# Laser Clinic Therapist, Ms A
# LCNZ Takapuna Pty Limited

## A Report by the
## Deputy Health and Disability Commissioner

## (Case 21HDC00153)

Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

**Contents**

## Executive summary

1. This report considers the care provided to a woman by a laser therapist at a laser clinic.

2. The woman attended her appointment on 24 January 2021 for hair removal treatment. During this session, the laser therapist used the incorrect laser settings, which resulted in burns to the consumer's face.

3. The report discusses the adequacy of care provided by the laser therapist, including both the mistake in laser settings and the aftercare provided. The report also discusses the need for open disclosure when adverse events occur, as the laser clinic did not communicate openly or honestly with the consumer about how or why the incident occurred.

### Findings

4. The Deputy Commissioner found that by using incorrect settings, and responding to the woman's burns inappropriately, the laser therapist did not provide the consumer's services with reasonable care and skill, and therefore breached Right 4(1) of the Code of Health and Disability Service Consumers' Rights (the Code).

5. The Deputy Commissioner also found that by misleading the consumer and avoiding accountability, the laser clinic breached Right 6(1) of the Code. Adverse comment was made about the working environment of the laser clinic, which contributed to the poor outcome suffered by the patient.

### Recommendations

6. The Deputy Commissioner recommended that the laser therapist provide a written apology to the consumer, and, should she return to work as a laser therapist, undergo further training on providing laser services to a range of skin tones, as well as training on burns and burn aftercare.

7. The Deputy Commissioner recommended that the laser clinic provide a written apology to the consumer, review the client booking system to consider whether longer breaks throughout the day would prevent stress on therapists, consider providing staff guidance on how to manage customer requests for treatment additional to what was booked, and create clinic protocols relating to appropriate products to give to a consumer in the event of a reaction. The Deputy Commissioner also recommended training sessions on responding to burns and appropriate burn aftercare, and providing laser services to a range of skin tones.

## Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided by Ms A at a laser clinic. The following issues were identified for investigation:

- *Whether LCNZ Takapuna Pty Ltd provided Ms B with an appropriate standard of care in January 2021.*
- *Whether Ms A provided Ms B with an appropriate standard of care in January 2021.*

9. This report is the opinion of Deputy Commissioner Dr Vanessa Caldwell, and is made in accordance with the power delegated to her by the Commissioner.

10. The parties directly involved in the investigation were:

| | |
|---|---|
| Ms A | Laser therapist |
| Ms B | Consumer |
| LCNZ Takapuna Pty Ltd | Laser clinic/group provider |

11. Further information was received from Ms C, director of LCNZ Takapuna Pty Ltd, and Ms D, previous director of LCNZ Takapuna Pty Ltd.

12. Technician Ms E is also mentioned in this report.

13. Independent expert advice was obtained from Ms Heather Thompson (Appendix A).

## Information gathered during investigation

### Introduction

14. This report discusses the care provided to Ms B at the laser clinic. Ms B was receiving laser hair removal treatment on her face at the laser clinic, and attended her second appointment on 24 January 2021. Unfortunately, Ms B suffered burns to her face at this appointment and had to seek medical advice.

### Laser technology

15. Laser hair removal is a permanent hair reduction treatment that treats hair follicles with a concentrated light beam to stop hair growing from the follicle. This is achieved by targeting pigment in the hair's root (or blood flow to the root, depending on skin tone), which absorbs the light, damaging the follicle and stopping growth. Each individual treatment is short (but varies depending on the area where hair growth is) and must be repeated six to 12 times with gaps of four to six weeks between each treatment. This is so that each treatment targets different points in the hair growth cycle.

16. Because laser uses intense light, it is recommended that sun exposure on the treated site is avoided. The skin in the area will be sensitive and more susceptible to sun damage than usual. Similarly, sun should be avoided before laser treatments, as it can make the skin more sensitive to the light used in the treatment, which can increase the risk of hyperpigmentation, burns, or scars.

17. In conjunction with the light beam, a cooling machine is used to blow cool air onto the skin while the laser is being used, to minimise any sensitivity in the skin.

**The clinic**

18. According to the laser clinic's website, the clinic is part of a network and offers a range of treatments, including laser hair removal, skin treatments, teeth whitening treatments, and cosmetic injectables. The website states that all laser hair removal and skin treatments are performed by a team of specially trained therapists, and all cosmetic injectable treatments are performed by registered nurses or doctors.

**Background**

19. Ms B attended her first appointment on 18 November 2020, but because she had undergone recent threading[1] on her face, it could not be treated. Therefore, the appointment for laser treatment was re-booked.

20. Prior to receiving her first laser treatment, Ms B had a consultation and signed a consent form (dated 18 November 2020), which was provided to HDC. The consent form lists medical concerns that the laser clinic must be informed of by clients, and notes the potential risks and reactions to treatments. The risks outlined on the consent form are:

- Lightening or darkening of the skin in the treated area(s)
- Skin redness, crusting, bruising, and, in rare cases, blistering or burns
- Development of infection that, in very rare cases, can lead to scarring
- Allergic reaction
- In rare cases, stimulation of new hair growth, which may require additional laser treatments.

21. The previous owner of the laser clinic, Ms D,[2] told HDC that during the discussion of the consent form, Ms B said that she had no history of any concern. On the consent form, Ms B ticked the statement: "I am not tanned from any source, including sun exposure, fake tans, tanning salons, or a tanning drug such as Melanotan II."

[1] A hair removal method that pulls out the hairs from the follicle.
[2] Ms D resigned as director of LCNZ Takapuna Pty Ltd in 2022, and Ms C was appointed. Ms D provided HDC with the information referred to in the provisional report, and Ms C provided the response to the provisional report.

