



New Zealand
Health Practitioners
Disciplinary Tribunal

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DECISION NO: 20/Nur05/09D

IN THE MATTER of the Health Practitioners
Competence Assurance Act 2003

-AND-

IN THE MATTER of a charge laid by the Director of
Proceedings pursuant to Section
91(1)(a) of the Act against
NAOMI DALE, registered nurse,
of Auckland

BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Dr D B Collins QC (Chairperson)
Dr M Bland, Ms K Bolton, Ms J Kilpatrick, and Professor I Snook
(Members)
Ms R Devore (Executive Officer)
Ms M Dawson (Stenographer)

HEARING: held at Hamilton on 10 October 2005

APPEARANCES: Mr J Tamm for the Director of Proceedings.

No appearance by or for Ms Dale.

Introduction

1 Naomi Dale, also known as Sally Dale, is a registered nurse. She now lives in Auckland. At the time of the events focused upon by the Tribunal, Ms Dale worked at a rest home in Putaruru.

2 On 25 May 2005, the Director of Proceedings laid a disciplinary charge against Ms Dale. The charge was laid pursuant to s.91(1)(a) of the Health Practitioners Competence Assurance Act 2003 (“the Act”). The charge was amended on the day of the hearing by the Tribunal. The amended charge is explained in paragraph 8 of this decision.

3 The Tribunal received evidence that the notice of charge, minutes of a directions conference, and details of the place, date and time of hearing were all served on Ms Dale. Ms Dale did not participate in the pre-hearing directions conference and indicated at an early juncture she would not attend the hearing of the charge.

4 The Tribunal convened in Hamilton on 10 October 2005 to hear the charge. That day the Tribunal heard evidence from ten witnesses called by the Director of Proceedings and considered submissions made by counsel for the Director of Proceedings. Later on 10 October 2005, the Tribunal advised that it had determined that aspects of Ms Dale’s conduct, as alleged in the charge had been established as constituting professional misconduct within the meaning of s.100(1)(a) of the Act. The Tribunal then heard submissions on penalty.

5 In this decision, the Tribunal explains its reasons for finding aspects of the charge have been established to the requisite standard, and the penalties it has imposed on Ms Dale.

- 6 The Tribunal has determined Ms Dale must, for the period of three years from the date of this decision, practise under the supervision of a registered nurse approved by the Nursing Council of New Zealand. The Tribunal explains later in this decision that the Tribunal’s objective in imposing this condition is to enable Ms Dale to continue to practise as a nurse, if she wishes, but at the same time ensure that Ms Dale practises in an environment that presents no risk to the community. This order is made pursuant to s.101(1)(c) of the Act.
- 7 The Tribunal has also determined Ms Dale should pay costs in the sum of \$10,000. This order is made pursuant to s.100(1)(f)(iii) and (iv) of the Act.

The Charge

- 8 The charge contains seven specific allegations, each of which related to Ms Dale’s role in the care of a resident in a rest home. In this decision, the resident will be referred to as “Mr B”. Ms Dale was the sole registered nurse employed at the rest home. She was also the manager of the rest home. Mr B passed away a matter of days after the events focused upon by the Tribunal.

- 8.1 The first particular of the charge alleged Ms Dale:

“Failed to adequately assess and/or monitor and/or evaluate and/or respond to the care provided to [Mr B].”

- 8.2 The second particular of the charge alleged Ms Dale:

“Failed to provide adequate and/or appropriate training to care givers in respect of:

- (i) monitoring and responding to [Mr B’s] changing blood glucose levels;*
- (ii) recognising the signs of consciousness [in Mr B];*
- (iii) the administration of insulin [to Mr B].”*

- 8.3 The third particular of the charge alleged that between 17 and 21 September 2003 Ms Dale:

“Failed to adequately assess and/or monitor and/or evaluate and/or respond to [Mr B’s] changing blood glucose levels”

8.4 The fourth particular of the charge alleged that on 20 September 2003, after being advised by a care giver at approximately 7.45pm that [Mr B] had suffered a seizure, Ms Dale failed to provide appropriate instructions for assessment and/or monitoring and/or feedback.

8.5 The next particular of the charge was inserted following an application by the Director of Proceedings. This particular alleged:

“4(A) On or about 20 September 2003 upon being advised by a phone call at approximately 8pm by a care giver ... that [Mr B] had a blood glucose level of 2.5 and that the care giver had been unable to take his blood pressure as [Mr B] had not settled after the seizure which was reported at 7.45, [Ms Dale] failed to provide appropriate instructions for assessment and/or monitoring and/or feedback.”

8.6 The next particular of the charge alleged that on 21 September 2003, after being advised by a telephone call from a care giver at approximately 9.30am that the patient’s:

- blood measurement was 3.2 mmol/l at approximately 8am; and
- that insulin had been administered to him; and
- that his blood pressure was 160/110

Ms Dale failed to provide appropriate instructions for assessment and/or monitoring and/or feedback.

