Tairawhiti District Health

Registered Nurse, Ms D

Registered Nurse, Ms F

Registered Nurse, Ms G

A Report by the

Health and Disability Commissioner

(Case 09HDC02146)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Background

1. This report is about the failure by Tairawhiti District Health (TDH) and two of its nurses to provide an appropriate standard of care to a patient who had recently suffered an acute inferior myocardial infarction (heart attack).

2. In 2009, Mr A, aged 71 years, was admitted to the Coronary Care Unit (CCU) at Gisborne Hospital for thrombolytic treatment[1] after suffering an acute inferior myocardial infarction.

3. Mr A's condition remained stable, and he was transferred to a general medical ward for acute patients. In the early afternoon of the following day, Mr A's family became concerned about his condition and thought he may be having a cerebrovascular accident (CVA),[2] noting that he was complaining of a headache, was drowsy, and was showing signs of confusion. Mr A's daughter, Ms B, communicated her concerns to the nurse on duty, registered nurse (RN) Ms D. RN Ms D arranged for Mr A's observations to be taken which were found to be normal. RN Ms D found Mr A to be easily roused and not confused, but complaining of a headache. Ms B remained concerned about her father and expressed this to the nurses on duty that evening (RN Ms F and RN Ms G). After taking Mr A's observations and speaking to him, RNs Ms F and Ms G did not have any concerns. However, Ms B remained concerned about her father and asked the nurses to contact a doctor to review him.

4. RN Ms F paged the house surgeon, Dr K, at 6.42pm and advised her that Mr A's family were requesting a family meeting as they had some questions. Dr K responded that she was too busy to attend the ward and that it would be best for the family to discuss their concerns with the team looking after Mr A.

5. At approximately 7pm, Mr A vomited and the nurses contacted Dr K again. Dr K advised that she was still too busy to attend, but that she would ask the other house surgeon, Dr L, to attend.

6. At approximately 8pm, RN Ms F asked the duty nurse manager to come to the ward to help "manage the situation" as there was tension between the nurses and Ms B.

7. At approximately 8.30pm, Dr L reviewed Mr A. He considered the possibility of CVA, but thought that the more likely cause for Mr A's confusion was a urinary tract infection or upper respiratory tract infection, and ordered tests to investigate. Dr L also requested that the nurses carry out neurological observations every four hours and record these on the Neurological Observations chart.

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[1] The use of drugs to break up or dissolve blood clots which are the main causes of both heart attacks and stroke.

[2] This is another name for a stroke (interrupted blood supply to any part of the brain), and a known complication of thrombolytic treatment. Source: http://www.nlm.nih.gov/medlineplus/ency/article/000726.htm.

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8. At 9.45pm Mr A's blood pressure was noted to be increasing, his heart rate was dropping, and he had an episode of "apnoea".[3]

9. At 10.30pm a page was sent to Dr L requesting a review of Mr A as his blood pressure was continuing to increase. Another house surgeon reviewed Mr A at 11pm and concluded that Mr A had a "possible posterior bleed" and hypertension.

10. A computed tomography (CT) scan was arranged for that night and revealed that Mr A had an intracerebral haemorrhage. Unfortunately, Mr A's condition continued to deteriorate and he died a few days later.

Decision summary

11. The medical care provided to Mr A was appropriate, and no individual doctors were investigated. However, RNs Ms F and Ms G breached Right 4(1)[4] of the Code by failing to take Mr A's observations after he vomited (given his condition, see paragraph 209 and expert advice at page 58). RN Ms F also breached Right 4(1) of the Code for signing off medication for Mr A without ensuring he had taken it, and failing to complete a full set of neurological observations as directed by Dr L.

12. RN Ms F breached Right 4(5)[5] by failing to contact a house surgeon in a timely manner following a significant change in Mr A's condition at 9.45pm. RNs Ms F and Ms G also breached Right 4(2)[6] of the Code for failing to complete documentation to an adequate standard.

13. RN Ms D did not breach the Code. However her response to reports of confusion and her documentation could have been better.

14. TDH breached Right 4(1) of the Code by failing to take reasonably practicable steps to ensure its staff were using the Tairawhiti Early Warning Score (TEWS) chart correctly in their everyday practice, including taking adequate observations (see paragraphs 248-255).

15. Comment was also made in relation to TDH's responsibility to foster a culture where staff communicate effectively with families and acknowledge their concerns.

16. The Health and Disability Commissioner recommended that all three providers apologise to Mr A's family for their breaches of the Code. He also recommended a number of steps for the providers to take to improve their standard of care.

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[3] A pause in breathing.

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

[5] Right 4(5) states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."

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

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Complaint and investigation

17. On 2 December 2009, HDC received a complaint from Ms B about the services provided by TDH to her father, Mr A. Ms B's main concerns were that her father had been transferred prematurely from the CCU to the general medical ward; that once on the general medical ward her father was not adequately monitored or assessed by the nurses; and that the nurses failed to listen to, or take seriously, the family's concerns about Mr A's increasing confusion.

18. An investigation was commenced on 28 April 2010. The following issue was identified for investigation:

The adequacy of the care provided by Tairawhiti District Health to Mr A in late 2009, in particular the nursing care.

19. On 8 March 2011 the investigation was extended to include the following issues:

The appropriateness and adequacy of the care provided by registered nurse Ms D to Mr A in late 2009.

The appropriateness and adequacy of the care provided by registered nurse Ms F to Mr A in late 2009.

The appropriateness and adequacy of the care provided by registered nurse Ms G to Mr A in late 2009.

20. The parties directly involved in the investigation were:

Mr A	Consumer (dec)
Ms B	Consumer's daughter/complainant
Ms C	Consumer's daughter/co-complainant
Tairawhiti District Health	Provider
Ms D	Registered nurse
Ms E	Registered nurse
Ms F	Registered nurse
Ms G	Registered nurse
Ms H	Registered nurse
Ms I	Registered nurse
Dr J	General medicine consultant
Dr K	House surgeon
Dr L	House surgeon

21. Information was reviewed from Mr A's family, the above providers and also:

Mr M (Inpatient nurse manager)
Ms N (Director of Nursing)
Ms O (Acting Director of Nursing)

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Also mentioned in this report:

Mr P	Registered nurse
Ms Q	Registered nurse
Ms R	Mr A's daughter
Ms S	First-year graduate nurse
Dr T	House surgeon

22. Independent expert advice was obtained from registered nurse Diane Penney (**Appendix A**) and general medical physician Dr David Spriggs (**Appendix B**).

Information gathered during investigation

23. At 3.45pm on a Thursday in late 2009, Mr A, aged 71, was admitted to the emergency department (ED) at Gisborne Hospital complaining of dizziness, and heaviness in the back of both arms. He was noted to be "near collapse in [the] waiting room". Mr A's baseline observations were taken[7] and standard tests were arranged (bloods, an electrocardiography (ECG), and chest X-ray).

24. At 4.30pm, Mr A was assessed by the on-call house surgeon, Dr L, who recorded Mr A's symptoms as sudden onset posterior arm ache bilaterally, no radiation, light-headedness, and no nausea, vomiting, palpitation, sweating, or shortness of breath. Dr L discussed Mr A with the on-call general medicine consultant, Dr J. A diagnosis of acute inferior myocardial infarction (heart attack) was made on the basis of Mr A's history and an ECG.

25. Mr A was admitted to the Coronary Care Unit (CCU) at Gisborne Hospital for thrombolytic treatment. It is recorded in Mr A's notes, and acknowledged by his family, that he was advised about the associated risks of receiving thrombolytic treatment (including CVA) and gave his informed consent.

26. Mr A was also given aspirin, metoprolol,[8] clopidogrel,[9] and enoxaparin.[10] Mr A was noted as being stable overnight and a repeat ECG and bloods were performed on Friday morning.

Oxygen saturation levels

27. Mr A had been commenced on oxygen therapy on admission to the ED. His oxygen saturation levels were recorded regularly until 10pm on Thursday and ranged from 96-99% (on 4-6 litres of oxygen per minute). Mr A's oxygen saturation levels were

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[7] All were normal except Mr A's blood pressure which was high (177/112mmHg). Normal blood pressure range is 110-140/70-80mmHg.

[8] Metoprolol is used alone or in combination with other medications to treat high blood pressure. It also is used to prevent angina (chest pain) and to improve survival after a heart attack.

[9] Clopidogrel is used to prevent strokes and heart attacks in patients at risk for these problems.

[10] Enoxaparin is used is used in combination with aspirin to prevent complications from angina (chest pain) and heart attacks. It is also used in combination with warfarin to treat blood clots in the leg.

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then recorded at 2.30am on Friday (98%), 5am (97%),[11] and 7.15am (97%).[12] From 9.45am until 10.20pm Mr A's oxygen saturation levels were recorded four times and ranged from 94-96%. There were no further recordings of Mr A's oxygen saturation levels until 4pm the following day, Saturday.

Friday — medical review

28. Dr J reviewed Mr A at 8.30am on Friday and noted Mr A had no further chest pain and the ECG was "improved". Mr A's pulse and blood pressure were recorded[13] and a physical examination was recorded (no pedal oedema, soft, non-tender abdomen, and normal foot pulses).

29. The plan for the weekend was for Mr A to remain in CCU until the next day when he would be transferred to the general ward. He was to remain on telemetry leads[14] over the weekend and undergo an exercise tolerance test on Monday if his observations were normal.

30. Two of Mr A's daughters, Ms R and Ms B (a former ambulance officer), visited him at approximately 10am. They noted that he was not receiving oxygen therapy and were concerned by this.[15] Their recollections of their father at this time was that he looked well, he was coherent, responding well, sitting up, talking, eating and drinking, joking, and was independently mobile to the toilet.

31. The nursing notes at 10pm on Friday state that Mr A's condition remained stable, that he denied any chest pain or discomfort, and he did not have shortness of breath. His vital signs were recorded[16] and he was noted to be "eating and drinking [OK]".

Saturday

32. Mr A's daughter, Ms C (who is a registered nurse), advised HDC that she visited her father on Saturday morning. She recalls that her father was bleeding from the luer site on his forearm, through his dressing, onto his clothing and bedding, and recalls discussing the bleeding with CCU RN Ms Q in relation to the anticoagulation therapy. Ms C advised HDC that she was not happy with the dressing, which she recalls was a small cotton pad loosely tacked to her father's arm, and discussed this with RN Ms Q. Ms C recalls RN Ms Q responded that they had tried to stop the bleeding, and that the bleeding resulting from the anticoagulation treatment was better than the alternative of no treatment. Ms C advised HDC she told RN Ms Q she understood that, but her

[11] The clinical notes also record at this time that the level of oxygen being supplied to Mr A was reduced from 4 litres per minute to 3 litres per minute.

[12] The clinical notes record that Mr A was taken off the oxygen supply at this time. Nursing notes state: "[Oxygen] discontinued [8am] & [saturation of peripheral oxygen] 94-95%".

[13] Mr A's pulse was normal. His diastolic blood pressure was high (92mmHg).

[14] Telemetry leads are attached to the patient using electrodes. The leads transmit signals to a monitoring station, where they can be watched by nurses.

[15] The Clinical Director at Gisborne Hospital advised that oxygen was not required as Mr A did not have any difficulty breathing, and noted that his oxygen saturation at 6.30pm on Sunday was 96%.

[16] Mr A's diastolic blood pressure was slightly high (82mmHg), as was his respiratory rate (ranging from 17 to 21 breaths per minute). A normal respiratory rate for adults at rest ranges from 8 to 16 breaths per minute. Mr A's other observations were normal.

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concern was about the amount of time her father had been bleeding, and the ineffectiveness of the current dressing. Ms C recalls that the dressing was then changed.

33. The nursing notes record that Mr A had "oozy (mild)" blood coming from the "puncture site on his [right] forearm and right [antecubital fossa] where luer was removed".[17] RN Ms Q documented "tourniquet pressure applied and pressure bandage to forearm" and she asked for this to be monitored by oncoming staff. RN Ms Q also recorded that Mr A "[has been up] for shower independently [in the morning]" and that he "[h]as watched Take Heart video (Australia) and Take Heart CD (NZ) and has rehabilitation pack".

34. The nursing notes for the morning shift on Saturday documented by RN Ms Q also record that Mr A was stable and pain free. His blood pressure was recorded prior to his morning medication (158/92mmHg), and again after his morning medication (145/94mmHg).

CCU observations

35. Mr A's heart rate, blood pressure, and cardiac rhythm were recorded on the Coronary Care Observation Record regularly (26 times) from his admission to CCU until 12.15pm on Saturday. However, Mr A's respiratory rate, temperature, and oxygen saturation were recorded less frequently (respiratory rate was recorded 18 times, temperature was recorded 5 times, and oxygen saturation was recorded 20 times). On Saturday, these observations were not recorded on this chart at all.

36. At 1.30pm on Saturday, Mr A's telemetry monitoring chart recorded a heart rate of 80 beats per minute, "S.R" (sinus rhythm), and blood pressure of 145/94mmHg.

Transfer to the general medical ward

37. Mr A was transferred to the general medical ward at 2pm on Saturday in accordance with Dr J's plan. Mr A's daughters recall that their father walked to the general medical ward from CCU and he appeared mentally and physically the same as he had appeared the previous day.

38. No observations (other than the blood pressure and heart rate taken at 1.30pm) or further medical assessment were carried out immediately prior to Mr A's transfer. His daughters queried whether their father was adequately assessed prior to transfer to the general medical ward, and whether he was transferred too hastily, noting that he had had two to three heart attacks two days prior (Thursday), there was an extensive cardiac history in their family, and CCU was very quiet (they recall there being only one other patient aside from Mr A in CCU).

39. Mr M, Inpatient Nurse Manager at Gisborne Hospital, responded to these concerns in a letter to Ms C. With regard to the lack of medical assessment prior to transfer, Mr M advised:

[17] The triangular area on the anterior view of the elbow.

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"Gisborne Hospital has one consultant physician on call over the weekend. The usual practice is for the consultant to see all new admissions and patients who are identified by other clinicians as requiring additional review over the weekend. For medical patients this process is through a consultant handover on Friday afternoon or when clinical concerns are identified by the House Surgeons and other clinical staff. [Dr J] thoroughly reviewed [Mr A] on Friday. He documented a plan of care for the weekend and because of [Mr A's] good progress did not feel handover to the weekend consultant was required. As a result of this [Mr A] was not reviewed by the on-call consultant on either weekend day. The Clinical Director confirms that this is established practice at Gisborne Hospital."

40. With regard to the lack of nursing observations taken prior to Mr A's transfer to the general medical ward, Ms N, Director of Nursing at Gisborne Hospital, advised HDC that:

"The nursing staff in Coronary Care are experienced nurses who use a full range of observation skills to assess patients. During the morning shift in the Coronary Care Unit, clinical observation of [Mr A's] heart rate and blood pressure were completed 4 times. The last observation was taken 30 minutes prior to [Mr A's] transfer to the ward.

In carrying out the assessment of blood pressure and heart rate, the nurse is able to observe patients breathing effort, colour, and general clinical wellbeing. While there is no formal recording of [Mr A's] respiration rate, [Mr A] was observed frequently. The clinical record documents [Mr A] had no complaints, had been watching an education video and had showered independently.

It is noted that in the enclosed National Institute for Clinical Excellence guidelines 'Acutely ill patients in hospital' (2007), physiological observation should be monitored at least every 12 hours unless a decision to increase or decrease this frequency has been made.

Although there was a departure from the formal measurement and documentation of his respiration rate this was not a contributing factor to [Mr A's] outcome."

41. With regard to the family's concern about whether Mr A's transfer to the general medical ward was too hasty, Mr M advised Ms C:

"[Mr A] was discharged from [the Coronary Care Unit] just under 48 hours following his cardiac event and thrombolysis. After reviewing [Mr A] on Friday, his primary consultant planned for discharge on Saturday as his recovery had been uncomplicated. He was discharged on telemetry as requested. The Clinical Director's opinion is that this was clinically appropriate and consistent with accepted practice."

TEWS chart

42. The TEWS chart was implemented at Gisborne Hospital in December 2008. The purpose of the chart is to assist in the early detection of potentially unstable patients

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and provide guidance on what steps to take in the event a patient's "score" is outside of the normal range. A patient's vital signs (temperature, systolic blood pressure, heart rate, respiratory rate, CNS score and urine output (for catheterized patients only)) are to be recorded at least every six hours (unless directed otherwise) on the chart. A "score" of 0, 1, 2, or 5 is then given to each vital sign. The scores for each of the vital signs are then totalled. If the total score is 0, there is no need to take any further action. If the total score is 1, then the nurse in charge must be informed, and the frequency of observations must be increased to two-hourly. If the total score is 2-4 then the nurse in charge must be informed, and the observations must be repeated within half an hour, and the house surgeon contacted if the total score remains unchanged when repeated. If the total score is 5 or more then the house surgeon must be called immediately.

43. Ms O, Acting Director of Nursing, advised HDC that the TEWS chart was first piloted on the general medical ward and was subsequently implemented hospital-wide. TDH held TEWS training sessions on the wards for staff to learn about how to use it, and a TEWS information board was rotated around each ward for at least a week at a time.

