that had not improved despite repeated doses of morphine.

128. For the above reasons, I find that Pegasus Health failed to provide services to Mrs B with reasonable care and skill, and, accordingly, breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

Australasian Triaging Scale (ATS) — other comment

129. The ATS is the default triage system for urgent care clinics in New Zealand.

130. Pegasus Health notes that one of the faults of the ATS is that it can give patients a higher triage score than appropriate in primary care. Dr Adams considers the use of ATS in urgent care clinics to be a major failing of the standards, and not the fault of Pegasus Health.

131. Dr Adams said that the ATS was developed and validated for emergency departments, not urgent care, which has a different population/case mix and different expectations of services from that population. Dr Adams considers the ATS less than ideal for urgent care in both assessing acuity and as an audit for wait times, as it has insufficient discrimination in categories three, four, and five in the urgent care caseload. Dr Adams also said that the waiting time performance cited (i.e., a triage score of five has a performance time of 70% of patients seen within 120 minutes) would be unacceptable to fee-for-service clinics in New Zealand. Dr Adams also notes that often the ATS is not used as designed.

132. I acknowledge Dr Adams' and Pegasus Health's thoughts on the use of the ATS in urgent care clinics. Given the importance of triaging patients appropriately in an urgent care setting, I am referring this matter to the Royal New Zealand College of Urgent Care for its consideration.

Changes made

133. Since this incident occurred, Pegasus Health has made the following changes to its processes and policies:

a) Relating to sending blood for testing — the process of sending tests to the laboratory. Prior to this incident, a taxi was called each time a test was completed. Now, a taxi is called every hour on the hour from 10.00am to 11pm. An exception would be made for urgent tests in between these times.

b) The "Reception Staff Guideline", which guided administration staff on when to seek urgent clinical input, has been amended. Prior to this incident, the guideline required reception staff to seek clinical support when a patient presented: "In cardiac arrest — e.g. chest pain or chest discomfort, clammy, pale." The triage policy has now been updated to state that reception should seek immediate clinical support when a patient presents with "chest pain or chest discomfort, clammy".

c) Pegasus Health asked the team to review the presentation, signs, and symptoms of patients with atypical myocardial infarction (heart attack),[15] and present this to peers.

134. Pegasus Health introduced an electronic version of iSoBAR in its observation unit, but it was not well utilised, and privacy was difficult as the screen was visible in patient areas. Pegasus Health reverted to paper-based versions of iSoBAR, and intends to undertake CPD sessions to reinforce its expectation and policy that all handovers be done using iSoBAR, and will monitor the use of the form.

135. RN A now includes all necessary information in both the electronic and paper records, and ensures that when she hands over patients to other nurses or health professionals, she conducts a verbal handover and documents the details of her handover.

136. RN F has reflected on the Code of Conduct principle 4.8 — "keep clear and accurate records" — and will now ensure that she includes doctors' responses, and the plan made in discussions with doctors, in her notes.

137. RN E told HDC that he has reflected on this event at length and has completed further education and gained further experience in the years following this event.

[15] Heart attack.

138. Dr D told HDC that he has undertaken significant further training and assessments aimed at improving his recognition of atypical cardiac events. In particular, between December 2019 and July 2020 he was employed as a Cardiology/Coronary Care unit registrar, and in that role was responsible for patient assessment and treatment, monitoring day-to-day care and discharge planning, while also having daily structured and unstructured teaching and education opportunities from cardiologists. Since these events he has also been awarded a fellowship from the Royal New Zealand College of Urgent Care.

139. Dr C told HDC that he has taken steps to reflect on his part in Mrs B's care, and he presented an anonymised version of events in a Pegasus Health peer review to seek the feedback of his peers and as a learning opportunity. He discussed the case with three clinical directors at Pegasus Health to review and reflect on the clinical care provided to Mrs B, and undertook reading to review his knowledge of atypical myocardial infarction.

140. Dr C also stated that now he reviews all nursing and triage notes fully when reviewing a patient, and told HDC that he has undergone further urgent care training, a clinical notes audit, a communication skills course, and multiple advanced life support training courses.

141. Dr C told HDC that he no longer works in New Zealand.

Recommendations

142. Acknowledging the above-mentioned changes, I recommend that Pegasus Health:

a) Provide a written apology to Mrs B for its breach of the Code. This is to be sent to HDC, for forwarding to Mrs B, within three weeks of the date of this report.

b) Share an anonymised case study with Pegasus Health clinicians to share learnings from this case. A copy of the case study and evidence that this has been shared with all staff is to be provided to HDC within three months of the date of this report.

c) Review and update its "Consult Documentation" policy to ensure that staff are compliant with the Nursing Council of New Zealand's standards of documentation, and inform its nursing staff of the updated policies, including the requirement that they must document the salient aspects of discussions with medical staff.

d) Arrange for its triage nurses to undertake the College of Emergency Nurses New Zealand (CENNZ) national triage course, and provide evidence of this to HDC within six months of the date of this report.

143. I recommend that the Royal New Zealand College of Urgent Care review the use of the Australasian Triaging Scale in urgent care clinics, and report back to HDC on the outcome of the review within six months of the date of this report.

144. In the provisional opinion, I recommended that RN A review the Nursing Council of New Zealand Code of Conduct as it relates to standards of documentation, and report back to

HDC with any changes that she will make to her practice. RN A has now met this recommendation.

145. In the provisional opinion, I recommended that RN F review the Nursing Council of New Zealand Code of Conduct as it relates to standards of documentation, and report back to HDC with any changes that she will make to her practice. RN F has now met this recommendation.

146. In the provisional opinion, I recommended that RN E discuss this case anonymously with an experienced nursing colleague and provide a report back to HDC on how the service he provided to Mrs B could have been improved. RN E has provided evidence of his reflection on this event.

Follow-up actions

147. A copy of this report with details identifying the parties removed, except Pegasus Health (Charitable) Limited and the experts who advised on this case, will be sent to the Royal New Zealand College of Urgent Care, the Nursing Council of New Zealand, and the Medical Council of New Zealand, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from urgent care specialist Dr Stephen Adams:

"Complaint C19HDC00866 Pegasus Health

My full name is Stephen Leslie Adams. My qualifications are MBChB University of Auckland and Fellow of the Royal New Zealand College of Urgent Care. I have trained and practised in Urgent Care from 1991 to the present.

I have been asked to provide Independent Advice on care provided to [Mrs B] at Pegasus Health on 2 September 2017, particularly:

1. The adequacy of the care provided to [Mrs B] at Pegasus Health
2. The reasonableness of the care provided by [Dr D] and [Dr C].
3. Any other matters in this case that leave or amount to a departure from accepted standard of care.

I have read the HDC guidelines for Independent Advisors and agree to follow these.

I have disclosed my membership of the Royal New Zealand College of Urgent Care of which I am aware both [Dr D] and [Dr H] are members …

It has been noted that different versions of events have been supplied and I have been advised that my advice should cover alternate scenarios. I have however tried to piece together a timeline which is agreed in both accounts (below) and it seems certain that [Mr and Mrs B's] timeline is in error at one point early in the day due to misidentification of the Triage Nurse.

I have been asked to rate the [departure] in Practice as Mild/Moderate/Severe. My assessments of these for each account is in bold parentheses.

Timeline — [Mrs B]

Arrival, reports chest pain	1345
Triage	1425
IV Placement	1445
New Doctor ([Dr C]) on ward	1600
In pain, nauseated	1625
Morphine for pain	1650
Pain in chest	1737
Pain in chest	1835

Timeline — notes

Triage	1341–1347
Treatment bay	1425
Seen by [Dr D]	
Blood tests ordered	<1445
IV Line placed	1445
Meds (Morphine, Ondansetron) ordered	1435
Nurse notes chest pain until 1625	1445
[Dr D] notes of exam	1509
[Dr D] (verbal) handover to [Dr C]	1600
Review by [Dr C]	1650
New nurse notes chest pain	1737
ECG performed	1835
Abnormal ECG noted	>1835
Referred to Cardiology	
Aspirin, GTN charted	1900
Ambulance called	1900

[Mrs B's] account, co-written with her husband, dated 30 April 2019 outlines events of the September 2 2017 from home until the treatment at [the public hospital].

At the first (telephone) communication with the [clinic] [Mr B] told the person answering that he thought his wife was having a heart attack. Advice to continue to [the clinic] would be in error unless they were very close to [the clinic] at that time. The correct routing would have been to the Emergency Department and by ambulance in most circumstances.

A wheelchair was provided at the door of [the clinic] at 1345 and she was taken to reception where she was questioned by a receptionist and a nurse (I believe from [the clinic's] notes this was actually the Triage Nurse) who was informed by both patient and husband that they believed she was having a heart attack.

She reports that Triage was delayed 40 minutes to 1425 during which time she was sitting in the waiting room. If this is the case (see above as it may be a misinterpretation) Triage should have been arranged more quickly. With the symptoms as reported she should have been Triage Category 2 (Imminently Life-Threatening or Important Time-Critical) and seen (for definitive care) within 10 minutes in a Resuscitation Room where an ECG would have been a high priority along with an Intravenous line and analgesia, followed by ambulance transfer to Hospital.

She states that her complaint of chest pain, the belief she was having a heart attack and needed an ECG was repeated at various times by herself or her husband and was not acted on until 1835 that evening.

In addition to delays in assessment/treatment she complains of:

- An arrogant and indifferent attitude from [Dr D] at one point where he also said an ECG would be ordered but did not.
- Blood samples having not been sent to the laboratory.
- Being told to go home when blood test results were returned normal ([Dr C] is not named but he was the only Doctor at the time the blood test results returned).

Her additional questions posed were:

- Why was I not given an ECG when I requested one on arrival?
- Why was I not given an ECG when My Husband asked for one on arrival?
- Why was I not given an ECG on the three occasions my Husband asked during the agonizing hours that ensued?
- Why were my documented symptoms of pain in neck, arm, chest not reacted to by any of the staff?
- Why did the first doctor ignore my symptoms?
- Why did the first doctor not change his opinion/diagnosis when my symptoms did not actually fit the drug reaction?
- What did he do to reverse the drug reaction — if that was his diagnosis?
- Why did he give only morphine and nothing to counter the drug reaction?
- At what point should efficacy of the so called drug reaction [have] started to cease?
- As my symptoms were consistent the entire time — why was this not queried?
- Why did the initial Doctor not test my blood for signs of a heart attack?
- Why did the initial Doctor not test the second lot of bloods for signs of a heart attack?
- Why did the Dr tell us to go home as there was nothing wrong with me?
- Why did the Dr and Nurses not at any point talk to each other about my arm/neck/chest pain and do something about it?
- Three further questions asked why [the clinic] and their doctors were lying in the internal Audit.

To summarize — shortfalls in care as seen in the Patient account:

1. When [Mr B] reported by telephone that [Mrs B] was having chest pain to an unknown person, she should have been directed to [the public hospital] by the most expeditious and safe route. (Moderate–Severe)
2. Triage was incorrect — someone reporting undifferentiated chest pain should have been Triage category 2 or 3. (Moderate)
3. With respect to delays in assessment and treatment, the complaint of chest pain could represent heartburn from vomiting, however the principles of ruling out myocardial infarction includes not ruling it out unless there is a very probable other cause. (Moderate). The added suggestion by patient and husband of a heart attack and request for an ECG should have mandated an ECG. (Severe)
4. [Mrs B] says she and her husband asked for an ECG three further times and again there is no reason why she should not have had one. Patient requests should not be dismissed without good reason which should be elaborated. If an ECG was promised by [Dr D] it should have been done. (Severe)
5. She continued to complain of continuing chest pain which should have resulted in reassessment of the diagnosis and need for an ECG. (Severe)
6. The delay of sending the blood test, while not in itself contributory to the outcome is a system failure within [the clinic]. The question of why the blood was not tested for a heart attack has also been raised. It is something of an Urgent Care mantra that if the concern about chest pain is sufficient to be ordering Troponin testing the patient should be referred to a Hospital as testing time is much quicker and the patient is in the right place if intervention is required. (Mild — in this case)
7. [Dr C] should not have told [Mrs B] to go home on the basis of blood test results — this was wrong as she was still complaining of symptoms. (Severe)

To answer those questions of [Mrs B] that I can:

8. The prescribed Ondansetron and fluids are an appropriate treatment for the presumptive diagnosis of Metronidazole induced vomiting.
9. It is something of an Urgent Care mantra that if the concern about chest pain is sufficient to be ordering Troponin testing the patient should be referred to a Hospital as testing time is much quicker and the patient is in the right place if intervention is required.
10. It is not clear whether a second set of blood tests was done. [The clinic] has no record of a second blood test.

The account of the consultation(s) of 2nd September from the Clinic point of view is derived primarily from the printed computer notes, the handwritten drug/observation charts and observation sheets and some elaboration from [an] Audit of 13th September 2017, and [Dr H's] internal investigation of 12th September 2018.

[The clinic] first became aware of [Mrs B's] illness by a telephone call from her GP to an unnamed Observation Ward Doctor. This call is referred to briefly in the notes by [a] staff member … made after [Mrs B's] arrival. She was expected, with a provisional diagnosis of reaction to Metronidazole.

She presented to [the clinic] just before 1341 and was triaged by [RN A] who noted in the paper Triage Form symptoms of nausea and pain in the sites of arms, chest and back, but did not specify a site in the electronic record. She was triaged T4 (Potentially serious) but should have been triaged T3 (Potentially Life-Threatening) as persistent vomiting and moderately severe pain are examples given in Ref (2), and chest pain of any type would mandate a T3 triage category.

[Dr D] examined [Mrs B] from about 1430 and requested an IV line, drugs and blood tests on the paper form that mentioned chest pain at the top. The blood tests appear to have been looking for signs of dehydration or electrolyte imbalance. No specific cardiac tests were done.

