Department of Corrections

A Report by the
Deputy Health and Disability Commissioner

(Case 17HDC01170)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Immediately prior to his imprisonment on 22 October 2016, Mr A sustained an injury to the ring finger of his right hand.

2. Mr A was assessed by a registered nurse later that day when he arrived at the prison. He was not reviewed by a medical officer until 32 days later, on 23 November 2016. An X-ray of Mr A's hand was requested at this review but it was not scheduled until 20 December 2016 — 27 days after the assessment and two months after the original injury occurred.

3. Mr A reinjured his finger on 8 December 2016 and an X-ray was taken two days later. On 6 March 2017, Mr A had surgery to correct a malunion of his fractured finger.

Findings

4. The Department of Corrections (Corrections) had the ultimate responsibility for the delivery of services to Mr A. The Deputy Commissioner considered that the following aspects of Mr A's care were particularly concerning:

- The delay in medical officer review;
- The process of obtaining an X-ray;
- The delay in definitive treatment; and
- The failure to provide follow-up care after Mr A's surgical procedure.

5. Accordingly, it was found that Corrections failed to provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

Recommendations

6. In the provisional opinion it was recommended that Corrections apologise to Mr A; provide training to its registered nurses on the management of acute injuries; review and update its policies and procedures on the management of acute injuries; review its policies and procedures relating to the recall process to ensure continuity and timeliness of care; and conduct an audit of the standard of its clinical documentation, including the Health Services Health Care Pathway. Corrections confirmed that it had met or would meet these recommendations.

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

Names have been removed (except the Department of Corrections and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Complaint and investigation

7. The Commissioner received a complaint from Mr A about the services provided by the Department of Corrections. The following issue was identified for investigation:

   - *Whether the prison provided Mr A with an appropriate standard of care between October 2016 and April 2017.*

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

9. The parties directly involved in the investigation were:

Mr A	Consumer
Department of Corrections	Provider
Registered Nurse (RN) B	Provider

Also mentioned in this report:

RN C	Registered nurse
RN D	Registered nurse
RN E	Registered nurse

10. Independent expert advice was obtained from a registered nurse, Barbara Cornor, and is included as Appendix A.

Information gathered during investigation

Introduction

11. Immediately prior to his imprisonment on 22 October 2016, Mr A sustained an injury to the ring finger of his right hand.

12. Mr A was assessed by a registered nurse later that day when he arrived at the prison. He was not seen by a medical officer until 32 days later, on 23 November 2016. An X-ray was taken on 8 December 2016. Mr A had surgery on 6 March 2017 to correct a malunion[2] of his fractured finger.

13. This report considers the care provided to Mr A by the Department of Corrections and its staff between October 2016 and April 2017.

[2] Incomplete or faulty union (as of the fragments of a fractured bone).

Prison Health Services

14. Corrections provides primary healthcare services to prisoners through its Health Service, which is staffed by nurses and doctors. On arrival at a prison facility, a Reception Health Triage Assessment[3] (RHTA) of the prisoner is conducted.

15. Following the RHTA, any prisoner with a health concern completes a Health Request Form (HRF) and places it in a locked box, which is cleared daily by a registered nurse on completing the medication round.

16. The HRFs are triaged by a registered nurse to determine whether the health issue requires follow-up immediately or later in the day, or for it to be placed on the Recall List for follow-up as soon as possible. The nurse then records the outcome of the triage and the plan for follow-up on the bottom of the HRF.

17. A photocopy of the HRF is then sent to the patient.

18. Each day the lead nurse prints and prioritises the Recall List according to urgency/need. A list of patients for follow-up is then allocated to staff. The list of prisoners requiring transfer to the health unit for assessment or treatment (movers list) is given to the custodial officer to facilitate movement to and from the health unit. Alternatively, the registered nurses go out to the unit to see prisoners for follow-up.

Assessments of finger injury

19. On arrival at the prison on 22 October 2016, Mr A had his RHTA completed by RN B, who reviewed Mr A's finger injury and documented:

> "[M]ild swelling seen, states he has been fighting. Looks … sprained. Patient has 95% of movements. Good sensation on the peripheries. Buddy strap[4] and review in two days time. R) middle finger and ring finger buddy strapped. Triage as priority 3 — Routine."

20. RN B did not advise Mr A to keep his hand elevated during the first 24–48 hours or to apply ice packs to the injured area every four to five hours to reduce the pain and swelling.

21. Corrections told HDC that although there was a recall in place for Mr A to be seen in two days' time, this did not occur, and Mr A was not reassessed until 31 October 2016 — nine days after the injury was sustained and first assessed.

