Registered Nurse, Ms C

A Medical Centre

A Report by the

Deputy Health and Disability Commissioner

(Case 13HDC00917)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of Contents

Executive summary

1. On 27 June 2013, Ms A attended her medical centre to receive a Depo-Provera injection.

2. Another patient, Ms B, was also awaiting a Depo-Provera injection.

3. Registered nurse RN C obtained two Depo-Provera injections from the drug cupboard and placed both in the same kidney dish.

4. RN C attended to Ms B first. After administering the Depo-Provera injection, she placed the used needle and syringe back in its box instead of immediately disposing of it in the sharps bin. The box was returned to the kidney dish.

5. RN C then attended to Ms A. Instead of taking a new needle and syringe, she injected Ms A with Ms B's used needle. In addition, RN C did not check Ms A's weight and blood pressure.

6. RN C realised her mistake immediately and mentioned to Ms A that the first syringe was empty, but did not explain that she had injected Ms A with a used needle. She then allowed Ms A to go home without informing her of the needle-stick error.

7. The following day, 28 June 2013, RN C advised the practice manager, Ms D, of the error. Ms D questioned her about the delay in reporting the error and requested that she complete two incident report forms — one for the needle-stick error and one for the delay in reporting the error. Ms D also told RN C to inform Ms A and Ms A's general practitioner, Dr E, of the error.

8. RN C completed her shift without advising Dr E or Ms A of the incident. She was on leave for the next four days. During this time she made no attempt to contact Dr E or Ms A to discuss the error.

9. On 3 July 2014, RN C returned to work and informed Dr E of her mistake. He asked her to contact Ms A immediately. Dr E also contacted Ms A and apologised for the error. He arranged for Ms A to attend the medical centre to undergo blood tests for Hepatitis B, Hepatitis C and HIV. Ms A's blood tests returned negative for all of the above.

10. In addition to the needle-stick error, RN C documented in Ms A's clinical notes that she had checked Ms A's blood pressure and weight when she had not done so.

11. The Deputy Commissioner found that the reuse of a needle from another patient indicated a lack of reasonable care and skill and breached Right 4(1)[1] of the Code of Health and Disability Services Consumers' Rights (the Code).

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

12. By failing to assess Ms A's blood pressure and weight, but documenting she had done so, RN C failed to comply with professional standards. Accordingly, RN C breached Right 4(2)[2] of the Code.

13. RN C's failure to notify Ms A of the adverse event promptly meant that RN C did not have the information that a reasonable consumer, in her circumstances, would expect to receive. Accordingly, RN C breached Right 6(1)[3] of the Code.

14. RN C should have appreciated the importance of reporting her error to Dr E in a timely manner, so that appropriate action could be taken. RN C's failure to disclose her error to Dr E openly and promptly was a departure from professional standards and a breach of Right 4(2) of the Code.

15. Whilst the medical centre had appropriate policies in place in relation to the administration of injections and managing stress in the workplace, adverse comment was made that the medical centre needed to be more cognisant of individual staff stress and of its ongoing responsibility to ensure that all nurses comply with its policies.

16. Adverse comment was also made about Ms D for failing to follow up with RN C to confirm that she had discussed the needle-stick error with Dr E and made arrangements for Ms A to return to the medical centre to undergo blood tests.

Complaint and investigation

17. The Commissioner received a complaint about the services registered nurse RN C at the medical centre, provided to Ms A. The following issues were identified for investigation:

- *Whether RN C provided adequate and appropriate care to Ms A from 27 June 2013 to October 2013.*
- *Whether the medical centre provided adequate and appropriate care to Ms A from 27 June 2013 to October 2013.*

18. An investigation was commenced on 13 December 2013. This report is the opinion of Theo Baker, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

19. The parties directly involved in the investigation were:

Ms A Consumer

[2] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."
[3] Right 6(1) states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive."

RN C	Registered nurse
Ms D	Practice manager
Dr E	Director of the medical centre and consumer's GP

Also mentioned in this report

Ms B	Other patient

20. Information was reviewed from: Ms A, RN C, Ms D, the medical centre and Dr E.

21. Clinical advice was obtained from HDC's nursing advisor, registered nurse Dawn Carey (**Appendix A**).

Information gathered during investigation

The medical centre

22. The medical centre is a seven-doctor practice. It cares for a patient base of approximately 10,000 patients. Patients can attend by appointment or on a walk-in basis.

Registered nurse RN C

23. RN C has been a registered nurse since 1980. She is employed by the medical centre on a part-time basis as a practice nurse. On commencement of employment at the medical centre in November 2012 she was given an orientation manual by the Charge Nurse, who also observed RN C administering injections. Other induction materials made available to RN C included the medical centre's policies and protocols on injections plus a procedure checklist to be used for the administration of Depo-Provera injections. Prior to her employment at the medical centre, RN C completed an online immunisation update course with the Immunisation Advisory Centre. She also completed an approved vaccinator update course and was authorised as an independent vaccinator by the DHB's Medical Officer of Health.