In his notes written at 1509 he recorded nausea and vomiting since the first dose of metronidazole, he mentions back and other muscle group aches and pains. Examination was unremarkable apart from difficulty examining the abdomen due to distress.

The next electronic nursing notes by [a nurse] indicate that an IV line was placed about 1445 and blood tests taken, an observation of 8/10 pain was made on the paper observation chart at 1450 but no site mentioned.

Further electronic nursing notes were made by [RN F] at 1445, 1500 and 1625 where chest pain was noted each time and treatment discussed with [Dr D] at 1500 and [Dr C] at 1625. Whether the presence of chest pain was discussed was not noted. At 1625 it was noted by [RN F] that [Dr C] had taken over care of the patient. These electronic nursing notes were not visible to anyone else until the notes were closed by [RN F] at 1637.

Patient was handed over verbally to [Dr C] at 1600 ([Dr H's] letter) but did not include seeing the patient. He did, at 1650, a review of bloods (which were found to have not left the building) and spoke to the patient, noted her condition was unchanged but did not register that she was having chest pain until a second consult at 1835 when the blood tests were available.

At 1835 he had the results of the blood tests (normal) and on reviewing the patient received reports of chest pain so an ECG was ordered which showed significant ST elevation then treatment and transfer was set in motion.

Significant negatives in the history elaboration as related by [Dr H's] internal investigation were of the Doctors' lack of knowledge of chest pain prior to 1835 and denial from all staff of being told of [Mrs B's] concern about a heart attack or that she asked for an ECG. In addition discharge home was not mentioned.

Shortfalls in the account of the events of 2 September 2017 as evident in [the clinic's] notes and [Dr H's] internal Audit:

1. No record of telephone call(s) preceding arrival. (Mild)
2. Incorrect Triage Category — should have been Category 2 or 3 based on the presence of undifferentiated chest pain which was noted on the written triage form. (Mod)
3. Failure to transfer the symptom of chest pain to the electronic triage record (Mod).
4. Failure of [Dr D] to note the presence of chest pain directly from the patient or from the written Triage form on which he had signed for medication. (Mod)
5. [Mrs B] arrived with a provisional diagnosis of reaction to Metronidazole; this was a reasonable provisional diagnosis given the history as nausea and vomiting are frequently reported with Metronidazole.[1] However it is important to keep an open mind until a full history and examination is done. (Mild)
6. Failure of [RN F] to close her electronic observation notes after each entry. This meant her observations and [Mrs B's] reporting continuing chest pain were not visible to other staff until finally closed at 1637 (Mod) and there is no account of what was discussed with [Dr D] at 1500, whether [RN F] discussed the patient in generalities or specified chest pain. The paper observation record, while dutifully completed to 1630 did not mention chest pain.
7. The first blood samples were not sent to the laboratory for two hours. (Mild — in this case)
8. [Dr C] also failed to ascertain [that Mrs B was] having chest pain at 1650 even though she had told nurses prior to and after this of her chest pain. (Mod)

Other Comments:

I note that [the] *Triage Policy* is somewhat vague and uses maximum waiting time as the criteria for classification rather than basing classification on symptom/sign/acuity. I think it would be useful if the triage policy included the descriptors in 'Guidelines On The Implementation Of The Australasian Triage Scale In Emergency Departments'.[2] I would also make the point that the ATS, though widely used, is designed for Emergency Departments, not for Urgent Care Clinics and consideration should be given to adapting it to the different caseload and resources of a given Urgent Care Clinic.

The *Reception Staff Guideline* states 'In cardiac arrest — e.g. chest pain or chest discomfort, clammy, pale.' This doesn't make sense and should be amended to 'Chest pain or chest discomfort, clammy, pale' as in the *Triage Policy — The Role of The Receptionist* where cardiac arrest is catered for under 'Unconscious'.

Staff should be instructed to close electronic entries in Patient notes when each entry is completed so it is visible immediately to other staff, not at the end of a shift.

Electronic Records should record opening time of notes at the front rather than relying on the Staff to make a note of the time. I believe this facility is not available in MedTech32 used in this clinic and staff should take care to annotate this until the notes system can do this.

References:

1. Flagyl — Metronidazole New Zealand Data Sheet 25-Jan-2018
2. Guidelines on the Implementation of the Australasian Triage Scale in Emergency Departments. Australasian College of Emergency Medicine July 2016

Stephen Adams BHB, MBChB, DAFARCS, DCEM, FRNZCUC"

The following further advice was received from Dr Adams:

"19HDC00866/[Mrs B] Second Request for information:

[Dr C]:

Firstly let me re-iterate that my opinion was sought in two parts — one using the patient and the patient's husband's recollections and the other using the various notes and statements of the clinicians. I have however noted a few strong discrepancies where a clear majority are at variance with a minority of the other observers.

In this context I can only note the discrepancy between the Nurses' notes plus statements and those of the Doctors and find that chest pain, with or without radiation to the arms and abdomen was known to the Nurses from 1445 and not to the Doctors until 1835.

I cannot say why neither electronic notes or verbal handover alerted [Dr C] from the information I have been supplied with as there are differences in individuals' statements on verbal handover. This discrepancy was critical to perhaps a 2 hour or more delay in definitive treatment. I have been asked to characterise any departures and 'moderate' seemed to me appropriate, partly as I cannot identify the root cause with any certainty. This ties in with the definitions in the Pegasus Incident Severity Assessment Table.

It should be noted that Diabetics are both at higher risk of ischaemic heart disease and more likely to have abnormal presentations. However chest pain radiating to the arms and abdomen is not an obscure presentation of myocardial infarction.

[Dr D]:

Firstly let me re-iterate that my opinion was sought in two parts — one using the patient and the patient's husband's recollections and the other using the various notes and statements of the clinicians. I have however noted a few strong discrepancies where a clear majority are at variance with a minority of the other observers.

It is not clear if [Dr D] grasped the significance of the chest pain which he says in his statement he was aware of at presentation. It was not referred to in any of his notes. Diabetics are both at higher risk of ischaemic heart disease — this patient was known to have elevated lipids and vascular disease — and more likely to have abnormal presentations so ischaemic heart disease should have been considered even if not included in the differential diagnosis.

With respect to later patient reports of chest pain to [RN F] I can only note the discrepancy between the Nurses' notes plus statements and those of the Doctors and find that chest pain, with or without radiation to the arms, back or abdomen was known to the Nurses from 1445 and not noted by the Doctors until 1835. I cannot say why this is from the information I have been supplied with as there are differences in individuals' statements, particularly on verbal handover.

It is also not clear if [Dr D] did view the nursing notes when he completed his notes at 1420, 1531 and 1538. Depending on configuration in some clinics the Nursing notes are visible in Medtech when Doctors' notes are completed and in others they are in another window that has to be opened separately.

[RN F]:

In reviewing [RN F's] notes as far as I can tell the 1430–1445 notes were not saved until 15:13 and the 1526 notes until 1546 , a nearly 30 minute delay and a 20 minute delay respectively. I am unable to say whether this might have made a difference by being visible to [Dr D] when he was in this patient's notes.

[RN A]:

The ATS level applied was clearly too light — level 3 should have been applied to a patient who was dry retching and possibly level 2 if the chest pain had been taken as significant.

[Clinical Leader]:

Triage System:

I am aware of the ATS being the default triage system for Urgent Care clinics in New Zealand and I consider this to be a major failing of the standards and not the fault of [the clinic]. The ATS system has been developed and validated for Emergency Departments, not Urgent Care, who have a different population/case mix and different expectations of service from that population.

It has two roles within Emergency Departments — assessing acuity/assigning priority and as an audit tool for wait times. I submit that it is less than ideal for Urgent Care in both roles as it has insufficient discrimination in the categories 3,4,5 in the Urgent Care caseload and the waiting time performance cited (such as ATS 5–70% of patients within 120 minutes) would be unacceptable to fee for service clinics in New Zealand.

Furthermore it is often not used as designed as in this case where following the ATS the patient should have been ATS 3 (vomiting, looked unwell, unable to speak) — or ATS 2 if the pain reported (site not specified in triage note) was considered significant rather than 'dismissive'. I note [RN A] has not described the complaint of chest pain as 'dismissive' in her statement.

Closure of Notes:

In reviewing [RN F's] notes as far as I can tell the 1430–1445 notes were not saved until 15:13 and the 1526 notes until 1546, a nearly 30 minute delay and a 20 minute delay respectively.

In General:

The use of 'localised' and 'focal' chest pain descriptions is disingenuous — cardiac pain is known to radiate from the 'focal' position in the chest to adjacent areas, in particular arm, neck, back and abdomen. It should be noted that Diabetics are both at higher risk of ischaemic heart disease and more likely to have abnormal presentations. However chest pain radiating to the arms, back or abdomen is not an obscure presentation of myocardial infarction."

The following further advice was received from Dr Adams:

"19HDC00866/[Mrs B] Third Request for Advice:

For this I have modified the Second Advice to the Commissioner to reflect further information received on 22/01/2020. I stand by other opinions given previously below. **Changes in italics.**

I note that a Nurse Practitioner has now given advice on the Nursing component of this complaint, while a General Practitioner has commented for ACC and two Cardiologists have also commented — I think also for ACC. The opinion in this document is based only on 'Scenario B' — accounts of staff and relevant clinical notes.

[Dr C]:

Firstly let me re-iterate that my opinion was sought in two parts — one using the patient and the patient's husband's recollections and the other using the various notes and statements of the clinicians. I have however noted a few strong discrepancies where a clear majority are at variance with a minority of the other observers.

In this context I can only note the discrepancy between the Nurses' notes plus statements and those of the Doctors and find that chest pain, with or without radiation to the arms and abdomen was known to the Nurses from 1445 and not to the Doctors until 1835.

I cannot say why neither electronic notes nor verbal handover alerted [Dr C] from the information I have been supplied with as there are differences in individuals' statements on verbal handover. With respect to the departures from standards [Dr C's]

I would describe as mild to moderate — he failed to see chest pain in the nursing notes as he did not look. Whether he knew of the chest pain from the nursing handover is not clear. [RN F] cannot recall the detail of her verbal handover and [Dr C] says no *focal* chest pain was communicated. This discrepancy was critical to perhaps a 2 hour or more delay in definitive treatment. I have been asked to characterise any departures and 'moderate' seemed to me appropriate, partly as I cannot identify the root cause with any certainty. This ties in with the definitions in the Pegasus Incident Severity Assessment Table.

It should be noted that Diabetics are both at higher risk of ischaemic heart disease and more likely to have abnormal presentations. However chest pain radiating to the arms and abdomen is not an obscure presentation of myocardial infarction.

[Dr D]:

Firstly let me re-iterate that my opinion was sought in two parts — one using the patient and the patient's husband's recollections and the other using the various notes and statements of the clinicians. I have however noted a few strong discrepancies where a clear majority are at variance with a minority of the other observers.

I am now given to understand that [Dr D] was not aware of chest pain at any point during his management of [Mrs B]. However [Mrs B] claims to have said she had chest pain and [RN A's] notes have confirmed this. Whether she said this in the presence of [Dr D] is unclear but a failure to elicit a highly significant symptom in a patient who had previously reported it is a departure from standard of practice. It is true that patients frequently modify their history as a result of previous questioning by another healthcare worker but this seems unlikely in that [Mrs B] also told [RN F] of chest pain shortly afterwards.

Diabetics are both at higher risk of ischaemic heart disease — this patient was known to have elevated lipids and vascular disease — and more likely to have abnormal presentations so ischaemic heart disease should have been considered even if not included in the differential diagnosis.

With respect to later patient reports of chest pain to [RN F] I can only note the discrepancy between the Nurses' notes plus statements and those of the Doctors and find that chest pain, with or without radiation to the arms, back or abdomen was known to the Nurses from 1445 and not noted by the Doctors until 1835. I cannot say why this is from the information I have been supplied with as there are differences in individuals' statements, particularly on verbal handover.

It is also not clear if [Dr D] did view the nursing notes when he completed his notes at 1420, 1531 and 1538. Depending on configuration in some clinics the Nursing notes are visible in Medtech when Doctors' notes are completed and in others they are in another window that has to be opened separately.

[RN F]:

In reviewing [RN F's] notes again as far as I can tell the 1430–1445 notes were not saved until 15:13 and the 1526 notes until 1546, a lesser 30 minute delay and a 20 minute delay respectively than my original opinion. I am unable to say whether this might have made a difference by being visible to [Dr D] when he was in this patient's notes. (With the new information showing a smaller interval I would downgrade this to 'mild').

[RN A]:

The ATS level applied was clearly too light — level 3 should have been applied to a patient who was dry retching and possibly level 2 if the chest pain had been viewed as significant. *I am in agreement with NP Tomlin that Triage Category 4 was not correct on the symptoms recorded.*

Reception:

With respect to the phone call to reception any clinically important information (such as [Mr B] saying his wife was having a heart attack) could also have been passed to clinical staff — there is a facility in Medtech32 to do this that does not open the notes. Unfortunately there is no record of the phone call by [the clinic] to show what was received.

[Clinical Leader]:

Triage System:
I am aware of the ATS being the default triage system for Urgent Care clinics in New Zealand and I consider this to be a major failing of the standards and not the fault of [the clinic]. The ATS system has been developed and validated for Emergency Departments, not Urgent Care, who have a different population/case mix and different expectations of service from that population.

It has two roles within Emergency Departments — assessing acuity/assigning priority and as an audit tool for wait times. I submit that it is less than ideal for Urgent Care in both roles as it has insufficient discrimination in the categories 3,4,5 in the Urgent Care caseload and the waiting time performance cited (such as ATS 5 — 70% of patients within 120 minutes) would be unacceptable to fee for service clinics in New Zealand.

Furthermore it is often not used as designed as in this case where following the ATS the patient should have been ATS 3 (vomiting, looked unwell, unable to speak) — or ATS 2 if the pain reported (site not specified in triage note) was considered significant rather than 'dismissive'. I note [RN A] has not described the complaint of chest pain as 'dismissive' in her statement.

