(1) ORDER PROHIBITING PUBLICATION OF NAME OR IDENTIFYING PARTICULARS OF THE AGGRIEVED PERSON

(2) ORDER PREVENTING SEARCH OF THE TRIBUNAL FILE WITHOUT LEAVE OF THE CHAIRPERSON OR OF THE TRIBUNAL

IN THE HUMAN RIGHTS REVIEW TRIBUNAL **[2021] NZHRRT 49**

I TE TARAIPIUNARA MANA TANGATA

	Reference No. HRRT 012/2021
UNDER	**THE HEALTH AND DISABILITY COMMISSIONER ACT 1994**
BETWEEN	**DIRECTOR OF PROCEEDINGS**
	PLAINTIFF
AND	**TARANAKI DISTRICT HEALTH BOARD**
	DEFENDANT

AT WELLINGTON

BEFORE:
Ms SJ Eyre, Deputy Chairperson
Ms BL Klippel, Member
Dr SJ Hickey MNZM, Member

REPRESENTATION:
Ms C McCulloch for the Acting Director of Proceedings
Mr H Kynaston and Ms E von Veh for the Taranaki District Health Board

DATE OF HEARING: **Heard on the papers**

DATE OF DECISION: **1 November 2021**

(REDACTED) DECISION OF TRIBUNAL[1]

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[1] [This decision is to be cited as *Director of Proceedings v Taranaki District Health Board* [2021] NZHRRT 49. Note publication restrictions.]

[1] These proceedings under the Health and Disability Commissioner Act 1994 were filed on 31 March 2021.

[2] Prior to the filing of the proceedings the parties resolved all matters in issue and the Tribunal is asked to make orders by consent. The parties have filed:

[2.1] A Consent Memorandum dated 31 March 2021;

[2.2] An Agreed Summary of Facts, a copy of which is annexed and marked 'A';

[2.3] A joint memorandum of counsel for the Director of Proceedings and for Taranaki District Health Board dated 14 October 2021, on name suppression.

[3] In the Consent Memorandum dated 31 March 2021 the parties request that the Tribunal exercises its jurisdiction and issues:

> 2(a) A declaration pursuant to section 54(1)(a) of the Health and Disability Commissioner Act 1994 ("the Act") that the defendant has breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("the Code") in respect of Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill; and
>
> 2(b) A final order prohibiting publication of the name and identifying details of the aggrieved person in this matter (Mr S (deceased)).

[4] Having considered the Agreed Summary of Facts the Tribunal is satisfied on the balance of probabilities that actions of the defendant breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 and that a declaration should be made in the terms sought by the parties in paragraph 2(a) of the Consent Memorandum.

[5] Having considered the submissions of counsel as to name suppression, and for the reasons set out below, the Tribunal is also satisfied that it is desirable to make a final order prohibiting publication of the name and identifying details of the aggrieved person.

[6] The Tribunal may order non-publication of the name and identifying details in accordance with s 107(3)(b) of the Human Rights Act 1993, if the Tribunal is satisfied that it is desirable to do so.

[7] To determine this, the Tribunal must consider whether there is material before the Tribunal to show specific adverse consequences sufficient to justify an exception to the fundamental rule of open justice. The Tribunal must also consider whether an order is reasonably necessary to secure the "proper administration of justice" in proceedings before it and does no more than is necessary to achieve that (see *Waxman v Pal (Application for Non-Publication Orders)* [2017] NZHRRT 4 at [66] (*Waxman*)).

[8] Open justice is an essential legal principle. It was described in *Waxman* at [56] where the Tribunal cited *Erceg v Erceg* [2016] NZSC 135, as follows:

> [2] The principle of open justice is fundamental to the common law system of civil and criminal justice. It is a principle of constitutional importance and has been described as "an almost priceless inheritance". The principle's underlying rationale is that transparency of court proceedings maintains public confidence in the administration of justice by guarding against arbitrariness or partiality, and suspicion of arbitrariness or partiality, on the part of courts. Open justice "imposes a certain self-discipline on all who are engaged in the adjudicatory process – parties, witnesses, counsel, Court officers and Judges". The principle means not only that judicial proceedings should be held in open court, accessible by the public, but also that media

> representatives should be free to provide fair and accurate reports of what occurs in court. Given the reality that few members of the public will be able to attend particular hearings, the media carry an important responsibility in this respect. The courts have confirmed these propositions on many occasions, often in stirring language. [Footnote citations omitted]

[9] The resolution of this claim arises from the death of Mr S and the acceptance by the Taranaki District Health Board that it failed to provide Mr S (deceased) with services with reasonable care and skill. As Mr S is deceased, it was not possible to seek his opinion on suppression of his name and identifying details.

[10] Mr S's wife (who shares Mr S's surname) and his adult children have already been through the lengthy and stressful process, after his death, of taking this complaint through the Health and Disability Commissioner's complaints process, leading up to this decision. Publishing Mr S's name and other identifying details along with the very detailed Agreed Summary of Facts would have the specific adverse consequence of causing Mr S's family significant further distress if this information was in the public arena.

[11] It was also submitted by counsel that as Mr S is not a party to this proceeding but was simply a consumer of the services provided by the Taranaki District Health Board, there is no public interest in knowing Mr S's name or his identifying details.

[12] The Tribunal considers the principle of open justice can be maintained by the publication of the Tribunal's decision and the detailed Agreed Summary of Facts with Mr S's name and identifying details redacted. Accordingly, the Tribunal is satisfied that it is desirable to prohibit publication of Mr S's name and identifying details.

DECISION

[13] The decision of the Tribunal is that:

[13.1] A declaration is to be made pursuant to s 54(1)(a) of the Health and Disability Commissioner Act 1994 that the defendant breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 in respect of Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill.

[13.2] A final order is made prohibiting publication of the name and of any other details which might lead to the identification of the aggrieved person. There is to be no search of the Tribunal file without leave of the Tribunal or of the Chairperson.

.....	.....	.....
Ms SJ Eyre	**Ms BL Klippel**	**Dr SJ Hickey MNZM**
Deputy Chairperson	**Member**	**Member**

"A"

This is the Agreed Summary of Facts marked with the letter "A" referred to in the annexed decision of the Tribunal delivered on 1 November 2021.

BEFORE THE HUMAN RIGHTS REVIEW TRIBUNAL
I TE TARAIPIUNARA MANA TANGATA

HRRT /21

UNDER Section 50 of the Health and Disability Commissioner Act 1994

BETWEEN **DIRECTOR OF PROCEEDINGS,** designated under the Health and Disability Commissioner Act 1994

Plaintiff

AND **TARANAKI DISTRICT HEALTH BOARD**

Defendant

REDACTED AGREED SUMMARY OF FACTS

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Level 11, 86 Victoria Street, Wellington 6011
PO Box 11934, Wellington 6142
Phone: 04 494 7900 Fax: 04 494 7901

Greg Robins - Acting Director of Proceedings

REDACTED AGREED SUMMARY OF FACTS

INTRODUCTION:

1. The plaintiff is the Director of Proceedings exercising statutory functions under sections 15 and 49 of the Health and Disability Commissioner Act 1994 ("the Act").

2. The "aggrieved person" in these proceedings is Mr S (deceased).

3. At all material times the defendant, Taranaki District Health Board ("TDHB") was a health care and disability services provider within the meaning of s 3 of the Act, and was providing health services to the aggrieved person within the meaning of s 2 of the Act.

4. At all material times, the defendant managed and operated Taranaki Base Hospital in New Plymouth ("the Hospital"), and was responsible for the services the Hospital provided.

