Nursing Council of Hong Kong

Disciplinary Inquiry

Nurses Registration Ordinance (Cap. 164)

No.: NC371/7/B

Dates of hearing: 25th October 2021, 30th November 2021 and 16th December 2021

Defendants: Ms. A ([redacted] ([redacted]))

& Ms. B ([redacted] ([redacted]))

DECISION

1. By a Notice of Inquiry dated 3rd June 2021, an inquiry was to be held against Ms. A ("Defendant A") and Ms. B ("Defendant B") in the matter as follows:

> *"[t]hat during the residence of Patient X ("the Patient") at the Ruttonjee & Tang Shiu Kin Hospital ("RTSKH"), on or about 7th December 2013, you, being a registered nurse of the RTSKH,*
>
> *i) failed to be responsible and accountable for individual nursing judgements and actions by failing to perform independent checking and/or confirm the correct dosage of the intravenous infusion drug (i.e. 200ml of 8.4% Sodium Bicarbonate (NaHCO3) intravenous Infusion) according to medical prescription before administration to the Patient; and/or*
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> *ii) failed to administer the correct dosage of the intravenous drug (i.e., 200ml of 8.4% Sodium Bicarbonate (NaHCO3) intravenous Infusion) to the patient according to medical prescription, thus jeopardizing the interests and safety of the Patient,*
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> *and that in relation to the facts alleged, either singularly or cumulatively, you have been guilty of unprofessional conduct."*

2. Defendant A and the Defendant B were represented by [redacted] of Cheung &Yip and [redacted] together with [redacted] both of Howse Williams respectively.

3. Defendant A has been a registered nurse since November 1987 and Defendant B since March 1998.

4. On 25th October 2021, [redacted] on behalf of Defendant B submitted that Defendant B did not "administer" the drugs as she had only taken a 100ml bottle of the drugs from the store room, primed it and hung it on the stand by the Patient; she did not connect the drip to the IV access.

5. The legal officer submitted that "administration" should be given the interpretation as defined in the Guide to Good Nursing Practice, Administration of Medication 2007, i.e. "Administration of medication is the process of identifying the correct medication, delivering it to the correct client by the correct route and the correct dosage at the time prescribed."

6. The Council accepts the Submission of the Legal Officer as it makes no sense, to the nursing profession at least, to pin a specific time as administration of drugs. Drugs are often handled by more than one nurse before given to patients, each step from the time the drug is taken out from storage until the time it is given to the patient should be handled by a qualified nurse and the requirement for signatures of 2 nurses acts as a check and balance to ensure that the patient's interest and safety is well protected.

7. It is further submitted on behalf of Defendant B that she did not appreciate her right to make submissions to the PIC and hence asked for the matter to be referred back to the PIC and/or to be heard after the determination of Defendant A.

8. The Legal Officer submitted that there is nothing in the information that Defendant B has given cannot be dealt with by way of evidence or legal submissions.

9. The Council agrees with the Legal Officer that there is nothing in the information provided by Defendant B which warrants the matter to be referred back to the PIC, nor is there any ground to defer the matter till after the determination of Defendant A.

10. The inquiry was adjourned for Defendant B to provide further information on the role she played and her duties at the material time; the reason she signed on the Drug Prescription and Administration Record and if she had signed any other records in respect of the drugs she handled, for example, records of drugs taken out of storage.

11. Defendant A did not object to the adjournment and deferred her mitigation after indicating that she would plead guilty to the notice.

12. The inquiry resumed on 30th November 2021 with the same representations.

Relevant Facts

13. It is not disputed that the Patient was a 69-year-old lady known to have diabetes mellitus and hypertension for over10 years. She was admitted to the CICU of the RTSKH on 6th December 2013. At about 22:53 hours on 7th December, her attending doctor prescribed 200ml Sodium Bicarbonate (NaHCO3) 8.4% intravenously initially over 1 hour.

14. It is not disputed that Defendant B, having heard the doctor's order verbally, went to the store room and got a bottle of 100ml Sodium Bicarbonate (NaHCO3) 8.4%, primed it and left it hung on the stand beside the Patient.

15. While it is not disputed that 3 other bottles of the same medicine were on the working table beside the Patient's bed, it is unclear as to who put them there.

16. It is recorded in the Drug prescription and administration record that at 23:15 hours the drug was given to the Patient. Both Defendant A and Defendant B signed on the column "Given By".

17. By 23:35 hours, the doctor reviewed the order and was not satisfied with the infusion rate; he then ordered the rest of the sodium bicarbonate to be administered over the next 15 minutes. The infusion was completed by 23:55 hours.

18. It must be noted here that the doctor had meant for the rest of the 200ml he prescribed to be administered within the next 15 minutes, but in fact the rest of the 400ml which was on the working table was administered.

19. The Patient's condition continued to go downhill and she was pronounced dead at 02:22 hours on the 7th December 2013.

20. At about 06:50 hours, Defendant A realized 400ml of the drug was administered instead of 200ml as prescribed and she reported the matter to the hospital.

21. No death inquest was held in respect of the Patient's death. It was found that she died of natural causes.

22. An expert report was commissioned from Professor [redacted] who in his report dated 2nd January 2015 opined that extra sodium bicarbonate was not a significant cause of death.

23. Defendant A admitted to a set of Brief Facts as the bases of her plea, a copy is attached as Appendix A herein.

Defendant B's case

24. Defendant B and the Legal Officer signed a set of admitted facts, a copy is attached as Appendix B.

25. Defendant B gave evidence in addition to 2 written statements she provided to this Council.

26. Defendant B said she assisted in getting one 100ml bottle of the drug from the store room, checked that it was the right drug, the right patient by the right route of the right dosage and since the IV access was not ready, she left the drug hanging on the stand. She did not take part in the actual connecting of the IV line to the Patient.