### 24 January 2021 appointment

22. Ms B attended the laser clinic for the second time on 24 January 2021. Initially she was seen by technician Ms E. However, Ms E was uncertain about treating Ms B due to hypertrophic acne scarring on her jawline.[3] Ms E consulted another technician, who suggested that Ms B provide a doctor's note. However, it is documented in the progress notes that Ms B indicated that she was willing to undergo the treatment without confirmation from a doctor regarding the scarring. In response to the provisional report, Ms B stated that the therapists were a little concerned at her second appointment, but they did not show this concern at her initial appointment, so she was happy to continue.

23. At this point, Ms E passed over to laser therapist Ms A to discuss further treatment. The clinical notations indicate that Ms A treated Ms B as planned, but "went around the hypertrophic scar" on Ms B's cheek. Ms A documented that Ms B was in a rush due to the limited appointment time. The time constraint occurred because Ms B had booked for lip and chin laser hair removal, but then requested a full face treatment, which takes a longer time. Ms A recorded in the progress notes:

> "Was in rush between clients and forgot to check whether machine had been switched to YAG mode.[4] Client booked for lip and chin laser hair removal but decided to get the full face done. So, we have limited time and I had to rush."

24. Ms A began the treatment, but once she had completed the area under Ms B's jaw, she noticed that the skin was starting to get very red. Ms A decided to reduce the settings on the machine and continue on the same cheek, but recalls hearing a "snapping" sound once she had finished treating the right cheek. The clinical notes indicate that Ms B stated that it was very hot, but she could bear it. At this point, Ms A noticed that the wrong settings were being used on the machine, and changed them to Ms B's settings.[5] Ms B recalls that Ms A asked her whether the laser was bearable, and she said she was okay in the beginning but later had to ask Ms A to stop as it was really painful. Ms B told HDC that she clearly remembers Ms A using a higher intensity laser, and by the time Ms A realised that the wrong setting was being used and Ms B asked her to stop, Ms B had already been burnt.

25. Ms A then applied "Laser Aid", which is a gel used to soothe and cool the skin and remove redness or irritation after laser treatment. Ms A continued to treat Ms B using the correct settings, and finished the left side of her face. Ms B told HDC that Ms A acted as if nothing had happened, and, after reducing the intensity, carried on treating the other side of her face.

[3] Hypertrophic scarring is a common type of scarring that can occur as a result of the acne healing process.
[4] The laser machine used at the laser clinic has "YAG" and "PRO" settings. YAG laser penetration is safer on darker skin types, because the energy produced by the laser is not able to concentrate where pigment resides in the skin.
[5] Ms A recorded in the laser clinical notes that she used PRO mode instead of YAG mode. Initially, the settings used were 755nm PRO 16 joules (jls)/18 millimetres (mm) (spot size)/3 milliseconds (ms)(Zimmer). Ms A then dropped the settings to 14 jls/18mm/3ms.

26. Upon completion of the treatment, Ms A documented having noticed that the skin on the right-hand side of the face was still darkening, and turning purple in colour. She applied further Laser Aid, and gave Ms B an ice glove wrapped in a wet disposable wipe, which she told her to keep on for 50 minutes. Ms B reported feeling extreme burning sensations.

27. Alongside the ice glove, Ms A documented having provided Ms B with Laser Aid, a glycolic scrub, Even Blend serum, retinol, and vitamin C. Ms A advised Ms B that the Laser Aid was to be applied to the burn every 30 minutes. Ms A recommended using only Laser Aid for one week, and then starting to use the other products. In the incident report, Ms A documented having given Ms B only Laser Aid and the ice glove to take home.

28. Ms B told HDC that she then drove home herself, holding the ice glove on her face with one hand and driving with the other. Ms B said that she was still in a lot of pain the next day and could not attend work due to the burns.

29. LCNZ Takapuna Pty Ltd stated that Ms B was advised to attend the next day for LED light therapy treatment[6] to help the healing process, and to see a doctor. Ms B told HDC that she did not return to the laser clinic after sustaining the burns, as she did not feel confident accepting further treatment from the staff.

**Follow-up care**

30. On 25 January, Ms D sent Ms B an email in which Ms D assured Ms B that the burns were not a result of negligence, as Ms A "is a senior therapist with extensive experience". Ms D stated that the reason for the reaction was not yet known, but suggested that as it was summer at the time, and sun and heat may have been trapped in Ms B's skin, the burns could be a result of this. Ms D said that they would organise treatments and products to "release the heat and heal the skin", but that she would be unable to speak with Ms B on that date and would call her later in the week.

31. Ms B went to an accident and medical clinic on 25 January 2021 with concerns about infection and pain. Her clinical notes state that in the first few minutes of her laser treatment she had felt "excruciating pain" in the burn locations, and that this was persisting. The clinical notes record that there were several circular patches of pigment change on the right lower chin/throat, and that there was a "2mm patch of broken skin", but otherwise there were no blisters or infection. The burns were cleaned and dressed, and it was suggested that Ms B speak to the laser clinic about aftercare. Ms B was prescribed paracetamol and codeine phosphate for pain relief, and diclofenac (an anti-inflammatory).

**Further information**

*Ms B*

32. On 24 January 2021, Ms B sent HDC a photograph that shows at least nine dark brown/purple-coloured circular patches under her jawline.

[6] LED light therapy treatment is a non-invasive treatment that uses light. It can be used to heal injured tissue and reduce redness, inflammation, or post-inflammatory scarring.

33. Ms B told HDC that she still has remaining keloid scars on her face, and suffered for quite a long time following the treatment. She said that she was unhappy with the treatment she received and the response from the laser clinic. She told HDC that she asked the laser clinic to repay the costs of her treatment, and they did.

*Laser clinic*

34. Ms D told HDC that the treatment began at 755nm PRO 16jls/18mm/3ms and was then dropped to 14jls/18mm/3ms. She said that the reason for using the 16jls setting was that it was high enough to avoid stimulation of the hairs.

