Department of Corrections

General Practitioner, Dr B

General Practitioner, Dr C

A Report by the

Deputy Health and Disability Commissioner

(Case 16HDC00776)

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Executive summary

1. Mr A, aged 41 years at the time of these events, was a prisoner at a correctional facility (the facility) operated by the Department of Corrections (Corrections).

2. Corrections provides health care, including nursing and medical services, to prisoners. The facility has a Health Centre staffed by a Health Centre Manager and registered nurses, who are employed by Corrections. In addition, Corrections enters into contracts for service with general practitioners (GPs) in the area. Nurses are available to review prisoners on a daily basis at the facility. GPs are available in person at the facility three days a week, and available for advice via telephone at all times as required. At the time of events, GPs Dr B and Dr C were contracted by Corrections to provide GP services to prisoners at the facility.

3. When prisoners report non-urgent health concerns, these are managed in line with the "Request for Non-Urgent Health Appointments Triage Process — Residential Units" policy (the Triage Policy) in place at the facility. The Triage Policy states that the purpose of the policy is to ensure "[t]hat all prisoners receive access to Health Services within seven (7) days of a non-urgent request for a health appointment being received by Health Services". In accordance with the Triage Policy, prisoners access health services by completing a health request form, which is available in all residential units.

4. Mr A fell from his bunk in his residential unit and injured his shoulder on an unspecified date in early 2016. He submitted his first health request form asking to be seen by a specialist because of his shoulder pain on 6 February 2016.

5. Mr A submitted a total of five health request forms and saw Corrections nurses on four occasions before eventually he was able to see a medical officer nine weeks after his original requests for health services were lodged. During this time he was prescribed arnica cream, Panadol, and Brufen, and he subsequently received an intra-articular steroid injection from Dr B, who had made a diagnosis of a soft tissue injury. Dr B did not feel that an X-ray was indicated when he reviewed Mr A.

6. Subsequently, two further requests were made by Mr A in an attempt to access health services for his shoulder injury, before he attended an appointment with Dr C. Dr C made a differential diagnosis of either a reaction to the steroid injection or an infection. He prescribed the antibiotic Augmentin to treat the infection. Dr C did not consider an X-ray to be clinically indicated.

7. Mr A was transferred to a public hospital two days later with a high temperature and a swollen, red upper arm. Hospital staff took an X-Ray and an ultrasound of Mr A's shoulder, and he was diagnosed with an extensive soft tissue abscess. He received treatment and was discharged back to the facility with a prescription for long-term antibiotics and follow-up at the hospital.

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Findings

8. It is Corrections' responsibility to ensure that its staff adhere to organisational policies, particularly those that are in place to protect the health of prisoners, who cannot choose their own healthcare provider. It is apparent that numerous nurses employed by Corrections failed to adhere to the Triage Policy in place at the time of events. Corrections was also responsible for the GP care provided to Mr A given Dr B and Dr C were contracted by Corrections to provide GP services to prisoners at the facility at the time of these events. Accordingly, it was found that Corrections breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[1] by failing to ensure that nursing and GP staff provided Mr A with services with reasonable care and skill.

9. It was found that Dr B breached Right 4(1) of the Code by (a) failing to undertake appropriate investigations, in particular an X-Ray, for the purpose of forming an appropriate diagnosis; (b) administering a cortisone injection without excluding a fracture following a fall onto a hard surface from a height; and (c) not documenting his assessments, clinical decisions, or any diagnosis.

10. Adverse comment is made about Dr C's failure to carry out further investigations to exclude a fracture or dislocation.

Recommendations

11. A number of the recommendations outlined to Corrections in the provisional report have been met. The Deputy Commissioner recommended that Corrections (a) provide evidence of nursing staff training in clinical assessment, diagnostic reasoning, pain management training and evaluation, and the appropriate escalation of clinical concerns; (b) update its operation manual to state the expectation that clear clinical records will be maintained at each contact by the doctor and/or nurse; (c) include a separate entry in its triage scale guide to cover "suspected fracture"; (d) provide an update on the progress of its changes for improvement of prison health services, including the effectiveness of the use of the SOAPIE format for documentation, the use of the OPQRST format for pain assessment, and the change to unit-based clinical care; and (e) undertake an audit of staff compliance with, and effectiveness of, the triage process in the facility.

12. As recommended in the provisional report, Dr B provided a written apology to Mr A.

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

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Complaint and investigation

13. The Health and Disability Commissioner (HDC) received a complaint from Mr A regarding the services provided to him at a correctional facility operated by the Department of Corrections.

14. The following issues were identified for investigation:

- *Whether the Department of Corrections provided Mr A with an appropriate standard of care between January and July 2016.*
- *Whether Dr B provided Mr A with an appropriate standard of care between January and July 2016.*
- *Whether Dr C provided Mr A with an appropriate standard of care between January and July 2016.*

15. This report is the opinion of Kevin Allan, Deputy Commissioner, and is made in accordance with the power delegated to him by the Commissioner.

16. The parties directly involved in the investigation were:

Mr A	Consumer/complainant
Dr B	General practitioner (GP)/provider
Dr C	GP/provider
Department of Corrections	Provider

Also mentioned in this report:

RN D	Registered nurse
RN E	Registered nurse
RN F	Registered nurse
RN G	Registered nurse
RN H	Registered nurse
RN I	Registered nurse

17. Information was also received from the District Health Board (DHB).

18. Independent expert advice was obtained from GP Dr Gerald Young (**Appendix A**) and from in-house nursing advisor registered nurse (RN) Vivienne Josephs (**Appendix B**).

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Information gathered during investigation

Introduction

19. Mr A, aged 41 years at the time of events, was a prisoner housed in a residential unit.[2]

20. Mr A complained to HDC about the delay in receiving treatment from Corrections staff after telling staff about his shoulder pain.

Department of Corrections Health Service

21. Corrections provides health care, including nursing and medical services, to prisoners. The facility has a Health Centre staffed by a Health Centre Manager and registered nurses, who are employed by Corrections. In addition, Corrections enters into contracts for service with GPs in the area. Nurses are available to review prisoners on a daily basis at the facility. GPs are available in person at the facility three days a week, and available for advice via telephone at all times as required. At the time of events, GPs Dr B and Dr C were contracted by Corrections to provide services to prisoners at the facility.

Triage Policy

22. When prisoners report non-urgent health concerns, these are managed in line with the "Request for Non-Urgent Health Appointments Triage Process — Residential Units" policy (the Triage Policy) in place at the facility.

23. The Triage Policy states that the purpose of the policy is to ensure "[t]hat all prisoners receive access to Health Services within seven (7) days of a non-urgent request for a health appointment being received by Health Services".

24. In accordance with the Triage Policy, prisoners access health services by completing a health request form (also known as a health chit) which is available in all residential units. Completed health request forms are placed in a secure box in a prisoner's residential unit.

Initial triage

25. The Triage Policy requires the nurse assigned as triage nurse to a residential unit to collect health request forms during the daily check of the designated collection area. The nurse who collects the form then conducts an initial paper-based triage to establish the nature of the health concerns and prioritise care. This paper-based triage process is based on what the patient has reported on the health request form.

26. The Triage Policy "Scale Guide" outlined that the triage scale ranged from 1 to 3, with 1 being the most urgent, with an "immediate health need — Clinical Intervention required on the day of reception", 2 being "Semi-urgent Need — Clinical Intervention required within 24 hours", and 3 being "Routine — Clinical Intervention required within 7 days if appropriate". The scoring system is intended as a guide to help nurses to identify the

[2] Wings/blocks/pods that house mainstream offenders and can usually hold from as few as 24 to as many as 240 offenders. Normally each unit is identified by classification such as High Security Unit, Low Security Unit, Segregated Unit, Remand Unit, etc.

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urgency of a patient's concerns during the paper-based triage process. "Clinical Intervention" involves assessment by the nurse in the residential unit.

Second triage

27. Once the nurse has triaged the health request forms, if a prisoner is considered to require immediate assessment, the nurse must organise with custodial staff for the prisoner to be assessed by the nurse in the residential unit. The Triage Policy states that once a nurse has obtained access to a prisoner, the nurse is required to:

"• Discuss with them the nature of their concern

• Conduct a Health Assessment appropriate to the nature of their concern

• Provide immediate intervention if appropriate while in the unit or advise them of the need for them to attend a clinic at the Health Centre. If they are required to attend the Health Centre advise the prisoner that this will be arranged as soon as possible. Do not state a definite time or day. An estimate may only be provided.

• Ensure nursing notes are made while attending the prisoner at the unit for transfer to the prisoners file in MedTech … on return to the Health Centre …"

Prisoner review

28. Following this second round of patient triage performed by nurses in the residential unit, prisoners can, if their health condition requires it, be referred for an additional nursing review, or "nurse clinic", or medical review by a GP in the Health Centre at one of several clinics held each week. The Triage Policy states that if the nurse establishes that a prisoner requires an additional review, the nurse is to advise the relevant residential unit prison staff that the prisoner is required to attend the Health Centre, and provide the "timeframe in which the prisoner's access to the Health Centre is considered necessary". The Triage Policy also states that following the nurse's return from the residential units, the nurse must "advise the Health Support Officer and Health Administration Support of any prisoners expected to arrive at the Health Centre and the estimated time frame if known".

29. The Triage Policy states that when prisoners arrive at the Health Centre for a review by a nurse, staff are required to:

"• Access prisoner's clinical notes in Medtech …

• Document detailed findings of interactions including any subjective and objective information, intervention provided or required.

• Schedule any follow up appointments necessary in the appropriate appointment books e.g. Medical officer or nurse appointment book …"

30. At the time of events, Corrections also had a policy entitled "Health Services Health Care Pathway", which applied to all Health Services staff employed or contracted to Health Services. The policy outlined that its purpose was to:

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> "Support Health Services staff to provide efficient and effective health care interventions according to the clinical needs of individual patients. This document provides guidance for the delivery of health care at each stage of imprisonment."

31. In addition to the healthcare processes in place outlined above, Corrections told HDC that pain analgesia (paracetamol) is available to prisoners from the Corrections officers (custodial staff) in the guardroom.

Nursing care 6 February 2016 to 26 March 2016

6 February 2016 — initial health request form

32. On 6 February 2016, Mr A submitted a health request form that documented: "My shoulder is broken and needs looking at, [I am] in pain all the time, I want to see a specialist." RN D, the nurse assigned to triage in Mr A's unit that day, received and reviewed the health request form from Mr A. No triage number was documented. RN D recorded in the clinical notes that she made an appointment for a nursing assessment to be carried out in the nursing clinic on 13 February 2016. This appointment was rescheduled by the Team Leader to 17 February 2016, and then further rescheduled to 22 February 2016. The appointment was then rescheduled again to 25 February 2016.

23 February 2016

33. On 23 February 2016, a nurse collected a health request form from Mr A. The nurse did not provide a triage score in this instance, but recorded in the clinical notes: "[Injured] shoulder, in pain waiting [four] weeks to see [medical officer]." A nursing assessment did not occur on this day, as an appointment with a nurse had already been scheduled for 25 February 2016.

25 February 2016

34. On 25 February 2016, in response to Mr A's 6 February 2016 health request form, Mr A was reviewed by RN E in the nursing clinic. Corrections staff told HDC that they do not know why Mr A was not seen in the clinic until 19 days after submitting his health request form. RN E documented that Mr A had been experiencing pain in his left shoulder for the previous four weeks.

