Registered Nurse, Ms B

A Health Trust

A Report by the

Deputy Health and Disability Commissioner

(Case 07HDC12369)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer
Ms B	Provider/Registered Nurse
Ms C	Health Trust Clinical Operations Manager
Mr D	CEO of Health Trust
Ms E	Mr A's cousin/whanau representative
Ms F	Former hospital services manager

Overview

In May 2007, Ms B was a registered nurse working full-time rostered duties at a Health Trust's rural hospital (the Hospital). At 11.50pm on 29 May 2007, Ms B administered Mr A 5mg of diazepam, which was not prescribed on his current medication chart. CEO Mr D met with Ms B to seek an explanation for her action. Ms B advised Mr D that she did not intend to prescribe, but gave Mr A the medication because he was unsettled. She did not telephone the on-call doctor to request sedation for Mr A, because she planned to ask the doctor to retrospectively prescribe the diazepam the next morning.

Complaint

On 12 July 2007 the Commissioner received a referral from the Nursing Council of New Zealand.[1] The Health Trust Clinical Operations Manager Ms C had advised the Council of concerns about the services registered nurse Ms B provided to Mr A. The following issues were identified for investigation:

- *The appropriateness of care provided to Mr A by Ms B on 29 and 30 May 2007.*
- *The appropriateness of care provided to Mr A by the Health Trust on 29 and 30 May 2007.*

An investigation was commenced on 24 August 2007.

[1] The Nursing Council of New Zealand is obliged to refer such concerns to the Health and Disability Commissioner.

Information reviewed

Information was received from:

- Ms B Provider/Registered Nurse
- Ms C Health Trust Clinical Operations Manager
- Mr D CEO of Health Trust
- Ms E Mr A's cousin/ whanau representative

Mr A's clinical records were obtained and reviewed as well as relevant Health Trust policies and procedures. Independent expert advice was obtained from registered nurse expert Dr Stephen Neville.

Information gathered during investigation

Background
Mr A, aged 72 years, was admitted to a rural hospital on 9 May 2007 with confusion and behavioural changes following a fall at his home the previous week. He was assessed by a doctor, who referred him for a CT head scan on 10 May. The scan showed that Mr A had recently sustained a subdural haematoma and there was some older damage to the right occipital area of his brain. The doctor spoke to Mr A's next of kin, his cousin Ms E, about these results and suggested that he be provided with palliative care only. Ms E agreed that there should be no aggressive intervention, and this decision was documented in Mr A's clinical records on 10 May.

Mr A was confused and restless for the next two days. He was prescribed clonazepam drops three times daily, to control his agitation, as well as "as required" diazepam 5 mgs to control anxiety. He was also prescribed the night-time sedation zopiclone. Mr A was able to mobilise with the assistance of two nurses and a mobility aid. He suffered a number of falls and minor injuries, abrasions and bruising. He was also incontinent of urine and faeces and needed assistance with feeding. These issues were discussed with his family on 14 May. However, they were keen to take him home. That afternoon Mr A's agitation increased. The nursing staff considered that his risk of falling had increased and his mattress was placed on the floor as a preventive measure. Mr A was discharged on 18 May.

Ms B
Ms B graduated as a registered nurse in 1982. She commenced work as a registered nurse at the Hospital on 31 January 2006 and underwent a formal reorientation programme. The Hospital Services Manager at that time, Ms F, was responsible for implementing orientation programmes. The orientation programme included advice to new staff about the hospital's policies on issues such as medication management.

On 20 September 2006, Ms F wrote to Ms B to inform her that nursing staff had brought to the attention of the Trust management their concerns about her practice. Ms F offered Ms B the options of stress leave, counselling and the employment assistance programme. A comprehensive work plan process was put in place and senior nursing staff continued to work with her to improve her performance.

Hospital management met with Ms B on 26 September and 3 October 2006 to discuss these issues. A formal plan was drawn up to address performance concerns, and further meetings on 16 October and 18 December were held with Ms B and a New Zealand Nursing Organisation representative (who was advising Ms B) to review the plan. A further meeting with the parties was held on 2 March 2007 to review the process for Ms B's continuing work plan.