35. Ms A stated that she asked Ms B to notify her if the laser felt uncomfortable, and she would adjust the settings based on her pain tolerance. Ms A said that she began on a higher setting, and changed this to a lower setting when Ms B said that she was experiencing discomfort, and she also used cooling air with the Zimmer machine. Ms A said that when she noticed the skin reaction, she quickly applied Laser Aid to treat the area, and provided an ice pack to Ms B.

36. Ms D told HDC that to determine a patient's skin type, a comprehensive consultation is undertaken based on information provided by the client. In the consultation, questions are asked to determine the Fitzpatrick phototype,[7] and alongside questioning, a visual chart in each consultation room helps to determine accuracy.

37. Ms D told HDC that LCNZ protocols include the requirement to patch test every client at each subsequent treatment. This involves a test of no more than four pulses, and it is recommended that the therapist wait for one minute to see the skin response before commencing treatment. If a rise in skin colour is immediate or uncomfortable, the therapist must stop immediately. During this time, a verbal tolerance out of 10 (in comparison with the client's last treatment) should be requested by the therapist to assess the client. If the client's response is four or less, the therapist can continue with observation of the treatment area. If the patient's response is five or more, the therapist must stop immediately and review all settings. Ms D said that if there are any doubts, the policy recommends seeking the immediate advice of a clinic manager. There is no record in the progress notes of a patch test having been carried out by Ms A. However, Ms D said that an initial test is carried out before every treatment, and to her knowledge this occurred both at Ms B's first appointment and at the appointment on 24 January.

38. Ms D told HDC that in the event of burns, LCNZ's protocols include completing adverse event reporting, and immediate contact with the laser clinical manager, franchise partner, and technical training specialist. Assistance from the medical team is also provided to allow ongoing management, and medical intervention if required.

[7] The Fitzpatrick skin phototype is a system used to describe a person's skin type in relation to response to ultraviolet radiation exposure. Points are given depending on physical traits such as skin, eye, and hair colour, sun sensitivity, and tanning habits. The patient is then assigned type one to six, with one being pale white skin and six being deeply pigmented dark brown to black skin.

39. Ms D said that burns are a low risk of the treatment, and that when settings are correct and the correct machine is used, there should be no (or very mild) discomfort.

*Ms A*

40. Ms A told HDC that prior to this event she had worked at the laser clinic for nearly two years. She holds a number of qualifications, gained in NZ and overseas.

41. Ms A told HDC that this event has had a significant impact on her career, and has caused severe anxiety and panic attacks, and changed her interest in a career in the beauty industry. Ms A advised that she is no longer working at the laser clinic, or in the beauty industry.

**Response to provisional opinion**

*Ms B*

42. Ms B was given the opportunity to read the "Information gathered" section of this report. Where possible, her comments have been incorporated to the report.

43. Ms B said that she realises that her complaint may have caused anxiety to Ms A, but she felt that she had no other option, and the purpose of her complaint was to ensure that therapists are extra-careful when dealing with cosmetic procedures, as they can damage a person emotionally and physically. Ms B stated that she suffered from the burn and had anxiety and trauma for months afterwards.

*Ms A*

44. Ms A was given the sections of the provisional report that were relevant to her. She advised HDC that she did not have any comments to add.

*The laser clinic*

45. The laser clinic was given the provisional report to read and provide comment. Ms D resigned as director during HDC's investigation, and the new director, Ms C, told HDC that she had no comments to add. She did, however, provide HDC with new protocols implemented by the laser clinic's board of dermatologists in response to the event, which included:

a) Updated laser hair removal protocols;

b) Updated treatment parameter guidelines; and

c) An updated client questionnaire.

## Relevant standards

46. The use of laser for hair removal and skin rejuvenation is largely unregulated in New Zealand. However, as the laser clinic is located in Auckland, it is subject to Auckland Council's "Health and Hygiene Code of Practice 2013: Part 7 — Pulsed light and laser treatment"[8] (Appendix B). It has minimum standards, additional standards, and additional recommended best practices.

47. Under Part 7(9), the Code of Practice states that all operators must ensure that a patch test is carried out prior to the treatment, to judge how the skin may react to the settings and the full procedure. Part 7(9) also states that the test patch protocol should include which areas to test, the laser settings, how long to wait to judge the skin response, and how to spot adverse reactions.

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## Opinion: Ms A — breach

48. Ms A provided care to Ms B at her appointment on 24 January 2021. Ms A documented that she was in a rush between clients that day and forgot to check the machine settings, and also that Ms B requested a longer treatment than she had booked. Ms B had been passed on to Ms A after her previous therapist, Ms E, expressed uncertainty about treating Ms B's hypertrophic acne scarring.

49. Ms A treated one side of Ms B's face before noticing that the skin was becoming red. Ms A responded by reducing the laser's settings. Ms B told the accident and medical clinic that in the first few minutes of her treatment she felt excruciating pain. Ms A stated that Ms B vocalised that the treatment was very hot, but that she could bear it. Ms A told HDC that this was the point at which she realised that the wrong settings were being used.

50. I received independent expert advice from Ms Heather Thompson (Director of Rejuv Ltd laser clinic in Tauranga and the IPL and Laser Training Academy) on the care provided by Ms A.

### Mistake in settings

51. Ms Thompson noted that Ms A was in a stressful work environment due to the back-to-back bookings in the LCNZ business model. Ms Thompson also noted that Ms A was under pressure to treat Ms B within the allotted time frame, as Ms B had requested a larger treatment area than had been booked. Ms Thompson stated that these treatments cannot be rushed, and there must be constant accuracy throughout the treatment.

52. Whilst I acknowledge that a potential factor in Ms A's error was the short turnaround time between clients, I remain concerned about the level of care provided to Ms B by Ms A.

[8] Auckland Council is the only council in New Zealand that provides any legislative requirements for the use of laser in its area.