35. RN E examined Mr A and documented that there was good range of motion. RN E recorded that Mr A was given arnica cream[3] to apply, and advised to perform "light duties only", and to contact the health service if his pain worsened.

36. RN E told HDC that Mr A described the pain as an ache he experienced when he did heavy lifting, and not as persistent pain. RN E stated that she did not document a pain score because Mr A did not report any pain at the time of the appointment. She also said that Mr A was aware that he could obtain paracetamol from the custody officers for his pain. RN E did not document that she had informed Mr A about how he could obtain pain relief. She stated that she did not obtain Mr A's vital signs because he was reporting a history of

[3] A liniment for bruises, sprains, and swellings.

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experiencing low-grade pain. RN E said that she should have documented the clinical history of Mr A's shoulder ache, as described by Mr A, more clearly in the clinical notes.

15 March 2016 — second health request form

37. On 15 March 2016, Mr A submitted a further health request form, which stated that his shoulder was causing him pain and that it had been doing so for seven weeks. After completing the initial paper-based triage, RN F documented: "Duration of symptoms: [unknown]." It is unknown why this was documented when Mr A was advising that he had been in pain for seven weeks.

38. RN F examined Mr A on the same day and documented that there was full range of motion. RN F did not organise for Mr A to be assessed further at the Health Centre. There was no escalation of care, as referenced in the Triage Policy. Corrections told HDC that RN F should have conducted a thorough assessment and reviewed the previous interventions for Mr A's shoulder, as well as potentially contacting the on-call doctor for medical advice. Instead, RN F advised Mr A to "have Panadol[4] in the [residential] unit" and to submit a further health request form if there was no improvement.

21 March 2016 — third health request form

39. On 21 March 2016, Mr A submitted a further health request form and recorded that he had fallen off the top bunk of his bed and hit his shoulder. He noted that he was in pain, and needed to see "a doctor or a nurse as soon as possible".

23 March 2016

40. On 23 March 2016, RN G recorded: "Health [request form] received dated [21 March 2016]". It is not known why the health request form was not actioned for two days, but it is noted that this is within the Corrections timeframe of seven days for a non-urgent appointment following receipt of a health request form. RN G visited Mr A in his residential unit during his triage round (a brief second triage after receiving the health request form) to determine the level of injury Mr A was suffering, and to clarify the contents of the health request form. RN G documented that Mr A had fallen from his bed onto his left shoulder and was in a lot of pain. RN G recorded that Mr A's shoulder pain centred around the anterior deltoid[5] and clavicle[6] (collarbone), he had reduced range of motion, and he was unable to raise his arm to shoulder height. Mr A was placed off sport until he was seen in the Health Centre for assessment. RN G documented that an appointment was made for further assessment by a nurse.

41. RN G told HDC that after the initial brief triage, he did not deem Mr A to have a life-threatening or other serious illness or injury. No triage number was recorded in the clinical notes. RN G told HDC that accepted practice at the time did not include using a triage score at the initial triage, and staff were unaware that this was a requirement, despite the

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[4] A painkiller.
[5] A thick triangular muscle covering the shoulder joint and used for raising the arm away from the body.
[6] A long bone that serves as a strut between the shoulder blade and the sternum or breastbone.

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Triage Policy being discussed and learnt in the induction process and otherwise adhered to in practice.

42. RN G stated that he was unable to complete an in-depth assessment of Mr A in the residential unit because Mr A's confidentiality could not be maintained in that environment. RN G said that he completed the triage without equipment, and did not have access to Mr A's notes and previous history as there was no access to a computer in the residential unit.

26 March 2016

43. On 26 March 2016, following RN G's clinical decision that Mr A needed to attend an appointment in the nursing unit, Mr A presented at the nursing unit and informed RN H that he had fallen off the top bunk onto his left shoulder. RN H examined Mr A and documented that his left shoulder was found to be very weak, and he was unable to push against her hand. RN H recorded: "Pain +++", and that there was a minimum range of motion and Mr A was unable to complete a full rotation of his left arm. Mr A was prescribed and administered Brufen[7] 400mg in the clinic, and was advised to continue with the Brufen at breakfast, lunch, and dinner until 31 March 2016. An appointment with a GP was scheduled for 12 April 2016. RN H told HDC that the delay between her assessment in the nursing unit and the GP appointment was because there were limited appointments available. RN H stated that during this assessment she completed an ACC form for Mr A's left shoulder. She said that she did not enter the medication on Medtech, but completed the Nurse Initiated Medications Verbal Orders — Standing Orders form.[8]

10 April 2016 — fourth health request form

44. On 10 April 2016, Mr A submitted a further health request form, which stated that his shoulder was painful and that "he needed to see a nurse or doctor". A nurse triaged the health request form. Because Mr A had already seen a nurse and had an appointment to see a GP on 12 April 2016, he was not seen in the nursing unit that day. The nurse recorded that Mr A was advised to take Panadol 4–6 hourly for the pain. The nurse did not document that Mr A was administered Panadol in the clinic.

GP care 12 April 2016 — the facility — Health Services Health Care Pathway

45. As outlined above, Corrections had a policy that outlined how medical services were to be provided to prisoners. The Health Services Healthcare Pathway policy required the GPs to consider patients' clinical symptoms, consider relevant health information, including the clinical history, and undertake relevant clinical assessments and investigations or organise for these to be completed. The policy required GPs to formulate clinical opinions following their completed assessments, and to document all assessments and clinical interventions in a patient's electronic file before going off duty for the day.

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[7] A brand name for ibuprofen, a non-steroidal anti-inflammatory drug used to relieve pain.

[8] A written instruction that permits a medicine to be supplied and administered to a prisoner by a registered nurse without a prescription, in circumstances specified in the standing order.

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12 April 2016 — GP appointment with Dr B

46. On 12 April 2016, GP Dr B saw Mr A for the first time, approximately nine weeks after Mr A had complained of pain in his shoulder. Dr B documented: "[F]ell from bunk … for steroid [injection] when next appointment." He also recorded that the Brufen was not helping. Dr B did not document any examination, clinical findings, or diagnosis.

47. Dr B told HDC:

> "Although my notes for the initial consult are regrettably brief, I refer in these notes to the nurse's record which is thorough and in keeping with my findings of that day, of a soft tissue injury.
>
> …
>
> The diagnosis was that of a rotator cuff injury … I recall the main reason for my diagnosis was that he had been in pain and discomfort for a long time, as well as suffering from restriction in movement."

48. Dr B stated that Mr A had had issues with shoulder pain prior to the fall, and he assessed that the pain Mr A was experiencing was what he had had for approximately 3–4 months, and therefore the symptoms he presented with on 12 April 2016 were more in keeping with a chronic process.[9]

49. Dr B also stated that Mr A had experienced considerable delays in obtaining oral analgesia,[10] and delays in seeing a GP for medical review, and that Mr A's shoulder pain had been ongoing for several months in spite of the oral analgesia. Dr B said that Mr A had not responded to non-steroidal anti-inflammatory medication, and it had already been approximately two weeks since seeing the nurse, and longer since his initial injury, with no improvement to his symptoms. Dr B stated: "It was my assessment at the time that a steroid injection would give him the best relief, thereby reducing his pain and allowing his shoulder to heal."

50. Dr B told HDC that he believes that he would have discussed the injection with Mr A, and would also have discussed "the natural history of shoulder soft tissue injuries". Dr B stated that he would have explained that the injection does not cure inflammation, but only assists with inflammation to provide pain relief and allow for healing of the injury to occur. Dr B did not document that he provided any information to Mr A about the proposed treatment with a steroid injection.

51. Dr B stated that as his clinical opinion and diagnosis was of a soft tissue injury, he did not feel that an X-ray was indicated. His recollection is that the factors he considered in forming his diagnosis included the reported prolonged history of shoulder pain. Dr B stated that, as a result, he did not think that the injury was acute, and therefore he did not order an X-ray or refer Mr A to physiotherapy.

[9] A condition that persists for a long time.
[10] Painkillers.

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52. Dr B told HDC that his level of note-taking is not of a standard he would normally accept, and he could "offer no excuse".

19 April 2016 — GP appointment with Dr B

53. On 19 April 2016, Dr B recorded that he obtained Mr A's verbal consent and administered an intra-articular[11] steroid injection of "Kenacort 40".[12] Dr B documented: "[Review] as needed." Mr A was advised to keep his activity to a minimum for the following two weeks.

Nursing care 29 April 2016 to 9 May 2016 — the facility

29 April 2016 — fifth health request form

54. On 29 April 2016, Mr A submitted a health request form complaining of pain in his shoulder. On 2 May 2016, after triaging the health request form, a nurse attempted to undertake initial assessments on Mr A in the residential unit. The nurse documented that Mr A could not be seen in his residential unit as he was absent. The nurse booked a future appointment with a nurse. Corrections staff told HDC that based on the severity of the symptoms presented in the health request form, nursing staff should have scheduled a nursing assessment for Mr A that afternoon, and handed over the case to the afternoon nursing shift to follow up.

55. On the same day, RN I was carrying out a morning medication round when she was informed that Mr A was not in his original unit. RN I documented that Mr A could not be located. Later that afternoon, a note was found in the Integrated Offender Management System (IOMS)[13] detailing that Mr A had been moved to another unit. RN I also documented that Mr A could not be given his afternoon medicine that day, as there was uncertainty as to where he had been moved. Nurses do not have direct access to patient medical or prisoner hard copy or electronic files whilst they are in the units or on medication rounds. However, this information was available to the nurse when she returned to the Health Centre.

56. Corrections told HDC that when prisoners transfer between residential units, the principal Corrections officer of the residential unit from which the prisoner is being transferred notifies a number of parties of the transfer, including the Health Centre and the residential unit to which the prisoner is being transferred. There is no evidence that the Health Centre was informed of Mr A's transfer on this occasion. However, staff will have had the opportunity to check IOMS to see where and why Mr A had been moved. The correct process is for a notification of prisoner movement form to be emailed to all relevant staff. Corrections was unable to locate the notification regarding Mr A's movements.

3 May 2016 — telephone call requesting medication

57. On 3 May 2016, a nurse documented that a telephone call had been received from a Corrections officer in Mr A's new residential unit to say that Mr A had requested

[11] Into the joint.

[12] Kenacort-A 40 — an anti-inflammatory medication used to treat painful muscles, joints, or tendons by injecting directly into the site of pain.

[13] Corrections' computerised offender database where information about each offender can be accessed by prison staff.

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medication for that night. The nurse added the request to the communications book for the afternoon medicine round. Nothing further was recorded.

5 May 2016 — sixth health request form

58. On 5 May 2016, Mr A submitted a health request form stating that he was experiencing pain in his shoulder throughout the day, and "he need[ed] to see a doctor". RN D recorded in the clinical notes that Mr A continued to complain of pain in his left shoulder.

59. RN D completed the paper-based triage and arranged to see Mr A in his residential unit for a second, in-person assessment and triage. RN D documented that she arranged an appointment for Mr A to be assessed by a GP at the next clinic on 11 May 2016. RN D did not carry out a pain assessment, and did not document a triage number.

9 May 2016 — nursing review

60. On 9 May 2016, Mr A was seen for his previously scheduled assessment with RN I at the 9.30am clinic. RN I documented that Mr A complained that he still experienced shoulder pain. During this review, at Mr A's request, RN I prescribed Voltaren,[14] and made a referral to a physiotherapist. RN I also made an appointment with a nurse (date not specified) for a cardiovascular risk assessment. RN I did not carry out a pain assessment, or document why this was not done. There is no evidence that a cardiovascular risk assessment occurred following this review.