5. On 14 July 2016, the aggrieved person's wife, Mrs S ("the complainant"), complained to the Health and Disability Commissioner ("the Commissioner") about services provided to her late husband by the defendant, at the Hospital.

6. On 2 September 2019, the Commissioner (appointed under s 8 of the Act) finalised his opinion that the defendant had breached the aggrieved person's rights under the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("the Code") and in accordance with s 45(2)(f) of the Act, referred the defendant to the plaintiff.

BACKGROUND

10 September 2015
Admission to the Emergency Department

7. Around 7.30pm on 10 September 2015, the aggrieved person, a 68 year old man, presented at the Emergency Department ("ED") of the Hospital with chest pain that radiated down his right arm. He reported that he had been experiencing the chest pain on and off for the past seven days.

8. At 8.00pm an electrocardiogram ("ECG")[1] was performed and a blood sample was taken. At this time, the aggrieved person was noted to be pain free with nil interventions required. At 8.16pm the aggrieved person was administered aspirin,[2] and at 8.30pm was taken for a chest x-ray.

9. At 9.00pm, ED medical staff administered one spray of glyceryl trinitrate ("GTN")[3] to the aggrieved person who was reporting chest pain at a level of 1/10.[4] GTN spray is used to relieve symptoms of angina by relaxing the blood vessels and allowing blood to flow more freely to the heart. GTN can cause a drop in blood pressure resulting in dizziness and fainting. For that reason mobilisation soon after the use of GTN carries a risk of falling over.

10. At approximately 10.00pm, ED medical staff recorded that the blood sample taken had returned a Troponin T high sensitivity level of 755

[1] The recording of the electrical activity of the heart.
[2] An antiplatelet medication that blocks platelet cells and slows down the body's ability to clot blood.
[3] A short acting vasodilator (medication that dilates the blood vessels).
[4] With 1/10 being the lowest pain score, and 10/10 being the highest.

ng/L,[5] and that the aggrieved person would be referred for medical review. The blood results, along with the ECG reading, indicated the aggrieved person had suffered a non-ST elevation myocardial infarction ("NSTEMI"), commonly known as a heart attack.

11. The aggrieved person was administered clexane, an anticoagulant used to reduce the likelihood of blood clots. The aggrieved person was not given metropolol[6] as his heart rate was only 60 beats per minute and it was decided to wait until after his medical review.

12. Another blood sample taken at 10.15pm returned a Troponin T high sensitivity level of 642 ng/L.[7]

13. At 11.10pm, a repeat ECG was taken, and it was noted that the aggrieved person was pain free and comfortable.

14. At 12.30am the aggrieved person was reviewed by the medical registrar (Dr B), and a decision was made to transfer the aggrieved person to a general medical ward to be monitored via telemetry[8] from the Coronary Care Unit ("CCU"). The aggrieved person was noted to be comfortable and awaiting medication to be given before transfer. The aggrieved person was subsequently administered ticagrelor[9] and atorvastatin.[10]

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[5] Troponin T is one of a group of proteins found in skeletal and cardiac muscle fibres that regulate muscle contractions. The normal range of Troponin T found in blood is 0 - 13 ng/L. Elevated levels of Troponin T indicate damage to the heart muscle or a heart attack.

[6] A beta-blocker used to treat angina and hypertension, and after a heart attack to prevent heart damage. It works by slowing the heart rate and lowering the blood pressure.

[7] Troponin levels rise over the first 24 hours after a heart attack, and then decline gradually over time.

[8] An automated communications process by which measurements and data (i.e: cardiac monitoring) are collected from one area and transmitted to receiving equipment for monitoring in another area.

[9] An antiplatelet medication.

[10] Used to lower cholesterol in the blood and reduce the chance of heart disease.

15. The decision to admit the aggrieved person to a general medical ward instead of to the CCU was against accepted guidelines, and TDHB's own recommended practice.

16. The European Society of Cardiology's ("ESC") *Guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation* (2015) recommends that NSTEMI patients at intermediate to high risk for cardiac arrhythmias are monitored in an ICU[11] / CCU or intermediate care unit for more than 24 hours.

17. Expert advice provided to the Commissioner confirmed that having been admitted for an NSTEMI, there was an increased likelihood the aggrieved person would experience malignant ventricular arrhythmias[12] within the first 48 hours after the NSTEMI. TDHB has accepted that the aggrieved person was at high risk for cardiac arrhythmias.

18. At the time of these events TDHB's recommended practice was that a new NSTEMI patient, such as the aggrieved person, would be admitted to the CCU, which is part of the Intensive Care/Coronary Care/High Dependency Unit (ICU/CCU/HDU) for at least 24 hours of monitoring. Patients admitted to the CCU rather than a medical ward are likely to receive a higher level of care, as managing complex clinical situations on the ward is more difficult owing to the significantly higher nurse-to-patient ratio.

19. TDHB has advised that despite recommended practice, admission to the CCU will at times need to be considered in the context of bed availability, and the availability of staff with the appropriate skills to

[11] Intensive Care Unit.

care for the patients in the CCU. TDHB has also advised that when the CCU is at capacity (either as a result of the number of beds or the number of staff), admission will require triaging of patients with the most stable patients being admitted to the medical ward with an appropriate management and monitoring plan in place. There is no evidence to suggest beds were not available in the CCU at the time of the aggrieved person's admission to the medical ward. However, a decision was made not to admit the aggrieved person to the CCU with reference to the fact that there had already been two recent acute admissions to the CCU and the aggrieved person was presenting as alert and not showing signs of acute or respiratory distress. TDHB's view was that telemetry monitoring and associated processes mitigated the potential risk from specifically, a malignant arrhythmia.

11 September 2015

Admission to general medical ward, and further administrations of GTN spray

20. At approximately 1.00am on 11 September 2015, Dr B admitted the aggrieved person to a general medical ward. Once admitted, and throughout this admission, the aggrieved person's heart rate and rhythm were monitored remotely via telemetry from the CCU, and he continued to be administered the anticoagulant and antiplatelet (blood thinning) medications.

21. At 2.45am, the float staff nurse,[13] RN C, took the aggrieved person's routine vital observations.[14] At this time, the aggrieved person told RN C

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[12] Abnormal heartbeats that originate from the lower heart chambers (ventricles), which may lead to cardiac arrest.

[13] Float nurses do not have their own patient loads but instead work between wards, assisting other nurses.

[14] Routine vital observations include monitoring blood pressure, heart rate, blood oxygen saturation, and temperature.

that he was experiencing some chest tightness and had a pain score of 3/10. RN C administered one spray of GTN to the aggrieved person.

22. At approximately 2.50am, the aggrieved person was still experiencing chest pain, and RN C administered one further spray of GTN. RN C took the aggrieved person's observations again, which were within normal range, and notified the night duty coordinator, RN D, that she had given two sprays of GTN to the aggrieved person. RN C did not record in the clinical notes the two sprays of GTN she had administered. RN C and RN D then carried out an ECG on the aggrieved person.

23. At approximately 2.55am, RN D reviewed the aggrieved person, who reported that he was still experiencing chest tightness, but with a pain score of 1/10. RN D took the aggrieved person's vital observations, which were stable. RN D administered two further sprays of GTN, for unresolved chest pain.

24. The recommended dose of GTN recorded on the aggrieved person's medication chart was 1-2 sprays sublingual PRN,[15] minimum dosage interval of 5 minutes, which may be repeated once after 5 minutes.

25. RN D did not appreciate that RN C had administered two sprays of GTN five minutes apart as opposed to two sprays of GTN at once.