28 May 2007
On 28 May 2007, Mr A was readmitted to hospital for three days of respite care. A doctor admitted him and wrote out a new prescription for Mr A for a Microlax enema and Codalax, 20 mls daily. The prescription was entered into Mr A's clinical records on the medication chart.

Mr A did not settle after his admission and became upset and distressed when left alone. Because of his mental state, he was moved from the ward to the interview room, so as not to disturb other patients. He was placed on a mattress on the floor for his safety. Later that day, he was prescribed six drops of clonazepam (Rivotril) as required, "for agitation".

Mr A's doctors did not prescribe diazepam during this admission.

29 May
On the evening of 29/30 May 2007, registered nurse Ms B and an enrolled nurse were on duty.

That night Mr A was calling out loudly and appeared distressed. Ms B felt that Mr A required sedation.

Ms B recalled that Mr A had been prescribed diazepam and clonazepam during his previous admission on 9 May. She also recalled that, during his previous admission, clonazepam was not effective in controlling Mr A's agitation, and he was prescribed the night-time sedation zopiclone.

Ms B recorded the events of the night shift for 29/30 May at 5am, noting:

> "Very unsettled early in shift — most recent medication chart from May 2007 admission checked — Diazepam charted on that chart, so 1X stat dose given with good effect. Slept comfortably after that in interview room floor."

Ms B recorded on Mr A's current medication record in the section "Once only / Non routine prescriptions" that she had given him 5mg of diazepam at 11.50pm on 29 May 2007. Ms B filled in the column "Prescribers signature and name" as, "RN [Ms B] (off old chart)".

Ms B explained her rationale for prescribing the diazepam:

> "I checked his ... medication chart from May 2007 and found that he had been prescribed regular Diazepam 5mg doses. As it was nearly midnight, I felt reluctant to phone the Dr to prescribe a one-off dose, as I didn't want to disturb her unnecessarily. I was aware that [Mr A's] medical condition had not changed, and that there was no reason documented in his clinical notes for him not to receive the diazepam. I documented clearly the action I had taken and my rationale for this."

Ms B believed that, because Mr A had been settled during his first night (28 May), his doctors had not realised that he might need night-time sedation. She said that she did not envisage a problem in administering the diazepam to Mr A, because the diazepam was "not a new prescription for him". She said she expected that the doctor would retrospectively prescribe the diazepam for Mr A the next morning, 30 May, and authorise the diazepam she had administered as a "one-off".

Disciplinary action taken by the Health Trust
On 30 May 2007 the Health Trust Chief Executive Mr D wrote to Ms B to advise her that:

> "[a] serious matter has been brought to the attention of the [Hospital Services Manager]. [This staff member had replaced Ms F in this position.]
>
> There is an allegation that on the night of 29 May 2007 you administered to a patient on the ward [Mr A], 5mg of diazepam, which was not prescribed on his current medication chart.
>
> As a registered nurse you will be aware that you must not administer without a verbal or written prescription from one of our medical officers any medications that are not part of standing orders.
>
> I want to meet with you at 2pm on Friday 1 June in my office.
>
> This is a serious matter which may affect your employment. If this allegation is proven your employment may be terminated. You are advised to bring a representative to the meeting."

On 1 June, Mr D, the Health Trust Clinical Operations Manager, Ms C and the Administration Manager met with Ms B and the NZNO Organiser. The issues were discussed. The NZNO Organiser requested time to obtain advice, and a further meeting was set for 8 June. It was noted that Ms B was on annual leave at this time.

On 8 June, the same parties met with the addition of another New Zealand Nurses Organisation organiser. The issues were again discussed. At the conclusion of the meeting Ms B stated, "I would approach another case like this really differently now. … It was an error of judgment." All parties agreed that registered nurses are not allowed to prescribe.

