A District Health Board

Rural Nurse Specialist, RNS F

Registered Nurse, RN H

A Report by the

Health and Disability Commissioner

(Case 13HDC00749)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In 2011, on 23 Month1[1], Mr A, aged 65 years, was admitted to a public hospital (Hospital 1/DHB1) with a fever and right hip pain. He had experienced recurrent infections of his right prosthetic hip joint. On 29 Month1, the first stage of a two-stage hip joint revision[2] was planned for the following week.

2. On 3 Month2, Mr A underwent the first stage of the hip joint revision. On 11 Month2, nursing notes included a brief entry about an incidental finding of a red skin tag on Mr A's back, entered by registered nurse (RN) RN D. She recorded that a senior house officer, Dr C, checked the tag and gave "no new orders". Dr C made no record of any examination. Dr C has no recollection of being asked to review a "skin tag" on 11 Month2, and cannot account for the nursing entry. Mr A was discharged on 12 Month2.

3. On 1 Month5, a Rural Nurse Specialist (RNS) RNS F at a medical centre[3] documented that Mr A had a large bleeding lesion on his back. She cleaned and covered it, and advised Mr A to have it checked. As Mr A was seeing his orthopaedic surgeon, Dr E, in the next few days regarding his hip, it was agreed that Mr A would ask Dr E to look at the lesion. RNS F did not formally document a request for medical review of the lesion, or any follow-up action. RNS F was off duty from 6 Month5, returning on 12 Month5.

4. On 4 Month5, Mr A saw Dr E, and underwent aspiration of his right hip joint. There is no record that Dr E reviewed Mr A's lesion at that time.

5. RNS G, a colleague of RNS F, saw Mr A while RNS F was on leave. On 9 Month5, medical centre nurse RN I received a call from RNS G about Mr A experiencing a graunching of his hip, and his blood tests indicating continued infection. There are conflicting accounts and a lack of clarity in the records whether Mr A's infection was discussed directly with Dr E at that time, including the possibility that the infection might be due to Mr A's back lesion.

6. On 12 Month5, RNS F saw Mr A again and noted that the lesion was not bleeding and had flattened. RNS F did not record in the notes a discussion she says she had with Mr A about his 4 Month5 consultation. There was no follow-up regarding Dr E's review, including whether he had viewed the lesion.

7. On 29 Month5, Mr A was admitted to Hospital 1 for the second stage of his hip joint revision. Inpatient nursing notes for 1 Month6 include an entry made by a surgical ward registered nurse, RN H, that a mole/lesion in Mr A's upper back was bleeding. There is no documented reference to RN H taking any action with respect to observation, monitoring, or initiation of a medical review of the lesion.

8. On 14 Month9, Dr E reviewed Mr A's hip joint and referred Mr A to general physician Dr J at DHB1 for review and advice on managing his recurrent hip joint infections. On 13 Month10, Dr J reviewed Mr A. The lesion was brought to Dr J's

[1] These events occurred during the period 2011-2013. Months are referred to as Month1 – Month20 to protect privacy.
[2] Repair of an artificial hip joint.
[3] Operated by DHB1.

attention by Mr A. Dr J diagnosed a malignant tumour and referred Mr A to the surgical department for excision.

9. On 26 Month11, DHB1 general surgeon Dr K excised the tumour. It was found to be a malignant melanoma. On 15 Month12, Mr A was referred for CT scans, which showed suspicious nodules in his lung. On 17 Month13, the original scar was re-excised. There was no residual melanoma. On 21 Month15, a subcutaneous recurrence of the tumour was excised by Dr K.

10. Mr A was referred to a plastic and reconstructive surgeon at another district health board (DHB2). He underwent a series of further surgeries. On 7 Month19, he had an MRI and surgery at Hospital 2. A PET[4] CT scan was ordered. There was nursing miscommunication about organisation of transport to take Mr A to the PET CT scan. On 8 Month20, Mr A experienced a very painful dressing change by RN L, but details of this were not recorded in the notes.

11. Sadly, a few months later, Mr A died as a result of his melanoma.

Findings summary

12. Upon forming her clinical view on 1 Month5 that Mr A's lesion required review, RNS F left it to her patient to progress the matter. RNS F did not instigate a written medical referral or follow-up with her colleagues to ensure that a medical review of Mr A's lesion took place in a timely manner. RNS F did not provide nursing services to Mr A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.[5]

13. Adverse comment is made that RNS F failed to record her 12 Month5 conversation with Mr A.

14. RN H, upon documenting Mr A's bleeding mole on 1 Month6, failed to take reasonable steps to ensure that the mole was monitored or medically reviewed, and this amounted to substandard nursing care. RN H did not provide nursing services to Mr A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

15. DHB1 was not considered directly or vicariously liable for RNS F's or RN H's breaches of the Code.

16. Criticism is made of DHB2 nursing miscommunication regarding booking transport for Mr A to attend the PET CT scan.

17. Adverse comment is made that RN L did not objectively assess and record Mr A's pain with reference to evaluating the effectiveness of analgesia.

Complaint and investigation

18. The Commissioner received a complaint from Mr A about the care and services provided to him by DHB1.

[4] A positron emission tomography (PET) scan is a type of imaging test.
[5] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."

19. The following issues were identified for investigation:

- *Whether RNS F provided care and services of an appropriate standard to Mr A.*
- *Whether RN H provided care and services of an appropriate standard to Mr A.*
- *Whether DHB1 provided care and services of an appropriate standard to Mr A.*

20. The parties directly referred to in the report are:

Mr A	Consumer, complainant
Ms B	Complainant, Mr A's daughter[6]
DHB1	Provider
Medical centre	Provider
Dr C	Senior house officer
RN D	Registered nurse
Dr E	Locum orthopaedic surgeon
RNS F	Rural nurse specialist
RNS G	Rural nurse specialist
RN H	Registered nurse
RN I	Practice nurse
Dr J	General physician
Dr K	General surgeon
RN L	Registered nurse
Dr M	Plastic surgeon

Also mentioned in this report:

Dr N	General practitioner

21. Information from DHB2 was also reviewed.

22. Independent clinical advice was obtained from in-house clinical advisor Dr David Maplesden (**Appendix A**).

23. Independent nursing advice was obtained from in-house nursing advisor Ms Dawn Carey (**Appendix B**).

Information gathered during investigation

Hospital 1, 23 Month1 to 12 Month2

24. On 23 Month1, Mr A, aged 65 years, was admitted to a public hospital's (Hospital 1/DHB1) surgical ward with a fever and right hip pain. Mr A had been experiencing ongoing episodes of infection of his right prosthetic hip joint, which had been fitted five years previously.

[6] Joint executor of Mr A's estate.

25. Mr A had pre-existing conditions of severe ankylosing spondylitis with a fused spine,[7] obesity, obstructive sleep apnoea, type 2 diabetes, gout, and hypertension. He was generally unable to lie on his front. At admission, Mr A was noted to be on 11 different medications. Mr A's daughter, Ms B, told HDC that her father was quite fair-skinned and had a number of moles on his back and body.

26. On 23 Month1, an initial history and examination was undertaken in hospital, including a respiratory examination (which would normally involve visualising the back). Mr A was diagnosed with likely folliculitis[8] and cellulitis,[9] and was commenced on IV antibiotics. Mr A was to be reviewed by an orthopaedic surgeon.

27. On 24 Month1, during a morning consultant ward round for Dr E (a locum orthopaedic surgeon), Mr A was examined further. Mr A was noted to have extreme folliculitis at the right hip. The treatment plan included an ultrasound and aspiration[10] of the hip. These procedures went ahead on 26 Month1.

28. Dr C was a senior house officer[11] on the surgical ward at the time of these events. Dr C told HDC that she first had contact with Mr A on the morning of 24 Month1 during the consultant ward round with Dr E, following a night shift. Dr C documented the morning ward round.

29. On 29 Month1, a PICC line[12] was inserted for intravenous antibiotic therapy. Mr A also had a chest X-ray. After discussion with Dr E, a two-step hip revision[13] was planned to begin the following week. There are no comments made in DHB1's Month1 clinical records regarding Mr A having, or complaining about, a mole/lesion on his back, or of a mole/lesion being visualised during Mr A's respiratory examination or chest X-ray, or during the insertion of the PICC line.

30. On 3 Month2, Mr A underwent the first stage of the two-stage right hip joint revision procedure. This involved removal of Mr A's prosthesis and insertion of an antimicrobial spacer.[14] Following surgery, Mr A was placed on the acute ward.[15]

31. Mr A told HDC that at some stage during this hospital stay, he raised concerns about a mole on his back. Mr A did not specify exactly when he raised this issue, or which staff he spoke to, although his complaint mentioned that it was shown to "several nursing staff including [a] house doc[tor]". He told HDC that he thought the mole had grown, and that it was painful and was leaking. There are no comments in the DHB1

[7] A form of arthritis that affects the spine and sacroiliac joints, characterised by long-term pain and stiffness.
[8] Folliculitis develops when bacteria, such as Staphylococcus, or a fungus enters the body through a cut, scrape, surgical incision, or other break in the skin near a hair follicle.
[9] A spreading bacterial infection just below the skin's surface.
[10] A procedure whereby a sterile needle and syringe are used to drain fluid from the joint.
[11] Dr C was employed by DHB1 for a year from mid 2011.
[12] A peripherally inserted central catheter (PICC) is a form of intravenous access that can be used for a prolonged period (eg, for chemotherapy regimens, extended antibiotic therapy, or total parenteral nutrition).
[13] Repair of an artificial hip joint.
[14] A device placed into the joint to maintain joint space and alignment.
[15] A ward dealing with surgical, orthopaedic, gynaecology and urology patients.

clinical records of any back lesion being present or observed at the time of the first stage of the hip joint revision.

32. Intraoperative theatre checklists on Mr A's clinical file (which include reference to a diathermy[16] plate used in the mid-back, as well as pre- and postoperative skin checks) do not mention any observation or presence of any notable skin lesion.

33. On 5 Month2, there is reference in physiotherapy progress notes to a "back wash" being performed. No concerns or issues are documented regarding the presence or observation of any lesion or mole on Mr A's back.

34. On 11 Month2, nursing notes for the morning, following an 8.10am ward round, include the following comment about a skin tag, as opposed to a mole or lesion, entered by RN D:

> "… Red skin tag[17] on back checked by [medical officer] [Dr C] — no new orders …"

35. RN D told HDC that she cannot recall whether the skin tag was checked during the ward round or afterwards. She also cannot recall whether she initiated the check or whether this was in response to Mr A raising a concern, or what the "skin tag" looked like. She said that reference to a skin tag would usually relate to something that was attached to, but hanging from, the skin. She said that skin tags are fairly common and are not something she would usually refer to a doctor, although she recorded it as a "red skin tag" in her notes, and it would be her usual practice to refer it to a doctor if the colour was unusual or concerning.

36. RN D said that her usual practice in orthopaedics is to check a patient's skin for unusual marks, cuts, or grazes, or anything carrying infection, and anything of concern she would refer to a medical officer to check. She said she would usually refer an unusually coloured skin tag to a doctor for this reason.