Closure of Notes:
In reviewing [RN F's] notes as far as I can tell the 1430–1445 notes were not saved until 15:13 and the 1526 notes until 1546, a nearly 30 minute delay and a 20 minute delay respectively. (With the new information showing a smaller interval I would downgrade this to 'mild').

In General:
The use of 'localised' and 'focal' chest pain descriptions is disingenuous — cardiac pain is known to radiate from the 'focal' position in the chest to adjacent areas, in particular arm, neck, back and abdomen. It should be noted that Diabetics are both at higher risk of ischaemic heart disease and more likely to have abnormal presentations. However chest pain radiating to the arms, back or abdomen is not an obscure presentation of myocardial infarction.

With respect to [the Clinical Leader's] further information of 18/12/2020:

Paragraph 34–36: Although it may not be industry standard clinics do record incoming calls — the chain of clinics I work for does so and the technology is widely available.

Paragraph 45: [The Clinical Leader's] statement that he does not see any problems with co-ordination of nursing and medical staff ignores the fact that the nurses knew of chest pain from 1445 but the Doctors did not until 1835. Due to differing accounts from each group it is not clear whether this can be laid entirely at the feet of the Doctors (who should have elicited this by questioning or seen this in the nursing notes) or whether inadequate verbal communication by the Nurses was also partly to blame.

Paragraph 52: I have modified this document in keeping with this new information.

Paragraph 63–67: One cardiologist has raised the possibility that the Myocardial Infarction was an event that occurred later during [Mrs B's] stay and I also had considered this a possible scenario but I think that, while only a Chemical Pathologist in concert with a Cardiologist might be able to make an estimate of the time of onset of cardiac injury on the basis of the pattern of cardiac changes on ECG and in serial Troponin samples, the existence of chest pain at presentation must be taken seriously.

Paragraph 68: I understand Dr … referred to the presentation as atypical however it should be noted that 'Atypical Chest Pain' pathways include rule out of cardiac origin.

Stephen Adams BHB, MBChB, DAFARCS, DCEM, FRNZCUC"

Appendix B: Independent nursing advice to Commissioner

The following expert advice was obtained from Nurse Practitioner Fay Tomlin:

"Independent Advisor Report

I have been asked to provide an opinion to the Commissioner on case number 19HDC00866, I have read and agree to follow the Guidelines for Independent Advisors (Office of the Health and Disability Commissioner, 2019). I am not aware of any conflicts of interest.

I am a Nurse Practitioner working in a DHB Emergency Department for more than four years, I previously managed an Accident and Medical department in New Zealand (2012–14) and a large Urgent Care Centre in the UK from 2006–2012, the last two years of which I was the Matron of Urgent Care Services. My qualifications include an MSc in Advanced Clinical Healthcare Practice, Bachelor (Hons) of Nursing and Bachelor (Hons) of Midwifery and various post-graduate diplomas and relevant advanced clinical skills courses. I have written numerous guidelines and policies around the subject area of triage, vital signs and clinical observations within an urgent/unscheduled/emergency care environment. I regularly mentor and provide clinical supervision to Nurse Practitioner Interns, post-graduate Registered Nurses and under-graduate student nurses in a variety of clinical settings, including emergency departments and primary health care clinics as well having done so at the Urgent Care Centre. I believe I have the relevant experience and qualifications to be able to provide my opinion and compile a report on the nursing care provided to [Mrs B] in case number 19HDC00866.

My instructions from the Commissioner were as follows:

Review the documentation and advise whether you consider the care provided to [Mrs B] by Pegasus Heath and the following nurses was reasonable in the circumstances, and why. In particular, please comment on:

1. The adequacy of the nursing care provided to [Mrs B] at Pegasus Health:
2. The appropriateness of the care provided by:
    1. [RN A];
    2. [RN F];
    3. [RN G];
    4. [RN E]
3. The appropriateness of the coordination of care and communication in relation to [Mrs B's] care between staff on this day;
4. Whether issues identified by you (if any) were due to systemic issues at Pegasus Health or whether it was more attributable to an individual or both. If there are any systemic issues, please elaborate on these with reference to how other urgent care clinics operate in this area.
5. The appropriateness of the training provided by Pegasus Health to its staff.

6. The appropriateness of the relevant Pegasus Health's policies provided.
7. Any other matters in this case that you consider warrant comment.

For each question, please advise:

1. What is the standard of care/accepted practice?
2. If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?
3. How would it be viewed by your peers?
4. Recommendations for improvement that may help to prevent a similar occurrence in future.

If you note that there are different versions of events in the information provided, please provide your advice in the alternative. For example, whether the care was appropriate based on scenario (a), and whether it was appropriate based on scenario (b).

List of all sources of information reviewed

1. Letter of complaint dated 30 April 2019;
2. Pegasus Health's response dated 14 June 2019 including its attachments:
   a. Pegasus Health's response to [Mrs B] dated 12 September 2018;
   b. Clinical records from Pegasus Health covering the care provided to [Mrs B] on 2 September 2017;
   c. Pegasus Health's internal audit of [Mrs B's] care (C735);
   d. Pegasus Health's early warning policy and procedure;
   e. Pegasus Health's clinical guideline on observation, monitoring, extended treatment;
   f. Pegasus Health's policies; version 4.0 and version 7.0.
   g. Other attachments
3. Email from Pegasus Health dated 2 October 2019;
4. Email from Pegasus Health dated 11 October 2019;
5. Email from Pegasus Health dated 19 October 2019 and its attachments including audit log and lab results;
6. Email from Pegasus Health dated 17 October and 24 October 2019;
7. Response from Pegasus Health dated 5 June 2020, including:
   a. Statement from [Dr C];
   b. Statement from [Dr D];
   c. Statement from [RN G];
   d. Statement from [RN A];
   e. Statement from [RN F];
   f. Statement from [RN E];
   g. Other attachments including relevant policies and training records.
8. Statement from [Mrs B's] usual GP [Dr I] dated 22 June 2020 which included
   a. Consultation notes from 1st Sept 2017 by [Dr I]

b. Consultation notes from 1st Sept 2017 by [nurse]
c. Acute Demand Referral document dated 4th Sept 2017 by [Dr I]

9. Two audio recordings from [telehealth service] about the call [Mr B] made to Pegasus Health prior to his [and his wife's] arrival on the 2nd Sept 2017

In addition I asked the investigator … if there was a recording of the conversation between [Mr B] and the receptionist from [the clinic] (in addition to the two received recordings). It was confirmed there is no recording and a statement from [the receptionist] was provided (dated 8 July 2020).

Brief factual summary of events:

On Saturday 2 September 2017 [Mr B] phoned his wife's General Practitioner advising her that [Mrs B] had pain and vomiting in what was initially suspected to be an adverse reaction to metronidazole. [Mr B] was advised to take [Mrs B] to [the clinic] to receive further care.

[Mr and Mrs B] presented at [the clinic] at 13:41 and [Mrs B] saw two doctors and was attended to by [RN A], [RN F], [RN G] and [RN E]. [Mrs B] alleged that she emphasised to all staff that she was having chest pain and wanted an ECG done. However, staff deny that they were told that [Mrs B] had chest pain specifically and that she wanted an ECG to be conducted.

At 18:38 the first ECG was performed, results being consistent with an ST elevation myocardial infarction (STEMI). An ambulance was called at 19:00 which arrived at 19:20 to transfer [Mrs B] to hospital.

1. The adequacy of the nursing care provided to [Mrs B] at Pegasus Health

1.1 What is the standard of care/accepted practice?

The standard of care for anyone presenting to an urgent care clinic is to be triaged by a suitably trained RN following RNZCUC/ACEM guidelines. It is acknowledged that the Australasian Triage Score (ATS) was developed for use in Emergency Departments but as there are no specific guidelines for primary care or urgent care, it is accepted and common practice for this tool to be used in other clinical settings (Urgent Care Standard, 2015).

Triaging involves recording some vital signs i.e. heart rate and respiratory rate, as well as recording the history of the presenting complaint and subjective data like a pain score (CENNZ, 2018).

Depending on the ATS figure, the patient can expect to commence medial assessment and treatment within an appropriate time frame i.e. ATS 1 = immediately, ATS 2 = 10 mins, ATS 3 = 30 mins, ATS 4 = 60 mins and ATS 5 = 2 hrs.

If the patient's condition changes i.e. worsens or improves whilst awaiting that next clinical assessment the triage nurse is responsible for repeating the ATS as necessary

and adjusting the score according to clinical indications (increased pain, new symptoms, change in vital signs); this can be an increase or decrease in the ATS figure.

The triage nurse has the role of placing the patient in whatever part of the clinical setting they feel is most appropriate whilst awaiting that next clinical assessment i.e. they can be returned to a waiting room, seated in a minors area, moved to a majors (treatment bay) area for example if they need to lie on a couch or straight into a resuscitation bay and handed over to colleagues.

It is common practice for the triage nurse to bring the patient into the department and inform a senior clinician i.e. nurse in charge, doctor (Dr) or nurse practitioner (NP) if the patient is ATS 2 so that the target of reviewing in 10 minutes can occur. Often in this instance the receiving RN working in that clinical zone (if he/she is adequately experienced) will start some diagnostic interventions in anticipation of what the reviewing clinician (Dr or NP) will want ordered i.e. repeating the triage nurse's baseline vital signs, recording a blood pressure, performing venepuncture or inserting an intravenous cannula for blood tests, recording an Echo Cardio Gram (ECG), facilitating collecting a urine specimen, reassessing pain score and providing these additional details to the reviewing clinician as well as documenting them in the patient's notes.

It is standard practice for the receiving nurse (also called primary nurse or named nurse) caring for a particular patient or clinical area to record regular vital signs and make contemporaneous notes and to report any changes or concerns (physiological or clinical) to the reviewing clinician (Dr or NP).

Pain scoring is commonly recorded as a figure between 0–10 (10/10 being the most severe pain) with an adult who can speak. We will document the number they give us following our explanation of what zero is and what 10 is. (It is adapted accordingly for those who cannot speak i.e. children or dementia patients.)

It is part of the RN's role to be an advocate for their patient i.e. if a patient is asking for an ECG or stating they have (cardiac sounding) chest pain, Principle 3 within our Code of Conduct (2012) states that we are to 'work in partnership with health consumers to promote and protect their wellbeing'. It would be common practice in this situation for a RN to acknowledge a request for an ECG and to either record an ECG or explain and document as to why it was not an appropriate/necessary investigation. A RN does not have to wait for a doctor or NP's request to undertake such an investigation. The RN would not be expected to interpret the recording unless they have undertaken additional education to do so, he/she would be expected to present the recording (labelled with patient's name, date/time etc) to the reviewing clinician in a timely manner.

Reviewing the documents/recordings provided the facts are:

- [Mr B] phoned ahead of their arrival to [the clinic] and was transferred from [the telehealth service] to the [clinic receptionist]. [Mr B] enquired if [Dr I] (his wife's GP) had called ahead, there was no mention of chest pain during this conversation. The

conversation between the [clinic] receptionist and [Mr B] was not recorded as Pegasus Health do not record their telephone conversations. The receptionist's statement (dated 08.07.20) states she is unable to remember this call, therefore I am not able to confirm nor refute if [Mr B] mentioned 'chest pain' or 'heart attack' to the receptionist.

- [Mrs B] was registered as arriving at [the clinic] at 13:41 and was triaged by [RN A] at 13:44 as documented on the handwritten clinical notes. Nausea was the presenting complaint, arm, chest and back pain were listed in the narrative section of the triage notes, the pain score section was left blank, the ATS score = 4. In the electronic clinical record triage was time stamped at 13:47 and had additional details 'looks unwell, unable to speak, declining analgesia as vomiting' …
- In [RN A's] statement she details how she was aware [Mrs B] would be coming in as reception had received a call from her GP saying she had been seen three times by them with nausea and diarrhoea possibly linked to metronidazole, and that [Mrs B] walked into reception. In [Mr and Mrs B's] complaint letter (30.04.19) they state they 'were met with a wheelchair'. I cannot reconcile these different accounts.
- Repeat vital signs at (02:30) presume the nurse (different signature to [RN A]) meant PM/14:30, again the pain score was left blank.
- There are regular nursing notes documented approximately every 30 minutes between 15:00 and 16:25 consistently saying that [Mrs B] had back/chest pain scoring 8/10 and that the plan was to discuss her pain with the doctor.
- Between 14:50 and 16:30 vital signs are regularly recorded on the adult observation chart (each entry initialled by an RN) again confirming persisting severe pain score of 8/10 and aligning these recordings with the morphine administration at 14:38 onwards as it was titrated (frequent small amounts — usual aim to get pain score to reduce sufficiently and safely i.e. ensure respiration rate doesn't drop under 10 breaths per minutes as respiratory depression is a common side effect of morphine) 2.5mg each dose at 15:00 & 16:25 — or 13:38 — the documentation is a little muddled due to lack of space on the form I suspect.
- [RN F's] … last entry in the narrative notes is at 16:25 and vital signs recorded at 16:30. [RN F's] shift finished at 17:00 and handover of care was to [RN E] …
- In [RN F's] statement (dated 07.05.20) she states that she cannot remember the conversation with [Dr D] at 15:00 nor details of the handover to the next shift. [RN F] clearly documents that she was not asked to perform an ECG by [Mr B] or [Mrs B], nor the doctor, nor that she felt it was needed as [Mrs B] was there due to adverse reaction following an antibiotic. [RN F] states she is competent and would be willing to record an ECG if it was needed or a patient requested it.
- There appears to be a gap in the notes until [RN E] documents vital signs at 17:30 and narrative notes at 17:37 'still states pain on arms, chest and back 8/10'.