44. TDH first audited the TEWS charts one year after they had been implemented.

Frequency of observations

45. While the TEWS chart states that standard observations are to be taken every six hours, Gisborne Hospital's Director of Nursing, Ms N, advised HDC that this is only a guide and clinical judgement can be applied to either increase or decrease the frequency of observations for each patient. Ms N further advised that, as a minimum, observations should be taken "at a frequency that allows staff to capture any changes in condition as part of ongoing assessment".

Saturday afternoon/evening

46. At some stage after Mr A's arrival on the general medical ward (but prior to 4pm) his heart rate was recorded (75bpm) on the TEWS chart. At 4pm, Mr A's temperature, blood pressure, heart rate, and oxygen saturation levels were recorded on the TEWS chart (see **Appendix C** for a table of Mr A's TEWS chart observations while he was on the general medical ward). At no point during Mr A's admission to Gisborne Hospital were his observations scored or totalled, as provided for on the chart.

47. At 9.30pm, Mr A's telemetry monitoring chart recorded NSR[18] and a heart rate of 77bpm. Mr A's nursing notes for the afternoon and evening were written by an enrolled nurse at 9.55pm and noted that his observations are stable (the actual observations were not documented). These notes were counter-signed by RN Ms I.

48. The nursing notes also record that Mr A was mobilising independently to the toilet and that his old IV luer site on his right wrist was reinforced as it was leaking. At the time of writing the notes, Mr A was noted to be in the lounge watching the rugby and

[18] Normal sinus rhythm.

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he had not voiced any complaints. Overnight, Mr A was noted to be sleeping on all checks.

49. No observations were recorded for Mr A from 4pm on Saturday until 8am on Sunday.

50. With regard to the lack of observations overnight, Ms N advised HDC:

> "Following transfer to the ward [Mr A] remained uncomplaining of any problems and sat up to watch the rugby. He settled late and it is reported he was asleep on all checks. Rest is an important part of the recovery for a patient following [myocardial infarction]. A full set of observations, including oxygen saturations, were completed at the commencement of the morning shift (0800hrs). These recordings were within the usual parameters expected."

Sunday

51. RN Ms D was on duty on the general medical ward from 7am to 3.30pm on Sunday. She recalls that her shift was very busy and she had a first-year graduate nurse, Ms S, assisting her to care for 11 patients. RN Ms D advised HDC that Mr A was an acquaintance and that he greeted her by her Christian name, therefore she had no reason to think he was not lucid.

52. Mr A's daughter, Ms R, visited her father at approximately 9am on Sunday. She recalls he appeared lucid and coherent. At approximately 10am, Mr A was visited by his grandson. Ms B advised HDC that at this time her father was again lucid and coherent (for instance he advised his grandson on the best roads to take to get to a rock slide, and used correct names for his grandson's friends). At 10.30am, the grandson text messaged his grandmother to say he was leaving the hospital as Mr A was going to have a shower.

Supervision during shower

53. RN Ms D recalls taking Mr A's towels and toiletries to the shower at approximately 11am and that, when she asked Mr A if he needed assistance with showering, he was adamant that he could shower himself. RN Ms D advised HDC that she removed Mr A's telemetry unit and showed him the call bell, and provided him with instructions on how to use it if he had any pain or needed help.[19]

54. Ms B advised HDC that at approximately 11.30am she and her mother arrived to visit Mr A, and were concerned to note that he was coming out of the shower unsupervised. RN Ms D advised HDC that, although she did not directly supervise Mr A while he was showering, she was either in Mr A's room or the room opposite Mr A's room at all times.

55. Mr M responded to the family's concerns about this and advised that he had spoken with the Clinical Director and the Clinical Nurse Manager of CCU and the Intensive Care Unit (ICU) who advised him that, if a patient is pain free and has had an

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[19] The telemetry unit was removed as it was not waterproof. TDH subsequently told HDC that telemetry units have been replaced with waterproof equipment.

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uncomplicated recovery, it is usual practice to allow them to mobilise and shower independently 24 hours after a cardiac event.

Signs of confusion

56. Ms B advised HDC that during their visit on Sunday morning she and her mother observed Mr A was showing signs of confusion. For instance, they noted that he could not remember where he had left his glasses (they were in the shower along with his other toiletries). Ms B advised HDC that her father is "usually relatively computer savvy" but when she tried to show him how to use her laptop to play a DVD, he was confused and repeatedly asked the same question. Ms B also recalled that her father looked unwell, he said he felt "heady, heavy in the head", he was sleepy and drowsy, and had no interest in food.

57. Ms B and her mother noticed that Mr A was vacant, staring into space, incoherent at times, using incorrect words for things, and unable to finish his sentences. Ms B also noted that when some close friends visited during this time, her father did not respond to them in his usual manner, which would be to joke and laugh. He said he was tired and just wanted to sleep.

58. Ms B sought out RN Ms D and told her of her concerns for her father. Ms B advised HDC that she made it clear to RN Ms D that this was not "normal" behaviour for her father and it was a sudden change from his behaviour earlier that morning. She suggested to RN Ms D that her father might be having a stroke. Ms B believed this was indicated by the fact that stroke was a known side effect of thrombolysis and her father's blood was thin — noting that he was "bleeding continually from the IV line site". Ms B recalls thinking that RN Ms D did not seem concerned and appeared "disinterested and flippant", so she then sought out another RN, Mr P, and advised him of her concerns. Ms B recalls RN Mr P saying he would go and see Mr A.[20] Ms B left the ward at approximately 12.30pm.

59. RN Ms D advised HDC that Ms B told her that Mr A "seemed a bit vague and drowsy". RN Ms D questioned Mr A who told her that he had a headache. In response, she asked the graduate nurse, RN Ms S, to do another set of observations on Mr A. RN Ms D advised HDC that RN Ms S checked Mr A's observations and told her they were within normal parameters.

60. RN Ms D also recalls telling the house surgeon, Dr L, about Mr A's headache and asking him to chart pain relief. She told Dr L about the family's concerns regarding Mr A's vagueness. RN Ms D said that Dr L "seemed unconcerned with what I told him and after charting the medication he left the ward".[21]

61. Dr L advised HDC that he does not recall this specific event or the actual conversation that took place, but accepts "it is plausible for [him] to have charted some simple

[20] RN Mr P does not recall Ms B approaching him about her concerns and he did not document anything in Mr A's clinical record that day.

[21] Dr L charted Mr A paracetamol PRN (as needed) on Thursday (when he first assessed Mr A). There is no record of Dr L charting any medication for Mr A on Sunday.

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analgesia at the request of the RN on passing the ward". There is no documentation in Mr A's clinical records of any contact or discussion between Dr L and RN Ms D at this time.

62. RN Ms D recorded in Mr A's clinical notes that at 1pm he was complaining of a headache and given paracetamol, and that at 1.45pm he denied having a headache. However, it is documented in Mr A's medication chart that he was given paracetamol at 12pm.[22]

63. RN Ms D recalls that Ms B left the ward at approximately 12.30pm, but before doing so she approached her again about her father's drowsiness. RN Ms D advised HDC that she assured Ms B that she would check Mr A regularly, which she did.

64. RN Ms D says that she checked Mr A at approximately 12.45pm and she recalls he was sleeping but easily roused. She also recalls that Mr A told her he was fine, that he addressed her by her Christian name, was oriented, and talked to her about a convention they had both attended several years earlier.

65. At 1.40pm, RN Ms S recorded the following in Mr A's notes:

> "Complaining of slight headache. Nil chest pain. Telemetry 77 NSR. Up to toilet as desired, preferring to remain on bed. All obs[ervations] satis[factory] and within normal parameters. Clexane due [5pm]."

Telephone call from Ms C

66. After leaving the hospital, Ms B telephoned her sister, Ms C, about her concerns. Ms C advised HDC that, after speaking to her sister, she immediately called the hospital and spoke to RN Ms D. In her letter to HDC Ms C wrote that she asked RN Ms D why her father had not been assisted with his shower, and expressed her "EXTREME concerns" [original emphasis] about her father's condition and "clearly expressed" to RN Ms D that she thought her father was having a CVA. Ms C also told HDC that she "clearly advised" RN Ms D that she was a registered nurse and her sister (Ms B) had been an ambulance officer trained in frontline emergency care and it was their clinical knowledge that led them to believe that their father was having a CVA.

67. According to Ms C, RN Ms D responded that she knew Mr A personally and felt he was "normal". Ms C also advised HDC that she found RN Ms D to be "nothing more than utterly indignant" and felt RN Ms D cut her off, stating that she had notes to write and "would like to get home at some time today".

68. RN Ms D recalls receiving a telephone call from Ms C at approximately 1.30pm. She recalls that Ms C was agitated and the conversation was long and difficult, with Ms C asking many questions about her father. Ms C's main concerns were that her father should not have been transferred from the CCU to the general medical ward, that he

[22] RN Ms D advised HDC that she gave Mr A the paracetamol at 12pm and she had incorrectly recorded it as 1pm in her notes.

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had been allowed to shower independently, and that his telemetry had been disconnected while he showered.

69. RN Ms D does not believe that Ms C mentioned to her at any time during the conversation that she thought her father was having a CVA, as RN Ms D did not record this concern in her notes. She also does not recall saying that she felt Mr A was "normal" and does not believe that she did say this.

70. RN Ms D advised HDC that she felt the conversation was going nowhere and she had notes to write for another patient. However, she does not recall saying that she "would like to get home some time today". RN Ms D further said that, after the conversation with Ms C, she felt "frustrated that [she] had not seemed to be able to calm [Ms C] down or to reassure her".

71. Ms C advised HDC that RN Ms D "provided no reassurance whatsoever" and she feels that RN Ms D's attitude "'infected' all staff involved with [her] father's care to the point that staff felt they were dealing with an anxious and alarmist family rather than a critically ill patient".

72. RN Ms D did not record in Mr A's notes any record of the conversation with Ms C. RN Ms D advised HDC that she had meant to add details of the conversation to Mr A's notes, but the ward was very busy and she only realised on her way home from work that she had omitted to do so.

73. RN Ms D advised HDC that she did consider the possibility that Mr A was having a CVA, but this was discounted after further recordings, investigations, and conversations with Mr A. She also advised HDC that, after speaking to Ms C, she checked on Mr A again and recalls Mr A assuring her that he had no pain at all, saying "I'm fine [Ms D]".

Afternoon documentation

74. At 2pm, RN Ms D recorded in Mr A's notes that he was independent with ADLs (activities of daily living) and that he "showered independently though observed".

75. RN Ms D also recorded "[f]amily say [Mr A] seems sl[ightly] confused. [Mr A] denies this though observed for same, not noticed. Recordings satis[factory], within his usual parameters. Telemetry NSR [heart rate] 77".

76. RN Ms D advised HDC that Mr A was sleeping when she left the ward at 3.45pm.

RNs Ms F and Ms G

77. RNs Ms F and Ms G took over Mr A's care from RN Ms D on the general medical ward at 2.30pm.

78. RN Ms G registered as a nurse in 2006 and advised HDC that she began working as a casual nurse at Gisborne Hospital in 2007. In April 2008 she commenced a permanent part-time position working on the general medical ward and then returned to casual employment in April 2009 (working regularly on the general medical ward).

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79. RN Ms G advised HDC that it is TDH policy that casual nurses are not to be "in charge" of acute patients. As the general medical ward operates a "team nursing" approach, she shared the care of the 12 patients on the general medical ward with RN Ms F who has worked as a registered nurse for 16 years (eight of which have been at Gisborne Hospital).

80. RN Ms D recalls telling the nurses at handover that Mr A had had a headache, that paracetamol had been charted and given to him, and that now he felt fine and his headache had gone. RN Ms G recalls being told by RN Ms D at handover that Mr A's condition had improved from the previous night, that he had mobilised independently from the bedroom to the television lounge to watch the rugby, and that he had showered independently that morning. She also recalls that RN Ms D spoke of having a "heated conversation" with one of Mr A's daughters that morning who had expressed concerns about her father's condition and who felt that Mr A had been moved out of CCU prematurely. She also recalls being told that the family were "hard work" but cannot recall who said this.

81. RN Ms G recalls that, at the start of her shift, Mr A's observations were stable and that he was oriented to time, place and person, and was showing no signs of confusion. RN Ms G recalls seeing some little spots of blood on Mr A's gown and asked him if he wanted her to change it, to which he replied that he was tired and just wanted to sleep.

4.30pm visit

82. Ms B advised HDC that at approximately 4.30pm her mother went to the hospital to visit Mr A, but returned home approximately half an hour later saying that she had been unable to rouse him after rubbing his shoulder, shaking him, and talking to him. When Ms B asked her mother if she had told the nurse, her mother responded that the nurse had been present and had told her that she too had been unable to rouse him.

83. RN Ms G advised HDC that, while she was doing the medication round, Mr A's wife told her that she would come back later as Mr A wanted to sleep. RN Ms G advised HDC that she assumed Mr A had told his wife this himself. RN Ms G does not believe she would have said that she had been unable to rouse Mr A, as she had had a conversation with Mr A earlier about the blood on his gown.

5pm drug round

84. Mr A's drug chart records that he was given metformin, enoxaparin, and lipitor at 5pm. RN Ms G signed for the metformin and the enoxaparin. RN Ms F signed for the lipitor, and also signed as the second nurse for the enoxaparin.

85. RN Ms G advised HDC that one of the drugs (enoxaparin) is given through an injection and the other (metformin) is tablets. She advised that she would have made sure Mr A took the metformin tablet at the same time that she gave him his injection. She recalls that Mr A was able to sit up in bed without assistance, was speaking in full sentences, and that his motor skills were fine (he was able to pick up a glass and drink its contents).

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86. RN Ms F advised HDC that she signed for Mr A's lipitor but when she went to his bedside and asked him to take the medication he refused to take it, telling her he was tired and would take it later. RN Ms F left the lipitor on Mr A's bedside table.

87. RN Ms F advised HDC that she is usually extremely vigilant about giving patients their medication and she is "well aware of the dangers of leaving medications by the bedside and of the need to ensure you have observed the patient taking the medication before signing for it". However, on this occasion she failed to follow her normal practice as she was "trying to be considerate to Mr A".

88. RN Ms F recorded that at 5pm Mr A was sleepy and refused his tea.

RN Ms E

89. RN Ms E was a nurse on duty in CCU. She was in charge of the telemetry patients that were being monitored in the general medical ward, and Mr A was one of the patients that she was monitoring. RN Ms E advised HDC that at approximately 5pm she went to see Mr A to check his telemetry leads as the right arm lead was alarming on the CCU monitor, indicating that his right upper monitoring lead was off and premature ventricular contractions (PVCs)[23] were showing on the monitor.

90. RN Ms E recalls that when she approached Mr A, he was sleeping and was hard to rouse but awoke briefly to a gentle shake and firm voice. She asked Mr A how he was, and he replied that he was "wiped out and tired" but did not open his eyes. He then opened his eyes and said "oh it's you" (RN Ms E had been a friend of Mr A's family for 41 years). RN Ms E recalls that she explained to Mr A that she was there to check on his telemetry as one of the leads was adrift, and then reattached the lead. Mr A then rolled to his side. RN Ms E noted that there were some tablets sitting on Mr A's bedside cabinet, which she recognised as lipitor. She reminded Mr A that they were there, but as Mr A did not appear to be able to take these on his own, she assisted him to take them. Mr A then went back to sleep.

91. RN Ms E recalls that, before returning to CCU, she approached RN Ms F and explained to her that she had reattached the telemetry leads as PVCs were occurring. She also recalls telling RN Ms F that she was concerned about the difficulty she had rousing Mr A, and that she had given him his tablets. RN Ms E recalls that RN Ms F replied that Mr A "had been sleeping all shift".

92. RN Ms E advised HDC that by informing RN Ms F of her concerns, it was her intention that this would lead RN Ms F to assess Mr A herself and alert her to the need to monitor Mr A more closely.

93. RN Ms F advised HDC that RN Ms E never spoke to her directly about Mr A.

[23] PVCs are premature heartbeats. They can be caused by heart attacks, electrolyte imbalances, lack of oxygen, or medications.

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5.30pm visit and assessment

94. Ms B advised HDC that she went back to the hospital, arriving at approximately 5.30pm. She noted that her father was asleep and did not look a good colour. She made a bit of noise and he stirred, looked at her and said "oh it's you". Ms B recalls that she asked her father if he was OK and he responded that he was very tired and just wanted to sleep.

95. Ms B also noted there was blood from the luer site all over her father's bed, sheets, through his hair, and on his pillow. She recalls pointing this out to RNs Ms F and Ms G and that RN Ms F "made no attempt to clean him up, but put a [gauze] pad, loosely placed with a single strip of 3M tape over his luer". Ms B recalls that she had to replace this herself a short time later, as it was not sufficient.

96. RN Ms F advised HDC that, at approximately 5.30pm while she was doing the medication round, Ms B alerted her to the bleeding from the luer site. She explained to HDC that it was not appropriate for her to leave the medication trolley at this time to go and get clean sheets for Mr A, but that as there was a gauze pad and tape on the medication trolley she put this over the original dressing to reinforce it (and in order not to disturb the site and cause more bleeding).

97. Ms B advised HDC that she told RNs Ms F and Ms G that she was concerned about her father's neurological state and that there had been a dramatic change from Saturday morning. Ms B recalls that RN Ms G told her that when she commenced her shift Mr A "wasn't a good colour" and that she had "tried to rouse him, but he wouldn't rouse" so she had left him to sleep. RN Ms G does not believe that she would have told Ms B that she had not been able to rouse Mr A, as she had had a conversation with him earlier about the blood on his gown.

