NEW ZEALAND HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL
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BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

HPDT NO	**1121/Nur18/429P**
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 E** of X, registered nurse **Practitioner**

HEARING held at Auckland on 29 June 2020 to 10 July 2020

TRIBUNAL	Ms M Dew QC (Chair) Ms D Fenton, Mr N Davis, Mr M McIlhone and Ms C Cooney (Members) Ms D Gainey (Executive Officer) Ms J Kennedy (Stenographer)
APPEARANCES	Mr M McClelland QC and Ms H de Montalk for the PCC Ms B Johns and Ms S Eglinton for the Practitioner

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DECISION OF THE TRIBUNAL

17 November 2020

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Introduction

[1] On 6 November 2018, the Professional Conduct Committee ("PCC") of the Nursing Council of New Zealand laid a charge of professional misconduct under the Health Practitioners Competence Assurance Act 2003 ("Act") against Ms E, a registered nurse of Auckland ("Practitioner").

[2] On 14 May 2019, an amended Notice of Charge ("Charge") comprising seven particulars ("Particulars") was laid.

[3] The Charge relates to Ms E's employment by the Auckland District Health Board ("ADHB") as a staff nurse at Starship Children's Health ("Starship Hospital") in the period [ ] 2016.

[4] The PCC alleges that on various occasions during that period the Practitioner failed to carry out patient observations, failed to administer medication, made incorrect or false entries in clinical records and engaged in other unprofessional conduct when being assigned patients by a Shift Coordinator. The Practitioner denies the Charge and each of the Particulars.

[5] The matter proceeded by way of a defended hearing, which ran for ten sitting days. The hearing was initially set down for May 2019 but was postponed several times at the Practitioner's request due to her health. A number of applications by the Practitioner were also dealt with by the Tribunal during the course of 2019 and into 2020, regarding the composition of the Tribunal, admissibility of evidence and a challenge to Particulars.

[6] At the hearing the parties produced an Agreed Bundle of Documents containing the clinical notes for patients relevant to the Charge, correspondence and notes of meetings between the Practitioner and the ADHB during the course of her employment, and other contemporaneous documents.

[7] The Tribunal also heard or received evidence from 15 witnesses (including the Practitioner).

The Charge

[8] In summary, the Charge alleges that on various night shifts in [ ] 2016, the following professional misconduct occurred:

(a) Particular 1 – A [teenage] female patient with asthma (Patient S). During the night shift on [ ] 2016, on the General Paediatrics ward, the Practitioner failed to give 1 to 2 hourly spacers of Salbutamol and documented that observations had been completed and spacers had been administered when they had not.

(b) Particular 2 – During the night shift on [ ] 2016, the Practitioner failed to carry out observations on four unnamed patients assigned to her care and/or documented these observations when she had not.

(c) Particular 3 – A [young] male child (Patient A) with pneumonia - During the night shift on [ ] 2016, failed to carry out observations and/or administer oral antibiotic medication and/or documented four hourly observations and administration of oral antibiotics medication, on the patient when she had not.

(d) Particular 4 – On [ ] 2016, when pooled to the Paediatric Surgery ward, acted in an inappropriate and/or unprofessional manner by refusing or failing to take two booked adolescent patients who had been assigned to her for that shift.

(e) Particular 5 – was withdrawn by the PCC prior to the hearing;

(f) Particular 7 – A [young child] female patient with bronchopneumonia (Patient N). During the night shift on [ ] 2016, failed to carry out observations and/or documented three full PEWS observations on the child between 5.15am and 5.45am, when they could not have been done at those times and changed the time of the three PEWS observations to between 4.15am and 4.45am, when they had not been done.

(g) Particulars 6 and 8 - An [baby] female patient with bronchopneumonia (Patient U). During the night shift on [ ] 2016, failed to carry out observations, administer medications and documented observations and medications when they had not been completed. This Particular also alleges that the Practitioner countersigned the administration of intravenous antibiotics by using the signature of another registered nurse, when this had not occurred.

Background Facts

[9] The Practitioner completed a Bachelor of Nursing degree at [ ] in [ ] and became a registered nurse. Her first role was as a graduate nurse at Starship Hospital in [ ] where she progressed to PDRP level 2 within 18 months. In the main, the Practitioner worked on the [ ] Wards [ ] and was sometimes pooled to other wards. She worked night shifts from [ ] onwards.

[10] The Practitioner worked at Starship Hospital on both a part-time and full-time basis over a period of [ ] years until her dismissal in [ ]. Since then, the Practitioner has worked for several aged care providers in caregiver and registered nursing roles in Auckland.

[11] In 2016, the relevant wards at Starship Hospital had [ ] beds,[ ]on the A side and [ ] on the B side. Most beds were in single rooms with some double rooms on the A side. There was a single nurses' station shared by both sides of Ward X where patient records, including drug charts, were kept. The medication room was next door to the nurses' station.

[12] Ward [X] had a Charge Nurse (who worked Monday to Friday on day shifts), whose office was on the B side. The Charge Nurse allocated one registered nurse to be the coordinator for each side of the ward on each night shift. The Shift Coordinator's responsibilities included liaising with the duty manager, allocating beds and reviewing sick patients. Generally, the Coordinator on side B was the main coordinator in charge with responsibility for all staffing and handovers over the whole of Ward [X].

[13] At the end of each shift, the nurses handed over the care of each of their allocated patients to the nurses assigned to those patients for the next shift. This involved going through the patient notes and charts, the observations done during the shift and the medications administered.

[14] In [ ] 2016, two parents of patients raised concerns with the ADHB about the Practitioner's care of their children. The ADHB also received two staff complaints regarding the Practitioner's communication and concerns from two nursing colleagues regarding the Practitioner's nursing practice.

[15] The events to which the Charge relates are all on night shifts over a five and a half week period, between [ ] 2016.

[16] In [ ] 2016, the ADHB notified the Practitioner about the complaints it had received and began a disciplinary investigation. That employment investigation ran until [ ] 2016. In [ ], the Practitioner's employment was terminated as a result of the employment investigation.

[17] On 17 January 2017, the ADHB reported the termination of the Practitioner's employment to the Nursing Council and provided its disciplinary investigation decision. The PCC conducted its own investigation over 2017 and 2018. In November 2018, the Notice of Charge was first laid before the Tribunal.

PCC evidence

[18] The PCC called ten witnesses including:

(a) Seven Registered Nurses (RNs) who had worked with the Practitioner on the relevant night shifts;

(b) Two mothers of the patients, Ms A and Ms U, who had both been at Starship Hospital on the ward over the course of two different night shifts and both raised concerns about the Practitioner's care of their children; and

(c) Dr [W], a doctor who had been on the [ ] 2016 night shift with the Practitioner.

[19] RN N has worked at Starship Hospital since 2012 (except for one year working in Christchurch). RN N had been working on Ward [X] for four years at the time of the relevant events. Her evidence related to Particulars 1 and 2 as she was working alongside the Practitioner on the night shifts on [ ] and [ ] 2016 and was also the Shift Coordinator on the shifts. RN N's evidence was that, over the course of both night shifts, she had not seen the Practitioner leave the nurses' station for any period sufficient to attend to her patients. Her evidence was that the Practitioner had remained at the back of the nurses' station working on the computer throughout the shifts and as a result she must have recorded observations and medication in her patient records which had not been completed.

[20] RN N gave evidence that she did not see Dr [W] visit the ward on the two extra occasions that the Practitioner alleged on the [ ] night shift. Her evidence

was that this would have been highly unusual unless there was an emergency, which there had not been.

[21] RN R started working as a nurse in 2014 and worked at Starship Hospital between January 2016 and August 2018. RN R gave evidence in relation to Particulars 1 and 2, as she had also worked alongside the Practitioner on the relevant shifts. RN R supported the evidence of RN N and that she had seen the Practitioner sitting at the back of the nurses' station on the computer for most of the night on both of the relevant night shifts [ ] and [ ]. RN R also confirms that she did not see Dr [W] return to the ward during the night shift on [ ] 2016, as reported and recorded by the Practitioner.

[22] Dr [W] works as a [ ] at the ADHB, Starship Hospital. On the night shift on [ ] 2016, she was the Starship Hospital on-call House Officer for the whole of the hospital. She gave evidence regarding Particular 1 relating to the [teenage] patient, Patient S. Dr [W] was initially called to Ward [X] by the afternoon nurse Shift Coordinator to review Patient S sometime between 11pm and 12pm and charted Salbutamol (via spacer) for the patient to be weaned out from one to two hourly intervals by the nurses. Dr [W] says it is unlikely that she returned on further occasions over the course of that night shift, as this would have indicated a high level of concern with the patient which would have been recorded in the patient notes.

[23] RN T (nee [ ]) works at Starship Hospital. She is currently the Charge Nurse for Ward [Y] at Starship Hospital. In 2016, she had been working as a registered nurse at the ADHB for some five years. She had also been the Acting Charge Nurse at times and worked on Ward [X] for about four and a half years in total at the relevant time. She gave evidence regarding several of the Particulars, including:

(a) Particular 3 - the Practitioner handed over patient A to RN T at the end of the Practitioner's shift on [ ] 2016. RN T confirmed that the patient notes handed over from the Practitioner had recorded observations and oral antibiotics given over the night shift as charted. However, when she spoke with the patient's mother that morning, the mother told her that no observations or oral antibiotics had been given to her son over the night shift as she had been with him all night.

(b) Particular 7 - RN T worked alongside the Practitioner on the shift related to patient N on [ ] 2016. RN T noted that the Practitioner had recorded three full PEWS observations completed in the patient records. On the morning of [ ] at about 4.45am, the Practitioner asked her to sign her clinical care review with the times for observations recorded as 5.15am, 5.30am and 5.45am. This error was noted by RN T at the time. The Practitioner then suggested she got the hour wrong and that the PEWs were all completed an hour earlier. However, RN T recalls at the time being certain she would have seen the Practitioner leaving the nurses station at 15minute intervals between 4.15am and 4.45am, if that had occurred.

(c) Particulars 6 and 8: RN T worked the day shifts prior to and following the Practitioner's shift and cared for the patient U on those shifts on [ ] 2016. On the morning of [ ] 2016, RN T spoke with the patient's mother, the mother was concerned that the observations and IV medication had not been given to her daughter over the night shift as charted by the Practitioner. The mother also told her that she had not refused observations being taken at 9pm as recorded in the clinical notes by the Practitioner. RN T then took a note of the mother's concerns dated [ ] 2016 which was presented to the Tribunal.[1]

[24] RN P has worked at Starship Hospital for 32 years. She works as a Senior Staff Nurse on Ward [Y] at Starship Hospital, in the [Ward Y]. RN P gave evidence relating to Particular 4 and the alleged unprofessional conduct by the Practitioner in refusing to assist on Ward [Y] in Paediatric Surgery admissions on [ ] 2016. The witness recalls they were short staffed on the shift and as a result, the Practitioner was asked to attend to two patients already on the ward to carry out routine observations and administer IV antibiotics. The Practitioner was also to be allocated two booked abdominal patients who were expected to be admitted to the ward during the shift from the [ ].

[25] RN P states that the Practitioner was belligerent and that she was unhappy with the patients allocated to her. Her recollection is that this caused tension and undue pressure for others on the ward and that RN O the Shift Coordinator was upset after a discussion with the Practitioner. The result was

[1] Document 12.

that the Practitioner was swapped out of the ward for an enrolled nurse, who came to attend to the patients that had been assigned to the Practitioner. This was not as helpful to the other RNs on the ward as an enrolled nurse has a more limited scope of practice and cannot administer all medications.

[26] RN O has worked at Starship Hospital for 15 years. She is a Staff Nurse on Ward [Y] and works mostly on night shifts. She gave evidence on Particular 4. She was the Shift Coordinator on the night shift on [ ] 2016, when the Practitioner was assigned to provide cover to assist on Ward [Y]. She recalls that any competent RN was able to attend to the patients she had assigned to the Practitioner that evening. In fact, she states she had assigned less complex patients to the Practitioner given she was providing cover. On this basis, she was surprised and upset at the rude and aggressive reaction from the Practitioner objecting to the allocation. At the time, she judged it simply easier to swap the Practitioner to another ward and assign an enrolled nurse even though this did not work as well for the busy ward that evening and created more work for other RNs on the shift.

[27] RN I has worked at Starship Hospital since 2002 and worked in Ward [X] ever since. RN I worked regularly with the Practitioner prior to [ ] 2016. She is currently a Level 3 RN. Her evidence relates to Particulars 6 and 8, as she worked alongside the Practitioner on the night shift on [ ] 2016. On [ ]2016, RN I was asked to review events on the shift the previous night. RN I was clear in her evidence that she had not been asked by the Practitioner to countersign for any IV medication which had been recorded as administered in the clinical notes for patient U at 5.00am that morning. She stated that while the signature looked like her signature on the patient record, it was not her signature.