There is no documentation after this until another RN ([RN G]) documents vital signs and pain score as 9/10 and has written retrospective narrative notes at 19:25 explaining

how she was called over by [Mr B] and alerted to increase in pain and nausea. In her revised statement (dated 07.05.20) [RN G] details how she informed the Dr … of [Mrs B's] increased nausea and subsequently picked up the ECG order request and was told of the chest pain radiating through to her back and arms 'experiencing such pain throughout the day' by [Mrs B] as preparing to record the ECG then identified the ST elevation as it was being recorded (18:38).

1.2 If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

In my opinion, based on the details above, it appears that the ATS is lower than expected (4 rather than 3) for someone who has persistent vomiting and/or perceived non-cardiac chest pain. This means [Mrs B] was potentially delayed in seeing the reviewing clinician (i.e. target of 60 minutes could have been reduced to 30 minutes). [Mrs B] waited 54 mins for her first dose of morphine for her severe pain. Some of this time period would have including the medication being charted by the Dr, getting venous access (on the second attempt) and the time taken for two RNs to document the removal of the medication from the controlled drug cupboard. I consider this to be a moderate departure from the standard of care.

If the scenario is as in [Mr and Mrs B's] complaint letter (dated 30.04.19) that they complained of 'severe chest pain', 'having a heart attack' and 'excruciating 10/10 pain' via phone call to receptionist prior to arrival, during the triage process and or during subsequent clinical discussions with any of the RNs, then in my view this would be a serious departure from accepted practice. It is normal practice for the ATS to be scored (or modified to be scored) as a 2 and as detailed above clinical review to be commenced within 10 minutes which would include an ECG recording.

1.3 How would it be viewed by your peers?

Triage nurses working in an unscheduled urgent care environment do take information from colleagues (receptionists/messages from GP) as well as the subjective and objective information in front of them to make a rapid decision as to the maximum clinically appropriate waiting time. I believe my triaging peers would vary in their response of choosing a category number 3 or 4. ATS 4 for a patient that has already been to the GP 2 or 3 times with what was perceived to be the same problem versus ATS 3 for severe pain/persisting vomiting. I do not believe any triage nurse would have identified a cardiac sounding chest pain (ATS 2) at the point of triage with the information given in this case by [RN A].

However, if the details provided in [Mrs B's] complaint letter are true then ATS 2 is entirely appropriate and commonly used to highlight and expedite medical care and investigations for such patients.

The fact that [Mrs B's] pain was consistently measured as 8/10 (I presume this is her choice of number although in her complaint letter she states it was 10/10) for nearly four hours despite titrating morphine (total 10mg which isn't a large dose) is concerning and we would hope that the nurses looking after her did have the discussions with the

reviewing doctor that they documented they were planning to. When nurses talk about pain we are used to asking the patient to describe its nature, location, duration, worsening/relieving factors — this helps us and our medical colleagues understand the potential cause i.e. muscular or cardiac or other.

1.4 Recommendations for improvement that may help to prevent a similar occurrence in future.

Pegasus Health could consider recording their telephone conversations to help protect both staff and patients from situations like this where recollections of events/conversations vary.

2. The appropriateness of the care provided by:

[RN A]:

2.1.1 What is the standard of care/accepted practice?

In summary [RN A] provided a timely triage assessment (commenced within 3 minutes), however, it could be argued that an ATS of 3 would be more clinically appropriate than an ATS of 4 for [Mrs B's] pain and other symptoms in (scenario a). [RN A's] recollection of events and the triage documentation should have included a pain score and respiratory rate. An ATS of 2 would be accepted practice if we follow the information given by [Mr and Mrs B] (scenario b). [RN A] had the opportunity to re-triage [Mrs B] after approximately 50 minutes into her wait in the waiting room ([Mr B] approached the triage desk on his wife's behalf saying she had increasing nausea and vomiting). The ATS was not amended at this point nor [RN A's] actions documented in the narrative electronic or hand written notes, however [Mrs B] was appropriately moved into a treatment bay for further assessment by the receiving nurse at 14:30 and had repeat of vital signs recorded and received intravenous medications (antiemetic at 14:35 and morphine at 14:38). The triage training provided by Pegasus Health is discussed later in section 5.

2.1.2 If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

I consider this to be either (in scenario a) a minor departure from standard of care at the initial point of triage due to lack of clinical detailing (pain score, respiratory rate documentation) to support her ATS (figure) selection. Or a severe departure (in scenario b) from the standard of care at the initial point of triage if [Mrs B] (via her husband or message from the receptionist) stated 'severe chest pain', 'heart attack', '10/10 chest pain'. I consider that a minor departure of standard of care occurred for not contemporaneously documenting the reason for the move from the waiting room to the treatment area for increased nausea/vomiting.

2.1.3 How would it be viewed by your peers?

I believe my triage nursing peers would agree with my suggestion that, in scenario a, an ATS of 3 would be most clinically appropriate. I believe my peers would agree with [RN A's] actions of moving [Mrs B] into a treatment bay due to persisting vomiting and pain,

I am unaware of the availability of a vacant clinical space upon [Mrs B's] initial triage (at 13:44) or if the department was full and space only became available at 14:30.

2.1.4 Recommendations for improvement that may help to prevent a similar occurrence in future.

I would expect that [RN A] has already reflected upon her actions that day and now realises the importance of thorough documentation (hand written/electronic). [The Clinical Leader] in their response to HDC (05.06.20) states that since 2016 there is a quarterly triage audit and these are reviewed and fed back to triage nurses. I have no further recommendations for how this can be improved as the system is now there to enable such documentation and review of that documentation.

[RN F]:

2.2.1 What is the standard of care/accepted practice?

[RN F] worked with another RN to check and administer [Mrs B's] initial intravenous medications and repeat vital signs monitoring when she came into the treatment bay area (14:30) and before and after the medications. [RN F] correctly documents all the elements on the Adult Observation Chart and electronically makes regular notes between 14:45 and 16:25, her shift finished at 17:00. There are some minor discrepancies between the timings on the electronic record and her timings given within her statement. [RN F] repeatedly writes 8/10 pain and documents her plan/intentions to discuss pain with [Dr D] and subsequently [Dr D] and [Dr C] over this 1hr 35 min time period. Providing [RN F] did have these conversations with the appropriate clinicians at the time of making her observations of ineffective pain relief this is an entirely appropriate standard of care.

In her statement (dated 07.5.20) [RN F] states she cannot recall the details of the conversation with [Dr D] at 15:00 nor the handover at the change of nursing shift.

2.2.2 If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

In the scenario that [RN F] did update the clinician(s) at the time of her observations and clinical notes then there is no departure from the standard of care. However [RN F] should have then documented the doctor's response to her updates and because this is omitted this constitutes a moderate departure from the required standard of documentation. In the scenario that [RN F] did not speak with the doctors and advocate for the severe pain and ineffective analgesia on behalf of her patient then this would be a serious departure from accepted practice and Principle 3 of our Code of Conduct as detailed earlier.

2.2.3 How would it be viewed by your peers?

I believe my urgent care peers would be satisfied with the frequency of observations (vital sign recording) and electronic documentation by [RN F]. As nurses we are all mindful that 'if it's not written down it didn't happen' mantra that is instilled in us during

our training and this is demonstrated in this scenario when 3 years later it is understandable that the nurse cannot recall specific conversations and the unfortunate ambiguity this leads to when reviewing the notes some time later.

2.2.4 Recommendations for improvement that may help to prevent a similar occurrence in future.

Audit of nursing notes/clinical documentation is useful to highlight these gaps if fed back to the nurses involved as a learning opportunity.

[RN G]:

2.3.1 What is the standard of care/accepted practice?

It appears in her contemporaneous notes and subsequent statement that [RN G] was not the main nurse responsible for [Mrs B's] care that afternoon, she was called over by [Mr B] when he informed her of his wife's increasing nausea and request for antiemetic and appropriately and promptly acted on that by informing the doctor. [RN G] also picked up the doctor's request for an ECG to be recorded and identified during this recording that there was a problem (ST elevation) and promptly brought this to the doctor's attention. Tasks like this are usually undertaken by the patient's own nurse unless they are not deemed competent in the particular task, or if they are busy with another patient in their care, or on a rest break in which case another RN will pick it up. I presume [RN G] is competent to undertake this advanced assessment and therefore she provided appropriate high quality nursing care and documentation required in the absence of the patient's primary (named) nurse.

2.3.2 If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

There has been no departure from the standard of care by [RN G].

2.3.3 How would it be viewed by your peers?

I believe my peers would be in agreement.

2.3.4 Recommendations for improvement that may help to prevent a similar occurrence in future.

[RN G's] notes could be (anonymised) shared as an example of good documentation to her peers.

[RN E]:

2.4.1 What is the standard of care/accepted practice?

[RN E] started his afternoon shift at 15:45 and took over [Mrs B's] care from his RN colleague at 17:00; it is standard practice when you receive verbal handover of your patient(s) that you go around and meet them, introduce yourself, check observations and medications etc are all up to date. At 17:30 [RN E] documented a set of vital signs and electronically wrote a set of notes at 17:37. This confirms his understanding that

[Mrs B's] plan of care was to await the blood results and continue monitoring nausea and pain. It is likely he had more than just [Mrs B] to care for so the timing of his review and observation notes are acceptable. It appears in the documentation that [Mrs B] received four titrated 2.5mg IV morphine doses between 14:45 and 15:36 so it should have been a concern to [RN E] that at 17:30 her pain score of 8/10 with no further pain relief charted that he could administer to relieve her pain. [RN E] makes no further vital sign observations on the chart or any further electronic nursing notes.

2.4.2 If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

As mentioned before under our Code of Conduct (2012) we work in partnership and advocate for the wellbeing of our patients, so documenting a pain score of 8/10 and not acting on it (or not documenting any action on it) I consider to be a moderate (or minor) departure from accepted practice of nursing care.

2.4.3 How would it be viewed by your peers?

The gap in the observation of vital signs of nothing being charted between 17:30 and 19:00 is concerning for someone that had pain scored 8/10 at 17:30 (I appreciate heart and respiratory rate and temperature all appear stable). We can only speculate as to the reason for this i.e. [RN E] being busy managing other patients, or possibly [Dr C] was with [Mrs B] for a period of time within that time frame ([electronic signature] wrote electronic notes at 18:35) and the ECG has the time 18:38 printed on it suggesting that the RN recording it was present before recording other observations at 19:00.

2.4.4 Recommendations for improvement that may help to prevent a similar occurrence in future.

Audit of nursing notes/clinical documentation is useful to highlight these gaps if fed back to the nurses involved as a learning opportunity.

3. The appropriateness of the coordination of care and communication in relation to [Mrs B's] care between staff on this day;

3.1 What is the standard of care/accepted practice?

It is accepted practice for the nurses and doctors providing care to a patient in an urgent care setting to communicate verbally and non-verbally with each other, for example use a white board listing orders/tasks or reading each other's electronic/paper notes as well as directly talking to each other and reporting findings and revising the plan of care.

The second review of [Mrs B] by the triage nurse expedited her move into the treatment bay and whilst I have made comments about the initial low ATS (4) and lack of documentation at the second review point, it does appear that communication occurred between the nursing staff and the doctor as she was promptly seen at arrival to the treatment bay by [Dr D] (14:30), this is within the 60 minute target.

The observations recorded on paper notes (initial hand written triage notes and the adult observation charts) have limited space for writing and signing of entries — initials

are used to confirm what staff member recorded the vital signs or gave the medication. There appears to be no space to correlate or match initials with a full name. I have noted that Pegasus have since moved from a paper based system to a chartless electronic system according to the HDC responses provided by their Clinical Director on 05.06.20.

As detailed in [the clinic's] own Clinical guideline for observation, monitoring, extended treatment (2017) it is stated that:

> 'Progress notes: both the doctor and nurse perform and document regular progress assessments and recommendations.' and
>
> 'On Transfer between staff: both doctors and nurses use the iSoBAR guide when handing over patients.'

In this case no clinician appears to have documented their use of the iSoBAR tool (acronym for Identify, Situation, Observations, Background, Agreed plan, Read back) which has been common practice for over a decade for standardising communication and improving shift to shift clinical handover (Porteous *et al.* 2009).

[RN F] and [RN A] used SOAP (acronym for Situation, Observation, Action, Plan) in their electronic narrative notes which provided a structured approach and makes reading notes easier for subsequent clinicians. [Other RNs] used a less structured approach but still recorded their subjective and objective observations and plan of care. As mentioned earlier I believe their documentation would have been of a better standard if they had recorded the responses from the doctors if/when they presented their observations especially in regards to [Mrs B's] pain.

3.2 If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

In scenario a (as per all clinicians' statements no request for ECG recording by [Mr or Mrs B] and so specific mention of chest pain) I consider there has been a minor departure from the standard of nursing care in that regular observations recordings and regular progress notes were made however the iSoBAR tool doesn't appear to have been documented as used at shift hand over. The clinical guideline for observation, monitoring and extended treatment, which states the iSoBAR should be used was written in May 2017, it also states that 'A specific form has been developed to assist with this and to ensure accurate transfer of care (in the near future this process will use an electronic hand over tool)'. There was no evidence of a specific form or electronic hand-over tool being used in [Mrs B's] case (September 2017). I am unable to confirm if this is an individual clinician's omission to use this paper or electronic tool or more of a system failure by Pegasus Health in that it was not yet available some four months later.

In scenario b (as per [Mr and Mrs B's] complaint letter) stating that they repeatedly mentioned severe chest pain and requested for an ECG to be recorded, then this would

constitute a severe departure from standard of coordination of care and communication about her health status by each nurse that they said those words to.

3.3 How would it be viewed by your peers?

I believe my peers would acknowledge that it is common for more than one nurse to look after a patient over a five hour period in an emergency or urgent care setting. We frequently rely on verbal hand overs and support each other when there are often conflicting demands on a nurse i.e. when you are assigned to multiple patients concurrently. It is also not unusual to have to read the patient's progress notes if their named nurse is not immediately available. We as nurses appreciate the importance of our documentation to ensure our patients are safe, vital signs recorded, diagnostic tasks (doctors' orders) are up to date so patients get the required care they need. I believe my peers would agree that there are some minor departures of standard of care i.e. not documenting the doctors' response when advised re inadequate pain relief but otherwise there seem appropriate coordination of care and communication between staff on that day based on their contemporaneous notes and retrospective statements.