98. RN Ms G recalls that her first contact with Ms B was after finishing the medication round. She says Ms B told her that her father had deteriorated, and that her response to Ms B was that her father was "actually more alert then than he had been at the beginning of [her] shift". RN Ms G also recalls that Ms B's major concern at that time seemed to be that her father had been transferred out of CCU too early and that she "appeared very agitated and upset by this". According to RN Ms G Ms B said to her in a very loud voice "I'm getting really angry and if something is not done I'm going to make a complaint". RN Ms G responded that there was no point in getting angry with her as she was not responsible for deciding when a patient is transferred out of CCU.

99. RN Ms G advised HDC that due to Ms B's "agitation and yelling at me", she thought it would be better if she kept some distance between herself and Ms B "to keep myself safe". Accordingly, both RN Ms G and RN Ms F decided that they would continue caring for Mr A together, but that RN Ms G would take a "back seat" with RN Ms F taking the "lead role". RN Ms G advised HDC that she does not think this compromised patient safety. RN Ms G did not record any of her interactions with Mr A's family. RN Ms F recalls that at approximately 6pm she was asked by RN Ms G to assess Mr A. She agreed and recalls that Ms B was in the room when she arrived. RN

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Ms F advised HDC that she asked Mr A how he was feeling and he replied that he was tired and wanted to be left alone. She then told Mr A that she would like to take his observations, to which he consented. RN Ms F recalls that she then took Mr A's observations, noting that they were all normal and his oxygen saturation was "borderline" at 92%. A set of observations was recorded on Mr A's TEWS chart at 6pm, including the oxygen saturation of 92%.

100. Ms B recalls telling RNs Ms F and Ms G that her father's oxygen saturation was not normal. She asked why her father was not on oxygen and the nurses responded that he did not need it. Ms B described how the nurses "bounced" this off each other (saying "92 that's OK aye [Ms F] … Yeah that's OK"). RNs Ms F and Ms G advised HDC that this is what they always do as part of team nursing and it was not due to either of them being unsure about what they were doing or the results.

101. Ms B recalls reiterating her concern to RNs Ms F and Ms G about her father's reduced level of consciousness and suggesting to both nurses that her father may be having a CVA as a result of being thrombolysed. Ms B recalls the nurses replying that her father was fine, and that RN Ms G then roused Mr A and asked him what his name was, what day it was, and if it was day or night, all of which Mr A answered correctly. Ms B felt this was an insufficient line of questioning to gauge her father's neurological state and noted that, even in responding, her father was very groggy and lethargic.

102. RN Ms G recalls that Ms B disagreed that her father was oriented, and told her that her father was confused and had fainted in the shower that morning. RN Ms G recalls that she then took Mr A's observations and found them to be stable. Only one set of observations is recorded on Mr A's TEWS chart at 6pm (as outlined in paragraph 99).

103. Ms B also recalls RN Ms F stating that her father was fully mobile and had no weakness. When Ms B asked RN Ms F what she was basing this on, she recalls RN Ms F responding that it was because Mr A had moved his left hand when she asked him to. Ms B recalls expressing concern at the adequacy of this assessment. Ms B told HDC that she did not tell RN Ms G that her father had fainted in the shower that morning.

104. RN Ms G advised HDC that she paged Dr K at approximately 6pm and asked her to review Mr A "as the family have serious concerns for him". RN Ms G advised HDC that her request for a doctor's review was about Ms B's anxiety and concerns, noting that there was nothing about Mr A's observations that warranted immediate medical attention. There is no record of this page in the records provided by TDH.

105. RN Ms G advised HDC that, in response to her page, Dr K telephoned the general medical ward, and she advised Dr K that Mr A's observations were stable and she did not think that there was an immediate need for a review but that she wanted her to come to the ward to address the family's concerns. She recalls that Dr K replied that

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she was too busy in ED but that she would arrange for another house surgeon (Dr L) to review Mr A and speak with his family on his ward round.[24]

106. RN Ms G recalls that, while waiting for Dr L to come to the general medical ward, they reassured Ms B many times that the house surgeon would come to review her father as soon as he could. She also recalls that Ms B was "rude and upset" and told them that if they didn't do something, she would complain.

107. Ms B says that she again expressed to RNs Ms F and Ms G her concerns about her father's reduced level of consciousness, and his deterioration from that morning. She recalls that the nurses "continued to fob [her] off" and she became "quite perturbed", explaining to the nurses she did not want to get angry with them but she felt that they were not listening to her concerns that there was something wrong with her father. Ms B told HDC that she was "desperately attempting to have her father's deteriorating state noted and have assistance sought, and inverventions put in place".

108. RN Ms F advised HDC that she did not feel it was necessary for Mr A to be seen by a doctor at this stage but, as Ms B seemed stressed and continued to express concern about her father's situation, she asked Ms B if she would like her to call a house surgeon, and Ms B replied that she would.

109. According to the page records provided by TDH, RN Ms F sent a page to house surgeon Dr K at 6.42pm reading: "2[general medical ward]. pt. [Mr A's] daughter wants to see you pls. pts obs are stable. [Ms F]."

110. Dr K advised HDC that after receiving RN Ms F's page, she telephoned RN Ms F. Dr K recalls RN Ms F telling her that Mr A's family had some questions and wanted a family meeting. She also recalls RN Ms F advising her that Mr A's observations were stable and that RN Ms F had no concerns. Dr K advised HDC that she then told RN Ms F that she was busy in ED and that as she did not know Mr A, it would be more appropriate for the team looking after him to conduct the family meeting.

111. RN Ms F says Dr K told her that she was busy in ED and could not come to the ward until the morning. RN Ms F recalls that she then passed this on to the family. RN Ms F accepts that she did not describe to Dr K the changes the family had noted in Mr A's condition, but believes that the family "were perfectly capable of relaying their concerns to the House Surgeon themselves". RN Ms F also advised HDC that it seemed to her that Ms B wanted her father to have one-on-one care similar to what is provided in CCU, and she explained to Ms B that they were not able to do that on this ward.

112. At 6.30pm RN Ms F noted in Mr A's clinical notes that his daughter was at the bedside and unhappy with her father's condition. She also recorded that Mr A's observations had been taken, reassurance was given to the daughter, and that the

[24] Dr K does not specifically recall this telephone conversation, but advised HDC that she recalls having two telephone conversations with the nurses on the general medical ward about Mr A on Sunday evening.

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house surgeon had been notified. Also recorded in the clinical notes are Mr A's observations from 3.45pm[25] and 6pm[26] (there are some slight differences from the observations recorded on Mr A's TEWS chart).

113. Ms B advised HDC that she was still very uneasy so she went to see RN Ms E in CCU to express her concern. RN Ms E advised Ms B that she had already been to see her father, that she too was concerned, and that she had advised the nurses on the general medical ward that he was not behaving normally.

114. RN Ms E advised HDC that she returned to Mr A's room with Ms B and briefly observed him again but did not do a full assessment. She recalls that he was pale, drowsy, difficult to rouse, and had been complaining of a headache. RN Ms E approached RN Ms F and informed her of her findings, and that he was "not the Mr A that [she] knew". She then returned to CCU.

115. RN Ms F advised HDC that she noticed RN Ms E "hovering and speaking with Mr A's daughter", and that she saw her talking with RN Ms H (another nurse on the general medical ward) but that RN Ms E did not attempt to talk to her or RN Ms G, which she found to be unprofessional.

116. RN Ms H advised HDC that she saw RN Ms E have a discussion with RN Ms F and RN Ms G about Mr A, but that she was not involved in the discussion. However, she recalls that RN Ms E came back later and discussed Mr A with her, telling her that Mr A had increased confusion. RN Ms H advised HDC that she told RN Ms G to send a page to the house surgeon and that, although she saw RN Ms G send a page, she is not sure of the contents of the page.

Headache and vomit

117. Ms B advised HDC that a short time after her father had been assessed by RNs Ms F and Ms G, her father roused and showed signs of nausea. She asked him if he wanted to vomit and he said yes. Ms B grabbed her father's water jug and rang the call bell. RNs Ms F and Ms G responded and Ms B told them her father was vomiting and asked for a bowl. Ms B recalls that RN Ms G handed her a vomit bowl and both nurses left the room, leaving her to deal with her father vomiting on her own. RN Ms F then returned with some Maxolon (an anti-emetic). Ms B advised HDC that she sent RN Ms E a text message, telling her that her father was vomiting. RN Ms G agrees with Ms B's account but explained that the reason she and RN Ms F left the room was to get the Maxolon for Mr A, which needed to be signed off by two nurses as it is given intravenously. Both RNs Ms F and Ms G advised HDC that neither of them saw Mr A vomiting, as they were out of the room getting the Maxolon. However, on returning to his room, they did note that he had vomited into the water jug.

[25] Temperature: 36.3°C, pulse: 80bpm, respiratory rate: 18 breaths per minute, blood pressure: 150/90mmHg, oxygen saturation: 96% on room air.
[26] Temperature: 35.5°C, pulse: 78bpm, respiratory rate: 20 breaths per minute, blood pressure: 150/90mmHg, oxygen saturation: 92% on room air.

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118. Ms C and Ms B were concerned that Ms B was left to manage their father's vomiting, and believed it would have been more appropriate for one nurse to leave to get the medication, which could then have been checked at the bedside by the second nurse.

119. RN Ms F recorded in Mr A's notes that Mr A was complaining of a headache and was given Panadol. This is recorded on the drug administration chart as being given to Mr A at 6.30pm. RN Ms F then recorded that at 6.45pm, Mr A was nauseous and was given Maxolon, but it does not say he vomited. Following this, RN Ms F recorded that Mr A had got up to use the toilet and that he was responding to staff and his daughter.

120. RN Ms G advised that they would have done a set of observations as the headache and vomiting were new events and she cannot understand why these were not recorded. RN Ms G told HDC "both [Ms F] and I (or [Ms F]) took obs." RN Ms F cannot recall if she took Mr A's observations after he vomited. She believes that RN Ms G's recollection that they took Mr A's observations, may have been in relation to the observations that were recorded at 6pm, before Mr A vomited. When asked by HDC what she thought when Mr A vomited, RN Ms F responded that she thought Mr A "would feel better".

121. RN Ms G advised HDC that while she is aware that vomiting and headache can be symptoms of a CVA, "there was nothing else to indicate that that this was the case and they can also be symptoms of a range of other illnesses". RN Ms G also noted that while Mr A was sleepy, it was not unusual for patients to be tired after a major event. RN Ms G advised HDC that after Mr A vomited she carried on doing "the rest of the work" and RN Ms F paged the house surgeon. RN Ms G later advised HDC that she "recognised that vomiting and headache could be related to cerebral bleeding and the house surgeon was paged accordingly by RN [Ms F]".

122. RN Ms F advised HDC that after giving Mr A the anti-emetic (this is recorded as being given at 7pm) she paged Dr K, telling her that Mr A was confused, nauseous and had vomited. A page was sent to Dr K at 7.07pm reading: "2plse ring [Ms G] asap [general medical ward], thanks". RN Ms F advised HDC that the fact she contacted Dr K demonstrated that she had listened to, and acknowledged, Ms B's concerns.

123. Dr K recalls receiving a telephone call from a nurse on the general medical ward (she cannot recall who), advising that Mr A's family were concerned and that he was confused. While she recognised this "as an acute change" in Mr A's condition, she was still busy in ED and knew she would be for some time, so she asked Dr L to go and see Mr A and his family. At 7.10pm a page was sent to Dr L reading: "plse r/v pt [Mr A] [medical ward], thanks, plse phn [Ms G] [number]".

124. Ms B advised HDC that she overheard RN Ms F on the telephone to the house surgeon advising that Mr A was nauseous, but she did not mention that he had vomited.

125. Ms B says that shortly afterwards RN Ms F said to her that it did not fit with the house surgeon's schedule to see her now, and the house surgeon had asked if she (Ms B) could come and see him tomorrow morning at 7am. Ms B advised HDC that she

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said to RN Ms F that she would be there tomorrow at 7am but she was concerned about her father's state now, and had been throughout the day. She also said to RN Ms F that a lot can happen in the next 12 hours so she wanted to see the doctor "now".

RN Ms E's review

126. RN Ms E advised HDC that she received a text message from Ms B at 6.53pm stating that her father had vomited and that the RNs had left her alone with him. Ms B also advised in her text message that she had overhead the RNs on the telephone to the house surgeon saying that Mr A's observations were normal and that he was stable.

127. RN Ms E returned to the general medical ward and recalls thinking that Mr A had deteriorated due to the vomiting, somnolence, and his slight confusion. This prompted her to discuss Mr A with RNs Ms G and Ms H. She recalls that they discussed the fact that Mr A had been thrombolysed, his low oxygen saturation (92% at 6pm), the lack of blood tests for that day, his transfer from CCU, and the possibility that he may be having a CVA as this was a complication of thrombolysing a patient with Mr A's condition.

128. RN Ms H advised HDC that they did not specifically discuss the possibility of Mr A having a CVA. However, she advised that, after reading in the notes that he had a headache and that the family were concerned he was becoming increasingly confused, she recognised that he may be having a bleed and paged the house surgeon. There is no record of this page. RN Ms H advised that she spoke to the house surgeon and told him what Mr A had come in for, the treatment he had received, his confusion, and headache, and that the house surgeon "came up immediately". RN Ms H could not recall what time this was but noted that the house surgeon's notes were written at 8.30pm.

129. RN Ms E recalls advising the RNs that "this was most unlike" Mr A, noting that he was "so sleepy and not as bright and perky as he normally would have been because he would have normally been giving me some cheek as this was our normal interaction". RN Ms E recalls that RN Ms G then paged Dr K, who advised her to call Dr L. RN Ms E then returned to CCU.

130. Both RNs Ms F and Ms G advised HDC that RN Ms E never spoke directly to them, although RN Ms F recalls seeing RN Ms E speaking to RN Ms H who was working on another part of the general medical ward. RNs Ms F and Ms G also recall seeing RN Ms E speaking with Ms B. RN Ms G recalls hearing "mumblings" from RN Ms E, and her saying that "this is not his normal behaviour". She also overheard RN Ms E and Ms B referring to the fact that Mr A usually had a good appetite and was not his usual joking self. RN Ms G advised that, on hearing this, she told RN Ms E that Mr A was tired and just wanted to sleep.

131. RN Ms F advised HDC that while taking Mr A's observations (there is no record of these), she found that his oxygen saturation was 93% and overheard RN Ms E whisper to Ms B that he should be put on oxygen as she thought his level of consciousness was compromised. RN Ms F advised HDC that she knew that RN Ms E had nursed Mr A in CCU and therefore decided to put Mr A on two litres of oxygen.

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132. There is no documentation in Mr A's clinical records of him being put on oxygen therapy at this time, nor the effect it had on his oxygen levels; and when Dr L later reviewed Mr A he was noted to be breathing room air. RN Ms F advised HDC that she can only assume the reason Mr A was breathing room air at this time was because the prongs had not been put back in place after Mr A went to the bathroom.

RN Ms I

133. RN Ms I was the duty nurse manager and her shift commenced at 3pm. RN Ms I advised HDC that she was in ED for the start of her shift as it was very busy. RN Ms F recalls that she first contacted RN Ms I at approximately 8pm as they had not been able to get a doctor to come to the general medical ward and there was "noticeable tension around the family". RN Ms F advised HDC that she asked RN Ms I to come to the ward to help them manage the situation and because she felt uncomfortable with how things were proceeding.

134. RN Ms I recalls receiving a page at approximately 5.30pm from the nurses on the general medical ward saying that they were concerned about Mr A. She then went to the general medical ward and spoke to RN Ms F and recalls her saying that Mr A's family were angry and concerned most of the day that he had not been seen by the on-call doctor. RN Ms I recalls that the nurses felt Mr A's observations were OK but noted that he was a bit sleepy, and that this was what the family were concerned about. RN Ms I recalls asking RN Ms F if she had paged the house surgeon, and RN Ms F responded that she had. RN Ms I advised HDC that she told RN Ms F to "page him again, send an urgent page".

135. RN Ms I advised HDC that Ms B was concerned and upset that the nurses did not recognise her father had problems and needed to be assessed by a doctor. She recalls advising Ms B that an urgent page had been sent to the house surgeon in ED.

136. RN Ms I says that she left the general medical ward because she was called to ICU, but that at approximately 7.30pm she received a page from the nurses on the general medical ward advising that the house surgeon had not yet come to the general medical ward. RN Ms I advised HDC that she told RN Ms F to "keep paging", and RN Ms F responded "but he might get annoyed". RN Ms I recalls telling RN Ms F that that was not their concern.

137. RN Ms I called the house surgeon in ED at 7.40pm and was told that the house surgeon was on his way up to the ward. RN Ms I advised HDC that she returned to the general medical ward to wait for the house surgeon, who she recalls arriving on the ward at approximately 8.00pm.

138. RN Ms F advised HDC that she and RN Ms G sent the house surgeon at least six urgent pages each during their shift asking for an urgent review of Mr A, but that there was no reply from the house surgeon. RN Ms G advised HDC that she paged house surgeon Dr K once at about 6pm in relation to the family's concerns, not about Mr A's condition, as she believed there was not an immediate need for review given that his observations were stable. A print out of the pages sent does not support this. It

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shows that two pages were sent from the general medical ward to Dr K— the first at 6.42pm and the second at 7.07pm, and one to Dr L at 7.10pm.