On 8 June, Mr D wrote to Ms B to advise her that she was suspended on full pay while further investigations into the allegation that she administered a non-charted drug to a patient were made. He advised Ms B that he would review her suspension on 12 June 2007.

Ms B resigned from the Health Trust before her suspension was reviewed.

Policies and procedures

The Health Trust (the Trust) has comprehensive policies and protocols relating to medications. The Trust's Medicine Management policy states, "Under statute the prescribing of all medications is the responsibility of the [Health Trust Medical Officer]." The policy also states that all queries regarding prescription instructions "shall be directed and clarified with the prescribing clinician". The Trust's 'Inpatient Medicine Management Policy' notes that the guidelines that apply to this policy are the Nursing Council of New Zealand's Administration of Medicines.

The Health Trust does not have any policies relating to, and does not allow, retrospective prescription of medications.

The Trust carries out competency drug tests for its registered nurses. The Trust provided evidence that Ms B was assessed for her drug competency. (The Drug Test form provided was dated 15 December 2003, which appears to be a typing error as the last revision date was noted to be 10 January 2006, and the date for next revision 10 January 2007.)

The Health Trust has a policy that outlines staff accountabilities. This policy states that staff members are responsible for "[b]ecoming familiar with and abiding by applicable policies and procedures, and relevant statutory guidelines". The policy also states that staff are responsible for "[f]ollowing established procedures to ensure safe performance of a given task".

Response to my Provisional Opinion

The majority of the parties' comments have been dealt with by amendments to the text. Remaining comments are outlined below:

Ms B
Ms B agreed to apologise to Mr A's whanau, and provided me with a letter of apology to forward to Ms E.

Ms B accepted that, by administering diazepam to Mr A, she made an incorrect decision. Although Ms B was very concerned about annoying the on-call doctor, and cited this as a major factor for not seeking a prescription over the telephone, she now appreciates that "it is more important to comply with legal and professional obligations than worry about how others will react if I bother them".

Ms B stated that her actions were a "one-off mistake" and considered them to be at the "less serious end of the spectrum". She submitted, through her legal counsel, that her actions do not warrant referral to the Director of Proceedings.

Ms E
Although Ms E understands that Ms B was not permitted to prescribe or administer the diazepam to her cousin, she did not support the complaint against Ms B. Ms E advised that Mr A was very difficult to care for and, in her opinion, all the staff at the Hospital were patient and kind to him and acted in his best interests.

Independent advice to Commissioner

Independent expert advice was obtained from Dr Stephen Neville and is attached as Appendix 1.

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4

Right to Services of an Appropriate Standard

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

Other relevant standards

Code of Conduct for Nurses and Midwives (published by the Nursing Council of New Zealand in 2006).

> "Principle One
>
> The nurse or midwife complies with legislated requirements.
>
> Criteria
>
> The nurse or midwife:
>
> 1.4 practices within the legislation which impacts on the practice of nursing and midwifery and the delivery of health and disability services."

Opinion: Breach — Ms B

Ms B was a registered nurse employed by the Health Trust. In May 2007 she was working full-time rostered duties at the Hospital.

Mr A had two admissions to the Hospital in May 2007 for confusion and behavioural change management and treatment. During the first admission from 9 May to 18 May, he was prescribed clonazepam, diazepam and zopiclone to control his agitation and anxiety.

When Mr A was admitted again on 28 May, the admitting doctor initially prescribed medication for constipation. Mr A was unsettled and had to be moved out of the ward

into a quiet side room. He was also prescribed clonazepam "for agitation". At 11.50pm on 29 May 2007, Ms B administered 5mgs of diazepam to Mr A. The diazepam had not been prescribed for Mr A at that time.

In explanation, Ms B stated that she had given Mr A the medication because he was "unsettled". He had been prescribed diazepam during a previous admission from 9 to 18 May and she considered that it was an "oversight" on the part of the doctor that it was not charted when he was readmitted on 28 May. Ms B stated that she had "documented clearly" the action she had taken and expected that the doctor would prescribe the diazepam the following morning and authorise her "one-off" administration of this medication. Ms B made no attempt to clarify this situation with the on-call doctor and took the decision upon herself, despite being aware that, as a registered nurse, she was not permitted to prescribe. Ms B did not have the knowledge or training to prescribe, and this action could have had serious consequences for Mr A.