None of my peers would be able to reconcile the difference between the complaint letter from [Mr and Mrs B] and the statements from all the clinicians involved regarding the request for an ECG recording or not.

3.4 Recommendations for improvement that may help to prevent a similar occurrence in future.

The Clinical Leader in their response to HDC (05.06.20) states that they have since updated their triage policy and moved to a chartless system which sounds appropriate. I would hope that they have also moved to an electronic iSoBAR hand over tool as per the plan detailed in their Clinical guideline for observation, monitoring, extended treatment (2017). A clear and structured handover between staff should highlight any concerns for the next shift i.e. need for review of pain/analgesia needs not being met which may prompt further investigation/expedite clinical review for the incoming shift.

4. Whether issues identified by you (if any) was due to systemic issues at Pegasus Health or whether it was more attributable to an individual or both. If there are any systemic issues, please elaborate on these with reference to how other urgent care clinics operate in this area.

I have not identified any major systemic issues at Pegasus Health. My comments have been more focussed on the individual RNs and the minor/moderate departures relating to their documentation, or in scenario b — severe departure relating to the individuals concerned.

The only small systemic issue I have mentioned is in regard to not recording incoming receptionist calls and I suggest this is something that [the clinic] may like to consider in the future. I am unable to comment at this time if this is something that other urgent care clinics in New Zealand do. We did record all incoming calls in the UCC that I worked

in over in the UK and it was something we regularly used for teaching/reflection purposes for both clinicians and our reception staff.

5. The appropriateness of the training provided by Pegasus Health to its staff.

5.1 What is the standard of care/accepted practice?

According to the Onboarding documents supplied, it is unclear if the four RNs had specific introduction to Pegasus policies and guidelines relating to triage, observations, early warning score, or acute chest pain. It isn't practical for an employer to list all the current policies you should read as a new employee but as registered health professionals it is accepted practice that you find out where they are all kept on the internal computer system and are responsible for making sure you are aware/ understand the contents of the documents that relate to your clinical area of practice.

It is unclear if Pegasus Health do their own 'formal' triage training or rely on external providers like the NZNO's CEENZ (College of Emergency Nurses New Zealand) national triage course. [RN A's] onboarding document is dated 2016, it is not explicit within this document or her statement as to when or where she completed a formal triage course. It is my understanding that you only need to undertake the CENNZ formal course once and after that you are encouraged to audit/peer review this type of advanced role as part of your ongoing professional development if it remains part of your clinical duties. It is common practice to share copies of certificates (paper or electronic) of advanced practice like triage with your employer (usually the clinical nurse manager would hold this information in your personal file) if you gained that certificate with a previous employer. NZNO have a data base for the past four years listing the RNs that have completed this course, prior to that the data is very sketchy according to the current course administrator that I have contacted. There is no absolute rule that you have to undertake the National course and some clinical areas do their own course and not all areas make it mandatory.

5.2 If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

If [RN A] has not undertaken a 'formal' triage course then this would be a serious departure from her employer's clinical triage policy, the Urgent Care Standard (2015) and accepted practice regarding undertaking this advanced senior nursing role.

5.3 How would it be viewed by your peers?

The NZNO's CEENZ is the only National Triage course provider, traditionally it was for emergency nurses but they have recently seen an increased number of nurses from the private sector i.e. Medical 'A & M's and GP practices. CEENZ utilize and teach the ATS (Australian Triage Score). I would suggest that this is regarded as the gold standard of triaging and triage training.

5.4 Recommendations for improvement that may help to prevent a similar occurrence in future.

I would suggest that it is appropriate that Pegasus Health's Nursing Staff undertake the CEENZ's national triage course (if they don't already do so) which would be in alignment with their DHB colleagues' training and is regarded as the emergency/urgent care standard.

6. The appropriateness of the relevant Pegasus Health policies provided.

6.1 What is the standard of care/accepted practice?

I assume (but have not verified) that Pegasus Health has endorsed certification to the Urgent Care Standard (2015), therefore they would have had to demonstrate robust urgent care processes within appropriate clinic facilities and demonstrate safe and quality outcomes for its service users.

Pegasus Health has provided two triage policies. One has the footnote 'version 4. Review date Oct 2016' so would have been the current version at the time of [Mrs B's] attendance. The other has the footnote 'Version 7. Review date Oct 2019' so is the current policy. Pegasus Health appear to regularly review their triage policy and having read both they appear appropriate. It is unclear what they regard as 'formal' triage training and who provides this.

The Clinical Guideline for Observation, Monitoring, and/or Extended Treatment provided was last reviewed in May 2017 and says 'due next review May 2019'. I believe this clinical guideline to be essentially appropriate, however it is a little vague in that 'observations must be undertaken at a minimum of 2 hourly intervals, and more frequently if appropriate'. I have not seen a copy of the revised 2019/2020 current document so I am unable to comment if the changes to the iSoBAR electronic tool have since come into being as alluded to in the 2017 version.

The Early Warning Score (EWS) Policy and Procedure (2019) appears to be a more recent document, it is not mentioned in the Clinical Guideline for Observation, Monitoring and or Extended Treatment (2017). The EWS document correctly identifies the importance of documenting vital signs consistently so that the trends can be easily recognised and assessed accurately. It is also entirely appropriate that they highlight the value of respiration rate as the first of the vital signs to deviate from normal range in the early stages of physical deterioration. This EWS document was not available at the time of [Mrs B's] attendance in 2017, however, respiratory rate was consistently documented on the Adult Observation Chart from 14:50 up until and including 17:30 then there is a gap until 19:00 which is after 18:38 when the ST changes on [Mrs B's] ECG were noted. It is not my place to say if observations had been recorded at 18:00 whether this would have led to slightly earlier identification of [Mrs B's] cardiac condition.

Pegasus provided a copy of their Consult and Documentation Policy (dated June 2018); this details 'The complete medical record may be formed by information gathered by both the nursing and medical team members, eg triage, nurse assessment, doctor

assessment, nurse treatment. All new Medical Officer contracts have a notes review at 3 and 6 months. All new Medical Officers have regular formal and informal notes review and case reviews in their supervision records.' I would suggest that it is accepted practice for this to happen for nursing staff too as part of their peer review professional development.

6.2 If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

At the time of the complaint this policy and clinical guidelines were within their planned review dates and appropriate.

6.3 How would it be viewed by your peers?

It is common practice for the current (most up to date) version of a guideline/policy/ or procedure to be available to all clinicians on an internal electronic database. At the time of this complaint the triage policy and clinical guideline regarding observation, monitoring and/or extended treatment were up to date.

6.4 Recommendations for improvement that may help to prevent a similar occurrence in future.

I would recommend that RNs have their documentation peer reviewed or reviewed by the clinical education or nurse clinical lead as part of their annual appraisal or professional development processes.

7. Any other matters in this case that you consider warrant comment.

None.

References:

College of Emergency Nurses New Zealand (2018) NZ Triage Course Pre-reading Workbook. 2nd Ed. New Zealand Nurses Organisation. Wellington

Nursing Council of New Zealand (2012) Code of Conduct https://www.nursingcouncil.org.nz/Public/Nursing/Code_of_Conduct/NCNZ/nursing-section/Code_of_Conduct.aspx accessed 17.07.20

Porteous J.M. *et al.* (2009) iSoBAR — a concept and handover checklist: the National Clinical Handover Initiative. Med J Aust. Jun 1 1:190(S11):S152–6

Urgent Care Standard (2015) https://rnzcuc.org.nz/clinic-accreditation/ucs/ accessed 17.07.20"

The following further advice was received from NP Tomlin:

"17 February 2021

Independent Advisor Report

I have been asked to provide further expert advice to the Health and Disability Commissioner on case number 19HDC00866, I have read and agree to follow the Guidelines for Independent Advisors (Office of the Health and Disability Commissioner, 2019). I am not aware of any conflicts of interest.

My qualifications and experience have already been provided in my initial Independent Advisor Report dated 22 July 2020.

I have reviewed the following new documents:

1. Further response from [the clinic] (Pegasus Health) dated 18 December 2020 and its appendices A–K.

The Commissioner has asked me to review the new documents and advise

1. Whether it caused me to amend the conclusion drawn in my initial advice, or make any additional comments.
2. Any further comments about the care provided by
   a. [RN A]
   b. [RN F]; and
   c. [RN E]
3. Any other matters in this case that I consider warrant comment.

1. I do not wish to amend the conclusions drawn in my initial advice however I am willing to provide additional comments to support my rationale for making the comments that I did about the care provided by [RN A] at the point of triage and [RN F's] and [RN E's] documentation in response to [the Clinical Leader's] comments.

I have read that [the Clinical Leader] respectfully disagrees with my conclusion that in scenario A (the clinicians' recollection of events) I categorised the selection of ATS category 4 instead of ATS 3 as a minor departure from the standards of care. [RN A] failed to record respiratory rate (RR) or a pain score, both of these signs could have supported her decision i.e. a medium or low pain score (6/10 or below) and an average RR could support a selection of triage category 4, but as they are both omitted I feel it is fair to conclude that there are minor departures in the standard of care. To clarify a little further, I am not referring specifically to chest (or cardiac sounding) pain — a pain score referring to generalised pain score of 7 or above would indicate an expedited review by an ATS category 3 or above. Another comment I would like to make is that [RN A] herself documented that the patient was 'unable to speak because of the nausea and retching' which would suggest the patient was in a more serious state of distress

than a T4 category clinically correlates with in my opinion. Therefore I stand by my original opinion that it is a minor departure from the standard of care.

Whilst I respectfully acknowledge that [the Clinical Leader] feels [RN F] has upheld the standard of medical records required by [the clinic] and the Urgent Care Standards 2015, I would like to point out that under our Nursing Council's Code of Conduct 2012, I believe that the lack of documentation of the doctor's response is a moderate departure from the required standard. It is clearly written under Principle Four — Maintain health consumer trust by providing safe and competent care; 'Keep clear and accurate records of the discussions you have, the assessments you make, the care and medicines you give, and how effective these have been'. (pg 21 of our Code of Conduct accessed via https://www.nursingcouncil.org.nz/Public/Nursing/Code_of_Conduct/NCNZ/nursing-section/Code_of_Conduct.aspx?hkey=7fe9d496-9c08-4004-8397-d98bd774ef1b)

I would kindly suggest that [RN F] and [RN E] refresh their awareness of the Nursing Council's Code of Conduct in relation to Principles 3 and 4 as we are not only judged under our employer's standards but also by the Nursing Council of New Zealand (our governing body's) standards. The Nursing Council advises us that the Code provides a yardstick for evaluating the conduct of nurses and whilst I appreciate that nurses work under concurrent pressures and time to document can be challenging, those few seconds or minutes taken to document (bullet points/summary is sufficient) outcomes of conversations with colleagues is as important as recording a vital sign like a temperature.

In summary, I stand by my original advice that [RN F's] lack of documentation is a moderate departure from the required standard of care. I also stand by my original advice that [RN E's] documentation of a pain score of 8/10 and not acting on it (or not documenting any action on it) I consider to be a moderate (or minor) departure from accepted practice of nursing care.

I was pleased to read that further thought has gone into the handover process at the [the clinic] due to the inconsistencies that this case has highlighted and that they intend to update the transfer of care policy and procedure.

There are no further matters that I feel warrant further discussion."

Appendix C: Royal College of New Zealand Urgent Care Standards

Royal New Zealand College of Urgent Care

RNZCUC

ROYAL NEW ZEALAND COLLEGE OF URGENT CARE

Urgent Care Standard 2015

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URGENT CARE STANDARD: 2015

Published by

Royal New Zealand College of Urgent Care

RNZCUC gratefully acknowledges the support and assistance of the following in developing this standard:

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1. Preface

1.1 Background

The urgent care standard (UCS) was developed by the Royal New Zealand College of Urgent Care (RNZCUC) using a committee of experts who provided a balanced representation of significantly-interested parties. RNZCUC owns the UCS and the urgent care certification scheme (UCSS) referred to herein.

The need for the set of generic urgent care standards was highlighted by individual service providers experiencing difficulties in meeting the varying requirements of RNZCUC and auditing agencies providing certification services to urgent care clinics. NZS 8151:2004 Accident and Medical Clinic Standard is no longer relevant because there have been significant changes in urgent care practice since 2004. In addition, quality management system standards have evolved during this time. The UCS captures these changes.

1.2 Urgent care standard

The UCS has been specifically designed by the urgent care sector for the urgent care sector. It is an outcome-based service standard and focuses on the key requirements for delivery of high-quality urgent care in an urgent care clinic, with reference made to management system requirements. Achieving RNZCUC –endorsed certification to the UCS is a rigorous undertaking that requires service providers to demonstrate robust urgent care processes within appropriate clinic facilities and to achieve safe and quality outcomes for service users.

1.3 Development of the urgent care standard

Development of a totally new and updated UCS was managed by RNZCUC and Health Audit NZ Ltd. Development involved consultation with significantly-interested parties including the Accident Compensation Corporation (ACC), urgent care clinics, RNZCGP, consumers of urgent care services, auditing agencies, iwi, Ministry of Health and District Health Boards. The development process was managed stepwise through the creation of UCS drafts, circulation to interested parties for feedback, testing of an UCS draft via trial audits in clinics, and review by the Joint Accreditation System of Australia and New Zealand (JAS-ANZ) prior to finalization and publication.

In parallel with the development of the UCS, an urgent care certification scheme (UCCS) was developed by RNZCUC. JAS-ANZ approval is pending. The UCCS is used by RNZCUC to manage the UCS audit and certification process.

