



**NEW ZEALAND
HEALTH PRACTITIONERS
DISCIPLINARY TRIBUNAL**
TARAIPUINARA WHAKATIKA KAIMAHI HAUORA

Level 24, AON Building, 1 Willis Street, Wellington 6011
PO Box 10509, The Terrace, Wellington 6143, New Zealand
Telephone: 64 4 381 6816
Email: gfraser@hpdt.org.nz
Website: www.hpdt.org.nz

BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

HPDT NO: 1051/Nur19/440P

UNDER the Health Practitioners Competence Assurance Act 2003 (“the Act”)

IN THE MATTER of a disciplinary charge laid against a health practitioner under Part 4 of the Act.

BETWEEN **A PROFESSIONAL CONDUCT COMMITTEE
appointed by the NURSING COUNCIL OF NEW
ZEALAND**

Applicant

AND **MS H** of X, registered nurse

Practitioner

HEARING held at Auckland on 13 – 16 August 2019

TRIBUNAL Ms A Douglass (Chair)

Ms A Kinzett, Ms T Campbell, Ms K Marshall and Ms H Pocknall
(Members)

Ms G Fraser (Executive Officer)

Ms H Hoffman (Stenographer)

APPEARANCES Mr M McClelland QC and Ms H de Montalk for the Professional
Conduct Committee (PCC)

Ms S Eglinton and Ms M Barnett-Davidson for the Practitioner.

CONTENTS

Introduction.....	3
The Charge	3
The hearing.....	3
Relevant law – professional misconduct	5
<i>Credibility</i>	<i>7</i>
Background Facts	7
The practitioner’s evidence	8
Procedural sedation – medication, policy and procedures.....	9
The Tribunal's consideration of the charge	11
<i>Treatment of Patient A.....</i>	<i>12</i>
<i>Particular 1 – Administration of Propofol</i>	<i>13</i>
<i>Particular 2 – Administration of Propofol without supervision</i>	<i>16</i>
<i>Particular 3 – Administration of Fentanyl</i>	<i>17</i>
<i>Particular 4 – Ketamine</i>	<i>18</i>
<i>Particular 5 – documentation</i>	<i>18</i>
<i>Particular 6 – false representation</i>	<i>19</i>
Patient B.....	19
<i>Particular 7– Administration of Propofol</i>	<i>20</i>
<i>Particular 8 – Administration of Propofol without supervision</i>	<i>20</i>
<i>Particular 9 – Administration of Ketamine.....</i>	<i>21</i>
<i>Particular 10 – Documentation</i>	<i>21</i>
Decision – liability	21
Is a disciplinary sanction required?	23
Permanent name suppression	24
SCHEDULE.....	29

Introduction

- [1] The practitioner, Ms H (the practitioner) is a registered nurse (RN). She faces one Charge (with ten particulars) of professional misconduct relating to two occasions in [] and [] 2017 when she provided procedural sedation to two paediatric patients. This involved the intravenous administration of Ketamine, Propofol and Fentanyl to Patient A and Ketamine and Propofol to Patient B, both of whom were undergoing orthopaedic procedures.
- [2] In [] 2016 until [] 2018, the practitioner worked as a Clinical Nurse Specialist (CNS) intern in the [children's ED] at [the Hospital] [the children's ED]. It was while the practitioner was working at [the children's ED] that the events in question are alleged to have occurred.

The Charge

- [3] The Particulars of the Charge before the Tribunal are set out in the Schedule to this decision.
- [4] In summary, the Professional Conduct Committee (PCC) alleges that the practitioner compromised the safety of each patient and was either practising outside her scope of practice as an RN by administering these medications without a prescription or, in the alternative, having obtained a verbal order from a Senior Medical Officer (SMO) failed to follow the procedures of the [the DHB], namely the Procedure: Medication (Medicines) Administration Policy. These procedural failures are alleged to be concerned with the supervision of administering Propofol, Fentanyl and Ketamine and the documentation of these medications under the verbal order.
- [5] The practitioner admitted that some (but not all) of her documentation was incomplete but denied the allegations that she administered Propofol, Fentanyl and Ketamine without a prescription and without supervision from an SMO. The practitioner also denied that she falsely represented herself as a CNS.¹

The hearing

- [6] The hearing proceeded over four days in Auckland.
- [7] The PCC called four witnesses who held various management and clinical roles in respect of [children's ED] while the practitioner was an intern CNS at the DHB: Ms Y, Clinical Nurse Director; Ms R, Clinical Nurse Specialist (CNS); Ms A, Nurse Manager of Emergency Department (ED) and Dr S, Emergency Medicine Specialist

¹ Document 8, Opening Submissions of Counsel for the Practitioner dated 12 August 2018, para 6.

and the Clinical Lead for Emergency Medicine at [the Hospital]. The practitioner gave evidence.

- [8] Prior to the hearing, counsel for the practitioner, objected to some of the proposed evidence in an Agreed Bundle of Documents. The parties agreed that the Chair could consider these objections and a prehearing ruling was made by the Chair alone in relation to those objections.²
- [9] The parties then produced a revised Agreed Bundle of Documents (ABOD) for the hearing. This included: the letter of complaint to the Nursing Council from the Director of Patient Care, Chief Nurse and Allied Health Professions Officer at the District Health Board (DHB), [the DHB];³ the various applicable Guidelines, Policies and Procedures that apply to procedural sedation in this context;⁴ the Standing Orders and required documentation guidelines;⁵ and the practitioner's recollection of the incidents and summary of the events.⁶
- [10] At the conclusion of the hearing, the Tribunal gave an indication of its decision that the Charge was established however, the practitioner's conduct was not sufficiently serious to warrant a disciplinary sanction.
- [11] Ms Eglinton, counsel for the practitioner, made an oral application for permanent non-publication of the practitioner's name and identifying details. Prior to the hearing, an interim order for non-publication was made in respect of the name and identifying details of the practitioner.⁷ The Tribunal reserved its decision and subsequently requested a written application and supporting evidence from the practitioner.⁸ The non-publication application was considered by the Tribunal on the written submissions of the parties and the order and reasons are set out at the end of this decision.
- [12] By consent, an interim order of non-publication in respect of the names of the two patients, referred to as Patient A and Patient B was made final at the conclusion of the hearing. The patients (or parents or guardians on their behalf) were not the complainants and were not contacted by the PCC to give evidence. The Tribunal

² Minute of Tribunal Chair Alison Douglass dated 1 August 2019

³ Agreed Bundle of Documents (ABOD) Tab 1.

⁴ ABOD: Paediatric Procedural Sedation Guideline, Tab 2; Medication Certification Process, Tab 3; Pyxis Audit, Tab 5; Policy and Procedure: Medication Management using Pyxis Medstation, Tabs 6 and 7; Procedure: Medication (Medicines) Administration, Tab 15 and Prescribing, Tab 16

⁵ ABOD: Standing Orders [the children's ED], Tab 17; Policy: Standing Orders for Delegated Medical Authority, Tab 20; Policy: Documentation in the Clinical Record, Tab 21; Procedure: Checking for Accuracy and Authorising Hand Written and Typed Entries in the Clinical Record, Tab 22; Guideline: Documentation and records in the Emergency Department, Tab 23.

⁶ The practitioner's reflection, ABOD Tab 25.

⁷ Minute of Chair Maria Dew QC dated 26 March 2019.

⁸ Minute of Chair Alison Douglass dated 30 August 2019.

was advised in the course of the hearing that there were no adverse outcomes for either of these patients in relation to their care.⁹

[13] In submissions, both counsel acknowledged that the practitioner’s credibility was at issue, with each counsel making detailed submissions on the evidence. The interpretation of the various relevant policies and procedures was also at issue. These matters form the focus of the Tribunal’s consideration of the Charge.

[14] We begin by considering the legal principles that applied in this case.