Depo-Provera

24. Depo-Provera is an injectable form of contraception, which is intended to prevent pregnancy for three months. It works by inhibiting the hormones that are required for the release of eggs from the ovaries. The recommended dose of Depo-Provera, when used as a contraceptive, is 150mg every three months. Apart from contraception, Depo-Provera is also used by individuals with endometriosis and certain types of cancer, including cancer of the breast, kidney and endometrium.[4]

25. Depo-Provera is contraindicated in individuals with certain medical conditions, including but not limited to: liver problems; severe, uncontrolled, high blood pressure;

[4] http://www.medsafe.govt.nz/consumers/cmi/d/Depo-Provera.pdf

thrombosis; and stroke. Two of the potential adverse effects of Depo-Provera are weight changes and an increase in blood pressure (BP).[5]

26. Depo-Provera is prescribed by a doctor. The Medsafe Datasheet[6] describes Depo-Provera as a white aqueous liquid, which is injected into the upper arm or buttock and can be administered by either a doctor or a trained nurse. The Depo-Provera Injection Protocol instructs that the syringe should be shaken vigorously prior to use. This helps to ensure that the dose being administered represents a uniform suspension.

Consultation

27. On 27 June 2013 Ms A, aged 42 years, presented at the medical centre to receive a Depo-Provera injection. She was booked to see registered nurse RN C.

28. RN C was working in the treatment room at this time. She advised that there were two separate walk-in patients at approximately 4.00pm, both of whom had rolled ankles. According to RN C, one of these patients required an X-ray, and the other was waiting in Clinic 2 to be taken to hospital by ambulance.

29. Ms A and another patient, Ms B, were both booked into Clinic 1 to receive the Depo-Provera injection. RN C recalls that they had been waiting to be seen for over 10 minutes.

Needle-stick error

30. RN C obtained two Depo-Provera injections from the drug cupboard and placed both in the same kidney dish. She injected Ms B first and subsequently placed the used needle and syringe back in its box. She then put the box in a kidney dish, which also contained the second box with the unused Depo-Provera injection intended for Ms A.

31. RN C then began to attend to Ms A, but was interrupted when the ambulance arrived to collect one of the patients with a rolled ankle. RN C completed handover of that patient and then returned to Ms A.

32. Ms A stated that RN C failed to ask her the usual screening questions, check her weight or take her BP prior to administering the Depo-Provera injection. RN C advised HDC that she followed the Depo-Provera Injection Protocol apart from determining Ms A's BP or weight. However, RN C documented in Ms A's clinical notes that her BP and weight had been taken, but there are no specific recordings.

33. According to Ms A, RN C inserted the needle and then stated, "Funny, seems to be empty." Ms A explained that RN C left to get another injection. At this point, RN C became aware that she had injected Ms A with the needle used on Ms B. RN C stated, "I then realised what I had done, told the patient there was an error and proceeded to give the Depo-Provera 2nd box." However, Ms A said that RN C did not elaborate on her comment that the syringe seemed empty, but administered the new injection. Ms A said that RN C then sent her home without advising her of the error.

[5] http://www.medsafe.govt.nz/profs/datasheet/d/Depoproverainj.pdf
[6] http://www.medsafe.govt.nz/consumers/cmi/d/Depo-Provera.pdf

34. RN C provided the following statement to HDC about the needle-stick error:

> "I noticed that two patients who were booked into Clinic 1 were waiting for over 10 minutes for Depo Provera Injections. I asked the clinic nurse to help with this. Seeing that they were not being attended to, I unlocked the drug cupboard and removed two Depo Provera injections in their boxes into a kidney dish. I assessed the patient that was going to hospital and proceeded to call in the first patient to give them the Depo Provera injection. Taking one box out of the kidney dish, I gave the Depo Provera, but then placed the used needle and syringe back into the box it had come from, and into the kidney dish. I entered all the data into the first patient's notes.
>
> I realised the 2nd patient had not been attended to so I started to attend to this patient. The ambulance arrived I escorted the ambulance officer into Clinic 2 room where there was a quick handover and the ambulance officer went to retrieve a splint. I came back to the 2nd patient who needed a Depo Provera injection, got the used Depo Provera injection from patient 1 and inserted the needle in left upper quadrant, I then realised what I had done, told the patient there was an error, and proceeded to give the Depo Provera 2nd box."

35. RN C further explained that she placed the used needle and syringe back in its box because the area was busy and she did not want the needle and syringe to be visible. She stated that the sharps box was behind the cubicle curtain, and drawing the curtains open would have meant a lack of privacy for the patient.

The medical centre's policies

36. At the material time, the medical centre had the following policies in place regarding the administration of injections:

- Depo-Provera Injection Protocol: The steps outlined clearly instruct the individual administering the injection to "Remove the sealed pack from the box. Remove the syringe and needle from sealed pack. Attach the needle provided to the syringe. Shake Depo-Provera syringe vigorously prior to use." Following administration of the injection, the individual is advised to dispose of the syringe and needle straight away in the sharps box.

- Infection Control Manual: This manual outlines the practices to be followed to prevent contamination and cross infection to both patients and staff. It includes the management and disposal of sharps waste, and clearly states that sharp items should be placed in the recommended rigid sharp containers at the completion of a procedure.

  The manual also outlines best practice in the event of a needle-stick or sharps injury. This includes completing ACC and incident forms, and carrying out a risk assessment and appropriate blood sampling of the person injured.

- Injection Protocol: This protocol outlines the precautions to be taken before administering an injection. It also describes the steps to be followed when administering injections from ampoules and injections from vials, as well as selecting the correct needle for the solution being administered. It clearly

> instructs that the needle should be disposed of as per the Infection Control Manual.