37. RN D stated:

> "It is therefore possible that I (as opposed to [Mr A]) raised the issue of the skin tag with [medical officer] [Dr C], although I cannot recall this. I have noted that there were 'no new orders'. By this I would mean that no intervention was required at the time."[18]

[16] Diathermy is a therapeutic treatment commonly prescribed for joint conditions such as rheumatoid arthritis and osteoarthritis. In diathermy, a high-frequency electric current is delivered via shortwave, microwave, or ultrasound to generate deep heat in body tissues.

[17] Skin tags are very common, soft, harmless lesions that appear to hang off the skin. Skin tags develop in both men and women as they grow older. They are skin-coloured or darker and range in size from 1mm to 5cm. They are most often found in the skin folds (neck, armpits, groin).

[18] RN D also told HDC that she recalled that another doctor (aside from Dr C) with the same first name had worked on acute ward at some point. DHB1 clarified from its employment records that another doctor with the same first name had indeed worked on the ward, but that particular doctor was employed by DHB1 from Month12 for 16 months only.

38. Dr C made ward round entries between 4 and 12 Month2 (except for 8 and 9 Month2 when she was off duty), and made additional "Resident Medical Officer notes" within the clinical records on 4, 5, 6 and 7 Month2 detailing Mr A's management plan.

39. On 11 Month2, Dr C made a short ward round entry at 8.10am prior to theatre. Dr C said that it was a routine ward round and primarily involved rewriting patients' medication. She said that she made no record of any examination, as she did not examine Mr A. She has no recollection of being asked to review a "skin tag" on 11 Month2, and said she could not account for the morning nursing entry by RN D.

40. Dr C also stated:

> "My standard practice when requested to review a matter, whether by the patient or by nursing staff, or if a management plan alters is to document this within the clinical notes. This would have been written as [a Resident Medical Officer] note such as those documented on the 4th, 5th, 6th, and 7th [Month2] for ongoing communication within the hospital and on discharge. This was of particular importance given the number of staff involved with [Mr A's] care …"

41. Mr A was discharged from Hospital 1 on 12 Month2. There is no reference to any back lesion or mole in the corresponding discharge summary sent to Mr A's primary care providers, the medical centre.

Review Month4

42. On 11 Month4, Dr E reviewed Mr A, who had a week of oral antibiotics remaining. His CRP[19] blood tests were normal. His mobility was improving. The PICC line was removed. The plan was to undertake regular blood monitoring and, once his antibiotics were finished, to have Mr A's hip aspirated.

Medical centre

43. The medical centre is a primary care practice operated by DHB1, and usually holds a doctor's clinic once a week. Mr A was a patient of the practice.

44. The medical centre's primary care records include entries relating to Mr A's care following his hip surgery in Month2. On 1 Month5, RNS F was on duty. She is based in a small town approximately 40km away, and her role covers a large geographical area. RNS F worked a seven day on/seven day off, 24-hour on-call roster with one other rural nurse specialist, RNS G.

45. RNS F told HDC that she travels over 1000km a week, servicing the needs of a population of 2000 (which over the holiday period may have been closer to 5000), and that the nature of her work means that she is often not in the office on a working day, making attending to administrative tasks more difficult. RNS F said that on 1 Month5 she would not have returned to the office at the end of the day.

[19] C-reactive protein (CRP) is a protein produced by the liver. Levels rise in response to inflammation. A normal result is <5mg/L.

Lesion noted — RNS F

46. On 1 Month5, RNS F saw Mr A at home and recorded the following:

> "Large haemangeous[20] lesion on back started to bleed. Cleaned and covered, advised to have checked asap, is seeing surgeon on [4 Month5] will get him to look."

47. RNS F told HDC:

> "[Mr A] would have phoned me, expressing that he had a spot on his back that was bleeding. This was the first occasion on which he presented with this. I saw him and cleaned and covered the area and advised him that this needed to be looked at as soon as possible. [Mr A] told me he was seeing the surgeon on [4 Month5] and I considered that, especially as we had no doctor's clinics over that period, it would be quite good to get the surgeon to look at it. I considered [Mr A] quite capable of and quite happy to ask the surgeon to look at the lesion. I recorded my advice in the patient notes."

48. RNS F later told HDC that she advised Mr A to have the lesion checked by a general practitioner (GP) as soon as possible. However, as it was New Year's Day, a GP would not be in the area for a further month. RNS F said that Mr A would have had to travel to the main township (a 90km round trip) to see a GP sooner. RNS F said that she was aware that Mr A was on a benefit and found the travel expense and cost of seeing a GP difficult. RNS F said that Mr A suggested that he show the mole to Dr E, whom he was seeing on 4 Month5. RNS F said that, owing to the unavailability of a doctor's clinic in Mr A's area in the next month, and her confidence in Mr A to raise this issue with Dr E, she agreed with Mr A's suggestion.

49. RNS F did not document any formalising of a request for an applicable medical review of the lesion, or any follow-up action to ensure that a review occurred.

50. RNS F acknowledged that no formal request was made to the orthopaedic surgeon or GP to see Mr A's lesion.

51. RNS F said:

> "In hindsight I recognise that I should have submitted a written request for review and noted this in my documentation. I could have also written a request to [Dr E] to look at the lesion for [Mr A] to take with him. My reasons for agreeing to [Mr A's] suggestion … are set out above."

52. RNS F considered that the practical aspects of her work as a rural nurse should also be taken into consideration. She said that she did not have a laptop at that time or access to electronic means of communication in order to send a formal request for Mr A to be reviewed. She also stated:

[20] Haemangioma-like. A benign tumour of vascular origin.

> "Having said that, I accept that I could have given a hand written note and asked [Mr A] to take it with him or made a written request when I returned back to the office on 3 [Month5] prior to going on leave."

53. RNS F was off duty from 6 Month5, returning on 12 Month5.

54. DHB1 stated to HDC:

> "[DHB1] agrees that any mole identified as bleeding on an on-going basis should be recognised as a symptom that requires further follow-up and investigation …"

Hip joint aspiration

55. On 4 Month5, Mr A saw Dr E at Hospital 1, and underwent aspiration of his right hip joint. He was discharged the same day. There is no reference in Dr E's operation note to a review, requested or otherwise, of any back lesion or mole.

56. Dr E told HDC:

> "[T]o the best of my recall no staff at [the medical centre] discussed or made me aware of [Mr A] having a mole/lesion on his back prior to him seeing me on the 4th [Month5]. To the best of my knowledge I did not view this lesion and [it] is unlikely that during the course of the hip aspiration on the 4th of [Month5] that I would have seen this."

57. Dr E also stated: "My focus of treatment for [Mr A] would have been on his hip problem. I am unable to recall seeing the lesion and as this is outside my normal scope of practice would not endeavour to make a diagnosis or treatment plan for this type of problem."

Further medical centre care

58. On 6 Month5, RNS G reviewed Mr A and recorded:[21]

> "Bloods taken and sent to Lab, area on back looking slightly better."

59. On 9 Month5, RNS G recorded in Mr A's clinical records: "[Mr A] informed of blood test results [from tests taken on 6 Month5] and [negative aspirate] happy with the news. For bloods and urine on the 13 [Month5]."

60. On 9 Month5, medical centre practice nurse RN I recorded the following:

> "Phone call from [rural] nurse [RNS G]
>
> [Patient] felt hip graunch when mobilising to toilet
>
> Nurse had taken bloods and CRP now 7
>
> ESR[22] has risen to 30

[21] This is the entire entry.

> [Rural] nurse to try for orthopaedic advice and [RN I] to ask [Dr N] to [review] results
>
> [RNS G] has spoken to [Dr E] and hip aspirate clear.
>
> Perhaps focus of infection is in his back lesion or due to aspiration procedure
>
> To watch and wait."

61. DHB1 later told HDC that the recorded comment that "[p]erhaps focus of infection is in his back lesion or due to aspiration procedure" was the view of Dr E as reported to RN I by RNS G.

62. In relation to the 9 Month5 telephone call from RNS G, RN I told HDC:

> "We arranged for [RNS G] to talk directly to the Orthopaedic Surgeon [Dr E] and I was to ask [Dr N] to review the blood test results; particularly the inflammatory markers. [RNS G] called back after speaking to [Dr E] and relayed that perhaps the focus of infection was in a lesion on the patient's back … A watch and wait plan was documented with a view to the Orthopaedic specialist reviewing both the hip and the back lesion at the next follow-up appointment."

63. RNS G told HDC:

> "I see from the MedTech[23] notes … that the practice nurse at [the medical centre] has recorded a conversation which I had with her on 9 [Month5]. I cannot now recall that conversation independently of the note so cannot elaborate any further on the contents."

64. RNS G later told HDC that she cannot recall having a discussion with Dr E relating to Mr A's back lesion. She said that if she had, she would have recorded it. She stated that she is unsure whether Dr E looked at Mr A's back lesion, as at that time the clinical focus was on Mr A's hip.

65. Dr E told HDC:

> "With regards to the documentation on the 9th of [Month5] which refers to discussions with myself about the possible source of [Mr A's] infection, this was not discussed with me … in my opinion it is very unlikely that this would be the cause of his hip infection and to the best of my recall this was not discussed with me as a potential cause of his infection."

66. On 9 Month5, Dr N recorded:

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[22] The erythrocyte sedimentation rate (ESR) is a non-specific test (measuring the rate at which red blood cells settle) to help detect inflammation associated with conditions such as infections, cancers, and autoimmune diseases. Normal range is 0–20mm/hr.
[23] Patient management software.

> "? source of rise of ESR was due to a procedure or a possible infected spot on the back; so observe at present as per advice via [RN I] from specialist."

67. Dr N told HDC that to his knowledge he did not speak to Dr E at any stage. Dr N was not Mr A's usual GP, and had not been directly involved with Mr A's care.

68. On 11 Month5, RNS G recorded: "Lesion seems to be decreasing looks paler, for bloods and urine …"

69. On 12 Month5, RNS F saw Mr A again and recorded:

> "Bloods taken, area on back flattened out and no longer draining, no cellulitis present."

70. RNS F told HDC that, upon returning to duty on 12 Month5, she read through Mr A's notes and saw the entry in MedTech by RN I dated 9 Month5. RNS F said:

> "I took this to mean that [Dr E] had seen [Mr A's] back and had discussed it with the nurse. Later in the day, I saw [Mr A] and dressed his back. I asked [Mr A] what [Dr E] had to say about his back. [Mr A] said to me that he ([Dr E]) saw it and would refer him ([Mr A]) on to have it dealt with. I recorded in the notes on MedTech that the lesion was flattened out and no longer bleeding."

71. RNS F had no direct communication with Dr E regarding the lesion. She did not record her discussion with Mr A in the clinical notes.

72. RNS F stated:

> "I did not document my conversation with [Mr A] on 12 [Month5] which again was a mistake. Since this I have been much more precise in my documentation, recording every conversation that I have with patients that are relevant to their healthcare."

73. On 13 Month5, RNS F recorded: "[G]iven blood results ESR and CRP back in normal range …"

74. RNS F said that Mr A did not mention his back to her again until 5 Month11 (discussed below). In the intervening period, RNS F saw Mr A in relation to his hip infection a further 10 times, predominantly to take blood for testing.

