Follow-up of incidental finding of lesion
(13HDC00749, 7 December 2015)

Rural nurse specialist ~ Registered nurse ~ Public hospital ~ District health board ~ Incidental findings ~ Lesion ~ Follow-up ~ Right 4(1)

A 65-year-old man was admitted to a public hospital with a fever and right hip pain, having experienced recurrent infections of his right prosthetic hip joint. The man underwent the first stage of a hip joint revision, and was discharged.

Three months later, a rural nurse specialist (RNS) documented that the man had a large bleeding lesion on his back. She cleaned and covered it, and advised the man to have it checked. As the man was seeing his orthopaedic surgeon in the next few days regarding his hip, it was agreed that the man would ask the orthopaedic surgeon to look at the lesion. The RNS did not formally document a request for medical review of the lesion, or any follow-up action. The RNS was then off duty for several days.

The man saw the orthopaedic surgeon, and underwent aspiration of his right hip joint. There is no record of any review of the lesion.

A second RNS, a colleague of the first RNS, saw the man while the first RNS was off duty. A primary care clinic nurse received a call from the second RNS about the man experiencing a graunching of his hip, and the man's blood tests indicating continued infection. There are conflicting accounts and a lack of clarity in the records whether the man's infection was discussed directly with the orthopaedic surgeon at that time, including the possibility that the infection might be due to the back lesion.

The first RNS saw the man again and noted that the lesion was not bleeding and had flattened. The RNS did not record in the notes a discussion she said she had with the man about his consultation with the orthopaedic surgeon. There was no follow-up regarding the man's consultation with the orthopaedic surgeon, including whether the orthopaedic surgeon had viewed the lesion.

The man was admitted to the public hospital for the second stage of his hip joint revision. Inpatient nursing notes include an entry made by a surgical ward registered nurse (RN) that a mole/lesion in the man's upper back was bleeding. There is no documented reference to the surgical ward RN taking any action with respect to observation, monitoring, or initiation of a medical review of the lesion.

The orthopaedic surgeon reviewed the man's hip joint and referred him to a DHB general physician for review and advice on managing his recurrent hip joint infections. When the physician reviewed him, the man brought the lesion to the physician's attention. The physician diagnosed a malignant tumour and referred the man to the surgical department for excision.

The tumour was found to be a malignant melanoma. The man was referred for CT scans, which showed suspicious nodules in his lung. The original scar was re-excised, but there was no residual melanoma. Some time later, a subcutaneous recurrence of the tumour was excised.

The man was referred to a plastic and reconstructive surgeon at a second DHB, and underwent a series of further surgeries. There was nursing miscommunication about organisation of transport to take the man to a scan. On another occasion, the man experienced a very painful dressing change by an RN, but details of this were not recorded in the notes and the man's pain was not objectively assessed. Sadly, the man died as a result of his melanoma.

Upon forming her clinical view that the lesion required review, the first RNS left it to her patient to progress the matter. The RNS did not instigate a written medical referral or follow-up with her colleagues to ensure that a medical review of the lesion took place in a timely manner. The RNS did not provide nursing services with reasonable care and skill and, accordingly, breached Right 4(1). Adverse comment was made that the RNS did not record her conversation with the man about the man's consultation with the orthopaedic surgeon.

The surgical ward RN, upon documenting the bleeding lesion, failed to take reasonable steps to ensure that the lesion was monitored or medically reviewed, and this amounted to substandard nursing care. The surgical ward RN did not provide nursing services with reasonable care and skill and, accordingly, breached Right 4(1).

The first DHB was not considered directly or vicariously liable for the nurses' breaches of the Code.

Criticism was made of the second DHB's miscommunication regarding booking transport for the man to attend a scan. Adverse comment was made that the RN at the second DHB did not objectively assess and record the man's pain with reference to evaluating the effectiveness of analgesia.