Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 21HDC00893)

Complaint and investigation

1. This report is the opinion of Deborah James, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. The report discusses the care provided to Mrs A by registered nurse (RN) B and a medical centre and considers multiple unsuccessful blood tests and the management of Mrs A after a fainting incident.

3. The following issues were identified for investigation:

- *Whether RN B provided Mrs A with an appropriate standard of care on 4 March 2021.*
- *Whether the medical centre provided Mrs A with an appropriate standard of care on 4 March 2021.*

4. The parties directly involved in the investigation were:

Mrs A	Consumer/complainant
RN B	Practice nurse
Dr C	General practitioner
RN D	Practice nurse

Names have been removed to protect privacy (except the advisors). Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Medical centre General practice

5. Further information was received from Health Hew Zealand|Te Whatu Ora (Health NZ).

6. In-house clinical advice was obtained from vocationally registered general practitioner (GP) Dr David Maplesden (Appendix A). Independent clinical advice was obtained from RN Barbara Cornor (Appendix B).

How matter arose

7. On 4 March 2021, Mrs A attended the medical centre as a casual patient for an immigration medical assessment. The assessment consisted of a blood test[1] with a nurse and a medical assessment with a GP.

Nursing care

Unsuccessful blood tests

8. The initial part of immigration assessment included paperwork and a blood test, which was undertaken by RN B. Mrs A told HDC that RN B made three unsuccessful attempts to take the blood test. She stated that on the third unsuccessful attempt, 'a little bit of blood came out' and it 'was very painful,' and she told RN B that she was feeling unwell. Mrs A noted that RN B then left the room to ask another nurse to assist with the blood test and did not give her any water prior to leaving the room.

9. RN B told HDC that Mrs A was sitting on the edge of the bed for the blood test. The first attempt was unsuccessful, and he attempted to take blood from her other arm, consistent with the medical centre's standard practice. He said that after the second attempt at the blood test, Mrs A reported feeling faint, so he provided her with water and advised her to rest. She remained sitting on the bed at this point.

10. RN B documented (retrospectively on 8 March 2021) that there were two attempts to take Mrs A's blood test and that she '[f]elt faint after attempts. Water given.' He told HDC that he estimates that Mrs A was alone 'for a couple of minutes' while he went to get a colleague to assist with the blood test. He noted that it is not his practice to leave patients on their own if they display any concerning signs or symptoms, and if he had been concerned that Mrs A had appeared 'unwell, or if there was anything to indicate that she should not have been left alone, [he] would have remained in the room with her'.

11. RN D told HDC that RN B asked for her assistance with a difficult blood test, although she does not recall whether RN B told her how many attempts he had made, nor that Mrs A felt faint. RN D went with RN B to assist with Mrs A's blood test.

Management following faint

12. Mrs A told HDC that when the nurses returned to the room, she was lying on the floor and was 'woken by a nurse'. She said that she told the nurses, 'I don't know how I am on the

[1] A sample of blood is taken from a vein in the arm. The process of puncturing a vein with a needle to gain venous access is known as 'venepuncture'.

ground,' and that she had 'fainted' and was 'feeling very unwell and [her] head was hurting'. She said that she asked for water and the nurses made her sit back on the bed. She noted that she had been incontinent of urine and her clothes were wet. Mrs A told the medical centre[2] that she was wearing a black dress, so any urinary incontinence may not have left a visible mark on her clothing, although she told HDC that the nurses 'saw [she] had incontinence' as the floor was wet, and the bedsheet got wet when she sat on it.

13. Mrs A told HDC that she was not provided with any medical assessment or treatment despite having a swollen head and being in pain. She stated that she sustained a knee injury, which she 'think[s] was very much visible and both the nurses did notice it,' and swelling under her eye, although she did not notice her facial injuries until later when she saw herself in the mirror. Mrs A told the medical centre that the nurses '[d]idn't even bother to check [her] blood pressure after the fall'.

14. RN B told HDC that when he returned to the clinic room, Mrs A was lying on the floor with her eyes open and was responsive. He said that he noted a patch of fluid and the cup he had given Mrs A earlier lying on the floor, and he assumed that the fluid was spilled water.

15. RN B said that he did not take Mrs A's blood pressure after she reported feeling unwell, but he addressed her underlying feeling of faintness by providing reassurance and 'more water and jellybeans, which is consistent with standard practice to provide hydration and increase blood sugar levels'. RN B stated:

> '[Mrs A] was not fully assessed by either of us for the possibility of a head injury as she showed no symptoms of having hit her head or reported [having hit her head] while I was out of the room.'

16. RN D told HDC that when she entered the room with RN B, Mrs A was 'lying on her back [on the floor] with her eyes open, awake and conscious', and when asked whether she had hit her head, she responded 'no' and 'I don't know'. RN D noted in her documentation (made retrospectively on 10 March 2021):

> 'I asked the patient at ground level what happened — patient unsure if fainted or felt faint and lowered self to ground … noted water spilt on edge of bed from cup of [water] given prior to being called in.'

17. RN D told HDC that during her initial acute assessment of Mrs A, Mrs A was alert and orientated and had no obvious injury to her face and head. RN D documented (retrospectively on 10 March 2021):

> 'Patient sat up on her own accord, self-transferred to bed. Advised patient to lay flat. Patient declined … Asked patient if she hit her head. Patient responded "I don't know". Asked patient if in pain anywhere, response was "I don't know" "maybe". Patient

[2] Mrs A raised her concerns about the event with the medical centre on 7 March 2021. The medical centre provided a complaint response that was not accepted by Mrs A.

> remained conscious and coherent throughout. No obvious signs of injury, no swelling no bruising to face seem. No vomiting while in the room.'

18. The medical centre noted in its complaint response to Mrs A that it was not clear how she came to be lying on the floor, but that regardless of whether she fainted and fell, or whether she lowered herself to the floor, 'neither outcome is satisfactory'. The medical centre also noted that '[i]t is not common practice to take the blood pressure of a patient who has fainted unless they continue to faint, as the blood pressure result does not significantly change the resulting treatment'.