[28] RN A has worked at Starship Hospital since 2011. She has worked on Ward [X] at Starship Hospital for much of her career. Her evidence relates to Particulars 6 and 8, as she also worked on the night shift on [ ] 2016. RN A had worked with the Practitioner on many occasions prior to that evening shift. She recalls that on this shift the Practitioner spent most of the shift sitting at the computer in the nurses' station and did not see her get up to attend to her patients on the ward. RN A also confirms that she did not countersign any drug chart for the Practitioner's patient U on that night shift. She does not recall RN I doing this during the shift. On [ ] 2016, RN A was asked by the ADHB about her recollection of events on the [ ] night shift. As a result, she made a file note that day, which was produced to the Tribunal.[2]

[2] ABD 13.

[29] Ms A, is the mother of Patient A, who was a [young child] year old boy in 2016. Ms A is an [ ]. In [ ] 2016, she was pregnant with her second child and attended Starship with her [ ] year old son who had pneumonia. They had had previous admissions to Starship with similar health concerns. She stayed in hospital with her son on the evening and into the morning of [ ] 2016. On the morning of [ ], she filled out the Starship Hospital Feedback Form and gave it to the nurse on the day shift noting her concern that her son had not been given his antibiotics and no observations were taken of him over the course of the evening shift. Ms A's feedback form dated [ ] 2016 was produced to the Tribunal.[3]

[30] On [ ] 2016, Charge Nurse, RN G met with Ms A and similarly recorded Ms A's concerns at the lack of observations or medications provided to her child over that night shift. A copy of the file note of that meeting was also produced to the Tribunal.[4]

[31] Finally, Ms U also gave evidence. She is the mother of Patient U, who was [a baby] old in [ ] 2016. Her evidence was in relation to Particulars 6 and 8. Ms U stayed overnight with her daughter on [ ] 2016 and confirmed that no observations or medications were given to her daughter over that night shift.

Practitioner's evidence

[32] Ms E gave evidence in her own defence. The Practitioner maintains that she is an honest and competent nurse and denies that she made any false entries in the patient notes. She states that she undertook all the patient observations and administered the medications properly, as recorded in patient notes.

[33] The Practitioner states that patients and their parents would often become stressed and sleep deprived so she would not wake them on night shifts. Over the years, she states she had developed the ability to expertly complete patient observations and administer medications without disturbing a child's sleep or that of their parents. The Practitioner considered herself an excellent communicator with patients and their families. She had remained as a Level 2 RN, only because her busy home and work life meant that she did not want the added stress of undertaking the additional education required to move to Level 3 and 4, which is the usual pathway for RNs.

[3] ABD 16.

[4] ABD 17.

[34] Ms E acknowledged that generally PEWs observations are completed and documented every 4 hours, though the recorded time may vary by 5-10 minutes or more if you were attending several patient PEWs on the same hour. The Practitioner said her practice was to record the observations and medication on a small square piece of paper in her pocket. When she got back to the nurses' station, she would transfer these recordings on to the patient notes.

[35] The Practitioner states that in [ ] 2016, the working environment at Ward [X] was abusive and that staff were abusive towards her. She believed that some staff members' dislike of her had caused them to make untrue allegations against her, including the RNs who gave evidence in this hearing.

[36] In relation to Particular 1, the Practitioner could not explain why Dr [W] could not recall the further visits the Practitioner had recorded for Dr [W] to the ward that evening or why Dr [W] had not noted any of these return visits in the patient notes for patient S. She does suggest that it may have been an oversight given Dr [W] was covering the whole of Starship Hospital on that night shift and would have had some 100 patients under her care.

[37] In relation to Particular 2, the Practitioner says it has been extremely difficult for her to answer this allegation as it relates to four unnamed patients that she is alleged to have failed to provide care to on the [ ] 2016 night shift. And she does not have a full set of patient records for the patients under her care that evening.

[38] In relation to Particular 3, Ms E had initially filed evidence with the Tribunal that she recalled clearly that she had provided care to patient A, and that she recalled his siblings and parents being present during the evening. The tenor of that evidence was that she recalled the mother being pregnant and vomiting and that as a result she had not wanted to wake the child or mother while carry out her observations and giving medications that night shift. However, after the conclusion of Ms A's evidence and on the next day of hearing, the Practitioner through counsel acknowledged that she had made an error and that her evidence and recollection in relation to Particular 3 was of a different patient and mother that evening. This was confirmed in her oral evidence to the Tribunal at the hearing. It was therefore very difficult for the Practitioner to refute the allegations set out in Particular 3 and the evidence of the RNs and Ms A. The Practitioner maintained that her entries in the patient notes were nevertheless correct.

[39] In relation to Particular 4, the Practitioner acknowledged that she did refuse to take both patients she was initially assigned on [ ] 2016 in Ward [Y]. She maintained this was for safety reasons as she did not feel competent to provide care to these patients as she had previously had difficult experiences with surgical patients with abdominal issues. The Practitioner accepts that she argued that the allocation of patients was "not right" but maintained that she then left the room to start receiving a handover of one of the patients. The Practitioner also accepts that her conduct can be abrupt and rude, and this was likely the case towards RN O as it caused her upset and offence. The Practitioner apologised for this in her evidence.[5] However, she maintained that she did not improperly refuse to take any patients.

[40] In relation to particular 7, regarding the [Patient N] patient, the Practitioner maintains that she took all of the six observations recorded on the [young child] year old child's PEWS chart between 11.30pm and 6am. However, she states she had inadvertently recorded the later three observations as taken at 4.30am, 4.45am and 4.55am, being exactly one hour later, as her watch had been incorrect, but that she corrected that immediately when it was pointed out by RN T. The Practitioner maintained that her nursing watch had a fault with it around this time and that she subsequently replaced it with a new watch.

[41] Finally, in relation to Particular 6 and 8, regarding the [baby] female patient U, the Practitioner denies failing to provide medications and taking observations from the patient on the night shift on [ ] 2016. She maintains that RN I did check and countersign the medications provided at around 5am and that she did not forge the signature of RN I on the medication chart. The Practitioner believes that RN I is simply mistaken and that she does not recall the events.

[42] At the hearing, the Practitioner also presented a further statement of evidence regarding Particular 6, in which she gives a detailed recollection of her interactions with the mother and child that evening. She recalls that at 1am, the mother and child were asleep bed sharing and that she needed to move the bed to give her access to the child to undertake the blood pressure observation. She recalls that she was able to undertake all the other observations without waking the patient or mother and that she recorded the observations on her mini-plan.

[43] The Practitioner also called evidence from RN M. RN M became a registered nurse in 1999. RN M worked at Starship Hospital from 2001 until December 2015. She had started as a Level 2 Competent staff nurse and had

[5] [E] Statement of Evidence at 171.

progressed to a senior staff nurse Level 4, during her time at Starship Hospital. During this period, she worked with the Practitioner most weeks on night shifts. RN M ceased working with the Practitioner from [ ] 2016 and they have not worked together since.

[44] RN M gave evidence about her observations of the Practitioner's clinical practice and her character during the time they had worked together. She found the Practitioner was dedicated, competent and caring in her nursing practice.

[45] RN M said she was aware of tensions in working relationships between the Practitioner and other nurses on Ward [X], but that she had always got on well with the Practitioner. She also gave evidence that at times she felt that personality conflicts on Ward [X] made it a difficult place to work at times, which she had also experienced. It was one of the reasons she left the ward in 2016.

[46] RN M gave evidence that in her experience as a paediatric nurse, it is possible to take observations and administer medications to a child while they are asleep. Their medication can be given via a spacer, by placing the mask very gently over their face to form a good seal but not enough to wake them. Her experience is that nurses working on the night shift endeavour to achieve their work quietly and with torches and reduced lighting to avoid waking a child if possible.

[47] In questioning from the Tribunal, Ms M did accept that it would be unlikely that a nurse would be able to administer spacers to a [teenage] patient while asleep and that she had never attempted this on an adolescent child. They would be woken to do this for themselves.[6] RN M stated that it would be unlikely that you would be able to carry out observations of a child's breathing and chest movement with a pen light only (as the Practitioner claimed) as this requires a larger torch light to achieve the observation in her experience.[7]

[48] Finally, RN M also noted that it would be unlikely that a nurse could achieve three or more PEWS observations over the course of a night shift without waking a child patient.[8]

Expert evidence – RN Thomas Gorte

[6] Transcript, M, 737.

[7] Transcript, M, 738.

[8] Transcript, M, 740.

[49] RN Gorte was called as an expert witness by the Practitioner. He is a registered nurse with 27 years' experience in child health. RN Gorte is currently a RN Educator and Senior Paediatric Nurse at the Hutt Valley District Health Board and a qualified Quality and Risk Management Auditor for the health and disability sector.

[50] RN Gorte holds a Bachelor of Science (with Honours) in Health Science and Management, a Certificate in Adult Education and a Master of Nursing. He qualified in the UK in 1993 and has worked in a variety of registered nurse roles (including Charge Nurse and RN coordinator) in the UK, New Zealand and Barbados since then. Currently, RN Gorte's RN Educator role is 0.8 FTE and he also works up to 0.2 FTE on the Children's Wards as a senior RN in paediatrics (being 1-2 shifts per fortnight).

[51] RN Gorte was engaged to provide general expert evidence on:

(a) the administration of medications (particularly on night shifts);
(b) undertaking observations (particularly on sleeping patients); and
(c) the consequences of failing to carry out observations and/or administer medications.

[52] RN Gorte also provided his expert opinion on the allegations before the Tribunal regarding the care of patients referred to in Particulars 1, 3, 6, 7 and 8, and based on his review of the clinical records and the witness statements provided.

[53] RN Gorte confirmed that nurses working on a night shift will consciously work to minimise noise and disruption to patients, particularly when they are asleep. In his opinion, nurses can and do undertake observations on paediatric patients while they are asleep particularly during a night shift. In his experience adolescents, toddlers and infants can all sleep through observations, when the RN is skilled at minimising disruption and working with equipment quietly. RN Gorte made the general observation that patients can sleep through observations and medications and not realise this the next morning.

[54] However, RN Gorte also explained that he would not advocate for routine administration of oral medications on a sleeping child as this would increase the risk of choking. He acknowledged that this may be possible and acceptable when the RN was administering small quantities (eg: 5mls) of medication to a sleeping child.

[55] RN Gorte noted that in his opinion, a RN can give a spacer to a child while they are asleep, by placing the mask over the child's face and allowing them to breathe naturally for six breaths or so. This process must generally be repeated up to six times in order for the child to receive the full administration of medication.

[56] In relation to each of the four patient cases reviewed by RN Gorte, he made the following observations in his evidence:

(a) Patient -S – [ ] 2016. RN Gorte agreed with Dr [W] that three separate reviews of this patient by the doctor within an eight hour shift would be more likely if there were concerns about a deteriorating patient, which was not indicted by the patient PEWS. RN Gorte would also have expected the doctor to have made some update notes in the clinical record for the patient if doing repeat assessments during the night. He noted that the morning observations showed a similar trend to the overnight observations so there was no clear evidence that the 2 hourly spacers of Salbutamol had not been given. However, RN Gorte did acknowledge that the patient could nevertheless remain stable if medication had not been given overnight. [9]

(b) Patient A – [ ] 2016. RN Gorte gave his opinion that the clinical notes of the next morning's PEWS observations, taken while the child was asleep, make it more likely that observations taken during the night were also while the child was asleep. The small dose of oral antibiotic medicine (5.5mls) also made it possible for this to be administered while asleep. RN Gorte could not reconcile how the mother did not recall these events if she says she was awake and did not see any of this occur. RN Gorte acknowledged that a lack of antibiotics overnight may not have caused any deterioration in any event. [10]

(c) Patient N – [ ] 2016. RN Gorte explained that this was a patient with bronchopneumonia who was on oxygen therapy via nasal prongs and had an intravenous cannula for the administration of antibiotics. RN Gorte considered it was possible for the

[9] Transcript, Gorte, 717.

[10] Transcript, Gorte, p 724-726.

medications and observations to have been completed as recorded by the Practitioner. He referred to the fact that the PEWS chart showed other RNs had done the same on [ ] at 8.40pm and 11pm and again on [ ]at 12noon.