My independent nurse expert, Dr Stephen Neville, advised that when Ms B prescribed and administered the diazepam to Mr A on 29 May, she worked outside her scope of practice as a registered nurse and did not comply with the legislated requirements associated with being a registered nurse and the Nursing Council of New Zealand's (NCNZ) professional standards.

Dr Neville stated that NCNZ specifies the scope of practice for registered nurses in accordance with section 11(1) of the Health Practitioners Competence Assurance Act (HPCAA) 2003. Conditions are placed on their scope of practice according to their qualifications and experience. Nurses can independently prescribe only if they have completed an approved clinical master's programme and passed an assessment against the Nurse Practitioner's competencies by an NCNZ-approved panel, and are registered with NCNZ as a Nurse Practitioner.

Dr Neville advised that Nurse Practitioners with prescriptive authority can independently prescribe only under the "Medicines (Designated Prescriber: Nurse Practitioners) Regulations 2005". He noted that diazepam (a controlled drug) is not a drug listed as a pharmacological preparation that nurses can prescribe, except under certain circumstances (specified in the Misuse of Drugs Act 1975),[2] such as when there is a standing order. However, the Health Trust did not have a standing order for the controlled drug diazepam.

Ms B is not a Nurse Practitioner. She does not have prescriptive authority and therefore in prescribing the diazepam for Mr A she worked outside her scope of practice and contravened the HPCAA and the NCNZ Code of Practice for Nurses.

[2] Section 8 (2Ab) of the Misuse of Drugs Act 1975 states, "A person who is authorized to issue a standing order may include in a standing order authority to supply and administer controlled drugs of any specified class or description, and a person who is authorized under a standing order to supply and administer any controlled drugs may supply and administer those drugs in accordance with that standing order."

Dr Neville advised that Ms B's peers would view her actions as a severe departure from the professional standards.

In forming my opinion, I have noted Ms B's lack of insight into the appropriateness of her actions. That Ms B does not appreciate the seriousness of her actions is evidenced by her meticulous documentation and continued insistence that no harm befell Mr A as a result of her actions. It is clear to me that Ms B continues to believe that she was justified in prescribing and administering diazepam to Mr A.

In my opinion, Ms B did not provide Mr A witha service with care and skill and that complied with professional standards, and therefore breached Rights 4(1) and 4(2) of the Code of Rights.

Opinion: No Breach — The Health Trust

Direct or vicarious liability
Under section 72(3) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority, in this case, the Health Trust, may be vicariously liable for the acts or omissions of an agent. As Ms B's employer, the Health Trust is vicariously liable for Ms B's breach of the Code unless it can show that it took reasonable steps to prevent it.

Ms B breached Rights 4(1) and 4(2) of the Code. The Health Trust had a policy that outlined staff responsibilities and informed staff that they were expected to comply with professional standards. Policies were in place to guide staff in relation to medication management.

I am satisfied that Ms B acted independently and her actions were outside the control of the Health Trust.

Accordingly, in my opinion the Health Trust did not breach the Code and is not vicariously liable for Ms B's breach of the Code.

Recommendations

I recommend that Ms B:

- undertake a competence review;
- undertake additional training and supervision in relation to medication management.

Follow-up actions

- Ms B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of this report will be sent to the Nursing Council of New Zealand and the relevant District Health Board.
- I will also refer Ms B to the Nursing Council for a competence review.
- A copy of this report, with details identifying the parties removed, will be sent to the Ministry of Health.
- A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings decided not to issue proceedings against the nurse.