37. RN C acknowledged that she failed to follow the medical centre's policies at the time of the incident, although she had read and understood them. She accepted that she did not dispose of the needle in the sharps box immediately after using it on Ms B, and that this omission contributed to the needle-stick error.

38. Procedure (1)(c) of the medical centre's Infection Control Manual advises that needles should not be recapped. RN C stated:

> "I expect that I did not recap the needle of the first Depo Provera injection. This should have been an indication to me at the time that it was a used needle and syringe and I do not know why I didn't consider that but can only conclude that perhaps the fact that I was interrupted at the time may not have helped."

39. RN C offered the following explanation for the error:

> "I believe that the Triage service provided by the medical centre added to the circumstances that led to this mistake. Patients attend without any warning and are put into the treatment room, which is often already booked out with dressing appointments. This was the situation on Thursday 27th June afternoon when I triaged two patients, one of them going to hospital via ambulance. I recognised that I was feeling stressed at the time and asked for help from other registered nurse[s] on several occasions but they were too busy to assist me."

40. RN C advised that stress was a contributing factor to the needle-stick error. In addition to the injection policies outlined above, the medical centre also had a policy that addressed stress management. The policy recognised that managing stress in the workplace is acknowledged as an important part of creating and maintaining a safe and healthy workplace. The policy outlined a non-exhaustive list of measures in place to manage workplace stress, which included the expectation that "staff will advise the practice manager if they are working hours or being expected to work hours to meet responsibilities which they are finding excessive".

Delay in advising the medical centre staff and Ms A of the error

41. On 28 June 2013, RN C informed the practice manager, Ms D, of the needle-stick error. That was a day after it had occurred. Ms D asked RN C to complete two incident report forms, one for the needle-stick error and another for the delay in reporting it.

42. According to RN C, she planned to complete the incident report form, notify Dr E of the error, and then notify Ms A. Dr E is one of the directors of the medical centre, and a practising doctor at the medical centre, and is Ms A's GP. RN C stated that she approached Dr E twice on the morning of 28 June 2013, but he advised that it was not a good time to speak. She then placed her name in Dr E's appointment book, but her appointment was overlooked, as she had not recorded her full name and Dr E did not know who was booked to see him.

43. Dr E provided an account of the efforts made by RN C to inform him of the error. He advised that on 28 June 2013, he saw 37 patients and also had a management meeting for two hours in the afternoon. Dr E explained that RN C approached him in the passage of the medical centre while he was between patients and said, "I've done something wrong and need to talk to you." He stated that he was under pressure at this time and said to RN C, "Look I have four patients — is the matter urgent if it isn't we could discuss this later." Dr E recalls that RN C stated that the matter was not urgent. He also recalls saying to her that he would like to discuss the matter and they would meet later in the afternoon after he finished consulting.

44. According to Dr E, he noticed that RN C's name was recorded in a non-appointment column and he expected to talk to her at the end of the day. He explained that he could not locate her after he had finished consulting, and was advised by reception staff that she had left. He said that he did not pursue the matter by telephoning RN C, as he was "completely unaware" of the serious error that had occurred. Furthermore, RN C had advised him that the matter was not urgent.

45. Dr E advised that he has non-consultation periods between 8.00–8.30am, 12.00–12.30pm and 5.00–6.00pm. However, RN C made no further attempts to speak to him until 3 July 2013, when she was next rostered to work. She made an appointment to meet with him formally at 11.40am, and explained the situation to him. He asked her to contact Ms A and inform her of the error, and also to put an action plan in place. Subsequently, RN C called Ms A and discussed the incident, along with the need for her to undergo blood tests for HIV and Hepatitis B.

46. Dr E also contacted Ms A to apologise on behalf of the practice and inform her of the action plan. On 4 July 2013, Ms A consulted with Dr E, who completed an ACC Treatment Injury form for her and explained that she could contact HDC and the Nursing Council of New Zealand.

RN C's account

47. RN C said that she cannot explain why she did not follow procedure and immediately inform the patient or anyone else about the incident. She said she allowed the patient to leave without an explanation because of the shock of what had happened. According to RN C, this was not an attempt to cover up or deny what had happened.

48. RN C stated:

> "The next day after the incident, Friday 28th June, I approached the Practice Manager, [Ms D], and told her of my mistake and completed the written incident form. I assumed that [Ms D] had read the incident form and would ensure that I got to report this to [Dr E]."

49. On 4 July 2013, RN C wrote to Ms A and apologised for the needle-stick error, as well as the delay in advising her of it. In the letter she advised that although she was aware of the mistake immediately, her instinct was to protect Ms A "from the burden that would ensue". She explained that she wanted to seek medical advice and discuss the matter with Dr E before informing Ms A of the error.

50. RN C considered that due to the nature of the injury, Ms A would be clinically safe while RN C sought medical advice and determined the correct protocol. RN C stated that she overlooked the emotional impact the needle-stick error would have on Ms A and acknowledged that the delay in informing her of the error would have added to her burden.