Hip revision stage 2 admission, 29 Month5 to 4 Month6

75. On 29 Month5, Mr A was admitted to Hospital 1 for the second stage of his hip joint revision surgery. DHB1 clinical notes describe a normal physical examination. On 30 Month5, Dr E performed the second stage of the hip joint revision procedure.

RN H

76. Inpatient nursing notes for 1 Month6 include an entry made by a surgical ward registered nurse, RN H, at 3.45pm:

> "Pt has mole in upper back area that appears to be bleeding small amount — Pt states this has been an ongoing problem."

77. RN H told HDC:

> "I do recall washing [Mr A's] back because he had numerous moles covering his back. I do not have a recollection of what the lesion I have documented looked like. There was only a very small amount of blood and it did not require a dressing …
>
> It is my usual practice to refer significant observations unrelated to the reason for the current admission such as this bleeding mole to the Resident Medical Officer, although I cannot recall the actions I took on observing this mole. I accept that I have not documented this follow-up action in the clinical notes. This may have been due to a lack of concentration when documenting."

78. There is no reference in the clinical record to any action taken by RN H with respect to monitoring of the lesion, or initiation of a medical review. There is no reference to Mr A's back lesion in subsequent notes during his admission.

79. RN H stated that it was her usual practice on handover to verbally report any observations she has written in the nursing notes to the staff for the next shift, and she would have reported her observation of the mole/lesion to the next shift. There is no further reference to the lesion in the clinical notes for 1 Month6. RN H was not directly involved in Mr A's care for the remainder of his admission.

80. DHB1 stated:

> "[DHB1] acknowledges that it would be reasonable to expect that a bleeding mole was referred for a medical review and that on-going monitoring should occur."

81. RN H accepted that a mole identified as bleeding on a regular basis requires a medical review.

82. In RN H's response to the provisional report, via her New Zealand Nurses Organisation representative, she stated that she accepted that "the clinical record that she made on 1 [Month6] did not document the follow-up action that she took on having identified a mole that was bleeding". She did not accept that she failed to take reasonable steps to ensure that the lesion was monitored or medically reviewed. She submitted that in light of her usual practice it was probable that she referred the lesion for review.

83. Mr A was discharged on 4 Month6. There is no further reference in Mr A's DHB1 records from this admission to a mole or lesion on Mr A's back.

Referral to physician

84. On 14 Month9, Dr E reviewed Mr A's hip. Dr E referred Mr A to DHB1 general physician Dr J for review and advice on managing the recurrent infections in Mr A's prosthetic hip joint. There is no reference in Dr E's clinical records to a mole or lesion on Mr A's back being noted or discussed on 14 Month9.

85. On 13 Month10, Dr J reviewed Mr A. The issue of recurrent infections was addressed[24] and, at the end of the consultation, it was also noted:

> "[Mr A] asked me to look at a lesion on his back, which he told me had been present for some time (certainly over a year) and had been bleeding. He told me he had drawn other doctors' attention to this previously. I found a fungating, friable, non-pigmented tumour between his scapulae. This was clearly malignant, and I referred him to the surgical department for excision."

86. Dr J at first thought the lesion might be a squamous cell carcinoma because the tumour was non-pigmented. Dr J's referral letter to the surgical department is dated 13 Month10.

Primary care visits and referral action

87. There is no further reference to Mr A's back lesion in his DHB1 or medical centre records until 5 Month11, when RNS F recorded:

> "Haemangeous growth on back has doubled in size, very friable … to see doc on [10 Month11][25] …"

88. On 11 Month11, RNS G redressed Mr A's lesion and recorded:

> "Area on back looks like a fungating small tumour, appt made to see [a GP] tomorrow …"

89. At 8.44am on 11 Month11, RN I (who was on duty as a medical centre triage nurse) received a telephone call from RNS G regarding her review of Mr A. RNS G told HDC that she cannot recall the telephone call.

90. RN I noticed that Dr J had sent a referral to the DHB1 surgical department on 13 Month10. The referral had been prioritised as semi-urgent. She called the DHB1 central booking unit to confirm this, and arranged for Mr A's referral to be expedited. RN I recorded:

> "… [R]e this man having a lesion on his back which is changing rapidly
>
> RNS concerned that lesion has grown rapidly and may be fungating (odour and appearance suggest this)
>
> Booked with [a GP] for review of lesion.
>
> [Central booking unit] phoned and message left to check if referral sent by [Dr J].
>
> Confirmed that … prioritised semi-urgent
>
> [GP] to consider reprioritisation request letter … for urgent action."

91. RN I had no further involvement in Mr A's care.

[24] Dr J advised that as Mr A's problem was difficult he also sought some advice from an infectious diseases physician.
[25] Mr A was not reviewed by a doctor until 12 Month11.

92. On 12 Month11, the GP saw Mr A and recorded:

> "Lesion on back now bleeding most days [discussed with general surgeon] [Dr K] who will see him directly at his next … clinic for excision of this lesion booked for 26 [Month11] [Dr K's] clinic."

Excision

93. On 26 Month11, DHB1 general surgeon Dr K reviewed and excised the tumour. It was found to be an aggressive malignant melanoma. Removal of the lesion was complex because of its fungating nature, size, and Mr A's general inability to lie flat owing to his comorbidities. Primary closure of the wound required deep heavy sutures due to the large size of the wound.

94. Mr A's recovery was complicated by infection of the wound. He was treated with antibiotics, and dressings were managed by the rural district nurses.

Further review

95. On 15 Month12, Dr K reviewed Mr A. Dr K noted the histology report, which was of a malignant melanoma. Mr A was referred for staged abdomen and chest computed tomography (CT) scans and also referred to oncology and anaesthetic services for evaluation prior to wider excision. A CT scan on 15 Month12 showed nodules in Mr A's left thyroid and right lung — the latter suspicious of metastases.

96. On 31 Month12, Mr A saw a medical oncologist who arranged for a Lung Cancer Multidisciplinary Meeting (MDM) to discuss Mr A's care and treatment. In his oncology clinic letter dated 31 Month12, the medical oncologist summarised the history of Mr A's lesion as relayed to him by Mr A:

> "He has had a mole in that region for thirteen to fourteen years and towards the latter part of 2011 it began to increase in size and also began discharging and bleeding. He drew it to the attention of a number of practitioners, including surgeons here at [Hospital 1] and was reassured about its potential nature … [Mr A] is obviously quite upset at what he perceives as an unacceptable delay in doctors getting round to removing his melanoma. I have given him contact details for the Patient Advocacy Service to help him work through these issues."

97. On 17 Month13, Mr A's original scar was re-excised with a wider circumferential margin of 1cm. No residual melanoma was identified. Because of anaesthetic concerns, the procedure was performed using local anaesthetic with Mr A in a sitting position.

98. On 21 Month15, Mr A required excision of a subcutaneous recurrence of the tumour, which had been detected by a CT scan on 12 Month15. The excision was performed by Dr K under local anaesthetic. A biopsy showed recurrent melanoma.

99. Dr K discussed Mr A's recurrent melanoma with DHB2 plastic and reconstructive surgeon Dr M. On 30 Month15, Dr M saw Mr A at a clinic, and she arranged urgent re-excision of the melanoma.

Care provided at DHB2

100. On 19 Month16, the re-excision of Mr A's melanoma was undertaken at a hospital in DHB2. The excision was performed under local anaesthetic, as Dr M and her colleagues felt that it had to be done without delay. Dr M also was of the view that Mr A had significant co-morbidities, which were major risk factors for general anaesthesia, particularly in the prone (face down) position.

101. Dr M told HDC that the extent of the excision was probably at the limit one would attempt under local anaesthetic, and "no doubt was difficult for patient and surgeon".

102. Dr M told HDC that she apologised for any distress Mr A experienced, but said that the clinical reasons for a local anaesthetic were justified, and these had been discussed with Mr A prior to surgery. Mr A healed well after the surgery.

103. Mr A later developed further metastatic nodules on his back. Dr M reviewed him on 7 Month19. She arranged for a magnetic resonance imaging (MRI) scan and surgery in DHB2. The MRI scan showed further nodules in the subcutaneous tissue of Mr A's back. Dr M ordered a PET[26] CT scan.

104. On 19 Month19, Mr A was admitted to the plastic surgery ward at a different hospital in DHB2 (Hospital 2). On 20 Month19, Mr A had a further excision of the original melanoma, and a split skin graft. The nature of this procedure, and the size and location of the area to be removed, meant that the surgery had to be done under general anaesthetic with Mr A in the prone position. Dr M said that only about half of the skin graft became adhered. Mr A had a second stage skin graft two weeks later on 3 Month20.

PET CT scan transport

105. Dr M saw Mr A on 27 Month19, and discussed the planned PET CT scan. Dr M explained to Mr A that she thought that it would not be performed until four weeks after the skin graft surgery.

106. Dr M told HDC that she discussed the PET CT scan with the radiologist, who advised that the scan could go ahead earlier.

107. Due to the change of plan at short notice, there was nursing miscommunication around booking transport for Mr A to the PET CT scan, and Mr A's family transported him by taxi to a private hospital. There were delays, and he went without food for a long period.

108. DHB2 responded directly to Mr A's daughter, Ms B, on this issue:

> "Your father had an appointment to go to [a private hospital] on 26 [Month20], and given his condition, staff should have booked an ambulance to transfer him to that appointment at the earliest possible opportunity, and due to the delay in booking an ambulance there was not one available at the time, necessitating

[26] A positron emission tomography (PET) scan is a type of imaging test. It may help evaluate organ and tissue functions. By identifying body changes at the cellular level, PET may detect the early onset of disease before it is evident on other imaging tests.

> transfer by taxi. Although staff provided an escort and ensured pain relief given, and provision of a pressure relief cushion, your father would have been more comfortable travelling by ambulance."

109. An apology was offered by DHB2 for any distress caused.

110. DHB2 told HDC:

> "The plastic surgery department has reflected on [Mr A's and Ms B's] concerns and takes on board the importance of clear communication to patients and their families regarding such plans, particularly when there are changes at short notice."

111. The PET scan report noted that the right lower lung nodule was likely to be a metastasis.

Dressing change, Month20

112. DHB2 told HDC that at the time of Mr A's admission to the plastic surgery ward, the ear, nose and throat (ENT) ward had been relocated to temporarily co-sharing with the plastic surgery ward, as there is some synergy with their respective patient groups, including reconstructive surgeries and managing grafts.

113. During this co-share period, the nursing teams combined to run the roster for the whole ward, so staff from both teams worked with patients from both specialties. Only for more complex patients would a dedicated Plastics or ENT nurse have been assigned as applicable.

114. On 8 Month20, Mr A was administered analgesia in accordance with his prescription,[27] prior to having his donor site[28] dressing removed by an experienced ENT registered nurse, RN L. The dressing removal was undertaken with Mr A in the shower.

115. Mr A told HDC that the dressing removal was extremely painful, and made him scream as RN L "ripped off the dressings down to bare flesh from the donor site". He also stated that RN L called him a "sook".