8.7 The final particular of the charge alleged that on 21 September 2003, after being advised by a telephone call from a care giver at approximately 9.50am that the patient’s blood measurement was 1.1mmol/l, Ms Dale failed to arrange for an ambulance to be called in a timely manner.

9 The principal events giving rise to the charge occurred between 17 and 21 September 2003. The notice of charge however, referred to a wider timeframe, namely 1 May 2003 to 21 September 2003.

10 The Director of Proceedings alleged that when viewed separately, or cumulatively, the particulars of the charge constituted professional misconduct within the meaning of s.100(1) of the Act.

Legal Principles

Onus and Standard of Proof

- 11 The Director of Proceedings accepted that she carried the onus of proof. She also correctly acknowledged that the degree of proof required was based upon the civil standard of proof, qualified by the requirement that serious allegations require a high level of proof.¹
- 12 In this case, where the Tribunal has made findings against Ms Dale it has done so because it is satisfied that the particulars of the charge have been established to the requisite standard.

Professional Misconduct

- 13 Professional misconduct is defined in sections 100(1)(a) and (b) of the Act. These subsections of the Act refer to a health practitioner being guilty of professional misconduct in two circumstances, namely:

- “(a) ... because of any act or omission that, in the judgment of the Tribunal, amounts to malpractice or negligence in relation to the scope of practice in respect of which the practitioner was registered at the time that the conduct occurred; or
- (b) ... because of any act or omission that, in the judgment of the Tribunal, has brought or was likely to bring discredit to the profession that the practitioner practised at the time that the conduct occurred ...”

- 14 The definition of professional misconduct in the Act is modelled on the definition of professional misconduct found in the Nurses Act 1977.
- 15 Those who drafted s100(1)(a) of the Act intended to draw a distinction between malpractice and negligence. Whilst there are differences between malpractice and negligence, it is quite conceivable for acts and omissions to constitute both malpractice and negligence.
- 16 Malpractice is defined in the Collins English dictionary² as meaning:

¹ *Ongley v Medical Council of New Zealand* (1984) 4 NZAR 369; *Gurusinghe v Medical Council of New Zealand* (1989) 1 NZLR 139; *Brake v Preliminary Proceedings Committee* [1997] 1 NZLR 71; *Re Aladdin* 12Den05/04D; 13Den04/02D.

² 2nd Edition

“The immoral, illegal or unethical conduct or neglect of professional duty. Any incidence of improper professional conduct.”

The same term is defined in the New Shorter Oxford English Dictionary³ as meaning:

“Improper treatment or culpable negligence of a patient by a physician or of a client by a lawyer ...a criminal or illegal action: wrong doing, misconduct”.

Negligence

- 17 The term negligence has a specific meaning in law. Before a plaintiff could successfully sue a health practitioner for negligence they would need to prove four matters, namely:
- 17.1 That the practitioner owed the plaintiff a duty of care;
 - 17.2 That the practitioner breached the duty of care they owed the plaintiff;
 - 17.3 That the plaintiff suffered compensable damage;
 - 17.4 That the damage suffered by the plaintiff was caused by the practitioner’s breach of the duty of care they owed the plaintiff.
- 18 It is highly unlikely the drafters of s100(1)(a) of the Act envisaged those prosecuting health practitioners would need to prove all the criteria required by the common law to establish negligence on the part of a health practitioner. In the Tribunal’s view, the term “negligence”, as used in s100(1)(a) of the Act focuses on a practitioner’s breach of their duty in a professional setting. The test as to what constitutes negligence in s100(1)(a) of the Act requires, as a first step in the analysis, a determination of whether or not, in the Tribunal’s judgment, the practitioner’s acts or omissions fell below the standards reasonably expected of a health practitioner in the circumstances of the person appearing before the Tribunal. Whether or not there has been a breach of the appropriate standards is measured against the standards of a responsible body of the practitioner’s peers.⁴

³ 1993 Edition

⁴ See for example, *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635 (HL).

- 19 The approach set out in paragraph 18 of this decision avoids the need for prosecuting authorities to prove damage. Thus, for example, a practitioner who fails to make appropriate notes of a consultation may not cause damage to their patient, but may nevertheless be guilty of negligence within the meaning of s100(1)(a) HPCA Act.

Discredit to the Profession

- 20 The term to “bring discredit to the profession” was considered by Gendall J in *Collie v Nursing Council of New Zealand*⁵ when considering an appeal brought under the Nurses Act 1977. His Honour noted:

“To discredit is to bring harm to the repute or reputation of the profession. The standard must be an objective standard for the question to be asked by the Council being whether reasonable members of the public, informed and with knowledge of all the factual circumstances, could reasonably conclude that the reputation and good standing of the nursing profession was lowered by the behaviour of the nurse concerned.”