Appendix 1

Independent expert advice obtained from Dr Stephen Neville:

> "Thank you for giving me the opportunity to review and give advice on the above case. The aim of the contents of this report to the Health and Disability Commissioner is to provide advice, as to whether in my professional opinion:
>
> [Ms B] complied with the professional standards in relation to the service she provided to [Mr A] on 29 May 2007.
>
> **Complaint**
>
> — *The appropriateness of the care provided to [Mr A] by [Ms B] on 29 and 30 May 2007.*
>
> — *The appropriateness of the care provided to [Mr A] by [the] Health Trust on 29 and 30 May 2007.*
>
> This report will begin with an overview of my professional qualifications and clinical experience, followed by a timeline outlining the events surrounding this complaint. Finally, my professional opinion on the case will be provided. The findings, as documented, are a result of reading through the information provided by the Health and Disability Commissioner's Office, my own professional clinical and research experience of working with adults and/or older adults, my extensive experience working as a nurse at all levels of the health care environment, and after reviewing the relevant literature related to the ethical and legal obligations of nurses in providing a nursing service to individuals as well as communities.
>
> **Personal and professional profile**
>
> I am a registered nurse, who has a doctoral degree in nursing, is a Fellow of the College of Nurses Aotearoa (NZ) and has been nursing for 29 years. I am currently working as a senior lecturer in the School of Health and Social Services, Massey University, Albany Campus, Auckland. I teach in postgraduate nursing programmes and am the paper coordinator for the prescribing practicum paper that gives nurses the educational preparation for prescribing. My clinical experiences include people with disabilities, acute care, operating theatre and health care of the older person. I am currently on the Management Board of Nursing Praxis in New Zealand and am an ex-officio Board Member of the College of Nurses Aotearoa (NZ) Inc. My research experience and publications are in men's health and well-being, nursing and older people, the social aspects of ageing, health assessment, vulnerable populations and health workforce issues. Finally, I have extensive experience in providing independent advice to the Health and Disability Commissioner related

to ensuring consumers of health services receive safe and appropriate standards of care.

Background

In May 2007, [Ms B] was a registered nurse working full time rostered duties at [the] Hospital. At l1.50pm on 29 May 2007, [Ms B] administered to [Mr A] 5mg of Diazepam which was not prescribed on his current medication chart. As a result, [the] Chief Executive Officer [Mr D] met with [Ms B] on 1, 8 and 12 June 2007 to seek an explanation for her action.

On 8 June [Ms B] advised [Mr D] that she gave the medication to [Mr A] because he was "unsettled". She saw that [Mr A] had been charted Diazepam nine days earlier and she felt that it was an 'oversight that the Diazepam was not charted on the current [chart]'.

On 12 June 2007, [Ms B] advised [Mr D] that it had never been her intention to prescribe the medication. She said that [Mr A] often needed the medication to settle and, because she 'believed that no harm would befall this patient' she did not telephone the doctor as she was 'loathe to interrupt her sleep' and 'did not envisage a problem with getting a stat dose signed off by her in the morning'.

Professional advice

I have been asked to advise the Commissioner on whether, in my opinion:

- [Ms B] complied with the professional standards in relation to the service she provided to [Mr A] on 29 May 2007.

Finally, as required, I will comment on any other aspects of the care that I deem necessary. The following professional advice is presented as it relates to the above point.

I conclude my advice with my opinion on the level of severity associated with the complaint made against [Ms B], documented as mild, moderate or severe.

Preamble

Nurses became a legal entity in New Zealand with the enactment of the Nurses Registration Act 1901 and in contemporary times are pursuant to the Health Practitioners Competence Assurance Act 2003 (HPCAA). The principle purpose of the HPCAA is to protect the health and safety of members of the public by providing mechanisms to ensure that health practitioners are competent and fit to practise their professions. The Nursing Council of New Zealand (NCNZ) has been appointed as an authority under the HPCAA (2003) as the regulatory body to ensure nursing practice delivers safe and competent care to consumers of health services in New Zealand. In other words, as the

statutory authority, the NCNZ governs the practice of nurses, sets and monitors standards in the interests of the public as well as the profession. Its primary concern is public safety.