116. RN L told HDC the following:

- It is easiest to remove donor site dressings in the shower.
- She ensured that Mr A had received analgesia prior to taking him to the shower, as she was aware that the dressing changes were painful.
- Mr A became distressed when the water got underneath the dressing, as it was hitting the raw skin of his donor site.
- She removed the dressing quickly in the hope of quickly relieving the pain that Mr A was experiencing.
- She does not remember calling Mr A a "sook".

[27] M-Eslon slow release, prescribed and administered twice a day (morning and evening) and Sevredol "as required" (PRN). Mr A was administered Sevredol at 8.00 and 11.00am.
[28] The portion of the body from which an organ or tissue is removed for transplant or grafting.

- She apologised to Mr A during the procedure, and again when he was back on his bed, for causing so much pain.
- She also apologised to Mr A's wife, who was present on the ward, and who went into the shower room to comfort her husband.
- She administered analgesia to Mr A after the dressing change.

117. The Acute Pain Service (APS) nursing documentation for 8 Month20 does not record the dressing change, or that Mr A experienced acute pain, and does not evaluate his pain experience against the administered analgesia. The documentation does not record whether Mr A received his prescribed paracetamol[29] on three occasions on 8 Month20.

118. Mr A was upset, experienced discomfort, and had very little sleep following the dressing change on 8 Month20. The APS review notes for 9 Month20 record "… 7/10 pain — constant, 'crying like baby'…", although it is not clear from the record which staff member made this entry.

119. RN L said that, with the benefit of hindsight, she considers that the use of '*Remove*' (an adhesive solvent) would have helped ease some of the discomfort that Mr A experienced.

120. RN L extended her sincere apologies to Mr A and his wife for the distress and pain that she caused.

121. Sadly, a few months later, Mr A died as a result of his melanoma.

Subsequent events and improvements

122. RNS F told HDC:

> "I consider that I have taken on board [HDC's] Nursing advisor's comments and improved my practice. I would like to say that I genuinely thought [Mr A's] back had been seen and that he was awaiting a referral, but I did not check the system to see if this had happened, which is not a mistake I will make again."

123. RNS F said that since this incident she has made a number of changes to the way she works, including:

- using an electronic tablet for ease of contemporaneous note-taking;
- being recently provided with a laptop, allowing better access to patient notes;
- ensuring that any lesions are seen in a timely manner and followed up to check that a review has been completed. In similar circumstances, she would now submit a written request for review; and
- undergoing an in-house training session on documentation.

124. RN H told HDC that, since this event and becoming aware of her error, she has ensured that all verbal communication between herself, a patient, and/or other health

[29] Prescribed four times daily.

professionals is included in the progress notes. She said that she would pursue a refresher course on documentation.

125. DHB1 reported to HDC the following areas of change and improvement since these events:

- ISBAR[30] essential skills training amongst frontline clinical staff has been rolled out across primary and secondary services within DHB1.
- The acute ward Nurse Manager regularly reinforces compliance with documentation requirements. All clinical staff are required to attend documentation training as a core prerequisite before working on units.
- An electronic clinical record system is now in operational use — allowing clinical staff across service areas better access to patient records.
- As the nature of skin lesion care prevents standardised care plans, DHB1 routinely includes skin lesion concerns in individualised patient care plans as a means of monitoring treatment progress.
- District nurses, practice nurses, and charge nurses have access to MedTech notes. The rural nurse specialist is equipped with remote rural wireless access via laptop and cellphone.
- A shared knowledge and clinical expertise approach exists between DHB2 and DHB1 via access to specialist knowledge and support.

DHB1 guidelines

126. DHB1 policies and procedures relevant to this matter include intranet guidance, which includes a section on melanoma (cutaneous). A sub-section on melanoma assessment is sourced from the November 2008 Ministry of Health practitioner resource (the MOH resource) "Melanoma: an aid to diagnosis",[31] which notes that "[m]elanoma may be found opportunistically during clinical examination for other indications". A highlighted practice point in relation to the history of a lesion is that "pain and/or bleeding are rare and may indicate an advanced or a nodular melanoma".

127. The MOH resource outlines the "ABCDE" method of clinical diagnosis,[32] as well as the "seven point checklist" for use in clinical assessment (which includes oozing crusting, or bleeding). The MOH resource notes that biopsy or referral should be considered for all suspicious lesions, and highlights that "the bottom line is that practitioners should strongly consider excision for lesions that are unusual, new, changing, or difficult to diagnose".

[30] Identity, Situation, Background, Assessment, Recommendation. The ISBAR communication framework is used to create a structured and standardised communication format between healthcare workers. It is particularly useful for reporting changes in a patient's status and/or deterioration between healthcare services or shifts.

[31] Which in turn is drawn from the reference: Clinical Guidelines on the Management of Melanoma in Australia and New Zealand — NZ Guidelines Group and Australian Cancer Network Guidelines.

[32] Asymmetry, Border irregularity, Colour variation, Diameter, Evolution.

Responses to provisional opinion

128. Ms B provided verbal feedback to HDC in response to the "information gathered" section of the provisional report. This has been incorporated into the report where relevant.

129. RNS F's response to the provisional report, via her NZNO representative, made the following key points:

- RNS F accepted that "although the circumstances and work practices of the Rural Nurse Specialists at the time of her involvement with [Mr A] made it more difficult to attend to administration tasks and follow-up, that she should have ensured that she confirmed arrangements for follow-up on [Mr A's] lesion in writing and followed up directly with the provider on any referrals made".
- She sincerely regretted that the care provided was not as thorough as it should have been on this occasion, and has made a number of changes to her practice since these events.
- RNS F acknowledged that she should have documented her conversation with Mr A on 12 Month5. She accepted that this represented a departure from relevant standards, but submitted that this was a minor departure and "when documenting interactions with patients, taking into account the time constraints on practitioners and the environments in which practitioners sometimes work, whilst it is appropriately an expected standard that all discussions with patients are documented, not every discussion between practitioner and patient will be documented in full. At the time of seeing [Mr A], [RNS F] would travel back to the clinic and rewrite her notes in the system."
- RNS F provided an apology for forwarding on to Mr A's family.

130. DHB1's response to the provisional report included the following key points:

- The issues raised by this case relating to documenting descriptions of skin features is being tabled at its Quality Improvement Team meeting for review.
- There is a disproportionate focus on nursing staff in relation to Mr A's back. On clinical review of the case, DHB1 considered that documentation was an issue across all disciplines. It advised that work is underway to address the issues identified around documentation, including a review of the audit process for clinical documentation across all disciplines.
- DHB1 wished to communicate to Mr A's family that it was sorry that he died as a result of melanoma and that there were lapses in the care he received. It wished to reassure Mr A's family that a lot had been learned from the case and it was committed to making changes across DHB1 to improve care.

131. DHB2 accepted HDC's findings. It acknowledged that there were shortcomings in communication and planning regarding Mr A's transportation to the private hospital.

132. DHB2 and RN L were sorry Mr A's dressing change was so painful and distressing for Mr A, and acknowledged that a more proactive approach to assessing and monitoring his pain should have occurred. RN L will provide an apology letter for forwarding to Mr A's family.

Opinion: Preliminary comment

133. When Mr A presented to Hospital 1 in Month1/Month2 and Month5/Month6, it was because he had been experiencing long-term difficulties with infection of his right hip prosthesis. I am mindful that this was the focus of his admissions and it was in this orthopaedic clinical context that an incidental issue of a concerning lesion present on his back was identified, and that Mr A was a patient who had many different moles and markings on his back.

134. I acknowledge that concerns about the lesion were appropriately documented by RNS F on 1 Month5 and again by RN H on 1 Month6.

135. Once identified, however, Mr A had the right to have his lesion followed up and treated in accordance with accepted standards.

136. It is unclear precisely when Mr A first raised concerns about the lesion on his back, and what exactly he may have told DHB1 staff. I acknowledge that, given the time elapsed since these events, recall may be limited. In his complaint to HDC, Mr A considered that he raised his concerns during his first-stage hip joint revision admission to Hospital 1 in Month2. While the clinical records for 11 Month2 reference a "red skin tag", the first reference to a lesion on Mr A's back was a note made by RNS F on 1 Month5.

137. I am unable to reconcile whether Mr A identified to staff at DHB1 a lesion on his back during his admission in Month2. I am also unable to reconcile the conflicting evidence as to whether Dr C reviewed a red skin tag, or whether that skin tag was the same as the lesion later identified on Mr A's back.

138. I am satisfied that, from the time Mr A brought the lesion to the attention of Dr J on 13 Month10, the care provided to him by DHB1 was reasonable in the clinical circumstances.

139. Accordingly, this report considers whether, between 1 Month5 (when the lesion was first documented) and 13 Month10, key DHB1 staff took appropriate action in response to the identification and documentation of Mr A's concerning lesion, including organising a timely referral for it to be reviewed medically.

Opinion: RNS F — Breach

Failure to refer

140. After his discharge from Hospital 1 on 12 Month2, Mr A had frequent contact with medical centre nursing staff. The first mention of Mr A actively raising the issue of a concerning lesion that is supported by the clinical record is on 1 Month5.

141. It is documented on that day that RNS F was concerned about the nature of the lesion present on Mr A's back. RNS F documented:

> "Large haemangeous lesion on back started to bleed. Cleaned and covered, advised to check asap, is seeing surgeon on [4 Month 5] will get him to look."

142. RNS F told HDC that this was the first time Mr A had mentioned the lesion to her. She said she advised Mr A that it needed to be looked at as soon as possible. As Mr A was seeing orthopaedic surgeon Dr E regarding his hip on 4 Month5, RNS F considered that it would be helpful to get the orthopaedic surgeon to review Mr A's lesion.

143. I am critical of RNS F's decision to rely on her patient to raise the need to review the lesion.

144. I acknowledge that, in this particular rural setting where primary care doctors' clinics were not frequently and readily available, RNS F was mindful of the issue of timely review of the lesion when she considered the availability and use of Dr E, an orthopaedic surgeon.

145. However, RNS F did not bring the lesion directly to Dr E's attention, or communicate with Dr E (or any other clinician) directly, to ensure that Mr A's lesion was reviewed. I consider that, having identified the lesion, it was RNS F's responsibility to ensure prompt medical review of the lesion. I note that it was also open to RNS F to bring the lesion to the attention of Mr A's usual GP, and this did not occur either.

146. RNS F has acknowledged that she did not make a formal written request to Dr E for review of Mr A's lesion, and could have done so.

147. Dr E told HDC that, when he saw Mr A on 4 Month5 for the hip aspiration, he was not made aware of any mole or lesion. Dr E's clinical record of the hip aspiration procedure made no reference to any back lesion.

148. My in-house clinical advisor, Dr David Maplesden, advised:

> "I do not think it was reasonable that an orthopaedic surgeon assessing the patient's hip should review an apparently unrelated and longstanding skin lesion, certainly without a formal written request to do so including the clinical rationale for making such a request …"

149. I do not rely on Dr Maplesden's opinion of the nursing assessment in forming a view of its adequacy, but I am mindful of his view as a clinician in the primary care context.

Follow-up with Dr E

150. RNS F was off duty from 6 Month5 to 12 Month5. Her colleague, RNS G, saw Mr A in this period to review his hip recovery.