(d) Patient U – [ ] 2016. RN Gorte considered it likely that the Practitioner could have taken the observations at 1am and 5am while the patient and mother were in a deep sleep pattern, after the recorded breastfeeding that took place at midnight. The midnight breastfeeding is something that both mother and the Practitioner recall. RN Gorte noted that previous observations on [ ] and during the day shift on [ ], both record the patient being asleep through these times. RN Gorte did not see any change in the PEWS scores for the child that would indicate any neglect of the child over the night shift.

Relevant law

[57] The Charge of professional misconduct is laid under section 100(1)(a) and/or section 100(1)(b) of the Act. The relevant provisions of s100 are as follows:

> **"100 Grounds on which health practitioner may be disciplined**
>
> (1) The Tribunal may make any 1 or more of the orders authorised by section 101 if, after conducting a hearing on a charge laid under section 91 against a health practitioner, it makes 1 or more findings that –
>
> (a) the practitioner has been guilty of professional misconduct 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) the practitioner has been guilty of professional misconduct 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 health practitioner practised at the time that the conduct occurred."

Professional Misconduct

[58] The Tribunal and the Courts have considered the term "professional misconduct" under s100(1)(a) and (b) of the Act on numerous occasions. The Tribunal draws on the guidance now available in those cases.[11] In *Collie v Nursing Council*, Gendall J states at paragraph [21]:

> "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."

[59] The Tribunal has also consistently adopted common usage definitions of "malpractice" as being [12]:

> "the immoral, illegal or unethical conduct or neglect of professional duty. Any incidence of improper professional conduct"; and
>
> "Improper treatment or culpable negligence of a patient by a physician or of a client by a lawyer… a criminal or illegal action: common misconduct."

[60] It is also for the Tribunal to determine, whether the conduct has or is likely to bring discredit on the medical profession under s100(1)(b) of the Act. In *Collie*, Gendall J discussed the meaning of this provision and 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

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[11] *PCC v Nuttall*, (8 Med04/03P), *Collie v Nursing Council of New Zealand*, [2000] NZAR 74, *Aladdin* (12/Den05/04 and 13/Den04/02D) and *Dale* (20/Nur05/09D).

[12] Collins English Dictionary, 2nd Edition and the New Shorter Oxford Dictionary, 1993 Edition.

reputation and good-standing of the nursing profession was lowered by the behaviour of the nurse concerned."

[61] There is a well-established two stage test for determining professional misconduct in this jurisdiction.[13] The 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 on 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 protection of the public and/or maintaining professional standards?

[62] The burden of proof is on the PCC. The PCC must produce evidence that establishes the facts on which the Charge is based to the appropriate civil standard of proof.

[63] The standard of proof is 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 considering the seriousness of the allegation, and the gravity of the consequences flowing from a particular finding.[14]

Credibility

[64] There are some material issues of credibility that arise in this case. As a result, the Tribunal is mindful of the approach it must adopt in determining credibility of the Practitioner and others giving evidence.

[13] *F v Medical Practitioners Disciplinary Tribunal* [2005] 3 NZLR 774 (CA), as applied in *Johns v Director of Proceedings* [2017] NZHC 2843.

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

[65] The Tribunal's approach to issues of credibility is guided by *Rabih,*[15] which discusses the test for credibility:

> "20. What is involved in any test for "credibility" was articulated by a Canadian Appellate Court (in *Farynia v Chorny* [1952] 2 DLR 354 (BCCA)) to be that the real test of the truth of the story of a 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.
>
> 21. So, the Tribunal, where relevant, must consider such factors as:
>
> > 21.1 The witness' manner and demeanor when giving evidence.
> >
> > 21.2 Issues of potential bias – to what extent was evidence given from a position of self-interest.
> >
> > 21.3 Internal consistency – in other words was the evidence of the witness consistent throughout, either during the hearing itself, or with regard to previous statements.
> >
> > 21.4 External consistency – in other words, was the evidence of the witness consistent with that given by other witnesses.
> >
> > 21.5 Whether non advantageous concessions were freely tendered."

[66] The modern approach to the assessment of witnesses has been to give somewhat less weight to attempting to assess the demeanour of a witness when weighed against other considerations such as the inherent likelihood of the

[15] Decision No. 300/Nur09/139P at paras 20-21; *Rabih v A Professional Conduct Committee of the Dental Council of New Zealand* [2015] NZHC 1110 and *M* 1051/Nur19/440P.

witness's story, records made at the time, contemporaneous and subsequent behaviour and sources of independent evidence.[16]

[67] The Tribunal wishes to record that having heard from all the witnesses over the period of the two week hearing, we found each of the RN nurse witnesses, Dr [W] and the two mothers, credible witnesses. They were careful in their evidence and made appropriate concessions when they had difficulty recalling matters after so many years. There was no motive apparent to the Tribunal for any of them to construct an untruthful version of events. While there were obvious tensions in some RN working relationships with the Practitioner, this was not the case for RN I or Dr [W] or the patient mothers. In the main, they were also able to rely upon contemporaneous written reports they made of the Practitioner's conduct within a few days of the events.

[68] The Practitioner in her evidence sought to undermine the credibility of the nurse witnesses called by the PCC. The reliability of the two mothers who gave evidence was also directly challenged.

[69] The Practitioner acknowledged that she had a very direct manner and that some of her nursing colleagues considered her communication intimidating. It appeared to be common ground that the Practitioner did not easily fit in with her peers and there were tensions between her and many of the other nursing colleagues on Ward [X]. The Practitioner suggested that this was the true motivation for the allegations made by her nursing colleagues. The Practitioner is entitled, in defending the Charge, to raise such challenges for consideration. However, the Tribunal was left in no doubt that the PCC witnesses provided honest and in the main reliable evidence to the Tribunal.

[70] In contrast, the Tribunal was left unimpressed by the Practitioner's evidence. Her assertion that she had a photographic recall of these patients was unconvincing to the Tribunal. After some four years distance from the events in 2016, the Practitioner gave a highly detailed account of her exact movements. She gave an almost minute by minute recall of interactions in relation to each of the named patients, which stretched credibility for the Tribunal. This was particularly so when, after Ms A had completed her evidence, the Practitioner advised the Tribunal that she had now realised that she had recalled the wrong patient and his mother.

[16] *R v Munro* [2007] NZCA 510, [2008] 2 NZLR 87.

[71] The Practitioner's credibility was also marred by other troubling aspects of her evidence, including:

(a) The Practitioner's recall of events relating to the care of the named patients and her interactions with the two mothers, appeared to improve and become more detailed over the passage of four years between the ADHB investigation and this hearing;

(b) The Practitioner presented in evidence a pink notebook she produced for the first time in her evidence before the Tribunal. [17] The notebook contained the Practitioner's handwritten notes of the patients who are the subject of the Charge, which she states was a contemporaneous record of her dealings with those patients. The Tribunal was told by the Practitioner that this notebook recorded events from handover sheets and mini-plans which she made on the relevant night shifts, but which are no longer available and from her memory of events. This notebook had not been presented at any time during her disciplinary investigation with the ADHB or the PCC investigation. The Practitioner maintained this was because she had not thought it relevant until she was preparing for this hearing. The Tribunal was not satisfied that this was a contemporaneous document at all. On the balance of probabilities, the importance of this notebook must have been evident earlier particularly in the absence of her handover sheets or mini-plans;

(c) The Practitioner accepted part way through her evidence that she had given a detailed but wholly incorrect account of her care for patient A, after hearing the mother's evidence;

(d) In her own evidence, the Practitioner was willing to attack the integrity of almost all the PCC health practitioner witnesses and even the mothers who gave evidence. While it is possible that at times witnesses' credibility and/or memory will need to be challenged, it stretched plausibility that so many health practitioners and two mothers would be willing to give false evidence or that they were commonly in error.

[17] ABD doc 29.

[72] Overall, the Tribunal found the Practitioner an unreliable witness. It appeared that at times she was willing to create for herself, and the Tribunal, a detailed recollection of events, based on what narrative she thought best fitted with the PEWS charts records she had made. This is a troubling assessment to have to make of any health practitioner. However, the Tribunal members were unanimous in this.

Circumstantial evidence

[73] Some of the evidence in this case is circumstantial. In particular, RN N and RN T gave evidence that they did not see the Practitioner enter patients' rooms at times. This was offered as evidence that the Practitioner did not carry out observations and/or administer medication to those patients.

[74] The Court of Appeal in *Commissioner of Police v De Wys* remarked:[18]

> "Circumstantial evidence allows a fact-finder to infer that a particular fact exists, even if there was no direct evidence of it. A single piece of circumstantial evidence will generally allow for more than one explanation. However, a number of separate items of circumstantial evidence, when considered together, may strongly support the drawing of a particular inference. Circumstantial evidence derives its force from the involvement of a number of factors that independently point to a particular factual conclusion. The analogy that is often drawn is that of a rope: any one strand of the rope may not support a particular weight, but the combined strands are sufficient to do so."

[75] The Court of Appeal in *Attorney-General v Strathboss Kiwifruit Ltd* affirmed that, "In New Zealand the recognised approach to circumstantial evidence is to treat such evidence as the "strands in a cable" rather than "links in a chain".[19]

Nursing Council of New Zealand Code of Conduct

[18] *Commissioner of Police v De Wys* [2016] NZCA 634 at [9].

[19] *Attorney-General v Strathboss Kiwifruit Ltd* [2020] NZCA 98 at [469].

[76] The PCC have referred the Tribunal to the following Principles and Standards in the Nursing Council's Code of Conduct (2012) as relevant:

> "Principle 4: Maintain health consumer trust by providing safe and competent care."
>
> > "Standard 4.8: Keep clear and accurate records…"
> >
> > "Standard 4.9: Administer medicines and health care interventions in accordance with legislation, your scope of practice and established standards or guidelines."
>
> "Principle 6: Work respectfully with colleagues to best meet health consumers' needs."
>
> > "Standard 6.1: Treat colleagues with respect, working with them in a professional, collaborative and co-operative manner..."
> >
> > "Standard 6.4: Your behaviour towards colleagues should always be respectful and not include dismissiveness, indifference, bullying, verbal abuse, harassment or discrimination..."
>
> "Principle 8: Maintain public trust and confidence in the nursing profession."
>
> > "Standard 8.1 Maintain a high standard of professional and personal behaviour …"

[77] While a breach of the Code of Conduct will not automatically result in a finding of professional misconduct, it is relevant to consider whether any established conduct will also amount to a breach of the Principles or Standards. This can assist the Tribunal in determining whether the conduct has fallen below acceptable standards for the nursing profession and in turn whether it is a sufficiently serious act that would warrant a finding of professional misconduct.

Consideration of Charges
Particular 1: Patient S - [ ] 2016

[78] Particular 1 relates to Patient S, the [teenage] female patient, who had been admitted earlier on [ ] 2016, with moderate to severe asthma. The patient was charted to receive Salbutamol (Ventolin) spacers during the night shift.

[79] It is alleged over the course of the night shift, the Practitioner failed in three respects:

(a) Particular 1.1 - failed to administer 1 to 2 hourly spacers of Salbutamol as charted by the House Officer Dr [W] at around 11.50pm and/or failed to do any of the observations on the patient during that shift; and/or

(b) Particular 1.2 – documented in the patient's clinical records that the on call House Officer had reviewed the patient three times during the shift and had made the decision to change the spacers to be administered 2 hourly, when Dr [W] had only visited the patient once at around 11.50pm and had not changed the timing of the spacers; and/or

(c) Particular 1.3 – documented in the patient's clinical records completed observations and/or administration of spacers when these had not been done.

[80] The Tribunal heard evidence from RN N, RN R, Dr [W] and the Practitioner in relation to this Particular.

[81] RN N and RN R both worked 12 hour shifts from 7.00pm to 7.30am. RN N was the Shift Coordinator. The Practitioner worked an eight-hour shift from approximately 10.45pm to 7.30am. This patient was allocated to her over the eight-hour shift.

[82] RN N had reviewed the patient in her role as Shift Coordinator at about 10.30pm, before the Practitioner came on shift. RN N was concerned that the frequency of the patient's medication (hourly Salbutamol (Ventolin) spacers) may be inadequate. At RN N's request, the patient was reviewed by Dr [W]. Dr [W] adjusted the charted medication at 11.50pm to allow the nursing staff flexibility

to administer the Salbutamol between 1 and 2 hourly, based on their assessment of the patient.

[83] The patient was in Room 2, which is five rooms down from the nurses' station. The Practitioner received a handover of the patient at about 11.00pm before the 11.50pm review of the patient by Dr [W]. However, the Practitioner was not present for the review by Dr [W] as the previous afternoon shift nurse attended.