Relevant law – professional misconduct

[15] Section 100 of the Act provides the grounds on which a health practitioner may be disciplined. The section provides that malpractice and/or negligence and/or conduct likely to bring discredit to the profession can constitute professional misconduct.¹⁰

[16] The Tribunal and the Courts have considered the term “professional misconduct” under s 100(1)(a) on many occasions. In *Collie v Nursing Council of New Zealand*,¹¹ Gendall J described negligence and malpractice as follows:

Negligence or malpractice may or may not be sufficient to constitute professional misconduct and the guide must be standards applicable by competent, ethical and responsible practitioners and there must be behaviour which falls seriously short of that which is to be considered acceptable and not mere inadvertent error, oversight or for that matter carelessness.¹²

“Malpractice” is defined as:

Immoral, illegal or unethical conduct or neglect of professional duties. Any instance of improper professional conduct”¹³ and, “Law Improper treatment or culpable neglect of a patient by a physician or of a client by a lawyer ... 2 *gen* criminal or illegal action: wrongdoing, misconduct.¹⁴

[17] Justice Gendall further addressed the issue at paragraph [23]:

Clearly it envisages conduct in the performance of the nurse’s usual professional duties if it amounts to “malpractice or negligence”. That requires, in line with the authorities an

⁹ Dr S, Transcript, p 26, lines 6-9.

¹⁰ HPCA Act, ss 100(1)(a) and/or 100(1)(b).

¹¹ [2001] NZAR 74.

¹² [2001] NZAR 74 at [21].

¹³ Collins English Dictionary (12th ed).

¹⁴ Shorter Oxford English Dictionary (1993 ed) as cited in *Dr E* 136/Med07/76D at [12] – [14].

accepted view, that the negligence or malpractice be of a serious degree and such as to be substantially below the standards expected of a nurse.¹⁵

[18] In *B v the Medical Council of New Zealand*¹⁶ a case decided under the previous legislation, the Court stated:

The structure of the disciplinary processes set up by the Act, which rely in large part upon judgement by practitioner's peers, emphasises that the best guide to what is acceptable conduct is the standards applied by competent, ethical and responsible practitioners. But the inclusion of lay representatives in the disciplinary process and the right of appeal to this court indicates that usual professional practice, while significant, may not always be determinative: the reasonableness of the standards applied must ultimately be for the court to determine, taking into account all the circumstances including not only usual practice but also patient expectations, including the expectation that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards.

[19] Under s 101(b) of the Act, the Tribunal must also consider whether the alleged conduct has or is likely to bring discredit on the medical profession. In *Collie*,¹⁷ Gendall J stated:

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 the 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.

[20] There is a well-established two-stage test for determining professional misconduct and the threshold is "inevitably one of degree".¹⁸ These two steps are:

- (a) First, did the proven conduct fall short of the conduct expected of a reasonably competent health practitioner operating in that vocational area? This requires an objective analysis of whether the practitioner's acts or omissions can reasonably be regarded by the Tribunal as constituting malpractice; negligence; or otherwise bringing or likely to bring, discredit to the profession; and
- (b) Secondly, if so, whether the departure from acceptable standards has been significant enough to warrant a disciplinary sanction for the purposes of protecting the public by maintaining professional standards and/or punishing the health practitioner.

¹⁵ *Collie v Nursing Council of New Zealand* [2001] NZAR 74.at [23].

¹⁶ [2005] 3NZLR 810.

¹⁷ *Collie v Nursing Council of New Zealand* at [28].

¹⁸ *F v Medical Practitioners Disciplinary Tribunal* [2005] 3 NZLR 774 (CA), endorsed the earlier statement of Elias J in *B v Medical Council* (High Court, Auckland 11/96, 8 July 1996) noted at [2005] 3 NZLR 810, as applied for example, in *Johns v Director of Proceedings* [2017] NZHC 2843.

- [21] The burden of proof is on the PCC. This means that it is for the PCC to establish that the practitioner is guilty of professional misconduct.
- [22] The PCC must produce evidence that establishes the facts on which the Charge is based to the civil standard of proof; that is, proof which satisfies the Tribunal that on the balance of probabilities the Particulars of the charge are more likely than not. The Tribunal must apply a degree of flexibility to the balance of probabilities taking into account the seriousness of the allegation and the gravity of the consequences flowing from a particular finding.¹⁹

Credibility

- [23] Credibility issues will arise in the course of the hearing. The test for credibility and for resolving such issues was stated by Canadian Appellate Court in *Faryna v Chorny*²⁰ and discussed in *Dawson*.²¹ The real test of the truth of the story of the witness must be at harmony with the preponderance of the probabilities which are practical, and which an informed person would readily recognise as reasonable in that place and in those conditions.
- [24] As confirmed in *Rabih v A Professional Conduct Committee of the Dental Council*, the Tribunal must consider the following factors:²²
1. The witness' manner and demeanour when giving evidence;
 2. Issues of potential bias – to what extent was evidence given from a position of self-interest;
 3. Internal consistency – was the evidence of the witness consistent throughout, either during the hearing or having regard to previous statements;
 4. External consistency – was the evidence consistent with that given by other witnesses; and
 5. Whether non-advantageous concessions were freely given.

Background Facts

- [25] By way of background, the practitioner became a registered nurse, having completed a Bachelor of Health Science Nursing from the Auckland University of Technology (AUT) in []. Following her registration as a nurse, the practitioner obtained a graduate position at Starship Children's Hospital where she worked until [] 2016.

¹⁹ *Z v Dental Complaints Assessment Committee* [2009] 1 NZLR (SC) at [112].

²⁰ [152] 2 DLR 354 (BCCA).

²¹ 300/Nur09/139P at paras 19-21.

²² [2015] NZHC 1110, Brown J.

During this period she progressed from a graduate nurse to Level 4 or expert registered nurse working in the E D. The practitioner also completed a post-graduate diploma in Health Science Child Health, a Masters in Health Practice Child Health and a post-graduate Certificate in Emergency Management, all from the Auckland Institute of Technology.

- [26] Since [] 2014, the practitioner has been employed by the [] to co-ordinate the courses which are run at least twice a year. In [] 2018 the practitioner became an instructor in these courses.
- [27] From [] 2016 until [] 2018, the practitioner worked as a Clinical Nurse Specialist (CNS) intern in the [children's ED]. She was employed on a training programme at the DHB for nurses wanting to become a CNS in Paediatrics. The interns attend university for the academic work and the DHB provides the practical workplace training in extended practice.²³
- [28] The complaint by the DHB that led to an investigation by the PCC arose after the practitioner was said to have disclosed to a colleague at a social gathering in [] 2017 that she had administered intravenous Propofol to paediatric patients in ED.²⁴ The administration of Propofol is out of the scope of practice of a CNS Intern and a registered nurse unless the protocols and guidelines are followed, including administering Propofol under a verbal order with supervision. On [] 2017 the practitioner was called to an investigation meeting with the practitioner's manager over these matters and at the end of the meeting she resigned from her employment with the DHB.²⁵

The practitioner's evidence

- [29] The practitioner could not recall mentioning the above interaction and surmises that the discussion about administering Propofol to a patient in [the children's ED] could have been at one of the training courses she attended around that time. In any event, the practitioner immediately identified one patient, Patient A, to whom she administered Propofol. After a review of the notes, a second patient, Patient B was also identified. The practitioner was appropriately cooperative with all due inquiries by her employer and in [] 2017 wrote a practice reflection from her memory and without viewing the clinical notes about her sedation practice and the care of these two patients.²⁶
- [30] The practitioner described her orientation as a CNS intern as poor. Often she did not have the support of another CNS working with her and there was a heavy workload. She attempted a few times to establish a mentor for herself. At the start of 2017 she

²³ Brief of Evidence of Ms A, Tab 3, para 3.

²⁴ Brief of Evidence of Ms Y, Tab 1, para 3.

²⁵ ABOD, Tab 1, Letter of Complaint from Jenny Parr.

²⁶ ABOD, Tab 25, p 186.

met with Dr S on a few occasions, although as Clinical Lead Dr S had wider responsibilities and was not often working with her.²⁷

- [31] On a usual day and evening shift in [the children's ED] there would be one registrar, one senior medical officer (SMO) (either a consultant, medical officer special scale (MOSS) or a fellow), a CNS or a CNS intern, nursing and care staff. The [children's ED] is located next to the Adult ED and medical and nursing staff work across both departments. If the SMO rostered to work in [the children's ED] was busy, either in [the children's ED] or in the Adult ED they could call on one of the other SMOs that were assigned to the Adult ED for that particular shift.
- [32] In her role as CNS Intern, the practitioner managed her own patients. At times, she had to manage [the children's ED] on her own, when the medical staff were required in the Adult ED and there was no other CNS on duty. She would see and assess all children that presented and if necessary put a child in the resuscitation room and manage this until a doctor was free to assist or take over the care.
- [33] A large part of the practitioner's role was to undertake procedural sedations, while another clinician performed the procedure. Patients were discussed with a SMO, MOSS or a fellow. They would decide whether they would see the child themselves or, if they were happy with her assessment then allow the practitioner as a CNS Intern to continue with the discussed plan for sedation. It is the operation of these guidelines and protocols in relation to verbal orders that lie at the heart of this Charge.