Successful blood test

19. When Mrs A was back on the bed, RN D successfully took her blood test. Mrs A told the medical centre that the nurses took her blood sample when she 'wasn't even fully conscious' and told HDC that after the blood test, she informed the nurses that she was 'not ready to go yet' and wanted to rest, and RN B said that she could 'go when [she was] ready to'.

20. RN D told HDC that she asked Mrs A 'if she was happy for [her] to look at her veins and try the blood test' and Mrs A offered her arm. RN D documented (retrospectively on 10 March 2021):

> '[I]nformed patient I had been called in to assist with blood taken, asked if I can attempt. Patient consented to [RN D] attempting venepuncture [blood test]. Offered patient to lay flat with attempt due to recent dizziness with last attempts. Patient declined. Bloods taken successfully.'

21. RN B told HDC that once RN D had left the room, he completed the immigration paperwork for Mrs A. He documented: '[B]loods taken, sent to lab.' RN B stated that Mrs A had an approximately 35-minute wait before her medical assessment with Dr C and asked whether she wanted to go through to the waiting room to wait, but she wanted to stay in the clinic room. RN B said that he confirmed that she was 'feeling OK', and before leaving the room he was not aware that she was feeling unwell. There is no documentation of safety-netting advice being provided to Mrs A if she experienced further feelings of faintness or pain.

Vomiting incident and communication with GP

22. Mrs A told HDC that after a few minutes 'lying there alone', she started to feel 'uneasy'. She said that after about 10–15 minutes she left the clinic room and vomited in the waiting area restroom. She then went back to the waiting room but returned to the restroom to vomit multiple (5–6) times.

23. RN B stated that in between his next appointments, he went back to check on Mrs A. He told HDC that Mrs A was not in the clinic or the waiting room, and he assumed that she had gone into her consultation with Dr C or had left the practice between her appointments. The medical centre told HDC that according to the practice software, Mrs A had been taken into the consultation.

24. RN B told HDC that he was not aware that Mrs A had vomited, and reception staff have a clear view of the waiting room and toilets, but no one raised concern that Mrs A had been

unwell while in the waiting room. He stated that he would have expected Mrs A to have reported any ongoing problems to Dr C.

25. RN B did not inform Dr C of Mrs A's faint prior to the consultation, and he accepted that with hindsight he should have done so, although he noted that when he last saw Mrs A, she did not appear to have any concerning signs or symptoms.

Documentation

26. Following Mrs A's appointment on 4 March 2021, retrospective entries were made by RN B on 8 March 2021 and by RN D on 10 March 2021.

27. RN B told HDC that his usual practice is to make contemporaneous clinical records. He noted that the medical centre is busy and there is not always time to document at the time or immediately after the appointment. At times he is required to make retrospective notes, and 'in this case [he] was encouraged to do so, usually because [he had] a number of patients to see'. RN B acknowledged that he should have specified the date of the appointment to which the retrospective notes were referring.

28. RN D told HDC that her usual practice is to document patient notes either during or directly after a consultation; however, in this case, she had been pulled away from her usual clinic work to assist with Mrs A and overlooked documenting her involvement when she resumed focus on her clinic duties. RN D documented her notes retrospectively on 10 March 2021 after the complaint was received, but she stated that she 'still had a strong recollection of events from 4 March 2021'.

Medical assessment

29. The medical centre told HDC that Dr C collected Mrs A from the waiting room and did not notice any concerns with Mrs A's walking.

30. Mrs A stated that she told Dr C about the 'whole incident', although Mrs A noted:

> 'I did tell [Dr C] that I fainted during the bloods and she did see my injury on the knee. I didn't tell her that I vomited and had incontinence as I was embarrassed of it. I did tell her that I was feeling uneasy and having a headache.'

31. Dr C told HDC that she completed the immigration medical, which included 'normal' neurological, musculoskeletal and ENT examinations, with no bruising around the eyes noted, although she did note a slight graze on Mrs A's knee, 'but this was a minor observation'. Dr C documented that Mrs A '[h]ad a faint on having blood tests but all OK now' and told HDC that she did not note any urine or odour on Mrs A's clothing at the time of her assessment.

32. Dr C told HDC that she did not file an ACC report as she was not aware that an injury had been sustained, and she did not provide any formal head injury safety-netting advice as she

understood that Mrs A had vasovagal syncope[3] and had recovered by the time she saw her, and she had no concerns with Mrs A's presentation during the appointment.

33. At Mrs A's subsequent appointment with Dr C on 31 March 2021, Dr C documented:

> 'Had been vomiting in the waiting room but didn't tell me that she had been struggling so much while waiting for her medical appointment … Seemed well, no vomiting in the room with me and I had no concerns with her at that point, but did not specifically address head trauma.'

Subsequent events

34. On 6 March 2021, two days after the immigration assessment appointment, Mrs A presented to the Emergency Department (ED) at the public hospital due to increasing head pain. She was diagnosed with a head injury and it was noted that she had '[m]ild swelling over zygoma (bony arch of the cheek), no signs of facial bone fracture'. Mrs A was later diagnosed with concussion.

35. In response to the provisional opinion, Mrs A told HDC that she continues to suffer ongoing health problems as a result of the events at the medical centre, including chronic migraines that can last for days. Mrs A stated that the pain and ongoing symptoms have 'significantly diminished [her] quality of life', which has become 'even more challenging' since the birth of her child.

Actions taken by the medical centre

36. Following Mrs A's complaint to the medical centre, an investigation into the incident was undertaken and a response letter was sent to Mrs A on 22 March 2021. In the response, the medical centre apologised to Mrs A and identified several aspects of the event that could have been managed better. In particular, the medical centre acknowledged the following:

- RN B should have emphasised the safety risks and strongly advocated that Mrs A lie on the bed when she felt faint after the attempt at taking blood, and RN B should not have left the room until any falls risk had been mitigated.
- When Mrs A was found on the floor, the nurses should have asked Mrs A directly whether she had any symptoms related to head injury and generated an ACC claim form to record the event and ensure appropriate medical care going forward.
- RN B should have confirmed that Mrs A was in the waiting room rather than assuming it (although the medical centre later told HDC that further investigation confirmed that RN B checked the practice software, which showed that Mrs A was with Dr C at that time, so the waiting room check was not required at that point).