[84] The Practitioner maintains that she completed all the care for this patient as documented in the clinical records. The clinical notes contain the following care delivered to the patient:

(a) The Practitioner recorded taking five separate observations of the patient at 12 midnight, 1.30am, 3.00am, 5.00am and 7.00am; and

(b) The Practitioner recorded that she also administered five spacers of Salbutamol at the same times as the observations were completed, together with an additional medication Ipratropium (Atrovent) at 3.00am and 7.00am.

(c) The Practitioner noted in the clinical records that Dr [W] returned to review the patient a further two times at 1.30am and 3am. This meant that the patient records noted Dr [W] visited this one patient three times between 11.50pm and 3.00am.

[85] The Practitioner states that the patient and mother remained asleep on each occasion that she entered the room overnight. She outlined that it had been her practice to administer spacers to child patients while they were asleep by placing the rubber mask over the child's face, gently creating a seal allowing the medication to be released and breathed in by the patient.

[86] RN Gorte confirmed that this was possible, although there was always a risk of the patient waking and it would not be regarded as best practice with a [teenage] patient. He explained that if the patient is a teenager, you would generally wake them to allow them to administer the medication themselves.[20] RN Gorte also noted that at each administration it required six breaths and then

[20] Transcript, Gorte, 679.

the process of refilling the spacer would need to be repeated six times, to administer one full dose in this way.

[87] Dr [W] says she came the first time to visit the patient at 11.50pm, but says it is highly unlikely that she would have visited two further times given the patient was stable and she had a busy hospital to cover. RN N and RN R both confirmed this would be highly unusual. They did not see Dr [W] return to the ward on the night shift after 11.50pm. They believe they would likely have seen Dr [W] again if this had happened as doctors will generally come to the nurses' station if they visit a ward.

[88] RN N and RN R both say they did not see the Practitioner leave the nurses' station to carry out any observations or administer the charted medication to the patient during the shift. They acknowledge that they were not always at the nurses' station as they had to attend to their own patients during the evening. However, they maintain it would be highly unlikely for the Practitioner to have conducted five observations of one patient over the course of the evening, without them hearing or seeing this occur at some stage.

[89] They did not raise any concerns with the Practitioner that evening as they both conceded they were wary of the Practitioner and her manner. However, it was the concerns they had from this evening that caused them to watch the Practitioner's movements more carefully on the next night shift on [ ] 2016.

[90] The Practitioner argues that there are a number of factors that should satisfy the Tribunal that this particular is not established including:

(a) The contemporaneous clinical records which support the Practitioner that she delivered the care required and that she took the clinical care reviews with RN N at 1.00am and 5.00am, which RN N confirms;

(b) RNs N and R could not have monitored the Practitioner throughout the shift as they each had their own patients to attend to and so could not have been at the nurses' station at all times;

(c) The patient would have been likely to have destabilised if she had not had the Salbutamol spacers administered throughout the night as alleged and this was supported by Dr [W];[21]

[21] Transcript, [W], 161.

(d) There is no contemporaneous evidence to rebut the clinical record from either the mother of the patient or the patient herself; and

(e) RN Gorte confirmed it is possible to administer Salbutamol to a sleeping adolescent even though this is not preferred.

[91] The Tribunal has carefully considered the Practitioner's evidence and argument. However, we are satisfied that Particular 1 is established on the balance of probabilities for the following reasons:

(a) the Practitioner would not have been able to provide five sets of observations (including blood pressure), five separate administrations of Salbutamol and three administrations of Atrovent between 12 midnight and 7am, without waking a [ ] year old patient;[22]

(b) Dr [W] did not return to visit this one patient three times in the course of one evening shift, when she was otherwise a busy on call House Officer, the patient was largely stable and Dr [W] has no recollection of this when it would have been unusual;

(c) Dr [W] would not have returned twice for a review and not made some note of her visit;

(d) RN N or RN R would have seen some evidence of Dr [W] returning to the ward at least once between them;

(e) The two RNs would likely have seen some evidence of the Practitioner returning five times to conduct the patient observations. This is particularly so for RN N who was the Shift Coordinator that evening and had attended the 11.50pm review with Dr [W];

(f) The Practitioner's PEWS records create an unrealistic picture of perfect alignment, between the times at which her observations were due and conducted at 1.30am and 3.00am and the alleged return of Dr [W] to conduct her second and three reviews at those same times;

[22] The patient notes described her as well built and 69kgs, so she was a small adult size.

(g) The evidence of RN Gorte confirmed that the Practitioner's administration of spacers to a [teenager] was unusual and would risk waking the patient. The Tribunal also noted the evidence of RN M who confirmed in her evidence that it would be unlikely for a [teenage] patient to sleep through the numerous sets of observations and medications given to this patient; and[23]

(h) The evidence of both Dr [W] and RN Gorte was that it is possible for a patient to remain stable through the night without receiving spacer medications. So, the lack of patient deterioration was not clear evidence that medications had been given.

[92] The Tribunal finds particulars 1.1 to 1.3 are established as follows:

(a) Particular 1.1 - The Practitioner failed to provide all five of the observations and spacers as detailed in the patient records between 12 midnight and 7.00am. The Tribunal considered it possible that perhaps one set of the observations and medications had been provided throughout the night but that it was not possible for all five observations or all five spacers to have been provided.

(b) Particular 1.2 – The Practitioner had documented that Dr [W] had returned to review the patient at 1.30am and 3.00am when those reviews had not taken place.

(c) Particular 1.3 – The Practitioner had documented that she had completed the five sets of observations and administered the spacers on five separate occasions, between 12 midnight and 7.00am, when these cares had not all been provided to the patient.

Particular 2: Four unnamed patients - [ ] 2016.

[93] Particular 2 relates to the Practitioner's care of four unnamed patients on Ward [X], during the night shift on [ ] 2016. It is alleged that the Practitioner failed to carry out observations of these patients (particular 2.1) and/or

[23] Transcript, Gorte, 737.

documented that the observations had been done in the clinical records when they had not been (particular 2.2).

[94] The Tribunal heard evidence from RN N, RN R and the Practitioner. The PCC did not call evidence from any patients or their parents and no clinical records for any of the four patients were produced to the Tribunal. The four unnamed patients the subject of this Charge were not well identified in the evidence before the Tribunal, but it appears from the evidence they included:

(a) An 5 -8 year old male patient in Room [x];

(b) A 13 year old in Room [y]

(c) A 12 year old in Room [z];

(d) An 11 week old in another room, not identified on the ward.

[95] The Practitioner was rostered to work a 12-hour shift on these dates starting at 7.00pm. She felt unwell on shift and finished early at 4.30am. RNs N and R also worked the night shift. The [teenage] female patient, who the Practitioner had cared for on the previous night shift, was assigned to RN R on this next night shift on [ ].

[96] RN R says the patient records appeared to contain inconsistencies and conflict with the care she had seen the Practitioner provide to this [teenage] patient the night before. She shared this observation with RN N and they decided to closely observe the Practitioner during the shift. They also moved the Draegar monitor and thermometer equipment to the other end of the ward (near Rooms 2 and 4) and placed an infant sized cuff on the Draegar, in order to see if the Practitioner attempted to use them. The Practitioner had been assigned four patients, three of whom were between 8 and 13 years old, which would require a large cuff to take their blood pressure.

[97] RNs N and R both say the Practitioner remained at the nurses' station throughout the night shift on [ ]. They did not see her get up to undertake her two hourly observations of any of her four patients assigned that evening. The two nurses both state that one or other of them, always remained at the nurses' station that evening so that they could monitor the Practitioner's movements. They both believe they would have seen or heard the Practitioner moving the

Draegar monitor machine around the ward to the patient rooms if this had happened. Their evidence was the ward is always noticeably quieter during the night shift and the monitors make a noise when they are moved around the ward or are used to conduct observations. They also state that they never saw the Practitioner with a stethoscope on the shift which she would have needed to carry out her observations.

[98] However, they did fairly concede that the Practitioner did move from the nurses' station at times that evening and that their own movements away from the nurses' station, made it possible that they may have missed some of her movements that evening. RN N also acknowledged that she had seen the Practitioner enter Room 8 briefly at 12 midnight and on another occasion to do a bolus feed that evening.

[99] RN N and RN R both raised their concerns about the Practitioner not performing her observations with the Nurse Educator before they left the shift the next morning. RN R then made a written statement on [ ] 2016, as part of her formal report of the incident. Both RNs then gave further written statements in [ ] 2016, during the ADHB employment investigation.

[100] The Practitioner states it is unfair for her to have to attempt to defend herself when she has not been provided with the clinical notes for these patients and is having to base her recollection solely on notes she made in [ ] 2016, in preparing for the ADHB disciplinary meeting.

[101] The Practitioner responded to the various allegations that she had not attended to the patients that evening, as follows:

(a) She would have likely obtained the Draeger monitor kept opposite Room 13 and used the blood pressure cuffs from that monitor;

(b) She has her own stethoscope and kept that in her nurse's uniform pocket or otherwise around her neck but not highly visible;

(c) She is able to move the monitors carefully and quietly around the floor to avoid disturbing the patients and keeps the monitors on a silent setting as much as possible while completing her observations;

(d) The RNs on shift with her that evening, were at times engrossed in their own conversations and away from the nurses' station attending to their own patients;

(e) The patient in Room 8 had been involved in a near drowning incident, which required careful monitoring and medications. If he had not been attended to during the night shift his oxygen levels or other aspects of his health would likely have been impacted and this did not occur.

[102] We accept that both RN N and RN R had genuine concerns and that they attempted to monitor the Practitioner's movements that evening. However, the Tribunal is not satisfied on the available evidence that either Particulars 2.1 or 2.2 are established. We make this finding for the following reasons:

(a) The Tribunal was left with a lack of clarity about the details of Particular 2 as the patients were not identified clearly and the clinical notes were not produced to the Tribunal; and

(b) RN N and R did fairly concede the Practitioner did leave the nurses' station on at least a few occasions that evening to undertake care and observations of the Room 8 patient and possibly others assigned to her. The RN witnesses also accept that they also left the nurses' station themselves and so may well have missed other activity by the Practitioner.

(c) The Tribunal was also not willing to find Particular 2.2 established. It is not possible to find that the Practitioner had created false documentation, without reviewing that documentation.

[103] The Practitioner and RN Gorte, both raised their concern that the two RN witnesses had taken deliberate steps to "entrap" the Practitioner by placing the Draegar monitors and other equipment further away from the nurses' station and simply observing the lack of care being provided to patients.

[104] The Tribunal does not wish to be critical of the RNs for them acting in this way. They both gave evidence that they found the Practitioner very confrontational and so they did not feel able to discuss the matter with her. They also stated that they had raised concerns about the lack of cares provided by the

Practitioner on other occasions but had been told by Nurse Managers that more evidence was needed. The Tribunal accepts that they both attempted to act in the best interests of the profession and patients generally. However, this should not be viewed as an ideal solution to the problem. The two RNs involved should not have been left trying to gather evidence in this way, to deal with serious concerns about another practitioner. Both said that on reflection and due to further learning since that time they would now handle the situation differently.

Particular 3: Patient A - [ ] 2016

[105] Particular 3 relates to the care of A, a [young] boy, on Ward [X], during the night shift on [ ] 2016. The patient had been admitted with pneumonia and was charted to receive eight-hourly oral antibiotics during the night shift, having received IV antibiotics the previous day.

[106] It is alleged that the Practitioner failed to carry out any observations on and/or administer the oral antibiotics (particular 3.1) but documented in the patient records that she had carried out four hourly observations at 8pm, 12 midnight and 4am and administered oral antibiotics at 4am, when this had not occurred (particulars 3.2 and 3.3).

[107] The Practitioner worked the night shift on these dates and handed over the patient to RN T, on the day shift at 7am on [ ] 2016. Ms A was with her son throughout the night as she stayed with him in his room. The Tribunal heard evidence from RN T, Ms A and the Practitioner, in relation to this night shift.

[108] In 2016, Ms A only had one child, her son, who was with her in hospital. Ms A had been in hospital with her son previously, so she was somewhat familiar with the night shift routines. Her husband was also with her earlier in the evening until he left some time after 8pm. She recalls the nurse coming to the room at about 8pm on [ ] 2016, with the observations trolley to give her son his medication. She did not recall if it included antibiotics or was just Pamol. Ms A gave her son the medications and she recalls the nurse saying she would come back later to do the observations once the father had left.

[109] The mother recalls that she remained awake from 8pm through until just after 2am. She had remained awake waiting for the nurse to return to undertake the further observations due at 12 midnight. Ms A particularly recalls that she was playing on her phone waiting and that she was in the habit of setting her

phone alarm with the times that her son's next medication was due, so she is certain that she was awake at 12 midnight and that the nurse did not come to do the observations.