RN C's follow-up actions

51. In her letter of 4 July 2013, RN C apologised to Ms A for both the needle-stick error and the delay in advising her of the error. In addition, RN C reflected on the incident and has undertaken professional supervision of her practice. As a result of this incident, she completed the Nursing Council of New Zealand's (NCNZ) competence assessment for nurses in clinical practice, and completed training in "serious event preview" and "infection prevention and control". RN C also attended a training workshop in "IV Medication" and a Nursing Competencies conference. She also had a meeting with the medical centre practice nurses and reported on the procedure for reporting adverse events.

The medical centre's investigation and follow-up actions

52. Practice manager Ms D advised that an investigation by the medical centre into this incident revealed that it had occurred because RN C was under pressure in the treatment room.

53. The medical centre advised that it has undertaken the following actions in response to this complaint:

— There are additional nursing staff on the floor each day to allow for back-up nurses in a busy period or for emergencies. According to Ms D, this will also help ensure nurses are not working under pressure.

— The medical centre's policies and procedures have been reviewed. All nursing staff have been involved in the review process to enable continuous improvement.

— Staff have been reminded via a memo and a staff meeting that all incidents must be reported immediately to the practice manager or a director.

— Patients requiring Depo-Provera injections are now booked into the nurse's clinic room, which is private and has sharps bins located within the curtained cubicle.

54. Ms A's blood tests returned negative for HIV, Hepatitis B and Hepatitis C. She advised that she wants to make sure this incident does not happen again. Ms A also stated that while she hopes that she has no major medical conditions from the error, there could have been severe consequences if a similar incident had happened with a baby or child.

Response to provisional opinion

55. RN C and the medical centre were invited to comment on my provisional opinion.

56. RN C did not wish to make any further comment and advised that she resigned from her position at the medical centre on 17 April 2014.

57. The medical centre accepted the provisional report without further comment and is in the process of preparing a response to the recommendations.

Relevant standards

58. The Nursing Council of New Zealand *Code of Conduct for Nurses* (June 2012) (NCNZ Code of Conduct) provides:

Principle 4 Maintain health consumer trust by providing safe and competent care

Standard 4.8 Keep clear and accurate records.

Principle 7 Act with integrity to justify health consumers' trust

Standard 7.3 Act promptly if a health consumer's safety is compromised.

Standard 7.4 Act immediately if a health consumer has suffered harm for any reason. Minimise further harm and follow organisational policies related to incident management and documentation. A full and prompt explanation should be made by the appropriate person to the health consumer concerned and, where appropriate, their family about what has occurred and the likely outcome.

Opinion: Breach — RN C

59. RN C is an experienced practice nurse. In this case she let down Ms A by not following safe practice in the administration of Depo-Provera, leading to the needle-stick injury, and also by her actions after the error.

Needle-stick error — Breach

60. On 27 June 2013 RN C was working in the treatment room at the medical centre. Ms A and Ms B were both booked to receive their Depo-Provera injections.

61. RN C obtained two Depo-Provera injections from the drug cupboard and placed them both in the same kidney dish.

62. RN C administered the first Depo-Provera injection to Ms B and, against protocol, placed the used needle and syringe back into its box and back in the kidney dish.

63. RN C admits that she was aware of the relevant policies at the medical centre for administering injections but did not follow the policies. She advised that she was feeling stressed at the time of the error and, although she had asked for help from the other registered nurses, they were too busy to assist.

64. The medical centre had policies in place to help reduce the risk of a needle-stick error such as this. The pre-injection care protocol for Depo-Provera injections clearly instructs the individual administering the injection to: "Remove the sealed pack from the box. Remove the syringe and needle from sealed pack. Attach the needle provided to the syringe. Shake Depo Provera syringe vigorously prior to use." Following administration of the injection, the individual is advised to dispose of the syringe and needle straight away in the sharps box.

65. RN C advised that she understood that all used needles were to be disposed of in the sharps box immediately to prevent harm, but, against her usual practice, she did not follow this procedure.

66. My expert advisor, registered nurse Ms Dawn Carey, advised that distractions, task overload and lack of concentrated focus are recognised "human factors" that contribute to errors. She noted that within healthcare these can have devastating results and a phenomenal impact on the continuing health of individuals and their trust in the system that is meant to care for them. According to Ms Carey, the nursing care provided to Ms A on 27 June 2013 was a departure from the accepted standards of nursing care.

67. RN C failed to dispose of the used needle and syringe appropriately. She also failed to remove a sealed pack from the box and attach the needle to the syringe. Instead, RN C picked up the used syringe, which was already assembled. In my view, the fact that the injection was already assembled should have been an indicator to check whether the needle had been used.

68. Furthermore, RN C did not shake the Depo-Provera injection before administering it to Ms A. The Medsafe Datasheet[7] describes Depo-Provera as a cloudy white liquid. The Depo-Provera injection protocol instructs that the syringe should be shaken vigorously prior to use. This helps to ensure that the dose being administered represents a uniform suspension.[8] Had RN C followed instructions and shaken the syringe, it is likely she would have noticed that there was no cloudy white fluid present.

69. I note that RN C was attempting to attend to four patients simultaneously, which was distracting. Whilst I accept that it was a busy day at the medical centre, and I agree with Ms Carey's advice that human factors can result in errors, this does not excuse the failure to follow protocol. There were a number of opportunities for RN C to

[7] http://www.medsafe.govt.nz/consumers/cmi/d/Depo-Provera.pdf
[8] http://dailymed.nlm.nih.gov

identify that she had picked up a used injection. The usual pre-injection care process that should be followed before Depo-Provera is administered would have alerted RN C to her error. Furthermore, it was poor practice for RN C to place both Depo-Provera injections in the same kidney dish.