151. I have been provided with conflicting accounts about the nature of nursing staff contact with Dr E about the lesion during this period.

152. Practice nurse RN I recorded on 9 Month5 that she had received a call from RNS G about Mr A experiencing a graunching of his hip, and his blood tests (a slightly raised CRP and ESR) indicating infection.

153. RN I's 9 Month5 medical centre entry records information relayed to her by RNS G. In my view, the latter part of RN I's entry — "… [RNS G] has spoken to [Dr E] and hip aspirate clear …" — indicates that RNS G said that a discussion had taken place about Mr A's hip infections.

154. However, it is difficult to determine conclusively whether the view in the next line of the entry — "… Perhaps focus of infection is in his back lesion or due to aspiration procedure …" — is attributable to RN I, RNS G, or Dr E.

155. RNS G told HDC that she could not recall her discussion with RN I, and could not recall having a discussion with Dr E regarding Mr A's lesion.

156. Dr E told HDC that the possible source of Mr A's infection was not discussed with him. Dr E also told HDC, upon review of the complaint, that in his opinion it was very unlikely that Mr A's back lesion would have been the cause of his hip joint infection.

157. RNS F told HDC that, on 12 Month5, she reviewed the earlier notes made by her colleagues and was under the impression that Dr E had seen Mr A's back and had discussed the lesion with RNS G.

158. RNS F told HDC that she saw Mr A on 12 Month5 and dressed his back, and that Mr A told her that Dr E had seen the lesion and would refer him on to have it dealt with. RNS F recorded in MedTech that the lesion had flattened out and was no longer bleeding, but did not record any discussion with Mr A.

159. RNS F did not have any direct formal communication with Dr E, or any other colleague, to confirm whether Dr E had reviewed Mr A's lesion, or whether a formal referral to review Mr A's lesion had been instigated. I accept her account that Mr A told her that Dr E had reviewed the lesion and would refer him on. However, it was unsafe to have left the matter in her patient's hands and, in my view, a prudent practitioner would have more actively followed this up. In my view, RNS F failed to "close the loop", and should have formally confirmed with colleagues that appropriate action to follow up Mr A's lesion had been taken.

160. My in-house nursing advisor, Ms Dawn Carey, advised:

> "In my opinion, [RNS F] should have followed up to ensure that the recommended review occurred. I would consider the failure to do so to constitute a moderate

> departure from expected standards of care. For the purpose of clarity, follow up in this context required communication between the providers — [RNS F] and the surgeon."

161. I agree with and accept Ms Carey's advice.

162. I am also concerned that RNS F did not document her discussion with Mr A. Accurate documentation is a critical element of nursing practice. Clinical records must be accurate and concise, and include the care that is given or planned. Discussions held with the wider healthcare team and the consumer also need to be captured.[33]

Conclusion

163. I note that RNS F has acknowledged her shortcomings in this case and has made changes to her practice. Nevertheless, upon forming her clinical view on 1 Month5 that Mr A's lesion required review, RNS F left it to her patient to progress the matter, and she did not fulfil her responsibility for instigating a written medical referral or following up with her colleagues to ensure that a medical review of Mr A's lesion took place in a timely manner. I remain of the opinion that RNS F did not provide nursing services to Mr A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

164. I am critical that RNS F failed to record her 12 Month5 conversation with Mr A.

Opinion: RN H — Breach

165. On 29 Month5, Mr A was admitted to Hospital 1 for stage two of his hip joint revision. On 30 Month5, the right hip joint replacement procedure took place.

166. Nursing notes on the surgical ward for 1 Month6 include the following within RN H's afternoon entry:

> "… Pt has mole in upper back area that appears to be bleeding small amount — Pt states this has been an ongoing problem …"

167. From this point on, I note that RN H's entry about the lesion was within the DHB system.

168. RN H stated that her usual practice involved bringing incidental issues such as this to the attention of a medical colleague, but she cannot recall whether she did this in Mr A's case, and she has acknowledged that she did not document any follow-up action in the clinical notes. RN H also accepted that a mole identified as bleeding on a regular basis requires a medical review.

169. RN H submitted, in response to my provisional report, that it was probable that she referred the lesion for review based on her usual practice.

[33] New Zealand Nurses Organisation (NZNO), Documentation (Wellington: NZNO, 2010).

170. RN H stated that part of her usual practice at handover was to read from her patient notes to staff on the next shift. However, there is no evidence in the DHB1 clinical records for this admission (29 Month5 to 4 Month6) that Mr A's lesion was subsequently monitored or medically reviewed.

171. The importance of the medical record is well established. Baragwanath J acknowledged the importance of medical records in *J v Director of Proceedings*, stating that meticulous record-keeping is a fundamental obligation of the practitioner.[34] Indeed, this Office has often observed that providers whose evidence is based solely on their subsequent recollections (in the absence of written records) may find their evidence discounted.[35]

172. RN H was not directly involved in Mr A's care for the remainder of his admission. In my view, it was very important for continuity of care that RN H followed DHB1 guidelines on melanoma assessment, and took responsibility for following up and instigating the necessary process to ensure that a review of the lesion took place.

173. The next documented occasion on which Mr A had his lesion reviewed was not until 13 Month10, when Mr A himself brought it to the attention of Dr J.

174. Ms Carey advised:

> "Whilst I accept that not all incidences of a mole bleeding, are a cause for concern, I am critical that there is no evidence that the RN considered the need for ongoing monitoring of [Mr A's] mole or sought a medical review. I am critical of the lack of follow-up in this instance as the bleeding was presented as an ongoing problem, which I consider to be a concerning feature that would require referral and investigation. In my opinion, the failure to monitor the status of [Mr A's] mole or initiate a medical review [constitutes] a moderate departure from the expected standards of nursing care."

175. I agree with and accept Ms Carey's advice. In my opinion, RN H, upon identifying Mr A's bleeding lesion on 1 Month6, failed to take reasonable steps to ensure that the lesion was monitored or medically reviewed, and this amounted to substandard nursing care. I remain of the opinion that RN H did not provide nursing services to Mr A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Opinion: DHB1 — No breach

176. DHB1 had a duty to ensure that services were provided to Mr A that complied with the Code. In addition, under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority may be vicariously liable for acts or omissions by an employee. Under section 72(5), it is a defence for an employing

[34] *J v Director of Proceedings* HC Auckland CIV-2006-404-2188, 17 October 2006 at [63] per Baragwanath J.
[35] See, for example, Opinion 04HDC03530 (14 February 2006), p 28.

authority to prove that it took such steps as were reasonably practicable to prevent acts or omissions leading to an employee's breach of the Code.

177. This Office has previously found providers not liable for the acts or omissions of staff, when those acts or omissions clearly relate to an individual clinical failure made by the staff member.[36]

178. I consider that DHB1 had a reasonable melanoma management policy and process in place, including referring staff to a Ministry of Health clinical assessment of melanoma resource for guidance, and had therefore taken steps that were reasonably practicable to prevent acts or omissions such as those identified by RNS F and RN H, which in my view were individual failings. Accordingly, I do not consider that DHB1 is directly or vicariously liable for RNS F's and RN H's breaches of the Code.

Opinion: DHB2 — Adverse comment

179. Once Mr A was referred to DHB2, further care was carried out under some urgency. In Month16, plastic and reconstructive surgeon Dr M arranged and performed urgent re-excision of the melanoma area.

180. I acknowledge that Mr A experienced some distress during the re-excision. However, I note that the surgery was undertaken urgently under local anaesthetic, with Mr A in a sitting position, to avoid any delay and reduce risk, and with Mr A's best interests in mind. I am satisfied that the care provided at this point was appropriate in the circumstances.

181. Mr A later developed further metastatic nodules. On 7 Month19, Dr M reviewed him and arranged for an MRI and surgery. The MRI showed further nodules in the subcutaneous tissue of Mr A's back. Dr M ordered a PET CT scan.

182. On 20 Month19, Mr A had further surgery. The surgery had to be performed under general anaesthetic, with Mr A in the prone (face down) position. Mr A had a second skin graft two weeks later, on 3 Month20.

183. On 27 Month19, Dr M saw Mr A and discussed the planned PET CT scan. Dr M explained to Mr A that she thought that the PET CT scan would not be performed until four weeks after the skin graft surgery.

184. However, Dr M was subsequently contacted by a radiologist and advised that the PET CT scan could go ahead earlier. Due to the change of plan at short notice, there was some nursing miscommunication regarding booking transport for Mr A. Mr A's family transported Mr A by taxi to a private hospital for the PET CT scan.

185. DHB2 informed Mr A's daughter, Ms B, that her father had an appointment at the private hospital on 26 Month20, and that nursing staff should have booked an

[36] For example, Opinion 12HDC01483 (12 July 2013), available at www.hdc.org.nz.

ambulance to transfer him to that appointment at the earliest possible opportunity. Due to the delay in booking an ambulance, there was not one available at the time, necessitating transfer by taxi. An apology was offered by DHB2 for any distress caused.

186. DHB2 told HDC:

> "The plastic surgery department has reflected on [Mr A's and Ms B's] concerns and takes on board the importance of clear communication to patients and their families regarding such plans, particularly when there are changes at short notice.

187. I am critical of the inadequate arrangements and poor communication regarding Mr A's transport, which could certainly have been improved.

Opinion: RN L — Adverse comment

188. Mr A told HDC that, overall, he considered that the nursing care he received on the plastic surgery ward was very good. However, he identified an exception.

189. On 8 Month20, Mr A was administered analgesia in accordance with his prescription, prior to having his donor site dressing removed by RN L. Mr A told HDC that the dressing removal was extremely painful and made him scream. He also alleged that RN L called him a "sook".

190. Mr A said that he experienced discomfort and had very little sleep following the dressing change on 8 Month20. The Acute Pain Service (APS) review notes for 9 Month20 include "… 7/10 pain — constant, 'crying like baby'…", although it is unclear from the record which staff member made this entry.

191. RN L responded that it is easiest to remove donor site dressings in the shower, and said that she ensured that Mr A had received prior analgesia, as she was aware that the dressing changes were painful. She said that Mr A became distressed when the water got underneath the dressing, as it was hitting the raw skin of his donor site. She said she removed the dressing quickly in the hope of relieving any pain. She does not remember calling Mr A a "sook". She apologised to Mr A during the procedure, and again when he was back on his bed. She administered analgesia to Mr A after the dressing change.

192. RN L said that, with the benefit of hindsight, she considers that the use of "*Remove*" (an adhesive solvent) would have helped ease some of the discomfort that Mr A experienced. RN L extended her sincere apologies to Mr A and his wife for the distress and pain that she caused.

193. Ms Carey agreed with Mr A that, overall, he received very good nursing care on the plastic surgery ward. Ms Carey advised that it is good practice to review administered analgesia prior to carrying out procedures such as dressing changes. She acknowledged that patients usually find donor site dressing changes considerably

more painful than the graft site, which can make the initial dressing change very challenging. Ms Carey also agreed that using water via a shower helps remove dressings and can help make the experience easier for the patient.