[110] Ms A is also certain that she would have woken at 4am, if medications and observations had been taken. It was usual for her to wake when she slept in the hospital bed with her son, as she did that night.

[111] The next morning on [ ], Ms A filled out a feedback form with her concern that medications and observations had not been completed during the night shift.[24] She was also interviewed by the Charge Nurse the next day and an interview statement was taken recording her concerns.[25] In cross examination, Ms A was told that the Practitioner recalls she was nauseous and vomiting and was given a yoghurt by the Practitioner to assist. Ms A stated she was pregnant at the time but denies vomiting or receiving a yoghurt from any nurse during that shift. She states this is something she would have recalled.

[112] RN T says she came on shift the next morning and spoke with Ms A at about 7am. She noted that the 8 hourly administration of the antibiotic was important. However, she became concerned that the observations and medication documented by the Practitioner for the night shift were not accurate as Ms A told Ms T that her son had not had any observations taken during the night shift and she did not believe he had been given any medications after 8pm. There was a particular concern that because the oral antibiotics had been documented as given at 4am, the next dose could not be given until 12 midday.

[113] The Practitioner says that she carried out the observations and administered the medication as recorded in the patient records. The patient notes record the four hourly observations being completed at 12 midnight and 4am and that oral antibiotics were given 8 hourly at 8pm and 4am. The notes record the mother declined the observation at 8pm. The clinical notes record near the end of the shift that "Mum UTD with plan" – meaning the mother was up to date with the plan.

[114] In the Practitioner's written statement of evidence filed and served prior to the hearing the Practitioner maintained she had a good memory of the mother, child and the care provided that evening. She recalled the mother was

[24] ABD Tab 16.

[25] ABD Tab 17.

not well with nausea and vomiting and that the patient's other sibling was present in the early evening. The Practitioner's evidence in her written statement provided a very detailed account of her recollection of her discussions with the mother, her observations, administration of medication and how the mother and child were both asleep during the observations and delivery of medication between 12 midnight and 4.00am.[26]

[115] The Practitioner also produced her handwritten notes dated [ ] 2016 from her "Pink Book", which detail her claimed recollection of this patient and his mother from the night shift. The Practitioner maintained, prior to the hearing and throughout Ms A's evidence, that these were a contemporaneous record based on her mini-plan notes made on the night. These notes also align with the evidence she prepared in her written statement filed with the Tribunal.

[116] However, the day after Ms A provided evidence to the Tribunal, the Practitioner through her counsel advised the Tribunal that she had made an error. She realised she had prepared her evidence and "Pink Book" notes based on the wrong mother and patient and that in fact her detailed recollection of events and notes are based on another pregnant mother that had a child on the ward that evening. The Practitioner gave evidence at the hearing that she had no recollection of Ms A or her child and that she had to rely on the accuracy of the clinical notes she made for the patient that evening. The Practitioner continues to maintain that she delivered the care to the patient as she had recorded in the patient notes at the time.

[117] The Practitioner also relies on the fact that the patient's clinical notes contain a record by the Practitioner of clinical care reviews being signed at 9pm, 1am and 5am over the course of that night shift. The Practitioner was unable to identify which nurse had signed the clinical care reviews, but maintained they were further evidence that she had completed the care of the patient as the reviews would not have been signed off by another nurse otherwise.

[118] The Tribunal accepts Ms A's evidence is, on the balance of probabilities, reliable and accurate. We were satisfied that she had a sound recollection of events that evening. Her care and attention to her child meant that she was more likely to have an accurate recall and to have been on alert for the care provided to her child. The Tribunal accepts her evidence that she was well rested and supported by her mother and husband that evening and that she stayed

[26] Practitioner's written statement of evidence, para [135] to [160].

awake until after 2am waiting for the nurse to return to complete observations. We also accept her evidence that it is likely that she would have woken and recalled any observations or medication being administered to her child at 4am, given that they were sleeping together in the same bed. We also accept her evidence that she had set the alarm on her phone for the scheduled times for medication to be administered.

[119] It is significant to the Tribunal, that Ms A immediately reported her concerns the next morning and provided a feedback form that morning. These documents are both consistent with her evidence to this Tribunal. Ms A has no motive to provide anything other than an accurate account of events.

[120] In contrast, the Practitioner's ultimate evidence was that she did not have any clear recollection of the patient or his mother. There were also other indications to the Tribunal that the patient records were likely not accurate:

(a) The Tribunal was left unconvinced by the Practitioner's evidence that she could have carried out two sets of observations at 12 midnight and 4am and administered antibiotics to this sleeping child at 4am without the child or mother being woken at some point given they were sleeping together in the same bed; and

(b) The patient notes made by the Practitioner for that night shift also record "Mum UTD with plan", when this was clearly not the case given the concerns raised by Ms A the next morning.

[121] The record of the clinical care reviews being signed was not sufficient to overcome the clear evidence from the mother and the likelihood that she would have been woken if the observations and medication had been completed by the Practitioner as recorded. The clinical care review is simply a check that the patient records have been updated and appear logical. The review assumes the events have taken place as recorded.

[122] The Tribunal finds that Particular 3 is established including each of the sub-particulars 3.1 to 3.3.

Particular 4: Unprofessional behaviour on Ward [Y] – [ ] 2016

[123] Particular 4 alleges that on [ ] the Practitioner was pooled to work on Ward [Y], due to a staff shortage on that ward. It is alleged that the Practitioner engaged in unprofessional conduct by refusing and/or failing to accept into her care:

(a) two booked adolescent patients with abdominal pain issues; and

(b) a patient with lymphadenitis who had been assigned to her for that shift.

[124] The Tribunal heard evidence from RN P, RN O and the Practitioner regarding this particular.

[125] RN O was working the evening/night shift on the [ ], Ward [Y], and as the Shift Coordinator was responsible for staffing and patient allocations. RN P was also working on Ward [Y] at the time. RN O determined that Ward [Y] was short staffed and advised the Duty Manager. The Duty Manager assigned the Practitioner to transfer to Ward [Z] for the shift.

[126] The Practitioner arrived on [Y] at about 11pm. RN O had allocated her one patient with lymphadenitis (swelling of the neck) and two booked adolescent patients with abdominal pain due to arrive during the shift.

[127] RN O says the Practitioner made clear to her that she was unhappy with her patient allocation and expressed in forceful terms they were 'not right' or 'not fair' and the Practitioner did not accept RN O's explanation for the allocation decisions made or that they were typical allocations for an RN of her experience.

[128] RN P was standing nearby and confirms RN O's account that the Practitioner was unhappy with her patient allocation. She recalls the Practitioner being belligerent and saw that the incident had made RN O upset.

[129] The Practitioner admits that she refused to take both of the adolescent patients, but claims that she did so for safety reasons, as she states she did not feel competent to provide care to them both but would have been prepared to

take one of them.[27] The Practitioner did also acknowledge that her rudeness had upset RN O and apologised for the offence she had caused.

[130] The Tribunal was not satisfied that the Practitioner failed or refused to take the patient with lymphadenitis, as we accept that the Practitioner was in the process of receiving a handover for this patient from another RN at the time RN O advised her that she could move to Ward [Y].

[131] However, the Tribunal is satisfied Particular 4 is established in the following respect; the Practitioner acted in an inappropriate and unprofessional manner by her belligerent and rude manner and in refusing to take the two booked adolescent patients with abdominal pain issues. The Practitioner admitted that her conduct had been rude and that she had refused to take both patients as allocated.

[132] This unprofessional conduct could not be excused by safety concerns, even if they were genuinely held. We were left unconvinced that the safety concerns were genuinely held in any event, as they were not raised at the time and we accept RN O's evidence that this was a typical and less acute allocation of patients that did not give rise to any safety issues. It is important that all RNs act in a co-operative manner and assist as required by a Shift Coordinator, particularly when a ward is short staffed. It was highly unprofessional not to do so and caused more pressure for the Shift Coordinator and other RNs on the shift.

Particular 7: Patient N - [ ] 2016

[133] This particular relates to a [young child] year old girl, N who had bronchopneumonia during the night shift on Ward [X] [ ] 2016. The Practitioner was working an eight-hour shift from 11.00pm – 7.00am on these dates. RN T was also working that night.

[134] It is alleged that:

(a) the Practitioner failed to carry out PEWS observations of the patient (Particular 7.1); and/or

[27] Practitioner's statement of evidence, para [161].

(b) recorded in the patient's clinical record that they had occurred at 5.15am, 5.30am and 5.45am, when they could not have been done at that time as she had presented them for signing to another RN as part of a clinical care review on or before 4.45am (Particular 7.2); and/or

(c) when confronted with this error, stated she had the hour wrong and changed the PEWS chart to record the observations at 4.15am, 4.30am and 4.45am (Particular 7.3).

[135] The Tribunal heard evidence from RN T and the Practitioner on this matter.

[136] A graduate nurse had cared for the patient during the previous day shift and when she handed over to RN T at 7pm, she noted that the patient's PEWS scores had been high during the day and she had struggled to take observations as the patient was difficult to gain a BP reading from. The patient was in Room 8 on the ward opposite the nurses' station.

[137] At about 4.45am, the Practitioner asked RN T to sign her clinical review of the patient, which recorded that full PEWS observations had been carried out at "0515", "0530" and "0545", all with PEWS scores of 3. When RN T pointed out that those observation times were after the then current time, the Practitioner said she'd made a mistake and corrected the times to "0415", "0430" and "0445" hours.

[138] Ms T said she was sure that the Practitioner had not carried out observations at the newly revised times. She says that she would have noticed her making those series of trips to Room 8 at that time if it had happened as she was sitting at the nurses' station at that time. RN T is also doubtful that an RN would get the times wrong by exactly an hour, there is a clock on the monitor and outside Room 8, and it would be unusual for the nurse's watch to be out by exactly at hour. Ms T was also sceptical given the history of the patient waking on the day shift.

[139] The Practitioner says that she performed the series of observations at 15 minute intervals as she was weaning the patient's oxygen which required close monitoring. The patient had been on oxygen and oximetry over the previous day shift and on the night shift with the Practitioner.

[140] The Tribunal was left uncertain about the timing of these observations, given the incorrect time initially recorded by the Practitioner and the apparent coincidental symmetry that they were out by exactly one hour. However, it is a significant leap from this incorrect time recording to make a finding that the Practitioner did not carry out any of these observations or others, on a very unwell child over the course of the 8 hour shift.

[141] The following matters lead us to conclude this Particular cannot be established with any certainty:

(a) The patient record shows that medications were administered and signed off by RN I at 6am. This was not challenged by the PCC;

(b) The record also shows that the patient's mother was present during the night shift and in the previous night shift when the Practitioner also cared for the patient. There is no evidence that the patient's mother complained about her daughter's treatment during that shift or at any time;

(c) The patient record shows observations taken by the Practitioner at 11.30pm, 3.20am and 6.00am. No issue was raised by RN T about these observations being completed. RN T did sign off the clinical care reviews at 1am and 5am, without any concerns being raised at the time that the observations and medications were not completed. RN T did not raise any concerns about the Practitioner's conduct on this night shift until some six weeks later once the ADHB employment investigation was commenced; and

(d) As RN Gorte noted, other nurses had completed observations on this patient when they were asleep earlier in the evening and the next day.

[142] The Tribunal makes no criticism of RN T in any of this assessment. She clearly had genuine concerns about the Practitioner's care of patients. The Practitioner had made an obvious error in recording, which rightly raised some concerns. However, without more evidence of a failure in care from a parent complaint or another RN witness or any obvious decline in the patient, we are not satisfied that Particular 7 is established

Particulars 6 and 8: Patient U - [ ] 2016

[143] Particulars 6 and 8 relate to the [ ] old girl, Patient U, who had bronchopneumonia and was on Ward [X] during the night shift on [ ] 2016. She was charted to receive the antibiotic Cefuroxime intravenously during the course of the night shift.

[144] Particulars 6 and 8, have been combined for consideration as they both relate to this patient. It is alleged that the Practitioner:

(a) failed to carry out observations and/or administer the intravenous antibiotics (Particular 6.1); and/or

(b) documented in the patient records the antibiotics had been given at 5am when they had not (Particular 6.2); and/or

(c) documented that observations had been completed at 9pm, 1am and 5am when they had not (Particular 6.3);

(d) failed to administer and/or have checked and countersigned by another registered nurse the administration of intravenous antibiotics (Particular 8.1) [28];

(e) countersigned the administration of the antibiotics as having occurred at 5am by using the signature of another registered nurse purporting to be that registered nurse when the registered nurse had not countersigned and the medication had not been administered. (Particular 8.2).