GP care 11 May 2016 — the facility

11 May 2016 — GP appointment with Dr C

61. On 11 May 2016, Mr A was reviewed by Dr C. Dr C documented that Mr A's temperature was 36.4°C[15] and he had swelling on his left upper outer arm (12cm x 10cm). Mr A had minimal shoulder movement owing to the pain. Dr C also documented: "? reaction to the kenacort." Mr A was advised not to exercise, and a plan was made to review him in one week's time.

62. Dr C told HDC: "[Mr A] had also been seen twice by Dr B, for assessment and to undergo steroid injection following his initial injury from falling out of bed." Dr C stated that he was also aware that Mr A had not suffered any further trauma since the injection. Dr C said that because of these factors, he did not suspect a fracture or dislocation.

63. Dr C told HDC that his examination did not reveal a deformity of the left shoulder compared to the right shoulder to suggest dislocation, and his opinion was that Mr A's movement of the left shoulder was reduced owing to pain from the left upper outer arm swelling, and not from the shoulder joint. Dr C stated that his differential diagnosis was of

[14] Voltaren (diclofenac) is a non-steroidal anti-inflammatory drug (NSAID) that is used to treat mild to moderate pain, or signs and symptoms of osteoarthritis or rheumatoid arthritis.
[15] Normal body temperature is typically in the range 36.5–37.5°C.

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either a reaction to the steroid injection or an infection. Dr C prescribed Mr A Augmentin.[16]

64. Dr C decided that an X-ray was not clinically indicated. He told HDC that he came to this conclusion because Mr A was "not clinically systematically unwell", as he did not have fever and the swelling was not fluctuant. Dr C stated that he prescribed and commenced Mr A on Augmentin because the clinical indication was of an infection.

65. Dr C also told HDC that he regrets the clinical decision he made on 11 May 2016 that Mr A's presentation did not warrant immediate referral to the public hospital.

Further care received 13 May 2016 — the facility and the DHB

13 May 2016 — nursing review

66. On 13 May 2016, Mr A was seen by RN I, who recorded that "his left arm upper was swollen++, sore, red". His temperature was recorded as 39.0°C. The nurse contacted Dr B, who recommended that Mr A be admitted to the public hospital.

Admission to the public hospital

67. Later that day, Mr A was admitted to the Emergency Department at the public hospital. An X-ray and an ultrasound scan were performed the following day. Mr A was diagnosed with an extensive soft tissue abscess on his left shoulder, which required incision and drainage. He was discharged from hospital on 24 May 2016 with a prescription for long-term antibiotics, and was required to attend the fracture clinic.

Further information

Medical Council of New Zealand

68. The Medical Council of New Zealand required that Dr B undergo a performance assessment as a result of this matter. In February 2019, the Medical Council determined that Dr B meets the required standard of competence for a doctor registered and working in the vocational scope of general practice, and that no further action is required. In making my findings, I have taken into account the Medical Council's decision.

Dr B

69. Dr B advised HDC that he underwent the required competence performance assessment by the Medical Council in October 2018. He said that the assessment involved examination of all aspects of his practice, including his clinical documentation, and that he obtained a Category 1 rating — the highest rating possible — and the Medical Council determined that no further action was required.

70. Dr B told HDC that he now takes time to document fully and more specifically — both positive and negative findings — and ensures that his notes are consistent and thorough.

71. Dr B also told HDC that he has attended workshops on joint infections and on communication skills, and has discussed these events with his peer review group. He is

[16] An antibiotic.

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also providing training in communication in the GP training programme, and has attended a workshop on bringing reflection and compassion into the consultation in order to help the clinician and patient.

Dr C

72. Dr C told HDC that he has changed his approach to management of swelling post-steroid injection, as he has learnt from this rare event, and has further educated himself on timely referral and appropriate management with X-ray and ultrasound.

Corrections

73. Corrections told HDC that following a comprehensive review of Mr A's clinical notes, it is not entirely clear about the injury Mr A sustained at the facility. Health Services accepts that the policies, procedures, and expectations for the delivery of health care to Mr A at the facility were not met.

74. Corrections also told HDC that in September 2015, the facility received remand prisoners, which required an increase in capacity in the health team and, as a result, at times processes were not consistently supporting patients' access to services in a timely manner.

75. In order to provide a more consistent service and improve continuity of health care by nurses and medical officers (GPs), the facility Health Services moved to unit-based nursing. A nurse is assigned to a residential unit for a minimum of three months. This nurse has oversight and is responsible for the care provided to patients in that residential unit. Nurses are attached to a residential unit for triaging patients. Medical officers (GPs) are also assigned to a particular residential unit, and provide care to prisoners in other units when a medical officer of another unit is on leave.

76. Corrections stated that it is working towards improvements to the delivery of health care provided at the facility, and has commenced various enhancements to support and strengthen its nursing practice, including the move to unit-based care as described above. Further enhancements and strategies include:

- Triaging responsibility is at the point of contact of the health request.
- An external two-day assessment training at a tertiary institute has been implemented for nursing staff, with a number of staff having already completed the training. The training recognises Corrections' need to continually improve assessment skills and knowledge of its nursing staff.
- Training of a nurse as a Professional Development Recognition Program Assessor.
- Chest pain audits on clinical practice.
- Mandatory use of the SOAPIE[17] format for documentation, and the OPQRST[18] format for pain assessment.

[17] A mnemonic for documentation — SOAPIE stands for Subjective, Objective, Assessment, Plan, Implementation, Evaluation.

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- Education sessions on the OPQRST pain assessment tool for nurses, as taught in the compulsory Pre-Hospital Emergency Training provided to all nurses within the first 12 months of their employment.
- Access for all nurses to the online manual used by clinicians to help to make assessment, management, and specialist request decisions.
- Support for postgraduate study in clinical nursing papers.
- Piloted telehealth consultations with specialists at the public hospital.
- Monitoring of nursing clinical assessments and documentation for best practice compliance.
- Development of pocket resource cards to support nursing assessment documentation.

ACC Guidelines

77. ACC has published guidelines to assist health practitioners and consumers to make informed decisions, and to improve health outcomes. "The Diagnosis and Management of Soft Tissue Shoulder Injuries and Related Disorders — Best practice evidence-based guideline" (ACC Guidelines) includes an evidence-based summary of the diagnosis and management options available for soft-tissue shoulder injuries and related disorders.

78. According to the Guidelines, a soft-tissue injury of the shoulder requires full clinical assessment, during which red flags or indications for referral should be considered. Where the "mechanism of injury" is a "fall/direct trauma", a fracture of the clavicle should be considered, and if there has been a "fall onto point of shoulder", an AC joint injury (separation of the clavicle from the shoulderblade) should be considered.

Responses to provisional opinion

79. HDC attempted to obtain comment on the provisional opinion from Mr A but was unable to.

80. Corrections provided a response to the provisional report, and its comments have been incorporated into the opinion where appropriate.

81. Dr B provided a response to the provisional report, and his comments have been incorporated into the opinion where appropriate. He stated:

> "I am deeply sorry for the complication that [Mr A] experienced following the shoulder injection I performed. I have never before, or since this case, experienced a patient develop any infection of the skin or joint following an injection I have given. I have reviewed the guidelines referred to in your findings and taken on board Dr Young's comments and will ensure that I follow the guidelines in cases presenting with soft-tissue injuries of the shoulder."

[18] A tool used to discern accurate reasons for a patient's symptoms and history in the event of an acute illness. The mnemonic stands for Onset, Provocation, Quality, Region and radiation, Severity, Time.

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82. In response to the provisional report, Dr C advised HDC that he had no further comments to make, and accepted the provisional findings.

Relevant standards

83. The Medical Council of New Zealand's publication *Good Medical Practice* (2013) states:

"…

Providing good clinical care

2. When you assess, diagnose or treat patients you must provide a good standard of clinical care. This includes:

   - Adequately assessing the patient's condition, taking account of the patient's history and his or her views, reading the patient's notes and examining the patient as appropriate
   - Providing or arranging investigations or treatment when needed
   - Taking suitable and prompt action when needed, and referring the patient to another practitioner or service when this is in the patient's best interests

…

Keeping records

5. You must keep clear and accurate patient records that report:

   - Relevant clinical information
   - Options discussed
   - Decisions made and the reasons for them
   - Information given to patients
   - The proposed management plan
   - Any medication or other treatment prescribed.

6. Make these records at the same time as the events you are recording or as soon as possible afterwards …"

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Opinion: Department of Corrections — breach

Overview

84. Section 75 of the Corrections Act 2004 states:

> "Medical treatment and standard of health care
>
> (1) A prisoner is entitled to receive medical treatment that is reasonably necessary.
>
> (2) The standard of health care that is available to prisoners in a prison must be reasonably equivalent to the standard of health care available to the public."

85. In addition, in accordance with the Code, Corrections has a responsibility to operate its health service in a manner that provides consumers with services of an appropriate standard. Corrections has an organisational duty to facilitate continuity of care, including ensuring that its staff work together and communicate effectively.

86. A person being held in custody does not have the same choices or ability to access health services as a person living in the community. Persons held in custody do not have direct access to a GP, and are entirely reliant on the staff at the Health Centre to assess, evaluate, monitor, and treat them appropriately. Accordingly, I am concerned about numerous instances of inaction and very poor communication and collaboration between the Health Service staff in the provision of health care to Mr A.

Nursing care

87. In my view, a number of failures by Corrections staff led to Mr A receiving care and treatment that was well below an acceptable standard of care. While many of the departures from an acceptable standard of care can be linked to individual Corrections staff, in my opinion these failures were largely a result of broader systems issues at Corrections.

88. Expert nursing advice was obtained from RN Vivienne Josephs. RN Josephs advised that between 6 February 2016 and 9 May 2016, there were multiple departures from the standard of care required by the Triage Policy.

89. Between 6 February 2016 and 10 April 2016, Mr A submitted four health request forms. The first health request form, submitted on 6 February 2016, was reviewed on the same day by RN D and, as a result, Mr A was reviewed in the nursing clinic on 25 February 2016 by RN E. The second health request form, submitted on 15 March 2016, was reviewed on the same day by RN F. The third health request form, submitted on 21 March 2016, was reviewed on 23 March 2016 by RN G and, as a result, Mr A was reviewed in the nursing unit on 26 March 2016 by RN H. The fourth health request form, submitted on 10 April 2016, was not actioned because Mr A had already been seen by a nurse in the nursing unit, and he had a scheduled GP appointment at the Health Centre on 12 April 2016.

90. RN Josephs advised that all the nurses who reviewed Mr A on the above dates failed to adhere to the Triage Policy in one way or another. The Triage Policy clearly outlined that

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prisoners were to be triaged and assessed in accordance with the policy. RN Josephs advised the following:

- There was a moderate departure from the standard of care required by the Triage Policy in the care provided to Mr A from 6 February 2016 to 26 March 2016.
- A number of actions should have been taken on receiving the health request form from Mr A on 6 February 2016. An initial triage should have been done as per the Triage Policy, and he should have been seen for a second triage in his residential unit. A set of vital signs should have been taken, as should a history of the presenting complaint. Further, a nursing assessment was required to ensure his clinical stability (including a triage score based on the Triage Policy). Appropriate intervention would have included analgesia (following a pain assessment) as per the facility's Standing Orders and as referenced in the Triage Policy. This should all have been documented in the clinical notes and the date of the next nursing appointment also documented.
- There was a mild to moderate departure from the standard required by the Triage Policy on 15 March 2016 with the absence of an initial triage on receipt of new health request forms from Mr A.
- There was poor nursing assessment (including assessment of pain) at the appointment of 26 March 2016 and when the health request form submitted on 10 April 2016 was reviewed. This also included the absence of a patient history of the complaint and poor documentation of subjective and objective signs relating to the complaint.
- The prioritising of care as documented in the Triage Policy also did not meet the standard because the assessment of pain and the intervention of pain relief was not addressed.
- There was a mild to moderate departure from the standard of the Triage Policy with the delay in prioritising care in the accessing of a medical review and the lack of documentation in the appointments book of a medical follow-up, which was referenced in the clinical notes on 25 February 2016.