26. Due to the fact that the aggrieved person's chest pain was considered an emergency, and because the MedChart system[16] required multiple log-ons, RN C did not log the GTN spray at the time it was given and the medication was not charted on the MedChart system until after the aggrieved person's chest pain had been treated, by which time RN C had

[15] As required.

gone to another ward. Rather than calling RN C back to the ward, RN D recorded and signed for "2 sprays" of GTN at 2.50am on behalf of RN C as well as her own administration of "2 sprays" of GTN at 2.55am.

27. As a result the timing and dose of the GTN sprays administered to the aggrieved person was not clear or factually accurate on the available documentation. Further, the documentation of GTN sprays administered to the aggrieved person was not consistent with relevant practice standards and guidelines current at the time of these events.[17] Expert advice provided to the Commissioner confirmed that systems should enable the administrator to sign for medication at or close to the time of administration, rather than requiring the administrator to delegate the responsibility to a colleague.

28. TDHB has acknowledged there are some limitations with the MedChart system whereby rapid administration by multiple users of a medication like GTN is unable to realistically occur in real time, as it requires logging in and out of the system multiple times by multiple users.

First electronic request for medical review

29. Subsequent to the 2.55am administration of GTN, and due to the aggrieved person's chest pain and need for GTN spray, RN D sent the

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[16] The Hospital's electronic medication prescribing and administration system.

[17] New Zealand Nurses Organisation *Guidelines for Nurses on the Administration of Medicines* (2014) at page 47: "After administration, the regulated nurse administering the medicine: makes clear and accurate recordings of the administration of each individual medicine administered or deliberately withheld, or refused, ensuring any written entries and the signature are clear and legible. Documentation must be timely …"; and Nursing Council of New Zealand *Code of Conduct for Nurses* (2012), and the Nursing and Midwifery Council *Standards for Medicines Management* (2010): "… you must make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring the signature is clear and legible."

following electronic message to the on-call night duty house officer, Dr E, via the Hospital's electronic notification tool, Task Manager:

"gtn x2 and down to 1/10, ecg to review please thanks. Obs ok".

30. The request was logged as priority 2 (semi-urgent), and labelled as "review patient – clinical concern" with a preferred time to be seen by 3.00am.[18]

31. The purpose of the Task Manager system was to relay routine tasks required of the on-call house officer. It was not intended to relay tasks which were clinically considered semi-urgent or urgent, which the aggrieved person's chest pain was considered to be. Anything clinically urgent (or semi-urgent) was to be phoned through to medical staff, and that should have occurred in this case. However, contrary to the Hospital's expected practice, at the time of these events, Task Manager was being incorrectly used to relay all requests for medical attention, except emergencies, and it was common practice to use Task Manager to request attention for resolved chest pain. RN D did not recall receiving any formal training about when Task Manager should be used.

32. Contrary to the Hospital's expected practice, RN D did not telephone Dr E to convey that a review was clinically semi-urgent, or follow up her request to Dr E in any way to ensure a medical review had taken place.

33. At an unknown time, Dr E read the electronic message on Task Manager left by RN D at 2.55 am, attended the ward, and reviewed the aggrieved person's ECG, which showed no acute changes compared to the previous ECG. Dr E did not review the aggrieved person's clinical notes,

[18] Tasks placed on Task Manager are given a priority rating of 1 – 3. 1 = urgent, 2 = semi-urgent, and 3 = routine.

or undertake a physical examination. Had Dr E read the aggrieved person's clinical notes, he would have learned the aggrieved person had been admitted only a few hours earlier for an NSTEMI. The aggrieved person's recent admission with an NSTEMI increased the likelihood that he would experience malignant ventricular arrhythmias, potentially requiring defibrillation, within the first 48 hours after the NSTEMI.

34. Dr E signed off the ECG but did not document his decision not to physically review the aggrieved person, or his reasons for that decision, on the aggrieved person's clinical notes or the Task Manager system.

Aggrieved person's fall after mobilisation post-GTN spray

35. Shortly after the administration of GTN spray at 2.55am, the aggrieved person advised RN C that he needed to use the toilet. RN C offered the aggrieved person a bottle to use at his bedside due to concern that mobilisation might trigger another episode of chest pain. The aggrieved person advised that he wanted to use the toilet. RN C checked the aggrieved person's blood pressure ("BP"), asked whether he was feeling dizzy, and was satisfied that the aggrieved person was not. RN C escorted the aggrieved person to the toilet, and left the room, leaving the aggrieved person unattended. RN C observed that the aggrieved person was very steady on his feet, but did not record this, her conversation, or her decision to allow the aggrieved person to go to the toilet unattended.

36. Due to the fact that this was only the aggrieved person's second use of GTN spray, more caution should have been exercised and the aggrieved person should have been instructed to use the bottle or to wait at least 10 minutes following the last administration of GTN spray before mobilising, due to the risk of a drop in blood pressure.

37. At 3.05am, the aggrieved person rang his call bell. RN D attended the aggrieved person who was found sitting on the edge of his bed. The aggrieved person told RN D that he had walked to the toilet unattended, felt dizzy after passing urine, and had woken up on the floor.[19] The aggrieved person complained of a sore elbow, but RN D recorded there was no apparent injury and that the aggrieved person did not appear to have hit his head.[20] RN D undertook a general visual check and checked his vital signs, but did not undertake a full physical assessment of the aggrieved person.

38. RN D recorded that the aggrieved person's BP was low at 86/56,[21] and queried: "? syncope[22] after having GTN spray".[23] At that time, RN D gave the aggrieved person a bottle to use the next time he wanted to pass urine, and advised him to call a nurse when he needed to get out of bed. RN D noted in the aggrieved person's clinical notes that only one spray of GTN was to be given in future, if the aggrieved person experienced chest pain.

39. The aggrieved person's low blood pressure triggered an Early Warning Score ("EWS") of 2.[24] According to the Hospital's recommended practice, as recorded on the Early Warning Systems Observation Chart, an EWS of 2 required medical review within an hour. That did not occur.

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[19] The aggrieved person's family have advised that the aggrieved person told them he had collapsed again after trying to get up, and then made it back to the bed. The aggrieved person showed his family bruises on his right arm and that he had an egg on his head.

[20] Recorded by RN D at 3.35 am.

[21] Low BP is defined as a BP reading under 90/60.

[22] A temporary loss of consciousness usually related to insufficient blood flow to the brain. It most often occurs when blood pressure is too low (hypotension) and the heart does not pump enough oxygen to the brain.

[23] Also recorded at 3.35 am.

Second electronic request for medical review

40. At 3.16am, RN D sent a second electronic message to Dr E, via Task Manager requesting medical review of the aggrieved person:

> "Pt rang bell, was sitting in bed but states he had collapse [sp] when in toilet, woke up and he was on the floor and didn't know where he was and then walked back to bed. BP 85/56 so likely vasovagal[25] after having gtn spray only 5 minutes earlier".

41. The message was marked as priority 2 (semi urgent), and labelled as "review patient – clinical concern", with a preferred time frame to be seen by 3.30am. As already noted, it was not appropriate to use the Task Manager system to relay tasks considered clinically semi-urgent. TDHB has acknowledged it was an error of judgment to use the messenger system in this way.

42. Expert advice provided to the Commissioner noted that the complexity of the aggrieved person's presentation (including his chest pain necessitating a repeat ECG requiring medical review; an unwitnessed collapse in the context of a reported loss of consciousness, recent GTN administration and previous antiplatelet and anticoagulant medication administration; and low blood pressure following collapse triggering an EWS of 2) warranted a telephone, or face-to-face conversation between the nurse and on-call doctor to ensure that clinical information was clearly articulated and the doctor was fully informed of the aggrieved person's situation.