Procedural sedation- medication, policy and procedures

- [34] In respect of these allegations of professional misconduct it is necessary to have an understanding of the various medications and the required standards and procedures for procedural sedation.

Procedural sedation

- [35] Procedural sedation is a technique of administering sedatives or dissociative agents with or without analgesics to induce a state that allows a patient to tolerate unpleasant procedures while maintaining cardiorespiratory function. The goals of procedural sedation are to provide an adequate level of sedation while minimising pain and anxiety, maximising amnesia, minimising potential for adverse drug-related events, controlling behaviour and maintaining a stable cardiovascular and respiratory status.

Propofol, Ketamine and Fentanyl

- [36] Propofol is an anaesthetic agent used for procedural sedation in the ED. It is a short-acting general anaesthetic that has a rapid onset. One of the main disadvantages of

²⁷ Document 9, Statement of Evidence of the practitioner dated 21 June 2019, paragraphs 15-27.

using it is the risk of respiratory depression. Propofol is always administered in the resuscitation room in case the patient requires resuscitation and airway management. It is not used very often with children but used more frequently in adults and adolescents. Importantly, the relevant Guideline states:²⁸

Propofol (IV)

should be performed in the resuscitation room due to high risk of apnoea. Should only be given under supervision of ED SMO.

- [37] Ketamine is used for procedural sedation. Nurses can be credentialled to be able to administer Ketamine, but it must be prescribed.²⁹ They must undergo training which involves learning airway management and advanced paediatric life support. The practitioner was credentialled to administer Ketamine which meant that she was able to administer if necessary the prescribed dose of Ketamine without supervision from a medical practitioner. Even though she was credentialled for Ketamine, the practitioner could not use a standing order for any of the drugs she used for procedural sedation.
- [38] Fentanyl is a short-acting opioid which is used for procedural sedation and as an analgesic. Fentanyl must be prescribed and is not able to be given under a standing order.
- [39] There are a number of procedures and guidelines which are critical to the circumstances of prescribing and administering these medications for procedural sedation. These include for example, the Policy for the use of the Pyxis Medstation, the dispenser that a practitioner takes drugs out of to obtain medicines;³⁰ the use of standing orders;³¹ verbal orders; and the procedures and guidelines for the safe prescribing and administration of medication;³²

Standing orders

- [40] There are two ways an ED nurse can administer a medication without a written prescription. Firstly, by way of a standing order or secondly a verbal order.
- [41] A standing order is a written instruction issued by a medical practitioner and authorises certain practitioners, such as nurses for example, on instruction to administer medicines and some controlled drugs.³³

²⁸ ABOD Tab 2, Pediatric Procedure Sedation Guideline, p 25.

²⁹ ABOD Tab 2, Pediatric Procedure Sedation Guidekines, p 18.

³⁰ ABOD Tab 6 and 7 Policy and Procedure :medication Management for Pyxis Medstation

³¹ ABOD, Tab 15, Procedure: Medication (Medicines) Administration, p 108.

³² ABOD, Tab 16 Procedure: Medication (Medicines) Prescribing.

³³ ABOD, Tab 17, Standing Orders [the children's ED], p 132 – definition of “standing order”.

Verbal orders

[42] In the Procedural Guideline verbal orders are described as follows:³⁴

Verbal orders for medications are reserved for exceptional circumstances and must be given by a prescriber familiar with the patient's current diagnosis and treatment.

The entry for the verbal order should be countersigned by the prescriber or so arranged, by another prescriber, as soon as practicable and within 24 hours.

[43] The verbal orders are traditionally used in the ward or other places where the Senior Medical Practitioner (usually a senior medical officer) is offsite, that is, there is no medical practitioner in the ward. Typically it involves a discussion over the phone by the SMO with two nurses listening. The verbal order is recorded on a medication chart, for example, which provides for "verbal orders".³⁵ The prescriber must sign this off within a 24 hour period.

Pyxis MedStation

[44] The Pyxis MedStation system of medication is an automated medication dispensing system. When the patient is admitted to the hospital, the patient's medication chart is faxed to the pharmacy. The medications are then checked by the pharmacists and electronically loaded on to the Pyxis. The Pyxis machine has drawers which contain a variety of medications. To administer the medication the user logs on to the Pyxis using their unique log-on and fingerprint, selects the patient and medication, and a drawer opens allowing the removal of each of the medications requested. The medication is then administered to the patient and the Pyxis records every transaction.³⁶

[45] The significance of the Pyxis MedStation is that for Patients A and B there would be another RN with the practitioner for the checkout process.

Tribunal's consideration of the Charge

[46] In respect of the procedures for verbal orders, the Tribunal was told that in the ED setting there was a variation on how the usual practice for verbal orders is applied because the medical practitioners in ED are on site, compared to the wards where the nurses may need to ring the speciality team to get a verbal order over the telephone and another nurse listens on the phone and records it.³⁷

³⁴ ABOD, Tab 15 p 116.

³⁵ ABOD Tab 12, p 99

³⁶ Ms Y, Brief of Evidence, para 12.

³⁷ Ms R, Transcript p63, lines 14-21.

- [47] The practitioner said that when it came to sedation the verbal order was “more like a discussion between her and the SMO in ED”.³⁸ They would agree on the sedation plan and medications to be used. The document of medications administered was put on the Emergency Care Procedure Form, not on medication charts or one of the specific paediatric forms.³⁹ There were two other options for charting. Medications for sedation also require titration because it depends on the patient’s needs, their weight and response and estimate dosage, i.e. the length of the procedure. In the practitioner’s case she had only worked as an RN in emergency settings and not on the ward. She documented the medications administered but did not know the SMO prescriber name (prescriber or “pp”); that is, the prescription standards were not met.
- [48] In respect of both of these two patients, each had a sedation plan which was appropriate and there was a good outcome for both patients. The relevant Guideline did not specify that the supervision must be direct, that is the prescriber, usually an SMO, is in the room or nearby. The practitioner was credentialed to administer Ketamine sedation and that was a significant part of her role.
- [49] Against this, there was no documentation of the actual verbal order. There was a variation in the verbal orders in the ED, that is, the policy was not applied. The practice in another ED than this one, was to use an Emergency Care Procedure Form to record the verbal order. The medications the practitioner administered are considered high risk. As a senior nurse she recognised that she should have known that some form of documentation of the verbal order was required. The practitioner acknowledged that in respect of these two patients there was poor documentation.⁴⁰
- [50] There was also no evidence of supervision of the administration of Propofol and at the very least this aspect should have been documented, including who the practitioner had consulted. The responsibility for countersigning was on the prescriber, namely, the SMO, although the evidence was that sometimes the nurse has to initiate follow-up with the doctor to ensure that the verbal order is eventually signed off.
- [51] All of the above evidence and witnesses have been carefully considered by the Tribunal, and where relevant we consider each of the particulars of the Charge in relation to the treatment of Patient A and Patient B. Even though the practitioner has admitted some of these particulars, the Tribunal nonetheless must be satisfied that those admissions are appropriate, based on the evidence before us.
- [52] We turn to consider each of the ten particulars of the Charge in respect of Patients A and B.

³⁸ The practitioner’s statement of evidence, para 34 and Transcript, p 226, lines 15-22.

³⁹ ABOD, Tab 12, p 91.

