# Dermatology Clinic

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

## (Case 20HDC01392)

Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

**Contents**

## Executive summary

1. A woman was receiving narrowband UVB treatment for her psoriasis from a dermatologist at a dermatology clinic. She had attended eight sessions with a slowly increasing dosage with no adverse reactions.

2. The woman attended her ninth session at the dermatology clinic on 24 July 2020. At this session, reception staff mistakenly entered the incorrect name into the system, and the woman received a longer session than expected. As a result of the long exposure time, the woman received a significantly higher dose of narrowband UVB, resulting in burns.

3. In subsequent sessions, the clinic failed to inform the woman about its investigation into the error, and did not tell her the cause of the error.

4. This report highlights the importance of adequate supervision and training of less experienced members of staff, and the importance of full disclosure of relevant information to the consumer.

**Findings**

5. The Deputy Commissioner found that the clinic's failure to supervise and train staff adequately led to the error, and constituted a failure to provide services to the woman with reasonable skill and care, in breach of Right 4(1) of the Code.

6. Adverse comment was made about the clinic's failure to disclose to the woman both its investigation into the event and the cause of the error.

**Recommendations**

7. The Deputy Commissioner recommended that the clinic provide a written apology to the woman, following receipt of the final report one staff member involved in the error refused to provide an individual apology to Mrs B; develop a comprehensive policy for adverse events; provide its reception staff with first aid training and guidance on managing an adverse event; amend the UVB set-up policy to include a more comprehensive double-checking protocol; and develop an open disclosure policy to ensure that patients are kept up to date with the status of internal investigations and the changes made as a result.

## Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint from Mrs B about the services provided by a dermatology clinic (the clinic). The following issue was identified for investigation:

- *Whether the clinic provided Mrs B with an appropriate standard of care in 2020.*

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

10. The parties directly involved in the investigation were:

| | |
|---|---|
| Mrs B | Consumer |
| Dermatology clinic | Provider |

11. Further information was received from:

| | |
|---|---|
| Dr A<br>Accident and medical clinic<br>District Health Board | Dermatologist/Director |

## Information gathered during investigation

### Background

12. At the time of events, Mrs B was a patient of dermatologist Dr A.[1] On 17 March 2020, Mrs B consulted Dr A regarding the treatment of her psoriasis[2] and, on his advice, she commenced narrowband UVB treatment (a form of phototherapy used to treat skin diseases). The treatment involves two to three sessions weekly in which the patient stands in the centre of a specifically designed machine containing fluorescent light tubes.

13. The results of narrowband UVB treatment vary, and depend on the skin type and the condition being treated, but for psoriasis, generally the patches will begin to become thinner after five to ten treatments. Narrowband UVB treatment can result in burning, and long-term exposure to UV radiation can cause skin aging and skin cancers, but this is mitigated by the narrow spectrum of light used. These potential side effects are outlined in the narrowband UVB fact sheet provided by the clinic.

14. The dosage is determined by the dermatologist, who assesses the person's skin type using the Fitzpatrick scale[3] before the first treatment. This information, along with the frequency of the session, is provided to the reception staff. The initial dose of the light therapy is determined by the computer program.[4] The computer program increases the dose in 10–15% increments automatically, and these dosage increases can be reviewed by the dermatologist at any point if there is an adverse reaction to the treatment.

[1] Dr A has practised as a dermatologist for many years and has an annual practising certificate from the Medical Council of New Zealand. He is a Fellow of the Royal Australian College of Physicians and is a member of the Royal Australasian College of Physicians, New Zealand. He is the sole director of the clinic.
[2] A condition in which skin cells build up and form scales and itchy, dry patches.
[3] A numerical classification schema for human skin colour.
[4] The clinic submitted to HDC that this computer program is from the manufacturers of the UVB treatment machine, and is approved by the Food and Drug Administration (an American regulatory agency).

15. During the initial consultation on 17 March 2020, it was decided that Mrs B would undergo treatments three times a week for a total of 10 to 15 sessions. Soon after this consultation, New Zealand went into "Alert Level Four"[5] lockdown due to COVID-19, and Mrs B did not begin the treatment until July 2020.