22. Mr A was next seen at his cell door on 31 October 2016 at 7.50am by RN C, a newly graduated nurse. RN C told HDC that there was no buddy strapping in place. The clinical

[3] Health Services staff obtain health information about prisoners who may need health services while in prison. The purpose is to ensure that the prisoner's immediate health needs are addressed in a timely manner.

[4] Strapping the injured finger to the next finger, allowing the injured finger to move whilst also protecting it.

notes state that Mr A reported to RN C that he thought his finger was broken. She examined it and recorded in the notes:

> "[Right] ring finger was visibly swollen; with bruising evident above the distal phalangeal[5] joint up to next joint. Finger appears deformed, with limited function. [Mr A] added to the mover list for further assessment in the health unit."

23. RN C told HDC:

> "The movers list is triaged in order to prioritise urgency of treatment; and is also limited by whether we have movers available to bring the patient to the health unit, along with the classification of other patients in the health unit at the time ... There is always push back from custody for sending people out for treatment and if it turns out not to be serious we get asked to explain our actions with regard to having sent a patient out … I also added recall in case [the patient] did not get seen, as can happen if no mover is available on the PM shift."

24. RN C told HDC that at 1pm she handed over to the afternoon shift, and told oncoming staff that Mr A still needed to be seen, as his finger might be fractured.

25. On 5 November 2016, RN B wrote in the clinical notes that Mr A declined to go to the health unit for review of his finger injury as it was already strapped. The documented plan was to offer a medical review the following day.

26. Mr A was seen on 6 November 2016 by RN D, who documented:

> "? # [fracture] right ring finger … finger swollen especially first joint. Patient can move finger, circ[ulation] brisk, all fingers on both hands cold to touch. Finger buddy strapped and ibuprofen prescribed … Plan review finger in 3 [days] for strapping."

27. Mr A was not reviewed on 9 November as planned.

28. On 12 November 2016 at 2.10pm Mr A was seen by RN D in the interview room, as no medical movers were available. She documented in his medical notes that his finger remained swollen and that he was now finding it hard to make a complete fist, as the joint was painful and stiff. He was unable to straighten his finger. RN D advised Mr A that he would be placed on the prison doctors' list for follow-up.

29. On 23 November 2016, Mr A was seen by the prison medical officer, who requested an X-ray. The X-ray was booked by the Administration Support Officer for 20 December 2016. The medical officer told HDC that when he saw Mr A's injury it was already a month old, and that although he did not document any urgency for the X-ray, usually it would be done

[5] Finger bone.

within one to two weeks,[6] and "it is disappointing that [Mr A] ended up waiting for a month".

30. Corrections told HDC that as the medical officer did not document that an urgent X-ray was required, it was scheduled as per normal practice. Corrections disagrees that it should have been booked earlier than 20 December 2016.

31. On 6 December 2016, Mr A wrote on an HRF:

> "I have banged my finger and it feels like its broken. I need to get xrays now [because] I've been in since October and it still hasn't got any better and the doctor said I was going [to] get xrays in the next couple days."

32. An annotation on the HRF dated 6 December 2016, says: "Hi [Mr A.] You have an xray [appointment] booked for before Christmas."

33. Mr A was seen at his cell door on the evening of 6 December 2016 by RN E, who told HDC that she observed swelling and bruising but was unable to assess Mr A any further, so instead requested an urgent recall for the following morning.

34. Mr A was seen in the health unit on 8 December 2016 by both RN E and RN B. The clinical notes state: "[M]oderate swelling, deformity and slight bruising noted." RN B spoke with the medical officer and, as Mr A had re-injured the finger two days previously, a decision was made to arrange for an X-ray that day. The X-ray report noted:

> "[A] fracture is seen of the proximal phalanx of the fourth digit. The fracture shows dorsal ulnar angular displacement some 50° and there is a thin dorsal ulnar calcified callus.[7]"

35. RN E told HDC that on returning from his X-ray Mr A was angry, and did not want her to tape his hand. However, he was happy to receive tape to do it himself, and was given tape and told that an orthopaedic appointment would be arranged.

36. On 10 December 2016, Mr A was seen in the cell wing by RN D. Mr A declined an offer of pain relief and to have his finger strapped. RN D wrote in the clinical notes that Mr A asked her when his orthopaedic appointment would be, as he wanted to tell his family. RN D advised Mr A that she was unable to provide this information.

37. On 14 December 2016, Mr A's X-ray appointment for 20 December 2016 was cancelled, as he was due in court that day. On 21 December 2016 the clinical notes indicate that the X-ray appointment was re-arranged for 10 January 2017, and that a semi-urgent priority orthopaedic appointment had been arranged for 19 January 2017. Corrections told HDC

[6] This was the medical officer's understanding. Corrections does not have a policy detailing expected time frames, and is not involved in allocating appointment times.