139. At 9.30pm RN Ms F recorded in Mr A's notes that the duty nurse manager was "aware of family dynamics".

Dr L

140. Dr L advised HDC that the first time he was contacted about Mr A on Sunday was at approximately 7.30pm via a page from Dr K. Dr L advised HDC that Dr K was "first on", meaning that she was the first point of contact for the nurses on the general medical ward. Dr L recalls that Dr K was busy in ED and asked him if he could see Mr A as the nurses had requested a review due to the family's concern that he appeared more confused than usual.

141. Dr L advised HDC that at the time of receiving Dr K's request he was in the paediatric ward reviewing an unwell child, but that as soon as he was finished he went directly to see Mr A.

Dr L's assessment

142. Dr L recalls arriving on the general medical ward between 8pm and 8.30pm. He recalls reading Mr A's notes and taking a history from the nurses before seeing Mr A and his family at approximately 8.30pm. Ms B's recollection is that Dr L arrived on the ward at approximately 9pm.

143. Dr L's time of his assessment is recorded at 8.30pm. He recorded the family's concerns that Mr A was drowsy and tired, slightly confused, complaining of a general headache, nausea and had vomited. Dr L noted that Mr A was now feeling better and denied having a headache or nausea, and his family reported that he appeared more alert and coherent compared to earlier that day but was still slow to respond to questions and had some word-finding difficulty.

144. On examination, Dr L noted that Mr A was alert, his temperature was 35.5°C, his heart rate was 80bpm and regular, his blood pressure was 150/90mmHg, and his oxygen saturation was 92% on room air. He was noted to have a Glasgow Coma Scale[27] (GCS) of 14/15 and he was oriented to time and place, but was unable to recall his daughter's name or the month. He was also noted to have occasional word-finding difficulty, such as being unable to say why he was in hospital or what he had for lunch, although he could visualise it.

145. Dr L recorded his impression as "confusion/delirium [with] some expressive dysphasia" and noted that the neurological examination was normal. Dr L recorded "consider [intracranial] event (unlikely) query [normal] neuro exam. Not on any psychotropic medication to explain confusion. Possibly ?[secondary] to infection" and noted the possibility of urinary tract infection or upper respiratory tract infection. RN

[27] The Glasgow Coma Scale is a tool used to evaluate a patient's level of consciousness. The patient is assessed against the criteria of the scale, and given a score between three and fifteen, with three indicating deep unconsciousness or death, and fifteen indicating a fully awake person.

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Ms G noted in her response to the complaint that it was Dr L's impression at this time that Mr A was suffering from an infection, not a haemorrhagic CVA.

146. Dr L's recorded plan was to obtain a mid-stream urine sample, discuss with the consultant as to whether they should do a CT scan of Mr A's head that night, consider recording Mr A's fluid input and output on a fluid balance chart, checking his urea and electrolytes, doing a chest X-ray, and recording his neurological observations four hourly. Dr L recorded that the nurses were to call the on-call house surgeon for review if Mr A's GCS dropped more than two points, if his systolic blood pressure fell below 90, if his heart rate was greater than 120bpm or less than 50bpm, if his oxygen saturation was less than 90%, if his respiratory rate was greater than 30 breaths per minute or less than 12 breaths per minute, or if they were concerned.

147. Ms B advised HDC that she asked Dr L if they would CT her father's head and he replied that it would be unlikely the consultant would allow it that night. Ms B recalls Dr L advising her that he felt confident her father's confusion was caused by an infection and reiterated that he did not think it was cerebral. Ms B advised HDC that she and her mother left the hospital at approximately 9.45pm.

148. Dr L advised HDC that it was approximately 9.30pm by the time he had finished reviewing Mr A and writing up his notes. He then went to ED to hand over to the on-call house surgeon and discuss Mr A over the telephone with the medical consultant, in particular, whether an urgent CT of Mr A's head was required. While not recorded in Mr A's notes, it is noted in TDH's overview of the case that the consultant decided not to do a CT scan at that stage due to the absence of any focal neurology but he requested an urgent review if any neurological or haemodynamic changes were noted.

Neurological observations

149. At 9.30pm, RN Ms F recorded in Mr A's notes that house surgeon Dr L was on site to speak to the family. Following this she recorded that Mr A was to have his neurological observations taken four hourly.

150. A Neurological Observations Sheet was commenced and it is recorded at the top of the chart as being commenced at 9pm. However, the first set of observations is recorded on the chart as being done at 8.30pm. The observations documented as being done at 8.30pm record Mr A's GCS (15/15), blood pressure (161/115mmHg), left pupil size (3mm) and reaction (tick). Nothing was recorded for the right pupil. RN Ms F advised HDC that she only checked and recorded Mr A's left pupil as she had read in Mr A's clinical notes that he had "assymetrical pupils — irregular [right] pupil — normal 3mm [left] pupil".[28] RN Ms F advised HDC that had she reported that Mr A's right pupil was non-reactive, "it could well have given false information and given an inaccurate clinical picture".

151. Mr A's arms and legs are noted as having "normal power". No temperature or pulse was recorded.

[28] This information had been recorded by Dr L in his admission notes for Mr A on Thursday.

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152. RN Ms F can not recall whether she took Mr A's observations at 8.30pm and then transferred them the Neurological Observations Sheet at 9pm, or if she took and recorded the observations at 9.30pm but mistakenly documented the time as 8.30pm.

Observations at 9.45pm

153. At 9.45pm RN Ms F recorded Mr A's observations in his TEWS chart. Under respiratory rate "apnoea" is noted. RN Ms F advised HDC that she had witnessed "a short period of apnoea" and she watched Mr A to see if it happened again, but it did not. Mr A's oxygen saturation is also recorded but appears to have been altered and is indecipherable. RN Ms F was unable to explain why the oxygen saturation figure was crossed out.

Neurological observations 10pm

154. RN Ms F did another set of neurological observations at 10pm. RN Ms F advised HDC that she chose to monitor Mr A "more regularly" than the four-hourly neurological observations that had been prescribed by Dr L, due in part to the family's concerns for Mr A. At 10pm Mr A's blood pressure is recorded on the neurological observation sheet (190/100mmHg). No other observations are recorded at this time.

155. The next blood pressure recording on the neurological observation sheet is not timed but records a blood pressure of 200/107mmHg. RN Ms F advised HDC that, as Mr A's blood pressure was continuing to rise, she decided to request a further review by the house surgeon. RN Ms F recorded in Mr A's clinical notes that his blood pressure was increasing and that the on-call house surgeon had been notified. Next to this RN Ms F recorded "[10.30pm] B/P 161/113, 190/100, 200/107. For review of B/P. ADD [patient] has a large distended tight abdomen."

156. TDH's page records show that a page was sent to Dr L at 10.30pm reading "[general medical ward] pls review b/p [Mr A]. 161/113. 200/107." This page was received by on-call house surgeon Dr T, who had taken over from Dr L.

Dr T's assessment

157. Dr T noted in Mr A's clinical record at 11pm that he was asked to see Mr A due to increasing blood pressure and confusion. Dr T recorded that Mr A continued to be confused but there was no headache, dizziness, nausea, vomiting, weakness or numbness, and that no problems with vision or speech had been noticed.

158. Dr T's examination of Mr A found that he had normal, symmetrical posture, he was afebrile, his blood pressure trend was up, his pulse was stable (80bpm) and his oxygen saturation was 92% on room air. Dr T also noted that Mr A was confused (he was oriented to person and knew his home address, but was not oriented to time or place), that he had some word-finding difficulty and some right-sided homonymous hemianopia.[29]

[29] Visual field loss in half the field of view on the same side of both eyes.

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159. Dr T noted that Mr A's pupils were asymmetrical (right pupil was larger than his left),[30] his face was symmetrical and he had normal power and normal sensation.

160. Dr T's impression was "possible posterior bleed" and HTN (hypertension). His plan was to CT scan Mr A's head, and monitor his blood pressure, noting that Mr A would probably need blood pressure control.

CT head scan results

161. Mr A was taken for a CT head scan after Dr T's review. The scan revealed that Mr A had an intracerebral haemorrhage and this was reported to Dr T at 12.50am on Monday. Mr A was transferred to ICU for closer monitoring and his family was informed.

Concerns about speech language therapy assessment

162. Ms C expressed concerns about the lack of a speech language therapy (SLT) assessment for her father while he was in ICU following the diagnosis of his CVA. Ms C advised HDC that on seeing her father being given water through a straw, she asked staff if her father had received an SLT assessment to assess his gag reflex, and was advised that he had not. Ms C recalls the consultant asking her if she would like a SLT assessment done, and she replied that she would like everything done to assist her father, and that an SLT assessment "should have gone without saying". On Monday, Dr J recorded in Mr A's notes under "Plan", for Mr A to have an SLT assessment.

163. Ms C advised HDC that when the SLT assessment did not occur she asked when it would be done, and was told that the speech language therapist was on leave. However Ms C recalls the physiotherapist advising her that other staff were trained in the SLT gag reflex assessment, including RN Mr P.

164. The following is recorded in Mr A's clinical notes at 3.50pm on Monday by an RN: "no problems [with] swallowing has had [water], ice, porridge without any problems, no aspiration … [Physio] has seen pt. SLT away till October. Please can pt. have swallow assessment done by ?ICU nurses."

165. At 11.30pm that night the clinical notes document that Mr A was "drinking thickened fluids well", and at 6am on Tuesday a different RN documented that Mr A was "tolerating thickened fluids well".

166. RN Mr P advised HDC that he recalls responding to a call bell from Mr A's room and being asked by Mr A's daughter if an SLT assessment could be done. RN Mr P cannot recall what his response was, but recalls noting that the nurse who was assigned to Mr A had recorded that Mr A's swallow reflex was OK, and he trusted the nurse's assessment.

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[30] Mr A's right pupil was chronically dilated due to recurrent iritis, and this was noted by Dr L in his review at 8.30pm.

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167. RN Mr P further advised HDC that he was very busy with a large case load and did not have time to do the SLT assessment right then, but believes he probably said to Mr A's daughter that if he got the opportunity he would carry out the SLT assessment on Mr A.

Deterioration

168. Unfortunately, Mr A's condition continued to deteriorate, and it was decided after discussion with his family that active treatment should be stopped and he should have palliative care only. Mr A died a few days later.

Changes made by individual nurses

169. RN Ms D has now retired from nursing. However, following these events and prior to retiring she advised HDC that she had done a lot of soul-searching. She advised that she did not believe she mismanaged Mr A, but did make changes to her practice by paying much more attention to her documentation, writing more detailed notes and re-reading her notes before leaving the ward to ensure she has not missed any important points. She also advised that she was more pro-active in dealing with patients' relatives and noting their concerns, acknowledging that the family may recognise changes in the patient that the nurses do not.

170. RN Ms G acknowledged that she did not use the TEWS system and advised that this was due to unfamiliarity with the system as it was "relatively new" to Gisborne Hospital. RN Ms G initially told HDC that she had not had time to attend any of the TEWS training workshops. However, TDH advised HDC that, according to its record of professional development, RN Ms G attended a TEWS teaching session on 13 November 2008, prior to the pilot commencing on the general medical ward. RN Ms G responded that she cannot remember having attended any TEWS training but accepts that she must have if it is recorded that she attended.

171. RN Ms G advised HDC that since these events she has made the time to study the TEWS scoring system and SBARR communication tool[31] and now implements them in her nursing practice on a daily basis. RN Ms G also advised HDC that she will be attending the next in-service training session "Sepsis/the deteriorating patient" and a seminar on "High dependency Acute Nursing Skills". RN Ms G told HDC that on 9 May 2012 she attended a course on "Open disclosure — conducting effective conversations with disappointed patients and families". She also told HDC that on 11 November 2011 she completed a recertification audit for the Nursing Council of New Zealand.

172. RN Ms G advised HDC that she believes the quality of care she provided Mr A, other than not using the TEWS system, was appropriate and did not compromise Mr A's

[31] In October 2008 Gisborne Hospital introduced the SBARR communication tool. SBARR is an acronym for Situation, Background, Assessment, Recommendation, and Response. The purpose of the tool is to improve the effectiveness of communication between staff. It provides a framework for delivering precise and relevant information to another person in the clinical situation, ensuring that relevant information is conveyed between clinicians when seeking clinical review, advice, or assessment.

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safety. She believes she acknowledged, and responded adequately to, the family's concerns.

173. RN Ms F advised HDC that she is "not as confident as the younger nurses coming out now to challenge things". She advised HDC that on 13 October 2009 she attended the in-service training on the TEWS system and now uses the TEWS system routinely on standard observations and notifies the house surgeon accordingly. RN Ms F added that she recognises how important the TEWS system is as it highlights the changes in the patient during the duty.

174. RN Ms F also advised that she now actively pursues learning initiatives and attends in-service seminars, and makes an effort to "respect, inform, educate and develop a comfortable rapport with the patient's family". TDH told HDC that on 23 February 2011 RN Ms F attended communication training.

175. RN Ms F told HDC that she also now pays particular attention to her senior role, and discusses any difficulties with her nursing colleagues and the duty nurse manager. She also advised that their workloads are now monitored more closely.

176. RN Ms F also noted that following this incident they have an extra nurse and health care assistant, and that the house surgeons are "much more responsive and ask more questions".

TDH's response to complaint

177. Ms C and Ms B initially approached TDH with their concerns about the care provided to their father. Mr M responded by way of letter on 3 December 2009, and some of Mr M's responses have already been incorporated in the earlier sections of this report.

178. Mr M advised that, as a result of the concerns raised, TDH undertook an extensive review of Mr A's care, with a specific focus on the events of Sunday.

179. Mr M acknowledged that inadequate observations were taken on Saturday evening and overnight. Mr M also noted that three complete sets of observations were taken between 1pm and 6pm on Sunday, and while none of those observations would have triggered a response through the TEWS alert system, he advised that "it is concerning and very disappointing that the recently implemented tool was not utilised by nursing staff".

180. Mr M advised that the organisation's TEWS chart has a scoring system and escalation process incorporated into it, and that there is also a supplementary chart for continuing observations that does not include the scoring system and escalation process. Mr M advised that the TEWS chart that was commenced in CCU prior to Mr A's transfer to the general medical ward was the supplementary chart. While accepting that this was not directly responsible for the nurses' failure to use the TEWS scoring system, Mr M believes that this did not support its effective use.

181. Mr M noted that while the Clinical Director found the observation-taking over the "critical afternoon period" on Sunday to have been adequate and appropriate, the

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wider concern, from a nursing perspective, was the absence of observations in the period following transfer from CCU, the failure to utilise the TEWS scoring system, and the discrepancy around the timing of observations later in the evening.

182. Mr M also acknowledged inadequacies in how the nurses communicated with the family, and responded to their concerns, noting that "the staff involved certainly identified tension but clearly saw it as an attitude you had rather than as a reflection of the care they were providing to your father and your family. I sincerely wish to apologise to you for this unhelpful attitude and it will likely be a key issue for address".

183. With regard to the delay in diagnosis, Mr M made the point that a full neurological examination at 8.30pm did not identify any focal neurology or functional deficit, and it was not until "newly diagnosed visual disturbances were present in the second examination at [11pm] that a head CT scan was ordered." Mr M commented that this supports the documented and reported situation that throughout the afternoon Mr A had "subtle symptoms that did not immediately alert either medical or nursing staff to his impending deterioration". This view was also supported by the Clinical Director at Gisborne Hospital, who commented that from reviewing the documentation "it appears [Mr A's] initial symptoms were rather non-specific".

184. Nevertheless, Mr M advised that it was concerning that the nurses failed to recognise the family's concerns about Mr A noting that, "in retrospect [the nurses] acknowledge that [the family] clearly recognised and tried to identify something was not right before staff recognised and escalated the situation". Mr M added that while the nursing staff involved were all able to articulate what they should be looking for in respect of detecting an intracranial bleed, this case has identified that "more subtle signs were not linked together to allow this awareness to occur sooner".

185. Mr M identified the following issues for addressing:

- Up-skilling the particular staff involved with Mr A's care in the recognition of the deteriorating patient by working through individualised plans. TDH subsequently provided HDC with a copy of RN Ms F's individualised plan which identified RN Ms F's development needs as: up-skilling in recognising the deteriorating patient; understanding the significance of the TEWS chart; and understanding the purpose and benefits of the SBARR tool. The plan lists three actions for RN Ms F to take: (1) arrange an in-service training session by a doctor to cover "Sepsis and the Deteriorating Patient"; (2) Work at the TEWS chart in her daily practice; (3) Recognise the importance of the SBARR chart in relation to communicating the changing condition of her patients. TDH advised HDC that each of the three follow-up actions had been "executed".

  TDH advised HDC that as RN Ms G was working at Gisborne Hospital on a casual basis at the time of the events, no individualised learning plan was developed for her. However, it noted that she has attended various learning sessions including personal restraint; dysphagia screening assessment for nurses; advance IV certification; The Liverpool Care Pathway; and Incident Management Training.

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- Up-skilling ward staff generally in the recogniotion of the deteriorating patient using focused education. Ms N, Director of Nursing, subsequently advised HDC that they held an in-service session for staff called “Sepsis and the deteriorating patient” and that staff who were directly involved with Mr A attended this. However, from the attendance form, it appears that RN Ms D and RN Ms G did not attend this session.