⁴⁰ ABOD, Tab 25 Reflective Statement p 186

Treatment of Patient A

- [53] Patient A involves Particulars 1 – 6 of the Charge that are concerned with the prescription and administration of Propofol, Fentanyl and Ketamine to Patient A, accompanying documentation and false representation.
- [54] On [] 2017, Patient A, who was a 15 year old adolescent male with a fractured and displaced left distal tibia and fibula was admitted to [the Hospital] initially to the adult ED and then moved to [the children’s ED]. At 19.30 he was seen by the practitioner and another nurse completed the full nursing assessment, including observations. At 20.10 IV morphine was prescribed by a doctor and administered by the practitioner with another nurse. At 20.30 Fentanyl, Propofol and Ketamine were checked out of the Pyxis MedStation. At 20.55 Patient A was seen by the orthopaedic registrar and house surgeon. There was a treatment plan for a closed reduction in ED under sedation. At 21.00 the sedation commenced through to 21.10 and medications were given and documented on the Emergency Care Procedure Form.⁴¹

Particular 1 – Administration of Propofol

- [55] Particulars 1.1 and 1.2 are alleged in the alternative: The practitioner prescribed outside of her scope of practice as an RN by administering intravenous Propofol to Patient A without a prescription; or having obtained a verbal order from a medical practitioner failed to correctly document the verbal order.
- [56] Counsel for the PCC submitted that verbal orders are only given in the paediatric ED in rare circumstances.⁴² The position taken by the PCC was that the practitioner had not provided details of the verbal orders in the medical records because no verbal orders were in fact provided.
- [57] The use of Propofol in the [children’s ED] is considered very rare. CNS Ms R had never administered Propofol and Dr S described administering it only twice in the past 12 months.⁴³ No evidence was adduced from any anaesthetist to support the claim that Propofol should not be administered in ED. Dr S (Clinical Lead for emergency medicine) in her evidence did explain she would not tell a CNS to use Propofol if she was not going to be present, and she believed it would be most unlikely for other SMOs to do so. Despite this, Dr S confirmed under cross-examination from Ms Eglinton, counsel for the practitioner, that the clinical care of these patients was appropriate. Having looked at the discharge summary and the notes, she considered the sedation was adequate, effective and the outcome good.⁴⁴
- [58] Similarly, in terms of SMO supervision in relation to Patient A, there was no evidence from the SMOs that they did *not* supervise the practitioner. The Tribunal

⁴¹ ABOD, Tab 11, p 79.

⁴² Document 10, Closing submissions of the PCC, para 17.

⁴³ Brief of Evidence of Dr S, paragraph 7.

⁴⁴ Transcript of Evidence, p 26, lines 6-9.

is satisfied, on the balance of probabilities, taking into account the seriousness of the Charge and the practitioner's evidence, that the practitioner did have supervision and was provided with a verbal order.

- [59] Counsel for the practitioner submitted that on each occasion there were three other staff (two doctors and an RN) in addition to the practitioner, present in the resuscitation room, when the sedation and procedure were carried out. We accept that none of these staff raised any concerns with the sedation being carried out by the practitioner without an SMO in the room at the time or subsequently. Further we note that an orthopaedic registrar, Dr I, stated in an email that although he could not recall this patient, ED staff would refer the orthopaedic problem and ask for assistance in doing the reduction in which they would provide and over-see the sedation.⁴⁵
- [60] The Tribunal also accepts that the busyness of the ED is a factor. Dr S has said that SMOs would be less likely to carry out the sedation in the ED. From this we infer that in appropriate circumstances an SMO's preference would be to provide the practitioner with the necessary supervision and verbal order so that she could go ahead and administer the sedation.
- [61] In relation to the sub-Particulars relating to documentation, the practitioner has acknowledged that she did not document the name of the SMO and did not complete full documentation of the verbal orders, including charting the drug names and the SMO's name who ordered them. She has been consistent with her position on this. The practitioner documented the care and treatment she provided to Patients A and B, not all of such documentation was her responsibility as there were other RNs who were assigned to the patients.
- [62] The Tribunal finds that the practitioner did have a verbal order in relation to administration of Propofol to Patient A but there were aspects of her documentation where she did not adhere to the administration of medications procedure.
- [63] The prescribing and administration of medications procedures for verbal orders state that these are reserved for exceptional circumstances and they must be given by a prescriber familiar with the patient's current diagnosis and treatment.⁴⁶ However, as noted above, it appears to be common practice to use verbal orders in the ED even if it is not an emergency care situation. For procedural sedations, the doses are titrated according to the patient's weight and response, with the actual dose administered noted post-procedure. The Tribunal finds that the practitioner documented the dose and time and medication on the Emergency Care Procedure Form,⁴⁷ however, she did not document the route (intravenous – IV). All of these medications are

⁴⁵ ABOD, Tab 9, p 52 and p 67.

⁴⁶ ABOD, Tab 15, p 116 and ABOD Tab 16 p 124.

⁴⁷ ABOD, Tab 11, p 79.

administered intravenously and therefore the failure to not document the route is a minor omission.

[64] We have identified possible places where the verbal order should be documented. For example, the National Medication Chart where the morphine (pre-procedure opiate – pain relief) was documented.⁴⁸ In this medication chart there is provision for “once only” administration. The verbal order policy does not specify this “once only” notation and notes that after the person receives the verbal order:

Document the verbal order onto the required medium (i.e. Medication Chart or electronic platform). The entry for the verbal order must include:

- New or changed order including drug, dose time, route and/or original order crossed off when discontinued
- New medication – new entry
- Change medication – new entry and old entry discontinued and dated
- Medication discontinued – entry discontinued and dated
- Sign the name of the person receiving the verbal order
- For hard copy only (i.e. Medication Chart) write the acronym “pp” (per procurationem) plus the prescriber’s name.

[65] The Tribunal accepts the practitioner’s statement that she would have had a discussion prior to the procedure. In the clinical assessment she has noted:

D/W Autho Reg? for reduction in ED.⁴⁹

[66] The house surgeon, writing on behalf of the orthopaedic registrar, also noted in the acute assessment:

Under sedation in ED.

[67] There are, however, some unsatisfactory aspects of the practitioner’s documentation regarding Patient A. As accepted by her, she failed to document the name of the SMO who gave her the verbal order. The practitioner did note that she was the “sedating clinician” by signing her name [“e”] on the Clinical Care Assessment Form. However, she did not write the acronym “pp” plus the prescriber’s name.

⁴⁸ ABOD, Tab 11, pp 74 and 75.

⁴⁹ ABOD, Tab 11, p 68.

- [68] The practitioner's evidence was that RN Ms O witnessed the verbal order and checked the medication to be utilised from the Pyxis MedStation.⁵⁰
- [69] In relation to Particular 1 two of the five Particulars and sub-particulars have been established. When considered as a whole, we find that Patient A's safety was not compromised due to the gaps in the documentation. There was not strict adherence to the Procedure: Medication (Medicines) Administration and these documentation standards were lower than desirable. We accept Dr S' evidence that the sedation for this patient was adequate and effective, and the outcome was good.⁵¹
- [70] Sub-particulars 1.2.2 and 1.2.4 are established. Sub-particulars 1.2.1, 1.2.3 and 1.2.5 are not established.

Particular 2 – administration of Propofol without supervision

- [71] Particular 2 of the Charge is concerned with the allegation that the practitioner administered the Propofol to Patient A without the supervision of an SMO or failed to document the name of the SMO who supervised her administering Propofol to Patient A. The specific guidelines for Propofol state:

Should be performed in the resuscitation room due to the high risk of apnea.

Should only be given under the supervision of ED SMO.⁵²

- [72] It was submitted for the practitioner that she considered she was acting within scope because she administered the sedation medications with the indirect supervision and verbal order of an SMO. This is supported by the Guidelines for Propofol which does not specify that the supervision needs to be direct. The Tribunal was advised that apparently these Guidelines have now changed and they do now specify that direct supervision by the prescriber, usually an SMO, is required. No evidence was called from any of the adult SMOs who could have provided supervision in light of the fact that the practitioner could not remember from whom she obtained the verbal order. There is a note from a Dr N; she could not recall the shift or the incident in relation to Patient A.
- [73] The Guidelines for Propofol are silent on the nature of "supervision". Supervision has been interpreted as both direct and indirect by practitioners. "Direct supervision" is understood to mean the supervisor is in the room. "Indirect supervision" means that the supervisor is in the department and aware that the procedure is being undertaken. Ms Y, Clinical Nurse Director for Acute Care at [the Hospital], initially described this guideline was a "protocol", that is, a prescriptive requirement for supervision. However, she then accepted that it was only a "guideline" and therefore

⁵⁰ Document 9, Practitioner's Statement of Evidence, para 65.