37. The medical centre refunded Mrs A's cost of the immigration medical and funded another GP appointment with Dr C on 31 March 2021, at which time a referral to ACC was made, along with a direct referral to the concussion service. The medical centre wrote to Mrs A on

[3] A usually transitory condition that is marked especially by fainting associated with hypotension, peripheral vasodilation, and bradycardia resulting from increased stimulation of the vagus nerve.

19 April 2021 to inform her that the referral would be followed up with the concussion service.

Further information

38. The medical centre told HDC that its nurses are taught to apply the public hospital's 'Peripheral Intravenous Cannulation[4] and Primary Care Specific Medication Administration' policy, which specifies that a nurse should escalate to a colleague if two attempts at these procedures have been unsuccessful. RN B undertook this training in August 2019, which included three hours of theory supported by practical mentoring.

39. The medical centre acknowledged:

> '[Mrs A] did not experience the standard of care we would expect during her consultation on 4 March 2021. We again express our regret that this occurred and apologise for the distress she experienced.'

40. The medical centre stated that 'this situation is out of character for [RN B]', and that during approximately two years of employment with the medical centre it has had no reason to doubt his competence and integrity.

Responses to provisional opinion

Mrs A

41. Mrs A was given an opportunity to respond to the information gathered during this investigation. Mrs A's comments have been incorporated into the opinion where relevant and appropriate.

42. Mrs A told HDC that she is seeking justice for the 'physical and emotional suffering [she has] endured' because of this incident and would like to see RN B held to account.

RN B

43. RN B was given an opportunity to respond to the provisional report. He stated that he accepted the findings and recommendations of the Deputy Commissioner and had no further comment to make.

RN D

44. RN D was given an opportunity to respond to the provisional report and had no further comment to make.

Medical centre

45. The medical centre was given an opportunity to respond to the provisional report. It stated that it had no further comment to make and thanked HDC for its 'efforts in completing this investigation during a busy and challenging time'.

[4] Placement of a small tube into a vein.

Relevant standards and policies

46. The hospital's 'Peripheral Intravenous Cannulation and Primary Care Specific Medication' policy (2017) (the Cannulation Policy) provides the following:

> 'A maximum of two attempts should be made by any one health care professional before seeking a more experienced inserter to complete the task.
>
> Cannula Insertion care bundle
>
> Practice: no more than two attempts at insertion by the same health care professional when alternative clinical support is available.
>
> Documentation: number of attempts if more than one and any associated complications.'

47. The medical centre's 'Clinical Documentation Guidelines' (undated) provides the following:

> 'Timely documentation of clinical activities is of vital importance. These notes form part of the patient's medical record, assist with continuity of care and support transferring clinical responsibility.
>
> *Retrospective notes*
> If you need to correct or add notes to your patients records sometime after an event, these must be clearly identified as corrections or additions. This should only be as a last resort, as the expectation is that all notes are documented accurately and at the time of the contact.
>
> The notes must state that:
> It is written retrospectively,
> Include the date/time of entry,
> Include the date/time of the care (that the retrospective notes refer to),
> Signature (only of paper documentation.'

48. The Nursing Council New Zealand 'Competencies for Registered Nurses' (approved December 2007, amended September 2016, reformatted June 2022) provides the following:

> 'Domain one: Professional responsibility
>
> Competency 1.1 Accepts responsibility for ensuring that their nursing practice and conduct meet the standards of the professional, ethical, and relevant legislated requirements.
>
> Domain two: Management of nursing care
>
> Competency 2.3 Ensures documentation is accurate and maintains confidentiality of information.
>
> Indicator: Maintains clear, concise, timely, accurate and current health consumer records within a legal and ethical framework.
>
> Domain three: Interpersonal relationships

Competency 3.3 Communicates effectively with health consumers and members of the health care team.'

Opinion: RN B — breach

Introduction

49. The Code of Health and Disability Services Consumers' Rights (the Code) establishes the right of consumers to have health services provided at an appropriate standard, which includes with reasonable care and skill (Right 4(1)).[5]

50. On 4 March 2021, RN B attempted to take a blood test from Mrs A while she was sitting on the bed. She reported feeling faint during this process, but no observations were taken, and she was not assisted to lie down. RN B then left Mrs A unattended while he sought another nurse to assist with the blood test.

51. When RN B returned to the room, Mrs A was lying on the floor. Mrs A was transferred to the bed and a blood test was taken successfully. Mrs A asked to stay in the clinic room following this event but was not assessed fully for any unreported injury nor given safety-netting instruction to report any signs or symptoms of injury. Furthermore, the event was not documented contemporaneously nor reported to Dr C, who was to undertake the medical part of the immigration assessment.

Attempts at blood test

52. The medical centre's Cannulation Policy specifies that a maximum of two attempts should be made by any one healthcare professional before seeking a more experienced practitioner to complete the task. The Cannulation Policy also requires clinicians to document the 'number of attempts if more than one and any associated complications'.

53. Mrs A told HDC that three attempts at a blood test were made, two from the left arm and one from the right arm. In contrast, RN B submitted that only two attempts were made, one on each arm, before seeking assistance from RN D. On 4 March 2021, RN B documented 'bloods taken' and retrospectively documented on 8 March 2021 that there were '2x attempts to get blood' and that Mrs A 'felt faint after attempts'. RN D told HDC that she does not recall whether RN B told her how many attempts he made, and the medical centre advised HDC that for reasons of patient privacy there are no CCTV cameras in clinical areas.

54. As outlined above, there are conflicting accounts regarding the number of blood test attempts that were made by RN B. RN B made retrospective clinical notes after the medical centre received Mrs A's complaint on 7 March 2021, and there is a lack of corroborating evidence available.

55. In these circumstances, I consider that a finding of fact cannot be made in respect of how many blood test attempts were made and whether RN B exceeded the maximum of two attempts specified in the Cannulation Policy.

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

56. However, I am pleased that the medical centre has reminded staff of the Cannulation Policy and that a maximum of two cannulation attempts should be made by any one clinician.

Remaining with patient

57. Mrs A was sitting on the edge of the bed during the unsuccessful blood test attempts, and she told RN B that she was feeling faint. Mrs A was left unattended while RN B sought assistance from another nurse.