Background Jurisprudence

- 21 In New Zealand, most discussions about the meaning of professional misconduct in a health setting commence with a reference to the judgment of Jeffries J in *Ongley v Medical Council of New Zealand*⁶. In that case His Honour formulated the test as to what constitutes professional misconduct as a question:

“Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct? ... The test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency, bearing in mind the position of the Tribunal which examined the conduct.”

Professional Misconduct under the Act

- 22 In its decisions in *Nuttall*⁷ and *Aladdin*⁸ the Tribunal explained that in its view much of the jurisprudence concerning the meaning of professional misconduct under earlier legislative regimes continues to be relevant under the Act. In particular, the Tribunal

⁵ HC Wellington, AP 300/99, 5 September 2000

⁶ *supra*

⁷ 8/Med03/04P

⁸ 12Den05/04D, 13Den04/02D

believes that the test as to what constitutes professional misconduct continues to involve a two step process:

22.1 The first step involves an objective analysis of whether or not the health practitioner's acts or omissions in relation to their practice can be reasonably regarded by the Tribunal as constituting:

malpractice; or

negligence; or

otherwise meets the standard of having brought, or was likely to bring discredit to the practitioner's profession.

22.2 The second step of the process requires the Tribunal to be satisfied that the health practitioner's acts or omissions require a disciplinary sanction for the purposes of protecting the public and/or maintaining professional standards and/or punishing the health practitioner.

23 The Tribunal has assessed Ms Dale's conduct in this case by addressing the tests explained in paragraph 22 in relation to each of the particularised allegations in the notice of charge. The Tribunal has borne in mind that the acts and omissions in question focused on the way Ms Dale discharged her clinical and professional responsibilities, and are therefore not readily embraced by the concept of "bringing discredit to the profession" as that term is used in s.100(1)(b) of the Act. Nor do Ms Dale's alleged acts and omissions fit comfortably with the term "malpractice" as used in s.100(1)(a) of the Act. In this case the Tribunal believes Ms Dale's alleged shortcomings are more appropriately examined as incidents of alleged "negligence" as that term is used in s.100(1)(a) of the Act.

The Evidence

24 The evidence from the Director of Proceedings fell into three distinct categories:

24.1 The widow and daughter of Mr B;

24.2 The owners and staff of the rest home where Ms Dale worked;

- 24.3 Ms Jan Featherston, a senior and very experienced nurse who is the manager and nursing director of an aged care facility in Auckland. Ms Featherston was called as an expert witness.
- 25 While some details and aspects of the events which unfolded were difficult to ascertain, the Tribunal was able to establish the following had occurred.
- 26 She was employed as the nurse/manager of the rest home in 2001. Ms Dale was employed to work 40 hours a week. Except on those occasions when she was on leave, Ms Dale was on call every evening and weekend. At the time Ms Dale was 61 years old. The owner of the rest home told the Tribunal that Ms Dale was also expected to be on call. He suggested this was not an onerous commitment because Ms Dale would only be called outside of her normal working hours approximately 2 to 3 times a month. The Tribunal received a copy of Ms Dale's employment contract. The contract made no reference to Ms Dale being on call outside of working hours.
- 27 The rest home was a 33 bed facility. Mr B, became a resident in October 1998. At that time Mr B was just 62 years old.
- 28 Prior to September 2003 the rest home had approximately 26 to 28 residents. However the advent of a new rest home in the region resulted in the number of residents in the facility dropping to 14 to 16 during September 2003.
- 29 Mr B suffered a number of debilitating conditions. He had Parkinsons Disease, was an insulin dependent diabetic and suffered hypertension and postural hypotension. During his time in the rest home, Mr B suffered transient ischaemic attacks (TIAs) on a regular basis. It was not unusual for Mr B to suffer more than one TIA episode on the same day.
- 30 Mr B's blood glucose levels were measured every morning and evening. During the period 17 to 21 September 2003 Mr B's blood glucose levels decreased. The readings in the chart in Mr B's records revealed:

<i>Date</i>	<i>AM</i>	<i>PM</i>
17 September	4.3	7.8
18 September	2.9	6.4
19 September	2.1	4.8
20 September	2.3	2.7
21 September	3.2	-

31 The Tribunal was told that at approximately 7.45pm on 20 September 2003 Mr B had a fit. It was said by the senior care giver on duty that Mr B's fit was different from his usual TIA's and that he lashed out his hands and feet. The Tribunal notes however, that in her oral evidence, Mrs B's description of Mr B's previous fits was identical to the description of what was said to be an "unusual" fit.

32 The senior care giver on duty telephoned Ms Dale and described the fit that had occurred. Ms Dale was also told that Mr B's blood sugar levels that evening were down to 2.7. Ms Dale told the senior care giver to re-check Mr B's blood glucose level, take his blood pressure and then call her back.

33 The senior care giver took Mr B's blood glucose levels again. It was down to 2.5. The care giver telephoned Ms Dale and told her the new blood measure. Ms Dale told the care giver to give Mr B some Milo and put rails on the side of his bed to stop him from falling. The Tribunal was told Mr B appeared to settle.