Forgetting to alter the machine settings to ensure that they were appropriate for Ms B's skin tone was a significant error with a severe outcome for Ms B. Ms A is an experienced technician, and had a responsibility to provide laser treatment to Ms B in a safe manner. Ms A also had the opportunity to decline Ms B's request for a longer treatment if she did not feel that it could be provided safely in the time frame available. As an experienced technician, I would expect Ms A to make these assessments and refuse further treatment if there was not ample time.

**Response to burns**

53. It is documented that during the treatment, Ms B communicated to Ms A that her face was "very hot" but she could bear it. In her clinical notes from the accident and medical clinic, Ms B described to the doctor that in the first few minutes of her procedure she had experienced "excruciating" pain, which was persisting when she presented at the urgent care clinic.

54. Ms A recorded in the progress notes that she began to treat the right-hand side of Ms B's face and noticed redness beginning to appear on Ms B's face, and reduced the settings and continued. Ms A documented being told that it was "hot", which is when she realised that the settings were incorrect and changed them. She then continued to treat the left-hand side of Ms B's face. Following this, she noticed that the right-hand side of Ms B's face was turning a dark purple, and she applied more Laser Aid and an ice glove.

55. I am concerned that Ms A continued to treat Ms B despite Ms B's feedback that it was "very hot", and despite an observable colour change on Ms B's skin. Ms Thompson advised HDC that on the first sign of client discomfort, the therapist should have stopped the treatment to ask the client how she was feeling. I accept that Ms A did ask Ms B how she was feeling. However, Ms Thompson noted that client pain tolerance may vary, and any pain felt should not be ignored. Ms B had indicated that she was in pain, and it would have been appropriate to enquire further (for example, using a 1–10 pain rating scale as suggested by Ms Thompson). Ms A chose to complete the treatment despite a severe reaction having occurred due to the use of the incorrect setting. Ms Thompson advised that not listening to client pain or heat complaints and subsequently stopping treatment to check results was a moderate to severe departure from accepted practice, and that continuing to treat a client once burns were present was a severe departure from best practice. I accept this advice.

56. Ms D told HDC that the patch testing policy requires a test to be carried out before each treatment, with no more than four pulses and then a one-minute pause to see whether the skin reacts. The policy also requires the therapist to ask the client how tolerable the pain is compared to their last treatment, on a scale of one to ten. Ms D stated that, as this is required for all treatments, to the best of her knowledge there was a patch test carried out at Ms B's appointment on 24 January 2021. However, this is not recorded in the progress notes. Further, in the images that Ms B provided to HDC, there are at least nine dark purple marks, indicating at least nine pulses that reacted. Based on this evidence, I believe that either a patch test was not completed at all, or, if it was, the wait time before assessing the skin's response was not sufficient. I note that it is also a requirement of the Auckland Council Code of Practice to undertake a patch test.

57. I accept that a genuine mistake was made in the settings used. However, I am concerned that Ms A did not respond appropriately to visual changes on Ms B's skin and complaints of pain. I accept Ms Thompson's advice that Ms A should have listened to Ms B's complaints and stopped the treatment to check how Ms B's skin was responding.

**Aftercare**

58. Ms Thompson commented that Ms A completed documentation and incident reporting in line with best practice, and I accept this advice. Ms Thompson also stated that it was appropriate to provide Laser Aid and an ice glove to Ms B for the burns.

59. However, Ms Thompson expressed concern about the aftercare products given to Ms B following her procedure, specifically retinol and a glycolic scrub. Ms A documented in the progress notes that she gave these products to Ms B. Ms Thompson explained that retinol products stimulate cellular turnover, and glycolic scrub is used to remove surface skin cells, making neither product appropriate for use on burns. She noted that Ms A recommended to begin using them one week after the burns occurred. However, Ms Thompson considers that this still would be too soon to use the products on burns. She said that prescribing these products was a mild departure from accepted practice, and she would expect the therapist to see the client in person after a week to assess the healing of the client's skin, and then consider whether these products should be used.

60. I accept Ms Thompson's advice that it was not appropriate to recommend these products, and therefore I am concerned that Ms A gave them to Ms B.

**Conclusion**

61. Ms A is described by Ms D as "a senior therapist with extensive experience". She has completed a range of training modules and certifications. I accept that even experienced therapists can make genuine mistakes with laser settings, but I am concerned about Ms A's initial use of the wrong laser setting, and her response to the event. I do commend Ms A for noting the error in the settings in her progress notes, and the probable cause of "being in a rush". Ms B's skin was reacting visibly, and she was reporting that the laser was very hot, but Ms A continued to treat her. The skincare products recommended and given to Ms B following the treatment were inappropriate for use on burned and damaged skin, and risked causing further damage. For these reasons, I consider that Ms A did not provide Ms B services with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[9]

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

## Opinion: LCNZ Takapuna Pty Limited — breach

### Working environment — adverse comment

62. Laser hair removal sessions are relatively short in length, with a facial laser procedure taking on average 5–10 minutes. The clinic therefore makes back-to-back bookings with short turnaround times in between to maximise appointments held in each working day. I have concerns about the effect that this has on staff.

63. I received independent expert advice from Ms Heather Thompson (Director of Rejuv Ltd laser clinic in Tauranga and the IPL and Laser Training Academy). Ms A documented that she forgot to change the laser machine's settings to Ms B's correct settings because she was in a rush between clients. Ms Thompson told HDC that it is very clear to her that the timeframes allowed for treatments potentially contributes to a stressful work environment. She said that these treatments cannot be rushed, and there must be constant accuracy throughout the treatment.

64. I accept this advice. I am concerned about the pressure put on staff by the booking system, and agree that this could affect the safety of customers, as seen in Ms B's case. I accept that the tight appointment timeframes was one of the factors in Ms A's error in using the wrong settings on the day of Ms B's appointment.