91. In addition, RN Josephs advised that it would be considered standard practice to review the effectiveness of a medication regularly, and escalate concerns if the pain is not resolving, as this could indicate a worsening injury. I accept RN Joseph's advice. I consider that it was inadequate and unhelpful practice for the nurses at Corrections to repeatedly tell Mr A to submit further health request forms if his pain was not resolving, rather than to arrange for further clinical assessment or intervention.

92. Following Mr A's consultation with Dr B on 12 April 2016, when Mr A was administered a steroid injection, Mr A submitted two further health request forms — the fifth and sixth health request forms — on 29 April 2016 and 5 May 2016. On 29 April 2016, following a review of Mr A's fifth health request form, prison staff and nurses could not locate him, as he had been transferred to a new unit. His health request form was not triaged, and he was not given his medication until the night of 3 May 2016. I am concerned that the Health

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Centre staff did not access information on the IOMS system to establish Mr A's whereabouts at this time.

93. On 5 May 2016, when Mr A submitted his sixth health request form, a Corrections nurse triaged Mr A but did not allocate a number according to the triage scale. After visiting him in his residential unit, the nurse organised for Mr A to be seen in the Health Centre on 9 May 2016 for a nursing assessment. On this date, a pain assessment was not carried out. Instead, the nurse made an appointment for Mr A to see a GP at the next available Health Centre clinic on 11 May 2016. RN Josephs has advised that not performing a physical and pain assessment, not checking the efficacy of pain relief, and not escalating concerns about unresolved pain at the nursing clinic assessment on 9 May 2016 amount to a mild to moderate departure from accepted standards of care.

GP care — the facility

94. As discussed below, there were also inadequacies in the GP care provided to Mr A. Doctors failed to assess and investigate Mr A's injuries adequately.

95. Although Dr B and Dr C are responsible for the care they provided to Mr A, at the time of these events they were contracted by Corrections to provide GP services to prisoners at the facility and, ultimately, Corrections was responsible for the care provided to Mr A.

Conclusion

96. As stated previously, a person being held in custody does not have the same choices or ability to access health services as a person living in the community. Persons in custody do not have direct access to a GP, and are entirely reliant on staff at the Health Centre to assess, evaluate, monitor, and treat them appropriately. Although Corrections operated nursing clinics and held GP clinics several times a week at the facility, Mr A was, for reasons very much outside his control, unable to gain access to a GP until over eight weeks after his initial complaint of injury to his shoulder.

97. It is apparent that numerous nurses employed by Corrections failed to adhere to the Triage Policy in place at the time of events. Indeed, many were unaware that a triage scoring system was required at the initial paper-based triage stage. It is Corrections' responsibility to ensure that its staff adhere to organisational policies, particularly those that are in place to protect the health of prisoners, who cannot choose their own healthcare provider.

98. In my view, Corrections was responsible for ensuring that Mr A was provided services with reasonable care and skill, and it failed to do so. There were multiple failures in the care provided to Mr A by multiple Corrections staff (nurses and GPs). Accordingly, I find that the Department of Corrections breached Right 4(1) of the Code.[19]

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

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Opinion: Dr B — breach

Clinical investigation and diagnosis

99. On 12 April 2016, Dr B examined Mr A. Dr B told HDC that he had reviewed the examinations and assessments documented by the nurses who had seen Mr A previously, and was aware that Mr A had received non-steroidal anti-inflammatory medication for the pain. Following this examination, Dr B documented that he planned to administer a steroid injection (Kenacort-A 40) to Mr A at the next appointment. Dr B did not document his clinical findings, diagnosis, or any assessment or reasons for his treatment plan, and did not undertake any further investigations.

100. In his response to HDC, Dr B stated that he accepts that his clinical notes for the initial consultation are "regrettably brief", and said that this is because his clinical notes referred to the more thorough nursing record.

101. Dr B told HDC that the main reason he formed the diagnosis of a soft-tissue injury was because Mr A had been in pain and discomfort for three to four months, and had also suffered from restriction of movement. Dr B also stated that the clinical notes taken by the nurses who saw Mr A previously were consistent with his findings of a diagnosis of a soft-tissue injury.

102. According to RN H's notes, documented on 26 March 2016, Mr A had "pain +++" in his shoulder, and a minimal range of motion after 21 March 2016, when he reported having fallen onto a hard surface from a top bunk.

103. According to the ACC Guidelines, a soft-tissue injury of the shoulder requires full clinical assessment, during which red flags or indications for referral should be considered. Where the "mechanism of injury" is a "fall/direct trauma", a fracture of the clavicle should be considered, and if there has been a "fall onto point of shoulder", an AC joint injury (separation of the clavicle from the shoulderblade) should be considered. My expert advisor, GP Dr Gerald Young, considered that Dr B's initial assessment and diagnosis undertaken on 12 April 2016 was a moderate to significant departure from the standard of accepted practice as referenced in the ACC Guidelines.

104. Dr Young advised:

> "With the history of a fall from the top bunk onto a hard surface landing on the left shoulder a fracture needs to be excluded, especially if a steroid injection is contemplated. If a fracture was present, then a steroid injection would not be indicated.
>
> …
>
> With the existing previous recent history of shoulder problems the fall may not have been the sole cause of the symptoms experienced and as long as a fracture and/or

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dislocation was adequately excluded by an X-ray then a cortisone injection was reasonable …"

105. Dr Young advised that "to use an intra-articular cortisone injection without an X-ray and an accurate diagnosis was a moderate to significant departure from an accepted standard of care." I accept Dr Young's advice.

106. Mr A had a history of left shoulder pain, and had complained of a fall onto a hard surface from a height. He had reported considerable pain and had minimal range of motion. In addition, on examination, his left shoulder was found to be very weak. By the time Dr B examined Mr A on 12 April 2016, these quite significant symptoms had persisted for 19 days. I accept Dr Young's advice, and am of the opinion that Dr B should have taken the appropriate step of ordering an X-ray of Mr A's shoulder to exclude a fracture prior to administering a steroid injection.

Documentation

107. From 6 February 2016 until 21 March 2016, Mr A complained of pain in his left shoulder. On 21 March 2016, Mr A reported having fallen from a height onto his left shoulder. In light of these complaints, Mr A's symptoms may not necessarily have been the result of a single event of falling from a top bunk.

108. Dr Young advised that Dr B should have documented the findings of his clinical examination, and that "[i]t was acceptable to refer to previous documentation of the history of the injury [and that] some more details such as estimated height of the fall should have been documented".

109. Dr Young's opinion is that "[t]he standard of the clinical records from [Dr B] is not of an acceptable standard [and] the departure is of a moderate degree". I accept Dr Young's advice, and consider that the standard of Dr B's documentation was inadequate. In addition, I note that Dr B's documentation provided very little information for the clinicians who reviewed Mr A subsequently.

110. The Medical Council of New Zealand's publication *Good Medical Practice* (2013) states that doctors must keep clear and accurate patient records that report relevant clinical information, options discussed, decisions made and the reasons for them, information given to patients, the proposed management plan, and any medication or other treatment prescribed.

Conclusion

111. By failing to undertake appropriate investigations, in particular an X-ray, for the purpose of forming an appropriate diagnosis, by administering a cortisone injection without excluding a fracture following a fall onto a hard surface from a height, and by not documenting his assessments, clinical decision-making process, or any diagnosis, I find that Dr B did not provide Mr A services with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

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Opinion: Dr C — adverse comment

112. On 11 May 2016, approximately three weeks after he had been administered the steroid injection, Mr A attended a consultation with Dr C. Dr C documented that Mr A had a "swelling firm red and tender over left upper outer arm" and fever. Dr C also recorded that Mr A had reduced shoulder movement owing to the pain from the swelling.

113. Dr C told HDC that his usual approach is to review the previous clinical records for the patient. He said that he was aware that Mr A had been seen twice by Dr B for an assessment and steroid injection, and that Mr A had not suffered any further trauma since the injection. Dr C said that because of these factors, he did not suspect a fracture or dislocation. He stated that following his examination of Mr A, he was satisfied that Mr A's shoulder was not dislocated and that the reduced arm movement was not a result of a complication with the shoulder joint. Dr C said that his differential diagnosis was either a reaction to the steroid injection or an infection.

114. My expert advisor, Dr Young, advised:

> "That there was significant tenderness with a 12 x 10cm swelling 3 weeks after a cortisone injection is definitely not an expected finding. It cannot be a simple injection reaction 3 weeks after the steroid injection was done. With a swelling of this size the exact cause needed to be defined so that appropriate treatment could be given."

115. Dr Young said that as there was an existing history of a shoulder problem, the fall may not have been the sole cause of the shoulder symptoms. The shoulder problem had been attended to by other providers since February 2016, and the clinical history involved more than a single fall from a bunk bed.

116. Dr Young advised that Dr C should have reviewed the records to confirm whether an X-ray had been performed to exclude a fracture/dislocation caused by the fall, and, on finding that it had not been done, he should have ordered an X-ray. Dr C relied on Dr B's assessments prior to the administration of the cortisone injection. However, as noted by Dr Young, Dr B's clinical records for 12 April 2016 and 19 April 2016 were inadequate, and would not have enabled Dr C to ascertain Dr B's diagnosis or whether an X-ray had been performed.

117. With an existing history of left shoulder injury and a fall onto a hard surface from a height, landing on an already painful shoulder, I am critical that Dr C did not take necessary steps to confirm whether an X-ray had been done to exclude a fracture and/or a dislocation.

118. I acknowledge and accept that the documentation for the previous assessments carried out on 12 April 2016 and 19 April 2016 was limited, and, as a result, Dr C had little information available to him at the time of his consultation on 11 May 2016. However, I consider that as there was no indication that an X-ray of Mr A's shoulder had already taken place, Dr C should have carried out further investigations to exclude a fracture or a dislocation.

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Recommendations

119. I recommended in my provisional report that Corrections provide a written apology to Mr A for its breach of the Code. This apology has been sent to HDC and will be forwarded to Mr A. Accordingly, this recommendation has been met.

120. In the provisional opinion, I recommended that Corrections provide training to the facility Health Services nursing staff on clinical assessment, diagnostic reasoning, pain management training and evaluation, and the appropriate escalation of clinical concerns, and provide evidence of that training to HDC. Corrections advised that to deliver this training, the facility has been engaging with a tertiary institute and that at present, 13 out of 17 nurses have already completed this training. The next available course date for training in these areas of care is in March 2020. Accordingly, I recommend that Corrections provide evidence of the completion of this course by all Health Services nursing staff by April 2020.