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[24] Early Warning System scores are used by hospital care teams to recognise early signs of clinical deterioration in order to initiate early intervention and management, such as nursing or medical attention, or activating a rapid response or medical emergency team.

[25] The vasovagal reflex, where blood pools in the lower body and less blood goes to the brain, is a common cause of fainting.

43. At an unknown time, RN D added an additional note to the clinical records, recording that she had performed a further ECG, notified Dr E of the fall, and completed a Patient Falls Form.[26]

44. On the Patient Falls Form, RN D recorded: how the fall had occurred, as the aggrieved person had told her; that the administration of the GTN spray had likely contributed to the fall, and that the aggrieved person had not sustained any injuries. RN D also recorded that in response she had notified Dr E, and that she had given the aggrieved person a bottle for urinating, and modified his GTN intake to prevent recurrence. Finally, RN D recorded that the aggrieved person had not met the criteria for a Falls Risk Assessment to be completed before he fell (despite the administrations of GTN spray in ED and on the ward), and no such assessment had been undertaken. There is no evidence that a falls assessment was undertaken following the aggrieved person's GTN use or after his fall.

45. At an unknown time, Dr E read the second electronic message on Task Manager. Dr E made a decision not to undertake a face-to-face review of the aggrieved person, or physical examination, on the basis that the aggrieved person had collapsed following GTN administration but had got himself back to bed and was now sleeping. Dr E did not review the aggrieved person's clinical notes before making this decision. Had he done so, he would have been aware that the aggrieved person was on three types of anticoagulation and antiplatelet medication and therefore

[26] A patient falls form is completed whenever a patient experiences a fall or near miss (for example, when a patient is lowered to the floor, to avoid an imminent fall) at the Hospital. It sets out what happened, what first aid action was taken, what contributed to the fall, the medical assessment following the fall, the actions taken to prevent recurrence, and addresses the patient's risk of falling again.

was at an increased risk of head injury complications, and therefore a high risk patient for falls. Despite reading that the aggrieved person had woken up on the floor, Dr E did not consider the possibility that the aggrieved person could have hit his head during the fall.

46. In addition and contrary to accepted practice, Dr E again did not document his decision not to undertake a face-to-face review, or his reasons for this decision. For adequate coordination of care, health care providers need to know whether medical review is still required or not. TDHB's system and operating environment should require that decisions made about a patient's care are clearly documented.

47. Expert advice obtained by the Commissioner confirmed that there were a number of clinical circumstances and risks that should have prompted Dr E to review the aggrieved person physically and perform a neurological assessment, including that the aggrieved person had ongoing angina, he had had an unwitnessed fall with a loss of consciousness, and he was on three different blood-thinning medications. The expert noted that in light of that history, the aggrieved person was at risk of intracranial bleeding and malignant ventricular arrhythmias.

48. At the time of these events there was no flag or warning system to identify patients on anticoagulant/antiplatelet therapy, and no flag to identify such patients in the electronic falls form. A flag/warning system may have assisted Dr E in identifying that the aggrieved person was a high risk patient for falls.

49. TDHB has acknowledged that Dr E should have reviewed the aggrieved person following his episode of chest pain and following his unwitnessed fall with a drop of blood pressure and loss of consciousness.

50. Dr E has acknowledged that the decision not to undertake a face-to-face review of the aggrieved person did not represent best clinical judgement. However, that decision was made in the context of a lack of experience (Dr E was in his first year of practising medicine at the time of these events), fatigue (he was working his 7th rostered night shift in a row), and issues with prioritisation and mode of review request. TDHB has acknowledged that Dr E had a very busy night, with multiple demands and a number of acute admissions.

51. Expert advice provided to the Commissioner confirmed that it is the responsibility of TDHB to explore the extent to which clinical workload impairs appropriate practice.

52. TDHB has further acknowledged that in the absence of a direct page or phone call that would signify urgency and/or concern from the nurses, it was always a risk that there would be a delay in getting a review from a house officer. In addition, TDHB confirmed that at the time of the events set out in this agreed summary of facts, there was no dedicated training that specifically taught new doctors how to prioritise their tasks when on call.

53. At 3.35am, RN D recorded the aggrieved person's BP as 102/67 and noted that he did not report any chest pain.

54. At some time after this, RN D went on her break. When she returned (between 4.30am and 5.00am) she did not know, and the other staff nurse was not sure, whether Dr E had reviewed the aggrieved person or not (subsequent to the electronic message sent to Dr E at 3.16am). TDHB did not have adequate systems in place to ensure that RN D was aware of whether or not the on-call house officer had reviewed the aggrieved person. Further, RN D did not follow up her second request with Dr E to ensure a medical review had taken place.

55. TDHB's Serious and Sentinel Event Analysis ("SSE Analysis") which was completed after these events, noted that the initial task on Task Manager was signed off as completed, based on Dr E having reviewed the ECG, even though there had been no physical review. The SSE Analysis noted that Task Manager gave nursing staff a false sense of "job completion", and may have led to no further follow-up occurring. TDHB has acknowledged that the use of Task Manager may have been contributing to an issue of complacency among nursing staff when they are requesting medical staff review.

56. Expert advice provided to the Commissioner agreed that the use of Task Manager contributed to an issue of complacency amongst nursing staff and was a factor in the aggrieved person's care.

Discovery of head injury during fall

57. At 6.15am, RN D collected a "fasting" blood sample[27] from the aggrieved person and noted that he had no further chest pain.

[27] A blood sample taken after the patient has not eaten or drunk anything (except water) for a certain period of time beforehand.

58. At 6.45am, RN D recorded: "[The aggrieved person] states that he think (sic) he must have hit his head when he fell as he feels a lump at the back of head…". RN D carried out a full set of neurological observations which were normal, and recorded a Glasgow Coma Score ("GCS") of 15/15,[28] and a BP of 122/79.

59. RN D did not update Dr E to advise that the aggrieved person had hit his head when he fell and had a lump on his head, instead choosing to document what had happened and advise incoming morning staff of the need for a medical review at handover. The explanation provided for this decision was that given the timing of the disclosure just prior to handover, the handover would result in the aggrieved person being seen soon afterwards as the morning medical ward round was due at approximately 8.30am.

60. Expert advice to the Commissioner highlighted that even if the incoming medical team saw the aggrieved person first (during ward rounds at 8.30am) this would have been five hours after the aggrieved person's fall, two hours after the disclosure of the head injury, and 15 minutes before the aggrieved person was due to receive a further dose of blood thinning medication.

61. TDHB has acknowledged that once it was identified that the aggrieved person had struck his head, Dr E should have been notified immediately due to the heightened risk of a patient fall with head injury in tandem

[28] The GCS is a common scoring system for evaluating and describing impairment to a patient's level of consciousness. The GSC assesses the patient's level of: eye response (on a scale of 1-4), verbal response (on a scale of 1-5), and motor response (on a scale of 1-6) and creates a total score from combining those responses. A score of 3 – 8 indicates a serious head injury, a score of 9 – 12 indicates a moderate head injury, and a score of 13 – 15 indicates a minor head injury.

with blood thinning medications. This was a missed opportunity for the aggrieved person to be reviewed earlier.

Nursing handover to morning shift and discontinuation of neurological observations

62. Also at 6.45am, RN D handed over to the morning nursing staff, including to the ward coordinator, RN F, and the morning nurse, RN G (who was subsequently assigned to care for the aggrieved person). RN D advised RN F and RN G that the aggrieved person had hit his head, that she had commenced neurological observations, and that he would require a medical review as soon as the morning medical team arrived.