58. My independent advisor, RN Cornor, considers that in such circumstances there were several expected actions from clinical staff, including around the management of Mrs A after she reported feeling faint. RN Cornor advised:

> 'Signs were indicated by [Mrs A] that she "felt faint". At the time she did not describe anything else that was happening to her … Symptoms of feeling faint would be a lowered blood pressure and/or fast or slow pulse rate. If the nurse had taken [Mrs A's] blood pressure and pulse rate this would have determined if this was a faint (syncope), and that [Mrs A] should be attended and supported during this …
>
> [N]ormal practice would be for the nurse to stay with the patient while they are feeling faint …'

59. RN Cornor advised that the failure to stay with Mrs A in such circumstances constituted a departure from accepted practice. I accept this advice and note that RN B has acknowledged that he was aware that Mrs A was feeling faint when he left the room (albeit briefly) to request assistance with her blood test. However, there is no record of RN B advising or assisting Mrs A to lie down on the bed when she first reported feeling faint, nor was her blood pressure recorded at that time.

60. I am critical that Mrs A was left unattended and that she remained sitting on the bed. I acknowledge that RN B considered that there were 'no signs of concern'; however, I also note that Mrs A's blood pressure and pulse were not taken to ascertain whether she was experiencing a physiological response to the blood test, and I am critical that this was not done.

Management following faint

61. When RN B returned to the clinic room with RN D, Mrs A was lying on the floor, and it was unknown how she came to be on the ground. RN B told HDC that an examination for the possibility of a head injury was not undertaken because Mrs A did not show symptoms and told the nurses that she was not sure whether she had hit her head. RN D documented that Mrs A was 'conscious and coherent'. RN D told HDC that when asked whether she had hit her head, Mrs A responded 'no' and 'I don't know'.

62. In contrast, Mrs A stated that she told the nurses that her 'head was hurting a lot' and said that her left eye was swollen, although she told HDC that she became aware of the swelling only later when she saw herself in the mirror.

63. On 6 March 2021 staff at the ED documented that Mrs A had facial swelling. However, Dr C did not note facial swelling during the medical assessment, which suggests that it was not apparent immediately after the event. Mrs A told HDC that both nurses noticed her knee injury, and I also note that when Dr C saw Mrs A, she noted that Mrs A had grazed her knee, but this injury was not documented by RN B.

64. RN B documented retrospectively that after finding Mrs A on the floor, he gave her jellybeans and water and elevated her feet. However, no vital signs were documented. RN B acknowledged that he 'should have taken BP and pulse' but stated: '[M]y colleague who is more senior that I am proceeded to do the blood test.' While RN D may have been a more senior colleague, I remind RN B that nurses are responsible for their own practice, and that Mrs A was his patient.

~~65.~~ Mrs A is noted to have transferred herself from the floor onto the bed and declined the offer to lie flat. However, RN Cornor advised that 'it is up to the clinician to keep the patient safe and provide a safe environment for them to recover', and that clinical staff should take the lead in ensuring that the patient is cared for in a safe manner (such as insisting the patient lie down). This advice would also apply to the management of Mrs A when she reported feeling faint during the blood test and after she was found on the clinic floor.

66. Dr Maplesden considers that Mrs A being unsure of how she ended up on the floor suggests a degree of confusion or amnesia. He advised that his expectation in this situation is for vital signs to be repeated and the GP notified of the situation, to enable a decision to be made regarding priority and extent of further assessment required. RN Cornor also considers that Mrs A's 'nurse should have taken a blood pressure and pulse to ensure full recovery and no further syncope attacks' and advised that not taking these recordings was a departure from normal practice.

67. I accept that further assessment of Mrs A was indicated and that she should have been assisted to lie down. While I acknowledge that the nurses (and subsequently Dr C) did not note swelling of Mrs A's face or head at the time of events, Mrs A was unsure of how she came to be on the floor and whether she had hit her head. In these circumstances, I am critical that further assessment did not occur.

68. After RN D had taken Mrs A's blood test, Mrs A asked to rest in the clinic room before her appointment with Dr C. RN B told HDC that before he left the room, Mrs A confirmed that she was feeling OK, and he was not alerted to the fact that Mrs A was vomiting in the waiting room restroom. Mrs A's account is that after 'a few minutes lying in there alone', she started feeling uneasy and later vomited.

69. Regarding whether Mrs A was checked on to ensure that she was improving, I note that RN B told HDC that he did attempt to check on Mrs A, but she was no longer in the clinic room, and the medical centre told HDC that the practice software shows that at that time Mrs A had been taken into her consultation with Dr C. In these circumstances, I am not critical that RN B left Mrs A in the clinic room following her syncopal event, and I am satisfied that he

returned in an attempt to check on her condition. However, I remain critical that RN B did not check Mrs A's vital signs following the syncopal event.

Communication with GP

70. RN B knew that Mrs A had an appointment with the doctor after her blood test and expected that this would have been an opportunity for Mrs A to explain what had happened and whether she was experiencing any symptoms. While RN B told HDC that he considered that Mrs A did not appear to be experiencing concerning symptoms, he accepted with hindsight that he should have informed Dr C of the fainting episode.

71. I note that the Nursing Council competencies require that registered nurses 'communicate effectively with health consumers and members of the health care team'. RN Cornor said that '[i]t would be expected and [a] priority for the RN to have communicated this incident to the GP' and advised that there was a departure from normal practice when this did not occur.

72. I accept this advice. Particularly in circumstances such as these where Mrs A was uncertain of the events that led to her being on the ground, I would expect a clinician-to-clinician handover to explain the events that occurred.

Documentation

73. On 4 March 2021, RN B's contemporaneous nursing documentation was limited to Mrs A's initial immigration assessment recordings (including blood pressure) and a comment that her blood test was taken. There is no documentation of the number of attempts to take blood, that Mrs A reported feeling faint during the blood tests, or the events that occurred after Mrs A was found on the floor.