[7] A mass of exudate (fluid that filters from the circulatory system into lesions or areas of inflammation) and connective tissue that forms around a break in a bone and is converted into bone in healing.

that the re-injury event on 6 December 2016 resulted in an urgent X-ray appointment being scheduled (8 December 2016), and therefore the 20 December 2016 appointment was no longer necessary.

38. Another X-ray was taken on 10 January 2017 and showed a dorsally angulated oblique fracture of the middle proximal phalange of the right ring finger, with some callus formation and soft tissue swelling evident around the fracture.

39. Mr A was seen by an orthopaedic surgeon on 19 January 2017. Following discussion of the available treatment options, Mr A opted for surgical intervention. The surgeon advised Mr A that physiotherapy and hand therapy would be necessary postoperatively.

40. On 6 March 2017, surgery was performed to correct the malunion of Mr A's fractured finger. The postoperative instructions on Mr A's discharge summary include keeping the dressing clean and dry, but do not reference the preoperative advice that physiotherapy and hand therapy would be required postoperatively.

41. Mr A returned to the prison the following morning and was assessed by a nurse. A Health Services Health Care Pathway Form (HSHCP) dated 7 March 2017 states that a dressing was in place, pain was to be minimised by offering pain relief, Mr A's arm was to be elevated, and his hand was to be reviewed following removal of the dressing. A review date of 14 March 2017 is documented, but there is no evidence in the clinical records that the plan was reviewed on or following this date.

42. Mr A was next seen in his cell by a nurse at approximately 7pm on 12 March 2017. The nurse wrote in the clinical record that Mr A asked whether he had to have the cast changed, as he thought it was full of blood and dirty. The nurse documented in the clinical record: "[P]lease get it reviewed in the morning and also check if [patient] has any follow up appointment booked for same."

43. The clinical notes record that on 13 March 2017 a yard officer telephoned the prison health unit on behalf of Mr A and asked when the cast/bandage would be changed. Mr A was seen that afternoon, and his wound was noted to be healing well. The sutures remained in place. His hand was cleaned and redressed, and the backslab and bandage reapplied.

44. The clinical records provided to HDC show that Mr A was seen in the health unit on a number of occasions following 13 March 2017. However, there is no documentation of any further wound reviews, dressing changes, removal of sutures, or update of the HSHCP.

45. On 12 April 2017, Mr A declined an arranged orthopaedic specialist and X-ray follow-up appointment scheduled for that day. The clinical notes state that the appointments were cancelled, and that on 10 May 2017 Mr A was to be transferred to another Corrections facility.

Further information

46. Mr A told HDC that he felt that he was not listened to when he told health staff that he needed an X-ray as he believed his finger was broken, and that the care and treatment he received at the time of the injury was inadequate.

47. In a letter to Mr A dated 9 June 2017, the Health Centre Manager apologised and stated: "[I]t is clear from your record that you did not have an x-ray of your R) 4th finger, or follow up assessment and intervention in a timely manner."

48. Corrections told HDC that "the communication about [Mr A's] injury between staff could have been better". Corrections acknowledged that Mr A could have been reviewed by a medical officer sooner, and therefore may have had an X-ray earlier.

Relevant Department of Corrections policies

Health Services Health Care Pathway Version No: 2

49. "5.8 Plan of Care

… A plan of care describes what you are going to do (a plan) after you have assessed the patient … This is recorded in the patient's electronic file (under 'Daily Record').

…

8.1 General Policy on Clinical Management

… Offer a patient appropriate clinical interventions after the patient has had a health assessment. Clinical interventions are offered according to

— the clinical presentation of the patient

— the patient's individual needs

…

Make sure all recalls and Appointment Book entries are actioned and reviewed in [a] timely manner. The Health Centre Manager or their designated delegate must make sure this happens."

Initial Health Assessment Policy and Procedures Version No: 1

50. "6.1 General Policy

…

All Health Centres must have a written process in place for recalling prisoners for follow-up care/tests/appointments/further assessments required …"

Health Services Local Operating Manual

51. "2.1 Appointments for external visits

…

Return from an external appointment and follow-ups

- The prisoner who comes back from the external appointment will be seen by the nurse prior to going back to the housing unit.

…

- The nurse will arrange any follow up needed, order prescribed medication from the pharmacy and create/add to a treatment plan with specific details of their condition and treatment required, Record all actions in the electronic clinical file."

Responses to provisional opinion

52. Mr A provided a response to the "information gathered" section of the provisional opinion. He told HDC that his injury was caused by an altercation where he used self-defence.