1.4 Relationship to other requirements

Certain parliamentary acts and regulations apply to urgent care service providers. Organizations that fund urgent care services have contractual requirements to be met by urgent care service providers. When implementing the UCS, consideration should be given to relevant legislation and funding requirements.

1.5 Scope of the urgent care standard

RNZCUC defines urgent care as primary care services that are episodic, with a no-appointments system, covered by RNZCUC's training programme, and are delivered from a RNZCUC-approved urgent care facility. Key features that distinguish an urgent care clinic are the presence of x-ray on-site or within (covered) wheelchair distance and extended hours, typically at least 8am – 8pm seven days. Other services, such as general practice, radiology, orthopaedic surgery and plastic surgery, may be provided from an urgent care facility. These services are outside the scope of the UCS.

1.6 Certification to the urgent care standard

An urgent care service provider may seek RNZCUC-endorsed certification to the UCS via a JAS-ANZ accredited certification body or ISQua accredited certification body. RNZCUC-endorsed certification signifies that a service provider has met the requirements of the UCS. For further information regarding RNZCUC-endorsed certification, refer to the urgent care certification scheme (UCCS).

1.7 Urgent care standard framework

The urgent care standard (UCS) is divided into four parts:

Part One	Consumer Rights
Part Two	Organizational Management
Part Three	Service Provision
Part Four	Facilities and Environment

Each part has standards to be considered and met in order to achieve appropriate outcomes. The standards have criteria that, when met, are expected to result in the achievement of the outcome. The criteria requirements provide the basis for assessing levels of achievement or compliance.

Important Note

The urgent care standard (UCS) has generic criteria that are applicable to the provision of urgent care services in New Zealand. Some criteria have particular requirements that are stipulated as part of the urgent care certification scheme (UCCS). Particular requirements are subject to periodic review and amendment by RNZCUC. Particular requirements of the UCS are published on the RNZCUC web site, www.rnzcuc.org.nz/clinicaudits.aspx.

2. Definition of terms

The definitions listed are specific to the urgent care standard. Alternative definitions may be used by different service providers and funders and under legislation.

Adverse Event	An unplanned and untoward occurrence that has unwanted consequences for the quality and/or safety of the service provided. An adverse event can be an accident or an incident and may be clinical or non-clinical in nature.
Advocacy	Independent provision of information, advice and support to individual service users.
Assessment	Collection and interpretation of information with service user involvement to determine the individual's need for urgent care.
Audit	**A** systematic, independent and documented process for obtaining audit evidence and evaluating it objectively to determine the extent to which audit criteria are fulfilled. Internal audits are conducted by, or on behalf of, the organization. External audits are conducted by an independent auditing agency.
Competence	Demonstrated ability to apply knowledge and skills.
Complaint	An expression made by a service user, in verbal or written form, of dissatisfaction with an urgent care service.
Continual Improvement	Recurring activity to increase the ability to fulfil requirements.
Corrective Action	Action taken to eliminate the cause of a detected nonconformity or other undesirable situation.
Document	The action of writing down the details of a system, for example as a documented policy, procedure or work instruction. A document can be in hard copy or in electronic medium.
Environment	The setting within a clinic necessary to meet requirements for safe urgent care services of adequate quality.
Facilities	The infrastructure necessary to provide urgent care services including: clinic building, workspace and associated utilities; medical equipment and supplies; equipment for supporting services, both hardware and software.
Induction	Process to assist new personnel to obtain any site-specific skills and knowledge needed to perform tasks competently.

Management	Implementing and overseeing the policies and procedures determined by the governing body and coordinating the day-to-day service activities.
Nonconformity	Nonfulfillment of a requirement.
Outcome	In the context of the UCS, the result of the urgent care service provided to satisfy the standards within each part of the UCS.
Orientation	Familiarising personnel with the organization.
Personnel	The people who undertake activities within the urgent care service, including medical practitioners, nurses and administrators. Personnel can be employed by, or can be contracted to, the service provider organization.
Policy	An operational statement of intent that guides sound decision-making and results in action that is legal and consistent with the aims of the service.
Preventive Action	Action taken to eliminate the cause of a potential nonconformity or other undesirable potential situation.
Procedure	The actions necessary to implement a policy.
Process	Set of interrelated or interacting activities which transforms inputs into outputs.
Quality Management System	Management system to direct and control an organization with regard to quality.
Quality Plan	Document specifying which procedures and associated resources shall be applied, by whom and when, to a specific project, service, process or contract.
Record	Document stating results achieved or providing evidence of activities performed. A record can be in hard copy or in electronic medium.
Risk	The chance of something happening that may have an impact on objectives.
Service Provider	Organization accountable for the provision of urgent care services.
Service User	The patient, consumer or person receiving the services.
Standard	A grade or level of excellence, achievement or advancement, taken by general consent as a basis for comparison.

3. Urgent care standard

Part One Consumer Rights

Standard 1.1 Consumer rights

Outcome – Service users receive services in accordance with the Code of Health and Disability Services Consumers' Rights (the Code).

1.1.1 The service provider shall document policy and/or procedure that addresses how the requirements of the Code are met and how implementation of the Code shall be verified.

1.1.2 The service provider shall display and make available to service users information about the Code and about advocacy.

1.1.3 Service provider personnel shall be familiar with their obligations specified by the Code.

Standard 1.2 Service user information and communication

Outcome – Service users are kept informed, and enabled to give informed consent, through appropriate communication channels.

1.2.1 The service provider shall inform service users of their right to have a support person or chaperone present during a consultation.

1.2.2 Service provider personnel shall communicate in a manner appropriate to the needs of the service users, their family/whanau and any accompanying support person.

1.2.3 The service provider shall make available to service users, in a format and languages suited to the needs of the local community, information about services provided by the clinic, including associated costs. The service provider shall make available information about services provided within the local community.

1.2.4 The service provider shall define a process to access interpreters when needed for service users with limited English proficiency.

1.2.5 Service provider personnel shall give service users, or their legally designated representatives, full and frank information and practise open disclosure in a manner that is appropriate to the needs of the service user and family/whanau.

1.2.6 Service provider personnel shall communicate to service users, or their legally designated representatives, their choices with respect to treatment, in order to make an informed decision.

Standard 1.3 Complaints management

Outcome – Service users can access and use an effective complaints management system.

1.3.1 The service provider shall maintain a documented complaints management process that is displayed in a manner that is accessible to service users, responsive and complies with Right 10 of the Code. One of the service provider's personnel shall be designated as responsible for monitoring implementation of the complaints management process.

1.3.2 Service provider personnel shall be familiar with the complaints management process.

1.3.3 The service provider shall maintain a complaints register that includes all complaints, investigation, resolution and communication of outcome to the complainant.

1.3.4 The service provider shall manage complaints using a process that is linked to the quality management system for corrective action and continual improvement.

Standard 1.4 Maori values and beliefs

Outcome – Service users who identify as Maori receive services in a manner that takes account of cultural values and beliefs.

1.4.1 Service provider personnel shall ensure service users who identify as Maori receive services that take account of needs and are in accordance with a documented Maori Health Plan.

1.4.2 Service provider personnel shall demonstrate competency in meeting the principles of the Treaty of Waitangi and in providing services that are consistent with Maori cultural values and beliefs.

1.4.3 The service provider shall consult with tangata whenua and other Maori organizations, provider groups and whanau when planning initiatives that may have significant impact on the needs of Maori service users.

Standard 1.5 Individual values and beliefs

Outcome – Service users receive culturally safe services that take account of individual values and beliefs.

1.5.1 Service provider personnel shall collect, collate and analyse service user ethnicity data in order to make provision for the needs of the community served.

1.5.2 Service provider personnel shall consult with service users, their family/whanau and any accompanying support person in a manner that takes account of individual cultural needs, values and beliefs.

Part Two Organizational Management

Standard 2.1 Quality and risk management

Outcome – The service provider documents and implements a quality and risk management system for safe and effective management of urgent care processes.

2.1.1 The service provider shall maintain a documented management system of policies, procedures and other documents that reflects best practice for urgent care and is implemented by clinical and non-clinical personnel. The documented management system shall be reviewed at stipulated intervals and updated as required to improve service delivery.

2.1.2 The service provider shall maintain a document control system to manage policies, procedures and other documents to ensure all controlled documents are approved, current, available to personnel, and managed to preclude the use of obsolete documents.

2.1.3 The service provider shall collect, collate and analyse data obtained from annual service user experience surveys (minimum sample size of 35 service users).

Particular requirement – the survey shall measure survey user experience with respect to:

(a) Interaction with service provider personnel;
(b) Service received;
(c) Service environment.

2.1.4 The service provider shall maintain a programme of internal audits of its policies and processes relating to consumer rights, organizational management, service provision, facilities and environment.

Particular Requirement: The programme of internal audits shall:

(a) Include, but not be limited to:
   i. Obligations with respect to the Code of Rights;
   ii. Control of documents and of service user information;
   iii. Human resource management of recruitment, orientation and induction, credentialing, and training and competency assessment;
   iv. Management of adverse events and complaints;
   v. Triage system;
   vi. Test tracking system and transfer of information;
   vii. Medical records;
   viii. Urgent care facilities and equipment;
   ix. Fire safety precautions;
   x. Infection prevention and control.

(b) Address and take account of:
   i. A history of conformity with quality requirements;
   ii. The introduction of new and amended processes;
   iii. Systems with known problems and / or significant associated risks.

2.1.5 The service provider shall identify, analyse, prioritize, control and mitigate risks, including organizational, financial and occupational risks, as well as risks associated with service delivery.

2.1.6 The service provider shall maintain a programme of continual improvement through:

(a) Corrective action that addresses identified systemic deficiency;
(b) Preventive action that responds to analysis of quality and risk related data;
(c) Implementation of quality plans with measurable objectives for systemic improvement and achieving clinical and non-clinical goals;
(d) Follow-up to internal audit findings;
(e) Follow-up to service user experience surveys.

Standard 2.2 Adverse events

Outcome – The service provider systematically records adverse events and near misses. These are managed by a quality and risk management system that meets any requirements for essential notification.

2.2.1 The service provider shall record adverse events and near misses in order to manage risk and to identify opportunities to improve urgent care processes.

2.2.2 The service provider shall manage the adverse event reporting system using a process that is linked to the quality management system for corrective action and continual improvement.

2.2.3 The service provider shall ensure the adverse event reporting system meets any statutory requirements for essential notification.

Particular requirement: The system for essential notification shall include, but is not limited to, reporting:

(a) Adverse reactions to medicines and immunizations to the Centre for Adverse Reactions Monitoring (CARM);
(b) Infectious diseases to the Ministry of Health;
(c) Health and safety to the Ministry of Business Innovation and Employment;
(d) Death to the coroner;
(e) Suspected child abuse to Child, Youth and Family Services.

Standard 2.3 Information management

Outcome – The service provider management system ensures service user information is uniquely identifiable, accurate, current, confidential, and accessible when required.

2.3.1 The service provider shall maintain the confidentiality of service user information through a system for control of access, storage, retrieval, retention, back-up, archiving and disposition of service user data and records. The system shall include service user information in either electronic or hard copy medium.

Standard 2.4 Human resource management

Outcome – The service provider manages human resources to ensure competent personnel deliver safe urgent care services of acceptable quality.

2.4.1 The service provider shall document the skills and knowledge required of each position, including any necessary clinical competency, together with the responsibilities, authority and accountability of each position. The service provider shall maintain signed current contracts for all personnel.

Particular requirement: Human resource management system documentation shall include employment processes and agreements that identify pertinent legislative and industrial requirements for pay, conditions, recruitment, selection, dispute resolution and resignation.

2.4.2 The service provider shall ensure a doctor and a registered nurse are on-site during the clinic hours of operation.

Particular requirement: Both doctor and nurse shall have current ACLS to the standard (refer to 2.4.7 and 2.4.8)

2.4.3 The service provider shall employ a Medical Services Coordinator (Medical Director).

Particular requirement: The Medical Services Coordinator (Medical Director) shall be:

(a) Either a Fellow of the Royal New Zealand College of Urgent Care;
(b) Or an urgent care vocational programme trainee whom the Royal New Zealand College of Urgent Care has approved in writing as medical director;
(c) Or another doctor approved as Medical Director by RNZCUC.

The Medical Services Coordinator (Medical Director) position holder shall:

i. Be responsible for clinical oversight including medical records review, performance appraisal, and clinical performance review of medical personnel, adverse event review and ongoing training of clinic medical personnel;
ii. Document any required collegial relationships of medical personnel;
iii. Have a current New Zealand Annual Practising Certificate;
iv. Work on-site a minimum of 20 hours per week.

2.4.4 The service provider shall employ a Nursing Services Coordinator (Charge Nurse).

Particular requirement: The Nursing Services Coordinator (Charge Nurse) shall:

i. Be a registered nurse with experience and training in urgent care and/or other associated specialities (such as emergency medicine, primary health care, orthopaedic surgery, plastic surgery);
ii. Be responsible for providing clinical leadership of urgent care services, including coordination of ongoing education of nurses, in accordance with New Zealand Nursing Council guidelines and directives, and in collaboration with the Medical Services Coordinator and/or other management personnel;
iii. Have a current New Zealand Annual Practising Certificate;
iv. Work on-site a minimum of 20 hours per week.

2.4.5 The service provider shall maintain a recruitment process that verifies the professional qualifications, curriculum vitae and references of personnel prior to commencement of employment.

2.4.6 Prior to commencement of independent practice, the service provider personnel shall undertake a recorded programme of recruitment, orientation to the organization and induction based on the skills and responsibilities of the position. The programme of orientation and induction shall be undertaken again by personnel after an absence greater than 12 months. The content of the programme of orientation and induction shall be pertinent to the urgent care skills required of the position holder.

Particular requirement: The recruitment process shall include verification of the professional qualifications, experience and references of personnel prior to commencement of employment.

2.4.7 The service provider shall maintain a system to identify, plan, facilitate and record the training needs of the organization and of individual personnel.