194. However, Ms Carey identified some mild departures from nursing standards. She advised that the APS nursing documentation for 8 Month20 does not record the dressing change, or that Mr A experienced acute pain, and does not evaluate Mr A's pain against the administered analgesia.

195. Ms Carey advised:

> "Objective pain assessment tools provide opportunities for the RN to explain the role of analgesia, and evaluate whether the prescribed analgesia and dose is effective or not. Inadequate pain management increases incidences of complications due to inadequate mobilisation or deep breathing, and leaves patients feeling uncared for and vulnerable … In my opinion, a more proactive approach to assessing and monitoring [Mr A's] pain experience on 8 [Month20] should have occurred."

196. I agree with Ms Carey, and am critical that RN L did not objectively assess and record Mr A's dressing change and his pain, with reference to evaluating the effectiveness of his analgesia.

Recommendations

RNS F

197. In my provisional report I recommended that RNS F:

a) provide a formal written apology to Mr A's family. The apology was to be sent to HDC in the first instance, within three weeks of this report being issued, for forwarding on;

b) provide HDC, within three months of this report being issued, an update on the effectiveness of her use of an electronic tablet for ease of contemporaneous note-taking, and the use of a laptop to allow better access to patient notes, in the context of rural nursing;

c) provide HDC, within three months of this report being issued, evidence of her further training and education relating to documentation; and

d) participate in refresher training on assessment, management, and arrangement of referrals to review suspicious moles/skin lesions, and documentation relating to such matters, and provide evidence of this to HDC within three months of this report being issued.

198. In response to my provisional report, RNS F:

a) provided HDC with an apology letter for forwarding to Mr A's family;

b) provided a reflective report to HDC on the effectiveness of her recent use of an electronic tablet and laptop in her role. She said that she has found this to be of significant advantage in making contemporaneous notes;

c) provided evidence of recent attendance at an educative rural nursing seminar on documentation, and a refresher course on electronic referrals; and

d) arranged for a specialist refresher teaching session on recognition of lesions and appropriate referrals, through the Director of Nursing at Hospital 1.

RN H

199. In my provisional report I recommended that RN H:

a) provide HDC, within three months of the date of this report, evidence of her further training and education relating to documentation; and

b) participate in refresher training on assessment, management, and arrangement of referrals to review suspicious moles/skin lesions, and documentation relating to such matters, and provide evidence of this to HDC within three months of the date of this report.

200. In response to my provisional report, RN H:

a) provided evidence of recent attendance at an educative rural nursing seminar on documentation; and

b) arranged for refresher training on monitoring and documentation of suspicious lesions, through the DHB1 Nurse Educator.

201. I recommend that RN H provide a formal written apology to Mr A's family. The apology is to be sent to HDC in the first instance, within three weeks of this report, for forwarding.

RN L

202. In my provisional report I recommended that RN L:

a) provide HDC, within three months of this report being issued, a review by an independent nursing peer of the quality of her objective patient pain assessment and its documentation, for a random selection of patients cared for in the last six months; and

b) provide a formal written apology to Mr A's family. The apology was to be sent to HDC in the first instance, within three weeks of this report, for forwarding.

203. In response to my provisional report, RN L:

a) provided HDC with an apology letter for forwarding to Mr A's family; and

b) advised via DHB2 that RN L's objective pain assessment and documentation for a selection of patients would be reviewed by the Plastic Surgery Nurse Educator and Clinical Nurse Specialist for Otolaryngology. RN L will also be participating in

further pain management professional development, including attendance at a relevant nursing study day.

204. I recommend that within three months of this report being issued, RN L provide HDC with evidence of her completion of the above professional development.

DHB1

205. In response to the provisional report, DHB1 advised HDC that:

a) it had scheduled a meeting between executive clinical leaders and patient safety staff to review the audit process for clinical documentation across all disciplines; and

b) three new clinical leadership roles (Medical Directors) were created. The Patient Safety Officer will meet with all three to discuss ongoing continuous improvement across all areas of the DHB.

206. I recommend that within three months of this report, DHB1:

a) provide its nursing staff (including the medical centre nursing staff) refresher training on assessment, management, and arrangement of referrals to review suspicious moles/skin lesions, and documentation relating to such matters;

b) provide HDC with a progress report on the effectiveness of the new clinical leadership roles created, and any initiatives taken by the Quality Improvement Team in relation to documentation and follow-up of incidental findings of concerning skin features; and

c) provide an update on the use of the ISBAR communication tool on the acute ward, including reporting on audit results.

Follow-up actions

207.
- A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of the names of RNS F and RN H.

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

Appendix A: Independent clinical advice to the Commissioner

The following expert advice was obtained from in-house clinical advisor Dr David Maplesden:

"1. Thank you for providing this file for advice. I have reviewed the available information: complaint from [Mr A] dated […] (two months before his death); response and clinical notes from [DHB2]; response and clinical notes from [DHB1] staff — [Dr J] (physician) and [Dr K] (general surgeon). [Mr A] complained about the delay in diagnosing a mole on his back as a malignant melanoma. He stated he was in [Hospital 1] for hip surgery in [Month1] and [Month6] and showed *several nursing staff including house doctor* a mole on his back which had recently grown and was discharging. He stated that nursing staff dressed the mole but no referral was made for biopsy or removal. In [Month11] the mole was finally removed *at the insistence of the registered nurse visiting me* and was found to be melanoma. Subsequent staging investigations found spread to the thyroid and lung. [Mr A] also complained that he was given inadequate local anaesthetic for a procedure performed at [Hospital 2] on 19 [Month16], and that nursing staff there were rough with dressing changes and called him a '*whimp*'. He complains that transport arrangements were unhygienic and uncoordinated, and he was given inadequate pain relief for transport home after one procedure. [Mr A] died as a result of his disease [a few months later].

2. [Dr J] responds that he saw [Mr A] for the first time on 13 [Month10] after he was referred by the DHB orthopedic service for advice on managing recurrent infections in a prosthetic hip joint. The hip problem was addressed and at the end of the consultation *[Mr A] asked me to look at a lesion on his back, which he told me had been present for some time (certainly over a year) and had been bleeding. He told me he had drawn other doctors' attention to this previously. I found a fungating, friable, non-pigmented tumour between his scapulae. This was clearly malignant and I referred him to the surgical department for excision.* Noting the tumour was non-pigmented, [Dr J] at first thought it might be a squamous cell carcinoma. The tumour was excised by surgeon [Dr K] on 26 [Month11] and was found to be an aggressive malignant melanoma.

Comment: [Dr J] recognized [Mr A's] tumour as likely to be malignant and requiring urgent excision. He referred [Mr A] appropriately for this excision. Whether or not [Dr J's] provisional diagnosis was correct, he recognized the abnormality of the lesion and need for removal. His management of [Mr A] was consistent with expected standards.

3. [Dr K] notes his first contact with [Mr A] on 26 [Month11] following referral by [Dr J]. The referral had been categorized as semi-urgent by head of department with comment [Mr A] should be seen within two months. [Dr J's] provisional diagnosis was of a large squamous cell carcinoma and [Dr K] concurred with this diagnosis on initial inspection of the lesion. Removal of the lesion was somewhat complex because of its fungating nature, size and [Mr A's] inability to lie flat. Nevertheless, the lesion was excised at the time of initial review and primary closure of the wound was achieved. Recovery was complicated by wound

infection treated with antibiotics, and dressings were managed by the district nurses. At review on 15 [Month12] [Dr K] noted the histology report which was of a malignant melanoma Clark's level 4–5, Breslow thickness at least 2.2mm (but in reality much thicker) and mitotic rate >40. The closest margin to resection was 4.3mm. [Mr A] was referred for staging CT scans and also to oncology and anaesthetic services prior to undertaking the wider excision indicated. CT scan (15 [Month12]) showed suspicious nodules in the thyroid and right lung. On 17 [Month13] the original scar was re-excised with a circumferential margin of 1cm. There was no residual tumour identified in that specimen. *Because of anaesthetic concerns this procedure also was performed with local anaesthetic and [Mr A] in a sitting position.* In addition to oncology involvement ([DHB2]) [Mr A] required excision of a local recurrence of tumour (detected by CT on 21 [Month15]), which was performed by [Dr K] under local anaesthetic. Despite a large area of skin being removed, the nearest margin was 0.8mm and further excision with grafting was advised and performed in [Hospital 2] by plastic surgeon [Dr M].

Comment: Management by [Dr K] was consistent with local guidelines[37] and with expected standards given the exophytic nature of the lesion (re initial removal technique) and final histological diagnosis. [Mr A] had pre-existing conditions of severe ankylosing spondylitis with fused spine, obesity, obstructive sleep apnoea (on CPAP at night), type 2 diabetes and hypertension. He was unable to lie on his front. This explains the desire to avoid general anaesthetic if possible and the positioning of [Mr A] for his surgeries.

3. I have reviewed the contemporaneous clinical documentation relevant to the responses of [Drs J and K] and it is consistent with their responses.

4. I have reviewed additional clinical notes from [Hospital 1] for [Mr A's] admission in [Month2] and 30 [Month5] to 4 [Month6].

(i) On 11 [Month2] nursing notes include *Red skin tag on back, checked by* [indecipherable]. No other notes for this admission are on file.

(ii) On 29 [Month5] [Mr A] was admitted to [Hospital 1] for his hip revision surgery. MO notes include description of a normal respiratory examination. Such an examination would normally involve auscultation over the back against the skin in which case I would expect observation of any abnormal skin lesion at the time to be recorded. There is no such record.

(iii) Nursing notes 1 [Month6] include *Pt has mole in upper back that appears to be bleeding small amount — Pt states this has been an ongoing problem.* There is no reference to any action taken with respect to the observation. There is no reference to the back lesion in subsequent notes during this admission.

(iv) It appears [Mr A] may have been referred for district nurse attention to his hip wound but there are no relevant notes on file.

[37] Ministry of Health. Clinical practice guidelines for the management of melanoma in Australia and New Zealand. 2008.

5. [DHB1] oncology clinic letter dated 17 [Month12] ([a medical oncologist]) summarises the history of [Mr A's] back lesion as *he has had a mole in that region for thirteen to fourteen years and [in] 2011 it began to increase in size and also began discharging and bleeding. He drew it to the attention of a number of practitioners, including surgeons here at [Hospital 1] and was reassured about its potential nature … [Mr A] is obviously quite upset at what he perceives as an unacceptable delay in doctors getting round to removing his melanoma. I have given him contact details for the Patient Advocacy Service to help him work through these issues.*

6. Additional comments on [DHB1] management of [Mr A]

(i) Clinical notes supplied indicate [DHB1] staff members reviewed [Mr A's] back lesion on 11 [Month2] (?nurse or MO) and 1 [Month6]. Neither set of notes contain an adequate description or history of the lesion nor outline any management plan. This may be a significant departure from expected standards.

(ii) To try and further clarify the possible role played by [DHB1] staff in the delayed diagnosis of [Mr A's] melanoma, I recommend the following information be obtained by the DHB:

a. narrative clinical notes required for each day of each admission during 2011, and copies of any outpatient letters or discharge summaries from 2011

b. district nursing service notes relating to contact with [Mr A] in 2011 and the first half of 2012

c. clarification of the role of the person reviewing [Mr A's] back lesion on 11 [Month2].