- Retraining and reinforcing the use of the TEWS system to assist in the recognition of the deteriorating patient across all acute wards. Ms N subsequently advised HDC that this was addressed by frequent attention at ward meetings; putting up a large sign in the office reminding staff to add TEWS scores; addressing staff individually “on the spot” regarding TEWS practice; and carrying out a vital signs audit in March 2010, which showed 100% of TEWS charts were being totalled. Ms O (Acting Director of Nursing) also advised HDC that TDH took educational sessions on TEWS to the wards in a “road show” type manner.

  TDH subsequently advised HDC that audits of the TEWS charts on the general medical ward were carried out in May 2011, November 2011, and March 2012. It advised that “each of the audits have shown good compliance with the documentation standards although audits have been small. Continuing audits of at least 10 charts per audit will be maintained”.

- Requesting that the Clinical Director discusses this event with his senior medical team to review whether the current process for weekend consultant cover and referral is appropriate. Ms N subsequently advised HDC that the medical team reviewed current processes including comparisons with other DHBs with similar services and considered the current processes to be appropriate.

- Discussing at a ward forum issues relating to attitudes towards families and facilitating effective communication with families. Ms N subsequently advised HDC that the Clinical Nurse Manager had reported that these issues had been raised at ward staff meetings and that, as a result, the Clinical Nurse Manager felt that overall performance in these areas has improved. Ms N also advised HDC that many more family meetings are being held where the medical, nursing, and allied health staff meet with the patients and family to discuss issues, and that where communication problems are emerging staff are encouraged to discuss these issues with their team and it is then decided as a team how best to resolve the issue.

186. Mr M also advised that he had spoken with “all the key participants in this event” and provided them with feedback on the family’s concerns, why the concerns arose, and the distress this created for the family.

Further information from TDH

187. Ms N provided further information on some of the issues raised by the complaint.

188. With regard to communication with the family, Ms N advised HDC that “TDH apologises for the added distress for [Mr A’s] family … which could have been

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lessened if the nursing staff had responded differently to the concerns raised". Ms N also advised HDC that TDH "has and will continue to focus on improving communication, however, effectiveness of communication also requires individual personal effort".

189. Ms N included the following comments from the Clinical Nurse Manager about the learning that has taken place since this incident:

> "I feel we have addressed and learnt from this incident and patients are better monitored and concerns addressed. We will continue to remind each other about attitude and communication with relatives and patients. Our work is such that we need on-going support from each other and reminding not to take issues on board but to discuss them in the proper environment."

190. With regard to communication between staff, Ms O advised HDC that she accepts that "sufficient clinical information was not passed over to the house surgeon when contacted, either based on nursing or family observations". Ms O advised HDC that the SBARR communication tool had been introduced in October 2008 to improve the effectiveness of communication, particularly between nursing and medical staff, and that much work has been done educating staff on the use of SBARR, including making available a SBARR DVD to all new staff, and to wards and units as a refresher.

191. With regard to the staff rostered on the general medical ward on Sunday, Ms O advised HDC that the staff numbers and skill mix "should have been sufficient to cope with the workload", and that clinical expertise and advice was available to the nurses from the duty nurse manager. However, Ms O has also advised HDC that she will make a recommendation that RN Ms D, RN Ms F, and RN Ms G commence the Professional Development and Recognition Programme and submit a portfolio for assessment within a three-month timeframe, which will provide reassurance that each of the nurses are practising at a competent level or provide a mechanism for remedial training and education.

192. Ms O also advised HDC that while a shift co-ordinator was rostered on the morning and afternoon shifts on Sunday, on both occasions the shift co-ordinator was also part of the team nursing allocation. While this was normal practice for the general medical ward on the weekend, Ms N advised HDC that, in light of this event, this practice will be reviewed.

TDH's response to provisional opinion

193. TDH told HDC that, "knowing that change in health care is slow to take effect, TDH does not feel that it was unreasonable for both iniatives [TEWS and SBARR] to be allowed to settle for a period of 12 months following which TDH did undertake an audit of both initiatives. The provisional breach finding appears to be based on an expectation that this new initiative would be operating faultlessly immediately." TDH also told HDC that it "did everything it could to enable staff to understand and use both the TEWS system and SBARR tools effectively, and it should not be held

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responsible for the failure of RN Ms F and RN Ms G to use the TEWS system or effectively communicate with this family".

Opinion: No breach — RN Ms D

194. RN Ms D was responsible for Mr A's care on the general medical ward from 7am until 3.30pm on Sunday. During this shift RN Ms D was responsible for 11 patients and was required to oversee and direct a new graduate nurse. My independent nursing expert, RN Diane Penney noted that this was a significant workload for one person. Overall, Ms Penney considers there were some minor shortcomings in the care provided by RN Ms D, particularly in relation to her response to the family's reports of confusion, and her standard of documentation. In my opinion however, these matters are not of sufficient concern to constitute a breach of the Code.

Supervision during shower

195. Mr A's family were concerned that he was not supervised while showering on Sunday. RN Ms D advised HDC that she did not directly supervise Mr A while he was showering but she was either in Mr A's room or the room opposite Mr A's room at all times.

196. Ms Penney considers it was acceptable, and in line with national and international practice for RN Ms D not to directly supervise Mr A given his condition at the time, but remain close by and within hearing and speaking distance.[32] I am satisfied that RN Ms D did not depart from an appropriate standard of care by allowing Mr A to shower independently on Sunday.

Response to reports of confusion

197. When Mr A returned from his shower, his family noted he was confused and reported this to RN Ms D. RN Ms D documented that Mr A denied being confused and she "observed" Mr A but the confusion was "not noticed". RN Ms D also advised HDC that she checked on Mr A regularly, however, no neurological or routine observations or timings were documented as being done during those checks.

198. I agree with Ms Penney that RN Ms D's assessment of Mr A, once confusion was first reported, was inadequate. There is no description of what RN Ms D observed and how she reached the conclusion that Mr A was not confused, which is insufficient, particularly in light of the family's clearly stated concerns in this regard. However, I note that RN Ms D asked RN Ms S to take Mr A's observations, and RN Ms S informed RN Ms D that these were within normal parameters. Furthermore, Mr A told her on a subsequent check that he felt fine. While I accept that RN Ms D has since reflected on and made positive changes to her practice, I consider that RN Ms D needs to think carefully about the adequacy of her assessment of Mr A. Nevertheless, in the

[32] On a separate point, Ms Penney noted that Mr A's telemetry unit was removed for his shower, as it was not waterproof. Ms Penney queried the value of using non-waterproof telemetry units on patients that require continuous monitoring where it will need to be removed for a shower that could take 30 minutes, and where there will potentially be no direct observation during much of that time. TDH subsequently advised HDC that telemetry units have now been replaced with waterproof equipment.

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circumstances I do not find that RN Ms D breached the Code regarding her assessment of Mr A.

Documentation

199. Ms Penney commented that RN Ms D's documentation could have been better in several areas. For instance, RN Ms D did not document her telephone conversation with Mr A's daughter, Ms C, which concerned several aspects of care provided to Mr A over the shift. RN Ms D also did not document the conversation she allegedly had with Dr L about Mr A's headache and vagueness. As mentioned above, RN Ms D did not document any observations during her "regular" checks of Mr A.

200. I also note a discrepancy between the drug chart and the clinical notes. While it is documented on the drug chart that Mr A was given paracetamol at 12pm, RN Ms D documented in the clinical notes that Mr A was given paracetamol at 1pm.

201. In my view, busy shifts and high workloads do not excuse poor documentation. Maintaining clear, concise, timely, accurate, and current client records is one of the competencies of a registered nurse.[33] While I consider RN Ms D's standard of documentation could have been better, I accept Ms Penney's advice that the deficiencies in RN Ms D's documentation were only a mild departure from an acceptable standard. In these circumstances I do not find that RN Ms D breached the Code regarding her standard of documentation.

202. I acknowledge that RN Ms D has since reflected on her practice, and advised HDC that when she was practising, after these events she paid more attention to maintaining accurate and detailed documentation, and was more pro-active when dealing with family members' concerns.

Opinion: RN Ms G

Introduction

203. I acknowledge that RN Ms G was not a permanent member of staff at Gisborne Hospital. However, four months prior to these events she was a permanent employee, and at the time of these events RN Ms G was employed by TDH on a casual basis. In any event, the standard of care required from a registered nurse is not altered by their permanent or casual employment status.

204. I also note that in the cardiac area of the general medical ward, where Mr A was, the nurses operate as a team. Accordingly, RN Ms G and RN Ms F shared the care of Mr A and the other 11 patients who were on the cardiac section of the general medical ward on Sunday.

[33] Competency 2.3 of the "Competencies for registered nurses" published by the Nursing Council of New Zealand.

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Assessments and communication with house surgeon prior to review — No breach

205. At 5.30pm on Sunday, Ms B raised her concerns about her father's deterioration in condition with RN Ms G. RN Ms G replied that Mr A was "actually more alert then than he had been at the beginning of [her] shift". She then assessed Mr A's level of consciousness by asking him to answer questions in relation to time, place, and person, and took his observations. She was satisfied with his observations and responses and, while noting that he was sleepy, did not consider medical attention was warranted. RN Ms F also reviewed Mr A at the request of RN Ms G, and agreed that Mr A was stable and did not warrant a medical review.

206. RN Ms G advised HDC that as Ms B remained dissatisfied with their assessments of Mr A, she paged Dr K to come and speak to the family to address the family's concerns. RN Ms G also says she made it clear to Dr K that Mr A's observations were stable and she did not have any concerns about them.

207. There is no record of RN Ms G's page to Dr K, and it is Dr K's recollection that the only page she received was from RN Ms F, not RN Ms G, and that page was received at 6.42pm. I therefore consider it more likely than not that RN Ms G did not contact Dr K about Mr A at 6pm.

208. In any event, I consider that it was reasonable for RN Ms G not to seek a medical review at that time in light of the fact that Mr A's observations were stable. I note that when Dr L reviewed Mr A at 8.30pm, Mr A's observations were very similar to the observations recorded at 6pm and were still considered by Dr L to be stable. In the circumstances, I do not find that RN Ms G breached the Code by not seeking a medical review of Mr A at that time, despite the concerns expressed by the family.

Failure to take observations after vomiting — Breach

209. I am, however, concerned about the absence of any observations after Mr A vomited. According to Ms Penney, when Mr A vomited and complained of a headache at around 6.45pm a new set of observations should have been taken and recorded, with another set being taken and recorded after 30 minutes. I note that no observations were recorded until 9.45pm. RN Ms G advised HDC that she believes observations were taken after Mr A vomited but cannot recall if they were taken by both her and RN Ms F together, or just RN Ms F. She cannot understand or explain why nothing regarding these observations was recorded in the notes. RN Ms F does not recall if she took Mr A's observations at that time and believes that RN Ms G's recollection (of them taking Mr A's observations together) may be in relation to the observations that were taken at 6pm, before Mr A vomited.

210. This Office has previously referred[34] to the decision of Baragwanath J in *Patient A v Nelson–Marlborough District Health Board*[35] where he stated that it is through the medical record that health care providers have the power to produce definitive proof of a particular matter (in that case, that a patient had been specifically informed of a

[34] See opinion 08HDC10236

[35] *Patient A v Nelson–Marlborough District Health Board* (HC BLE CIV–2003–406–14, 15 March 2005).

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particular risk by a doctor). This applies to all health professionals who are obliged to keep appropriate patient records. Health professionals whose evidence is based solely on their subsequent recollections (in the absence of written records offering definitive proof) may find their evidence discounted. Given the lack of evidence to support RN Ms G's recollection, I am of the view that no observations were taken and this was inadequate care.

211. I acknowledge that the family's interactions with RN Ms G meant that her focus at times was on managing the family, and potentially clouded her ability for sound decision making. Nevertheless, nurses have a duty to provide their patients with adequate and appropriate nursing care and must have strategies in place to ensure that they are able to do so.

Documentation — Breach

212. There were several discrepancies in the recording of Mr A's observations once the neurological observation chart was introduced. It is also difficult to ascertain from these records what Mr A's blood pressure was at what time. Both RN Ms G and RN Ms F were documenting Mr A's observations on the TEWS chart and neurological observations chart. In my view they are both accountable for the inaccuracies and discrepancies.

213. RN Ms G also failed to document anything about her interactions with Mr A's family. For instance, RN Ms G advised HDC that Ms B was "agitated and yelling" at her when they first met at the beginning of the shift, which prompted her to ask RN Ms F to take the "lead role" to allow some distance to be kept between herself and Ms B. However, there is nothing written in the notes about this.

214. In addition, RN Ms G failed to enter total scores on Mr A's TEWS chart for his observations recorded at 3.45pm, 6pm, 9.45pm and 11.15pm on Sunday. This failure is not excused by RN Ms G's assertion that she was unfamiliar with the system as the system had been in use by Gisborne Hospital for nine months by the time Mr A was admitted.

215. Maintaining clear, concise, timely, accurate, and current patient records is a registered nurse competency.[36] It is particularly important for continuity of care, as it provides those unfamiliar with the patient with a clear and accurate history of the patient, and assists them in detecting any changes from the patient's usual condition. I agree with Ms Penney's opinion that the standard of documentation kept by RN Ms G was well below the acceptable standard for a registered nurse.

Communication with family — Other comment

216. I am concerned by the effect RN Ms G's response to Mr A's family's concerns about Mr A's deterioration had on her relationship with the family. Her response to Mr A's family's concerns caused the family to lose confidence in RN Ms G which in turn created an atmosphere of distrust, making effective communication difficult.

[36] See footnote 33.

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217. Trust and communication are key to a good patient-nurse relationship (or in this case, the relationship between the patient's family and the nurse). As Ms Penney has advised, RNs need to develop a plan of communication with patients and patients' families, which is individual to them and their particular situation. I note that once RN Ms G recognised that there was discord between her and Ms B, she did attempt to defuse the tension that was building by choosing to take a "back seat", with RN Ms F taking a "lead role". However, this did little to improve the situation. In my view it was unsuccessful because it failed to address the underlying cause of the tension — the family's view that the nurses were taking a dismissive attitude toward their concerns. The issue of communication with families and failing to acknowledge the value of their input in informing clinical management has been the subject of previous HDC complaints.[37]

218. It is pleasing that Mr M has recognised that a key issue for the nurses to address is their attitude towards family members and the need to facilitate effective communication with families.

Changes to practice

219. RN Ms G advised HDC that she believes that the care she provided Mr A was appropriate and did not compromise the safety of Mr A. However, on reflection of these events, RN Ms G advised HDC that she has made time to study the TEWS system and SBARR communication tool, and now implements them in her nursing practice on a daily basis. She has also attended a course on open disclosure — conducting effective conversations with disappointed patients and families, and intends to attend the next in-service training on "Sepsis and the deteriorating patient".

Summary

220. In my opinion, RN Ms G did not provide Mr A with an appropriate standard of care on Sunday by failing to take and record a new set of observations after Mr A vomited and thus breached Right 4(1) of the Code. While I do not consider that RN Ms G breached the Code by not seeking a medical review of Mr A when his family raised concerns about his condition, communication with the family could have been better.

221. I also consider RN Ms G breached Right 4(2) of the Code by failing to complete her documentation to an adequate standard.

Opinion: RN Ms F

Introduction

222. As I have noted, the nurses operate as a team in the cardiac area of the general medical ward, where Mr A was being cared for. Accordingly, RN Ms G and RN Ms F shared the care of Mr A and the other 11 patients who were on the cardiac section of the general medical ward on Sunday.

[37] See opinions 08HDC04311and 08HDC17105.

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223. RN Ms F and RN Ms G were both responsible for Mr A's care. However, I note that RN Ms F was the more senior nurse on the team, being a permanent member of staff at Gisborne Hospital and having more experience than RN Ms G.

Assessments and communication with house surgeon prior to review — No breach

224. At approximately 5.30pm on Sunday, RN Ms F was alerted to Ms B's unease about her father's drowsiness and confusion. On finding that Mr A's vital observations were stable, RN Ms F was of the view that Mr A did not warrant a medical review. Nevertheless, RN Ms F did contact the house surgeon at approximately 6.40pm and RN Ms F was clear in her communication with Dr K that while Mr A's family had concerns, his observations were stable and she had no concerns herself. Under the circumstances, I consider RN Ms F's approach to advising Dr K was reasonable and note that her clinical assessment was later affirmed by Dr L who, at 8.30pm, found Mr A's observations to be stable.

225. RN Ms F advised HDC that she contacted Dr K via page at 7.07pm after Mr A vomited, and told her in the page that Mr A was nauseous and had vomited. However, this is not supported by the page records. Nor is it supported by Dr K's recollection of the telephone conversation with a nurse after this page.[38] While I acknowledge that it is not clear what information RN Ms F provided Dr K about Mr A when she spoke to Dr K on the telephone, I consider that RN Ms F did recognise that this change in Mr A's condition warranted a medical review, and asked Dr K to review Mr A. Dr K was busy in ED and so she asked Dr L to review Mr A. At the time of this request, Dr L was reviewing another patient, and came to review Mr A as soon as he was finished.

226. While I acknowledge that RN Ms F may not have provided the house surgeon with all of the information about Mr A's condition, in all the circumstances, I consider that RN Ms F's actions in contacting the house surgeon were appropriate, and I do not find that RN Ms F breached the Code in this respect.