63. There is no evidence that RN D highlighted for the morning nursing staff that the aggrieved person was on multiple antiplatelet and anticoagulant medications and the potential risks associated with those medications in the context of an unwitnessed fall and head injury.

64. Despite being aware that the aggrieved person had hit his head, RN G undertook routine observations (which were normal), but did not continue with neurological observations (for example, RN G did not assess the aggrieved person's pupil reaction to light, or record any observations on the aggrieved person's neurological observations chart). Following the initial neurological assessment completed by RN D, no further neurological assessments were completed.

65. RN G did not record her decision to stop neurological observations, or her reason for that decision on the neurological observation chart, or in the aggrieved person's clinical notes.

66. Neurological observations are undertaken to detect the possibility of subtle, early changes should they occur. Irrespective of the aggrieved person presenting as alert, stable, and communicative, that did not negate the need to continue to undertake neurological observations of a patient who had hit his head during an unwitnessed fall, and especially when that patient is receiving antiplatelet therapy, at least until the patient has been reviewed by a doctor.

67. TDHB has acknowledged this was an error of judgment and that neurological observations should have continued until an informed decision was made to discontinue them by the medical team.

Medical handover to morning medical team

68. Handover protocol at the Hospital was that, at 8.00am the on-call night house officer (Dr E) and night medical registrar, would provide a face-to-face handover to the incoming medical team. However, at 8.00am, Dr E was attending to a patient in respiratory distress who required urgent transfer to ICU and was unable to attend the handover meeting (although even had he attended the handover meeting he would not have identified that the aggrieved person had hit his head as he was not aware of this himself).

69. As a result, Dr B presented handover and advised the incoming medical team (including consultant physician Dr I) that the aggrieved person was a 'heart attack' patient, under treatment. No concerns about the aggrieved person were raised during the handover and there was no mention of any fall or head injury. As a result the incoming medical team were unaware of the aggrieved person's fall, or that he had hit his head.

Continued administration of blood thinning medication

70. At 8.15am, the aggrieved person was administered his antiplatelet medication (aspirin), as well as metropolol, and paracetamol. At 10.21am RN G administered to the aggrieved person his anticoagulant medication (clexane). RN G did not seek medical advice before administering the medication to the aggrieved person despite knowing the aggrieved person had had a fall overnight and had hit his head. RN G did not complete a full physical assessment of the aggrieved person, or a neurological assessment, prior to administering the medication.

71. The New Zealand Nurses Organisation's *Guidelines for Nurses on the Administration of Medicines* (2014) includes the following:

> **"12.2 Prior to administration**
>
> Prior to administration of medication, the regulated nurse … administering the medicine:
>
> - ensures they are aware of the client's current assessment and planned programme of care; and makes a clinical assessment of the suitability of administration at the scheduled time of administration.
> - is aware of the therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contra-indications;
> - contacts the prescriber/pharmacists, designated senior health professional as appropriate if:
>   - there are potential adverse interactions with other medicines;
>   - where contra-indications to the administration of any prescribed medicine are observed; …"

72. Expert advice to the Commissioner confirmed it would be expected that a registered nurse who has been informed of a patient's history, which includes a fall, potential head injury and recent administration of multiple antiplatelet and anticoagulant medications, would make the clinical decision to withhold further doses of such medications until the patient had been reviewed by a doctor.

73. TDHB has acknowledged that the decision to administer blood thinning medication to a patient who had a fall overnight and knocked his head without first consulting with the medical team, reflected a lack of appreciation of the significant risk posed by patients on blood thinners who injure themselves, even more so when it involves a head knock.

74. However, TDHB also acknowledged that at the time of these events, the increased use of blood thinning medications for acute coronary syndrome had not been accompanied by an increase in education for its staff on the associated risks with those medications.

75. At 10.30am, a cardiac nurse specialist ("CNS") visited the aggrieved person. The CNS recorded the aggrieved person's recent admission history, and that he was: "[E]ncouraged to report ongoing episodes [of chest tightness]". The CNS also documented the aggrieved person's recent fall, recording: "See previous notes re. syncope with NLS [nitrolingual spray/GTN]".

Review by medical team and continued prescription of blood thinning medication

76. Shortly after this, the medical registrar, Dr I, and two house officers (collectively referred to as "the medical team") arrived to see the

aggrieved person during their morning ward round, but he was away from the ward having an echocardiogram.[29]

77. At 11.35am, the medical team returned and reviewed the aggrieved person. The house officers presented the aggrieved person to Dr I, and advised him of the admitting notes, examination notes, diagnosis and management. Dr I examined the aggrieved person, but does not appear to have noted the lump on the aggrieved person's head, or bruising to his elbow which the aggrieved person's family have confirmed was present at this time.

78. At the time of the medical review, RN G was on her lunch break and no other nurses attended the ward round as they were busy with complex patients. The medical team did not review the nursing notes and the fact of the aggrieved person's chest pain overnight, his fall, and that he had hit his head was not verbally relayed to the medical team by nursing staff.

79. Dr I recorded his plan which included continuing medical management by way of the anticoagulant and antiplatelet medication the aggrieved person had already been prescribed, and a transfer to Waikato Hospital for an angiogram.[30] Dr I noted that if the aggrieved person experienced any further chest pain he was to be reviewed and transferred to HDU. A subsequent entry in the aggrieved person's clinical notes recorded that the aggrieved person was for transfer "1-2 days".

80. Expert advice to the Commissioner confirmed that it would be important for the medical team to know how the aggrieved person's symptoms

[29] An ultrasound of the heart.

progressed after an admission with a heart attack and in the absence of any other handover information to that effect, it would be standard to read the nursing notes.

81. TDHB has acknowledged that while it is unrealistic to expect that every ward round will be able to have a nurse escort (although desirable), when a nurse escort is not present, there is extra responsibility on both the nursing and medical teams to ensure good communication occurs which clearly did not happen on this occasion.

82. The inadequate verbal handover from night medical staff, and the failure to read the nursing notes, resulted in significant events (namely that the aggrieved person had fallen overnight and had hit his head) not being communicated to the incoming medical team, who then continued to prescribe blood thinning medication to the aggrieved person.

83. At 1.02pm, when RN G returned from her lunch break, she administered further antiplatelet medication (ticagrelor) to the aggrieved person. RN G incorrectly assumed that the medical team had seen the clinical notes regarding the aggrieved person's fall when reviewing the clinical record while seeing the aggrieved person. On that basis, RN G presumed there had been an informed decision to continue with the blood thinning medication, despite Dr I's notes not referencing the fall or whether the medical team had considered this issue in the morning review. RN G did not complete any physical or neurological assessment of the aggrieved person, and did not undertake the aggrieved person's routine observations prior to administering the medication, or at any other time during the remainder of her shift.

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[30] A diagnostic test that uses x-rays to take pictures of blood vessels. Dye is administered to the

Handover to afternoon/evening nursing shift

84. At 2.45pm, RN G provided hand over to the afternoon nurse assigned to care for the aggrieved person, RN H, who was also the ward coordinator, and responsible for supervising a student nurse. RN G advised RN H that the aggrieved person had fallen during the night, but not that he had hit his head. RN H was also unaware that the medical team was not aware of the aggrieved person's fall.

85. At 3.30pm, a student nurse, under the supervision of RN H, assessed the aggrieved person and took his observations, which were normal.