[145] The Tribunal heard evidence from three nurses, RNs I, A and T, the patient's mother Ms U and the Practitioner. The Practitioner worked the night shift along with RNs I and A. The Practitioner was allocated the care of the patient. RN T took over the care of the patient on the following day shift.

[146] Ms U was summoned to attend the Tribunal hearing at the request of the PCC. It was submitted for the Practitioner that, as a result of this reluctance to attend, the mother's evidence should be approached with caution both as to

[28] Particulars 6.1 and 8.1 overlap in that they both allege a failure to "administer" the

reliability and credibility. However, Ms U's reluctance to attend to give evidence was only because she had been dealing with her own mother's ill health. The Tribunal was satisfied that she was both reliable and credible, she had no motive to give untruthful evidence to the Tribunal.

[147] The patient's clinical notes document that the Practitioner carried out observations at 1.00am and 5.00am without waking the patient and administered the Cefuroxime at 5.00am. There is a countersigned signature for the Cefuroxime, in accordance with the normal practice.

[148] When a medication is to be administered intravenously, the nurse administering it first takes the patient's medication chart into the medication room and prepares/mixes the medication. That nurse then requests another RN to come to the medication room to countersign. This involves the second nurse checking the details on the chart along with the prepared medication and dose, before adding his or her signature to the chart. This process must occur at the time the medication is being prepared and before it is given.

[149] RNs I and A both say they did not see the Practitioner carry out the observations or administer the medication. They are certain that neither of them countersigned the patient's chart in relation to the Cefuroxime.

[150] RN I had a reasonable working relationship with the Practitioner but acknowledged that the Practitioner's authoritative manner did impact her relationship with other nurses on the ward at times. The Practitioner also acknowledges they worked well together. RN I recalls it was the next morning on [ ] 2016, that she was asked by the Charge Nurse to review the clinical record for this [baby] female patient and that the night shift was fresh in her memory. She was asked to identify the countersignature for the 340mg Cefuroxime entry on [ ] at 5am. RN I confirmed at the time and in her evidence to the Tribunal, that while it looked like her signature this was not her signature. She did not countersign for that medication at 5am and recalls she was on her own break at that time. RN I also confirmed that the only other person who could have countersigned at 5.00am was RN A and she did not believe that was her signature either. RN I also completed an interview in the ADHB employment disciplinary process in [ ] 2016, in which she confirmed the same recollection of events. [29]

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medication.

[29] ABD Tab 12, RN I interview statement provided to ADHB employment investigation dated [ ] 2016.

[151] RN A gave evidence that the observations by nurses on the Starship Hospital ward are usually done 4 hourly; at 8.00am, 12 noon, 4.00pm, 8.00pm, 12 midnight and 4.00am. She recalls that on the night shift on [ ] 2016, the Practitioner spent most of the evening sitting at a computer in the nurses' station. She did not see the Practitioner on the ward attending to any of her patients, using the Draegar monitors or obtaining any medications from the drug room next to the nurses' station. However, RN A also acknowledged that she was in and out of the nurses' station attending to her patients at times.

[152] RN A confirms the countersignature on the patient records for the 5am entry is not her signature. She does not believe it is RN I's as RN I was away on her break at that time and she recalls RN I arriving back on the ward at 5.15am. RN A was asked for her recollection of these events on or about [ ] 2016 and she provided her written interview statement to the ADHB employment investigation which is consistent with her evidence to the Tribunal.[30]

[153] RN A also gave evidence that in her experience it is very unusual to be able to carry out observations on an unwell paediatric patient without waking them. This is particularly her experience if the parent is sleeping in the child's room as they usually wake if you enter and that the Draegar monitors will always make some noise that will wake a patient or parent.

[154] The patient's mother, Ms U, was staying in the room with her [baby] daughter. She gave evidence that she was a light sleeper and was clear that she always tended to wake when nurses came into the room. Ms U acknowledged that she was tired, concerned and stressed at her daughter's health on this occasion as she had been on previous occasions when her daughter had been admitted to Starship. However, she was firm that she had a set practice that she would ask the nurses to place her daughter's cot next to her bed so she could sleep facing her daughter and holding her hand. She also recalls making sure that the curtains were drawn around her bed to protect her daughter from the air-conditioning. Ms U did acknowledge that she would likely have slept at times over the night, but did not believe it would have been possible to conduct various sets of observations and administer IV medication to her daughter without her waking given they were both sleeping so close to each other, her own light sleeping pattern and her experience that she would wake if a nurse came to

[30] ABD Tab 13, RN A interview statement provided to ADHB employment investigation dated [ ] 2016.

attend to her daughter. She felt concerned enough about this to raise this concern with RN T the next morning.

[155] RN T confirmed that when she came on shift the next morning, the patient was asleep in her cot and the mother's bed was pushed up against the cot with the curtain pulled around the bed and cot. RN T said she could not get to the patient without waking the mother. She went back at 8am to do the observations and the patient woke while doing this and the mother woke instantly.

[156] RN T confirmed the mother had raised her concern that no antibiotics had been administered overnight and so she was unsure of the plan for her child. The mother became confused when RN T advised her that the patient records recorded the antibiotics had been given at 5am. The mother's reaction at the time was that this was not possible and that the only intervention over the night shift was the IV antibiotics at 9.00pm, but otherwise no observations were taken or other medications given. The mother's recollection was recorded by RN T at the time in a detailed note dated [ ] 2016.[31] This note is consistent with the evidence she provided to the Tribunal.

[157] The Practitioner denies all of Particulars 6 & 8 and says that she completed the observations and administered the medication as documented.

[158] The Tribunal accepts that the Practitioner administered the IV medication at 9.00pm and each of the observations but not the blood pressure, this was not disputed by the patient's mother. There was no complaint about the Practitioner's conduct at 9.00pm, when Ms U's concerns were raised the morning after the shift.

[159] It is the later observations and medication records for 1.00am and 5.00am that the Tribunal is satisfied, on the balance of probabilities, did not take place. In particular, the combination of the following evidence was compelling:

(a) The mother immediately raised her concerns about the lack of cares given over the night, when RN T came onto morning shift.

(b) While it is no doubt possible for parents to sleep through a nurse coming to the bedside, we were satisfied by the mother's evidence

[31] ABD doc 12.

that this was unlikely to have been the case on this occasion, given:

(i) the observations said to have taken place on two separate occasions (1.00am and 5.00am) and the IV antibiotics (5.00am); and

(ii) the mother's close sleeping arrangements with her daughter on this shift, the positioning of the cot next to the mother's bed and her recall of the curtain being positioned around the bed to protect her child from the cool air-conditioning, make it unlikely that she and the child would have not woken particularly when BP observations are said to have been undertaken by the Practitioner at 1.00am and 5.00am;

(c) The mother's evidence is also supported by RN T's observations of the patient and mother's close sleeping arrangements and their waking the next morning when observations were being conducted and the concerns immediately raised with RN T;

(d) RN I and RN A did not observe any occasion during the shift when the Practitioner was preparing to undertake observations or entered the drug room to arrange medications for administration. Most significantly, neither of them countersigned the IV antibiotics; and

(e) The patient notes made by the Practitioner include her reference that mother "UTD with plan", which was clearly not the case for this mother.

[160] It is the combination of this evidence that is significant for the Tribunal. We acknowledge that there was no material decline in the patient's PEWS overnight or the next morning and that RN I signed off the clinical care reviews with the Practitioner over the course of the night shift. However, the IV antibiotics had been delivered at 9pm and so the impact of missing one dose at 5.00am is unlikely to cause a decline over such a short time period. The clinical care reviews, as discussed earlier in this decision, are not evidence that the observations and medications were delivered. These two items, even together

with the Practitioner's evidence, were not sufficient to outweigh the other stronger indicators to the contrary.

[161] The Tribunal was unconvinced by the Practitioner's highly detailed description of how she claims she was able to conduct the series of observations and administer the IV medication, without waking this patient or mother. While we accept the expert evidence that this is possible by experienced nurses, the specific circumstances of this patient and mother, including the arrangement of the cot and the pulled curtain, together with the other evidence that the Practitioner did not take the steps she claims, is a more compelling picture.

[162] The Tribunal found particulars 6.1 to 6.3 established as follows:

(a) The Practitioner failed to carry out observations at 1am and 5pm on the night shift on [ ] 2016;

(b) The Practitioner documented that she had administered antibiotics to the patient at 5.00am when she had not; and

(c) The Practitioner documented in the patient records that she had completed observations at 1.00am and 5.00am when she had not.

[163] The Tribunal found particulars 8.1 and 8.2 established as follows:

(a) The Practitioner failed to administer the intravenous antibiotics charted 340mg cefuroxime to her patient at 5.00am; and

(b) The Practitioner countersigned the administration of the intravenous antibiotics to her patient as having occurred at 5am by signing in the name of another registered nurse, when another registered nurse had not countersigned and the medication had not been administered.

Tribunal decision on liability

[164] In summary, the Tribunal's factual findings on each of the Particulars are as follows:

(a) Particular 1 – Established including 1.1-1.3;

(b) Particular 2 - Not established;

(c) Particular 3 – Established including 3.1-3.3;

(d) Particular 4 – Established;

(e) Particular 7 – Not established;

(f) Particulars 6 & 8 – Established including 6.1-6.3 and 8.1-8.2.

Is professional misconduct established?

[165] The Tribunal must also apply the two step process to consider whether professional misconduct is established, either separately or cumulatively.

(a) First, did the proven conduct fall short of the conduct expected of a reasonably competent health practitioner operating in that vocational area?

On an objective analysis the Tribunal is satisfied that the conduct established in Particulars 1, 3 and 6 & 8, each amount to malpractice, negligence and are likely to bring discredit to the nursing profession. These separate failures in care to each of the three patients involved, fall well short of the care expected of a nurse dealing with young patients.

(b) Secondly, the Tribunal is also satisfied that Particulars 1, 3 and 6 & 8 are each departures from acceptable standards that are significant enough to warrant a disciplinary sanction for the purposes of protection of the public and or maintaining professional standards. While it is fortunate that no harm was caused to the three patients, this does not excuse the serious failures; recklessness in failing to deliver the care and dishonesty in misrepresenting that the care was given. They are separately and cumulatively established as professional misconduct under sections 100(1)(a) and/or (b) of the Act.

[166] In relation to Particular 4, the Tribunal did not consider this was sufficiently serious, on its own, to warrant a separate finding of professional misconduct. However, cumulatively it is part of a pattern of failure in nursing duties owed by the Practitioner, that makes it serious enough to warrant being part of any disciplinary sanction.

Penalty

[167] In relation to the five Particulars established, the Tribunal must go on to consider the appropriate penalty under section 101 of the Act. The penalties may include:

(a) Cancellation of the Practitioner's registration;

(b) Suspension of registration for a period not exceeding 3 years;

(c) Censure;

(d) An order that the Practitioner may only practise with conditions imposed on employment or supervision or otherwise;

(e) A fine of up to $30,000; and

(f) An order as to costs of the Tribunal and/or the PCC to be met in part or in whole by the Practitioner.

[168] The Tribunal accepts as the appropriate sentencing principles, those contained in *Roberts v Professional Conduct Committee*,[32] where Collins J identified the following eight factors as relevant whenever the Tribunal is determining an appropriate penalty. In particular, the Tribunal is bound to consider what penalty:

(a) most appropriately protects the public and deters others;

(b) facilitates the Tribunal's important role in setting professional standards;

(c) punishes the practitioner;

[32] *Roberts v Professional Conduct Committee* [2012] NZHC 3354 at [44]-[51].

(d) allows for the rehabilitation of the health practitioner;

(e) promotes consistency with penalties in similar cases;

(f) reflects the seriousness of the misconduct;

(g) is the least restrictive penalty appropriate in the circumstances; and

(h) looked at overall, is the penalty "fair, reasonable and proportionate in the circumstances."

PCC submissions on penalty

[169] The PCC seeks cancellation of the Practitioner's registration, together with a censure and costs. The PCC submit that the seriousness of the established Particulars of the Charge leaves the Tribunal without any other viable option but to cancel the Practitioner's registration.

Practitioner's evidence and submissions on penalty

[170] In relation to penalty, the practitioner presented two witness statements:

(a) The affidavit of RN M dated 16 March 2020. RN M worked with the Practitioner for some 14 years up until December 2015. She found her to be a dedicated nurse with a caring nature, though she noted some personality conflicts other nurses; and

(b) A signed statement from RN H dated 20 March 2020. Due to Covid-19 restrictions, Ms H was unable to attend the hearing in person and the Practitioner elected to present this evidence by way of signed statement on penalty. RN H worked with the Practitioner at Starship Hospital between 1997 and 2003. RN H states that she always found the Practitioner to be a conscientious and competent nurse. She did note that the Practitioner had a strong and direct communication style that could at times appear confrontational to others and that she had recommended she undertake a series of intensive communication training courses.