65. I do acknowledge that Ms A chose to accept Ms B's request for an alternative treatment option, which took more time than the booking allowed. I acknowledge that this, alongside the rigid booking times, contributed to Ms A selecting the wrong settings for Ms B's laser treatment. However, the clinic needs to ensure that therapists feel comfortable and supported in declining to treat patients if the therapist does not feel able to provide the treatment safely in the time frame available. Guidance in this area could have ensured that Ms A did not feel pressured either by the business or the customer to undertake more work than could be achieved at the booked appointment.

66. The clinic has a responsibility to its customers to provide services with reasonable care and skill. In order to achieve this, it must ensure that its staff have a supportive and well-resourced working environment in which to complete the procedures. Unfortunately, in this situation the strain on staff contributed to the outcome for Ms B.

### Open disclosure — breach

67. Following the adverse event, Ms B asked the clinic how the burns to her face occurred. It was not until after her complaint had been made that Ms B found out that the incorrect settings had been used for her treatment.

68. Under Right 6(1) of the Code, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive. This includes details of how adverse events occurred.

69. Ms Thompson commented that offering repair treatments was excellent practice by the laser clinic, but that there was a lack of urgency to make the appointments for these

treatments. In the email sent to Ms B on 25 January 2021 (the day after she sustained the burns), Ms D indicated that she was not available to discuss the appointments, but would follow up later in the week. Ms Thompson pointed out that this is not very comforting for a client with burns on her face, and the laser clinic showed no desire to learn more from Ms B or gain her recollection of the potential cause of the burn. Ms Thompson said that this was "reasonably dismissive" and a mild departure from best practice. I accept this advice.

70. In her email to Ms B, Ms D also noted that there was no negligence, and that while the reason for the reaction was unknown, it could be the result of sun and heat trapped within the skin layers. In her response to HDC, Ms D noted that once Ms B mentioned discomfort, the settings were lowered on the laser device. However, this does not acknowledge the mistake made with the settings, although Ms D did attach the progress notes and incident reporting to her response, both of which contain Ms A's clear documentation: "Accidentally treated YAG client with PRO settings on MAX machine. Was in rush between clients and forgot to check whether machine has been switched to YAG mode."

71. Ms Thompson complimented the laser clinic for its comprehensive progress notes and incident reporting. I agree that this was completed thoroughly and to a high standard. However, the clinic failed to pass on to Ms B information about the mistake, which is recorded clearly in the progress notes and the incident report. Not only did the clinic fail to advise Ms B about how the incident occurred, but it also suggested that Ms B was to blame for the burns due to sun exposure. Ms B noted that she did not understand why a reaction due to sun exposure would have happened only to one side of her face, and she had confirmed on her consent form that she was not tanned from any source, including sun exposure or tanning beds. The incorrect, higher settings were used on the side of Ms B's face where burns occurred. I do not believe this was due to sun exposure, and the clinic did not respond to the adverse event with honesty or transparency.

72. The clinic has still not provided Ms B with a truthful explanation of what occurred, and has not provided an apology. I am critical of the clinic for failing to inform Ms B of the cause of her burns. An error was made that resulted in harm to a patient. It is unacceptable that this was not disclosed to Ms B. I find that by misleading the consumer and avoiding accountability, LCNZ Takapuna Pty Limited breached Right 6(1) of the Code.[10]

[10] Right 6(1) of the Code states that every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive.

## Recommendations

73. I recommend that Ms A:

a) Within three weeks of the date of this report, provide HDC with a written apology to Ms B for the breach of the Code identified in this report. The apology will be forwarded to Ms B.

b) Should she return to work as a laser therapist, complete further training on burns and burn aftercare, including skincare products used to treat burns.

c) Should she return to work as a laser therapist, complete further training on providing laser services to clients with a range of skin tones.

74. I recommend that LCNZ Takapuna Pty Limited:

a) Within three weeks of the date of this report, provide HDC with a written apology to Ms B for the breaches of the Code identified in this report. The apology will be forwarded to Ms B.

b) Undertake a review of the client booking system, including consideration of breaks either between clients or throughout the day to avoid therapists feeling overwhelmed. LCNZ Takapuna Pty Limited is to provide HDC with the outcome of its consideration within six months of the date of this report.

c) Consider providing guidance to staff on expectations from the business on how to manage situations in which customers request procedures that are different from the booking made, particularly if they are likely to compromise safe service delivery. LCNZ Takapuna Pty Limited is to provide HDC with the outcome of its consideration within six months of the date of this report.

e) Conduct a training session for staff about responding to burns and appropriate burn aftercare, within six months of the date of this report.

f) Conduct a training session for staff on providing services to clients with a range of skin tones, within six months of the date of this report.

## Follow-up actions

75. A copy of this report with details identifying the parties removed, except LCNZ Takapuna Pty Limited and the expert who advised on this case, will be sent to Auckland Council and the Ministry of Health, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

## Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from Ms Heather Thompson (Director Rejuv Ltd laser clinic):