In 2006 the, NCNZ published a 'Code of Conduct for Nurses' (http://www.nursingcouncil.org.nz/Publications/code%20of%20conduct%20June%202006.pdf). The Code of Conduct for Nurses provides a guide for the public to assess minimum standards expected of nurses and for nurses to monitor their own performance and that of their colleagues. Four principles form the framework for the code. These are that the nurse:

- complies with legislated requirements
- acts ethically and maintains standards of practice
- respects the rights of patients/clients
- justifies public trust and confidence.

It is these four principles that I will use as a model to guide my critical appraisal of this case.

- Did [Ms B] comply with the professional standards in relation to the service she provided to [Mr A] on 29 May 2007?

I have been provided with extensive information which has been useful in placing this case within a context, for example that:

- diazepam had been charted and administered on a previous admission
- [Ms B] did not want to disturb the duty doctor unnecessarily
- the duty doctor had not 'been pleased' when phoned earlier in the shift by the complainant.

On another level the above information provided, although useful, is extraneous to this particular case because [Ms B] worked outside of her scope of practice; that of Registered Nurse. As such, [Ms B] did not comply with legislated requirements associated with being a registered nurse, as well as the NCNZ professional standards when providing a health care service to [Mr A] on 29 May 2007.

Under section 11(1) of the Health Practitioners Competence Assurance Act 2003 the NCNZ specifies the 'Scope of Practice — Registered Nurse' as:

Registered Nurses utilise nursing knowledge and complex nursing judgement to assess health needs and provide care, and to advise and support people to manage their health. They practise independently and in collaboration with other health professionals, perform general nursing functions and delegate to and direct Enrolled Nurses and Nurse Assistants. They provide comprehensive nursing assessments to develop, implement, and evaluate an integrated plan of

health care, and provide nursing interventions that require substantial scientific and professional knowledge and skills. This occurs in a range of settings in partnership with individuals, families, whanau and communities. Registered Nurses may practise in a variety of clinical contexts depending on their educational preparation and practice experience. Registered Nurses may also use this expertise to manage, teach, evaluate and research nursing practice. There will be conditions placed on the scope of practice of some Registered Nurses according to their qualifications or experience limiting them to a specific area of practice. The HPCAA (2003) provides no provision for nurse initiated independent prescribing by registered nurses regardless of the context.

Nurses can only independently prescribe if they are registered with the NCNZ as a Nurse Practitioner. The NCNZ requirements for training that Nurse Practitioners must undertake before commencing prescribing for the first time include:

- the completion of an approved clinical master's programme.
- passing an assessment against the Nurse Practitioner competencies by a NCNZ approved panel.

Nurse Practitioners authorised to prescribe within their defined area of practice, must undertake:

- a minimum of 40 hours per year of professional development aggregated over a five year period within their defined area of practice.
- a minimum of 40 hours per year ongoing nursing practice aggregated over a five year period within their defined area of practice.

Nurse Practitioners with prescriptive authority can only independently prescribe under the 'Medicines (Designated Prescriber: Nurse Practitioners) Regulations 2005'. On looking at these regulations I do not see diazepam listed as a pharmacological preparation that nurses can prescribe. Section 8 (2Aa) of the Misuse of Drugs Act 1975 does identify that a designated prescriber may be authorised to prescribe controlled drugs (such as Diazepam). Section 8 (2Ab) of the same act states. '... A person who is authorised to issue a standing order may include in a standing order authority to supply and administer controlled drugs of any specified class or description, and a person who is authorised under a standing order to supply and administer any controlled drugs may supply and administer those drugs in accordance with that standing order'. However, in the present complaint it is my understanding that Diazepam is not listed as being able to be administered under standing orders.

[Ms B] is not a Nurse Practitioner, does not have prescriptive authority and as earlier mentioned worked outside of her scope of practice. As earlier stated I think this case is straight forward. As such, it is my expert opinion that the complainant has contravened the HPCAA and the NCNZ Code of Conduct for Nurses. I rate [Ms B's] actions as severe."