34 There was a change of staff at the rest home at 11pm on 20 September. During the evening of 20 September the night staff thought Mr B was unresponsive. Their entry in Mr B's progress notes reads:

"Not very co-operative this morning as he was very heavy. B/P at 120/80. Temp 34.1. Tried to give him Milo but kept on dribbling out of his mouth".

35 There was another change of shift at 7am on the morning of 21 September. The new senior care giver, Ms W, was told by the night staff Mr B had not been "*his usual self*". Because of these comments Ms W took Mr B's blood measure which was recorded as being 3.2. Ms W repeated the blood measure at 8am. The reading was still 3.2. Ms W then gave Mr B his usual 20 units of insulin. She thought this would increase Mr B's blood glucose levels. The Tribunal was told that at this time there was a policy in place at the rest home concerning the administration of insulin. The Tribunal has examined that policy and notes that while the policy describes in detail how insulin is to be administered, it does not specify the circumstances in which it is to be administered or withheld.

- 36 At approximately 9.30am, Ms W checked Mr B and noted he was not responding to her voice. She took Mr B's blood pressure which was recorded as being 160/110. At this point Ms W telephoned Ms Dale and told her Mr B "*wasn't really with it*". Ms W told Ms Dale that she had given Mr B his regular dose of insulin at 8am but that "*he hadn't picked up*". The Tribunal was told that Ms Dale told Ms W to check Mr B's level of consciousness. Ms W's evidence was that Ms Dale told her that she could check Mr B's level of consciousness "*... by touching his eyelashes to see if he responded with a twitch. She said that if he twitched he was conscious.*" Ms W said she "*hadn't any training in relation to determining a person's level of consciousness prior to this*". Ms W also said that Ms Dale told her to take Mr B's blood measure again and to ring her back if Ms W was not happy with the blood measure reading.
- 37 Ms W said that she followed Ms Dale's instructions. She touched Mr B's eyelash. It apparently twitched. Ms W said in light of Mr B's apparent consciousness, she decided to give him some Milo to raise his blood sugar levels. Ms W said Mr B drank one and half cups of Milo.
- 38 Ms W told the Tribunal she checked Mr B's blood measure levels again at 9.50am. By this time it was down to 1.1. Ms W said she rang Ms Dale and asked if an ambulance should be called. Ms W said Ms Dale "*... didn't reply to my question and instead told me to check [Mr B's blood measure] every quarter of an hour*". Ms W could not remember how many times she did this but thought it would have been at least twice more. The last blood measure she recorded was 2.1.
- 39 After taking a final blood measure reading Ms W made her third telephone call to Ms Dale that morning. Ms W told Ms Dale that Mr B wasn't responding. At this point Ms Dale asked Ms W to call an ambulance.
- 40 An ambulance was called at approximately 10.50am. The first ambulance officer who attended Mr B found Mr B to be unresponsive. He gave Mr B a Glasgow Coma Scale of 3, which in general terms means the patient is unconscious or unresponsive. The ambulance officer noted Mr B was making "*rattling breathing sounds*" which indicated to him that Mr B had a chest infection and/or heart failure. The ambulance officer began treating Mr B for hypoglycaemia by administering glucose intravenously. Shortly after, an advanced paramedic arrived. Mr B was assessed as being in a critical condition. He was taken to a local hospital. Later that afternoon Mr

B was transferred by air to the Intensive Care Unit at Waikato Hospital where he was placed on a ventilator.

41 Mr B did not respond to treatment at Waikato Hospital. He was taken off the ventilator and transferred to Tokoroa where he passed away on 24 September 2003.

Ms Featherston's analysis

42 The Tribunal had the benefit of Ms Featherston's expert analysis of the facts of this case.

43 Ms Featherston has impressive qualifications. She became a registered community nurse in 1976 and a registered comprehensive nurse in 1984. Her academic qualifications include a Bachelor's of Commerce, a Bachelor's of Science, and a Master's of Business Studies. Ms Featherston is currently the manager and nursing director of Waimaire Aged Care Hospital in Auckland. She is extremely well qualified to provide expert evidence on the way Ms Dale discharged her professional responsibilities in this case.

44 In reaching her opinions, Ms Featherston paid special regard to the Nursing Council's stated competencies for entry to the register of comprehensive nurses. That statement of competencies was last amended on 8 February 2002 and sets out the basic competencies required of a nurse seeking registration in New Zealand. The competencies relevant to this case are the requirements that a registered nurse:

- “1.9 *Communicates clearly, verbally, and/or in writing, when giving instruction about client care to enrolled nurses, health service assistances or client's family/carers.*
- 3.4 *Obtains, documents and communicates relevant client information.*
- 3.7 *Determines the level of care required by individual clients and makes appropriate decisions when assigning care, delegating activities and providing direction and supervision for enrolled nurses and others, including health service assistants or family/carers.*
- 4.5 *Uses professional judgment, including assessment skills, to assess the clients' health status and to administer prescribed medication and/or to consult with the prescribing practitioner and/or to refer clients to other health professionals.*