(iii) **I recommend comment from [Mr A's] GP be requested (in particular whether [Mr A] had ever mentioned a back lesion to his GP) together with a copy of GP notes for [mid] 2010 to [Month11].**

7. I have reviewed the [DHB2] response and clinical notes;

(i) [Dr M] has outlined the reasons for [Mr A's] excision of 19 [Month16] being performed under local anaesthetic and these are similar to those noted in comments of section 3. The extent of the excision was probably at the limit one would attempt under local anaesthetic *and no doubt was difficult for patient and surgeon.* Inability to insert an IV line was noted. [Dr M] apologized for any distress [Mr A] experienced, but noted the clinical reasons for a local anaesthetic were justified, and these had been discussed with [Mr A] prior to surgery.

Comment: Under the circumstances, I feel [Mr A's] management on 19 [Month16] was consistent with expected standards.

(ii) An apology was offered by the DHB for any distress caused by [Mr A] having to travel by taxi rather than by ambulance for his PET scan on 26 [Month20]. *The plastic surgery department has reflected on* [Mr A's] *concerns and takes on board the importance of clear communication to patients and their families regarding such plans, particularly when there are changes at short notice.*

Comment: The confusion over [Mr A's] transport arrangements, and subsequent arrangements made, on 26 [Month20] were certainly suboptimal. However, I feel the actions of the DHB in response to the complaint were appropriate and I have no further recommendations regarding this aspect of [Mr A's] care.

(iii) I have reviewed the complaint made by [Mr A] to the DHB regarding the nurse changing his dressing in late [Month19]. The nurse response has also been reviewed. She indicates she ensured [Mr A] had pain relief before and after the procedure in question. She admits removing the dressing in a rapid fashion, but this was in an attempt to release water from under the dressing which she felt was causing the dressing change to be exceptionally painful. She does not recall calling [Mr A] a 'whimp'. She admits in hindsight removal of the dressing may have been better effected by using a dressing solvent (Remove), and she apologises for the distress [Mr A] experienced.

Comment: Nursing management on this occasion probably departed from expected standards to a mild degree. However, the remedial action taken by the DHB (discussion with the nurse concerned, apology offered) I think has been reasonable and I have no further recommendations.

(iv) Overall, I feel the [DHB2] response to [Mr A's] complaint has been reasonable and any issues felt by his family to remain unresolved (with respect to [DHB2] involvement in his care) might be best addressed by meeting with relevant DHB personnel.

8. Addendum 2 February 2014

A. Relevant [Hospital 1] clinical notes have been provided

(i) [Mr A] was admitted to [Hospital 1] on 23 [Month1] with *fever and hip pain.* There is no reference to a back lesion in the history or examination that day, although examination findings did include a respiratory examination. He was diagnosed with cellulitis and commenced on IV antibiotics. Further respiratory examination was documented on 24 [Month1]. On 29 [Month1] a PICC line was inserted and chest X-ray performed for check of position. These are all occasions on which [Mr A's] back would presumably have been visualised and there is no comment regarding any notable back lesion.

(ii) On 3 [Month2] [Mr A] underwent the first stage of a two stage hip revision. Given [Mr A's] respiratory issues I would expect the anaesthetist to have performed chest auscultation prior to surgery, and there is no mention of a significant back lesion being observed. On 5 [Month2] there is reference to a 'back wash' performed by nursing staff but no concerns documented regarding a back lesion.

(iii) Nursing notes 11 [Month2] include *Red skin tag on back checked by RMO [Dr C] — no new orders.* [Mr A] was discharged on 12 [Month2]. There is no reference to a back lesion in outpatient letters through 2011.

Comment: Despite several occasions on which [Mr A's] back was likely to have been viewed by nursing and medical staff, there is only one occasion on which a

back skin lesion has been noted and it is unclear whether this was reviewed because of concerns by the patient or nursing staff. I am mildly to moderately critical the MO concerned did not document any clinical findings or history related to the lesion having been asked to review it. Without a documented history of the lesion and without having viewed the lesion or a photograph of the appearance of the lesion at this point, it is not possible for me to determine whether there were features suspicious of malignancy in either the history or appearance. However, it is apparent the lesion did not raise particular concerns with the many physicians and nurses likely to have viewed it as part of unrelated examinations and procedures during the admission. With the benefit of hindsight, it is likely the lesion was an early presentation of the melanoma which subsequently grew rapidly and ulcerated, although it is unclear whether intervention at this stage would have significantly altered the clinical outcome.

B. [Medical centre's] (based at [Hospital 1]) clinical notes and district nursing notes

(i) [Medical centre] notes have been reviewed from [mid] 2010. These include multiple notes relating to [Mr A's] care following his hip surgery in [Month2]. The first mention of a back lesion is 1 [Month5] (provider [RNS F]) — *large haemangeous lesion on back started to bleed. Cleaned and covered, advised to check asap, is seeing surgeon on [4 Month5]will get him to look.* On 6 [Month5] provider [RNS G] has written ... *area on back looking slightly better* and on 11 [Month5] *lesion on back seems to be decreasing* ... On 12 [Month5] [RNS F] has written *area on back flattened out and no longer draining* ... I note [Mr A] saw orthopaedic surgeon [Dr E] on 4 [Month5] and had an aspiration of his right hip joint. There is no reference in the operation note to a back lesion. [Mr A] had a subsequent admission to [Hospital 1] in [Month7] for further IV antibiotics and following review by [Dr E] on 14 [Month9] he was referred to [Dr J] for review of his recurrent infections. Subsequent events are discussed earlier in the report.

(ii) There is no further reference to the back lesion (although there is reference to a chronic skin infection at the base of the spine) until 5 [Month11] when provider [RNS F] has noted *haemangeous growth on back has doubled in size, very friable ... to see on* [10 Month11] ... On 11 [Month11] provider [RNS G] has written *Area on back looks like a fungating small tumour, appt made to see [GP] tomorrow* ... NB by this time [Mr A] was already on the semi-urgent waiting list for excision of the lesion and subsequent the medical centre notes refer to ensuring the referral process is underway.

Comment: There was apparently a missed opportunity for earlier diagnosis of [Mr A's] malignancy in [Month5] when he mentioned it had been bleeding (a suspicious but not diagnostic feature) and [medical centre] staff (I think practice nurses) failed to ensure timely medical review of the lesion but instead appear to have assumed that [Dr E] reviewed it on 4 [Month5] (and whether or not [Dr E] did review the lesion remains undetermined — he could perhaps be asked to comment definitively on this matter) or that medical staff would have managed the lesion appropriately during [Mr A's] admission to [Hospital 1] from 30 [Month5]. I am concerned that the lesion was not commented upon by medical

staff during the [Month5] and [Month7] hospital admissions, assuming a competent respiratory examination would have involved viewing [Mr A's] back, and certainly if he did, as claimed by him, mention the lesion on numerous occasions. I am moderately critical that nursing staff in [Hospital 1] documented the lesion on 1 [Month6] (see 4(iii)) but evidently did nothing about it. However, my comments must be tempered by the fact that I cannot confirm the appearance of the lesion on the occasions in question (from [Month5]) to determine whether the failure to recognise it as potentially malignant in [Month5], [Month6] and [Month7] was a significant departure from expected standards. Nevertheless, the failure by various staff at [Hospital 1] and the medical centre between [Month5] and [Month7] to ensure there was at least documented clinical review of [Mr A's] *large haemangious lesion* on his back, which had been bleeding (ie to ensure the referral cycle was completed even if only informal referral advice had been given), was a moderate departure from expected standards. By this I mean the departure does not relate to the failure to diagnose malignant melanoma, but a failure to ensure a bleeding exophytic lesion was investigated in a timely manner once it had been brought to the provider's attention."

Dr Maplesden provided further comment:

"1. I have reviewed the response from orthopaedic surgeon [Dr E] dated 14 July 2014. [Dr E] does not recall receiving any information from [medical centre] staff regarding [Mr A's] back lesion, nor any specific request from [the medical centre] to review the lesion. He does not recall seeing the lesion when he undertook hip aspiration on [Mr A] on 4 [Month5], nor would he expect a lesion in the area concerned to have been visualised during the process of hip assessment and aspiration. [Dr E] does not recall any conversation on 9 [Month5] relating to [Mr A's] back lesion as being a possible source of his recurrent hip infections, nor does he think the lesion would have been the likely source of the infection.

2. There is nothing contained in [Dr E's] response that alters the conclusions documented in my advice dated 7 November 2013 (addendum 2 February 2014). With respect to [Dr E's] involvement, I do not think it was reasonable that an orthopaedic surgeon assessing the patient's hip should review an apparently unrelated and longstanding skin lesion, certainly without a formal written request to do so including the clinical rationale for making such a request. Noting [the medical centre] staff had observed the lesion and expressed some concern (see section 8B(ii) of my original advice) I think they had a responsibility to ensure appropriate clinical review of the lesion was undertaken by way of formal referral to an appropriate clinician (be that GP or specialist in the first instance). If there was an assumption [Dr E] would review [Mr A's] back lesion, this should have been followed up by those [medical centre] providers seeing [Mr A] after the orthopaedic appointment rather than an assumption being made that specialist review had been undertaken, particularly when there was no reference to the back lesion in correspondence from [Dr E].

3. Other factors contributing to the delay in [Mr A's] diagnosis have been discussed in my original advice and my comments in that regard remain unchanged."

Appendix B: Independent nursing advice to the Commissioner

The following expert advice was obtained from in-house nursing advisor Ms Dawn Carey.

"1. Thank you for the request that I provide clinical advice in relation to the complaint from the now deceased, [Mr A]. [Mr A's] complaint spans multiple health care providers at [Hospital 1] and [Hospital 2]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following documentation: complaint from [Mr A]; response and clinical notes from [DHB1] including [medical centre] notes; response and clinical notes from [DHB2].

3. **Background and complaint**
I have been asked to provide clinical advice in response to [Mr A's] complaint about provided nursing care.

[Mr A] spent three weeks as an inpatient in [Hospital 1] in [Month1]. He reports drawing attention to a mole on his back, which had grown in size and required regular dressings by the registered nurses as it was discharging. Despite this no referral was made for the mole to be investigated for malignancy.

In [Month11], [Mr A] had the mole excised, and it was found to be a malignant melanoma. Subsequent staging investigations showed significant metastatic melanoma. [Mr A] died as a result of his disease [a few months later].

[Mr A] also complained about the standard of nursing care provided to him at [Hospital 2] during [Month20], 2013. He complained that a RN was rough as she performed a dressing change and called him a *whimp* or a *sook* when he cried out in pain.