74. The Nursing Council Competencies for Registered Nurses requires that the registered nurse '[m]aintains clear, concise, timely, accurate and current health consumer records within a legal and ethical framework'. RN Cornor advised that the writing of retrospective notes is not encouraged in any circumstances, and especially in this case, where the care and condition of the patient was out of the ordinary.

75. There are two important reasons for clinical notes to be recorded at the time of events. First, as RN Cornor notes, up-to-date information is important for continuity of care, and I consider that if further detail had been documented about Mrs A's care and the events that occurred on 4 March 2021, this information would have been available to Dr C (during Mrs A's medical appointment) and to Health NZ (during Mrs A's subsequent presentation to the ED). Secondly, RN Cornor noted that contemporaneous documentation puts clinicians in the 'best possible situation to respond fully to a query or complaint about the care the patient has received', and I note that in this case, the retrospective documentation occurred on Monday 8 March 2021, after the complaint had been received on 7 March 2021.

76. I also remind RN B of RN Cornor's advice that in circumstances where retrospective records are necessary, clinicians must clearly state the date of events referred to in the retrospective entry. I note that this advice is consistent with the medical centre's clinical documentation

guidelines. Although RN B acknowledged that he should have specified the date of the appointment to which the retrospective notes were referring, I am critical that important information was not documented contemporaneously, and that the retrospective entry did not clearly identify the date of the events to which it referred.

Conclusion

77. In my view, there were several deficiencies in the care provided by RN B to Mrs A; in particular:

- Mrs A was left alone after she reported feeling faint;
- RN B did not adequately consider the possibility of a head injury following Mrs A's syncopal event;
- Mrs A's vital signs were not recorded when she reported feeling faint or following the syncopal event;
- RN B did not inform the GP of Mrs A's faint; and
- Mrs A's clinical notes were not documented contemporaneously, and the retrospective entries did not specify the date of the events.

78. Accordingly, I find that RN B failed to provide Mrs A services with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: RN D — educational comment

Informed consent

79. The Health and Disability Commissioner Act 1994 states that '… no health care procedure shall be carried out without informed consent'.[6]

80. RN D was working in the clinic when RN B asked her to assist with Mrs A's blood test. RN D assisted in Mrs A's initial assessment after Mrs A was found on the floor and took Mrs A's blood test successfully.

81. Mrs A told HDC that the blood test was taken without her consent and when she 'wasn't even fully conscious'. Both the nurses who attended Mrs A note that while Mrs A was lying on the floor her eyes were open and she was responsive and talking with them, and that she self-transferred onto the bed.

82. RN D told HDC that Mrs A was 'talking, alert and orientated' and that she asked Mrs A if she was 'happy' for her to attempt the blood test and Mrs A offered her arm.

83. On the balance of probabilities, I consider that by presenting her arm to RN D for the blood test, it was reasonable for RN D to have concluded that Mrs A consented to the blood test.

[6] Section 20(1)(a). In addition, Right 7(1) of the Code states: 'Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.'

However, I note Dr Maplesden's comment that Mrs A was 'unsure of how she ended up on the floor [which] suggests a degree of confusion or amnesia'.

84. I accept Dr Maplesden's point, and I take the opportunity to remind RN D that consent is a dynamic and ongoing process. I consider that it would have been prudent for RN D to have proceeded with additional caution by confirming Mrs A's consent verbally, particularly given that RN D was aware of the syncopal event (and the risk of temporary diminished competence) prior to taking Mrs A's blood.

Documentation

85. RN D documented her notes retrospectively on 10 March 2021 (after the medical centre received Mrs A's complaint).

86. I recognise that Mrs A was not RN D's patient, and that RN D may have been distracted from other clinic duties. However, I consider that RN D should have documented the blood test she took from Mrs A. Further, I remind RN D that when retrospective notes are made, they should refer to the date of events in question, consistent with the medical centre's Clinical Documentation Guidelines.

Opinion: Medical centre — no breach

87. Mrs A was not enrolled with the medical centre and attended for an immigration assessment as a casual patient.

88. As discussed previously in this report, I consider that the deficiencies in this case were the result of individual clinical failings, for which RN B has been found in breach of Right 4(1) of the Code.

89. In addition, I consider that the medical centre's policies and guidelines at the time of events were appropriate (outlined above). For example, the Cannulation Policy clearly stated that a clinician should make a maximum of only two blood test attempts before seeking support from a more experienced practitioner and noted the associated documentation requirements. In addition, the Clinical Documentation Guidelines clearly outlined the importance of timely documentation of clinical notes and the requirements clinicians must follow if retrospective notes are made.

Subsequent events

90. Following Mrs A's ED presentation on 6 March 2021 and complaint of 7 March 2021, the medical centre arranged for a follow-up assessment with Dr C and ACC referrals for treatment. My independent clinical advisor, Dr Maplesden, advised that upon receipt of the complaint, the medical centre undertook investigations in an appropriate manner and facilitated a GP review with Dr C (when it became apparent that Mrs A did not have primary care support). Dr Maplesden noted that subsequent delays in accessing the concussion service were outside the control the GP. I accept this advice and consider that the medical centre's subsequent actions after becoming aware of the incident were adequate. Further, RN Cornor told HDC that '[The medical centre has] made excellent advances in improving

their service through added nurse training and the implementation of policies and procedures to support the staff in their practice'. I commend the medical centre for having reflected on the care provided to Mrs A and having introduced new SOPs to provide clearer guidance to its staff (outlined below).

91. Accordingly, for these reasons, I find that the medical centre did not breach the Code.

Changes made since events

RN B

92. RN B told HDC that he has undertaken self-directed learning regarding syncope and head injuries. He has reflected on his blood test practice and is more cautious about considering the potential for patients to experience syncope during blood tests and the associated risk of falls. He also ensures that patients who are feeling faint are not left alone and does his best to document patient interactions comprehensively and contemporaneously and to date any retrospective entries clearly.

93. RN B told HDC that the medical centre now has a process for instant messaging and calling of colleagues from their computers and phones.