- 4.12 *Combines effective assessment and professional judgment in determining the needs of the client and the preparation and ability of the health service assistance or family/carers to perform the delegated activities in relation to assistance with care.*
- 6.6 *Administers interventions, treatments and medications within legislation, codes, scope of practice and according to authorised prescription, established policy and guidelines.*
- 6.7 *Exercises responsibility in direction and supervision of enrolled nurses, and in delegation of appropriate activities to health service assistants and client's family/carers".*

45 Ms Featherston was of the view that Ms Dale failed to meet these basic competencies.

46 Ms Featherston was particularly critical of the following:

- 46.1 Inadequate records of the nature of the TIA's suffered by Mr B;
- 46.2 Ms Dale's failure to calibrate the blood measure machine. The machine was meant to have been calibrated in August 2003 but was in fact not re-calibrated until September 2004 (after Ms Dale ceased working at the rest home);
- 46.3 Ms Dale's failure to discuss Mr B's blood glucose levels with the care givers in the rest home;
- 46.4 The lack of appropriate detail in Mr B's care plan;
- 46.5 The progress notes made by Ms Dale which Ms Featherston described as being *"well below the standard expected of a registered nurse, and are inadequate as a means of monitoring, evaluating and responding to the care provided to [Mr B] between 1 May and 21 September 2003"*;
- 46.6 Ms Dale's failure to assess the cause of Mr B's decreasing blood glucose levels during the period 17 to 21 September 2003.
- 46.7 Ms Dale's failure to give clear instructions for the staff to follow if Mr B's blood sugar levels continued to decline after Friday 19 September 2003;
- 46.8 The absence of clear policies for the taking of blood measures and ascertaining a person's level of consciousness;

- 46.9 Ms Dale's response to the telephone calls she received about Mr B from a senior care giver on the evening of 20 September 2003. Ms Featherston described Ms Dale's inadequate responses as "... *serious departures from accepted professional standards*".
- 46.10 Ms Dale's inadequate responses to the three telephone calls she received from Ms W on the morning of 21 September 2003. Again, Ms Featherston characterised Ms Dale's responses as "... *serious departures from accepted professional standards*".
- 46.11 Ms Featherston was also of the view that Ms Dale's "... *failure to adequately train staff in relation to monitoring and responding to changing blood glucose levels, the administration of insulin and in recognising the signs of consciousness each constituted a serious departure from accepted professional standards*".

Tribunal's Findings in relation to each particularised allegation

Particular One: Ms Dale failed to adequately assess and/or monitor and/or evaluate and/or respond to the care provided to Mr B.

- 47 The Tribunal believes that this particular of the charge is in effect a summation of a number of features of the remaining particulars of the charge. Because the Tribunal has made specific findings against Ms Dale in relation to five of the remaining particulars of the charge, it does not believe it is necessary or appropriate to make any findings in relation to this particular allegation.

Particular Two Ms Dale failed to provide adequate and/or appropriate training to care givers in respect of:

- (i) monitoring and responding to changing blood glucose levels;**
- (ii) recognising the signs of consciousness;**
- (iii) the administration of insulin.**

48 The Tribunal has found that this particular of the charge has been clearly proven by the Director of Proceedings. The Tribunal is very satisfied Ms Dale failed to provide adequate and appropriate training to care givers in relation to the three matters specified in this particular of the charge. The Tribunal believes Ms Dale's failure to provide adequate and appropriate training to care givers were serious omissions and that her conduct fell well below the standard expected of a registered nurse in her position. Furthermore, the Tribunal is satisfied that a disciplinary finding is warranted in order to maintain professional standards and protect the public.

Monitoring and Responding to Changing Blood Glucose Levels

49 The Tribunal was told by Mrs DB, a manager and care giver at the rest home, that she recorded Mr B's blood measures on the mornings of 17, 18 and 19 September. She said Ms Dale did not raise any concerns about those measures. Furthermore, she could not recall any occasion on which Ms Dale discussed Mr B's blood measures.

50 Ms W told the Tribunal that she could not recall ever receiving any advice from Ms Dale on how to measure a patient's blood glucose levels.

51 Another senior care giver explained that she took Mr B's blood measures on the evenings of 18 and 19 September. She said Ms Dale did not discuss those readings with her and she could not recall any occasion when Ms Dale had discussed such matters with her.

Recognising the Signs of Consciousness

52 A senior care giver explained that the training she received from Ms Dale did not cover monitoring a resident's level of consciousness.

53 Similarly, Ms W told the Tribunal that prior to the events of September 2003 she did not receive any training from Ms Dale about how to ascertain a person's level of consciousness.

54 In her evidence, Mrs DB told the Tribunal that she did not receive any training in relation to recognising the signs of consciousness in a resident.

Administering Insulin

55 The Tribunal was surprised to hear that staff at the rest home said they had received no training in the administration of insulin.