70. RN C's failure to follow the standard protocols in place to counter the risk of human error led to the needle-stick injury. In my view, RN C breached Ms A's right to have services provided with reasonable care and skill pursuant to Right 4(1) of the Code.

Open disclosure — Breach

71. RN C stated that she was aware of her mistake. She said she told Ms A that there was an error, but did not elaborate on what the error was. In contrast, Ms A said that RN C simply commented that the syringe appeared to be empty, administered the new Depo-Provera injection, and then sent Ms A home without advising her of the mistake.

72. The following day, RN C advised Ms D of the error. Ms D stated that she questioned RN C about the delay in reporting the error and advised her to inform Dr E and Ms A immediately.

73. Dr E recalled RN C approaching him in the passage of the medical centre on 28 June 2013. According to Dr E, he asked RN C if the matter was urgent. He stated that her response was that it was not urgent and, accordingly, he did not pursue the matter. He noted that the next time he spoke to RN C was on 3 July 2013 when she advised him of the error.

74. Dr E said he contacted Ms A immediately after becoming aware of the needle-stick error. He explained what had happened to Ms A and apologised to her on behalf of the medical centre. He also arranged to see Ms A the following day on 4 July 2013 to discuss a management plan, which included blood tests for Hepatitis B, Hepatitis C and HIV, and completing an ACC treatment injury claim.

75. RN C said that she made efforts to speak to Dr E on 28 June 2013, including making an appointment to see him, but he was busy with patients and overlooked her appointment, as she had recorded only her first name and he did not realise it was her. RN C then had days off work and spoke to Dr E on her return on 3 July 2013.

76. RN C said that she probably allowed Ms A to go home without an explanation because she (RN C) was in shock. According to RN C, she was not trying to cover up or deny what happened. She said she considered that Ms A was clinically safe and it was her intention to seek medical advice and determine correct protocol before discussing the error with Ms A.

77. RN C stated that she "assumed that [Ms D] had read the incident form and would ensure that I got to report this to [Dr E]".

78. At the time of the needle-stick error, the medical centre had in place a procedure to be followed in the event of a needle-stick, sharps or body fluid injury/contact. The

procedure advises that a risk assessment and appropriate blood sampling should be carried out immediately.

Conclusions

79. I note the discrepancy between RN C's and Ms A's recollection of the comments made by RN C immediately after the needle-stick error. In my view, it is more likely than not that RN C did not tell Ms A that there had been a needle-stick error. I consider that, before leaving the medical centre, Ms A would have pursued the matter further to determine whether she had suffered any adverse effects.

80. I consider that RN C should have appreciated the potential gravity of the needle-stick error and not waited five days before making further attempts to discuss the matter with Dr E. In my view, RN C made insufficient attempts to advise Dr E of the error. In contrast, Dr E acted immediately after being made aware of the error and initiated a management plan for Ms A.

81. RN C knew that she had made an error and therefore had a professional and ethical obligation to advise Ms A immediately, as well as Dr E as Ms A's GP, and the practice manager or a director of the medical centre. It is clear that RN C's failure to do this in a timely manner was a breach of standards 7.3 and 7.4 of the NCNZ's Code of Conduct.

82. Standard 7.3 and 7.4 require a nurse to act promptly if a health consumer's safety is compromised. The standards also recommend that a full explanation be given to the patient, and that further harm is minimised, and organisational policies followed. I consider that RN C should have advised Ms A of the error immediately, and then discussed the matter with Dr E to arrange for the appropriate blood tests to be done. RN C should also have contacted Ms B without delay and requested that she attend the medical centre to undertake appropriate blood testing. An incident form should have been completed at this stage, along with relevant ACC documentation.

83. RN C advised that she believed that Ms A was clinically safe and therefore did not immediately disclose the needle-stick error to her. I find RN C's lack of candour concerning. Ms A had a right to know what had happened to her without delay. RN C had a duty to disclose the error to Ms A in accordance with Right 6(1) of the Code, which states that every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive. In my view, RN C's failure to notify Ms A of the adverse event promptly meant she did not have the information that she would expect to receive. Accordingly, I find that RN C breached Right 6(1) of the Code.

84. Furthermore, I do not consider that RN C made a reasonable effort to bring the error to the attention of Dr E. Whilst I note her unsuccessful attempts to discuss the matter with Dr E on 28 June 2013, in my view it is a poor excuse for her to state that she assumed Ms D would ensure the matter was reported to Dr E, as Ms D had read the incident form. Ms D questioned RN C about the delay in reporting the error and advised her to speak to Dr E and Ms A immediately. Although I consider that Ms D

should have alerted Dr E, in my view it was not appropriate for RN C to rely on Ms D to do so, and she should have taken responsibility for this herself.

85. I consider that RN C's failure to notify Dr E until five days later displayed a lack of accountability for her mistake. RN C should have appreciated the importance of reporting her error in a timely manner, so that the appropriate actions could be taken. I find that by failing to disclose the needle-stick error to Dr E openly and promptly, RN C failed to comply with professional standards and therefore breached Right 4(2) of the Code.