4. **a. [DHB1] response**
The [DHB1] response is provided by [Dr J] and [Dr K]. I note that their responses are consistent with the relevant contemporaneous documentation. I have not received a response from [DHB1] that pertains to [Mr A's] complaint that registered nurses were providing regular wound care due to his mole bleeding.

b. [DHB2] response
Following receipt of the complaint direct from [Mr A], [DHB2] report reviewing his clinical notes and speaking with the RN in question. The RN reports that

- it is easiest to remove donor site dressings in the shower

- she ensured that [Mr A] had received analgesia prior to taking him to the shower as she was aware that the dressing changes were painful
- [Mr A] became distressed when the water got underneath the dressing, as it was hitting raw skin of his donor site
- she removed the dressing quickly in the hope of relieving the pain that [Mr A] was experiencing
- she does not remember calling [Mr A] a 'sook'
- she did apologise to [Mr A] during the procedure and again when he was back on his bed
- she also apologised to [Mr A's wife] who was present on the ward and who went into the shower room to comfort her husband
- she administered analgesia to [Mr A] post the dressing change
- with the benefit of hindsight she considers that the use of 'remove' would have helped ease some of the discomfort that [Mr A] experienced
- she extends sincere and heartfelt apologies to [Mr A] and his wife for the distress and pain that she caused

5. **a. [Medical centre] (based at [Hospital 1])**

(i) I have reviewed the available notes, which commence [mid] 2010. I am unsure which of the practitioners involved are part of the rural RN specialist teams.

(ii) There is no reportage pertaining to a mole being noted, or concerns being raised by [Mr A] until 1 [Month5] (provider [RNS F]) — *Large haemangeous lesion on back started to bleed, cleaned and covered, advised to have checked asap is seeing surgeon on [4 Month 5] will get him to look.*
Comment: I am unsure whether [Mr A's] lesion was reviewed by [Dr E] on 4 [Month5]. Available contemporaneous documentation would suggest that [Mr A's] back was not reviewed.

In my opinion, the [medical centre] provider should have followed up to ensure that the recommended review occurred. I would consider the failure to do so to constitute a moderate departure from expected standards of care. **For the purpose of clarity, follow up in this context required communication between the providers — [RNS F] to the surgeon.**

(iii) 6 [Month5] (provider [RNS G]) — … *area on back looking slightly better*
Comment: I agree that it was appropriate to monitor the status of the noted back lesion.

(iv) Documentation for 9 [Month5] (providers [RN I] and [Dr N]) — refers to discussions with [Dr E] about the possible source of [Mr A's] infection. Whilst the back lesion is referred to as a possible source, it is not definitive whether the author is querying this or whether this possibility was discussed with [Dr E].

(v) 11 [Month5] (provider [RNS G]) — *Lesion seems to be decreasing …*

(vi) 12 [Month5] (provider [RNS F]) — *… area on back flattened out and no longer draining …*

(vii) There is no further commentary relating to [Mr A's] back lesion being reviewed until almost 6 months later — 5 [Month11] (provider [RNS F]) — *Haemangeous growth on back has doubled in size very friable … to see doc on Tues*[10 Month11].

(viii) 11 [Month11] (provider [RNS G]) — *Area on back looks like a fungating small tumour app made to see [GP] tomorrow …*
Comment: Following this appointment, [Mr A] had the mole excised, which was found to be malignant melanoma.

b. Review of clinical records — [Hospital 1]

(i) [Mr A] was an inpatient at [Hospital 1] on two occasions before [Month11] when his mole was excised; 23 [Month1] to 12 [Month2]; 29 [Month5] to 4 [Month6].

(ii) During his first inpatient period, there is no reportage of any noted skin issues relating to [Mr A's] back until 11 [Month2], when documentation reports … *red skin tag on back checked by RMO [Dr C] — no new orders …* I note that the RMO review and assessment is not documented, which I would consider to be a departure from expected standards. Nursing entries regularly report noted skin changes and assisting [Mr A] to maintain his hygiene needs. I also note good evidence of contemporaneous care-planning that reflects need for wound care, and evaluates provided interventions.
Comment: Other than the single entry on 11 [Month2], there is no mention of any features, concerning or otherwise, being noted on [Mr A's] back. The documented description lacks sufficient detail for me to determine whether the RN considered the skin tag to be atypical or concerning in any way. I also cannot determine whether the RMO review was sought in response to [Mr A's] expressing a concern or initiated by the RN.

In my opinion, the provided nursing care meets expected standards.

(iii) During his second inpatient period, documentation on 1 [Month6] reports … *pt has mole in upper back area that appears to be bleeding small amount — pt states this has been an ongoing problem …* There is no further reportage during this admission that relates to [Mr A's] mole being noted or any intervention due to it bleeding.
Comment: Whilst I accept that not all incidences of a mole bleeding, are a cause for concern, I am critical that there is no evidence that the RN considered the need for ongoing monitoring of [Mr A's] mole or sought a medical review. I am critical of the lack of follow up in this instance as the bleeding was presented as an ongoing problem, which I consider to be a concerning feature that would require referral and investigation.

In my opinion, the failure to monitor the status of [Mr A's] mole or initiate a medical review constitute a moderate departure from the expected standards of nursing care.

6. **Review of clinical records — [Hospital 2]**

(i) The provider response and the contemporaneous nursing entries do not report [Mr A] having his donor site dressing removed and experiencing acute pain. Based on ward round entries, Acute Pain Service (APS) entries, administered analgesia, and the RN care planning signature, I am presuming that the dressing change that [Mr A] has complained about occurred on 8 [Month20].

(ii) I note that on 8 [Month20], [Mr A] was administered analgesia in accordance with his prescription — M-Eslon SR prescribed and administered twice a day (morning and evening) and Sevredol 'as required' (PRN). [Mr A] was administered Sevredol at 8.00 and 11.00, which fits with the RN response that she ensured that analgesia was administered prior to the dressing change and post procedure. I agree that it is good practice to review administered analgesia prior to carrying out procedures such as dressing changes.

(iii) I acknowledge that patients usually find donor site dressing changes considerably more painful than the graft site, which can make the initial dressing change very challenging. In my experience leg donor sites are associated with more pain. I agree with the RN response that using water via a shower helps remove dressings and can help make the experience easier for the patient. I acknowledge that [Mr A's] experience does not support this. I also agree with the nurse's reflection that using an adhesive solvent wipe such as 'Remove' would have been a good adjunct treatment prior to water being applied and I would advise that this becomes a standard part of her wound care practice.

(iv) Whilst I acknowledge that there is evidence of appropriate nursing care planning for this period, I am critical that the contemporaneous nursing documentation does not report the dressing change, [Mr A] experiencing acute pain or evaluate his pain experience against the administered analgesia. In my opinion, an objective pain assessment should always be used when assessing pain and evaluating the administered analgesia. Objective pain assessment tools provide opportunities for the RN to explain the role of analgesia, and evaluate whether the prescribed analgesia and dose is effective or not. Inadequate pain management increases incidences of complications due to inadequate mobilisation or deep breathing, and leaves patients feeling uncared for and vulnerable. I note that [Mr A] did not receive his prescribed Paracetamol on three occasions on 8 [Month20] and I am critical of this. There is no recording to explain this omission e.g. patient refused. Based on the contemporaneous nursing entry [Mr A] experienced discomfort and had very little sleep following the dressing change on 8 [Month20]. The APS review on 9 [Month20], records *... 7/10 pain — constant, 'crying like baby' ...* In my opinion, a more proactive approach to assessing and monitoring [Mr A's] pain

experience on 8 [Month20] should have occurred. I also consider this to be required to meet the relevant Nursing Council of New Zealand competencies[38] and other relevant standards[39]. I acknowledge that my criticisms relate to more than the RN that [Mr A] has identified in his complaint.

(v) In my opinion, the nursing care provided to [Mr A] on 8 [Month20] was a departure from the expected standards of nursing care. I consider that there were a series of mild departures in relation to pain assessment, pain management, documentation, medication management, wound care and communication. I acknowledge that the identified departures appear to be 'isolated' events rather than a trend. I would recommend that [DHB2] highlight these omissions with the wider nursing team. I agree with [Mr A] that he did receive very good nursing care overall.

7. **Clinical advice**

Registered nurses are accountable for ensuring that all health services that they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards[40,41,42]. In my opinion, the care provided to [Mr A] departed from expected standards of nursing care.

a. [DHB1] — A response from [Dr E] should be sought. However, on preliminary review, I am moderately critical of the nursing staff failing to ensure a timely medical/surgical review of [Mr A's] mole. In my opinion, a mole that is identified as bleeding on an ongoing basis should be recognised as a symptom that requires investigation.

b. [DHB2] — In my opinion, the nursing care provided to [Mr A] at [Hospital 2] demonstrates mild departures from the expected standards. Whilst I consider the remedial actions — in response to [Mr A's] complaint — undertaken by the DHB to be appropriate, I would recommend that they highlight the additional areas identified as demonstrating departures.

Addendum: I have reviewed the response provided from [RNS F] and note that she agrees with my provided advice. I note that she reports genuinely thinking that [Mr A's] back had been seen by [Dr E] and that a referral for a specialist review would be forthcoming. I note that [Mr A's] clinical file could only be accessed via the office computer. While I acknowledge that this may be a contributory issue to the length of time — 6 months — which elapsed before [RNS F] reviewed [Mr A's] lesion again, I remain critical that [RNS F]

[38] Nursing Council of New Zealand (NCNZ), *Code of conduct* (Wellington: NCNZ, 2012)
[39] Standards New Zealand (NZS), *8132:2008 Health and disability (general) services standards* (Wellington: NZS, 2008).
[40] Nursing Council of New Zealand (NCNZ), *Code of conduct* (Wellington: NCNZ, 2012).
[41] Nursing Council of New Zealand (NCNZ), *Competencies for registered nurses* (Wellington: NCNZ, 2007).
[42] Standards New Zealand (NZS), *8132:2008 Health and disability (general) services standards* (Wellington: NZS, 2008).

did not communicate with [Dr E] or log that [Mr A] was awaiting a specialist referral for his lesion. I consider such communication and documentation to be a necessary part of safety netting practice. I consider the practice changes reported by [RNS F] to be appropriate."

Ms Carey provided further comment:

"1. Thank you for the request that I review the response from [Dr E] — dated 14 July 2014 — and consider whether it alters my clinical advice — dated 14 May 2014. [Dr E's] response is relevant to my review of the provided nursing care due to documentation by provider [RNS F], at [the medical centre]. This is detailed in section 5a(ii) of my preliminary advice. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. [Dr E's] response reports not recalling any discussions or being made aware that [Mr A] had a mole/lesion on his back prior to 4 [Month5]. He also reports that he does not recall viewing the said lesion and comments that it would be unlikely that he would view it during the course of a hip aspiration, which is why [Mr A] saw him on 4 [Month5]. [Dr E] also does not recall a conversation with [the medical centre] — 9 [Month5] — where [Mr A's] back lesion was discussed as a possible source of his hip infection. He comments that it would be very unlikely for a back lesion to be a cause for hip infections.

3. Following a review of [Dr E's] response and my preliminary advice, I remain moderately critical of the lack of follow up by [medical centre] nursing staff to ensure that a timely medical/surgical review of [Mr A's] mole occurred. I remain of the opinion, that a mole identified as bleeding on an on-going basis should be recognised as a symptom that requires investigation."

Ms Carey also advised:

> "I have reviewed the statement from [RN H] dated 15 June 2015 and determined no cause to amend my advice. I continue to hold the opinion that the failure to monitor the status of [Mr A's] mole or initiate a medical review constitutes a moderate departure from the expected standards of nursing care."