Failure to take observations after vomiting — Breach

227. I am concerned about the absence of any observations after Mr A vomited. Ms Penney advises that, once Mr A vomited, a new set of observations should have been taken and recorded, with another set being taken and recorded 30 minutes later. No observations were recorded until 9.45pm. RN Ms G advised HDC that she believes observations were taken after Mr A vomited but cannot recall if they were taken by both her and RN Ms F together, or just RN Ms F. RN Ms F does not recall if she took Mr A's observations at that time and believes RN Ms G's recollection (of them taking Mr A's observations together) may be in relation to the observations that were taken at 6pm, before Mr A vomited.

228. This Office has previously referred[39] to the decision of Baragwanath J in *Patient A v Nelson–Marlborough District Health Board*[40] where he stated that it is through the

[38] Dr K only recalls being advised that Mr A's family had concerns about him and that he was confused.

[39] See opinion 08HDC10236.

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medical record that health care providers have the power to produce definitive proof of a particular matter (in that case, that a patient had been specifically informed of a particular risk by a doctor). This applies to all health professionals who are obliged to keep appropriate patient records. Health professionals whose evidence is based solely on their subsequent recollections (in the absence of written records offering definitive proof) may find their evidence discounted. Given the lack of evidence to indicate that RN Ms F took Mr A's observations after he vomited, I am of the view that no observations were taken and this was inadequate care.

229. I acknowledge that the family's anxiety and distress meant that RN Ms F's focus at times may have been on responding to the family, which potentially impacted on her ability for sound decision-making. However, this in no way diminishes RN Ms F's responsibility to provide safe and effective nursing care at all times. In my view, nurses need to have in place strategies to ensure they are able to continue providing appropriate nursing care in such circumstances. Providing adequate care to a patient, while at the same time managing anxious family members, is a skill that RNs are required to demonstrate.

Assessments and communication with house surgeon after review — Breach

230. Following Dr L's review at 8.30pm, RN Ms F was directed to do a full set of neurological observations every four hours. However, the first set, which were recorded as being done at 8.30pm (but may have been done at 9.30pm) were incomplete. For instance, Mr A's temperature and pulse were not documented. RN Ms F advised HDC that she did another set of neurological observations at 10pm. However, only Mr A's blood pressure is noted at that time. I agree with Ms Penney that RN Ms F's failure to record a complete set of neurological observations was inadequate.

231. RN Ms F also failed to contact a house surgeon in a timely manner following a significant change in Mr A's blood pressure at 9.45pm. At this time, Mr A's blood pressure was 161/113mmHg, which Ms Penney notes was "alarmingly higher than previous observations", and he was noted to have had an episode of apnoea. A house surgeon was not paged until 45 minutes later. In my view a house surgeon should have been contacted at 9.45pm and asked to review Mr A given the significant change from his previous observations.

Documentation — Breach

232. Both RN Ms G and RN Ms F were documenting Mr A's observations on the TEWS chart and the neurological observations chart. In my view they are both accountable for the inaccuracies and discrepancies.

233. There were multiple discrepancies in Mr A's blood pressure observations once the Neurological Observation chart was introduced, making it difficult to ascertain what Mr A's blood pressure was at what time. It is also not clear whether the first entry on the Neurological Observation chart was Mr A's observations from 8.30pm and then

[40] *Patient A v Nelson–Marlborough District Health Board* (HC BLE CIV–2003–406–14, 15 March 2005).

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transferred over to the chart at 9pm when it was commenced, or whether they were Mr A's observations from 9.30pm but mistakenly recorded as 8.30pm. I agree with Ms Penney that this is not an acceptable standard of documentation for a registered nurse.

234. Ms Penney is also critical of RN Ms F's subjective documentation relating to the family rather than objective documentation relating to what was concerning the family. For instance, while RN Ms F documented that Mr A's daughter was unhappy with her father's condition, she did not describe what it was that the daughter was unhappy about. RN Ms F also documented that the Duty Manager was "aware of family dynamics" without any further information about what dynamics she was referring to, or the outcome of the conversation with the Duty Manager.

235. I also note Ms Penney's concerns in relation to RN Ms F's failure to document clinically significant events, for instance, the administration of oxygen to Mr A, the rationale for doing so, and its effects on Mr A's oxygen levels; that Mr A had vomited; the duration of the episode of apnoea and what action was taken in response, and events following Dr L's review in relation to the possible CT scan. In addition, RN Ms F failed to enter total scores on Mr A's TEWS chart for his observations recorded at 3.45pm, 6pm, 9.45pm, and 11.15pm on Sunday.

236. In my opinion RN Ms F's standard of documentation on Sunday was inadequate. Maintaining clear, concise, timely, accurate and current patient records is not only a registered nurse competency, but it is a particularly helpful aid in the detection of a deteriorating patient, especially for those who are unfamiliar with the patient.

Medication round — Breach

237. Mr A's medication chart noted that he had been given metformin, enoxoparin and lipitor at 5pm on Sunday. RN Ms G signed the Administration Record indicating that she had administered the metformin and enoxoparin, and RN Ms F signed as administering the lipitor. However, instead of watching Mr A take the lipitor, RN Ms F left the medication on Mr A's bedside table as he told her he was tired and would take it later. RN Ms F advised HDC that she failed to follow her normal practice of watching the patient take the medication before signing for it, as she was "trying to be considerate to [Mr A]".

238. Ms Penney advises that the RN who signs for the medication as having been administered is responsible for ensuring that the patient takes the medication. RN Ms F signed for the lipitor tablets as having being administered, but failed to ensure that Mr A took them. In my view this is below the standard expected of an RN and is poor care.

Response to bleeding from luer site — No breach

239. Ms B was dissatisfied with RN Ms F's response to her concerns about her father's bleeding from his luer site. Ms Penney has advised that "ongoing bleeding or oozing from [a] luer site is relatively common post thrombolysis. Reinforcement over existing gauze to take as an immediate action, with an expectation of follow-up is a

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reasonable nursing action". I accept Ms Penney's advice and am therefore satisfied that RN Ms F's response to this issue was appropriate.

Communication with family — Other comment

240. When Ms B noticed her father had deteriorated and requested RN Ms F seek a medical review to investigate this further, rather than acknowledging and valuing Ms B's concerns, RN Ms F remained of the view that a medical review was not warranted because Mr A's observations were stable. I am concerned with the effect this response had on RN Ms F's relationship with Mr A's family. Such a response to the family's concerns caused Mr A's family to lose confidence in RN Ms F which in turn created an atmosphere of distrust, making effective communication difficult.

241. Trust and communication are key to a good patient-nurse relationship (or in this case, the relationship between the nurse and the patient's family). I agree with Ms Penney that RNs need to develop a plan of communication with patients and patients' families, which is individual to them and their particular situation. I note that later in the evening RN Ms F did seek assistance from the duty nurse manager, RN Ms I, to help her "manage the situation". However this did little to improve the situation. In my view it was unsuccessful because it failed to address the underlying cause of Ms B's distress, that is, the family's view that the nurses were taking a dismissive attitude toward their concerns. As noted above, the issue of communication with families and failing to acknowledge the value of their input in informing clinical management has been the subject of previous HDC complaints.[41]

242. It is pleasing to note RN Ms F's advice that she now makes an effort to "develop a comfortable rapport with patients' families".

Changes to practice

243. RN Ms F has indicated some learning from these events. For instance, as well as attending the in-service training on the TEWS system on 13 October 2009 and actively pursing learning initiatives, she advised HDC that she also pays particular attention to her senior role, discusses any difficulties with her colleagues and duty nurse manager, and makes "great efforts" to respect, inform and educate family members, and to develop a comfortable rapport with them. RN Ms F has also attended communication training and was assessed as "competent" after completing the Professional Development and Recognition Programme at TDH.

Summary

244. RN Ms F did not provide Mr A with an appropriate standard of care and in my view she breached Right 4(1) of the Code by failing to ensure a set of observations were taken and recorded after Mr A vomited, signing off medication for Mr A without ensuring he had taken it, and failing to complete a full set of neurological observations as directed by Dr L after his review of Mr A. While I do not consider that RN Ms F breached the Code in terms of her requests for medical review of Mr A when his family raised concerns about his condition, communication with the family could have been better.

[41] See opinions 08HDC04311and 08HDC17105.

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245. I consider that RN Ms F breached Right 4(5) of the Code by failing to contact the house surgeon in a timely manner following a significant change in Mr A's observations at 9.45pm.

246. In my view, RN Ms F also breached Right 4(2) of the Code by failing to complete her documentation to an adequate standard.

Opinion: Tairawhiti District Health

247. TDH is responsible for ensuring it has robust systems in place to provide an appropriate standard of care to its patients. It is also responsible for taking reasonably practicable steps to ensure its staff understand, and are compliant with its policies, procedures and guidelines. Ms Penney identifies several deficiencies in Mr A's care that stem from failures by TDH at the organisational level.

TEWS chart— Breach

248. The TEWS chart had been piloted on the general medical ward prior to its implementation hospital-wide in December 2008. TDH had held training sessions for staff on each ward on how to use the TEWS chart, and an information board was placed on each ward for at least one week when it was being implemented as a resource for staff. In light of this, I consider that TDH had provided its staff with adequate opportunities to learn how to use the TEWS chart. However, TDH is also responsible for taking steps to ensure that, once it has introduced tools, such as the TEWS chart, it is then integrated into practice in accordance with policy, by being clearly understood and then adhered to by its staff.

249. There was widespread failure by the nurses on the general medical ward who cared for Mr A to use the TEWS system. I agree with Ms Penney that this indicates "a pattern of custom and acceptance of this practice in [the general medical ward]", and a failure by management to ensure the tool had been effectively integrated into ward practice. TDH did not audit the TEWS charts until one year after it had been introduced. This was to allow the TEWS initiative to "settle". TDH told HDC that the provisional breach finding for failing to evaluate the integration of the TEWS chart into ward practice "appears to be based on an expectation that this new initiative would be operating faultlessly immediately".

250. I disagree that a breach finding in this respect is based on an expectation that the TEWS chart would be "operating faultlessly immediately". At the time of these events, the TEWS system had been in place at TDH for nine months. In my view, it would have been preferable to take steps to evaluate the effectiveness of, and compliance with, this new system earlier than one year.

251. Mr A was transferred to the general medical ward at 2pm on Saturday, but a full set of observations was not done until 4pm that day. Ms Penney advises that a full set of observations should have been done on transfer to give the nurses a baseline for ongoing management of the patient. The TEWS chart requires standard observations

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to be taken six hourly. However the next set of observations was not done for another 16 hours. Ms Penney advises that the 16-hour delay in taking observations was "unacceptable nursing practice".

252. In summary, Ms Penney considers that overall "the identification of any pattern of appropriate observation taking has been a virtually impossible exercise".

253. Mr M advised that the TEWS chart that was commenced in CCU prior to Mr A's transfer to the general medical ward was a supplementary chart which did not include the scoring system and escalation process. Mr M believes that the use of the supplementary chart did not support the effective use of the TEWS chart by the nurses on the general medical ward. However, I note that the TEWS chart used on the general medical ward was commenced on Mr A's transfer to the general medical ward and was different to the chart used in CCU.

254. As noted earlier, Mr M acknowledged that the lack of observations over the 16-hour period after Mr A's transfer was inadequate. Since this incident, TDH has taken steps to ensure all staff understand, and are using the tools appropriately, including holding education sessions and carrying out audits.

255. In my view, TDH must take some responsibility for the inadequate approach to observations taken by several of its staff through its lack of audits to ensure compliance.

Communication with family — Adverse comment

256. As noted above, there was a breakdown in the relationship between nursing staff and Mr A's family due to poor communication. Effective communication with those closest to the patient is a vital part of providing good quality care. When concerns are raised by family members, staff need to ensure that families are aware that their concerns have been taken seriously. TDH must take responsibility for encouraging and fostering a culture where communication with families is effective and where staff listen to, and take seriously, the concerns of family members. It is pleasing to see that TDH has recognised these issues and responded by raising awareness at staff meetings, and encouraging staff to address emerging communication problems early on.

SLT assessment — Adverse comment

257. Although there was a plan for an SLT assessment to assess Mr A's swallow reflex in the consultant's notes on Monday, RN Mr P (a trained SLT assessor) did not consider that an SLT assessment was required, as it was documented that Mr A was able to tolerate fluids. Ms Penney considers this was adequate care.

258. In Dr Spriggs' view, communication about who was to carry out the SLT assessment could have been better, noting that it was not clear who was expected to action the request for an SLT assessment, given that the therapist was on leave until October. I agree with Dr Spriggs that TDH should have "a clear delegation of responsibility during times of the therapist's absence and ensure that there are adequate numbers of staff trained in swallow assessment".

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Adequacy of changes made

259. While I acknowledge the steps taken and changes made by TDH in response to this complaint, in my view, TDH could take some additional steps and these have been outlined below under "Recommendations".

Summary

260. TDH failed to take reasonable steps to ensure its staff were using the TEWS chart and taking observations in accordance with policy.Therefore, TDH failed to provide Mr A with an appropriate standard of care, and breached Right 4(1) of the Code.

Opinion: Medical care

261. Independent expert general medical physician, Dr David Spriggs, considered that the standard of medical care provided to Mr A was appropriate and in keeping with current guidelines and standards.

Transfer from CCU and consultant review

262. Mr A's family raised concerns about the timing of his transfer from CCU to the general medical ward, believing that it was too hasty. Both my experts considered that it was appropriate for Mr A to be transferred from CCU to the general medical ward, 48 hours after his heart attack, and Dr Spriggs noted that a 48-hour stay in CCU is longer than standard practice.

Discontinuation of oxygen

263. Mr A's family also raised concerns about the fact Mr A's oxygen therapy was discontinued at 7.15am on Friday. Both of my experts agree that this was an appropriate decision. While Mr A's oxygen did fall below 94% at times, it was not persistently below this threshold. Dr Spriggs also notes that there are "good reasons to believe that oxygen given inappropriately in this circumstance can do more harm than good".

Recommendations

264. The following recommendations made in my provisional opinion have been completed:

- TDH confirmed to HDC that RN Ms G and RN Ms F have attended an appropriate course on effective communication and on the actions arising from it.

- TDH provided HDC with:

    (i) a copy of the individualised plan that was implemented in relation to up-skilling RN Ms F, in relation to the recognition of the deteriorating patient, together with the outcomes;

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(ii) information about the outcomes of the Professional Development and Recognition Programme undertaken by RN Ms F, and RN Ms G; and

(iii) the results of audits on the general medical ward of the TEWS charts to evaluate compliance with the requirement to carry out observations every six hours.

- TDH reviewed the value of having non-waterproof telemetry units being used by patients requiring continuous monitoring, where the unit will need to be removed for a shower, and reported back to HDC on the outcome of this review.

265. I also make the following recommendations:

- RN Ms F, RN Ms G and TDH apologise to Mr A's family for their breaches of the Code. The apologies are to be sent to HDC by **31 July 2012**, to be forwarded to Mr A's family.

- RN Ms G provide evidence of attendance at a training session on Sepsis/The deteriorating patient and at the seminar on High Dependency/Acute Nursing Skills, by **31 July 2012**.

- TDH provide HDC with:

(i) additional information about actions taken in relation to the outcomes of the Professional Development and Recognition Programme undertaken by RN Ms F and RN Ms G, by **31 July 2012**; and

(ii) an update on the review undertaken by TDH of the weekend practice on the general medical ward whereby the shift co-ordinator also works as part of the team nursing allocation, by **31 July 2012**.

- TDH ensure there is a clear process for times when the speech language therapist is absent, by **31 July 2012**.

Follow-up actions

- A copy of the final report with details identifying the parties removed, except the experts who advised on this case and TDH (Gisborne Hospital), will be sent to the Nursing Council of New Zealand, and it will be advised of RNs Ms D, Ms G and Ms F's names. I will recommend to the Nursing Council that Ms G and Ms F undergo a review of their competency.

- A copy of the final report with details identifying the parties removed, except the experts who advised on this case and TDH (Gisborne Hospital), will be sent to the College of Nurses Aotearoa (NZ) Inc and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A — Independent nursing advice to Commissioner

The following expert advice was obtained from registered nurse Diane Penney:

> **"Advice provided for the Health and Disability Commissioner regarding [Mr A] (deceased) NHI:. [number]**
> My name is Diane Penney. I have been a registered nurse since 1975 and have worked in various senior roles within Cardiology since 1977.
>
> My experience has included acute Cardiac care including thrombolysis and interventions in the acute patient with myocardial infarction, recovery and rehabilitative care of the patient.
>
> My recent role in project management was of a review of Cardiac Surgery services which included the patient journey through Cardiology and implementing the recommendations of that review.
>
> I am currently the Unit Manager of cardiothoracic and vascular surgery, and am about to commence a three year full time ACS (acute coronary syndrome) project for the Midland region.
>
> I have had a national profile and have been a long standing New Zealand Nurses Organisation (NZNO) delegate. I have provided advocacy and support for nurses in different types of processes. I have not been an active delegate for a number of years.
>
> **Conflict of Interest**
> I declare the following:
>
> In my current role as Unit Manager cardiothoracic surgery, I have had e-mail contact regarding operational business relating to my role with […] from Gisborne.
>
> In the role I am about to commence, I may have contact with both medical and nursing leadership in Gisborne, as the project mandate includes improving access to tertiary services for ACS patients from Tairawhiti.
>
> **[Mr A] (deceased) NHI : [number]**
> I have been asked to provide advice for the Health and Disability Commissioner relating to the nursing care provided by Tairawhiti DHB. [Mr A] was admitted with an inferior myocardial infarction, suffered a CVA post thrombolysis, and subsequently died.
>
> My response will be set out under the headings as requested by the Commissioner. I have not made comment regarding medical care of [Mr A].