Documentation of assessment of blood pressure and weight — Breach

86. Ms A said that RN C did not check her BP or weight prior to administering the Depo-Provera injection. Ms A stated:

> "I went to [RN C] for a depo provera injection. [RN C] did not ask the usual screening question, take my BP or weight as usual but went straight to do the injection."

87. In contrast, RN C documented in Ms A's clinical notes of 27 June 2013, "Have checked bp and weight." However, in subsequent correspondence, RN C explicitly stated that she did not check Ms A's weight or BP.

88. Ms Carey advised that periodic monitoring of a patient's weight and BP is recommended for those receiving hormonal contraceptives such as Depo-Provera. She explained that this is due to weight gain, BP changes and fluid retention being reported as potential side effects, and the possible impact of such side effects on a patient's health. The evaluation of such risk factors can occur only with appropriate monitoring. I recognise that the medical centre's Depo-Provera injection protocol did not specify the need for BP or weight monitoring; however, RN C understood that it was an expected part of practice. I am critical of RN C's failure to check Ms A's BP and weight.

89. Standard 4.8 of the NCNZ Code of Conduct requires nurses to keep clear and accurate records of their discussions and the assessments they make. In my view, a detailed and clear record of a patient's assessment is one of the cornerstones of good care, and is essential to a patient's seamless care.

90. Notes need to be comprehensive, accurate and contemporaneous. By failing to assess Ms A's BP and weight, but documenting that she had done so, RN C failed to comply with professional standards. Accordingly, RN C breached Right 4(2) of the Code.

Opinion: The medical centre — Adverse comment

91. RN C was employed by the medical centre on a part-time basis as a practice nurse. On commencement of her employment at the medical centre in November 2012, the Charge Nurse gave RN C an orientation manual and also observed RN C

administering injections. The medical centre's policies and protocols on injections, along with a procedure checklist to be used for the administration of Depo-Provera, were made available to RN C. Within the orientation manual, internal policies at the medical centre had been highlighted in regard to the administration of injections. RN C had read and understood these policies.

92. The medical centre has provided copies of the relevant policies regarding the administration of injections in general and the process to be followed when administering Depo-Provera. These procedures were active at the time of the needle-stick error, and were in place to prevent such an incident from occurring.

93. Ms Carey reviewed the medical centre's protocols in relation to the administration of injections, and the management and disposal of sharps waste. She advised that the protocols were of an adequate standard for qualified health professionals to follow. However, she noted that additional actions could be included in the policies to make them more robust (see my proposed recommendations).

94. In addition to the above policies, the medical centre also had a policy that addressed stress management. The policy recognised that managing stress in the workplace is acknowledged as an important part of creating and maintaining a safe and healthy workplace. The policy outlined a non-exhaustive list of measures in place to manage workplace stress, which included the expectation that staff will advise the practice manager if they are working hours, or being expected to work hours, they are finding excessive.

95. RN C advised that she was feeling stressed at the time of the needle-stick error. She explained that she asked for help from other registered nurses on several occasions, but they were too busy to assist. According to RN C, the triage service at the medical centre was a contributing factor that led to the needle-stick error. She stated that "patients attend without any warning and are put into the treatment room, which is often already booked out with dressing appointments. This was the situation on Thursday 27th June afternoon when I triaged two patients, one of them going to hospital via ambulance."

96. Ms D advised that the medical centre's investigation into the needle-stick error confirmed that it occurred because "[RN C] was under a lot of pressure in the treatment room at the time of the incident".

97. According to Ms D, the medical centre now ensures that there are "enough nursing staff on the floor every day so nurses can call in another nurse as back up in a busy period or for emergencies". This initiative was implemented to help reduce pressure on staff during busy times at the medical centre.

Conclusion

98. A medical centre has a duty to monitor the performance of its practice nurses. Additionally, medical centres have an obligation to ensure that the work environment is conducive to providing quality care to its patients, and to have effective mechanisms in place to prevent adverse events from occurring.

99. The medical centre had adequate policies in place to help prevent a needle-stick error from occurring, and to manage stress in the workplace. I am satisfied that the medical centre had provided sufficient training and had a clear expectation of professional responsibilities. RN C advised that she understood the policies at the medical centre, but she failed to follow the protocol for administering Depo-Provera, as she was under a lot of pressure.

100. I note that RN C attempted to manage the stressful situation she found herself in by asking for help, but the other nurses were unable to assist with the workload. the medical centre accepts that there were extenuating circumstances, as RN C was under pressure. As a result of this incident, the medical centre has employed extra nursing staff to assist during busy periods and emergencies.

101. A medical centre should have an environment that supports safe care, promptly identifies risks to patient safety, and responds appropriately. The medical centre had appropriate policies in place in relation to the administration of injections and managing stress in the workplace. However, the medical centre had an organisational responsibility to ensure that the work environment and culture supported staff to adhere to its policies. It is meaningless to have policies in place if staff are under too much pressure to follow them. I consider that in future the medical centre needs to be more cognisant of individual staff stress and the medical centre's ongoing responsibility to ensure that all nurses and other staff are complying with its policies.