55.1 Mrs DB said that she had received training on administering insulin from Mrs Dale's predecessor, but Ms Dale herself never provided training on this topic;

55.2 Ms W could recall Ms Dale discussing how to administer insulin, but Ms Dale never observed or monitored the way Ms W undertook this task;

55.3 A senior care giver, who is herself diabetic and knew how to administer insulin said Ms Dale never gave advice on how the care giver should administer insulin to patients.

56 The Tribunal agrees entirely with Ms Featherston who said that Ms Dale needed to put in place procedures which ensured staff in the rest home knew how to monitor and respond to any continuing decline in Mr B's blood glucose levels. The staff needed to know that if Mr B's blood measures continued to decline after Friday 19 September then they should contact her immediately, or alternatively, if she were unavailable, an on-call general practitioner.

57 The advice which Ms Dale gave Ms W on the morning of 21 September about assessing Mr B's level of consciousness was unorthodox. Asking a care giver to test for eye-lash twitching is not a recognised technique in assessing a person's consciousness. The staff should have learned how to apply the "Glasgow Coma Scale" or another recognised method of classifying someone's level of consciousness. The Glasgow Coma Scale was the test administered by the ambulance officer when he arrived at the rest home at about 11am on 21 September.

58 Ms Featherston was "*greatly concerned*" about the staff's lack of knowledge about the administration of insulin. Whilst there was a policy in place which explained how to administer insulin, no training had been given on when to withhold administering insulin. This was particularly important on the morning of 21 September. The Tribunal endorses Ms Featherston's views that "*Ms Dale's failing in respect of the training she gave staff in regard to the administration of insulin amounted to a serious departure from accepted professional standards*".

59 The Tribunal notes Ms Dale's job description included a requirement that she:

“...provide on the job training to staff as appropriate to ensure the residents received a high standard of care at all times”.

60 It is clear that Ms Dale did not comply with this requirement of the terms of her employment. More importantly, from the Tribunal’s perspective, it is important to emphasise that as the sole registered nurse in the facility it was incumbent on Ms Dale to ensure that care givers had fundamental skills and received basic training so as to ensure the health and safety of patients was not compromised.

61 When the three sub categories of particular two of the charge are viewed cumulatively, there is no doubt Ms Dale failed to discharge her fundamental obligation to ensure staff at the rest home were properly trained in basic techniques and procedures. Ms Dale’s shortcomings were a serious departure from accepted standards and a disciplinary finding is necessary in order to maintain professional standards and protect the public.

Particular Three: Between 17 and 21 September 2003 Ms Dale failed to adequately assess and/or monitor and/or evaluate and/or respond to Mr B’s changing blood glucose levels.

62 The Director of Proceedings has proven this particular of the charge to the requisite standard. The Tribunal is very satisfied Ms Dale failed to adequately assess, monitor, evaluate and respond to Mr B’s changing blood glucose levels between 17 and 21 September 2003. Ms Dale’s errors were serious and justify a disciplinary finding against her for the purposes of protecting the public and maintaining professional standards.

63 The evidence before the Tribunal was that Mr B’s blood glucose levels deteriorated during the period 17 to 21 September. All of the blood measure records for 17 to 21 September were low. Because Mr B’s blood measures were low over a number of days, it was incumbent on Ms Dale to discuss with Mr B’s care givers, an appropriate course of action.

64 Ms Featherston told the Tribunal that Ms Dale needed to consider the reasons why Mr B’s blood measure levels were falling. She said an appropriate management plan would have required Ms Dale to:

- 64.1 Make sure Mr B was eating and drinking appropriate food and liquid. There was no evidence of Ms Dale evaluating Mr B's diet.
- 64.2 Assess if Mr B's medical circumstances were causing the drop in his blood measure. Ms Featherston said a fundamental step would have been for Ms Dale to arrange tests of Mr B's urine.
- 65 Ms Featherston stressed the need for Ms Dale to ensure that staff knew to either call her or an on-call general practitioner if Mr B's blood measures continued to be a source of concern after Friday 19 September.
- 66 Ms Featherston was adamant that Ms Dale's failure to take any of the steps suggested by Ms Featherston meant Ms Dale's conduct "*fell well short of accepted professional standards in regard to her assessment, monitoring, evaluation and in particular response to [Mr B's] blood glucose levels for the period 17 to 21 September*".
- 67 After evaluating the evidence, the Tribunal has found itself in complete agreement with Ms Featherston's assessment. The Tribunal is very concerned that Ms Dale appears not to have adequately assessed, evaluated or responded to Mr B's decreasing blood glucose levels from 17 to 21 September. Her failings in this regard were serious and constituted conduct which fell well below the standards which the Tribunal could expect of a nurse in Ms Dale's position. The Tribunal is in no doubt that in this regard Ms Dale's conduct justifies a disciplinary sanction for the purposes of protecting the public and maintaining professional standards.