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Standard of Nursing Care provided in CCU and [the general medical ward] between [Thursday and Sunday] 2009.

CCU

- CCU's specific observation chart showed appropriate timing of observations taken during IV GTN infusion. Once IV GTN was discontinued, the timing of observations decreased to enable the patient to sleep. Cardiac monitoring is continuous and the ICU/CCU environment enables close observation by nursing staff without the need for such regular observations when they are within normal parameters.
- Oxygen recordings differ from observation record (97%-98%) and clinical notes 96%-97%) although this is clinically insignificant.
- Discontinuing of oxygen at 07.15 ([Friday]). This was an appropriate decision as there is no written evidence that [Mr A] was short of breath or had other clinical indication for requiring it.
- The order written in ED at time of admission should have been signed and crossed off by medical staff at that point or on the ward round.
- Nursing notes of [Saturday]. 0700-1300 identify that nursing assessment occurred over the shift; pain free, blood glucose within normal parameters, blood pressure post medication within similar range as previous day, independent in shower and he had begun the rehabilitation phase and had watched Take a Heart video.

]The general medical ward.]
[Mr A] was transferred on telemetry at 1400hrs. The overall workload and staff numbers and skill mix is considered in my response.

A busy ward of patients with different acuity is divided and looked after by two nursing teams.

On the morning shift of [Sunday], one part of the team was an RN and a new graduate who "assists" and is delegated tasks by the more senior nurse working with her.

The team for the afternoon shift of [Sunday] comprised of two nurses, one of whom is a casual pool nurse who states that in accordance with organisational policy did not take "charge" of acute patients, instead worked in a team nursing approach.

The 12 patients under their care included pre and post operative patients, patients who were confused and required "specialing" inferring that either this was an organisational request and 1:1 nursing care of these patients was expected or a loose interpretation of "specialing" where a higher degree of care was required.

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Using the team approach, it is reasonable that the two nurses within that team (in this instance [Ms F] and [Ms G]) bounce clinically significant issues and plans with each other. It does not necessarily mean that either nurse does not know what to do in a particular situation. Collegial discussion in collaboration, especially as [Ms G] was a casual nurse, is appropriate.

It is not indicated that the whole ward had a lead or co-ordinating nurse assigned for the shift. This role is important in a team approach, particularly when the workload demands are high.

The background regarding the family was described at the verbal handover of the family "being hard work". This infers an underlying theme of the nurse being required to manage the family as well as looking after the patient.

TEWS observation chart

- Commenced on transfer as different to chart used in CCU.
- The full TEWS observation chart with detailed parameters or scoring system to use as a guide to flag early deterioration was not available amongst the documentation and so not used to record [Mr A's] observations. The chart used is likely to be the additional sheet designed for use when the full TEWS chart has been filled.
- No scoring was done over shifts of nurses that the chart was used. This shows a pattern of custom and acceptance for this practice in [the general medical ward] and opposes DHB introduction and expectation for its use. This indicates a lack of quality improvement focus amongst the nursing staff and nursing management of the ward.
- Although heart rate was entered into first column, the time is not stated. The first observations taken after transfer were two hours later at 1600hrs. This timeframe is inadequate. A full set of observations at transfer to give the ward nurses a baseline should have been done.
- There is no pattern to the frequency of observations taken, with 16 hours between the first and second set from transfer to [the general medical ward]. This is an unacceptable nursing practice and contrary to hospital policy.

Bleeding

- Ongoing bleeding or oozing from luer site is relatively common post thrombolysis. Reinforcement over existing gauze to take as an immediate action, with an expectation of follow-up is a reasonable nursing action.

Supervision in shower

- On [Sunday] [Mr A] was observed by family as being lucid and coherent prior to his shower.

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- Close (within the environs of the shower or bathroom and within hearing and speaking distance) however not direct supervision and observation of [Mr A] whilst he is showering is acceptable nursing practice and in line with both national and international practice.
- At that stage his recovery from MI was unremarkable, there was no post infarct chest pain or shortness of breath reported and he had been becoming increasingly independent with bathroom privileges in CCU on the day after admission, and independent in shower prior to transfer to [the general medical ward].
- It is documented that the telemetry unit was removed as it was not waterproof. I have to question the value of having or using telemetry units for continuous monitoring of a cardiac patient that requires removing for a shower that could take around 30 minutes or so.

Documentation

Reference: Tairawhiti SBBAR guideline

- Written in clinical notes at 1340hrs "complaining of slight headache" with no time, no report of action taken or whether the headache had disappeared. Documentation of this clinical incident not of a good standard.
- On return from shower was the first time family indicated to [Ms D] that [Mr A] was confused and his condition had changed suddenly. RN [Ms D] "questioned' [Mr A] who said he had a headache and in her statement she indicates that she spoke with the house surgeon about this and paracetamol was charted. This conversation was not recorded in the nursing notes. I am unable to find paracetamol that was charted on [Sunday] nor a specimen signature for [Dr L].
- There is discrepancy around paracetamol administration times. Drug chart and statement indicate 1200hrs, however nursing notes indicate 1300hrs. Discrepancy also in recording time [Mr A] reported his headache had gone.
- Recording of a significant telephone conversation with [Mr A's] daughter that is recalled differently between the parties was not recorded in the nursing notes.
- RN [Ms D] states that she checked on [Mr A] regularly and did not observe that he was confused. No neurological or routine observations, nor timings were documented as been done during these checks.

Afternoon shift of [Sunday]

- Early in the shift collegial support was requested and given relating to ongoing communication and interaction with the family and how that would impact on being able to care for [Mr A].
- Discrepancies in timings, recollection, documentation and events occur from around 1700hrs:

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- [Ms G] states she signed for and gave Clexane (enoxaparin) and metformin and that [Mr A] sat himself up in bed, was speaking in full sentences and was able to pick up his glass and drink its contents.
- [Ms E] states [Mr A] was hard to rouse and she had to help him take lipitor tablets.
- [Mr A's] daughter states that at 1700hrs [Mr A's wife] indicated she could not rouse her husband.
- At 1730hrs [Mr A's] daughter [Ms B] arrived and found that her father was not a good colour, was able to be roused, however was very tired. She was concerned as she noted a dramatic change from the morning.
- The medication chart prescribed metformin, enoxoparin SC and lipitor at 1700hrs.
- [Ms F's] initials and signature is identified from the specimen signature section as having administered lipitor, and as the second (and checking) initials for enoxoparin.
- Another set of initials not identified in the specimen signature section having signed for metformin, and as first initials for enoxoparin is recognizable as "[XX]" (**[Ms G]**).
- It is at this point that [Mr A's] daughter [Ms B] approached [Ms G] and indicated her father had deteriorated.
- [Ms G] states that she "told" [Ms B] that he was more alert than at the beginning of the shift.
- [Ms B] asserted her concerns and is described by [Ms G] as 'agitated'.
- [Ms F] states that [Ms G] had asked her to take over the care of [Mr A] as she ([Ms G]) had difficulties with rapport with his daughter who would not accept [Ms G's] findings.
- [Ms G] states she went to [Mr A] and took observations and found them stable.
- [Ms F] states that at the request of [Ms G] she went to assess [Mr A] at 1800hrs and she took observations.
- The TEWS observation chart indicate **one** set of observations were documented at 1800hrs.
- At this time [Ms F] asked [Ms B] if she wanted to see the house surgeon ([Ms B] did).
- [Ms F] and [Ms G] both state that they paged and spoke with the house surgeon [Dr K].
- [Ms F] states that she discussed with [Dr K] that [Mr A's] family were concerned and would like to see her, and that [Mr A's] observations were normal. [Ms F] states that [Dr K] said she was busy in ED and could not come until the morning.
- [Ms G] states that at approx 1800hrs she paged [Dr K] and asked her to review [Mr A] as the family had serious concerns. Her subsequent telephone discussion with [Dr K] was "not based on clinical concern" as the observations were stable but more about the anxiety of the family. [Dr K] indicated she was busy in ED and she would arrange for

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[another house surgeon] to review [Mr A] and speak with the family on his rounds.

- [Ms F] states that she contacted the house surgeon by page after [Mr A] vomited, and advised that he was nauseous and vomited. Metoclopramide (Maxolon) given at 1900hrs.
- At 7.07pm (1907hrs) page was sent by [Ms G] to [Dr K] 'plse ring [Ms G] asap [on ward], thanks'.
- [Ms F] states she made the decision to administer oxygen at 2L/min via nasal prongs based on 'the fact that [Ms E] had nursed [Mr A] in CCU and she ([Ms E]) felt [Mr A's] consciousness was compromised with an SaO2 of 93%'.
- Observations not recorded on TEWS observation chart.
- Oxygen administration not documented, nor its effects on SaO2. The house surgeon records of 2030hrs state 92% RA (room air).
- Between the first page with the house surgeon and review of [Mr A] at 2030hrs, [Ms B's] increasing assertive verbalised concern of her father's deteriorating clinical condition was not communicated with the house surgeon by either [Ms F] or [Ms G]. Rather, any communication regarding the problem at hand was based on [Ms B's] deteriorating interactions with them.
- The house surgeon review at 2030hrs lasted around an hour and although the neuro exam was normal, he considered an intracranial haemorrhage and need for CT scan to discuss with the consultant on-call.
- There is no documentation in the clinical records of any discussion with the consultant on-call.
- 4 hourly neurological observations requested and neurological specific observation chart commenced at 2100hrs.
- Two different observation charts now used to document observations.
- Documentation of the timings of observations are significantly different and difficult to ascertain what BP was taken at what time.
- It appears that the initial neurological observation documented at 2030hrs (BP 161/113) was entered in retrospect as the chart was documented as being commenced at 2100hrs and the house surgeon was reviewing [Mr A] at 2030hrs and noted his BP at 150/90 (which was the same reading recorded on chart at 1800hrs).
- Documentation of assessment of (R) pupil was not done.
- At 2145hrs, a dramatic and clinically significant event of apnoea was documented on TEWS chart with no reference made in clinical notes of how long it lasted for and what actions were taken. The SaO2 entry cannot be deciphered and appears to have been altered. The heart rate had dropped to 65bpm from a regular pattern of around 80bpm and BP was at 161/113 — alarmingly higher than previous observations.
- The page was not made to house surgeon until at 10.30 (2230hrs) and [Mr A] was reviewed at 2300hrs.

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Conclusions
CCU

- 48hrs post uncomplicated infarct treated by thrombolysis is both a nationally and internationally established appropriate length of time in CCU. In busy units the length of stay may be considerably less.
- The observations and comments made in the nursing entries determined that [Mr A's] condition was stable with no evidence of chest pain or shortness of breath and he could be safely transferred to [the general medical ward] which occurred at 1400hrs.
- Any potential side effects from lipitor could easily be managed in the ward setting.
- The frequency of observations for [Mr A] were adequate.
- Stop date for treatment orders no longer required were not filled in (as in oxygen to keep SaO2 > 95%).
- The nursing care in **CCU** of adequate standard.

[The general medical ward]
There are significant issues in the nursing care of [Mr A] whilst he was a patient in [the general medical ward].

Organisational

- The lack of a ward identified co-ordinator or team leader for the shift does not readily facilitate an escalation plan for nurses whose skill level may not match the patient acuity.
- Rostering [Ms F], who identifies herself 'I am a good nurse but I am behind the others', on a weekend when the support systems and oversight of the ward management is not there, with a nurse from the casual pool who is not able to 'take charge of acute patients' is a recipe for disaster.
- A registered nurse, even though being a new graduate, should not be rostered to 'assist' the other RN on duty ([Ms D]). Rather, the new graduate RN should have a patient load appropriate to skill level with oversight and mentorship from colleagues working with them. If the skill level of the new graduate is not appropriate to manage an independent patient workload, they should either be supernumery on the roster, or be allocated a small number of patients with acuity matched to skills.
- Post myocardial infarct patients are encouraged to increase their mobilisation and independence, however require continuous cardiac monitoring via telemetry units. By removing the telemetry unit because it is not waterproof in order for the patient to have a shower that could take around 30 minutes, and with potentially no direct observation during much of that time, increases the clinical risk to the patient.

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Documentation

- The standard of documentation is well below the standard that is expected of registered nurses providing evidence of the care given over a shift. Whilst the shifts were described as busy and the workload high, this is not a reason or excuse for lack of a documented record of the shift. [Ms D] did not document the discussion with the house surgeon relating to [Mr A's] headache and prescribing of paracetamol. She did not document a significant and heated telephone conversation she had with [Mr A's] daughter, [Ms C], relating to several aspects of the care of [Mr A] over the shift even though this conversation was mentioned to the next shift at handover and potentially could set the scene for the quality of family and nursing staff interactions. [Ms F] did not document that she had administered oxygen to [Mr A] or her rationale for doing so, or that [Mr A] had vomited even though she had documented that he was nauseous and was given Maxolon IV, nor was it documented whether the nausea was resolved. She did not document a description or outcome of conversation with the Duty Manager that indicated the Duty Manager 'was aware of family dynamics', nor describe anything related to the apnoea episode she recorded on the TEWS chart at 2145hrs. [Ms G] did not document her interaction with the family that resulted in her requesting that [Ms F] and she care for [Mr A] jointly.
- Significant events were not documented. The effect and outcomes of events that were treated were not documented. An event of apnoea documented on the TEWS chart at 2145hrs was not commented on in the clinical notes in terms of how long it lasted, effect on [Mr A] or any actions around it. [Ms F] should have made reference to this event and actions around it in the clinical notes. There is no documentation relating to the outcome of the discussion with the on-call consultant regarding a possible CT scan. (I would expect that if a CT was a possibility, then the nursing notes would demonstrate discussion with the patient and/or family and workup in preparation should it eventuate.)
- Some signatures are illegible and writers not identified in many nursing entries in the clinical records
- Transcribed records from observation chart to clinical records differed. [Ms F] documented in clinical notes the set of observations at 1545hrs BP was 150/90, O2 stats 96% whereas the TEWS chart it is recorded as BP 142/98, O2 states 92%. The house surgeon reviewing [Mr A] at 2030hrs documented in his clinical notes that BP was 150/90, however this BP was recorded on chart taken at 1800, whereas a clinically significant BP of 161/113 at 2030hrs was also documented by [Ms F] as part of initial neuro observations at 2100hrs.
- There were many instances where the times documented did not relate to the actual observation taken, retrospective documentation of observations, illegible entries. [The following comments were deleted

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as they were not related to nursing care.] The initial neurological observation documented at 2030hrs (BP 161/113) was entered in retrospect as the chart was documented as commenced at 2100hrs, when an initial and whole set of neuro observations should have been done. I attribute this to [Ms F]. The SaO2 entry cannot be deciphered and appears to have been altered. I attribute this to [Ms F].

- Discrepancies in the recollection of both [Ms F] and [Ms G] relating to whom was responsible for what set of observations. One set of observation recorded and yet both state they took the observation.
- Subjective documentation relating to the family was written, rather than objective documentation relating to what was concerning the family. [Ms F] did not describe what the daughter was actually unhappy about regarding her father's condition, rather documented that 'daughter unhappy with fathers condition'. [Ms F] also documents that 'Duty Manager aware of family dynamics' with no description of anything relating to the reasons behind the dynamics. [Ms G] in her statement indicates that [Ms B] was 'agitated and yelling' when they first met at the beginning of the shift, however does not describe the rationale around why [Ms B] might be doing this. The subsequent telephone discussion [Ms G] had with the H/S was 'not based on clinical concern' but more about the anxiety of the family.

Observations

The identification of any pattern of appropriate observation taking has been a virtually impossible exercise.

- There was widespread failure of the nursing staff to use the TEWS system. The fact that the system was relatively new to Gisborne Hospital is not a reason for either its non or incorrect use. Whilst the organisation and nursing management are responsible to ensure learning opportunities are available for nursing staff to learn how to use and understand new tools, individual nurses have an inherent responsibility to ensure they become familiar with and gain an understanding of any new tools used in their daily work.
- The standards around the observations taken on the afternoon shift of [Sunday] and documented by both [Ms F] and [Ms G] was well below an acceptable standard for registered nurses. Two different charts were in use after [Mr A] was reviewed by the house surgeon and neuro observations were ordered with multiple discrepancies in the timings and documenting of observations.
- A set of observations taken at 2145hrs that clearly indicated a dramatic change in clinical events which [Ms F] did not act on until 2230hrs when the house surgeon was paged to review [Mr A].

Communication

- There was failure by [Ms F] and [Ms G] to achieve an effective communication strategy with the family of [Mr A]. That failure

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affected the therapeutic relationship between nurse, patient and family and subsequently affected the care of the patient. The strategy to 'keep themselves safe' clouded appropriate nursing judgment in clinical decision making. To a lesser extent, [Ms D] was not able to engage with [Ms C] in a telephone conversation and the outcome was that the family was described as 'hard work' to other members of the nursing team at handover.