Medical centre

94. In response to these events, the medical centre made the following changes:

- It introduced a Clinical Documentation policy that includes information about retrospective entries and refers to the New Zealand Nurses Organisation guidelines. The policy is referenced directly in the nurse induction process.
- It introduced a formal policy and external venepuncture training for nurses with a local laboratory. Internal support is provided to support and maintain that competency.
- The registered nurse induction process directly refers to the clinical resources available to support staff regarding the management of syncope and head injury/concussion.
- Refresher training on syncope management and transfer of clinical responsibility is now part of the nursing professional development schedule.
- It implemented a 'Transferring clinical responsibility' policy aimed to maintain effective communication during the patient's care journey.

Recommendations

RN B

95. I recommend that RN B:

a) Provide a written apology to Mrs A for the criticisms identified in this report. The apology is to be sent to HDC, for forwarding to Mrs A, within six weeks of the date of this report.

b) Reflect on the deficiencies in care identified in this case and provide a written report on his reflections and the changes to practice he has instigated as a result of this case, within two months of the date of this report.

c) Undertake further education/training on syncopal events and recognising head injuries. The education/training should be in conjunction with, or endorsed by, the Nursing Council of New Zealand. Evidence of attendance (such as a certificate of completion) is to be provided to HDC within three months of the date of this report.

Medical centre

96. I recommend that the medical centre provide evidence of the changes made, including updated policies, messaging between clinical staff, and that induction and refresher training for registered nurses has been implemented. A copy of the updated policies is to be sent to HDC within three months of the date of this report.

Follow-up actions

97. A copy of this report with details identifying the parties removed, except the advisors on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN B's name.

98. A copy of this report with details identifying the parties removed, except the advisors on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from GP Dr David Maplesden:

'CLINICAL ADVICE — MEDICAL + Addendum

FROM : David Maplesden

CONSUMER : [Mrs A]

PROVIDER : Staff of [the medical centre]

FILE NUMBER : C21HDC00893

DATE : 5 October 2021; **Addendum 4 September 2023 (s5)**

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1. My name is David Maplesden. I am a graduate of Auckland University Medical School and I am a practising general practitioner. My qualifications are: MB ChB 1983, Dip Obs 1984, Certif Hyperbaric Med 1995, FRNZCGP 2003. Thank you for the request that I provide clinical advice in relation to the complaint from Ms S [Mrs A] about the care provided to her by staff of [the medical centre]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following information:

- Complaint from [Mrs A]
- Response from [the medical centre]
- [Medical centre] clinical notes and associated information
- [Hospital] clinical notes

3. [Mrs A] ([Year of birth]) complains about her management by staff of [the medical centre] in relation to an immigration medical undertaken on 4 March 2021 and subsequent management of a head injury sustained at that time. She states the nurse attending her initially made three unsuccessful attempts to take blood off her and she began to feel faint. She was left unattended while the nurse sought assistance from a colleague and she then found herself on the floor of the examination room unsure how she had got there. She had been incontinent of urine and had a sore head. She states the two nurses who then attended her did not provide any assessment and proceeded with another attempt at taking blood (successful). She was then left unattended again while waiting the GP immigration medical examination, and vomited several times. [Mrs A] was then assessed by the GP and states *I told her about the whole incident too*. [Mrs A] states she had a further vomit on getting home and suffered increasing head pain so attended [the public hospital] the next day and had a CT scan (normal). She was advised to

rest for a few days and was subsequently reviewed at [the medical centre] and referred to the ACC Concussion Service. At the time of the complaint [Mrs A] states she remains unwell and is still awaiting ACC assistance.

4. The [medical centre's] response notes [Mrs A] was not a registered patient at [the medical centre] but attended for an immigration medical examination on 4 March 2021 and preliminary paperwork undertaken by [RN B]. A blood test was required and [RN B] attempted the procedure once on each arm but was unsuccessful. After the second attempt [Mrs A] advised she was feeling faint and she was provided with a glass of water before [RN B] sought assistance with the phlebotomy. On returning with a second nurse, [Mrs A] was found lying on her back on the floor. She was conscious with eyes open but was unsure if she had fainted or had lowered herself onto the floor after feeling faint. Spilt water was noted. [Mrs A] was able to sit up and get herself back onto the bed unassisted and the phlebotomy was performed successfully. [Mrs A] was unsure if she had struck her head when asked but did not report any pain at the time. There were no obvious signs of injury and [Mrs A] remained alert and coherent. She asked to remain in the examination room while considering if she would proceed with the immigration medical (GP consultation). When the nurse returned sometime later [Mrs A] had left the examination room and was assumed to have returned to the waiting room. Nurse notes record observations required for the immigration medical (normal). There is no reference in the nurse notes to the presumed fainting episode until retrospective entries (identified as such) on 8 March 2021 ([RN B]) and the other attending nurse (10 March 2021).

Comment: I note there are significant discrepancies between the retrospective nursing notes and [Mrs A's] recollection of events (see e-mail from her to [the medical centre] dated 25 March 2021). It is unfortunate there was difficulty performing [Mrs A's] blood test but I would regard two or even three attempts as being consistent with accepted practice provided they were undertaken with patient consent. However, it was appropriate to seek assistance when [Mrs A] expressed feeling faint after the second attempt. I would be mildly critical if [Mrs A] was left sitting on the edge of the bed at this stage. It is likely she was experiencing a vaso-vagal reaction to the phlebotomy process and standard practice in this situation is to lie the patient flat until recovered. [Mrs A] was conscious but on the floor when [RN B] returned with his colleague. The provider response suggests [Mrs A] had a degree of confusion or amnesia, she being unsure precisely how she had ended up on the floor. There was no obvious sign of external injury. My expectation in this situation is that vital signs were repeated and the GP notified of the situation to enable a decision to be made regarding priority and extent of further assessment required. [Mrs A] reports vomiting several times while still in the examination room (a potential red flag following head injury) but it is not apparent clinical staff were aware of this or of [Mrs A's] urinary incontinence. It is not clear to me that there was any direct communication between [RN B] and [Dr C] and, as noted, there was no documentation at this time referring to the incident. I find this somewhat

concerning but as I am not a peer of [RN B] I recommend a practice nurse peer is asked to comment on his management of [Mrs A].

5. [Dr C] performed an immigration medical assessment of [Mrs A] shortly after the incident in question. This involves a comprehensive systems assessment including cardiorespiratory and neurological. This is recorded briefly in the clinical notes as normal but I would expect there to be further detail in the immigration medical form. Notes include *Had a faint on getting blood test done but all OK now.* This is the only reference to the preceding incident.