[171] Ms Johns for the Practitioner submits that conditions on the Practitioner's scope of practice, or at most a period of suspension, together with a censure would be the appropriate penalty.

[172] Counsel submits that the Practitioner had more than 20 years' experience, she would be a great loss to the profession and was capable of rehabilitation. The Practitioner seeks a second chance to enable her to continue to practise as a nurse with firm conditions placed on her. The conditions proposed for a period of 12 months are twofold; being monthly supervision and 3 monthly reporting to the Nursing Council on her work performance and fitness to practise.

[173] The mitigating factors raised for the Practitioner included the fact that this is the first time in 24 years of nursing that she has been before this Tribunal, the personal reflection the Charge has caused for her, and her engagement with a psychiatrist and psychotherapist. The Practitioner also raised as mitigation her stressful personal circumstances at the time of the offending including the poor work environment on the ward at that time. Finally, her counsel, Ms Johns, also pointed to the fact that the misconduct did not endanger patients as there was no evidence of deterioration in their health at the time.

Comparable cases

[174] The parties referred the Tribunal to several cases which similarly involved some form of falsification of patient records. In the first three cases referred to below, each involved findings of dishonesty and resulted in the practitioner's registration being cancelled.

[175] In *Hepi*,[33] a registered nurse falsely recorded that she had enrolled a number of older adults on a community health programme, visiting them in their homes and carrying out health assessments. The records were falsified over 5 months and involved 10 patients. Ms Hepi did not appear before the Tribunal. The Tribunal regarded the false enrolment records as negligent, but "more of an employment issue". However, the Tribunal went on to state at [52]:

> "Of far more concern is the falsification of notes and the assertion that interventions had been carried out when they clearly had not."

[33] 224/Nur09/114P.

[176] The Tribunal found this was professional misconduct and when dealing with penalty concluded at [58]:

> "… A nurse who lies about enrolling and visiting patients and who creates fictitious notes is deserving of significant condemnation by her own profession. The Tribunal does not consider that it has any option but to cancel Ms Hepi's registration."

[177] In *Joyram*,[34] a registered nurse faced three charges of professional misconduct; including falsifying the recordings of vital signs of two patients, failing to adequately check and assess a patient's blood glucose levels (resulting in the inappropriate administration of insulin) and asking another nurse to steal Tramadol from the wards for him. The practitioner did not appear before the Tribunal. Mr Joyram's registration was cancelled on the basis that "the breaches reveal serious issues of public safety, maintenance of standards and dishonesty."[35] The Tribunal noted at [36]:

> "As the Tribunal has said on numerous occasions, honesty and documentation are essential tools for a nurse. Honesty in documentation is an even more essential tool."

[178] In *Devi,*[36] a registered nurse created false clinical documentation following the death of a patient. The practitioner also instructed a group of nurses to rewrite, backdate and add new documentation to the clinical record of the patient. The practitioner defended the charges. Credibility was a central issue with the Tribunal preferring the evidence of the practitioner's colleagues. The Tribunal was satisfied that the conduct involved dishonesty and deception and cancelled the practitioner's registration, censured her and ordered costs.

[179] The Tribunal was also referred to three cases involving creation of false records which did not involve cancellation of registration:

(a) In *Clark*,[37] the practitioner also made retrospective changes to the clinical records of a deceased patient. She was asked by her employer to tidy up the patient's notes before they were sent to

[34] 359/Nur10/160P.

[35] At [47].

[36] 943/Nur17/399P.

[37] 242/Nur09/122D.

the Office of the Health and Disability Commissioner. The practitioner admitted the conduct and accepted that presenting the records as contemporaneous when they were not amounted to professional misconduct. However, there was no finding by the Tribunal that any of the added information was false and the PCC did not seek cancellation as a penalty. The practitioner was censured and fined and had conditions imposed on her scope of practice.

(b) In *Sharma,*[38] the practitioner arranged for a false reference to be provided to prospective employers. She provided false contact details for a former manager and then either impersonated (or arranged for someone else to impersonate) the manager on the phone. The Tribunal was close to ordering cancellation of her registration, but the Tribunal elected not to do so as it had been satisfied that Ms Sharma was capable of rehabilitation.

(c) In *Tamma*,[39] a doctor admitted to retrospectively falsifying patient records in an attempt to justify an inappropriate intimate examination. The doctor was suspended for 18 months and subject to conditions for a further three years after he recommenced practice. The Director of Proceedings did not seek cancellation of the doctor's registration and the Tribunal noted that mitigating factors included the practitioner's guilty plea and the fact that he was no longer practising, having left New Zealand.

Tribunal findings on penalty

[180] The Tribunal has considered the aggravating and mitigating factors for this Practitioner.

[181] The aggravating factors we consider relevant are:

(a) The established Charges 1, 3, 6 and 8, all involve significant findings of failure to administer care and carry out observations on young and vulnerable patients. This conduct related to three

[38] 882/Nur16/362P.

[39] 577/Med13/247D.

patients and occurred over three different shifts in [ ] 2016. This was not a "one off" or momentary lapse of judgment;

(b) The established Charges also highlight the Practitioner's failure to observe her responsibility to be in partnership with the parents of the children. The Tribunal notes these are important Principles under the Nursing Council Code of Conduct Principles 3.2 and 3.5.

(c) Finally, at the hearing the Practitioner strenuously denied creating the false patient records or failing to provide care to the patients. The Practitioner spent much of her evidence being highly critical of her former nursing colleagues, blaming the ward environment and even challenging the integrity of the two mothers who gave evidence. As a result, the Tribunal was left with significant concerns about the Practitioner's level of insight and her ability to engage effectively in rehabilitation.

[182] The Tribunal accepts that the Practitioner is entitled to recognition of the following mitigating factors:

(a) This is her first appearance before the Tribunal in 24 years of nursing;

(b) She has appeared before the Tribunal to answer the Charges;

(c) There is some limited evidence of reflection as a result of therapy undertaken by the Practitioner about her communication style, as discussed in her doctor's report;

(d) Since 2017, the Practitioner has worked for some three years as a registered nurse in aged care without any further reported incident or restrictions on practice sought by the Nursing Council; and

(e) There were some work and personal pressures for the Practitioner during 2016, which provide context for her conduct.

[183] The most comparable cases are, in our view, the first three cases referred to above of *Hepi, Joyram and Devi*. These cases all involve the dishonest creation

of patient records which is at the heart of this case. Each of the cases resulted in cancellation. The cases of *Clark, Sharma and Tamma*, are each distinguishable as less serious cases. In the case of *Sharma*, the practitioner did not falsify patient records and the Tribunal was more certain that rehabilitation could be achieved.

[184] The Tribunal has considered whether it may have been possible to impose a penalty short of cancellation. However, in our view the protection of the public and the maintenance of professional standards and trust and confidence in the profession require cancellation in this case. The established conduct goes to the heart of the Practitioner's role to provide safe and competent care and maintain honest and accurate patient records. While the Practitioner did not intend to cause any harm to her patients, the risk of harm was certainly present. The fact that there was no harm caused on these occasions is not in our view any mitigation, the risk of harm was evident.

[185] Having observed the Practitioner giving evidence, the Tribunal was left wholly unconvinced that she has any real insight or acceptance of her established misconduct. The evidence of her efforts to gain insight into her behaviours is, at best limited. The doctors' reports she presented did not provide the Tribunal with any comfort that the Practitioner had been able to gain significant insight or show remorse for her conduct. There was no sustained show of this during her evidence before the Tribunal. The Practitioner maintained a persistent air of disrespect and disdain for her former nursing colleagues, which the Tribunal found highly concerning.

[186] The Tribunal also notes the Practitioner was only able to present very limited evidence of support for her professional career. The two registered nurse witness statements provided were from nurses who had worked with the Practitioner many years previously and both prior to 2016. There was no evidence of support for her as a practitioner from her current employer or others she has worked within the last five years.

[187] Finally, the Tribunal was not convinced that 2016 was a unique period of significant professional and personal stress for the Practitioner. The Practitioner has remained under continued personal and health pressures since that time and even at the time of the hearing. Her own evidence has confirmed the continued and significant concerns she has for her son's health, her own health and the financial pressures for her. Sadly, these risks remain present for the Practitioner and her conduct.

[188] The Tribunal considers it appropriate to order the following penalties; censure, cancellation of the Practitioner's registration and a condition that the Practitioner is not permitted to apply for reregistration for a period of three years, under s102 of the Act.

[189] The later penalty condition is imposed as the Tribunal considers it necessary to ensure that the Practitioner does not attempt to return to the nursing profession without a lengthy period of cancellation, reflecting the seriousness of her misconduct.

Costs

[190] Under s101(f) of the Act, the Tribunal may order the Practitioner to pay part or all of the costs and expenses of and incidental to the PCC investigation and this prosecution, so far as they relate to the subject matter of the Charge. There is no GST awarded on costs in the Tribunal, as is the case in costs before the Courts.

[191] Costs in any health professional disciplinary proceeding involve a judgement as to the proportion of the costs which should properly be borne by the profession as a whole (being responsible for maintaining standards and disciplining its own profession) and the proportion which should be borne by the guilty practitioner who has caused the costs to be incurred.

[192] In this jurisdiction, it has long been established that in considering the appropriate quantum of costs, the Tribunal must consider the need for the Practitioner to make a proper contribution towards the costs. In doing so, the Tribunal takes 50% of the total reasonable costs as a starting point, in accordance with the dicta in *Cooray v Preliminary Proceedings Committee*.[40] This percentage may increase or decrease depending on the individual case.

[193] An award of costs is not intended to be punitive and the practitioner's means, if known, should be considered.[41]

[194] The PCC's costs were discussed at the hearing as being in the region of $130,000 to $140,000. The PCC noted that there may have been an element of double counting with costs of the Tribunal and so arranged to clarify the PCC

[40] HC Wellington, AP 23/94, Doogue J, 14 September 1995.

41 *Vatsyayann v PCC* [2012] NZHC 1138.

costs following the hearing. The PCC confirmed these costs by a detailed schedule of costs, summarised below:

PCC investigation expenses	$6,565.48
PCC prosecution costs	$26,780.01
Counsel's fee	$97,000.00
Total	**$130,345.49**

[195] The level of costs is high in this case given the nature of the full defence by the Practitioner and the length of hearing. There were also several interlocutory applications made by the Practitioner and additional costs associated with an adjournment of the hearing set for May 2019. This adjournment was granted on the application of the Practitioner.

[196] The PCC acknowledges that there should be some reduction for the two Particulars that were not established, but otherwise seeks 50% of its total costs and disbursements and those of the Tribunal.

[197] The Tribunal's Estimated Costs Schedule presented at the hearing shows costs of $145,322.00**.** The Tribunal indicated at the hearing that the estimate would likely be reduced to reflect less time for decision writing, so the final costs of the Tribunal are estimated as **$140,000.**

[198] The Practitioner seeks a minimal costs order. She has provided an affidavit of financial means dated 9 July 2020, as evidence of her limited financial means. The Tribunal has taken this into account in considering the appropriate level of costs.

[199] The total costs of the PCC and the Tribunal are a very significant sum in this case, being **$270,345** (GST exclusive). It is appropriate to acknowledge that Charges 2 and 7 were not established. As a result, the Practitioner should not bear the costs of those matters. Overall, we apply a 20% reduction (or $54,000) from the total costs to take account of those two Particulars. This leaves the total costs as:

(a)	PCC costs	$130,345 less 20%	$104,276
(b)	Tribunal costs	$140,000 less 20%	$112,000

	Total costs	$216,276

[200] This then leaves the Tribunal with a starting point for the consideration of a 50% award of costs or some lesser figure to take account of the Practitioner's financial position.

[201] The Tribunal is willing to apply a further discount of 10% to take account of the Practitioner's financial circumstances. This discount reflects our view that while we acknowledge the Practitioner may have some difficulty in paying this award of costs, the profession should not be left to bear the cost of her defence of the Charge more than it already will.

[202] The Practitioner is ordered to pay 40% of the total PCC and Tribunal costs of $216,276, as set out below:

(a)	Costs to be paid to the PCC (40%)	$41,710
(b)	Cost to be paid to the Tribunal (40%)	$44,800
	Total costs to be paid	**$86,510**

Suppression of Name

[203] The Practitioner was granted interim name suppression pending the Tribunal hearing. The Practitioner has sought permanent name suppression under s95 of the Act, which is opposed by the PCC.