53. Corrections provided a response to the provisional opinion. Corrections stated:

"We accept that the management and coordination of care of [Mr A's] finger injury was deficient. Corrections recognises that a medical officer review and an appointment for an X-ray should have been organised earlier. Additionally, comprehensive post-operative follow up care should have been provided.

We acknowledge that Corrections failed to provide services to [Mr A] with reasonable care and skill and, accordingly, breached Right 4(1) of the Code …"

Opinion: Department of Corrections — breach

Relevant legislation

54. Section 75 of the Corrections Act 2004 states:

"(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."

Preliminary comment

55. Corrections is responsible for delivering health services in a manner that provides prisoners with a standard of care that is reasonably equivalent to that available to the

public. It also has an organisational duty to facilitate continuity of care. This includes ensuring that its staff work together and communicate effectively.

56. 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. People in custody do not have direct access to a general practitioner, and are entirely reliant on the staff at prison health centres to assess, evaluate, monitor, and treat them appropriately. Accordingly, I am concerned about the instances of lack of communication and collaboration amongst the health team that occurred in the assessment and management of Mr A's injury.

57. My expert advisor, RN Barbara Cornor, advised:

> "While often viewed as trivial injuries, a poorly treated finger fracture … can have significant functional consequences. Appropriate understanding of finger fracture patterns, treatment modalities, and injuries requiring referral is critical for optimal patient outcomes. Accurate diagnosis and timely management of these injuries continues to be the cornerstone of optimal hand care … The differential diagnosis for finger injuries includes fracture collateral ligament rupture, and tendon laceration or avulsion. A careful examination of the flexor tendons, extensor tendons, and neurovascular function must be documented."

Delay in medical officer review

58. Mr A injured his hand on 22 October 2016 and, following his transfer to the prison later that day, he was assessed by RN B. RN B assessed Mr A's finger, documented the injury, buddy strapped the finger, and administered pain relief. RN Cornor advised that these steps are best practice.

59. RN Cornor advised that first aid treatment following injury is to keep the hand elevated, and during the first 24–48 hours to apply ice packs to the injured area every four to five hours to reduce pain and swelling. I agree with Ms Cornor's advice and am critical that RN B did not give this advice to Mr A.

60. A plan was made for Mr A to be reviewed in two days' time, but this review did not take place until 31 October 2016, which was nine days later. RN Cornor advised that at the initial assessment Mr A should have been referred for radiology assessment, or at least provided with a medical officer appointment as soon as possible.

61. Between 22 October 2016 and 12 November 2016, Mr A was assessed four times by three different registered nurses. On 12 November 2016, he was placed on the prison doctors' list for follow-up, but this did not occur until 11 days later on 23 November 2016 — a total of 32 days following Mr A's injury. I have been advised by Ms Cornor that "this timeframe for this type of injury which was acute on arrival and is showing no signs of healing is unacceptable practice and is a severe departure from accepted standards".

62. I agree with RN Cornor's advice. The delay in Mr A receiving treatment for his injured finger is unacceptable, and reflects a lack of care and critical thinking about Mr A's non-

healing injury. I would expect a registered nurse to be concerned, and to escalate those concerns by seeking timely medical review.

63. The Department of Corrections policy states:

> "Make sure all recalls and Appointment Book entries are actioned and reviewed in [a] timely manner. The Health Centre Manager or their designated delegate must make sure this happens."

64. I am critical that this policy was not followed.

Process of obtaining X-ray

65. An X-ray of Mr A's hand was requested when Mr A was assessed by the medical officer on 23 November 2016. The X-ray was then scheduled for 20 December 2016 — 27 days after the assessment and two months after the original injury occurred.

66. The medical officer did not mark the X-ray as urgent, and told HDC that he expected it to be done within 1–2 weeks. The appointment was made by an administrator for four weeks' time.

67. RN Cornor advised:

> "The initial evaluation of these injuries following assessment requires X-rays to define the injury and determine an appropriate treatment plan: non-operative versus operative.
>
> …
>
> It is difficult to understand why, after this lengthy period of time the X-ray could not be completed earlier and [Mr A] was expected to wait another four weeks. This practice is unacceptable for an acute injury which is not showing signs of improvement during the timeframe."

68. RN Cornor is also of the opinion that the security processes should not interfere with a prisoner accessing external health appointments.

69. I accept RN Cornor's advice and agree that Mr A should have been scheduled for an X-ray earlier. There is a lack of clarity in Corrections' procedures around the booking and prioritisation of X-rays, and ultimately this resulted in a delay in Mr A receiving an X-ray.

70. In the context of the existing delay in seeing a medical officer, this additional delay in receiving imaging, and subsequent treatment for the injury, is concerning and unacceptable.