Particular Four: On or about 20 September 2003, upon being advised by a phone call at approximately 7.45pm by a care giver that Mr B had had a seizure that was different from his usual TIA, Ms Dale failed to provide appropriate instructions for assessment and/or monitoring and/or feedback.

- 68 The Tribunal is not satisfied to the requisite standard that this particular of the charge has been proven.
- 69 The evidence is that a care giver telephoned Ms Dale at approximately 7.45pm and described Mr B's condition. Ms Dale told the care giver to take Mr B's blood measure and blood pressure and call her back.

70 It would have been highly desirable for Ms Dale to have also told the care giver to check Mr B's level of consciousness at this stage as well as his pulse and rate of respiration. However, the Tribunal believes that as Ms Dale told the care giver to check Mr B's blood measure and blood pressure and then "*call her back*", Ms Dale met the minimum standard expected of her on this occasion. The instruction to the care giver to call Ms Dale back provided Ms Dale with an opportunity to monitor and re-assess Mr B once further information was obtained. Although Ms Dale's conduct was far from excellent, the Tribunal believes that her response to the first telephone call on the night of 20 September met the minimum standard expected of a nurse in her position.

Particular Four A: On or about 20 September 2003, upon being advised by a phone call at approximately 8pm by a care giver that:

- (a) **Mr B had a blood glucose level of 2.5;**
- (b) **The care giver had been unable to take his blood pressure;**
- (c) **Mr B had not settled after the seizure reported at 7.45pm**

Ms Dale failed to provide appropriate instructions for assessment and/or monitoring and/or feedback.

71 The Tribunal is satisfied this particular of the charge has been proven to the requisite standard.

72 The evidence before the Tribunal was that when the care giver made her second call to Ms Dale on the evening of 20 September, Ms Dale did not respond in an appropriate manner. Ms Dale was told by the care giver that Mr B's blood measure was only 2.5 and that the care giver had not been able to take his blood pressure because "*he hadn't settled enough*".

73 The fact Mr B had not "*settled enough*" to enable his blood pressure to be taken should have been a source of concern for Ms Dale. At this point it was mandatory that she instruct the care giver to check Mr B's level of consciousness. It would also have been advisable for the care giver to be told to check Mr B's pulse and rate of

respiration. Instead of giving these basic instructions, Ms Dale told the care giver to give Mr B Milo and call her back if there were any problems. It was essential that fluids not be administered to Mr B at this stage without first checking his consciousness.

74 The Tribunal agrees entirely with Ms Featherston's evidence when she said Ms Dale's failure to instruct the care giver to check Mr B's level of consciousness before giving him fluids was a serious departure from accepted professional standards. It is also the Tribunal's view that Ms Dale's errors were so serious that a disciplinary finding is required in order to maintain professional standards and protect the public.

Particular Five: On 21 September, when advised by a phone call by a care giver at approximately 9.30am that:

(a) Mr B's blood measurement was 3.2mmol/l at approximately 8am; and

(b) Insulin had been administered to him; and

(c) His blood pressure was 160/110

Ms Dale failed to provide appropriate instructions for assessment and/or monitoring and/or feedback.

75 The Tribunal has determined that this particular of the charge has been proven to the requisite standard.

76 The evidence is that when Ms W telephoned Ms Dale at approximately 9.30am on 21 September Ms Dale was told:

76.1 Mr B's blood glucose levels had been measured at 8am and found to be 3.2mmol/l;

76.2 Ms W had administered Mr B's usual dose of insulin at 8am;

76.3 Mr B's blood pressure was 160/110;

76.4 Mr B "*wasn't really with it*".

- 77 Ms Dale responded to this information by instructing the care giver to check Mr B's level of consciousness, and to provide him with Milo if he were conscious.
- 78 It was entirely appropriate for Ms Dale to ask that Mr B's level of consciousness be determined. However, the technique Ms Dale told the care giver to use to check Mr B's level of consciousness is a source of concern. Ms Dale told the care giver to check Mr B's level of consciousness by seeing if his eye lashes would twitch if touched. This is not a recognised method of assessing a patient's level of consciousness. Ms Dale should have told the care giver to administer the "Glasgow Coma Scale" or use another recognised test to ascertain Mr B's level of consciousness. If the care giver did not know how to administer a recognised test then Ms Dale should have gone to Mr B and undertaken the assessment herself.
- 79 The Tribunal is of the view that Ms Dale's response at 9.30am on 21 September constituted a significant departure from the standards expected of a nurse in her circumstances. Ms Dale should have given proper instructions to assess Mr B's level of consciousness, recheck his blood sugar levels and determine the true nature of his condition. The Tribunal is of the view Ms Dale's errors at 9.30am on 21 September justify a disciplinary sanction for the purposes of protecting the public and maintaining professional standards.

Particular Six: On or about 21 September 2003 upon being advised by a phone call from a care giver at approximately 9.50am that Mr B's blood measure was 1.1mmol/l, failed to arrange for an ambulance to be called in a timely manner.