Opinion: Ms D — Adverse comment

102. RN C advised that she informed Ms D of the needle-stick error on 28 June 2013. According to Ms D, she questioned RN C about the delay in reporting the error and advised her to speak to Dr E and Ms A immediately. Ms D also requested that RN C complete two incident report forms, one for the needle-stick error and another for the delay in reporting the error. RN C did not speak to Dr E about the error until 3 July 2013. As outlined above, she explained that she unsuccessfully attempted to speak to Dr E, but he was busy with patients. RN C advised that she thought Ms D would help ensure that RN C spoke to Dr E.

103. Whilst I do not consider that it was Ms D's responsibility to facilitate the meeting between RN C and Dr E, I am critical of Ms D's lack of action after she was made aware of the error. I would expect that, as practice manager, Ms D would have followed up with RN C to confirm that she had spoken to Dr E and made arrangements for Ms A to return to the medical centre for blood tests, or taken the initiative to alert Dr E that the event had occurred.

Recommendations

RN C

104. I note that RN C has provided Ms A with a written apology and has also taken steps to review relevant aspects of her practice, including completing a self-assessment. Further to the steps already taken, I recommend that RN C undertake the following:

- Reflect on her documentation practices and ensure that future clinical documentation is completed in accordance with accepted standards.
- Review initiatives at her current workplace to deal with stress, and implement strategies to deal with pressure in the workplace in order to help prevent this type of error from occurring again.
- Review her time management and prioritisation skills in order to manage patients better during busy periods.
- Ensure that she adheres to workplace policies at all times.

The medical centre

105. I note that the medical centre has investigated this complaint and implemented initiatives such as employing additional nursing staff to reduce the pressure during busy periods. In addition to the steps already taken, I recommend that the medical centre undertake the following:

- Include additional actions in the needle-stick, sharps and body fluid injury/contact protocol that reflect the required actions when a needle-stick injury is sustained by a consumer. I would appreciate receiving an updated copy of the protocol within one month of the date of this report.
- Consider reviewing the Depo-Provera injection protocol, so that it mirrors all the required practice steps. The protocol should also include the circumstances when administration should not proceed.
- Update the Depo-Provera injection protocol to indicate clearly the expectations regarding the monitoring of BP and weight.

Ms D

106. In my provisional report I recommended that Ms D provide a written apology to Ms A for failing to ensure that she was made aware of the error in a timely manner. Ms D provided a formal written apology letter, which has been forwarded to Ms A.

107. In my provisional report, I also recommended that Ms D:

- Reflect on her actions after she was made aware of the needle-stick error, and report back to HDC on what more she could have done.
- Review and familiarise staff on the medical centre's policies on incident reporting.

I recommend that Ms D confirm that the above recommendations have been met by **2 July 2014**.

Follow-up actions

108.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Nursing Council of New Zealand and the District Health Board, and they will be advised of RN C's name.

- RN C will be referred to the Nursing Council of New Zealand with the recommendation that she undergo a competency review. I recommend that the Council determine any necessary conditions on her practice, supervision and monitoring, and training needs, and advise HDC accordingly.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand Nurses Organisation.

- A copy of this report with details identifying the parties removed, except the name of the expert who advised on this case, will be sent to the Health Quality & Safety Commission New Zealand for consideration as part of its medication safety work.

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

Appendix A — Expert nursing advice to the Commissioner

The following expert advice was obtained from registered nurse Dawn Carey:

"**BRIEF CLINICAL ADVICE**

CONSUMER: [Ms A]

PROVIDER: [RN C] / [the medical centre]

FILE NUMBER: C13HDC00917

DATE: 10 September 2013

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1. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms A] about the care provided by [RN C]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have read and reviewed the documentation on file: complaint from [Ms A]; response and statements from [RN C] including competency assessment, response and notes from [the medical centre].

3. Following a review of the submitted documentation, I note the following:
   (i) [RN C] and [the medical centre] have offered apologies to [Ms A]. These apologies appear very sincere.
   (ii) [The medical centre] was proactive and appropriate in its investigation into the circumstances that led to [Ms A] receiving a suboptimal standard of care.
   (iii) Since the needle-stick incident, [RN C] has received professional supervision and undergone additional training.
   (iv) [RN C] admitted that she was feeling rushed when the needle stick injury occurred.
   (v) [RN C] admits that she did not follow [the medical centre's] relevant policies, Nursing Council of New Zealand competencies, and other relevant health and safety legislation.
   (vi) [RN C] reports that her intention in not informing [Ms A] immediately was due to the wish to have correct information about the actual risks to [Ms A], rather than any lack of honesty or professional integrity. [RN C] realises that her delay in informing [Ms A] was a departure from the expected standards of nursing practice.
   (vii) In response to the findings of the internal investigation, [The medical centre] have increased their RN staffing levels, reviewed their policies and procedures and involved clinical staff in this process, highlighted their expectations of open disclosure, shared some of the learning from this complaint with staff, and initiated a performance managing process.

4. Distractions, task overload and lack of concentrated focus are recognised 'human factors' that are contributory issues that lead to errors. Within healthcare these can have devastating results and a phenomenal impact on the continuing health of the individual, and their trust within the system that is meant to care for them. In my opinion, the nursing care provided to [Ms A] on 27 June 2013 was a mild–moderate departure from the expected standard of nursing care. I am most critical of [RN C's] lack of timeliness in informing [Ms A]. I accept that [RN C] has reflected fully and understood the seriousness of her error. I consider that the steps taken by [the medical centre] are appropriately focussed on ensuring that their systems facilitate the delivery of a high standard of nursing care to their patients.