Follow-up care

71. Postoperatively Mr A returned to prison and an HSHCP was completed. The HSHCP stated that a dressing was in place, but it did not specify what dressing changes were required or

how frequently. There was no reference to the physiotherapy and hand therapy recommended in the orthopaedic surgeon's preoperative assessment.

72. RN Cornor advised that the lack of postoperative follow-up care for Mr A is a severe departure from accepted standards.

73. I am guided by RN Cornor's advice that follow-up care should have been provided, and it is concerning that there was an absence of this following Mr A's surgery.

Conclusion

74. RN Cornor concluded that aspects of the care provided to Mr A were a severe departure from the appropriate standard of treatment.

75. I consider that the management and coordination of care of Mr A's finger injury was unacceptable. As outlined above, the following aspects of Mr A's care are particularly concerning:

a) The delay in medical officer review;
b) The process of obtaining an X-ray;
c) The delay in definitive treatment; and
d) The failure to provide follow-up care after Mr A's surgical procedure.

76. A number of staff assessed Mr A between October 2016 and April 2017. In my view, the overall theme of the care provided reflects a lack of critical thinking and follow-up from a number of Corrections staff. In addition, I am concerned at the lack of robustness in the policies and procedures that covered the process for obtaining an X-ray for Mr A in a timely manner.

77. I consider Corrections to be ultimately responsible for the delivery of services to Mr A, and for the deficiencies in care outlined above. In my opinion, Corrections failed to provide services to Mr A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

Recommendations

78. In the provisional opinion, I recommended that the Department of Corrections provide HDC with evidence that the following has occurred:

a) All registered nurses at the prison to have completed training on the management of acute injuries. In addition, the Department of Corrections Health Centre Manager to have conducted a primary assurance audit of a random sample of acute injury assessments and treatments at the prison that occurred following the training, to ensure that there has been the expected improvement in the standard of care — and

for the result of the audit to be subject to a secondary assurance assessment by the Regional Clinical Quality Assurance Advisor.

The Department of Corrections advised that all registered nurses have completed Health and Disability Advocacy Service training, and Acute Injury assessment, management, and documentation training. The audit and assessment have also been completed.

b) The Department of Corrections policies and procedures to have been reviewed and updated to provide clear guidelines for staff on the management of acute injuries — and for the review to include the process and responsibilities for requesting and scheduling X-rays.

The Department of Corrections provided an updated copy of the Health Unit Local Operating Manual, and advised that its nurses have been given access to electronic clinical pathways.

The Department of Corrections advised that its policies and procedures relating to the recall process have been reviewed and updated to ensure continuity and timeliness of care, and the Health Care Pathway, which provides guidance on the recall process, has been reviewed and provided to Health Services staff.

Accordingly, this recommendation has been met.

79. I recommend that the Department of Corrections provide a written letter of apology to Mr A for its breach of the Code. The apology is to be provided to HDC within three weeks of the date of this report, for forwarding to Mr A.

80. I recommend that within three months of the date of this report, the Department of Corrections provide HDC with evidence that it has audited the standard of clinical documentation, including the Health Services Health Care Pathway. HDC is to be provided with the results of the audit and the follow-up recommendations. The Department of Corrections has advised HDC that in early 2019 the Regional Clinical Director is to audit the delivery of care at the prison measured against the Health Care Pathway, and that the results of the audit will be provided within the timeframe specified.

Follow-up actions

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

Names have been removed (except the Department of Corrections and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A: Independent advice to Commissioner

The following expert advice was obtained from RN Barbara Cornor (Masters of Nursing, NZ Nursing Council 051169):

> "[Mr A] believes, had his injured finger been correctly diagnosed and treated he would not have required surgery. The key issues for him are not being listened to, care and treatment was inadequate and the delayed treatment resulted in surgery with the possibility of further surgery.
>
> The history of [Mr A's] injury is that [on] 22/10/16 he was involved in an altercation and injured his finger and thought it was broken. An X-ray was not requested by the Medical Unit at [the] Prison until 24 November, 2016 and undertaken on 10 January, 2017.
>
> **Bone Injuries of the Hand**
>
> Bone injuries of the hand are common. While often viewed as trivial injuries, a poorly treated finger fracture (#) can have significant functional consequences. Appropriate understanding of finger fracture patterns, treatment modalities, and injuries requiring referral is critical for optimal patient outcomes. Accurate diagnosis and timely management of these injuries continues to be the cornerstone of optimal hand care.
>
> These injuries may result in chronic pain, stiffness, and deformity; preventing patients from participating in activities of daily living. It is not uncommon for stable fractures to be over treated and unstable fractures to be neglected, both potentially resulting in permanent disability.
>
> **Signs and Symptoms**
>
> A doctor or nurse or nurse practitioner will assess the mode and mechanism of the injury, examine the injured finger and, if necessary following that assessment, refer for an X-ray to find out which bone is fractured, and how it is fractured.
>
> The signs of injury are usually obvious: pain, swelling, tenderness, bruising, deformity, and/or skin abrasions. The differential diagnosis for finger injuries includes fracture, collateral ligament rupture, and tendon laceration or avulsion. A careful examination of the flexor tendons, extensor tendons, and neurovascular function must be documented.
>
> Correct recognition of finger injuries that require operative intervention for optimal outcome is as important as proper treatment of stable finger fractures to maintain function. Attempted non-operative treatment of these injuries will result in the delay of appropriate care, which in most instances will negatively affect the ultimate outcome.