86. At an unknown time during the afternoon shift, the student nurse completed a routine Risk Assessment form, which determined there was "no risk identified".[31]

87. At around 7.30pm, the aggrieved person's family advised nursing staff that the aggrieved person had a headache. RN H and the student nurse took the aggrieved person's observations, and recorded his vital signs were stable. The aggrieved person complained of feeling dizzy when he stood up, and of chronic neck pain. The aggrieved person's family advised that the sore neck was a long-standing issue and it was arranged for the aggrieved person's daughter to bring in the aggrieved person's own pillow. RN H attributed the dizziness to the introduction of the aggrieved person's new beta-blocker medication (metoprolol),[32] which slows the heart rate and lowers the blood pressure, and thought that the

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arteries prior, to make the blood vessels visible on the x-ray.

[31] The aggrieved person was assessed as having a risk level of 1 out of 10. A score of 3 – 4 is seen as a medium risk, requiring risk management measures to be implemented. A risk of 5 or more is seen as high risk.

[32] Beta-blocker medication can cause dizziness as it slows the heart rate and lowers blood pressure.

neck pain could have caused the headache. RN H did not record the aggrieved person's complaint of a headache, dizziness and a sore neck, her review of the aggrieved person, or her opinion as to the cause, in the clinical notes at this time. Retrospectively, at 9.50pm, RN H recorded: "Prior to Emergency, pt had had visitors, eaten tea & mobilised indep[endently]. He had felt slightly unsteady when he got out of bed earlier. Panadol given for slight headache".

88. At 7.46pm, RN H administered paracetamol and atorvastatin to the aggrieved person. The aggrieved person told RN H that Panadol had been effective on previous occasions. Following the medication, the aggrieved person settled into bed and made no further complaint of having a headache.

89. RN H remained unaware of the aggrieved person having hit his head, despite RN D's clinical notes documenting the bump to the aggrieved person's head and that neurological observations had been undertaken earlier that morning. RN H did not undertake further neurological observations, or seek a medical review, and continued to treat the aggrieved person as a cardiac patient.

90. At the time RN H was under a significant clinical workload including student supervision and ward coordination. Expert advice to the Commissioner confirmed that the decision not to recommence neurological observations and inform the doctor on call of the change in the aggrieved person's condition represented poor clinical decision-making. However, the expert highlighted that unacceptable communication failures and clinical workload demands contributed to the nurse's ability to be fully informed of the aggrieved person's

condition, and those contextual factors significantly affected RN H's ability to make informed, and appropriate clinical decisions in this case.

91. The aggrieved person's family left the hospital ward around 8.30pm.

Aggrieved person found unresponsive

92. At approximately 9.10pm, RN H smelled vomit from the corridor. The student nurse investigated and discovered the aggrieved person had vomited, was breathing abnormally and was non-responsive. The student nurse rang the emergency call bell and a 777 call was put out.[33] RN H commenced CPR[34] and the aggrieved person was stabilised.

93. At 9.30pm, the aggrieved person's family was contacted, and they returned to the Hospital.

94. At 9.40pm, following resuscitation, it became clear the aggrieved person's neurological function was severely compromised. The aggrieved person's pupils were fixed and dilated,[35] he had bilateral up-going plantars,[36] and showed no response to pain. The aggrieved person's GCS was recorded at 3/15.

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[33] "777" is the Hospital's internal emergency number, used to request emergency teams such as a resuscitation team.

[34] Cardiopulmonary resuscitation. An emergency procedure of chest compressions often with artificial ventilation intended to manually preserve intact brain function until further measures are taken to restore spontaneous blood circulation and breathing in a person who is in cardiac arrest.

[35] When the pupils dilate (widen) without a change in the level of light, and do not respond to a change in the level of light by constricting. This can be an indication of a traumatic brain injury.

[36] The plantar reflex is the reflex of the toes and foot when the sole of the foot is brushed with a blunt tool or thumb. The typical response is for the toes and foot to flex downwards. An atypical response, where the toes and foot flex upwards (are up-going), in adults can indicate disease or injury to the spinal cord or brain. In a bilateral response, both feet produce an upwards reflex.

95. At 9.55pm, the aggrieved person was sent for an urgent CT scan[37] which identified a massive subdural haemorrhage[38] with midline shift.[39] The impression formed by the medical registrar was that the aggrieved person had likely had a massive intracranial haemorrhage in the context of anticoagulation medication. It was recorded that the aggrieved person had a very poor prognosis given his current clinical condition.

96. At 10.36pm, the full CT scan report was provided to the attending physician. The aggrieved person's family was then informed of the diagnosis and poor prognosis.

Palliative care[40]

97. Following discussion with the aggrieved person's family, it was decided the aggrieved person would receive palliative care. RN J was the primary nurse overseeing the aggrieved person during this time.

98. Throughout his time in palliative care, the aggrieved person appeared distressed, with very loud gasping respirations, despite receiving oxygen. The aggrieved person's family found it distressing to see the aggrieved person struggling to breathe.

99. At 10.30pm, 2.5 – 5 mg of morphine[41] was charted for the aggrieved person, to be given two-hourly. At 11.28pm, a nurse gave the aggrieved

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[37] Computerised tomography – a scan combining a series of x-ray images taken from different angles around the body, which uses computer processing to create cross-sectional images (slices) of the bones, blood vessels, and soft tissues inside the body.

[38] A type of bleeding where blood gathers between the outside of the brain and the skull. It is usually associated with a traumatic brain injury.

[39] A shift of one side of the brain over its centre line, often caused by intracranial pressure.

[40] The provision of medical and personal care and support for people facing life-limiting illnesses or conditions.

[41] An opioid painkiller, used for the relief of moderate to severe pain.

person 2.5 mg of morphine. At 12.40am, RN J gave the aggrieved person a further 2.5 mg of morphine.

100. Midazolam[42] was prescribed for the aggrieved person from 12.27am as required for comfort cares, agitation, or dyspnoea[43] with a minimum dosage interval of two hours. At 12.57am, RN J gave the aggrieved person 2.5 mg of midazolam, and paracetamol.

101. At 2.15am, RN J recorded that the family was visibly distressed at the fact that the aggrieved person was struggling to breathe oxygen through the non-rebreather mask,[44] and asked for it to be removed.[45] The oxygen mask was replaced with nasal prongs but RN J advised the aggrieved person's family that the aggrieved person would continue to make gasping sounds.

102. At around 2.20am, the aggrieved person's family requested that he be administered further medication. RN J declined, advising that she would not administer the additional medication because it was not due for another 30 minutes. RN J believed that she was locked out of the medication chart until the next dose was due. However, while morphine was not due at that time, an extra 2.5 mg of midazolam was available (as prescribed), and could have been administered to the aggrieved person.

103. During the time the aggrieved person was receiving palliative care, his family were not provided with sufficient information about what to

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[42] A benzodiazepine, used for its relaxing and sedating effect.
[43] Difficult or laboured breathing.
[44] A device used to assist in the delivery of oxygen to someone who can breathe unassisted. A non-rebreather mask allows for the delivery of higher concentrations of oxygen than low-flow nasal cannulae.
[45] The aggrieved person's family had been told by the evening shift nursing staff that the non-rebreather mask could be removed if they wished.

expect, and the options available to keep the aggrieved person comfortable during this time (such as further medication) were not discussed with the family. In addition, the aggrieved person's family were concerned at the lack of sensitivity shown by RN J.

104. TDHB has acknowledged that RN J could have administered further medication to the aggrieved person but explained that she had misunderstood the medication chart. Further, that there were more options available to keep the aggrieved person comfortable during the end stages of his life that were not explored.