⁵¹ Dr S, Transcript, p 26, lines 6-9

⁵² ABOD, p 25.

there would be some flexibility as to how it is interpreted by practitioners. Ms Y said:⁵³

Guideline – (means) how you go about doing this framework. This is what you should do but need to change it a little but according to the patient need. Use your clinical judgement.

[74] Ms R suggested that there had to be direct supervision, although she accepted that the written guideline on administration of Propofol is silent on whether supervision can be direct or indirect.⁵⁴

[75] We find that the supervision in the context of administering these IV medications in the ED can be direct or indirect and therefore this particular is not established. The practitioner accepts that she did not document the name of the SMO who supervised her administering Propofol to Patient A. While it may have been prudent to do so, there was no strict requirement to document the supervisor for the purpose of administering Propofol under these guidelines.

[76] Particular 2 is not established.

Particular 3 – Administration of Fentanyl

[77] Particular 3 is alleged in the alternative, either the practitioner administered intravenous Fentanyl to Patient A without a prescription (3.1), or, under a standing order but contrary to the purposes of the standing order (3.2) or, having obtained a verbal order failed to follow the correct procedures (3.3). For the reasons set out in Particular 1 above, we find that there was a verbal order for Fentanyl to be administered to Patient A.

[78] The PCC submitted that the practitioner had inferred in her Reflection on Practice that she believed she was acting under a “standing order” when administering Fentanyl.⁵⁵ The standing order relates to intra-nasal Fentanyl not IV Fentanyl.⁵⁶ The practitioner recognised that, although there is a standing order for Fentanyl, it does not cover using it for sedation and is, therefore outside the scope of the standing order.

[79] As Fentanyl is a controlled drug, the practitioner was required to have another RN to witness and obtain these medications from the Pyxis MedStation. In relation to Patient A, this was RN Ms O. While no evidence has been provided by this nurse that they did indeed witness the dispensing of the medication, there was no evidence to the contrary. The Tribunal accepts the submission for the practitioner that best practice would dictate that these RNs would not have witnessed and assisted with the

⁵³ Transcript, p 148, line 12.

⁵⁴ Transcript, p58, lines 20-24. Brief of Evidence, paras 12 and 16.

⁵⁵ Tab 11, Practitioner’s Reflection, p 185.

⁵⁶ ABOD, Tab 17, p 146.

removal of medications from Pyxis without seeing a medication chart with the medications charted or hearing (witnessing) the verbal order from the SMO.⁵⁷

[80] We accept the practitioner's explanation under cross-examination that she did administer Fentanyl under a verbal order.⁵⁸

[81] Sub-particulars 3.3.1, 3.3.3 and 3.3.5 are not established. Sub-particulars 3.3.2 and 3.3.4 are established.

Particular 4 - Ketamine

[82] In Particular 4 there is an identical allegation as to Particular 1; however, this aspect of the Charge involves the administration of Ketamine which the practitioner was credentialed to administer with a prescription and relied upon a verbal order.

[83] For the reasons set out in Particular 1, sub-particulars 4.2.2 and 4.2.4 are established. Sub-particulars 4.2.1, 4.2.3 and 4.2.5 are not established.

Particular 5 - documentation

[84] Particular 5 was concerned with failing to complete full and accurate documentation in Patient A's clinical notes. At the conclusion of the hearing, it was accepted by the PCC that the allegations of failure to document that Patient A had received intravenous morphine (5.3), failure to document Patient A's ASA score (5.5) and failure to complete an Emergency Care Assessment form (5.6), were incorrect as they were in fact documented.⁵⁹

[85] However, the Tribunal finds that the practitioner did not document specifically that she had administered Propofol or Fentanyl on the Acute Assessment page (Particulars 5.1 and 5.2), of her post-procedure notes.⁶⁰

[86] By way of explanation the practitioner stated that although she wrote "Ketamine sedation done" because she does a lot of Ketamine sedations, this was a mistake. She had meant to write "Procedural sedation done" to cover off all medications given. The practitioner accepted that she failed to document administration of these medications and these sub-particulars are proved. In relation to the allegation of lack of documentation at the foot of the Emergency Care procedures chart of Patient A's condition during and after the procedure (5.4), it was accepted by the practitioner that she did not tick "none" on this page.⁶¹ In explanation CNS Ms R said it was accepted that for completeness these boxes "should be ticked and checked 'none'". However,

⁵⁷ Closing submissions of counsel for the practitioner, para 21.2.

⁵⁸ Transcript, p196 line 27- p 197, line 1.

⁵⁹ Document 10, Closing submissions of the PCC, para 28.

⁶⁰ ABOD, Tab 11, p 63.

⁶¹ ABOD, Tab 11, p 79.

the procedure documentation showed that vital observations were documented and post-procedural documentation confirmed: “Ketamine sedation done. Pt stable throughout”.

- [87] Sub-particulars 5.1 and 5.2 are established. Sub-particulars 5.3, 5.4, 5.5 and 5.6 are not established.

Particular 6 – false representation

- [88] The PCC alleges that on [] 2017 the practitioner had signed as a Clinical Nurse Specialist (CNS) rather than a “CNS Intern” on the Clinical Assessment form.⁶² It was accepted, however, that these notes written on the computer self-populate the clinician’s name and title and cannot be amended.⁶³ This Particular is not established.

Patient B

- [89] Patient B involves Particulars 7- 10 and are concerned with the prescription of Propofol, Ketamine and accompanying documentation.

- [90] Patient B was an 11 year old girl who had fractured her left ankle. She was large and heavy for her age and she was also very tall. On [] 2017 Patient B had been referred directly to the orthopaedic team. At 17.30 she was seen by the practitioner and given paracetamol and ibuprofen under the standing order. At 18.50 she was seen by a play therapist. At 20.57 Ketamine was checked out from the Pyxis MedStation. At 21.20 to 21.45 the sedation was undertaken. At 21.55 the registrar’s notes confirm that there was a manipulation under sedation with Ketamine and Propofol. The practitioner recorded Patient B’s co-morbidities which had been established by looking up the electronic health record for further information.

- [91] As Patient B was referred directly to the orthopaedic service, it was the practitioner’s evidence that she did not see Patient B again until around 21.00 hours, some three and a half hours later when she was asked to perform the sedation by one of the SMOs on duty. They then discussed the type of sedation to be used. On the basis of a verbal order at 20.57 the practitioner took the Ketamine out of the Pyxis MedStation and administered Ketamine and Propofol at 21.20 hours and again at 21.35 hours. The closed reduction of Patient B’s left ankle was undertaken and she was discharged a few days later.

Particular 7 - Administration of Propofol

- [92] As with Patient A, the Tribunal finds that a verbal order for medication to be administered to Patient B was obtained under Sub-particular 7.2 but aspects of the

⁶² ABOD, Tab 11, pp 67 and 68.

⁶³ Ms R, Transcript, p 59, line 22.

documentation did not comply with the administration procedures described above. The practitioner completed the Emergency Care procedures form where the administration of Ketamine and Propofol is recorded and [“e”] is noted as the “sedating clinician”.⁶⁴

- [93] In Patient B’s case, the [children’s ED] booklet was used and at page 7 of that booklet is a “medication is documented”. The documented dose and time of medication but not the route (i.e. via IV) was once again recorded.
- [94] The Tribunal finds that the practitioner failed to document the name of the SMO who gave the verbal order (sub-particular 7.2.2) and to write the acronym “pp” (sub-particular 7.2.4). However, it is not accepted that she failed to document her name as a person receiving the verbal order under sub-particular 7.2.3 or that she failed to ensure a person witnessed the verbal order. As noted in the records, Nurse E was present during the procedure⁶⁵ and Nurse E was noted as witnessing the Ketamine removal from the Pyxis MedStation.⁶⁶
- [95] There is no documentation of the name of the SMO who gave the verbal order and the signing of the name. These aspects did not compromise Patient B’s clinical safety or fail to comply with accepted professional standards for verbal orders.
- [96] Sub-particulars 7.2.2 and 7.2.4 are established. Sub-particulars 7.2.1, 7.2.3 and 7.2.5 are not established.