The recovery time for a broken finger may be as short as a few weeks or up to a year, depending upon multiple factors. The prognosis also depends on various factors, such as if there is an associated nerve injury or vascular injury.

Diagnosis of Hand Fractures

The initial evaluation of these injuries following assessment requires X-rays to define the injury and determine an appropriate treatment plan: non-operative versus operative. Stable fractures without rotational deformity or intra-articular extension are best treated non-operatively with gentle reduction, appropriate splinting, and early motion to provide an environment for fracture healing without excessive residual stiffness.

Fractures that cannot be managed conservatively, including those with residual deformity, intra-articular extension, or tendon injury, are best handled with referral to an orthopaedic specialist for appropriate early management.

Treatment

First aid treatment following injury is to keep the hand elevated. During the first 24–48 hours ice packs to the injured area for 20 minutes at a time every four to five hours is recommended to reduce pain and swelling.

Treatment for a broken finger depends on the location of the fracture and whether it is stable. Closed non-displaced or minimally displaced fractures with acceptable alignment that are the result of a low-energy trauma usually have sufficient supporting tissues remaining intact making them stable and amenable to treatment by protected mobilization, either with local splinting of the fracture or 'buddy strapping' to adjacent fingers.

An orthopaedic surgeon will determine the best treatment approach for a complicated fracture. Pins, screws, and wires are useful in surgical procedures for broken fingers. Proper diagnosis, treatment, and rehabilitation of broken fingers help to preserve hand function and strength and prevent deformities.

Would I expect imaging to have been requested and undertaken earlier?

- 22 October — [Mr A] Reception Health Triage Form describes a 'sprained R ring finger' and 'mild swelling seen', 'looks like sprained', 'good sensation to peripheries'. There is no documented assessment of deformity, bruising, mode or mechanism and '95% of movement' does not describe what that movement is. The finger was 'buddy strapped' and for review in 'two day's time'.
- There is no further assessment until 31 October, where [Mr A] was seen at his cell door stating he thinks his finger is broken. The writer documents 'visibly swollen, with bruising evident. Finger appears deformed, with limited function'. He was placed on the 'mover list for further assessment' and the plan indicates he will be assessed in the health unit.

- 5 November — [Mr A] refused to attend health unit. His finger was buddy strapped although the nurse was not aware it had been done and could find 'no evidence'.
- 6 November — seen in health unit for Initial Assessment and finger reassessed and buddy strapped. Plan to 'review and restrap in 3 days'.
- 9 November — [Mr A] declined to see the health staff and declined his anti-inflammatory medication.
- 23 November — [Mr A] seen in the health unit. Pain and deformity reported by him and the writer documents 'since then has not come right'. The plan was for X-ray and an ACC form was completed.
- 24 November — appointment received for 24 December for X-ray R finger.
- 6th December — [Mr A] writes 'I have banged my finger and it feels like it is broken I need to get X-rays now because I have been in since October.'

I would expect at initial assessment, [Mr A] should have been referred for radiology assessment but if nurses are unable to sign radiology forms, at least be provided with a Medical Officer appointment as soon as possible. The first delay occurs from October 22nd (the finger was assessed) until 31 October ([Mr A] suggests his finger is broken, the nurse assesses a painful, deformed, limited movement finger) and was put on the 'movers list' for the health unit, which led to another five day delay, waiting until 5 November to be taken to health unit. Unfortunately, [Mr A] refused assessment until the following day (16 days post injury). During this time the splint had been removed and reapplied and medications refused. Acute injuries should not wait that long prior to radiology and all treatments should be complied [with] by the patient. This is poor practice by the health team.

It is difficult to understand why, after this lengthy period of time, the X-ray could not be completed earlier and [Mr A] was expected to wait another four weeks. This practice is unacceptable for any acute injury which is not showing signs of improvement during the timeframe.