105. TDHB has further acknowledged that RN J's actions fell short of expectations in the circumstances but noted that RN J was confronted with an uncommon clinical situation which was very difficult to manage. During her shift, RN J was responsible for 11 patients, shared the admission of four new patients, and managed the deaths of two patients, including the aggrieved person, which is likely to have affected her level of care. TDHB accepts that this workload constrained RN J's ability to spend time with and respond to the wider needs of the aggrieved person's family as well as the aggrieved person during his last hours.

106. Expert advice provided to the Commissioner confirmed the end of life care the aggrieved person received was inadequate, and in particular, that further doses of midazolam could have been administered by RN J. However, the expert accepted that the failures in care related to an unachievable workload. As already noted, it was ultimately TDHB's responsibility to consider the extent to which clinical workload would impact on a provider's ability to undertake appropriate practices.

107. At 2.30am, the aggrieved person passed away. The likely cause of death recorded in the aggrieved person's medical record was "subdural haematoma/haemorrhage" with the likely contributing factors listed as: "fall and head injury – likely hypotensive fall given GTN administration" and "antiplatelet agents given to treat ACS[46] contributing to haemorrhage".

THE DEFENDANT'S RESPONSE TO EVENTS

108. TDHB has acknowledged that this was a tragic case where a number of deficits in its care of the aggrieved person contributed to a calamitous outcome for him (and his family). TDHB has met with the aggrieved person's family, and has apologised for the cumulative effect of its actions and inactions that led to the aggrieved person's death and as a result caused huge distress to the family.

109. TDHB has accepted that had the aggrieved person been admitted to the CCU instead of the medical ward, the closer supervision the aggrieved person would have received in the CCU due to the higher nurse/patient ratio would have made a fall much less likely.

110. TDHB also acknowledged that following these events, ongoing monitoring of its electronic notification system made it aware of some continued inappropriate use by nursing staff for signalling semi-urgent clinical tasks that the DHB would consider non-routine. As a result TDHB instructed its Clinical Nurse Managers to remind staff that the system is to be used only for communicating routine tasks.

[46] Acute Coronary Syndrome refers to a large number of heart-related conditions, including myocardial infarction.

Modifications to the system were being sought to remove any potential for further confusion and/or risk.

111. As a result of the aggrieved person's death, TDHB carried out a SSE Analysis which found (among other things):

- Some patients admitted to the Hospital who had experienced a NSTEMI (such as the aggrieved person) were not always being transferred to ICU/HDU/CCU for a period of monitoring to ensure stability as is the expectation. Had the aggrieved person been transferred to the ICU/HDU/CCU it is possible that this tragedy may not have eventuated.

- The ward nurses have a significantly lower nurse to patient ratio (than nurses in the ICU/HDC/CCU) and this can make it more difficult to manage complex clinical situations.

- The Task Manager tool used to notify the doctor was signed off as completed but the aggrieved person was not physically reviewed post his fall. Task Manager may give a false sense of "job completion" to nursing staff, and may have led to no further follow-up phone calls to the medical team.

- There was no flag or warning system to identify patients who were on anti-coagulant/anti-platelet therapy, and no flag or alert on the current electronic falls form to identify such patients to ensure this additional risk factor was taken into account and to ensure they were assessed by a doctor.

- There was a communication breakdown between nursing and medical teams, between nursing shifts, and between doctor shifts. The miscommunications between the teams meant that a medical team never assessed the aggrieved person with regards to his fall. Had this assessment occurred, it is possible that the medical team would have

withheld the blood thinners and carried out an urgent CT head scan, and/or that closer neurological monitoring of the aggrieved person would have occurred.

112. As a result of these findings, TDHB took the following actions, as recommended in the SSE Analysis:

- Presentations and education sessions reinforcing to all nursing staff via case review of this event the following:
    - Safe use of GTN and risk of mobilisation;
    - The risks of anti-coagulation and anti-platelet therapy with patient falls;
    - Importance of good communication between all clinical teams; and
    - Electronic doctor requests and the importance of ensuring follow-up.
- Presentation of the case at the public hospital's Multidisciplinary Morbidity, Mortality & Improvement Meeting in March 2016, highlighting:
    - The risks of antiplatelet and anticoagulation therapy and falls;
    - The doctor review of patients following falls;
    - The handover of relevant events between shifts and between doctor teams;
    - The importance of good communication between all clinical teams; and
    - The importance of reviewing previous nursing shift reports, more particularly when there is no nurse escort available during medical ward round.

- Introduction of a bright green fluorescent sticker to the inpatient wards, and other updates to nursing documentation and processes, to alert staff to patients who are receiving anticoagulation and antiplatelet medications.

- Updated the Patient Fall Flowchart and Form to provide an instruction to withhold any anticoagulation medication until doctor review.

- Added an electronic alert icon to the electronic whiteboard in the medical/surgical/older peoples' health/ICU inpatient wards so that any patient at higher risk due to therapeutic anticoagulant/antiplatelet therapy is identified.

- Medical teams and ICU nursing staff have been advised, and since reminded, that all NSTEMI patients are to be transferred to ICU/CCU/HDU for +/- 24 hours of cardiac monitoring unless contraindications exist.

113. TDHB also changed its roster system, and it is no longer appropriate practice for a medical practitioner to work for seven nights in a row (as was the case for Dr E). The maximum consecutive number of nights that a house office is allowed to be rostered on to work is four.

114. In addition, TDHB followed-up with RN J regarding the palliative care provided to the aggrieved person (including the family's concerns), and highlighted for RN J (and the wider team) the responsibility to liaise with medical staff to get an appropriate dose of analgesic and/or sedative medication prescribed for a dying patient to keep them comfortable.

115. TDHB has also complied with the recommendations made by the Commissioner in his report dated 2 September 2019.

EXPERT ADVICE

116. Dr Nicholas Szecket, internal medical specialist, provided expert advice on the care provided to the aggrieved person by TDHB's medical staff, in particular:

a) That the failure to prioritise the face-to-face review of the aggrieved person, by Dr E, was poor clinical judgement and taking into account surrounding circumstances, was a moderate departure from accepted practice. There were several important indicators to physically review the aggrieved person that night including: the fact that the aggrieved person had been admitted with a NSTEMI with symptoms that did not settle, such as the aggrieved person's on-going angina; the risk for malignant ventricular arrhythmias, potentially requiring defibrillation, in the first 48 hours; and the strong possibility of complications from blood thinning medication in a patient who had had an unwitnessed fall with loss of consciousness. However, Dr E was undoubtedly being pulled in multiple directions with a need to continuously prioritise his work, and given the impersonal, electronic message rather than an urgent personal phone call, it was not difficult to envisage the request for review being dismissed as a faint in a healthy, naïve to medications man who had just received 4 GTN sprays and had then mobilised;

b) That it is standard practice to document in the patient's notes any review or decision made about a patient's care. Dr E made a very active decision that no further investigation was necessary on the basis that the ECG was unchanged from previous. That clinical decision should have been documented and it was a moderate departure from accepted practice not to do so;

c) That in the absence of any medical or nursing handover information regarding how the aggrieved person's symptoms had progressed

overnight, it would be standard for the morning medical team to read the nursing notes during their review of the aggrieved person. The failure to read those notes in the circumstances was a mild departure from accepted standards of care;

d) That the main themes arising in this case relate to documentation and handover. With respect to handover there ought to be a blanket policy that all patients require verbal handover to the next care team. Similarly, all clinical interactions, whether or not any changes resulted to a patient's plan, should be carefully documented in the patient notes.