> "Thank you for sending me the information regarding a complaint from [Ms B] dated 24 January 2021 following her laser hair removal treatment at [the laser clinic]. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors, and that you are not aware of any conflicts of interest.
>
> I have over 30 years' experience in clinic using lasers and IPL. I am a beauty therapist internationally graduating in the 80s, own my own clinic which I am the only operator, and also run the IPL & Laser Training Academy. I see all different skin types on a daily basis and understand the effects of laser radiation on skin especially darker Fitzpatrick skin types. I teach the importance of understanding skin colour as the main factor in laser and IPL treatments whether it is hair removal or skin rejuvenation.
>
> The Commissioner is seeking my opinion on the care provided by [Ms A] and [the laser clinic] to [Ms B] at and following her appointment on 24 January 2021. I do not have a personal or professional conflict in this case.
>
> I have reviewed all documents provided, photos, and statements from both clinic and client, including computer logged treatment records.
>
> **Background**
>
> [Ms B] received laser hair removal treatment to her face on 24 January 2021, which resulted in burns to the chin, face, and neck area due to her therapist, [Ms A], using the wrong settings on the laser machine. [Ms A] noticed [Ms B's] skin growing red, and dropped the strength of the settings. She then reported hearing a snapping sound close to the hairline, and [Ms B] advised that it was very hot, but bearable to continue. [Ms A] then checked the machine and realized she was using the wrong setting. [Ms A] applied Laser Aid and finished the other side of her face on the correct setting. She noticed the skin was darkening on the right side, so applied more Laser Aid and provided [Ms B] with an ice glove. An incident form was completed. [Ms B] sustained burns to the right side of her face, primarily under her jawline. She attended a medical centre for further medical treatment as advised by [the laser clinic]. Over email, on the day following her appointment, [Ms B] contacted [the laser clinic]. In response, [the laser clinic] did not advise that there was a mistake made, and suggested [Ms B] may have reacted due to sunlight already trapped within the layers of her skin.
>
> Having reviewed the information provided my comments are as follows:
>
> 1. The appropriateness of the laser therapy treatment provided to [Ms B] by [Ms A] on 24 January 2021.
>
>    The consultation and the form was completed by the client, with the consent form signed. The client had had one treatment previously with the burn happening

according to the client at her second appointment. There appears to have been a few missed appointments with multiple therapists and multiple entries on the same day and it has raised some confusion from reading the progress notes. I've decided the initials are the therapist and the name at the end of the entry is the receptionist or person entering the notes from some written form, or potentially as I believe the notes are written on the client's file on the computer booking system, that the name we see next to the date and time is the actual person who logged in at that particular time.

[Ms B] could not have her treatment on 2 earlier occasions; one being too late to proceed and another having threaded (pulled the hair out) so could not proceed with treatment. This should have been made clear to her at the consultation? Although clients often forget information. The hair needs to be inside the skin for the treatment to work, pulling it out means the laser has nothing to heat up — there will be no use in treating. Even on a third appointment, [Ms B] didn't get her treatment as the therapist was confused who she was taking into the treatment room. It is very clear to me the timeframes allowed for treatments and potentially the number of clients waiting is confusing therapists, and providing a potentially stressful work environment. I totally understand this is the business model for [LCNZ Takapuna Pty Ltd] but to me it is clearly one of the reasons for the state of mind of the therapist on this day, leading to her mistake in setting selection. This is my opinion but the facts are the treatment took longer than the permitted time.

From her own admission [Ms A] was under pressure to get the client treated in the allotted time as the client wanted a larger area treated than had been booked for. In her rush the therapist made a mistake with the setting selection on the laser and she began the treatment using the incorrect wavelength or energy level. She comments on hearing a snapping near the hairline and redness in the skin, then realized her mistake. A loud snap sound is often associated with longer (hair above the skin line and therefore not shaved) thicker hair being fired upon. Around the hair line is an indication to me the actual hair was accidentally treated. It could have been as innocent as the length of the head hair being stuck in gel on the skin or got in the way. These treatments cannot be rushed, there must be accuracy constantly throughout the treatment. This is a moderate to severe departure from accepted practice.

The client says the therapist ignored her pain so we assume the client [Ms B] was either saying it hurt or was showing signs of discomfort.

On the first sign of client discomfort the therapist should have stopped the treatment to ask the client how she was feeling. Clients vary in their pain tolerance but they must not be ignored. One easy way to gauge if it's really hurting is ask the client 'out of 10, 10 being the worst pain, what do you feel?' When a client's reaction is 'excruciating pain' — the client's words — and the skin presents with redness, the therapist should be stopping immediately. A zimmer greatly cools the skin (often blowing up to –25 degrees celsius) if the client was feeling sore with the zimmer on

the skin, then it must have really been sore. Not listening to the client and stopping to check the results of the treatment (on realizing the client is not comfortable) is a moderate to severe departure from accepted practice.

From the photos we can see the full half of the client's under chin area was treated before the therapist made the effort to check the laser setting. This should have happened within the first few shots fired. Not listening to the client and stopping to check the results of treatment (on realizing the client is not comfortable) is a moderate to severe departure from accepted practice.

It seems [Ms A] was an experienced therapist who understood the treatment process and how to adjust settings for skin types but in this case she felt pressured to do this treatment fast, and that is down to the treatment timeframes allowed per client. Once it was determined there were burns appearing, or even severe redness treatment should have stopped and gone no further. This to me is a severe departure from accepted practice.

From the previous history notes on this client (many missed treatments), [Ms A] chose to complete the treatment even though there was a severe reaction to the incorrect setting. If [Ms A] was in fact rushing through the treatment and if [Ms A] felt under pressure to complete this treatment within the time frame, this to me is a severe departure from best practice to continue to treat the client once burns were present.

Offering [Ms B] the post laser lotion and ice glove to take away was commendable and best practice.

It is accepted practice to offer the client aftercare treatment or product in the case of an incident such as this. I am concerned though to read in the notes the entry 24 January 2021 3.08pm from [Ms A] the client was given products of glycolic scrub (never to use over burns as it removes surface skin cells, glycolic being alpha hydroxy acid) and retinol (a product designed to stimulate cellular turnover — never should be used on burns). [Ms A] stated to start using post 1 week, but even then would be too soon. I feel this is a mild departure from accepted practice, as I would be recommending the therapist see the client's healed skin post 1 week before recommending such products.

I do commend the record keeping from [Ms A] but I do feel more training would be beneficial in how to deal with burns on the skin, healing times etc, especially on a darker skin type.

[Ms A] has made several entries from the time of the treatment burn as to the incident and her request for assistance … as to how to better look after [Ms B's] skin and ongoing after care (noted 24 Jan 2021 4.04pm). This is best practice.