[204] Every hearing of this Tribunal must be held in public unless the Tribunal orders otherwise. Section 95 of the Act deals with the Tribunal's powers in this regard as follows:

> **"95 Hearings to be 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 the complainant) and to the public interest, the Tribunal is satisfied that it is desirable to do so, it may (on the application of any of the parties or on its own initiative) make any 1 or more of the following orders: …[including private hearing orders or suppression of publication orders].

[205] The Tribunal must consider the important presumption of openness in judicial proceedings as set out in s95 of the Act. The discretion given to the Tribunal under s95 to order non-publication must only be used in accordance with the guidance given under that section and in the case law.

[206] When the Tribunal is considering an application to suppress the name of any person appearing before it, or whether parts of a hearing will be in private, it must consider whether it "is satisfied that it is desirable" to make such an order taking into account the following:

(a) The interests of any person; and

(b) The public interest.

[207] The interests of any person will include any complainant, the applicant and any third parties.

[208] The public interest will include an evaluation of the relative strength of the public interest factors namely:

(a) There is a public interest in knowing the name of a practitioner accused or found guilty of a disciplinary offence;

(b) Accountability and transparency of the disciplinary process which is subject to a statutory presumption that hearings will be in public unless ordered otherwise;

(c) The importance of freedom of speech and the right enshrined in s14 New Zealand Bill of Rights Act 1990.

[209] A useful summary of these interests has been provided by the Court in *Anderson v PCC*,[42] in which Gendall J states:

> "[36] Private interests will include the health interests of a practitioner, matters that may affect a family and their wellbeing, and rehabilitation. Correspondingly, interests such as protection of the public, maintenance of professional standards, both openness and 'transparency' and accountability of the disciplinary process, the basic value of freedom to receive and impart information, the public interest in knowing the identity of a practitioner found guilty of professional misconduct, the risk of other doctors' reputations being affected by suspicion, are all factors to be weighed on the scales.
>
> [37] Those factors were also referred to at some length in the Tribunal. Of course publication of a practitioner's name is often seen by the practitioner to be punitive but its purpose is to protect and advance the public interest by ensuring that it is informed of the disciplinary process and of practitioners who may be guilty of malpractice or professional misconduct. It reflects also the principles of openness of such proceedings, and freedom to receive and impart information."

[210] The Tribunal also recognises that once the practitioner has been found guilty of professional misconduct, the public interest factors may become weightier as the public interest in knowing the name of a practitioner found guilty of professional misconduct may mean it is difficult to say suppression orders are "desirable". However, the Tribunal notes that the threshold for desirability is lower than that required in the criminal jurisdiction, rather the question is whether there are sound reasons for making any suppression orders sought, with the starting point being the fundamental principle of open justice.[43]

[211] In *Dr X v Director of Proceedings*,[44] the Court stated that there must be something more "sufficiently compelling" than stress or embarrassment to justify suppression of a practitioner's identity. The practitioner's or a family member's serious health concerns may be sufficient to warrant suppression of the practitioner's identity.

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[42] HC, Wellington, CIV 2008-485-1646 (14 November 2008).

[43] *Johns v Director of Proceedings* [2017] NZHC 2843, at [166]-[167].

[44] *Dr X v Director of Proceedings* [2014] NZHC 1798 at [15].

[212] The Practitioner's application for permanent name suppression is made on the following private interest grounds:

(a) The Practitioner's unique surname would lead to recognition for her and her family. Their name is unique and they are the only family in New Zealand with this name;

(b) The adverse impact on the health of both the Practitioner and her son;

(c) The potential adverse impact on her husband's ability to perform his role as an employee with [ ].

(d) The potential impact on the Practitioner's therapeutic relationships with her patients.

(e) The harm to the Practitioner's reputation and likely impact on her ability to do her job.

[213] The Practitioner submitted an affidavit in support of the application for name suppression, which addressed her own health issues (she suffers from anxiety and depression) and the likely impact on her son, who is currently a young adolescent and has been diagnosed with [ ]. Reports from the Practitioner's psychiatrist and the son's paediatrician were also attached to the Practitioner's affidavit.

[214] The paediatrician's report noted that the Practitioner's son will risk suffering material harm because of publicity about this case and the adverse findings against his mother. In particular, the son's [ ] may be affected negatively by the increased social and psychological challenges publicity would cause for him. The son currently struggles with [ ].

[215] A statement from the Practitioner's husband was submitted to address the potential impact of publication on his employment. The Practitioner and her husband are both concerned that publicity could make him a target at his work and negatively impact his employment.

[216] The Practitioner also relies upon the risks to her own mental health. The Practitioner's own physiatrist report confirms that publicity is likely to have an

adverse impact on her mental health. The report states "publication of her name would be highly detrimental to her mental well-being". It is submitted that this health risk goes well beyond "inevitable embarrassment" to the Practitioner.

[217] Finally, the Practitioner says there are two additional grounds that warrant her name suppression:

(a) Therapeutic relationships should not be damaged - if she is allowed to continue to work in the profession, then her colleagues and patients need to have confidence in her as a nurse and that confidence would be undermined by publication; and

(b) Her reputation in the profession should be maintained to allow her rehabilitation.

[218] The Tribunal accepts that the Practitioner's surname is sufficiently uncommon that her husband and son would be readily identifiable as related to her. The Tribunal also accepts, based on the medical reports presented, that there is a real risk of harm to the mental health of both the Practitioner and her son, if name suppression is not granted. These are the matters that are the most compelling grounds in support of the suppression application.

[219] The risk of harm to the husband's employment was not supported by any direct sworn evidence from her husband or his employer. In the circumstances of this limited evidence, it was not sufficient to outweigh the important public interest factors in this case. The risk to the Practitioner's therapeutic relationships and damage to her reputation were also matters that the Tribunal does not consider would outweigh the public interest factors in this case.

[220] However, the considerable risk to the Practitioner's son's health is a matter that the Tribunal is willing to give significant weight. This risk combined with the risk to the Practitioner's health is sufficient to convince the Tribunal that it is desirable to grant permanent name suppression to the Practitioner.

[221] We acknowledge that there are material public interest factors at play in this case, including promoting the openness and transparency of disciplinary proceedings and the public interest in knowing the name of a practitioner who is found guilty of professional misconduct. However, the private health interests of the practitioner's son warrant protection in this case. While the Practitioner's

own health interest may not, on its own, have been sufficient in this case, the risks to her health have also contributed to the overall conclusion that the private health interests in this case are significant.

[222] The important public interest factors of protecting the public and maintaining professional standards, will still be served by the order of cancellation, censure and the conditions placed on the Practitioner's return to practice, if she ever made the application for re-registration. The public interest in openness and transparency of the disciplinary proceeding will also be sufficiently served by the otherwise full reporting of this decision.

[223] The Tribunal also grants permanent suppression orders in relation to the names and identifying features of any of the patients named in the Charge and the names of the patients' parents. The registered nurses who gave evidence at the hearing and any other registered nurses named in the evidence do not seek permanent name suppression and any interim name suppression orders made for those registered nurses are now lapsed.

Orders of the Tribunal

[224] The Tribunal has found the Practitioner guilty of professional misconduct under s100(1)(a) and s100(1)(b) of the Act. The penalty orders of the Tribunal are as set out below and will take effect 20 working days from the date of this decision:

(a) Cancellation of the Practitioner's registration under s101(1)(a) of the Act;

(b) Censure of the Practitioner under s101(1)(d) of the Act;

(c) The Practitioner is not permitted to apply for reregistration for a period of three years under s102 of the Act;

(d) The Practitioner is ordered to pay $86,510 being 40% of the costs of the PCC and the Tribunal; $41,710 to the PCC and $44,800 to the Tribunal;

(e) The Practitioner's application for permanent suppression of her name and any identifying features is granted, including the name of her son and husband;

(f) Under s103(2A) of the Act, the Tribunal directs the Executive Officer to ensure that a copy of the orders set out in this decision are given to the Practitioner's current employer and any future employer in the event of the Practitioner's re-registration; and

(g) The Tribunal orders permanent name suppression of the names and any identifying features of the patients and their parents named in the Charge or the evidence.

[225] Pursuant to s 157 of the Act, the Tribunal directs the Executive Officer:

(a) To publish this decision and a summary on the Tribunal's website, subject to the suppression orders made above; and

(b) To request the Nursing Council to publish either a summary of, or a reference to, the Tribunal's decision in its 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 Auckland this 17th day of November 2020

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M Dew QC, Deputy Chair, Health Practitioners Disciplinary Tribunal

Appendix: Notice of Charge

Particulars of Amended Charge dated 14 May 2019

The PCC charges that when working as a staff nurse at Starship Children's Health ("Starship Hospital") in the period [ ] 2016 Ms E, registered nurse of Auckland:

1.0 During the nightshift on Ward [X] (General Paediatrics) on [ ] 2016:

1.1 failed to provide care for a [teenage] female patient with asthma (patient A) in that she failed to give the patient q1-2 hourly spacers of Salbutamol as had been documented on the patient's medication chart by the on-call House Officer at around 2350 hours and/or failed to do any observations on her patient during the shift; and/or

1.2 documented in the patient's clinical records that the on-call House Officer had reviewed the patient three times during the shift and had made the decision to change the spacers to be administered every two hours when the on-call House Officer had only reviewed the patient once (at 2350 hours) and had not changed the timing of the administration of the spacers to two hourly; and/or

1.3 documented in the patient's clinical records that she had completed observations and/or administered the spacers to her patient when observations had not been done and/or the spacers had not been given; and/or

2.0 During the nightshift on Ward [X] on [ ] 2016:

2.1 failed to carry out observations on patients assigned to her care; and/or

2.2 documented in her patients' clinical records that she had completed observations on her patients during the shift when she had not done them; and/or

3.0 During the nightshift on Ward [X] on [ ] June 2016:

3.1 failed to carry out any observations on and/or administer oral antibiotic medication to a [young] male child with pneumonia; and/or

3.2 documented in her patient's clinical records that she had carried out four-hourly observations (at 2000 hours, 2400 hours and 0400 hours) on her patient when she had not done so; and/or

3.3 documented in her patient's clinical records that she had administered oral antibiotic medication to her patient at 0400 hours when she had not administered the medication.

4.0 On [ ] 2016 when pooled to Ward [Y] (to cover patient numbers due to short-staffing, Ms E acted in an inappropriate and/or unprofessional manner by refusing and/or failing to take two booked adolescent patients with abdominal pain issues and a patient with [ ] who had been assigned to her for that shift; and/or

5.0 (deleted)

6.0 During the nightshift on Ward [X] on [ ] 2016:

6.1 failed to carry out observations on and/or administer intravenous antibiotics to an [ ] old female[45] toddler with bronchopneumonia (patient B); and/or

6.2 documented in her patient's clinical records that she had administered antibiotics to her patient at 0500 hours when she had not given that medication; and/or

6.3 documented in her patient's clinical records that she had completed observations at 2100 hours, 0100 hours and 0500 hours when she had not done observations; and/or

7.0 During the nightshift on Ward [X] on [ ] 2016:

[45] The gender of the patient was incorrectly stated as male in the Charge and this was amended without objection at the start of the hearing.

7.1 failed to carry out observations on a [young] child with bronchopneumonia; and/or

7.2 on or before 0445 hours when she asked a level 3 registered nurse to sign her clinical care review of the patient, documented on her patient's PEWS chart that she had completed full PEWS observations on the child at 0515, 0530 and 0545 hours when she could not have done them at those times; and/or

7.3 when confronted by the level 3 registered nurse about the timing of the PEWS observations being after the current clock time of 0445 hours, stated that she had got the hour wrong and changed the PEWS chart to record her having completed observations at 0415, 0430 and 0445 hours when she had not done them; and/or

8.0 On the nightshift on Ward [X] on [ ] 2016 when assigned to care for a [young] female patient (patient OP) with bronchopneumonia:

8.1 failed to administer and/or have checked and counter-signed by another registered nurse the administration of intravenous antibiotics (charted 340mg Cefuroxime) to her patient at 0500 hours; and/or

8.2 Countersigned the administration of intravenous antibiotics to her patient as having occurred at 0500 hours by using a signature purporting to be that of another registered nurse, when another registered nurse had not countersigned the giving of the patient's medication and/or the medication had not been administered.

The conduct alleged in Charges 1.0. 2.0, 3.0, 4.0, 6.0, 7.0 and 8.0 amounts to professional misconduct under section 100(1)(a) and/or (b) of the Act and particulars 1.1-1.3, 2.1-2.2, 3.1-3.3, 6.1- 6.3, 7.1 -7.3, and 8.1 -8.2 either separately or cumulatively, are particulars of that professional misconduct.