117. Dr Jane Hardcastle, registered nurse, provided expert advice on the care provided to the aggrieved person by TDHB's nursing staff, in particular:

a) Health care practice is founded on the right information getting to the right people at the right time so that appropriate informed decisions can be made. A recurrent theme throughout this case is the significantly challenging workload that negatively impacted on the various health professionals involved in the care of the aggrieved person. Whilst clinical demands inevitably affect one's ability to provide care as expected, the prevalence of busyness as a means of explaining inadequate care provision warrants exploration by TDHB. The Health Board have a responsibility to enable staff to provide quality care;

b) It appears several assumptions were made regarding communication between health professionals involved in the care of the aggrieved person that negatively impacted upon appropriate health assessment, data analysis, and clinical decision-making;

c) Inadequate communication among and between the nursing and medical staff led to clinical decisions being made by several health professionals who were inadequately informed of relevant information about the

aggrieved person's condition. Each individual breakdown in communication was a mild departure from expected standards of care which cumulatively had a detrimental effect on the aggrieved person, making it a moderate departure from expected standards. The actions and/or inactions of staff were likely influenced by systems and processes within the clinical context impacting on individuals' ability to provide care;

d) The documentation of the GTN spray administered was not consistent with best practice standards and guidelines, specifically, the timing or dose of the drug administered is not clear or factually correct from the documentation. The practical challenges created with electronic MedChart use contributed to the factually incorrect recording of the drug administration. In particular, the inability of the person administering medication to electronically sign for medication on the MedChart at or near to the time of administration (due to the need for multiple log-ons and time constraints created by urgent situations) represents a moderate departure from expected standards of care. Systems should enable the administrator to sign for medication 'close' to the time rather than delegate the responsibility to a colleague;

e) The assumption made by the nurse caring for the aggrieved person overnight that a medical review would occur within an hour at the morning ward round was detrimental to the aggrieved person's outcome. In order to ensure that relevant information was communicated to the appropriate health professional, a telephone call to the on-call house surgeon to inform him/her of the head injury and time elapsed since the fall would have been more appropriate (and a reasonable expectation). The contextual influences, including systems and processes, are likely to have significantly influenced this moderate departure that appears to have arisen from cumulative assumptions or presumptions regarding

communication of important information rather than deliberate action or omission on the part of any individual;

f) Physical assessments did not occur prior to, or after administration of the aggrieved person's antiplatelet and anticoagulant medication (after his fall) and the medications were administered despite absence of medical review and prescription confirmation. Further, neurological observations were discontinued. The care provided subsequent to the aggrieved person's fall, and decisions made were inappropriate given the circumstances. Communication had not occurred appropriately and, consequently, the nurse's decision to administer anticoagulant and antiplatelet medications and discontinue neurological observations following a known fall and head injury without clarification from medical staff, represents a moderate departure from expected standards. Several contextual factors relating to clinical workload challenges are likely to have contributed to an assumption that appropriate communication had occurred to enable informed decision-making;

g) It would be expected that a registered nurse would have knowledge of the signs and symptoms associated with intracerebral (brain) haemorrhage and raised intracranial pressure (raised pressure within the skull). Headache is a well-known symptom of raised intracranial pressure. It would be expected that if a patient complained of a headache when there was also suspicion of head injury the nurse would initiate neurological observations and seek medical review as a matter of urgency. Dizziness may also be associated with head injury and/or raised intracranial pressure. The decision not to recommence neurological observations and inform the doctor on call of the change in the aggrieved person's condition (headache and dizziness) represents poor clinical decision-making. However, unacceptable communication failures and clinical workload demands contributed to the afternoon shift nurse's ability to be fully

informed of the aggrieved person's condition (such that the aggrieved person had hit his head when he fell) and these contextual factors have significantly affected her ability to make informed, and appropriate clinical decisions;

h) A number of assumptions were made regarding communication between the health professionals involved in the care of the aggrieved person on the morning of 11 September 2016 (during handover and medical review) that prevented key clinical information being shared. Assumptions were made on multiple levels and highlight a shared responsibility amongst medical and nursing staff to ensure that good communication occurs. The cumulative effect of communication errors was detrimental in this case. It is clear that clinical workload demands negatively influenced the ability of many health professionals to communicate important clinical details regarding the aggrieved person's condition and the events overnight. The lack of information communicated verbally to medical staff undoubtedly impaired their ability to make appropriate decisions, although written information was available in the clinical record that was not considered by medical staff;

i) there was a failure to appreciate the significance of the aggrieved person's fall, head injury, and the effect of the antiplatelet and anticoagulant medication which negatively influenced the nursing staff's efforts to communicate personally with medical staff and/or to attend the ward round to ensure that this key information was communicated and received. The failure to have the aggrieved person seen by a doctor as a matter of urgency prior to ward rounds, and to have the attending nurse present at those ward rounds or personally communicate with the doctor post-exam to discuss alterations to the care plan, was a moderate departure from expected standards;

j) The nursing care provided to the aggrieved person and his family in the remaining hours of his life was inadequate, and distressing for the family. This represents a moderate departure from expected standards, taking into account that the nurse had an extremely heavy and challenging workload that exceeded her ability to provide care to the standards expected.

BREACH OF RIGHT 4(1) OF CODE

118. TDHB accepts that the care provided to the aggrieved person fell well below the standard expected of hospital level care in New Zealand. There was a lack of attention to the basic aspects of monitoring, assessment, communication, and critical thinking, and a failure to adequately consider the care the aggrieved person required. This was a collective failure of the system, and the people operating in it, for which TDHB was ultimately responsible.

119. The overall care provided to the aggrieved person was of a very poor standard. As a result, TDHB accepts it breached Right 4(1) of the Code in that it failed to provide care to the aggrieved person "with reasonable care and skill". In particular, TDHB accepts the following failures in care:

a) the aggrieved person was admitted to the medical ward instead of the CCU;
b) medication administered to the aggrieved person was recorded inaccurately in MedChart, contributed to by software that required multiple log-ons;
c) the aggrieved person was left alone in the bathroom despite having recently been administered GTN sprays;
d) Task Manager was used inappropriately to notify medical staff of issues of clinical concern;

e) nursing staff failed to follow up Task Manager messages with medical staff;

f) there was poor clinical judgement by the overnight house officer, who decided not to review the aggrieved person despite his chest tightness and having required GTN sprays, and later having experienced a fall;

g) the house officer did not review the aggrieved person's clinical notes before making a decision not to review him;

h) documentation was poor, including the overnight house officer not recording his decision not to review the aggrieved person;

i) there was poor communication between staff about the aggrieved person's fall, particularly at the nursing and medical handovers;

j) there is evidence that it was not uncommon practice for doctors not to document in the notes when they had attended patients;

k) nursing staff did not notify the house officer of the aggrieved person's head injury;

l) there was no flag or warning system to identify patients on antiplatelet / anticoagulant therapy, and no flag to identify such patients in the electronic falls form;

m) despite having been told that the aggrieved person may have hit his head, there was a lack of critical thinking by nursing staff, who continued to administer his blood-thinning medication, and stopped his neurological observations;

n) there is no evidence that a falls risk assessment was undertaken following the aggrieved person's GTN use or after his fall;

o) there was no face-to-face handover to the medical team from the house officer;

p) the nursing notes were not reviewed by the medical team during their morning round;

q) it appears that the aggrieved person's knock to the head was not relayed verbally to the afternoon staff during the nursing handover;

r) the nursing notes were not always reviewed by incoming nursing staff; and

s) additional medication was available for the aggrieved person when he was in palliative care, but the nurse was not aware of this.

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Greg Robins
Acting Director of Proceedings

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Date

I, for or on behalf of TDHB agree that the facts set out in this Summary of Facts are true and correct.

_____

For or on behalf of Taranaki District Health Board

_____

Date