Particular requirement: Training of personnel, to the extent and as determined necessary through competency assessment, shall be undertaken and shall include but is not limited to:

(a) Implementation of requirements of the Code of Health and Disability Services Consumers' Rights (The Code);
(b) The documented procedure that defines how the service provider implements the requirements of the Privacy Act 1993 and Health Information Privacy Code 1994;
(c) The Treaty of Waitangi including the principles of partnership, participation and protection;
(d) Cultural competence and cultural safety;
(e) Urgent care service skills including:
    i. Triage with competency assessment that shall include review of the results of the triage internal audit programme (applicable to all personnel);
    ii. Receptionist first aid (receptionists shall have a documented guideline for identifying life-threatening conditions);
    iii. X-ray interpretation (applicable to medical personnel);
    iv. ECG interpretation (applicable to medical personnel);
    v. Slit lamp use (applicable to equipment users);
    vi. IV cannulation (applicable to clinical personnel);
    vii. Plastering (applicable to nursing personnel);
    viii. Wound care (applicable to nursing personnel);
    ix. Burns management (applicable to nursing personnel);
    x. Procedural sedation (using clinic guidelines that reflect best practice) if applicable;
    xi. Closed reduction (applicable to medical personnel);

xii. Advanced cardiac life support certification (applicable to all clinical personnel) that includes, but is not limited to:
- Basic cardiopulmonary resuscitation;
- Airway management including use of LMA;
- Use of defibrillator, automatic and manual;
- Use of emergency drugs during resuscitation;
- Understanding of ECG rhythms that require urgent intervention.

(f) Infection control practices for sterilization and disinfection, for personnel responsible for managing infection control;
(g) New procedures and equipment.

2.4.8 The service provider shall maintain a system to credential clinic personnel.

Particular requirement: The credentialing system shall include:

(a) Currency of practice certification/registration;
(b) Currency of medical indemnity for each clinical staff member;
(c) Currency of advanced cardiac life support (ACLS) certification criteria, as defined by the Royal New Zealand College of Urgent Care as mandatory, or as endorsed by the Royal New Zealand College of General Practitioners;
(d) Documenation of training and supervisory arrangements required by MCNZ and administered through colleges and other professional bodies;
(e) Recorded review of clinical competency for all clinical personnel including identification of training needs.

2.4.9 The service provider shall document and implement a process that determines personnel levels and skill mixes in order to provide safe service delivery.

2.4.10 The service provider shall document a service continuity plan.

Particular requirement: The service continuity plan shall include:

(a) Delegation of responsibilities and authority to competent personnel who will perform nominated functions in the absence of the usual position holder;
(b) The role of the clinic in the event of a civil emergency;
(c) Management of workloads to ensure capacity and capability to provide safe and timely services.

Part Three Service Provision

Standard 3.1 Accessibility

Outcome – Service users can access urgent care during hours that meet the needs of the community served.

Particular requirement:

3.1.1 The service provider shall open the clinic every day including public holidays from 8am to 8pm, unless the service provider has written approval to do otherwise from RNZCUC with an accompanying rationale for the approval decision.

Standard 3.2 Triage

Outcome – Service users undergo an initial assessment of the severity of their condition in order to determine priority of treatment.

3.2.1 The service provider shall document a triage system based on the Australasian College for Emergency Medicine (ACEM) triage scale, or an equivalent that is approved by the Royal New Zealand College of Urgent Care. The system shall include guidelines for:

(a) Identifying life-threatening conditions when a service user arrives at the clinic;
(b) Directing reception personnel not to give medical advice or make clinical decisions unless specified in the guidelines;
(c) Directing reception personnel to alert clinical personnel immediately when a service user presents with life-threatening symptoms;
(d) Directing service users to telephone for an ambulance when they telephone for advice about life-threatening symptoms;
(e) Appropriate triage decision-making, categorization and waiting times.

3.2.2 The service provider shall maintain a signage system that:

(a) Directs service users to the reception area on arrival;
(b) Informs service users about a triage process that prioritizes urgent cases;
(c) Lists life-threatening symptoms and informs service users that they should advise clinic personnel immediately when they present with life-threatening symptoms.

3.2.3 The service provider shall implement the triage system including:

(a) Informing service users on request about the waiting time or general waiting times or a change in waiting time, for example by a displayed notice that shows the current waiting time;
(b) Ensuring a member of the service provider's personnel is in the reception area at all times during opening hours and is monitoring the waiting area regularly;
(c) Seeing service users according to the triage priority rating.

3.2.4 The service user shall maintain a programme of internal audits of the triage system.

Particular requirement: The program of internal audits of the triage system shall include:

(a) Minimum sample size of 50 service users selected across the opening hours;
(b) Verification that triage has taken place, or if no triage occurred, that absence of triage is appropriate;
(c) Assessments and measurements of time from presentation to triage and from presentation to treatment;
(d) Assessment of the appropriateness of triage decisions, categorization and waiting times;
(e) The frequency of audit shall be not less than six-monthly;
(f) When an assessment finds nonconformity with triage system requirements:
    i. The frequency of audit shall be increased;
    ii. A review and corrective action process shall be implemented.

Standard 3.3 Service user information

Outcome – Service users receive information regarding their diagnosis and are involved in planning of their treatment, referral and follow-up.

3.3.1 The service provider shall implement a process that gives a service user the option of being notified of all test results, or of being notified only of test results that need follow-up. The process shall include recording of communications with service users about notification options and safe handling and follow-up of test results.

3.3.2 The service provider shall inform service users, through displayed notices and/or information sheets, that they can access information about test results, public health information, injury prevention and treatment, and community services.

Standard 3.4 Service user follow-up

Outcome – Service provider has a process for timely follow-up of diagnostic reports.

3.4.1 The service provider shall maintain a test tracking system.

Particular requirement: the test tracking system shall include:

(a) Tests that have been ordered and not performed;
(b) Diagnostic reports including laboratory results, imaging reports, investigations, and relevant clinical referral letters;
(c) Timely follow-up of diagnostic reports, and immediate and appropriate actions to give assurance of patient safety.

3.4.2 A clinic doctor shall take responsibility for:

(a) Review and action of all diagnostic reports within 48 hours of receipt;
(b) Annotating as suitable for filing all diagnostic reports prior to filing.

Standard 3.5 Collection and transfer of information

Outcome – Service users' information is sent to their usual primary care provider or general practitioner unless the service user specifically requests otherwise.

3.5.1 The service provider shall maintain a service user registration process that collects demographic and essential health information.

Particular requirement – the system for collection of health information shall include, where available:

(a) Name
(b) Address
(c) Date of birth
(d) Contact phone number
(e) NHI number
(f) CSC number and expiry date
(g) Date of last visit
(h) HUHC number and expiry date
(i) Gender
(j) Ethnicity
(k) Medical alerts and drug allergies
(l) Preferred primary care provider, lead maternity carer or GP

3.5.2 The service provider shall ensure information is transferred to the primary care provider or general practitioner within the next working day. If electronic medical

note transfer is not possible, a hard copy of the medical notes shall be given to the service user for the attention of the primary care provider or general practitioner and the action shall be recorded. The information transferred shall include case notes, laboratory referrals and tests requested.

3.5.3 The service provider shall, when seeing service users in the clinic, give the option of not disclosing their consultations to their usual primary care provider or general practitioner. The chosen option shall be recorded.

Standard 3.6 Referrals

Outcome – The service user has referrals made through effective links with other health and disability service providers.

3.6.1 The service provider shall maintain a contact list and referral details for other health and disability service providers.

Particular requirement – the contact list and referral details shall include and are not limited to:

(a) Tertiary referral centres including hospitals and outpatient clinics;
(b) Clinic support services including pharmacy, laboratory, radiology, physiotherapy, dentist and podiatry;
(c) Government and community agencies including health advocates, translation services and social welfare.

Standard 3.7 Medical records

Outcome – The service user medical records detail each consultation episode in accordance with best practice and statutory requirements.

3.7.1 The service provider shall maintain a medical record of each consultation episode with sufficient information to describe the consultation and meeting current best practice and legislative requirements.

Particular requirement: The details within medical records shall include:

(a) History of presenting complaint;
(b) Relevant past medical history;
(c) Known drug allergies and other allergies and sensititvities;
(d) Examination findings including system relating to presenting complaint, and other systems that support diagnosis;

(e) Differential diagnosis, working diagnosis and rationale for working diagnosis if clinically appropriate;

(f) Treatment including drugs and advice given;

(g) Follow-up including whom to see, when, and criteria for attending.

(h) Additional information if relevant;

i. Consent(s);

ii. Diagnostic tests ordered and results;

iii. Referrals made;

iv. Progress;

v. Unique ID alerts;

vi. Surgical record(s);

vii. Transfer letter(s);

viii. Letters from secondary care providers;

ix. Letters from referrers.

(i) Prescriptions of all medicines including controlled drugs, recorded in the electronic record and complying with pertinent legislative and regulatory requirements;

(j) Repeat prescribing in conformance with documented clinic policy;

(k) Any actions under Standing Orders, in conformance with Ministry of Health Guidelines;

(l) Disease classification.

3.7.2 The service provider shall maintain a programme of internal audits of medical records in order to verify;

(a) Requirements for medical records of criteria, 3.5.1 and 3.7.1 are being met;
(b) Competency of clinical-decision making;
The frequency of audit shall be not less than six-monthly. When an audit finds nonconformity with medical record system requirements and/or evidence of inappropriate clinical-decision making, the frequency of audit shall be increased, and a review and corrective action process shall be implemented.

Part Four Facilities and Environment

Standard 4.1 Facilities

Outcome – Service users receive urgent care within and using facilities that are fit for purpose.

4.1.1 The service provider shall maintain urgent care facilities that include:

(a) A treatment area with auditory and visual privacy;
(b) A designated resuscitation area with defibrillator, airway management equipment, ECG machine, mobile bed, IV fluid resuscitation equipment, and emergency medications;
(c) A designated area for plaster application and removal;
(d) A designated area for nappy-changing;
(e) A private area that can be used for breast-feeding;
(f) Medicine, medical equipment and medical supplies, stored according to the supplier's directions, inaccessible to unauthorized persons, and sufficient to provide safe treatment of service users;
(g) An alert system for identifying and managing service users who are seeking drugs of addiction;
(h) Secure storage for medicines and accessible only to designated personnel;
(i) An x-ray facility on-site or with short covered access suitable for a wheelchair trip
(j) An x-ray image is made available to the attending doctor immediately after the x-ray is taken and the clinic doctor records a reading.
(k) An x-ray report made available by a radiologist within 72 hours.
(l) A clinic with a current building warrant of fitness.

Particular requirement: Essential equipment facilities shall include:

General

i. Computerized consumer register
ii. Phone and fax
iii. Photocopier

Sterilisation

Autoclave sterilization with equipment for pre-treatment cleaning and sterile packaging that states the expiration date. If autoclave has print-outs that demonstrate a desired sterilization temperature with each cycle, then there is no need for a biological indicator test. Otherwise, it must have weekly testing with a biological indicator.

Diagnosis

i. Blood taking equipment
ii. Syringes and needles
iii. Spatulas
iv. Blue light
v. Fluorescein
vi. Ophthalmoscope
vii. Otoscope earpieces, child and adult sizes
viii. Reflex hammer
ix. Scales
x. Snellen eye chart
xi. Sphygmomanometer with a full range of cuffs and connections
xii. Stethoscope
xiii. Tape measure
xiv. Tuning forks, 256 Hz and 512 Hz
xv. Thermometer
xvi. Eye local anaesthetic

Resuscitation

i. Airway suction
ii. Bag-mask ventilators
iii. Laryngoscope / laryngeal masks – all sizes
iv. Oro-pharyngeal airways – all sizes
v. Oxygen supply with regulator, tubing, nebulisers and masks

Cardiac

i. 12-lead ECG machine
ii. 3-lead ECG monitor/recorder
iii. Manual defibrillator or an automatic electronic defibrillator (AED) with manual function. Note: an AED alone without a three lead ECG monitor is inadequate.

Shock

i. IV administration sets – includes pump sets and metrisets
ii. IV fluids – 0.9% saline
iii. IV luer plugs
iv. IV set-up and infusion, 14-26 gauge

Wound care

i. Adhesive dressings
ii. Angle poised lamp
iii. Fine needles
iv. Lignocaine

v. Local anaesthetic
vi. Monofilament nylon sutures, 3/0 – 6/0
vii. Skin closures
viii. Suturing equipment
ix. Wound glue

Fracture management

i. Crutches
ii. Electric plaster saw
iii. Mallet finger splints (all sizes)
iv. Plaster scissors
v. Plaster splitter
vi. POP splints
vii. Wrist, hand and thumb splints – all sizes
viii. Moonboots – all sizes
ix. Rigid neck collars (all sizes)
x. Ring cutter
xi. Wheelchair
xii. X-ray viewer/spotlight for x-ray
xiii. Knee splints or Robert Jones bandaging materials.