Comment: If [Dr C] was under the impression [Mrs A] had had a simple faint in association with an attempted phlebotomy procedure I would regard her management as reasonable. In notes dated 31 March 2021, [Dr C] does comment: *Had been vomiting in the waiting room but didn't tell me that she had been struggling so much …* The assessment required for a young otherwise well person who has suffered a syncopal attack with an obvious precipitating factor would be covered as part of the immigration medical assessment. However, if [Dr C] was informed there was a possibility [Mrs A] may have suffered a head injury during the faint, I would expect this to have been documented in the notes (together with completion of relevant ACC documentation) and enquiry made regarding potential head injury red flags including headache, vomiting and amnesia. If [Mrs A] conveyed a history of recurrent vomiting since the event, consideration might have been given to ED referral for observation/possible imaging. If symptoms and assessment findings were reassuring, I would expect the patient to be provided with appropriate head injury information and safety netting advice such as that produced by ACC. In summary, if [Dr C] was aware [Mrs A] had suffered a possible head injury at the time of her faint, I would be mildly to moderately critical at the standard of the documented history and assessment, and the failure to provide the patient with appropriate head injury information and safety netting advice. However, it appears there was no direct communication between the practice nurse and [Dr C] regarding the incident, no contemporaneous clinical documentation from the practice nurse regarding the incident (which might have been expected if it was felt to be significant), and limited information provided by [Mrs A] herself (which could in fact relate to her post-head injury status at the time). It is somewhat strange there was no apparent observation by [the medical centre] staff of [Mrs A] vomiting repeatedly in the waiting room prior to her appointment with [Dr C].

Addendum 4 September 2023: [Dr C] has provided a statement received 25 July 2023. She confirms [Mrs A] mentioned in passing only she had fainted during the phlebotomy procedure and there was no complaint of head injury, headache, incontinence or vomiting. There was no abnormality noted during the comprehensive immigration medical examination that might have raised suspicion of recent head injury. There was no information received from nursing staff prior to the consultation in relation to [Mrs A's] faint, and this has been identified as a potential handover issue and addressed with further education

and use of tools such as Microsoft Teams to facilitate urgent communication between providers. I believe [Mrs A's] management by [Dr C] on 4 March 2021 was consistent with accepted practice.

6. [Mrs A] attended [the] ED on 6 March 2021. ED notes include history: *Was at GP practice. Getting bloods done for immigration medical. Multiple attempts. Was on a high bed, felt strange like would faint, had syncope, woke on ground, had incontinence, not witnessed to have seizure. Recovery, then following this had bloods retaken. Vomiting started following that and had multiple vomits that day. That night slept 13 hours solid, and since yesterday increasing right sided headache, couldn't sleep with the pain. No new neurological deficits …* Neurological and neck examination was recorded as normal with mild swelling noted over the zygomatic arch*. Given severity of headaches and prolonged vomiting episode CT head performed — NORMAL*. [Mrs A] was provided with a prescription for analgesia and a head injury advice sheet and discharged for GP follow-up.

Comment: Management was consistent with accepted practice.

7. The [medical centre] response notes a written complaint was received from [Mrs A] on 7 March 2021 and investigated in what appears to be an appropriate manner. Following a further e-mail from [Mrs A] on 25 March 2021 it became apparent she did not have any primary care support and her request for GP review was facilitated with an appointment on 31 March 2021 with [Dr C]. The consultation is well documented and recounts [Mrs A's] history and subsequent symptomatology. Symptoms were assessed as likely due to a combination of concussion and soft tissue neck injury as a consequence of the fall. [Mrs A] was prescribed analgesia and a muscle relaxant, and referrals made for physiotherapy and ongoing management by the ACC concussion service. Subsequent delays in accessing the concussion service are outside the control of the GP. I believe management on this occasion was consistent with accepted practice.'

Appendix B: Independent clinical advice to Commissioner

'To: Health and Disability Commissioner

Expert Adviser:

Barbara Cornor RN, MN NCNZ 051169

Complaint: [Medical centre]

Ref: C21HDC00893

I have been asked to review and provide a response:

1. The general standard of care provided regarding the taking of blood, as well as the RN's actions following the consumer's fainting episode.

I noted there are different versions of events in the information provided and will provide advice on whether the care was appropriate based on scenario (a), and whether it was appropriate based on scenario (b).

Scenario (a) in accordance with the clinical notes written in retrospect:

Following x2 attempts at venepuncture to obtain blood for testing, the nurse followed [the hospital's] "Peripheral Intravenous Cannulation and Primary Care Specific Medication" 2017 policy (P.36) which states, "A maximum of two attempts should be made by any one health care professional before seeking a more experienced inserter to complete the task."

[Mrs A] advised the nurse she was "feeling faint" and was given a glass of water by that nurse prior to them leaving the room to get another nurse to do the venepuncture. [Mrs A] was lying down at the time.

Normal practice would be for the nurse to stay with the patient while they are feeling faint. Signs were indicated by [Mrs A] that she "felt faint". At the time she did not describe anything else that was happening to her. Symptoms of feeling faint would be a lowered blood pressure and/or fast or slow pulse rate. If the nurse had taken [Mrs A's] blood pressure and pulse rate this would have determined if this was a faint (syncope) and that [Mrs A] should be attended and supported during this. It is noted at some time on March 4, 2021, as part of the clinical assessment, [Mrs A's] blood pressure was 124/70 which is within normal limits. There is no time documented.

[Mrs A] was lying down and was given a glass of water. Lying down on a bed with her feet up reduces the effects of fainting by allowing the blood to flow to the brain rather than filling the peripheral blood vessels and affecting the "faint" feeling. The glass of water provides hydration, and the coolness would reduce the faint "feeling".

The nurse, even knowing they would be returning to the room quickly, could not have been confident in [Mrs A's] safety, should she faint. This is a supposition by the reviewer

as there is nothing documented, except to say the nurse left the room to seek another professional to do the venepuncture. Staying with the patient during this period would have provided support and reduced the anxiety associated with feeling faint.