- There was failure to adhere to guidelines demonstrated in the SBARR communication tool in use at Gisborne Hospital. Had [Ms D], and [Ms F] adhered to the organisational SBARR communication tool, documentation in the clinical notes would have reflected the current situation in regards to [Mr A] including background to the clinical problem, their assessment of the problem, recommendation of what they wanted to happen and if their expectation had been met.
- There was failure from both [Ms F] and [Ms G] to advise the medical staff of the actual concerns of the family relating to both subtle and significant changes they had recognised as noted in [Mr A's] clinical condition. Rather, the messages to the medical staff was around the anxiety of the family. The use of the SBARR communication tool as a guide in this situation would have guided them and thus prompted them to advise the medical staff of the whole clinical picture.
- There are discrepancies in the number and times pagers and calls were made to the house surgeon that are stated by [Ms F] and [Ms G] and the actual printout supplied, as are there discrepancies in relation to whom spoke with the house surgeon at what point during the shift.
- There are only four occasions documented that the house surgeon was contacted regarding concerns and requesting review: 6.42pm ([Ms F] to [Dr K]), 7.07pm ([Ms G] to [Dr K]), 7.10 ([Ms F] to [Dr L]) all prior to the first review and 10.30pm (to [Dr L] for the second review).
- There was an unacceptable time delay by [Ms F] in making contact with the house surgeon until 45 minutes after observations were taken at 2145hrs on [Sunday] which indicated a significant change from previous observations.

Post CVA / CT

SLT assessment

- Documented in clinical notes that [Mr A] did not have problems with swallowing water/ice/or porridge.
- SLT assessment documented in plan in consultant round notes on [Monday].
- Swallowing assessment requested by nurse on morning shift nurse on [Monday] by '?ICU nurses'.
- Mr P is trained in SLT assessments. He happened to answer [Mr A's] call bell and in response to family request for a SLT assessment, he noted that the nurse assigned to [Mr A] documented that he had no

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problem with swallowing. [Mr P] was satisfied this was an accurate assessment. He does indicate however that should an assessment have been necessary at the time, his own workload would have dictated whether he would be able to carry out that assessment.
- Dietitian documents that family requested palliative care on [Tuesday]. Seen by palliative care team.
- Documented on PM shift [Tuesday] that BNO (bowels not open) with no evidence of how long for.
- [Wednesday] – Fleet enema given with watery result. BNO 5-7 days.
- Comprehensive documentation of all interaction with family throughout shift.
- Physio discussion with daughter re withdrawing physio treatment ‘daughter OK with this decision’.
- Family requested treatment for runny eyes – suffers from hay fever – resolved with treatment.
- Deterioration and ultimate death on […] 09

Conclusions (post CVA)

Standard of nursing care provided to [Mr A] post CVA
- Overall the standard and quality of nursing care provided post CVA was adequate. Interaction and effective communication with the family is largely evident with comprehensive documentation of explanations, discussions treatments and decisions made.
- Although there was plan for an SLT assessment, a trained assessor indicated that an SLT assessment was not required as it was documented that [Mr A] was able to tolerate fluids.
- Assertive family interaction with nursing and other staff requesting care for BNO, palliative care and treatment for hay fever resulted in no delay in treatment and care of [Mr A].

Identification of individual nurses who have failed to provide an appropriate standard of care

[Ms D]
A registered nurse of over 50 years experience. This would mean her age would be at least 70 years of age, which in itself does not preclude either working or infer that she would not be able to manage working in busy medical ward. The fact that she was responsible for the ‘overall supervision’ of 11 patients, and had oversight of, and was required to direct the new graduate to do tasks whilst she was doing the medication round indicates that her workload was both physically demanding and she infers that she was responsible for the work of the new graduate.

I am not able to ascertain whether task delegation and that the new graduate registered nurse was assisting, was a self imposed responsibility for [Ms D] or if it is an organisational expectation or requirement.

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This overall supervision of 11 patients and directing another RN throughout any shift is a significant workload for one person, let alone for someone of at least 70 years of age.

In this instance, on [Sunday] [Ms D] failed to provide appropriate care for [Mr A] because she:

- Did not complete an adequate assessment when confusion reported for the first time.
- Did not adequately convey symptoms of drowsiness and vagueness associated with headache to house surgeon.
- Did not document in clinical notes significant events of the shift that would provide an accurate recording of events and a baseline for oncoming shifts (discussion regarding headache with house surgeon, telephone conversation with patient's daughter).
- A further statement dated 29th March 2011 indicates considerable learning and reflection of the events surrounding her provision of nursing care of [Mr A]. These include much more attention to accurate and detailed documentation and proactive dealing with patient's families regarding their concerns.
- Whilst this reflection and learning with a positive change in practice is acknowledged, the provision of care on [Sunday] was inadequate.

I believe peers would view this with mild disapproval.

[Ms F]
A registered nurse of greater than [16] years experience. Describes herself as "a good nurse, but I am way behind the others." On [Sunday] was one of two nurses working as a team and caring for 12 patients on an afternoon shift in a busy acute medical ward.

In this instance, on [Sunday], [Ms F] failed to provide an appropriate standard of care for [Mr A] because she:

- Did not recognise a clinically deteriorating situation
- Did not convey urgency of the situation to the house surgeon
- Did not treat the family concerns with urgency
- Did not take or record observations on the using the TEWS system
- Did not do a full set of neurological observations as directed
- Did not page the house surgeon for 45mins after clinically significant deterioration in observations
- A further statement of 30 March 2011 of further explanations regarding the above, does not alter my findings in any way. [Ms F] has indicated some learning and reflection. These have included using the TEWS system for observations, proactively pursuing relevant in-services and attention to her senior role and escalation of issues. Whilst

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learning and reflection is acknowledged, the provision of care on [Sunday] was inadequate.

I believe peers would view this conduct with moderate disapproval.

[Ms G]
A registered nurse of less than five years experience and works as part of a casual pool.

On the afternoon shift of [Sunday], was one of two registered nurses in a busy acute ward [Ms G] failed to provide appropriate standard of care for [Mr A] because she:

- Did not treat the family concerns of patient deterioration seriously, focusing instead on the manner of the responses, rather than what was being conveyed.
- Did not clarify the meaning behind "this is not his normal behaviour" from someone who knew [Mr A] personally, instead made assumptions of behaviour (usual joking self) that had not been exhibited or described by [Ms G].
- Did not recognise the urgency of making contact with the house surgeon for review of [Mr A] should have related to clinical condition rather than anxiety of the family.
- Did not recognise that vomiting and headache could possibly be related to haemorrhagic CVA in a patient following thrombolysis rather than from other illnesses.
- Did not recognise the difference between rousing a patient from sleeping as opposed to from a deteriorating clinical event.
- Did not use the TEWS system to record observations.
- In her further statement of 24 March 2011 [Ms G] states that she believes the care she provided was appropriate and did not compromise the safety of [Mr A]. These further explanations are not accepted and the findings above remain.

I believe peers would view this conduct with moderate disapproval

Systems and policies in place to ensure patients receive appropriate and timely care.

- Tairawhiti did not ensure of the integration of TEWS system and SBBAR into practice guidelines to all nursing staff.
- The nursing management of [the general medical ward] did not monitor the use of TEWS and SBARR by all nursing staff.
- The skill mix and nurse numbers for the afternoon shift on [the general medical ward] insufficient to meet the demands of the patient acuity.
- The staff numbers, patient type and acuity indicated in the further statement of March 25 2011 by the Acting Director of Nursing, differs from what the nurses describe.

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- The explanation of the DON relates to the delay in contacting the house surgeon before [Mr A] was assessed at 2030hrs. My finding relates to the 45min delay in contacting the house surgeon when [Mr A's] blood pressure dramatically increased and was recorded at 2145hrs as 161/113 and then at 2200 to 190 /100 and 200/110 (no time recorded). The house surgeon was paged at 2230hrs and attended at 2300hrs.

Adequacy of changes made by Tairawhiti DH since the event

- In general, the changes made by Tairawhiti DH are appropriate, including the review of the weekend co-ordination role in [the general medical ward].
- The in-service record of the "Sepsis/deteriorating patient" of [Sunday] does not indicate that [Ms D] or [Ms G] attended that particular session. It is imperative these nurses attend an in-service and that the topic is repeated annually. [Ms G] indicates in her further statement of 24 March 2011 that it is her intention to attend the next in-service training of "Sepsis/deteriorating patient".
- Ongoing hospital wide work, including at nursing and medical orientation relating to the correct use of the TEWS chart and SBARR communication tool.
- Follow-up audits and ongoing monitoring by an effective nursing leadership in terms of further discussion with nursing management, the performance appraisal process and the three named nurses being required to complete the PDRP (Professional Development Recognition Programme) within a three month timeframe.

[The following comments were deleted as they did not relate to the nursing care provided by RNs [Ms D], [Ms G] or [Ms F].]

Family of [Mr A]

- Whilst the family of [Mr A] are in no way responsible for the inadequate provision of nursing care in [the general medical ward], the unfolding situation caused tremendous distress to them, and this was manifested by unconstructive interactions with the nursing staff caring for their father. These interactions potentially clouded the ability for sound decision making of the nurses whose focus at times, became keeping themselves safe and managing the family. It is a reasonable expectation that nurses would have the ability and skills to manage families in such situations and provide adequate nursing care."

On 30 May 2011, Ms Penney provided the following response to the question "Can you please comment on the adequacy of RN [Ms F] leaving [Mr A's] lipitor tablets on his bedside cabinet?":

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> "The nurse who signs for the medication as having been administered, has the responsibility to ensure the patient takes the medication. It is practice below the standard expected of an RN."

On 23 June 2011, Ms Penney advised HDC that if RN [Ms F] and RN [Ms G] did not take a new set of observations after [Mr A] complained of headache and nausea, and vomited, this would be a moderate departure from an appropriate standard of care. Ms Penney further advised that after taking a new set of observations, RN [Ms F] and RN [Ms G] should have taken another set of observations after 30 minutes.

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Appendix B — Independent medical advice to Commissioner

The following expert advice was provided by general medicine physician Dr David Spriggs on 22 March 2010:

> "I work as the Clinical Director of General Medicine at Auckland District Health Board. I practice in the field of General Medicine and Geriatrics and I am a vocationally registered health practitioner (MCNZ No: 18739). I have been asked to review the complaint from [Ms B] about the care of her father [Mr A] between [Thursday and Sunday] 2009 at Tairawhiti District Health. In particular I have been asked to give advice "to enable the Commissioner to determine whether, from the information available, there are concerns about the clinical care provided by the doctors which require formal investigation". I have been provided with details of the complaint including the letter from [Ms B] to the HDC dated [late] 2009 and the response to that complaint from Ms N at Tairawhiti District Health dated 22nd February 2010. Also included are internal letters within Tairawhiti with regard to the complaint: these letters are dated between [shortly after Mr A's death and two months later]. The last of these being a specific response from the [Clinical Director of Medicine]. Also included is a copy of the clinical notes relevant to this admission.

[At this point in his report, Dr Spriggs sets out the facts of the case. This detail has been omitted for the purpose of brevity.]

> **Opinion**
> It is my opinion that the diagnosis of myocardial infarction in [Mr A] is secure, the early management with aspirin, thrombolysis, metoprolol and clopidogrel is appropriate. The dose of thrombolysis is also appropriate. It is stated in the notes that consent was given. I have no details at to nature of information given to [Mr A] and his family about the risks of thrombolysis. It is not usual practice to get such patient's to sign a formal 'consent form' and nor do DHBs routinely have patient information leaflets for such patients. The expected intracerebral bleed rate in this situation is about 1% and these thrombolysis induced intracerebral bleeds have a very high mortality. I believe that our failure to have formal consent forms and patient information leaflets is a reflection of the urgency that is required in the treatment of such patients and it is acceptable. In cases where 'every minute counts' the amount of information given to patients is necessarily limited. I also believe that it is very unlikely that most patients will be able to adequately assess the risks and benefits when they are having an acute myocardial infarction.
>
> The subsequent management of [Mr A] in the Coronary Care Unit is standard. I am aware of the family being upset about the lack of oxygen given to [Mr A]. There is considerable clinical debate about the use of oxygen in this circumstance and the British Thoracic Society Guidelines from 2008 suggest that oxygen not be routinely administered unless there is demonstrable hypoxia. These guidelines suggest a lower threshold of 94% oxygen saturation. [Mr A's] saturation dropped at times below this threshold but not

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persistently. There are good reasons to believe that oxygen given inappropriately in this circumstance can do more harm than good. I do not believe that the lack of oxygen had any bearing on the outcome.

The 48 hour stay in the Coronary Care Unit is longer than standard practice and in the absence of any complications there is no reason to believe that he was transferred to the ward too early. Likewise in an uncomplicated myocardial infarction it would not be routine or standard management to insist on a consultant review at Day 2. The practice at Tairawhiti would be in keeping with most hospitals in that such patients would not usually be reviewed unless there were any complications.

On [Sunday evening] there is some miscommunication between the nurses and the house surgeon. The latter thinking that the request to speak to the family was to discuss their concerns, the nurses however were asking for a clinical assessment. This clinical assessment was only delayed by a short period while the House surgeon was dealing with other patients. The clinical assessment done by the House Surgeon at 2030 hrs on [Sunday] was appropriate. It may be that the significance of word finding difficulties was underestimated however this was discussed with the consultant and at that stage a CT scan was not requested. This decision however was reviewed appropriately at 2300 hrs and a CT requested. I do not believe that this delay was clinically significant. I also believe that with the information available it was not unreasonable to delay the request until the review at 2300 hrs. I have not been asked to review in detail the subsequent management of [Mr A] as this was not a feature of the family's complaint.

An ACC referral is indicated and this should be routine in such cases.

In summary, I believe that the medical care given to [Mr A] was appropriate and in keeping with current guidelines and standards, and the documentation of his care is satisfactory. My only reservation is with regard to the communication between the nurses and House Surgeon around 1800 hrs on [Sunday]. Should you wish for any further information please do not hesitate to contact me.

Yours sincerely

David Spriggs, MBChB, MRCP(UK), FRACP, MD

Clinical Director
General Medicine
Auckland District Health Board"

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The following further advice was provided by Dr Spriggs on 18 January 2011:

"Opinion

1. My initial advice remains and I do not think it requires any changes in the light of new information. I have now stepped down from my role as Clinical Director and practice as a General Physician and Geriatrician for Auckland District Health Board.
2. On [Monday morning], after the intracerebral bleed, [Mr A] was assessed by the SMO concerned at 0830 hrs and was placed 'NBM' (nil by mouth). However the nursing note timed at 1550 hrs says that [Mr A] was eating and swallowing 'without problems'. I am unable to read a sentence in this entry which I think says "was …NBM this morning placed onto IVF (intravenous fluid)". Later in that nursing note there is a request from the nurse to 'follow up if pt (patient) able to eat and drink prn… SLT away until October. Please can pt have swallow assessment done by ?ICU nurses.". It is unclear who was expected to action this request. [Mr A] continued to be fed until the end of [Tuesday]. There is no documented swallow assessment nor are there any further medical instructions about feeding. I do not consider that the confusion over appropriate feeding for [Mr A], in any way, adversely impacted on his outcome.
   I note the organisational guideline from Tairawhiti on the Role and Training of Registered Nurses in Dysphagia Screening authored by the Speech Language Therapist. It is not clear whether any nurses available had undergone this training. It is unclear what plans were in place when the SLT is not available and patients admitted to Tairawhiti District Health require an urgent swallowing assessment. The hospital should be asked to demonstrate a clear delegation of responsibility during times of SLT absence and ensure that there are adequate numbers of staff trained in swallow assessment. At times of prolonged SLT leave, there must be access to trained SLT assessment on a non-urgent basis if needed.
3. Tairawhiti DHB Policy for "Thrombolysis for ST elevation myocardial infarction" both the earlier and revised versions are satisfactory. The target oxygen saturation of 96% is greater than that of some other guidelines.
4. Apart from the absence of clear and consistent advice about the appropriateness or otherwise of feeding [Mr A], there are no other aspects of care provided by doctors or Tairawhiti DHB that warrant additional comment.
5. I have no further suggestions with regard to actions to be taken by either individual doctors or Tairawhiti DHB. As said in my initial advice it is important to have clear guidelines about ACC referral in cases of treatment related injuries.
   If you wish further information please do not hesitate to contact me.

   Yours sincerely
   David Spriggs, MBChB, MRCP(UK), FRACP, MD
   Physician, General Medicine, Auckland District Health Board"

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Appendix C — TEWS chart observations

Saturday					
	Temperature	**Blood Pressure**	**Heart Rate**	**Oxygen Saturation**	**Respiratory Rate**
4pm	36.5°C	140/80mmHg	79bpm	93% on room air	-
[Sunday]					
	Temperature	**Blood Pressure**	**Heart Rate**	**Oxygen Saturation**	**Respiratory Rate**
8am	36.4°C	120/80mmHg	-	92% on room air	22 breaths per minute
1pm	-	138/75mmHg	74bpm	93% on room air	20 breaths per minute
3.45pm	36.3°C	145/95mmHg	78bpm	96% on room air	19 breaths per minute
6pm	35.5°C	155/90mmHg	79bpm	92% on room air	20 breaths per minute
9.45pm	-	161/113mmHg	65bpm	Indecipherable	apnoea
11.15pm	-	190/95mmHg	80bpm	-	-

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