Particular 8 – Administration of Propofol without supervision

- [97] Although it has been accepted by the practitioner that she did not document evidence of the SMO who prescribed the Propofol, the Tribunal accepts that it was again a situation of indirect supervision, namely that there had been a discussion between the practitioner and the unidentified prescriber but those details had not been documented in the clinical notes. It is noted that “Ms H” an orthopaedic registrar undertaking the procedure and Dr K, house surgeon confirm in the notes that “manipulation plus cast under Ketamine and Propofol”.⁶⁷ This Particular is not established. There is in fact no expectation or requirement to record the supervision by the prescriber in those guidelines.

⁶⁴ ABOD, p 95.

⁶⁵ ABOD, p 95.

⁶⁶ ABOD, p 101.

⁶⁷ ABOD, pp 94 and 95.

Particular 9 – Administration of Ketamine

[98] Once again the Emergency Care procedure form was used, not the medication chart and the practitioner noted herself as being the “sedating clinician” (Sub-particulars 9.2.1 and 9.2.3).

[99] The Ketamine prescribed for Patient B was documented in the Emergency Care procedure form but was not put on the medication chart and the name of the SMO who gave the verbal order was not documented and she failed to write the acronym “pp” (sub-particulars 9.2.2 and 9.2.4). The Tribunal accepts that the practitioner had a person, RN Ms E, witness the verbal order, when the Ketamine was released from the Pyxis MedStation.

[100] Sub-particulars 9.2.2 and 9.2.4 are established. Sub-particulars 9.2.1, 9.2.3 and 9.2.5 are not established.

Particular 10 – Documentation

[101] It is alleged that the practitioner failed to complete full and accurate documentation in Patient B’s clinical notes. The Tribunal finds that none of these sub-particulars are established and the Emergency Care booklet used for paediatric patients post-care did have some documentation.⁶⁸ Again the booklet that was used is a form of “clinical notes” and the use of Propofol and Ketamine was in fact documented.⁶⁹ While the practitioner did not complete the Emergency Care Assessment form for Patient B she was not assigned as the RN and it is accepted that it was not her role at that point in time to complete the post-procedural notes.⁷⁰

[102] Particular 10 is not established.

Decision - liability

[103] The Tribunal has carefully considered the evidence of the witnesses called by the PCC and that of the practitioner in relation to this Charge. The practitioner is an experienced paediatric nurse and at the time was working in advanced practice as an Intern CNS. The Tribunal has found her to be a reliable and credible witness and to have made consistent statements about those matters she can recall and generally her practice in undertaking sedation procedures.

[104] The practitioner has accepted that there were aspects of her practice that were below professional standards. She has reflected upon these in her document entitled “Recollection of the Incidents and Summary of Events that Followed” written by her

⁶⁸ ABOD, pp 90, 91 and 93.

⁶⁹ ABOD, p 95.

⁷⁰ Document 9, Brief of Evidence of practitioner, para 98.

in approximately [] 2017, some six months after Patient A and approximately three months after Patient B, and without the benefit of the clinical notes to refresh her memory. In relation to Patient B, for example, The practitioner noted:

I am myself disappointed at the sedation record for this patient as it is incomplete and I know that my standards are normally high especially when completing the sedation record. I also noted that there was not a single note from the ED nurse through the PT notes in 8 hours of being in the Department. There was also no sedation note written by myself. When I reviewed my other PT notes from this day I had been involved in other procedural sedations and I wrote a procedure and/or sedation note. Therefore, I find it unusual that I did not for this patient.⁷¹

[105] The Tribunal considers that it is an important part of ongoing professional education that RNs complete these statements and reflect on their practice. Practitioners should be encouraged to give an open and honest account of the events and their experiences and to learn from them to improve their future practice.

[106] The practitioner, as a registered nurse, is responsible for her practice and adhering to professional standards and policies. That said, her orientation as an intern CNS to [the children's ED] was less than ideal. As can be expected, this ED is a busy department.⁷² Dr S, the Clinical Lead for this ED accepted that while she and the practitioner had had two meetings at the practitioner's request, there had not been as much mentoring as Dr S would have been liked.

[107] There is one Charge before the Tribunal with 10 Particulars. In summary, in relation to Patient A, the particulars (and sub-particulars) that are established are: 1.2.2, 1.2.4, 3.3.2, 3.3.4, 4.2.2, 4.2.4, 5.1 and 5.2. In relation to Patient B, the following particulars (and sub-particulars) are established: 7.2.2, 7.2.4, 9.2.2 and 9.2.4.

[108] The Tribunal is satisfied that when these proven parts of the Charge are considered cumulatively, and on the balance of probabilities, the practitioner's conduct constitutes negligence. This conduct amounts to professional misconduct under s 100(1)(a) of the Act. The practitioner has departed from the acceptable standard required of a registered nurse as she failed to adequately document the administration of Propofol, Ketamine and Fentanyl to Patient A and Propofol and Ketamine to Patient B. In respect of each patient, having obtained a verbal order from a medical practitioner (here, an SMO), the practitioner failed to follow the DHB's documentation procedures, namely the Procedure: Medication (Medicines) Administration Policy.

⁷¹ Practitioner's reflection, Tab 25 p 187.

⁷² Document 4, Newshub, July 2017 "Emergency departments at breaking point".

Is a disciplinary sanction required?

[109] The determination of professional misconduct requires the Tribunal to apply a two-stage test. In addition to finding the Charge (and particulars) established, the Tribunal is required to determine whether the conduct is sufficiently serious to warrant a disciplinary sanction for the protection of the public, maintaining professional standards, or punishing the practitioner. When identifying the threshold for disciplinary sanction, the Tribunal recognises that this assessment is one of degree. As Moore J observed in *Johns*:⁷³

..given the wider range of conduct which might attract sanction in this jurisdiction the threshold should not set (sic) unduly high. It is a threshold to be reached with care having regard to the purposes of the Act and the implications for the practitioner.

[110] The correct keeping of comprehensive notes by a nurse is an important aspect of protecting the public by maintaining professional standards. In *PCC v Tunnicliff*,⁷⁴ for example, Ms Tunnicliff was a specialty clinical nurse who failed to document the appropriate clinical records with regard to consultations she had had with a total of 87 patients, in some cases more than once. Ms Tunnicliff was found to have placed patients at risk by failing to refer patient concerns appropriately. In that case the charges were established and the professional misconduct being malpractice or negligence was likely to bring discredit to the nursing profession. A disciplinary sanction was called for on the basis that there was no documentation at all and there were so many lapses over such a long period and that does impact on the standards of the nursing profession and does place the public at risk.⁷⁵

[111] The facts of this case can be distinguished from *Tunnicliff*. The practitioner did complete documentation of the sedation procedures but failed to adequately document the verbal orders and was in breach of the professional standards required of her. Notwithstanding the potential for harm to patients through inadequate record-keeping of clinical notes, the gaps in documentation did not compromise the clinical safety of these patients.

[112] In the *Director of Proceedings v Vatsyayann*,⁷⁶ Gilbert J dismissed the Director's appeal in respect of the Tribunal's finding that the practitioner's failure to adequately document the care of his patient, Ms L, did not warrant disciplinary sanction despite the findings of his failure to follow up with Ms L's signs of pathology. The High Court considered the correct approach when considering an omnibus charge (when separate charges are considered cumulatively). In these circumstances, the Tribunal is required to make separate findings on the evidence in relation to each charge. The

⁷³ *Johns v Director of Proceedings* [2017] NZHC 2843, Moore J at [82]-[83] citing *Martin v Director of Proceedings* [2010] NZAR 333(HC Auckland) per Courtney J.

⁷⁴ 570/Nur13/248P.

⁷⁵ *Tunnicliff* at [39] and amounted to misconduct being malpractice or negligence likely to bring the nursing profession into discredit

⁷⁶ [2012] NZHC 2588.

separate charges (or in this case, the particulars and sub-particulars of each charge) should then be considered cumulatively as to whether they constitute professional misconduct warranting disciplinary sanction.⁷⁷

[113] The Tribunal finds that some of the particulars (and sub-particulars) of the Charge are established and that cumulatively the practitioner's conduct has fallen short of the conduct expected of a reasonably competent registered nurse. In respect of the second step of our assessment however, we are not satisfied that the gravity of the conduct in the circumstances of this case warrants disciplinary sanction for the purposes of protection of the public and monitoring professional standards. To impose a penalty on this practitioner would be a disproportionate response to the seriousness of the conduct in question. Therefore, no penalty will be applied.