Emergency drugs and antidotes

i. Adrenaline
ii. Amiodarone
iii. Aspirin
iv. Atropine
v. Glucagon
vi. 10 % glucose (injectable)
vii. Glyceryl trinitrate
viii. Oral and injectable corticosteroids
ix. Naloxone hydrochloride
x. Benztropine
xi. Narcotic (injectable)
xii. Salbutamol

Essential drugs

i. Antibiotics (injectable)
ii. Antiemetic
iii. Antihistamine
iv. Benzodiazepine (injectable/rectal)
v. Fentanyl

vi. Frusemide
vii. Local anaesthetic
viii. Paracetamol
ix. Sterile water for injection
x. Vitamin K for injection

Miscellaneous

i. Blood glucose testing equipment
ii. Cricothyroidotomy set
iii. Immunoglobulin (readily available if not on-site)
iv. Nasal packing equipment including lighting, speculae, forceps and suitable packing
v. Packs for delivery of babies
vi. Peak flow meters and mouthpieces – all ranges and sizes
vii. Placebo inhalers
viii. Spacer devices
ix. Pregnancy testing kits
x. Urinary catheterization sets and catheters
xi. Sponge forceps for vaginal examination
xii. Tetanus toxoid
xiii. Midazolam
xiv. Proctoscope
xv. Ultrasound for foetal heart beat detection
xvi. Urinalysis testing equipment
xvii. Vaginal speculae
xviii. Ear syringing apparatus
xix. Mobile bed or trolley
xx. Pulse oximeter
xxi. Slit lamp

For intravenous sedation if used;

i. Midazolam
ii. Flumazenil
iii. A current guideline or protocol that reflects best practice for using intravenous sedation

Particular requirement: An internal audit shall be performed annually to verify:

i. For each piece of medical equipment:

a. Documented instructions where necessary for use are readily available;
b. Servicing and maintenance requirements are being met;
c. Pertinent regulatory requirements for electrical safety are being certified as met;

ii. Medicines and medical supplies stock levels are being maintained and are within expiration date.

Particular requirement: Controlled drugs facilities shall include:

i. Controlled drugs shall be stored in a controlled drugs safe;
ii. A controlled drugs register shall be maintained.

Particular requirement: The x-ray facility shall open on weekdays for 6 hours per day, as a minimum;

4.1.2 The service provider shall maintain clinic facilities that include:

(a) Prominent external signage.

Particular requirement:

i. Signage does not use the words 'emergency', 'casualty' or any other term commonly used in hospital emergency department signage;
ii. All new or replacement signage shall include the term 'Urgent Care', and not 'Accident and Medical', 'Casualty', the word 'Emergency' or any other term commonly used in hospital emergency department signage. For these purposes, 'new' is defined as 'installed or changed after a facility's first audit under the 2015 urgent care standard'.
iii. Signage that indicates opening hours;
iv. Signage that indicates services available (such as laboratory, pharmacy, podiatry, dental, physiotherapy, audiology, optometry);
v. Signage that indicates how to access urgent care services (including other urgent care providers and after-hours telephone services) when the clinic is closed.

(b) Prominent internal signage.

Particular requirement: Prominent internal signage that displays:

i. Clinic opening hours;
ii. Consultation fees;

(c) Facilities for service users with disability or mobility limitations.

Outcome – Service users receive urgent care services within a safe clinic environment.

4.2.1 The service provider shall manage fire safety within the clinic area.

Particular requirement: Fire safety management shall include:

(a) An evacuation plan approved by the New Zealand Fire Service;
(b) Periodic fire evacuation drills with records that include any follow-up actions;
(c) An internal audit of the fire safety precautions installed within the clinic facilities and taken by personnel, as stipulated in the documented health and safety management system.

4.2.2 The service provider shall maintain a smoke-free environment within the clinic building.

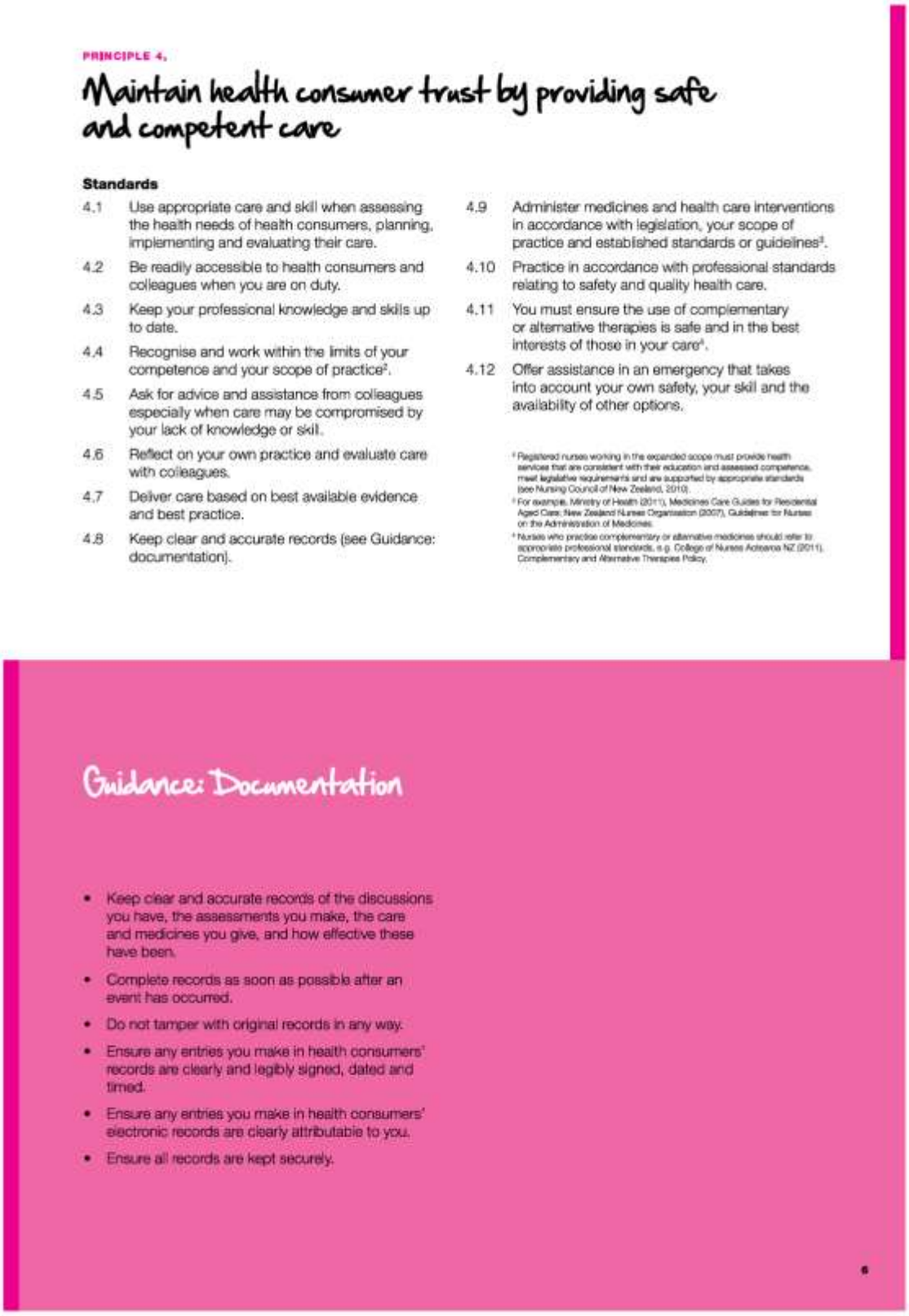
4.2.3 The service provider shall maintain an infection prevention and control programme.

Particular requirement: The infection prevention and control programme shall include:

(a) Cleaning, disinfection and sterilization of medical and surgical equipment;
(b) A documented procedure that defines categorization, safe storage, collection and disposal of waste and hazardous substances;
(c) Storage of used sharps in clearly-marked designated puncture-resistant containers that are out of reach of children;
(d) Management of laundry;
(e) A certified cold chain system;
(f) Regular and incidental cleaning of the clinic using appropriate cleaning agents;
(g) Identification of contributory factors responsible for spread of infection such as water, air, vermin and other environmental factors;
(h) Safety of all patients and staff members when managing patients with serious highly infectious diseases.

4.2.4 The service provider shall have arrangements for the security of service users, personnel and the clinic facility, including a system to summon timely emergency assistance.

Appendix D: Nursing Council of New Zealand Code of Conduct



PRINCIPLE 4.

Maintain health consumer trust by providing safe and competent care

Standards

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

4.2 Be readily accessible to health consumers and colleagues when you are on duty.

4.3 Keep your professional knowledge and skills up to date.

4.4 Recognise and work within the limits of your competence and your scope of practice[2].

4.5 Ask for advice and assistance from colleagues especially when care may be compromised by your lack of knowledge or skil.

4.6 Reflect on your own practice and evaluate care with colleagues.

4.7 Deliver care based on best available evidence and best practice.

4.8 Keep clear and accurate records (see Guidance: documentation).

4.9 Administer medicines and health care interventions in accordance with legislation, your scope of practice and established standards or guidelines[3].

4.10 Practice in accordance with professional standards relating to safety and quality health care.

4.11 You must ensure the use of complementary or alternative therapies is safe and in the best interests of those in your care[4].

4.12 Offer assistance in an emergency that takes into account your own safety, your skil and the availability of other options.

[2] Registered nurses working in the expanded scope must provide health services that are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards (see Nursing Council of New Zealand, 2010).

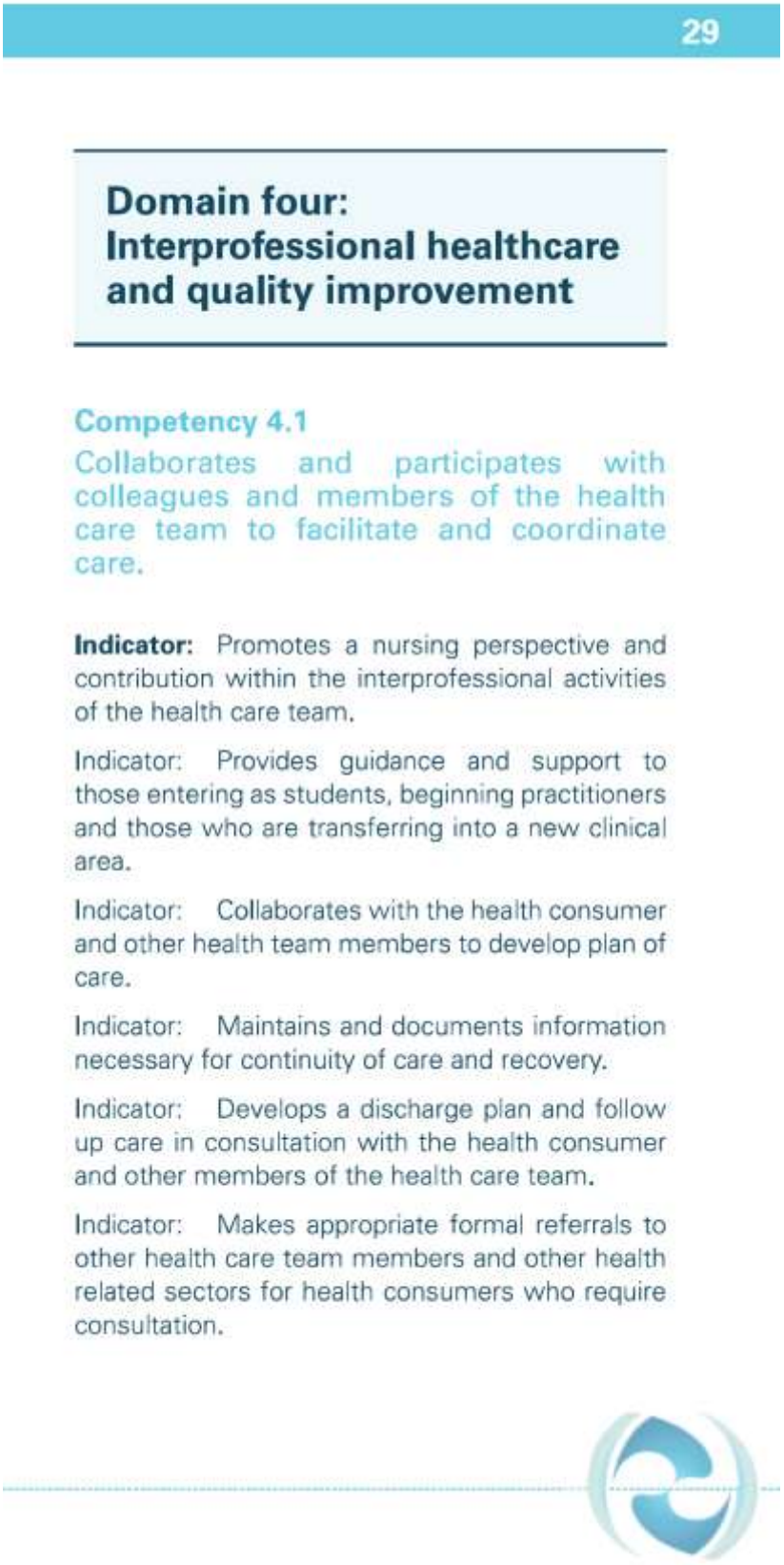
[3] For example, Ministry of Health (2011), Medicines Care Guides for Residential Aged Care; New Zealand Nurses Organisation (2007), Guidelines for Nurses on the Administration of Medicines.

[4] Nurses who practise complementary or alternative medicines should refer to appropriate professional standards, e.g. College of Nurses Aotearoa NZ (2011), Complementary and Alternative Therapies Policy.

Guidance: Documentation

- Keep clear and accurate records of the discussions you have, the assessments you make, the care and medicines you give, and how effective these have been.
- Complete records as soon as possible after an event has occurred.
- Do not tamper with original records in any way.
- Ensure any entries you make in health consumers' records are clearly and legibly signed, dated and timed.
- Ensure any entries you make in health consumers' electronic records are clearly attributable to you.
- Ensure all records are kept securely.

Appendix E: Nursing Council of New Zealand competencies for registered nurses



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Domain four: Interprofessional healthcare and quality improvement

Competency 4.1

Collaborates and participates with colleagues and members of the health care team to facilitate and coordinate care.

Indicator: Promotes a nursing perspective and contribution within the interprofessional activities of the health care team.

Indicator: Provides guidance and support to those entering as students, beginning practitioners and those who are transferring into a new clinical area.

Indicator: Collaborates with the health consumer and other health team members to develop plan of care.

Indicator: Maintains and documents information necessary for continuity of care and recovery.

Indicator: Develops a discharge plan and follow up care in consultation with the health consumer and other members of the health care team.

Indicator: Makes appropriate formal referrals to other health care team members and other health related sectors for health consumers who require consultation.