121. In the provisional opinion, I also recommended that Corrections undertake the following within four months of the date of my final report:

a) Consider an amendment to the "Request for Non-Urgent Health Appointments Triage Process — Residential Units" policy (the Triage Policy) to include a requirement to obtain a set of vital signs, and consider an amendment to the "Triage Scale Guide" included in the policy, in light of its purpose to ensure that all prisoners are allocated a triage score number and have access to the Health Service within seven days, and provide HDC with the outcomes of these considerations.

   Corrections advised that access to health services, triage requirements, and documentation standards are all considered in the recently amended and implemented Health Care Pathway (April 2019). The Triage Policy is being reviewed and will become part of the Local Operating Manual (LOM) to reflect both the revised Health Care Pathway document and service delivery processes. This will include a section detailing the requirement that nursing staff undertake a set of clinical observations when clinically indicated.

   Accordingly, this recommendation has been met.

b) Consider the following improvements suggested by my nursing advisor, RN Josephs, and report back to HDC on these considerations:

   - An update of the "Local Operation Manual" for "Doctors Clinics" and "Registered Nurse Clinics" to state the expectation that clear clinical records will be maintained at each contact by the doctor and/or nurse.
   - The inclusion of a separate entry in the "Triage Scale Guide #2" to cover "suspected fracture".

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Corrections accepts the recommendation regarding clinical documentation expectations and changes to the LOM regarding the maintenance of clinical records by both medical officers and nursing staff, and advised that this will be completed and provided to HDC within four months of the date of this report.

Corrections advised that a "suspected fracture" separate entry will be included in the SCHF LOM, and this amended LOM will be provided to HDC within four months of the date of this report. Further, the requirement for health services staff to access and use the DHB clinical pathways (available through the MedTech system) will be communicated to staff.

c) Provide an update on the progress of the changes for improvement of prison health services outlined in paragraph 76 of this report, including an update on the effectiveness of the use of the SOAPIE format for documentation, the use of the OPQRST format for pain assessment, and the change to unit-based clinical care.

   Corrections agreed to provide comprehensive updates on this within four months of the date of this report.

d) Undertake an audit of staff compliance with, and effectiveness of, the triage process in the facility over one month, and report back to HDC on the results of this audit and the actions taken to address any issues from the audit.

   Corrections advised that this is a focus area for it going forward, and recognises that it will require attention to staffing, clinical space, and prisoner movements in order to aid compliance with the Triage Policy. Corrections has agreed to undertake the audit as outlined above.

122. I recommended in my provisional opinion that Dr B provide a written apology to Mr A for the breach of the Code identified in this report. This has since been provided to HDC, and will be forwarded to Mr A. Accordingly, this recommendation has been met.

123. I note that as a result of this case Dr B underwent a performance assessment by the Medical Council of New Zealand, and that in February 2019 the Council determined that Dr B meets the required standard of competence for a doctor registered and working in the vocational scope of general practice, and that no further action is required. In light of this, I have not made any further recommendations for Dr B.

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Follow-up actions

124. A copy of this report with details identifying the parties removed, except the experts who advised on this case and the Department of Corrections, will be sent to the Nursing Council of New Zealand.

125. A copy of this report with details identifying the parties removed, except the experts who advised on this case and the Department of Corrections, will be sent to the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners, and they will be advised of Dr B's and Dr C's names.

126. A copy of this report with details identifying the parties removed, except the experts who advised on this case and the Department of Corrections, will be sent to the Office of the Ombudsman and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent general practitioner advice to the Commissioner

The following expert advice was obtained from GP Dr Gerald Young.

"**Expert Opinion Report One**

Advice on [Mr A] C16HDC00776

I have been asked to provide specific advice regarding the care provided to [Mr A] by [Dr B] and [Dr C] at [the facility].

In preparing the advice on this case to my knowledge I have no personal or professional conflicts of interest giving advice in this case.

References provided to complete the report:

- Letter of complaint dated […].
- Response from [Health Manager] dated 18 August 2016.
- Response from [Dr B] dated 10 August 2016.
- Response from [Dr C] dated 22 September 2016.
- Clinical records from [Health Services] covering the period 15 March 2016–19 July 2016.

Other references used:

The Diagnosis and Management of Soft Tissue Shoulder Injuries and Related Disorders. Best practice evidence-based guideline. July 2004. (http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_comnnunications/documents/guide/wcnn0 01684.pdf)

I have been asked to comment on the following issues:

A. [Dr B]

1. The standard of the initial assessment and diagnosis undertaken on 12 April 2016.

The initial assessment and diagnosis undertaken on 12 April 2016 is a moderate to significant departure from the standard of accepted practice as referenced in the ACC 'The Diagnosis and Management of Soft Tissue Shoulder Injuries and Related Disorders. Best practice evidence-based guideline — July 2004.'

The history disclosed that the shoulder injury was caused by [Mr A] falling from the top bunk onto the floor landing on his left shoulder. The exact date of the injury was not documented in the records reviewed but occurred prior to 23 March 2016 approximately 3 weeks before being assessed by [Dr B]. The nurse assessment noted significant 'pain +++, Very weak in the left shoulder, minimal range of motion (ROM)'.

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He was given Brufen a non-steroidal anti-inflammatory then paracetamol was also added as the pain was not settling.

He was seen by [Dr B] on 12 April 2016 and recorded 'fell from bunk as per inj 23/3 po nsaid not helping for steroid inj when next appointment'. The notes are very brief and do not document any examination or a diagnosis. [Dr B] in his reply to the complaint states that he did examine the shoulder and his findings were 'in keeping' with the nurse examination findings of 26 March 2016. An exact diagnosis was not recorded and in [Dr B's] reply, the diagnosis suggested was '... a soft tissue injury'. A cortisone injection was planned for the following week on 19 April 2016.

With the history of a fall from the top bunk onto a hard surface landing on the left shoulder a fracture needs to be excluded, especially if a steroid injection is contemplated. If a fracture was present, then a steroid injection would not be indicated. Indeed, if a steroid injection is contemplated an accurate and definitive diagnosis should be made (after an X-ray in this case to exclude a fracture) if a specific diagnosis cannot be ascertained with certainty on the clinical exam alone then further imaging, for example with ultrasound, should have been performed. A 'soft tissue injury' is a non-specific descriptive term that covers all possible non bony injuries.

[Mr A] had a lot of tenderness, weakness and limited shoulder movement after his fall which could be caused by a fracture so this needed to be excluded.

2. The appropriateness of the treatment — intra-articular joint injection undertaken on 19 April 2016 including post care instructions. Please identify

As stated in #1 above it was not appropriate to consider a steroid injection to the left shoulder until a fracture had been excluded. As stated in #1 above a specific diagnosis of the type of shoulder injury should be made and documented before an intra-articular joint injection is undertaken to ensure that the cortisone injection is indeed indicated and delivered by the appropriate method to the specific damaged structure in the shoulder. Not all shoulder cortisone injections are intra articular.

The post op advice given was 'minimal activity next 2 weeks' which was appropriate and reasonable. Other advice that should have been included was that there may be localised pain around the injection site for no more than 2 to 3 days, if there is pain after this time, especially increasing pain and/or swelling then review is required.

Based on the above the decision to use an intra-articular cortisone injection without an X-ray and an accurate diagnosis was a moderate to significant departure from an accepted standard of care.

3. Whether further investigations should have been considered prior to the steroid injection.

As discussed in #1 and #2 above, with a history of the left shoulder injury being caused by a fall from the top bunk onto the floor then an X-ray should have been done. With

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this history of trauma, an X-ray should definitely have been performed prior to any cortisone injection to the shoulder being contemplated. As discussed in #1 and #2 above if an accurate definitive diagnosis for the cause of the pain cannot be made by the clinical exam alone then further imaging should be used, such as ultrasound scanning.

4. *The standard of the contemporaneous documentation.*

The standard of the clinical records from [Dr B] is not of an acceptable standard and the departure is of a moderate degree.

It was acceptable to refer to previous documentation of the history of the injury however some more details such as estimated height of the fall should have been documented.

[Dr B's] own findings on his clinical examination should have been documented. A specific differential diagnosis was not recorded; an accurate specific diagnosis is important and a requirement if a cortisone shoulder injection is contemplated.

5. *[Mr A's] subsequent diagnosis of septic arthritis.*

The diagnosis of septic arthritis may have been made earlier and possibly may have been prevented if earlier assessment was performed. The records note that [Mr A] tried to get medical attention for his shoulder pain on 2nd and 5th of May 2016 but he was not seen. He was seen by a nurse (entry code […]) on the 9th May 2016, there is no examination recorded and was given 'voltaren BD' (dose not recorded). [Mr A] was not seen again until 11th May 2016 by [Dr C] who recorded that swelling over the left upper arm was noticed a few days after the cortisone injection. 'Since then [exact timing not recorded] noticed redness and swelling over the left upper arm'. He complained of pain and pain with movement of the left arm.

The examination revealed a 12cmx10cm swelling over the left upper arm, which was firm, red and tender. Minimal shoulder movement was possible due to pain. Temperature was recorded as 36.4.

The differential diagnosis was '? Reaction to Kenacort'.

Treatment given was cetirizine (antihistamine) 10mg daily and Augmentin 500 (antibiotic) 1 three times daily.

[Mr A] was seen again 2 days later 13th May 2016 by [the nurse], he was now febrile with a temperature of 39 because of this he was referred acutely to hospital. The diagnosis of septic arthritis was made in hospital.

After the cortisone injection it would be reasonable to expect some pain and tenderness over the injection site for 2–3 days, however it was 2 weeks later that [Mr A] complained to nursing staff about ongoing left shoulder pain, it was not

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documented on the 2nd, 5th and 9th May 2016 contacts if the shoulder pain was worse or better than prior to the cortisone injection and this should have been ascertained. If it were worse, then immediate medical review should have been provided. If it were the same or better, then a routine clinical appointment would have been appropriate.

When [Dr C] consulted [Mr A] on the 11th May 2016 because an exact diagnosis had not been established, in particular, that a fracture had not been excluded, [Dr C] needed to be very circumspect of the exact cause of the deterioration in the shoulder pain. This was another opportunity to get an X-ray to exclude a fracture and probably an ultrasound scan would have been appropriate at the same time, especially if there were no fracture on the X-ray, to assess the significant tender mass documented as 10x12cm that had developed on the left shoulder.

By the 13th May 2016 [Mr A] was systemically unwell with a fever of 39 so acute hospital admission was appropriate.

It is possible that if [Mr A's] pain was properly assessed earlier and symptoms/and or signs of infection noted and treatment provided then septic arthritis of the left shoulder may have been avoided.

6. Any other matters in this case that you consider warrant comment.

Dealing with a patient that is incarcerated is not the usual clinical setting for a GP consultation. This has added complexities to the management for [Mr A]. Of note he cannot see a doctor when he chooses, he has to be given permission to attend the clinic. This has added delays to when he has been able to get medical attention both at the initial assessment of the injury and in the follow up after the cortisone injection. It appeared that he was not able to choose which doctor he could attend each time, so seeing a different doctor for his follow up post injection was not as ideal as seeing [Dr B] who did the injection in the first instance as [Dr B] would have had a better understanding of [Mr A's] pre-injection clinical status. Continuity of care improves clinical outcomes.

Management of a patient in prison probably adds to the complexities of obtaining an X-ray and other investigations, because of the security issues that would need to be addressed to have this done. I am not sure if this factor did impact on both [Dr B] and [Dr C] deciding not to get an X-ray done.

These are mitigating factors of the system that did and could have impacted on the care provided to [Mr A].