Permanent name suppression

[114] At the conclusion of the hearing counsel for the practitioner made an oral application for permanent suppression of the practitioner's name and any identifying details.⁷⁸ That application was initially opposed by counsel for the PCC. Ms de Montalk submitted that if the practitioner is granted permanent name suppression then this would mean that other nurses working in [the children's ED] would have their names impugned.

[115] The Tribunal reserved its decision in respect of this application and subsequently requested that further information be provided by the practitioner in respect of her private interests so that the Tribunal could consider both the private and the public interests before deciding whether it is desirable for the Tribunal to make a permanent order under s 95 of the Act.⁷⁹ A written application and supporting affidavit evidence and submissions were then filed by the parties. Counsel for the PCC subsequently filed a memorandum advising that having considered the practitioner's written application, including her affidavit and supporting documents that the PCC would abide the decision of the Tribunal.

[116] In her affidavit and submissions on her behalf the practitioner raised a number of grounds in support of an order for permanent name suppression.⁸⁰ These included: firstly, damage to her reputation. The practitioner says her reputation as an individual, [providing a particular voluntary service in the community] and a nurse will likely be damaged because of where she lives and the likelihood of rumours and innuendo spreading quickly throughout the community.

⁷⁷ *The Director of Proceedings v Vatsyayann* [2012] NZHC 2588 per Gilbert J at [34] and [38].

⁷⁸ An interim order for non-publication of name and identifying details was made in Minute of the Chair Maria Dew QC dated 26 March 2019.

⁷⁹ Minute of the Chair A Douglass dated 30 August 2019.

⁸⁰ Affidavit of practitioner dated 20 September 2019.

[117] Secondly, the publication of the decision would adversely affect the therapeutic relationship that she has with her patients and their caregivers. Where she works at a hospital there are [patients] who are admitted for a few weeks. During this time as a nurse she does a lot of teaching to the [patients] about caring for []. The practitioner is concerned that if her name was released this important trusting relationship would be damaged and therefore she would not be able to fully carry out day-to-day duties. In support of this ground, the practitioner's current clinical nurse manager provided a letter to the Tribunal setting out her concerns around building trust with patients and their families if the practitioner's name is published. It was further stated that as a senior nurse in the department publication of her name may impinge upon junior nurses working with her who often approach her for advice and assistance with their patients, as well as the staff she teaches at an interdepartmental level.

[118] Finally, the practitioner stated that publication would adversely affect her employment with a professional education group and a community organisation in which she [provides a voluntary service]. In support of this concern, the Chairman of the organisation she provided education for provided a letter confirming that publication could impact on the practitioner's capacity to continue working in this important professional educational role.

[119] A letter was provided by the community organisation, confirming that publication of the practitioner's name could mean that her position as a volunteer could also be put in jeopardy.

[120] All these letters filed in support were highly complementary of the practitioner's professionalism in her various roles and her commitment to the nursing profession.

[121] Counsel for the practitioner submitted that the private interests outweigh the public interest considerations and therefore it is in the interests of justice and "desirable" for an order permanently suppressing the practitioner's name and other identifying details to be granted.

[122] Counsel for the practitioner submitted that there was no evidence of impugning other nurses. The PCC had previously had the opportunity to provide such evidence with its reply to the practitioner's application. The events in question occurred more than two years ago and at the time, the only other CNS intern who was working in the ED Department was on maternity leave. It was therefore unlikely that her reputation would be affected by suspicion. Importantly, this was a case where no-one was harmed and the practitioner had not received a penalty and is able to continue practising.

Discussion

[123] Section 95 of the HPCA Act provides:

95. Hearings to be in public unless Tribunal orders otherwise

- (1) Every hearing of the Tribunal must be held in public unless the Tribunal orders otherwise under this section or unless section 97 applies.
- (2) If, after having regard to the interests of any person (including, without limitation, the privacy of any complainant) and to the public interest, the Tribunal is satisfied that it is desirable to do so, it may (on application by any of the parties or on its own initiative) make any 1 or more of the following orders:
 - ...
 - (d) an order prohibiting the publication of the name, or any particulars of the affairs, of any person.

[124] The starting point in s 95(1) of the Act is that the Tribunal’s hearing must be held in public. This is the primary principle and endorses the principle of open justice. Section 95(2), however, gives the Tribunal discretion to grant name suppression where it is “desirable”. The public interest factors to be considered by the Tribunal, have been set out in a number of decisions and these include:⁸¹

1. Openness, transparency and accountability of the disciplinary process;
2. Protection of the public;
3. Maintenance of professional standards;
4. Public interest in knowing the identity of a health practitioner charged with a disciplinary offence;
5. Importance of freedom of speech and the rights enshrined in s 114 of the New Zealand Bill of Rights Act;
6. Unfairly impugning other practitioners’ reputations being affected by suspicion.

[125] In any application under s 95 of the Act for an order for non-publication of the name or identifying details there must first be consideration of whether it is desirable for the order to be made, and secondly, an exercise of discretion as to whether the order should be made. The above public interest factors are to be balanced against the private interests of the practitioner and the interests of her patients and their caregivers.

⁸¹ *Johns v Director of Proceedings* [2017] NZHC 2843, Moore J at [177] and *B v B* HC Auckland HC 4/92, 6 April 1993 at [99].

- [126] The threshold under s 95 also invokes a considerably lower threshold than the usual civil test. The “desirable” test involves a lower threshold than the “exceptional” test commonly used by the courts.⁸²
- [127] Every decision of the Tribunal will necessarily be case and fact dependent requiring the weighting of the public interest and the particular interests of any person in the context of the facts of the case under review. Non-publication of a practitioner’s name has been declined in some cases despite the charge not having been established.⁸³ In other cases, the Tribunal has granted permanent name suppression where a charge has been dismissed, although there were failures but not sufficiently below the standard to warrant disciplinary sanction.⁸⁴
- [128] The Tribunal is satisfied that the protection or promotion of the public good – the “public weal” – as Moore J put it in *Johns*,⁸⁵ will be better served by granting name suppression to this practitioner. The practitioner’s private interests outweigh the public interest in knowing the identity of the practitioner. In addressing the public interest factors, publication of the Tribunal’s decision, excluding the practitioner’s name and identifying details, meets the public interest in accountability of the disciplinary process and the openness and transparency of disciplinary proceedings.
- [129] The Tribunal has taken into account that there was no harm to Patients A and B. The seriousness of the professional misconduct has not warranted disciplinary sanction.⁸⁶
- [130] The Tribunal considers that the reputational prejudice to the practitioner outweighs the requirements for open justice. In the Tribunal’s view, the public interest will be better served by allowing this practitioner to continue with her professional practice and develop her career with the confidence of the professionals, patients and the public. The practitioner undoubtedly is making a valuable contribution to the nursing profession. The Tribunal acknowledges that the practitioner has received the full support of her current employer and a senior medical colleague. She also has the support from the professional and volunteer bodies with whom she works as an RN.
- [131] Accordingly, there will be an order for non-publication of the name and identifying details of the practitioner, the names of the various organisations who have supported this application and the location of this practitioner’s current employer and location.
- [132] Pursuant to section 157 of the Act and subject to the suppression orders made above, the Tribunal directs the Executive Officer to publish this decision and a summary, on the Tribunal’s website. The Tribunal also directs the Executive Officer to request the Nursing Council of New Zealand to publish either a

⁸² Ibid *Johns* at [164]-[166].

⁸³ *Scherp* 532/Mid12/221D and *Merilos* 212/Nur08/111D.

⁸⁴ *Dr M* 840/Den15/337P.

⁸⁵ *Johns* at [177].

⁸⁶ *Johns* at [226].

summary of, or a reference to, the Tribunal's decisions in its principal professional publications to members, in either case including a reference to the Tribunal's website so as to enable interested parties to access the decision.

DATED at Wellington this 7th day of November 2019

A handwritten signature in blue ink, appearing to read 'A Douglass', written in a cursive style.

.....
A Douglass
Chair
Health Practitioners Disciplinary Tribunal

SCHEDULE**PARTICULARS OF CHARGE**

Pursuant to section 91 of the Act, the Committee laid the following charges against Ms H.