The appropriateness of the treatment provided to [Mr A] prior to the undertaking of imaging in January 2017, given his presentation.

The reasonableness of the care provided to [Mr A] by [Prison] Health Centre staff between October 2016 and June 2017.

- 22 October — arrived in prison.

Injury documented and finger buddy strapped which is usual treatment for this injury.

Pain relief was prescribed and offered which is also normal and best practice.

No ice packs provided to reduce swelling and pain.

The writer documented 'review in two days time'. This did not occur.

- 31 October — [Mr A] reminded the nurse 'he thinks his finger is broken'.

There is no evidence of follow up nor any care plan and the nurse documented on 31 October they could not find 'any notes in the last 2 weeks anyone strapped his fingers'. It is not documented on this date, if any treatment was provided (eg. the finger was buddy strapped or re-buddy strapped) although from the assessment of the finger being 'appears deformed, with limited function' I would suggest not. There is again, no further plan of care or treatment provided except 'pt to be assessed in the health unit ?#'. (# — fracture).

- 12 November — first assessment since 31 October by a nurse in the cell block interview room.

It is stated [Mr A] 'has only been taking pain relief periodically' and 'strapping removed'. As there has been no further assessment/follow-up over the previous 12 days, [Mr A] must have removed the strapping himself. This situation is not good for healing and unacceptable by the health team who should have made it their responsibility to regularly assess and discuss the process with [Mr A] to encourage compliance.

The patient is 'encouraged' by the nurse on this date to become more compliant with the treatment options and it is only now the nurse suggests the 'need for X-ray as injury occurred last month'. If assessments had been more regular this conversation could have occurred at an earlier stage and compliance may (or perhaps may not, if the patient did not consent) have occurred.

- 23 November — First assessment by a Medical Officer

11 days following the last assessment and 32 days from arrival at [the] Prison. This timeframe for this type of injury which was acute on arrival and is showing no signs of healing is unacceptable practice and is a severe departure from accepted standards.

The Medical Officer requests an X-ray. The date for X-ray is received and it is nearly a month away. This should not be accepted and is poor practice by Corrections health staff for any injury. There are facilities for x-ray of acute injuries within the [district health board] area. There will be security processes for Corrections around external health appointments, but these should not interfere with the prisoner's health state.

- 6 December — Re-injury of finger reported by [Mr A].

Swelling and bruising documented with no further health assessment as required for any injury.

- 8 December — X-ray showed a displaced fracture with some callus and referral sent for an orthopaedic appointment.

[Mr A] was provided with tape to strap the injury. No evidence is provided as to why the nurse did not apply the strapping as would be expected, or if [Mr A] had been educated as to how this procedure should be done for effectiveness. This is a severe departure from nursing requirements in the care of this injury.

[The] Orthopaedic Surgeon examined [Mr A] January, 2017. He documented 'a fracture of the proximal phalanx of the right ring finger has occurred that has malunited'. He discussed with [Mr A] his impression there was 'reasonably good hand function' but [Mr A] denied this and 'remained keen on a surgical option' which he pointed out also had 'significant risks such as stiffness' and physio and hand therapy would be 'essential for a good outcome'. The recovery process would take 'approximately three months'. Surgery was undertaken in March 2017.

No further assessments of the injury are documented prior to his surgery in March 2017. [Mr A] returned to the prison on March 7, the day after surgery. No care plan is documented and it is not until March 13 when [Mr A] asked for a review was any plan documented. This plan included follow-up requirements only. Again, there is [no] documentation to support any of the follow-up which is a severe departure from nursing requirements of a post-operative procedure.

The orthopaedic surgeon had told [Mr A] that physio and hand therapy would be essential for his recovery. There is no evidence of this occurring which would be a moderate departure from [the] accepted standard [of] care … this [could] be a result of the hospital not referring, but there again has been no follow-up by the health unit [and] this situation is not made clear at all. In fact, there are no further assessments of the finger, post op surgical requirements, dressing, plaster of paris, or joint movement following March 13 which is a severe departure from post operative outcomes for the patient.

- 12 April, 2017 — [Mr A] declined to go to the external appointment at [an] Orthopaedic Centre.

A severe departure from documentation requirements is evidenced as there is no evidence/documentation of discussion with [Mr A] to ascertain his reason for declining this appointment and/or to make alternative plans.

Documentation from the Health Unit reflects [Mr A] was transferred to [another region] in May, 2017 and released from [prison] in June 2017. As far as I can ascertain from the documentation, he left with his plaster intact and no instructions for follow-up?