B. [Dr C]

1. The standard of the assessment and treatment provided on 11 May 2016.

The standard of care provided by [Dr C] on 11th May 2016 was a moderate to significant departure from the expected standard.

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The fundamental reason for this finding has been discussed, in that a fracture was not excluded in a left shoulder injury caused by a fall from a reasonable height. Excluding a bony injury is an important first step in the ongoing management.

It is possible that [Dr C] may have assumed that an x-ray had already been done however in the context of the clinical findings of that consultation he needed to be sure if an X-ray had been done or not as there was no clear diagnosis for the shoulder pain documented.

That there was significant tenderness with a 12x10cm swelling 3 weeks after a cortisone injection is definitely not an expected finding. It cannot be a simple injection reaction 3 weeks after the steroid injection was done. With a swelling of this size the exact cause needed to be defined so that appropriate treatment could be given.

The prescription of an antibiotic was not inappropriate as an infection of some type was probable but with such a large swelling a collection that required drainage was also very probable and this needed to be identified with certainty and managed accordingly.

I am unsure of the benefit of the prescription of cetirizine an antihistamine in this situation as at 3 weeks post steroid injection this was not an acute sensitivity reaction.

2. *In your opinion, was appropriate consideration given to possible complications from the treatment administered on 19 April 2016?*

[Dr C] clearly considered that [Mr A's] symptoms and findings could have been secondary to the cortisone injection and stated this in his consultation records. An antibiotic was initiated for possible infection.

The problem as already discussed, was not enough was done to investigate the cause for the significant tender swelling noted and to ensure a fracture was excluded.

3. *The standard of the contemporaneous documentation.*

The clinical records of [Dr C] were of a reasonable standard.

4. *Any other matters in this case that you consider warrant comment.*

The comments in #A6 above also apply here, in particular the possible barriers to getting appropriate investigations when required.

Expert Opinion Report Two

Further advice on: Complaint: [Dr B] and [Dr C] at [the facility] Our ref: 16HDC00776

In providing this further advice I have reviewed the following documents provided:

1. Letter of complaint dated […].
2. Response from [Health Manager] dated 18 August 2016.

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3. Responses from [Dr B] dated 10 August 2016 and 13 September 2017.
4. Responses from [Dr C] dated 22 September 2016 and 11 September 2017.
5. Clinical records from [Health Services] covering the period 15 March 2016–19 July 2016. Additional clinical records requested for periods 1 Dec to 31 Dec 2015 and 01 Jan to 15 Mar 2016.
6. Information provided by [the DHB] and received on 9 August 2017
7. Information from the [the facility]
   a) Incident report dated 13 May 2016
   b) Information on how the health service responds to a prisoner's request for a medical appointment
   c) Healthcare Pathway Policy and Procedures
   d) Managing your Health in prison pamphlet
   e) Facility's Local Operation Manual — Doctors' and registered nurses' clinics
   f) Final response to HDC
8. Information provided by the ACC.

Further specific advice:

1. *Does the information provided by [Dr B] on 13 September 2017, in any way change the expert advice you provided on 19 October 2016?*

The information provided by [Dr B] and additional information provided does not significantly alter my opinion on the standard of care provided by [Dr B], the departure from the standard of care is a moderate to significant departure from an expected reasonable standard of care.

The reasons why the additional information has changed in my opinion are:

a) Although [Mr A] was noted to have an existing shoulder problem that he had been complaining of from 6th Feb 2016, he did re-present with the history of significant trauma with a fall onto a hard surface off the top bunk.

[Dr B] did not record his clinical findings on his initial consult on 12th April 2016 but stated in his letter of 10th August 2016 that he agreed with the findings of the nurse on 26th March 2016. At that nurse assessment the shoulder was noted to have quite significant clinical findings '… Pain+++, very weak in L) shoulder unable to push against nurses hand. Minimal ROM.' This means that these quite significant symptoms have persisted for 19 days, in particular a pain score of 3 plus, by the time [Dr B] consulted [Mr A].

With this history and persisting high level of pain and loss of function, an X-ray should have been done to exclude a fracture and/or dislocation of the shoulder before considering a cortisone injection.

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I note that in [Dr B's] reply of 13th September 2017 he states that '… I recall the main reason for my diagnosis was that he had been in pain and discomfort for a long time, as well as suffering from restriction of movement.' [Dr B] also states that he assessed that '… the pain he was experiencing was what he had had for 3 to 4 months.'

These findings are not consistent with the nursing records, the 15th March 2016 consult record that he did have pain for 7 weeks but had a full range of motion. The nurse assessment on 23rd March 2016 and 26th March 2016 after the fall, record that the shoulder pain was much worse; '… has a lot of pain' and 'Pain +++'. Also, the range of motion was noted to be significantly reduced from the nurse assessment of 15th March 2016 and after the fall assessments on 23rd and 26th March 2016.

If the symptoms and findings had materially changed from the last nurse assessment on 26th March 2016 then these should have been documented in the records by [Dr B].

b) An X-ray should have been requested to exclude a fracture and/or a dislocation of the shoulder, caused by the fall from the bunk, prior to the cortisone injection. If there was a fracture and/or dislocation of the shoulder, then a cortisone injection would be contra-indicated. A clinical examination alone is not completely reliable in excluding an undisplaced fracture and/or a posterior dislocation of the shoulder.

The records from [the public hospital] that were provided supports this conclusion; in that when [Mr A] was assessed on arrival at the Emergency Department at [the public hospital] on 13th May 2016 an X-ray was requested immediately to exclude a fracture and or dislocation of the shoulder ('?#/dislocation' recorded in ED radiology referral).

c) With the previous history of shoulder pain and if an x-ray had excluded a fracture or dislocation, it would be reasonable to make a diagnosis that the fall caused an acute exacerbation of a previous non-traumatic shoulder problem. An ultrasound whilst desirable would not be essential before a cortisone injection to the shoulder in this scenario.

The care provided is a moderate to significant departure from a reasonable standard of care because an x-ray should have been requested with a history of a fall from the top bunk onto a hard surface to exclude a fracture and/or a dislocation, but with the existing previous recent history of shoulder problems the fall may not have been the sole cause of the symptoms experienced and as long as a fracture and/or dislocation was adequately excluded by an X-ray then a cortisone injection was reasonable without an ultra sound scan.

2 *Does the information provided by [Dr C] on 11 September 2017, in any way change the expert advice you provided on 19 October 2016?*

The additional information provided does change my opinion on the care provided by

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[Dr C] that it is a mild departure from a reasonable standard of care. As noted in the discussion above there was an existing history of a shoulder problem so the fall may not have been the sole cause of the shoulder symptoms. The shoulder problem had been attended to by other providers since February 2016. When [Dr C] was following-up the complications of the cortisone injection to the left shoulder the initial cause for the shoulder symptoms was not necessarily the single event of falling from the top bunk. With the clinical history being more involved [Dr C] would have been more reliant on the assessments of [Dr B] prior to giving the cortisone injection. [Dr C] should have ideally reviewed the records to confirm if an X-ray had been done to exclude a fracture and/or dislocation caused by the fall and ordered the x-ray if none had been done. That the clinical records of [Dr B] on the 12th and 19th April were inadequate would not have enabled [Dr C] to ascertain what [Dr B] thought the diagnosis was and easily confirm if an X-ray had been done. With a more chronic history it is understandable that [Dr C] focused on the immediate issue of the complication of the cortisone injection and probably assumed that adequate investigations/assessments had already been done prior to the cortisone injection. There is no criticism of [Dr C's] management of the acute complication of the cortisone injection.

3 *Please provide advice on the adequacy and appropriateness of the Health Care Pathway Policy for the provision of health care services to prisoners at the Facility.*

4 *The 'Health Care Pathway Policy' is a detailed and comprehensive document detailing the policy for the provision of health care in prison. The Policy is adequate and appropriate.*

5 *Please also comment on the adequacy of the Facility's Local Operation Manual.*

The Facility's Local Operation Manual for 'Doctors Clinics' and 'Registered Nurse Clinics' is clear on the procedures involved to prisoners appointed to the clinic to be seen and the responsibilities involved.

The 'Facility's Local Operation Manual' for 'Doctors Clinics' and 'Registered Nurse Clinics' are adequate. An improvement may be to clearly state the expectation that clear clinical records will be maintained at each contact by the doctor and/or nurse. This will ensure that other providers that may need to be involved find records that are easy to follow and clear on the clinical thinking and treatment provided to date.

The operations 1.4 Triage Guideline may not be clear enough with respect to suspected fractures with a delayed presentation. It is noted that it took [Mr A] more than 19 days from reporting the injury to be assessed by a doctor. A separate entry may need to be made in the 'Triage Scale Guide #2' for 'suspected fracture', obvious acute fractures are adequately covered in #1 under 'acute physical conditions'.

6 *Any other comments you wish to make.*

An issue that arises with having clinics run by multiple doctors is ensuring that there is seamless continuity of care for each patient. This is not easy when a patient may see

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more than one provider for ongoing care for one problem or complications of a medical condition, especially if the problem has been ongoing for a number of months.

This is the scenario encountered by [Mr A]. Avoiding these clinical care gaps requires good clinical notes at each step so that each provider's findings, thinking and treatment intentions are very clear. Where appropriate they should include the presenting history, objective clinical findings, any investigations done or planned and treatment plan."

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Appendix B: Nursing advice to the Commissioner

The following expert advice was received from in-house nursing advisor RN Vivienne Josephs:

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

2. Documents reviewed

a) Summary of patient complaint by [HDC]
b) Response from [the facility] [Health Manager] dated 18 August 2016
c) Letter from Director Offender Health, Department of Corrections dated 25 September 2017
d) Discharge Summary dated 25 May from [the DHB]
e) Clinical Notes from [the facility] dated 6 February 2016–13 May 2016
f) Admissions note from [the DHB]
g) Letter from [the] General Manager, Corporate Services, Department of Corrections dated 2 February 2018
h) Standing Order Guidelines for Nurse Administered Medications
i) Department of Corrections letter dated 18 August 2016
j) Healthcare Pathway Policy and Procedures version No 2
k) [Facility] Operations manual — Doctors and Registered Nurse Clinics

3. Complaint

[Mr A's] complaint relates to the care he received from the medical and nursing staff at [the facility] in managing his left shoulder injury. His complaint includes the time taken to see medical staff whilst he was a prisoner at [the facility].

Review of Clinical Documentation

The first clinical entry in the notes from [the facility] relating to [Mr A's] left shoulder was on 6 February 2016 with a health chit requesting to see a specialist as '*my shoulder is broken and needs looking at. I am in pain all the time*'. He was not seen by a nurse but an appointment was made for a nurse assessment. There was no history or cause of pain documented or documentation of any treatment or medications administered.

On 23 February 2016, clinical notes state that [Mr A] had injured his shoulder and had been in pain waiting for 4 weeks to see the doctor. There was no documentation about being assessed, whether pain medications had been administered or that a referral/appointment had been made for a medical review.

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He was seen and assessed by [RN E] on 25 February 2016 for his left shoulder 'ache'. He was found to have a good range of movement (ROM), given Arnica cream, prescribed light duties and advised to inform them if the pain worsens. No history or vital signs were taken. No documentation of a pain assessment or medications other than the Arnica was documented. There was no reference to a referral to a medical officer.

On 29 February 2016, it is documented that [Mr A] did not receive his medications as [the nurse] was unable to locate him in his unit. It is not clear if those medications included analgesia.