Patient A

Propofol

1.0 That on or about [] 2017 while employed as a registered nurse and Clinical Nurse Specialist Intern for [the DHB] at [the Hospital's] [children's ED], The practitioner compromised the safety of Patient A in that she:

1.1 either practised outside her scope of practice as a registered nurse by administering intravenous Propofol to Patient A without a prescription; or

1.2 having obtained a verbal order from a medical practitioner for Propofol, failed to follow the Procedure: Medication (Medicines) Administration Policy of [the DHB] relating to verbal orders for medications. In particular:

1.2.1 The practitioner failed to document the verbal order onto the required medium (the medication chart) including the drug, dose time, and route; and/or

1.2.2 The practitioner failed to document the name of the SMO who gave the verbal order;

1.2.3 The practitioner failed to document/sign her name as the person receiving the verbal order; and/or

1.2.4 The practitioner failed to write the acronym 'pp' plus the prescriber's name; and/or

1.2.5 The practitioner failed to ensure a person witnessed the verbal order.

2.0 That on or about [] 2017 while employed as a registered nurse and Clinical Nurse Specialist Intern for [the DHB] at [the Hospital's] [children's ED], The practitioner compromised the safety of Patient A in that she:

2.1 either administered Propofol to Patient A without the supervision of a Senior Medical Officer ('SMO'); or

2.2 failed to document the name of the SMO who supervised her administering Propofol to Patient A.

Fentanyl

3.0 That on or about [] 2017 while employed as a registered nurse and Clinical Nurse Specialist Intern for [the DHB] at [the Hospital's] [children's ED], The Nurse compromised the safety of Patient A in that she:

- 3.1 either administered intravenous Fentanyl to Patient A without a prescription; or
- 3.2 administered Fentanyl to Patient A under a standing order but contrary to the purpose of the standing order; or
- 3.3 having obtained a verbal order from a medical practitioner for Fentanyl, The practitioner failed to follow the Procedure: Medication (Medicines) Administration Policy of [the DHB] relating to verbal orders for medications.

In particular:

- 3.3.1 The practitioner failed to document the verbal order onto the required medium (the medication chart) including the drug, dose time, and route; and/or
- 3.3.2 The practitioner failed to document the name of the person who gave the verbal order;
- 3.3.3 The practitioner failed to document/sign her name as the person receiving the verbal order; and/or
- 3.3.4 The practitioner failed to write the acronym 'pp' plus the prescriber's name; and/or
- 3.3.5 The practitioner failed to ensure a person witnessed the verbal order.

Ketamine

4.0 That on or about [] 2017 while employed as a registered nurse and Clinical Nurse Specialist Intern for [the DHB] at [the Hospital's] [children's ED], The practitioner compromised the safety of Patient A in that she:

- 4.1 either practised outside her scope of practice as a registered nurse by administering intravenous Ketamine to Patient A without a prescription; or
- 4.2 having obtained a verbal order from a medical practitioner for Ketamine, The practitioner failed to follow the Procedure: Medication (Medicines) Administration Policy of [the DHB] relating to verbal orders for medications.

In particular:

- 4.2.1 The practitioner failed to document the verbal order onto the required medium (the medication chart) including the drug, dose time, and route; and/or
- 4.2.2 The practitioner failed to document the name of the person who gave the verbal order;
- 4.2.3 The practitioner failed to document/sign her name as the person receiving the verbal order; and/or
- 4.2.4 The practitioner failed to write the acronym 'pp' plus the prescriber's name; and/or
- 4.2.5 The practitioner failed to ensure a person witnessed the verbal order.

Documentation

5.0 That on or about [] 2017 while employed as a registered nurse and Clinical Nurse Specialist Intern for [the DHB] at [the Hospital's] [children's ED], The practitioner compromised the safety of Patient A by failing to complete full and accurate documentation in Patient A's clinical notes. In particular:

- 5.1 The practitioner failed to document on the Acute Assessment page of Patient A's clinical notes that they had received intravenous Propofol;
- 5.2 The practitioner failed to document on the Acute Assessment page of Patient A's clinical notes that they had received intravenous Fentanyl;
- 5.3 The practitioner failed to document on the Acute Assessment page of Patient A's clinical notes that they had received intravenous Morphine; and/or
- 5.4 The practitioner failed to document at the foot of the Emergency Care procedures chart Patient A's condition during and after the procedure; and/or
- 5.5 The practitioner failed to document Patient A's ASA score; and/or
- 5.6 The practitioner failed to complete an Emergency Care Assessment form for Patient A.

False representation

6.0 That on [] 2017 The practitioner falsely represented herself as a Clinical Nurse Specialist by signing Patient A's Clinical Assessment form as "The practitioner (CNS) (Clinical Nurse Specialist)" when she knew or ought to have known that she was a Clinical Nurse Specialist Intern.

Patient B*Propofol*

- 7.0 That on or about [] 2017 while employed as a registered nurse and Clinical Nurse Specialist Intern for [the DHB] at [the Hospital's] [children's ED], The practitioner compromised the safety of Patient B in that she:
- 7.1 either administered intravenous Propofol to Patient B without a prescription; or
 - 7.2 having obtained a verbal order from a medical practitioner for Propofol, failed to follow the Procedure: Medication (Medicines) Administration Policy of [the DHB] relating to verbal orders for medications. In particular:
 - 7.2.1 The practitioner failed to document the verbal order onto the required medium (the medication chart) including the drug, dose time, and route; and/or
 - 7.2.2 The practitioner failed to document the name of the SMO who gave the verbal order;
 - 7.2.3 The practitioner failed to document/sign her name as the person receiving the verbal order; and/or
 - 7.2.4 The practitioner failed to write the acronym 'pp' plus the prescriber's name; and/or
 - 7.2.5 The practitioner failed to ensure a person witnessed the verbal order.
- 8.0 That on or about [] 2017 while employed as a registered nurse and Clinical Nurse Specialist Intern for [the DHB] at [the hospital's] [children's ED], The practitioner compromised the safety of Patient B in that she:
- 8.1 either administered Propofol to Patient B without the supervision of an SMO; or
 - 8.2 failed to document the name of the SMO who supervised her administering Propofol to Patient B.

Ketamine

- 9.0 That on or about [] 2017 while employed as a registered nurse and Clinical Nurse Specialist Intern for [the DHB] at [the Hospital's] [children's ED], The practitioner compromised the safety of Patient B in that she:
- 9.1 either administered intravenous Ketamine to Patient B without a prescription; or

- 9.2 having obtained a verbal order from a medical practitioner for Ketamine, The practitioner failed to follow the Procedure: Medication (Medicines) Administration Policy of [the DHB] relating to verbal orders for medications. In particular:
- 9.2.1 The practitioner failed to document the verbal order onto the required medium (the medication chart) including the drug, dose time, and route; and/or
 - 9.2.2 The practitioner failed to document the name of the SMO who gave the verbal order;
 - 9.2.3 The practitioner failed to document/sign her name as the person receiving the verbal order; and/or
 - 9.2.4 The practitioner failed to write the acronym 'pp' plus the prescriber's name; and/or
 - 9.2.5 The practitioner failed to ensure a person witnessed the verbal order.

Documentation

- 10.0 That on or about [] 2017 while employed as a registered nurse and Clinical Nurse Specialist Intern for [the DHB] at [the Hospital's] [children's ED], The practitioner compromised the safety of Patient B by failing to complete full and accurate documentation in Patient B's clinical notes. In particular:
- 10.1 The practitioner failed to make an entry in Patient B's clinical notes;
 - 10.2 The practitioner failed to document in the clinical notes that Patient B had received Propofol;
 - 10.3 The practitioner failed to document in the clinical notes that Patient B had received Ketamine;
 - 10.4 The practitioner failed to complete an Emergency Care Assessment form for Patient B.

The conduct alleged in Charges 1.0 to 10.0 amounts to professional misconduct pursuant to section 100(1)(a) or (b) of the Act and particulars 1.1 to 1.2; 2.1 to 2.2; 3.1 to 3.3; 4.1 to 4.2; 5.1 to 5.6; 7.1 to 7.2; 8.1 to 8.2; 9.1 to 9.2 and 10.1 to 10.4 either separately or cumulatively, are particulars of that professional misconduct.”