- 80 This particular of the charge has been proven to the requisite standard.
- 81 The evidence before the Tribunal was that Ms W's second telephone call to Ms Dale occurred at approximately 9.50am on 21 September. At that time Ms Dale was told:
- 81.1 Mr B's blood measure was down to 1.1;
- 81.2 That Ms W was very concerned
- Ms W asked Ms Dale if an ambulance should be called.

82 The Tribunal was told that Ms Dale did not respond to Ms W's question about whether or not an ambulance should be called. Instead, Ms Dale told Ms W to check Mr B's blood measures every 15 minutes.

83 The Tribunal is particularly concerned about Ms Dale's inappropriate response to Ms W's telephone call at 9.50am. By this stage, Mr B's blood measure was dangerously low. It was essential that an ambulance be called immediately. Mr B was at this time in a critical condition. Ms Dale should have appreciated that an urgent response was required. Her failure to respond in an appropriate manner was a serious omission and constituted a significant departure from the standards ordinarily expected of a nurse in Ms Dale's position. Ms Dale's inappropriate response to Ms W's telephone call at 9.50am justifies a disciplinary finding for the purposes of protecting the public and maintaining professional standards.

Cumulative Charge

84 The Tribunal has found five particulars of the charge constitute professional misconduct. It is accordingly not necessary to consider the alternative cumulative charges.

Penalty

85 The Tribunal shall impose one cumulative penalty in relation to all of the findings it has made against Ms Dale.

86 The Director of Proceedings urged Ms Dale's name be removed from the register of nurses or alternatively that Ms Dale be suspended. This submission was based on the proposition that Ms Dale's acts and omissions were serious and fell well below the standards expected of a nurse.

87 Regrettably, the Tribunal did not hear from Ms Dale and has not been able to obtain her explanation for the events that occurred. Nor has the Tribunal been able to glean much information about Ms Dale's circumstances. The Tribunal has however been able to establish the following mitigating facts:

- 87.1 Ms Dale is now 65 years old. This is the first occasion she has been the subject of a disciplinary hearing. Ms Dale is entitled to considerable credit for her previously unblemished record.
- 87.2 It became apparent to the Tribunal that during the period 17 to 21 September 2003 Ms Dale was suffering a number of unusual stresses. The owner of the rest home confirmed to the Tribunal that he was aware that Ms Dale was suffering from a distressing family circumstance which had come to a head at this time. The Tribunal gained the distinct impression that Ms Dale was distracted by her family crisis at the time she should have been focusing on Mr B's circumstances.
- 87.3 Ms Dale bore the responsibility of ensuring the rest home met the requirements of accreditation by the Ministry of Health as a Stage 2 rest home, as well as carry out her normal duties as carry out her normal duties as a registered nurse/manager. This would have been a very onerous task, compounded by the fact the rest home was rapidly losing residents to a new facility that had recently opened in the same area.
- 88 In assessing the appropriate penalty, the Tribunal has kept uppermost in its mind that its principal purpose is to protect the health and safety of members of the public.⁹
- 89 The limited information made available to the Tribunal about Ms Dale and the circumstances of this case have led the Tribunal to conclude that this is not a case which justifies Ms Dale's name being removed from the register. Nor is suspension warranted. Instead, the Tribunal believes that the public's safety can be ensured by requiring Ms Dale to practise under the supervision of a registered nurse approved by the Nursing Council of New Zealand. In setting this condition on Ms Dale's ability to practise the Tribunal is endeavouring to provide Ms Dale with the opportunity to continue practising as a nurse if she wishes. At the same time, it is essential that Ms Dale receive mentoring and guidance from an appropriately qualified registered nurse who can supervise the manner in which Ms Dale discharges her professional responsibilities. This condition is to remain in place for three years from the date of this decision. This order is made pursuant to s.101(1)(c) of the Act.

⁹ Refer s.3(1) of the Act

- 90 The Director of Proceedings also sought an order for costs. The amount sought was 50% of the costs incurred by the Director of Proceedings. The Tribunal does not know what actual costs were incurred by the Director of Proceedings. Nor does the Tribunal know anything about Ms Dale's financial circumstances other than that she was paid just \$15 per hour when working at the rest home and is therefore unlikely to be financially well off.
- 91 It is appropriate Ms Dale be required to pay some costs to reflect the fact that she has not responded to the charge and has put the Director of Proceedings through the expense of calling 10 witnesses to prove the charge.
- 92 Ms Dale will be required to pay \$10,000 costs comprising \$7,500 to the Director of Proceedings and \$2,500 to the Tribunal. These orders are made pursuant to s.101(1)(f)(iii) and (iv) of the Act.
- 93 The Executive Officer is required to publish a summary of the Tribunal's findings in Kai Tiaki, the Journal of the New Zealand Nurses Organisation. This order is made pursuant to s.157(2) of the Act.

DATED at Wellington this2nd..... day of November 2005

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Dr D B Collins QC

Chairman

Health Practitioners Disciplinary Tribunal