Clinical documentation

Clinical documentation is a legal record of patient care. It is essential for good clinical communication and a core requirement of the Nursing Council of New Zealand (NCNZ) competencies for scope of practice. Good documentation helps to protect the welfare of patients by promoting:

- High standards of clinical care
- Continuity of care

- Better communication and dissemination of information between members of the multidisciplinary care team
- An accurate account of treatment, care planning and delivery
- The ability to detect problems, such as changes in the patient's/client's condition, at an early stage (Collins, Cato et al. 2013).

When documenting in the clinical record, it is important to remember many people are required to read the notes that are written. All health professionals who are involved in the planning, implementation and evaluation of care — from the time of admission through to discharge must complete documentation to meet the needs of all health professionals. External bodies in the case of an investigation e.g. NCNZ, MCNZ, Accident Compensation Corporation (ACC), Health and Disability Commissioner (HDC), Health Practitioners Disciplinary Tribunal (HPDT) or the Coroner are also required to read the written notes.

Documenting all relevant information ensures others know what the health professional observed and what clinical interventions were taken and what the result was. Documentation must show evidence of clinical judgement and escalation/referral as appropriate and evaluation of the care provided. There is an old saying which remains relevant to this day — *If care is not recorded, then it is assumed the care was not given.* In the review of this case, it appears to the writer a lot of evidence is missing and there is a severe departure from documentation requirements as described below.

Documentation should also include care that could not be given and the reason why, so that it does not get overlooked. When addressing ethical dilemmas in care delivery, health professionals are advised to document steps/care intentionally not taken and the rationale for the decision e.g. it may further endanger the safety of the individual etc.

Documenting for individual patient documentation should:

- Be factual, objective, consistent and accurate.
- Be written as soon as possible after an event has occurred, providing current information on the care and condition of the patient including standard care and out of the ordinary care.
- Be written clearly.
- Be written in a manner that any alterations or additions are dated, timed and signed so the original entry can still be read clearly.
- Be accurately dated and timed.
- Avoid inclusion of abbreviations, jargon, meaningless phrases, irrelevant speculation and offensive subjective statements.

- Be readable on any photocopies — ideally written in black ink.
- Have a unique identifier on both sides of every page (NHI, Date of Birth).

In addition, records should:

- Identify problems that have arisen and the action taken to rectify them.
- Provide clear evidence of the care planned, the decisions made, the care delivered and the information shared, with rationale for the nursing action and/or inaction.

Conclusion:

The timeframes and processes documented above, taken from the evidence provided to me reveals very limited evidence of appropriateness of treatment or acceptable practice for a non-healing bony injury or a post-operative procedure. This is a severe departure from appropriate treatment and current best practice.

There is no evidence to support [Mr A], that had his injured finger been correctly diagnosed and treated he would not have required surgery. [Mr A] was non-compliant with the treatment provided of buddy strapping and this may have contributed to some mal-union also. The delayed treatment was not the reason [Mr A] required surgery as the orthopaedic surgeon documents 'he thought the fracture was healing and there was good hand function'. Surgery was an option he provided, an option [Mr A] chose. There is no documented evidence of any further surgery being required.

It is suggested the 're-injury' may have caused the displaced fracture. Had an x-ray been done following first assessment this could reflect a change, but as there is no x-ray there is no evidence and therefore, never will be determined.

I have previously acknowledged there has been some non-compliance by [Mr A] but would suggest that with the obvious lack of regular assessment and support of health staff to this injury, it is no wonder. This is a severe departure from best practice and treatment. [Mr A's] key issue of 'not being listened to' is well founded.

The Health Centre Manager [of the] Prison apologised to [Mr A] for the 'delay in gaining appropriate medical intervention'. He has also instructed his staff to address 'situations such as these' with a Doctor as soon as [possible]. This indicates [the] Prison's health service has acknowledged and could have provided an improved process for diagnosis. It does not acknowledge however, the inconsistency of documentation, the irregularity of assessments or limited planning of treatment to ensure best processes and outcomes for [Mr A].

Recommendations:

- Assessment of persons seeking health treatment is completed in a timely manner.
- Assessment, treatment and plans of care of acute injury is in accordance with the signs, symptoms and required outcomes.

- Update and training on assessment guidelines and tools for specific conditions, particularly suspected bony injuries.
- Formal review and improvement in all health documentation with the outcome to ensure all documents reflect the health assessment, treatment, outcomes and informed consent for all seeking health treatment. A Quality Improvement project will provide the framework for this change.
- Training for all clinicians of a consistent framework for documentation.
- Regular audit of compliance of all health professionals with documentation requirements.
- Development of a consistent health plan to meet the needs of the patient and to indicate the outcomes.
- GP assessment of acutely injured prisoners is conducted on a soon as possible basis.
- There is a review of Radiology request timeframes to ensure there is no time delay for possible bony injuries.

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