2. The appropriateness of the advice provided to [Ms B] when she contacted [the laser clinic] the following day.

   The email [Ms B] received from [the laser clinic] did appear to point the finger at potential sun exposure on the client's skin prior to treatment as the reason for the burn occurring.

   The clinic was fast to offer repair treatments which is excellent practice, but there wasn't an urgency from [the laser clinic] to make these appointments and told the client they were not available to discuss this but will follow up later in the week. That is not very comforting to a client who has burns on her face. I feel this was below adequate response from [the laser clinic], showing no desire to learn more from the client and get the client's full recollection of the potential cause of burns. The response from [the laser clinic] via email was reasonably dismissive in my view and mild departure from best practice.

   If during summer having tanned skin or even sun exposed skin ([the laser clinic] stopped short of saying the client had a tan) then [the laser clinic] should have extra consents at the beginning of each treatment that the client has not tanned their skin or had recent sun exposure on the area, or has worn sunscreen every day, and the client should be asked to sign this prior to treatment.

   The area that has been burnt is under the chin and this area is not the most exposed area on the face in my experience, so it's unlikely was the cause, and as the client points out, the other areas that were treated showed no burns.

3. The adequacy of the documentation of the treatment and the incident reporting.

   The clinic shows excellent incident reporting. I find that the treatment records are noted on the client file which is on [the laser clinic's] booking system, ie on the computer which is the progress report that we have a copy of. The progress notes show us 5 entries for 24th January 2021.

   The progress notes are very comprehensive and give us a really good timeline and history of this client's interaction with [the laser clinic]. On several occasions the client could not get treatment due to lateness or misidentification from [the laser clinic]. All was noted which is excellent protocol.

   On one occasion [Ms E] noted hypertrophic scaring on the client's skin in the treatment area associated with the client's acne. The therapist gained further advice from another staff member who suggested client get a medical consent to treat over. The client then got upset and told therapist to treat anyway. The therapist then passed [Ms B] on to [Ms A]. This was the correct thing to do if she wasn't feeling confident to treat. [Ms A] performed the treatment and notes from 3.08pm showed us the burn had happened. And a further more complete note at 3.53pm from [Ms A].

   As the progress and incident report shows us, we see the settings correctly documented. I commend the therapist's honesty in this.

4. What policies and procedures for this treatment, incident reporting and consent would be accepted practice for [the laser clinic] to have?

   It appears from the copies of both the consultation and consent form as well as the incident report that [the laser clinic] has followed excellent policies and their recording procedures are also excellent.

   The only policy that I might comment about is the allotted treatment time as mentioned previously. It does lead to confusion amongst staff leading to a lack of treatment care as we see with the setting selection in this case, if the therapists are rushing to get treatments done in a short timeframe. Adding to this stress on the therapist, is the client's annoyance especially if they are running late for the appointment, and may be overbearing toward the therapist. Possibly some coping strategies for this type of situation would be good to see, or longer more realistic treatment times implemented.

   I have already mentioned the possibility of a separate consent that clarifies at the beginning of each treatment how much sun the client has had on their treatment area, at least this starts the conversation around tanned skin etc. Most clients don't realise or remember the effects sun has on the skin and its relationship with a laser or IPL treatment. It is the therapist's/clinic's responsibility to address this at each appointment.

5. What level of induction/orientation and ongoing training would be accepted practice for laser therapy staff to have at [the laser clinic]?

   I believe to offer competent laser hair removal therapists should have 3 full days, at least, initial training. This would cover laser safety, theory or light, hair removal specific theory and at least 6 practical treatments. There may also be case studies to complete in the following 6 months with guided support and follow up. Ongoing training should be completed yearly but I understand that if there is a high staff turnover this may not be practical in that instance. I see a great issue with how to treat darker skin types. I think there should be ongoing training for this type of skin with regards to laser treatments. It is true that lasers pose less risk for darker skin than IPL for instance, but we can see lasers are not fool proof, it is the therapist that decides the setting which if incorrect could lead to a burn. So more support and education or a simple 1 hour every 6 months refresher of the theory of dark skin treatment would be of benefit.

6. Any other matters you consider warrant comment including any other issues you identify with the care provided, the management of [the laser clinic] and the response provided to the HDC to date.

   I have made comments above that address this question.

Please let me know if you require any further information or advice.

Kindest regards

Heather Thompson, Director Rejuv Ltd"

## Appendix B: Auckland Council Health and Hygiene Code of Practice 2013: Part 7: Pulsed Light and Laser Treatment

Last updated 5 March 2014

Health and Hygiene Code of Practice 2013

Part 7

Pulsed Light and Laser Treatment

Pulsed light is a practice using a powerful flash of broad spectrum, non coherent light intended to remove hair and/or for skin photo-rejuvenation, and may include, but is not limited to, Intense Pulsed Light and Variable Pulsed Light. Laser treatment is a practice involving the use of a laser device, which amplifies light and usually produces an extremely narrow beam of a single wavelength (one colour), intended to remove hair and for skin photo-rejuvenation.

Services involving the use of pulsed light and laser treatment have the potential to burn the skin and lead to longer term skin conditions. Pulsed light may be considered to carry a risk of delayed recognition of skin cancers and mis-diagnosing malignant skin lesions, including melanoma. Lasers capable of breaking the skin, such as those used for laser tattoo removal, carry the risk of drawing blood. The use of lasers capable of breaking the skin may be considered to carry a risk of transmitting blood-borne diseases.

The minimum standards contained in this part of the code aim to ensure that operators who are undertaking pulsed light and laser treatment conduct their operations in a safe and hygienic manner so as to reduce risks to public health.