Two weeks later on 15 March 2016, [Mr A] submitted a health chit stating that he had been in pain for seven weeks. He was seen by [RN F] and found to have a good ROM of his shoulder. [RN F] documented that he had been seen by a nurse on 25 February 2016 and that '*nil issue (was) raised'.* [RN F] advised him to take Panadol and to submit a health chit if there was no improvement. This was the first documentation of analgesia being given.

On 23 March 2016, a health chit was received from [Mr A] stating that he had fallen off his top bunk and hurt his left shoulder. He stated he was in pain and needed to see a doctor as soon as possible. Clinical notes document that [Mr A] was seen in the unit triage by [RN H] and [RN G]. Nursing assessment found the pain to be centred around the anterior deltoid and clavicle. There was reduced ROM, he was unable to raise his arm to shoulder height and movement was painful. There was no pain score or assessment documented or any immobilisation of the shoulder recommended. There is no reference to [Mr A's] previous shoulder pain or whether this is a new injury on the same shoulder. He was advised to not do sport and an appointment made for a further nurse assessment. There is no documentation of analgesia administered or of any medical follow up.

On 26 March 2016, he was assessed in the nursing clinic by [RN H]. Nursing assessment found tenderness around the anterior shoulder joint, limited range of movement of the shoulder. He was found to have pain+++, was commenced on Brufen and an appointment made for a doctor's review.

On 10 April 2016, he submitted a health chit requesting to be seen by a doctor or nurse about his shoulder. He was not seen but was informed that he would be seeing the doctor on 12 April 2016. [A nurse] advised him to take 4–6 hourly Panadol for pain.

He was seen by [Dr B] on 12 April 2016 who confirmed the previous RN assessment of a soft tissue injury. He found the Brufen wasn't being effective and a decision was made for a steroid injection which was administered on 19 April 2016. This was the first time [Mr A] had been seen by a doctor.

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On 21 April 2016, [Mr A] stated that he made a request to the prison wardens for a chit to see a doctor or nurse as he was experiencing breathing difficulties and feeling faint. He states that his request was refused. This request appears in [Mr A's] complaint but there is no documentation of this in the clinical notes.

On 29 April 2016, [Mr A] submitted a health chit complaining of continued pain in his left shoulder. This was seen by the nurses on 2 May 2016, but they were unable to locate him to follow up and to give medications as he had moved to another unit and the nurses had not been informed. It is not clear if those medications included analgesics and anti-inflammatories.

On 3 May 2016, patient requested 'PRN' for the night. It is not clear which PRN medication is referred to.

[Mr A] was seen in triage on 5 May 2016 complaining of daily pain in his shoulder and requesting to see a doctor. An appointment was made for a medical review. At this nursing triage, there was no physical or pain assessment done by [RN D] and no documented review of current analgesia. On 9 May 2016, [Mr A] was seen in the nurse's clinic and he was commenced on BD Voltaren. There was no pain or physical assessment documented.

On 11 May 2016, he was seen by [Dr C] who found the shoulder to be painful, red and swollen and commenced him on oral antibiotics with a plan to review in a week's time. He was afebrile with reduced shoulder movement secondary to pain.

On 13 May 2016, he presented to the health clinic with a temperature of 39 degrees, tachycardia and a swollen, painful red shoulder. Nursing staff called the doctor on call and [Mr A] was admitted to [hospital].

4. Clinical Advice

I have been asked to advise whether the nursing care provided to [Mr A] by the nurses at the [the facility] was reasonable in the circumstances and why.

I have been specifically asked to comment on:

1. **Whether [Mr A] was provided a reasonable standard of nursing care by the nursing staff of the prison health Services at [the facility].**

   In my opinion, I do not believe [Mr A] received a reasonable standard of nursing care in the following areas:

   a) The time taken before nursing assessment occurred following receipt of [Mr A's] health chits complaining of shoulder pain on 6 February 2016
   b) Clinical assessment (including history taking), pain monitoring and analgesic administration
   c) The time taken for a referral to be made for medical review

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d) Clinical Documentation

2. **Please state if there was a departure from a reasonable standard and how significant was that departure.**

   Yes. There was a departure from a reasonable standard of nursing practice.

   a) Time taken for initial nursing assessment — mild departure.
   b) Clinical assessment — mild to moderate departure.
   c) Time taken for a referral for medical review — mild to moderate departure.
   d) Clinical documentation — mild departure.

3. **What is the standard care/accepted practice?**

   a) If a client/patient complains of pain with a suggestion that his shoulder could possibly be broken, then accepted practice would be that the patient is seen, that the possibility of a severe injury to his shoulder is eliminated and adequate analgesia given. If the patient is clinically stable, a full assessment could be done in the next 1 to 2 days. I am critical that [Mr A] had to wait two weeks from the time he submitted his health chit on 6 February 2016 stating he was in pain *all the time*, to see a nurse when nurses are available at the prison daily. It would be standard practice to have seen [Mr A] the day of the request to obtain more information regarding the injury and based on that discussion and after first having 'eye-balled' [Mr A], to then have booked a further nursing appointment. I believe my peers would be in agreement with this.

   b) It is standard practice that a clinical assessment includes an initial set of vital signs including a pain score and if pain is present and whilst considering possible reasons for that pain, providing adequate analgesia and ongoing monitoring. It should also include a history of the presenting complaint. I am critical that a history of his injury wasn't taken when he was seen on 25 February 2016 and that a pain score was not recorded. Regular analgesia is important in soft tissue injuries. [Mr A] appears not to have received analgesia when he first complained of pain or ongoing on a regular basis. There were standing orders for paracetamol but it doesn't appear to have been given regularly. I am surprised that only Arnica was given and no other analgesia from the Medication standing orders. His health chit submissions refer to continued pain and the clinical entries document repeated advice to submit another chit if the pain is not resolving but with no seeming intervention to treat that pain. Clinical and pain assessments should have taken place on 5 and 9 May 2016. It would be considered standard practice to review the effectiveness of medications regularly and escalate concerns if the pain wasn't resolving. This could indicate a worsening injury or the need to look at medication management. I believe my peers would be in agreement with this. There did appear to be some logistic issues locating [Mr A] on two occasions as he had moved units. This led to a delay in him receiving his medications on time. This would be important if these were analgesia medications that needed to be administered regularly to enable

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good pain control. [Mr A] received an appropriate standard of care on 13 May 2016 when nursing staff recognised the clinical deterioration in his left shoulder, contacted the on call doctor and, facilitated his transfer to [hospital].

c) If pain is not responding to medication, then a medical review is required to rule out other clinical causes and to relook at pain management options. The doctor should have been contacted to discuss concerns. It would be standard practice for nursing staff to have booked a medical review following the nursing assessment of the 23 March 2016. [Mr A's] pain was not resolving and he had a decreased ROM which was different to previous assessments and followed the history of a fall and possible new injury. A medical review was booked two days later when he was seen at the next nursing assessment on the 25 March 2016 but he wasn't seen by a doctor for another two weeks. [Facility] nursing staff did check [Mr A's] ROM at each assessment which would be considered acceptable practice. I believe my peers would be in agreement with this.

d) It is standard practice that documentation includes all nursing interventions and observations undertaken. It should also document the plan for ongoing care/treatment. There was documentation in the notes on the 23 February 2016 that [Mr A] was waiting to see the doctor but no documentation stating that a referral or a booking had been made. I am critical of [RN F's] entry on 15 March 2016 that [Mr A] had been seen on 25 February 2016 and that *'nil issues raised'* when [Mr A] continued to complain of having on going pain. Additionally, there is no documentation of any possible causes of [Mr A's] first complaint of shoulder pain or clarification of why he thought his shoulder was broken. This would have differentiated an acute from a chronic injury. In the Department of Correction's letter of 2 February 2018, it is recorded that [Mr A] reported to a nurse on 25 February 2016 that he sustained his shoulder injury through heavy lifting in the kitchen.

4. If there was a departure from a reasonable standard of care, please identify the individual(s) responsible for the departure.

The nursing staff at [the facility] who:

— received [Mr A's] health chit on 6 February 2016

— saw him on 23 February 2016, 25 February 2016, 23 March 2016

— saw him on 5 May 2016 and 9 May 2016

<u>[RN D]</u>
On 6 February 2016 — mild departure by not conducting an initial assessment of [Mr A] after receiving his health chit stating he was in pain.

On 5 May 2016 — mild to moderate departure by not performing a physical and pain assessment, not checking efficacy of pain relief and not escalating concerns about unresolved pain.

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[RN I]
On 9 May 2016 — mild to moderate departure by not performing a physical and pain assessment, not checking efficacy of pain relief and not escalating concerns about unresolved pain.

[RN E]
On 25 February 2016 — mild to moderate by not performing a clinical and pain assessment or referring for medical review.

[RN H] & [RN G]
On 23 March 2016 — mild to moderate departure by not referring for medical review.

Mild departure by not documenting that analgesia had been provided.

Nursing Staff
Mild to moderate departure by delayed referral to a medical officer from 6 February 2016 and with the possible second injury on 23 February 2016 mild departure for standard of documentation especially of clinical and pain assessment and of referral for medical review.

5. Please comment on the adequacy of the Health Services health care Pathway as it relates to nursing care

The Health Services Health Care Pathways, in my opinion, is a comprehensive and adequate document when followed. Sections 7.4 and 10.1 relate to the Time Frame for health assessments and the need for a Plan of Care if patients are receiving clinical interventions. [Mr A] waited longer than the stated Time frame to be clinically assessed and did not have a documented Plan of Care.

6. Comments and Recommendations

In my opinion, [Mr A] experienced a significant wait before seeing a doctor for a review of his shoulder. He appears to have been in pain since February 2016 and had repeatedly submitted chits for ongoing shoulder pain. He had been seen by nursing staff but did not see a doctor until 19 April 2016. It appears to me that [Mr A] was booked in for further assessments and advised to submit a health chit if the pain wasn't resolving. However, definitive pain management and clarification of the causes of his pain, delayed the time it took for [Mr A] to get adequate analgesia and a timely medical review.

Prison health clinics do differ from general practices and are a nurse led service. Although the GP visits are weekly, the nurses are available on a daily basis and they have access to a GP by phone if required. Patients experiencing ongoing pain which is not responding to standard nursing interventions, including regular pain relief, should prompt the nurse to seek medical advice and facilitate a prompt medical review.

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I note from the letter from the Department of Corrections dated 25 September 2017, that [the facility] is now moving to unit based nursing and that the nurses are attached to a unit for triaging patients. This appears to be an appropriate positive action taken to provide consistency and continuity of care. I would also add that there is a need to ensure that follow up is made up of all patients complaining of or presenting with pain to ensure that appropriate nursing interventions and medical reviews occur.

The lack of physical clinical and pain assessments on 5 May 2016 and 9 May 2016 were acknowledged by the Department of Corrections and seen as falling short of what they would have expected. They have addressed this by sending nursing staff for two day assessment training at [a tertiary institute]. I would support the appropriateness of this training. I would also suggest having all new nursing staff joining the facility, complete clinical assessment/diagnostic reasoning training within the first 3 months of employment if they have not done this previously. These skills are especially important in an environment where there is only a doctor on site once a week. A record of this training should be kept.

Expert Opinion Report two

Thank you for the responses received from [RN E], [RN G] and [RN H] in response to my clinical advice on 8 March 2017.

I have reviewed both my original advice and the nurses' responses and provide my comments below as relates to each nurse.