[Mrs A] was given a glass of water but being left alone when she was "feeling faint" is a severe departure from expected practice.

On returning to the room the nurses found [Mrs A] on the floor "conscious", "eyes open", and "thought" she had fainted or "felt faint". She was given "jellybeans" to increase her blood sugar levels. [Mrs A] is recorded as "stood up" and "transferred herself back to the bed". The nurse noted the water she had been given previously had "spilled on the bed". [Mrs A] declined the offer to lay flat and consented to the venepuncture after which the blood collection was successful.

A physical examination revealed [Mrs A] did not complain of any pain and had "no obvious" injuries apart from a "small graze on her knee". The reviewer would again suggest the nurse should have taken a blood pressure and pulse to ensure full recovery and no further syncope attacks. This is a severe departure from normal practice.

[Mrs A] had an appointment with the Doctor and when asked if she wanted to go in told the nurse she would "sit a bit".

Scenario (b) in accordance with [Mrs A's] complaint letter:

[Mrs A] states the nurse attempted venepuncture "x3 before getting another nurse" and that she felt faint and was "not" given a glass of water.

X3 attempts at venepuncture is a severe departure of practice as the policy states "A maximum of two attempts should be made by any one health care professional before seeking a more experienced inserter to complete the task."

Not being given a glass of water is a medium departure from expected practice, but leaving the patient alone is severe.

[Mrs A] states she "was in so much pain", "my head was swollen" and "I started feeling uneasy and vomited 5–6 times while waiting for the appointment". Leaving the patient in this case is a severe departure from normal practice. That none of this is documented in the clinical notes is again a severe departure, although reading the retrospective documentation this did not occur. There is no indication or evidence of any vomitus sightings in either the clinical room or waiting room. [Mrs A] told the GP she had been vomiting.

The reviewer asks — Did [Mrs A] have a vomit bowl or bag, or did she take herself to the restroom and why did she not report this to a nurse?

2. Whether the RN should have taken contemporaneous notes at the time of the incident, noting the retrospective entries on 8 and 10 March 2021.

The writing of retrospective notes is not encouraged in any circumstances. Relying on memory cannot be depended upon. Documentation should be written as soon as possible after the event has occurred. It should provide all current information on the care and condition of the patient and especially in this case, something which was out of the ordinary in a health practice facility.

The documentation provided to the reviewer clearly states on March 8 and 10 2021, it is retrospective, but it does not state what date the retrospective entry was referring to. This is a severe departure from expected practice and policy.

Documenting all relevant information at the time ensures others know what was observed and what interventions were taken. Documentation shows evidence of clinical judgement and escalation as appropriate, and the evaluation of that care provided. "If care is not recorded, then it is assumed the care was not given" (New Zealand Nurses Organisation, 2017).

There are two good reasons why it is important that contemporaneous records are made wherever possible. Firstly, it provides up to date information and helps ensure good continuity of care for the patient. In this case all the clinicians would have been aware of the incident and the clinical outcomes and plan of care.

Secondly it puts the clinicians in the best possible situation to respond fully to a query or complaint about the care a patient has received.

3. The expected level of communication from the attending RN to the GP following this type of incident.

It would be expected and priority for the RN to have communicated this incident to the GP, and it is a severe departure from normal practice. This is a situation where something out of the ordinary has occurred to a patient in the health facility. The GP documented (which is assumed to have come from the patient) "Had a faint on having blood tests but all OK now" and the GP completed a full medical assessment including neurological without noting any abnormalities.

When the nurse found [Mrs A] was not in the consult room but assumed her to be in the waiting room the use of software to see where she was, is a severe departure from normal practice following an incident of this type. Viewing [Mrs A] to ensure she had improved, would have put the patient at ease and at the same time the doctor would be advised.

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

The manager of the health facility has documented they have "identified areas where our initial clinical management of this situation could have been better and discussed with the parties involved".

The reviewer recommends all staff are provided training and peer review on this specific situation. To understand this incident is out of the ordinary and has basic physical observation requirements and that the patient must come first is priority. The patient being provided with clinical, psychological support and communication during this syncope episode would have prevented any of this review occurring.

When these incidents do occur, it is up to the clinician to keep the patient safe and provide a safe environment for them to recover. Offering or suggesting they do something eg lie on the bed, is not as effective as telling them what you, as the clinician, is going to do for them!

To ensure all clinicians within the facility are aware all incidents occurring out of the ordinary they should be documented contemporaneously. Also, if they are to see another clinician, they should verbally be made aware of that incident immediately.

B Cornor 08/12/2021'

'Complaint: [Medical centre]
Ref: C21HDC00893
Further ADVICE — ADDENDUM 15 September 2023

Barbara Cornor RN, MN
NZNC 051169

I have been asked if any of the new information included in attached documents causes me to amend the conclusion drawn in your initial advice or make additional comments?

My initial advice does not change but it must be acknowledged [the medical centre] has accepted their part and regrets this incident. [The medical centre] [has] made excellent advances in improving their service through added nurse training and the implementation of policies and procedures to support the staff in their practice.

- The Clinical Documentation policy specifically includes information about retrospective entries and references New Zealand Nurses Organisation (NZNO) guidelines. This policy also emphasises the importance of a nursing assessment and plan.
- Policy, process and external training of venepuncture skills. Internal support is provided to support and maintain that competency.
- Syncope management guidelines will see the patient not being left alone if they feel faint, completing a nursing assessment, obtaining comprehensive details from that patient, and completing a full assessment.
- Head Injury/concussion guidelines.
- An up to date Health Pathways and Best Practice Advocacy Centre clinical resources directly reference these resources and are part of the Registered Nurse induction process.

- Transferring clinical responsibility policy aims to maintain effective communication during the patient's journey and acknowledges if communication is not effective the continuity of care is broken down and there is increased harm to the patient.

One further comment —

Not only the lack of communication by the RN with the patient and to other staff, but the communication between the patient, the RN and other staff has created some misperception for the writer/reviewer. Her distress is clearly documented in her response, but it is difficult to determine why the patient didn't inform staff of her vomiting which required several trips to the restroom or that no others noticed her.

Barb Cornor'