Minimum Standard 7: Pulsed Light and Laser Treatment

All operators must comply with the following standards:

- Minimum Standard 1A (Permanent Premises) or Minimum Standard 1B (Mobile or Temporary Premises)
- Minimum Standard 2 (Operator Conduct)

*Training in the provision of pulsed light*

7(1) All operators of pulsed light equipment must have the knowledge and skills necessary to provide pulsed light services, including skin type identification and the safe use of equipment, which can be achieved through the following:

(a) National Certificate (or international equivalent) in Electrology, evidence of professional development in pulsed light services, and commercial industry experience of 12 months or more; or

(b) commercial industry experience of five consecutive years or more using pulsed light equipment, and evidence of professional development in pulsed light services; or

(c) evidence of training with a pulsed light training provider, and industry experience of 12 months or more;

*Training in the provision of laser treatment*

7(2) All operators of lasers that risk breaking the skin must comply with Minimum Standard 4: Risk of Breaking the Skin;

7(3) All operators of lasers that risk breaking the skin, including those used for laser tattoo removal, must have the knowledge and skills necessary to provide laser services including:

(a) skin type identification; and

(b) safe use of lasers based on AS/NZS 4173: 2004 and any updates, additions or amendments to that standard; and

(c) commercial industry experience of 12 months or more;

7(4) All operators of lasers that are designed to remove the skin must be a health practitioner and must be trained in the safe use of lasers based on AS/NZS 4173: 2004 and any updates, additions or amendments to that standard;

*Display of qualifications*

7(5) Qualifications must be displayed in a prominent position so customers can read them, and must be in the name of the operator performing the procedure;

*Precautions, consent and aftercare*

7(6) Prior to the commencement of any pulsed light or laser treatment, the operator must:

(a) advise the customer who wishes to undergo such service of the risks associated with the service; and

(b) give written advice appropriate to the procedure to be undertaken, concerning precautions and post service procedures that should be taken by the customer who wishes to undergo the service;

7(7) Before commencing any pulsed light or laser treatment, a customer must sign a consent form including medical history and skin type;

7(8) Before commencing any pulsed light or laser treatment, all operators must identify if the customer is suitable for the service. Any customers with a family history of melanoma must be exempt from all pulsed light and laser treatment;

7(9) All operators must ensure that a patch test, or a trial exposure of a small area of representative skin and hair, is carried out to determine the parameters and to judge how the skin might react to full service. Test patch protocol should include which areas to test, the pulsed light or laser settings, how long to wait to judge skin response, and how to spot adverse reactions;

*Record keeping*

7(10) All operators must keep records of:

(a) a customer consent form with medical history and skin type;

(b) a record of service including:

(i) the date on which the pulsed light or laser treatment was undertaken;

(ii) the type of the service;

(iii) the location on the body where the pulsed light or laser was undertaken; and

(iv) equipment calibration and maintenance;

7(11) Such records must be kept secure and confidential for a minimum of 2 years and made available to the council for inspection on request;

*Health practitioners to treat skin lesions/moles only*

7(12) Skin lesions and/or moles on any customer may be managed and removed by a health practitioner only;

*Medical consent required*

7(13) All operators must obtain written medical consent to undertake pulsed light or laser treatment on any customer for the removal of hair from moles;

*Controlled area*

7(14) All operators must ensure there is a "controlled area" for the pulsed light or laser equipment, which will have:

(a) clear and detailed safety rules which describe how to use the area correctly, any hazards the operator or customer might be exposed to, who is authorised to use the equipment, and what to do in the event of an accident;

(b) no windows to prevent eye damage to any passerby;

(c) no reflective areas such as mirrors;

(d) clear signs or warning lights showing when it is safe to enter or when the laser/ intense pulsed light is on; and

(e) suitable door locks or keypads;

*Protective eyewear*

7(15) All operators must ensure suitable protective eyewear is worn by the customer and operator appropriate for the wavelength of light to be used. If the face is being treated the customer must wear opaque metal eyewear;

7(16) All operators must ensure protective eyewear is either disinfected or, if disposable, completely replaced after use;

*Use of pulsed light equipment*

7(17) All operators must ensure the pulsed light equipment is calibrated to make sure that it is working properly and accurately. The wavelength and service parameters of the equipment must be set according to skin type, hair type, test patch results, and previous service settings;

*Cleaning and disinfecting*

7(18) All equipment that does not need to be sterile must be cleaned and then disinfected by a thermal or chemical disinfection procedure appropriate to the level of disinfection required and the item being disinfected maintaining the product-specific recommended contact time, to the satisfaction of the council.

Additional Standards

In addition to the minimum standards above, several other legislative acts, guidelines and codes of practice are also relevant:

- AS/NZS 3130: 1995 "Australian and New Zealand Standard for approval and test specification — beauty therapy equipment".
- AS/NZS 3200.2.22: 1997 "Australian and New Zealand Standard for diagnostic and therapeutic laser equipment".
- AS/NZS 3760: 2003 "Australian and New Zealand Standard for in-service safety inspection and testing of electrical equipment". The New Zealand Association of Registered Beauty Therapists does not recommend the use of Pulsed Light equipment that has not been inspected and tested annually.
- AS/NZS 4173: 2004 "Guide to the safe use of lasers in health care".
- Electricity (Safety) Regulations 2010
- Hairdressing and Beauty Industry Authority UK "Safe Use of Lasers and Intense Pulsed Light Equipment 2003". Additional Recommended Best Practice Operators should:
  - seek formal instruction in the recognition of skin cancers;
  - understand the importance of not treating pigmented lesions about which they have concerns;
  - advise customers with such lesions to seek the advice of a registered health practitioner.

*Skin preparation for pulsed light*

The area to be treated should be:

- Cleansed and all make-up removed;
- Clean skin close-up photographed;
- Hair shaved or trimmed for hair removal;
- Adequately chilled.

*Use of pulsed light equipment*

- The light applicator should be placed onto the skin and a short pulse of light released.
- The applicator should be moved to the neighbouring area and the process repeated until the whole area is treated.

*After pulsed light*

- The chilled gel should be removed, the treated area cleansed and soothing cream applied.
- The treated area should be close-up photographed.