1. [RN E]

In my advice on 8 March 2016, I advised that there was a mild to moderate departure from a reasonable standard of care in the areas of clinical assessment, pain assessment and referral for medical review.

Updated Advice

Clinical assessment:

[RN E] saw [Mr A] in the health clinic on 25 February 2016 in response to a health chit submitted on 6 February 2016. The health chit stated '*my shoulder is broken and needs looking at'* with clinical notes from 23 February 2016 documenting '*an injury*'. When [RN E] saw him on 25 February 2016, [Mr A] presented with *l) shoulder ache.* I can appreciate [RN E's] statement in Point 5 regarding the inconsistencies that can occur in the prison environment between the written chit and a verbal history of a complaint. However, I would see this as even more reason to have obtained a good clinical history of the presenting complaint and of the prior shoulder complaint — particularly if the pain had been there for 4 weeks and of documenting that assessment well. [RN E] provided additional clinical information in her response and has reflected on the prior advice. She concludes that since this incident, she now makes it part of her usual practice to clarify the concerns in the health chit with the patient at the end of each consultation. My advice remains unchanged with no further recommendations.

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Pain assessment:
[RN E's] response stated that [Mr A] had described his pain at the 25 February 2016 visit as *an ache when he did any heavy lifting that had been going on for four weeks and* added that *he did not describe persistent pain.* [RN E] explained that she had not documented a pain score as there wasn't any pain at the time of the appointment. However, [Mr A's] reason for the nursing review was ongoing pain as the presenting complaint. I would consider that a pain assessment using a tool such as SOCRATES[20] or PQRST would have been a reasonable expectation at this appointment. I note from [RN G's] response that it is now a requirement to use the PQRST tool for pain assessment.

[RN E] states in Point 13 that she had checked about whether the pain radiated and stated she had taken a clinical history of the shoulder ache. However, these were not documented. [RN E's] response in Point 9 stating that [Mr A] had been aware that paracetamol was available and was taking this as required. However, this still requires documenting in the clinical notes. My advice remains unchanged.

Medical Review
I have reviewed my original advice and [RN E's] statement with the additional background to the appointment on the 25 February 2016 provided. The advice she provided to [Mr A] to contact the nursing staff if the pain worsened would be accepted practice. I would amend my advice to no departure from accepted practice.

2. [RN G]
In my advice on 8 March 2016, I advised that there was a mild to moderate departure from a reasonable standard of care by not referring [Mr A] for a medical review following the appointment on 23 March 2016 and a mild departure by not documenting that analgesia had been provided.

Updated Advice

Referral for medical review
[Mr A] was seen by [RN G] on the same day the chit (23 February 2016) was received and a brief assessment took place on the triage round. This was a Wednesday and the day that [RN G] states that the Dr visits [Mr A's] unit. If he wasn't seen that day, it would mean he would need to wait till the following Wednesday for a medical review unless he became acutely unwell. I am not familiar with the prison environment and the organisation of the doctors clinics, but would have thought if [Mr A] could not have been seen in the doctors clinic that day, then there could have been an opportunity for a quick conversation with the visiting doctor to discuss the possible diagnosis of a soft tissue injury and whether further interventions such as an x-ray would be required.

[20] SOCRATES (pain assessment) is a mnemonic acronym used by health professionals to evaluate the nature of a patient's pain. It stands for: Onset, Character, Radiation, Associated factors, Time, Exacerbating/relieving factors, Severity.

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My advice remains unchanged.

Analgesia
There was no reference in the clinical notes to pain or provision of analgesia. [RN G's] response stated that the patients know how to access paracetamol. However, this was an acute injury and more guidance as to regular administration and a follow up of the effectiveness of that pain relief is required. The advice and recommendation given by the RN and the effect of the medication needs to be documented. [RN G] has reflected on this and states that he now documents advice he gives patients regarding the use of paracetamol. My advice remains unchanged.

[RN H]
Updated Advice

[RN H] advises in his/her statement that he/she did not see [Mr A] on 23 March 2016.

[Mr A] was seen on 26 March 2016 by [RN H], given appropriate analgesia and a doctor's appointment was scheduled. The medication chart attached to his/her statement confirms the commencement of Brufen. [RN H] has stated that she has made improvements in her assessments of patient injuries and has completed a Nursing Assessment course at [a tertiary institute] and has attended in service education on the medication administration policy provided by the facility. As [RN H] did not see [Mr A] on the 23 March 2016 and did commence appropriate analgesia on 26 January 2016, there is no departure from accepted practice.

Additional Comments:

There was acknowledgement in all three responses of the need for clinical assessments and pain assessments to be clearly documented.

In my opinion, it remains a mild to moderate departure from a reasonable standard of care that [Mr A] was not seen by a doctor from 23 March 2016 to 12 April 2016 especially with ongoing symptoms and an unresolved clinical need.

[RN G] stated that prisoners who submit a health chit have a 'brief' nursing visit before they are booked into a nursing clinic. He stated this was standard practice but I couldn't find a reference to this in the Health Care pathway. It is also not clear how soon after a chit is received that the patient is seen for a 'brief' visit from the nurse. This did not occur for the chit that was presented on 6 February 2016.

I note that both [RN E] and [RN G] documented in their statements that in the prison environment, it is common for there to be inconsistences in the clinical details submitted on the health chits by the patients and the presenting symptoms when they are seen by the nurse in clinic. This should not cloud the importance of considering all information when performing good clinical assessment that is then clearly documented.

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Thank you for the opportunity to provide updated advice.

Expert opinion three

Thank you for the opportunity to provide further advice following the request to review the document 'Request for Non-Urgent Health Appointments Triage Process-Residential Units'[21].

I have reviewed this document, my advice of 8 March 2018 and 31 July 2018, the responses of [RN E], [RN H] and [RN G] and the clinical notes from 6 February 2016 to 13 May 2016.

I have been asked to comment on the standard of care provided to [Mr A], in light of the policy above with consideration of the responses of the named nurses. I have been asked to identify departures in care, the degree of that departure, and advise what action should have been taken. I have also been asked to comment on the adequacy of triage.

<u>Review of the Policy</u>

5.1.4 The policy requires an initial triage to be done on all requests for non urgent health appointments. This requires reading of the chits, establishing the nature of the health concern and prioritizing care.

5.1.5 Following that, a triage round takes place where the prisoners are to be 'accessed' in their units. There is a triage bag that is to be taken on the triage round which is to include equipment for vital signs and OTC medications.

The nature of their concern is to be discussed, a health assessment conducted which is appropriate to that concern and immediate intervention provided in the unit if required.

5.1.5 If the prisoner needs to attend the Health Centre, they are to be advised that it will be 'arranged as soon as possible'.

5.1.6 Clinical nursing notes and OTC medications administered are to be documented in Medtech 2.

5.1.8 If prisoners are to be seen in the health clinic following an initial triage, their patients clinical notes are to be accessed via Med Tech and subjective and objective findings as well as interventions provided or required are to be documented. Any follow up appointments are to be scheduled in the appointment book. The policy of this document is stated as 'arranging to provide the necessary interventions to prisoners within seven (7) days of receiving the request.

[21] Dated 28 June 2010. For review 12 May 2016.

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<u>Standard of Care provided to [Mr A] in the light of this policy.</u>
In my opinion, there was a moderate departure from the standard of care required by this policy in the care provided to [Mr A] from 6 February 2016 to the 26 March 2016.

1. There has been a moderate departure from the standard required by this policy on the 6 February 2016 in the following areas:
   - Absence of an initial triage including seeing [Mr A], 'establishing the nature of the health concern' and 'prioritizing care'. This includes the absence of a Triage score according to the facility Triage Guidelines and not taking a set of vital signs as part of that triage process.
   - Absence of an initial nursing assessment including pain assessment and history of the presenting complaint, addressing the concern raised in the chit and the provision of immediate appropriate intervention.
   - Not being seen within seven days of the health chit being received on 6 February 2016 as required by policy. [RN E] stated that she did not know why this occurred.
   - Lack of documentation in the appointment book for a follow-up nursing assessment appointment following receipt of the health chit on 6 February 2016 leading to a nineteen day delay in being seen.

2. There are a number of actions that should have been taken on receiving the health chit from [Mr A] on 6 February 2016. An initial triage should have been done as per policy and he should have been seen in his unit. A set of vital signs should have been taken, a history of the presenting complaint and a nursing assessment sufficient to ensure his clinical stability. This would have included a triage score based on the facility Triage Guide. This would determine if he needed to be assessed in clinic within 24 hours (Triage 2) or within 7 days (Triage 3). Appropriate intervention included analgesia (following a pain assessment) as per [the facility's] Standing Orders and as referenced in the policy. This should have been documented in the clinical notes and the date of the next nursing appointment also documented.

3. There was a mild to moderate departure from the standard required by this policy on [25] February 2016 and 15 March 2016 with the absence of an initial triage on receipt of new health chits from [Mr A]. There was also poor nursing assessment (including assessment of pain) at the appointments of 26 March 2016 and 10 April 2016, including the absence of a patient history of the complaint and poor documentation of subjective and objective signs relating to the complaint. [RN E's] response did include additional clinical information that she acknowledges should have been documented at the clinic visit of 25 February 2016. The prioritizing of care as documented in the policy also did not meet the standard as the assessment of pain and the intervention of pain relief was not addressed.

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4. There was a mild to moderate departure from the standard of this policy with the delay in prioritizing care in the accessing of a medical review and the lack of documentation in the appointments book of a MO (medical) follow up which was referenced in the clinical notes on 26 February 2016.

5. Action that should have been taken to avoid these departures included the performing of an initial triage on all health chits received from [Mr A]. Each attendance at the clinic should have had a nursing assessment done including a history of the presenting complaint especially with differing aetiologies with his shoulder pain and this should be documented clearly. Nursing assessments should use a recognized format and be consistent. For example, on 25 February 2016, the clinical notes documented [Mr A's] ongoing pain as separate from the heavy lifting whereas [RN E's] response indicates that the pain was due to the heavy lifting.

6. There was an accepted standard of care in consideration of this policy on 23 March 2016 in the performance of an initial triage on receiving [Mr A's] health chit by [RN G] and [RN H]. The nature of [Mr A's] concern was discussed and a health assessment was conducted appropriate to the concern. However, there was a mild to moderate departure in the absence of intermediate intervention in assessing [Mr A's] pain and providing an ongoing plan for analgesia.

<u>Triage Process</u>
If the Initial Triage was performed as documented in this policy and the health assessment appointment made within the accepted guidelines, the prisoner should have received an accepted standard of care. I would add, however, that a set of vital signs is part of any triage process and should be included in this policy. This provides an initial clinical baseline and allows trends to be analyzed with future appointments. I do question the seven day timeframe for a Triage 3 patient to be seen. However, if a patient is assessed as Triage Level 3 (to be seen within seven days), the nurse should be additionally required to assess how many days the prisoner can clinically safely wait within that timeframe.

It is not stated in the policy that each patient submitting a health chit should have an Initial Triage conducted although that appears to be the intention from the policy. This would ensure that all patients should be seen on the day the health chit is received. I note from [RN G] that the process for patients to be seen is now unit based. It is hoped that this will facilitate a smoother process from initial triage to the first nursing assessment.

<u>Comments</u>
Both [RN G] and [RN E] stated in their responses that there were often differences in the patient's description on the health chit of their presenting complaint and the verbal explanation when they are later seen in clinic. This highlights, in my opinion, the importance of that initial triage in clarification of nature of that complaint in assessing, evaluating and planning nursing care."

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