27. Defendant B in her evidence maintained that the Patient was not within her care at the material time; she had to care for another 2 patients in Bed 3 and 4. The CICU was full with 6 patients and 3 nurses and Defendant A was the nurse in charge.

28. Defendant B said she overheard the Dr's prescription verbally and went to effectively help out in getting the drug from the store room. As she was coming out of the store room, Defendant A said 1 bottle was not enough. Defendant B then primed the bottle of drug and left it hanging on the stand as the Dr. and Defendant A were right beside the Patient trying to get an access. Defendant B said she signed the drug prescription and administration record under the column "Given". Defendant B said she then went back to her 2 patients.

29. When asked, Defendant B said nothing of significance happened to the 2 patients she was assigned to at the material time. Defendant A was more experienced and it was not possible for her to check on when and how much of the NaHCO3 was given to the Patient. Defendant B said she could have checked only if Defendant A had told her.

30. Defendant B said further in her evidence that she had said to Defendant A "only 200ml" and Defendant A confirmed. Defendant B said she did not ask questions on why 3 other bottles of 100ml were taken out. She said though the store room is very close to the CICU, going to the store room would mean taking their eyes off the patients and hence it was a common practice to take one more dosage out just in case. Defendant B also said Sodium Bicarbonate (NaHCO3) 8.4% has always come in 100ml bottles for as long as she could remember.

31. Defendant B said there was no specific demarcation to separate the extra dosage taken out but patients requiring Sodium Bicarbonate is normally very urgent and needed it ASAP. At the material time the extra 2 bottles were placed on one end of the table while the other prescribed bottle on the other end was separated by files in between. There were no markings or labels to differentiate them.

32. Defendant B said with hindsight, she would have taken the drugs out of storage and see it through to giving it to the patient.

33. Defendant B said countersigning the record means she has checked the 5 rights.

34. When asked, Defendant B said Defendant A told her that one bottle had dripped to the floor and another bottle had to be used to replace it. Defendant B, however, was unable to say if the replaced bottle was an extra bottle or one from the extra dosage on the table. Defendant B was never asked to countersign again.

35. There appeared not to be a system for a record of the number of bottles of Sodium Bicarbonate in the storage at the time in the RTSKH.

36. Defendant B repeatedly said Defendant A was more experienced and was in charge in the ICU at the time; she had expected Defendant A would know the extra bottles even without labeling them as extras.

37. When asked the countersigning requirement does not differentiate seniority or experience, Defendant B admitted she did not think it through.

38. It is submitted on behalf of Defendant B that Defendant B should not be judged with hindsight. She had 2 other patients allocated to her.

Determination

39. It cannot be emphasized enough that the Council's primary function is to supervise the proper discharge by nurses of their professional obligations, and guard the public interest. Patients are in their utmost vulnerability when placed under the care of the medical professionals, nurses are expected to be at the top of their game at all times when they are on duty.

40. The requirement of another nurse countersigning for the administration of a prescription of drugs is to ensure the patient gets the correct drug in the correct dosage. The system is in place to double check and it is not a defense to rely on the experience of another nurse, nor is it a reason when one is just helping out. Once a nurse takes on the responsibility of countersigning, her duty does not end with

leaving it to the experience or good sense of another nurse. The contrary would defy the countersigning system.

41. While appreciating the difficulties nurses may find themselves in when they are short staffed and that circumstances may seem impracticable or sometimes seem silly to insist on following the rules to the straight and narrow, the primary duty of a nurse is and always be to the patient. Administration of drugs one of the primary duties of a nurse, once taking on the duty of countersigning on the administration of a drug that requires so, a nurse's duty does not end until he/she sees it through to the end to ensure no more and no less is given to the patient.

42 Dr [redacted] in his expert report concluded the wrong dosage was not a significant cause of death, it was nonetheless a medication error.

43. The council is of the view that Defendant B did fail as described in the 2 charges as in the Notice and the failure singly and in combination amounts to misconduct. The charges are therefore proved.

44. In the case of Defendant A, the Council is of the view that the facts as admitted supports the charges against her and hence find the charges proved.

45. The Inquiry was adjourned for the Council to consider the case against Defendant B with the agreement of Defendant A. The Inquiry resumed on 16th December 2021.

Consideration of Sentence and Sentence

46. Both Defendant A and Defendant B mitigated through their legal representatives [redacted] and [redacted].

47. [redacted] further submitted that Defendant B is remorseful and extends her apology to the Patient's family.

48. Both Defendant A and Defendant B have a clear disciplinary record and have been nurses for over 20 years. Defendant A has since 2019 retired.

49. The Council have taken all written and oral submissions on behalf of Defendant A and Defendant B into consideration.

50. As a consequence of this matter, HA had put Defendant B put under supervision for a year which was uneventful.

51. Defendant B has since taken on a practice to ensure that no extra dosage is placed in advance.

52. The Patient was not directly under Defendant B's care.

53. Defendant B has since taken various academic studies and been promoted since the incident.

54. The Council accepts that Defendant B's role is secondary to Defendant A at the time and that the system then in practice at the CICU about placing extra dosage by the patient was far from satisfactory.

55. Defendant A is to be suspended for a period of 3 months.

56. Defendant B is to be reprimanded.

57. Both sentences are to be gazetted.

Professor Agnes TIWARI
Chairman, Nursing Council of Hong Kong