In my opinion, I consider that the educational and reflective response from the Providers to be appropriate and adequate.

Dawn Carey (RN PG Dip)
Nursing Advisor
Health and Disability Commissioner
Auckland.

SECONDARY CLINICAL ADVICE

CONSUMER: [Ms A]

PROVIDER: [RN C] / [The medical centre]

FILE NUMBER: C13HDC00917

DATE: 3 February 2014

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1. Thank you for the request that I provide additional clinical advice in relation to the complaint from [Ms A]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. This additional advice is to be read in conjunction with my preliminary advice.

2. I have read and reviewed the additional response from [RN C]; additional response from [the medical centre] including the following protocols: Depo Provera (DP) Injection Protocol, Injection Protocol, and Infection Control Manual.

3. I have been asked to review my preliminary advice and provide comment on [RN C's] failure to complete the expected monitoring observations on [Ms A] — blood pressure (BP) and weight — on 27 June 2013 despite her documenting otherwise.

I have also been asked to review the standard of the [the medical centre's] DP Injection Protocol, Injections Protocol, and Infection Control Manual — in relation to management and disposal of sharps waste.

4. Following this review I note the following:

- Consultation notes completed on 27 June 2013 by [RN C] reports … *have checked BP and weight …*This is in contrast with her additional response *… I followed this procedure but did not do the weight or blood pressure …*
- That [the medical centre's] Injection Protocol and Infection Control Manual — in relation to management and disposal of sharps waste — are of an adequate standard for qualified health practitioners to follow.
- That [the medical centre's] DP Injection Protocol is not detailed in relation to some administration specificities e.g. need to shake the injection suspension vigorously just before use to ensure a uniform suspension; blood pressure/weight monitoring; circumstances when a dose may be contraindicated and medical advice should be sought by the RN.
- [RN C's] responses demonstrate that she is aware of the need to shake the DP suspension vigorously prior to administration and that there is an expectation to check the patient's weight and BP prior to administration of DP injection.
- That [the medical centre] has a protocol concerning expected actions following a needle stick injury. These actions are documented as needing to occur *immediately* and include notification, documentation, assessment of risk and required serum tests.
- That the *Needle stick, sharps and body fluid injury/contact* protocol appears to be written from the perspective of a health worker receiving a needle stick from a patient.

5. **Comments**

Periodic monitoring of a patient's weight and BP is recommended for those receiving hormonal contraceptives such as DP[1]. This is due to weight gain, BP changes and fluid retention being reported as potential side effects and the possible impact of such side effects on a patient's health. In my opinion, the evaluation of such risk factors can only occur with appropriate monitoring. Whilst I note that the submitted DP Injection Protocol does not specify the need or frequency for weight or BP monitoring, [RN C] reports an understanding that it was an expected part of practice. Whilst I agree that it should be, my criticism is levelled at [RN C] recording that she took [Ms A's] BP and weight when she did not. In my opinion, such documentation practice endangers the trust that the nursing profession is held in.

[1] Depo-Provera Data Sheet. Retrieved from: http://www.medsafe.govt.nz/profs/datasheet/d/Depoproverainj.pdf

6. **Recommendations**

Whilst I consider the [the medical centre's] Injection Protocol and Infection Control Manual — in relation to management and disposal of sharps waste — to be of an adequate standard for qualified health practitioners to follow; I would recommend that additional actions are included in the *Needle stick, sharps and body fluid injury/contact* protocol, that reflect the required actions when a needle stick injury is sustained by a patient.

I would also recommend that [the medical centre] consider reviewing the DP Injection Protocol. In my opinion there is less potential for errors when protocols mirror all the required practice steps. In my opinion clinical protocols should always report the circumstances when administration should not proceed.

Availing of the full learning opportunities within this incident; I would also recommend that [the medical centre] consider implementing a communication tool such as SBAR[2] to frame interdisciplinary clinical communication.

7. **Clinical Advice**

Registered nurses accept responsibility for ensuring their nursing practice and conduct meet the standards of professional, ethical and relevant legislative requirements such as NCNZ competencies[3,4] and Health and Disability Service Standards[5]. My preliminary advice reported my peer opinion that the nursing care provided by [RN C] to [Ms A] on 27 June 2013, was a mild–moderate departure from the expected standards of nursing care. From the outset I was most critical of [RN C's] lack of timeliness in alerting [Ms A] to the fact that she was subject to a needle stick injury, and I remain so. I am also critical of her reporting monitoring — BP and weight — that did not occur. Based on my further review I now consider that the provided nursing care was a moderate departure from expected standards.

Dawn Carey (RN PG Dip)
Nursing Advisor
Health and Disability Commissioner
Auckland."

[2] Available from: http://www.ihi.org/resources/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx
[3] Nursing Council of New Zealand (NCNZ), *Competencies for registered nurses* (Wellington: NCNZ, 2007).
[4] Nursing Council of New Zealand (NCNZ), *Code of conduct* (Wellington: NCNZ, 2012).
[5] Standards New Zealand (NZS), *8132:2008 Health and disability (general) services standards* (Wellington: NZS, 2008).