16. Mrs B told HDC that she returned to the clinic on 6 July 2020 to begin the treatment. Reception staff explained the process to Mrs B, and it was arranged that her treatments would continue on Mondays, Wednesdays, and Fridays going forward, beginning that day. The clinic told HDC that when a patient presents to the clinic for treatment, they check in at the front desk and give their name. The patient is then given goggles and asked to proceed to the treatment room. The practice advised that there was no deviation from this process in Mrs B's case.

17. In response to the provisional opinion, the clinic stated that the receptionist explained the process to Mrs B and showed her the lightbox facility,[6] including taking her through the safety mechanism in place to pause or stop treatment if she had any concerns. The clinic stated that this is standard procedure prior to a patient's first treatment.

18. The duration of the exposure was to increase slowly with each treatment by approximately 10% each time. The length of the first treatment on 6 July 2020 was approximately 53 seconds. Mrs B attended eight treatment sessions[7] without issue, with the last of the sessions being approximately two minutes in length.

**24 July 2020 treatment (the event)**

19. Mrs B attended her ninth session on Friday 24 July 2020 at 8.40am. Following normal procedure, she reported to the clinic reception, where she waited until the machine was free. In the incident evaluation report[8] completed by the practice manager after these events, it was noted that the two reception staff working on this day were less experienced in managing a busy front desk unassisted, as the most experienced staff member was on leave.

20. Mrs B told HDC that once the machine became free, she took the safety goggles provided by reception and went into the narrowband UVB machine, where she pressed the start button. She stated that this time, the automated voice in the machine noted that the treatment would be approximately eight minutes long. Mrs B said that she was surprised that the timeframe was so long, but did not question it and remained in the machine, where she "assumed everything would be fine".

[5] In 2020, New Zealand imposed strict restrictions in response to the spread of COVID-19 in the community, requiring all non-essential service businesses to close under "Alert Level Four".
[6] The lightbox facility refers to the narrowband UVB treatment machine.
[7] Doses of narrowband UVB given at each session were as follows from first to last: 283mJ, 326mJ, 372mJ, 427mJ, 493mJ, 564mJ, 652mJ, 750mJ, 3135mJ.
[8] Discussed further below.

21. As a result of the long exposure time, Mrs B received the wrong dose of the narrowband UVB — 3135 m joules rather than the planned 825 m joules.

22. Following the treatment, Mrs B returned to the reception and mentioned to the reception staff that she believed it was strange that the session had lasted eight minutes, when the previous session had lasted only two minutes. She told HDC that the two reception staff expressed confusion and looked at the screen, noting that it said seven minutes and forty-five seconds, and told her that they would look at the computer and it would be corrected for the next appointment. One of the receptionists told HDC: "My colleague and I [were] concerned and told her to report back if there were any problems." Mrs B stated that when she informed the reception staff that the treatment was eight minutes long, which was a substantial increase on the previous treatment, one of the receptionists looked surprised and replied, "Eh?"

**Complications following treatment**

23. At approximately 1.15pm the same day, Mrs B began to feel itchy around her neck and waistline, and it was then that she discovered that her skin had reddened everywhere except for her feet and the palms of her hands. Mrs B telephoned the clinic at 1.35pm from her cellphone and left a message advising that she had suffered burns following the session. She then called again on her landline and informed a receptionist of the redness and asked to speak to one of the doctors. She was told that the receptionist would call the practice manager, and that she would call Mrs B back.

24. Dr A told HDC that the usual process in this situation would be for the practice manager to contact the patient, then to contact him directly about the problem. Dr A would then contact the patient directly that same day. On the day on which Mrs B called, the practice manager was in a meeting, and did not speak to Mrs B. In the incident report, the receptionist noted that she discussed the issue with the practice manager, who advised that Mrs B could be added to Dr A's calendar for Monday. The practice manager did not contact Dr A and, as a result, Dr A was unaware that Mrs B had been exposed to the incorrect dose of narrowband UVB until he arrived at work on the following Monday.

25. At 2.19pm on 24 July 2020, the reception staff called Mrs B and told her that she could not speak to a doctor because no doctors were at the practice, as they had all left by 1.30pm. There was a discussion about the application of Aloe vera gel, and Mrs B was offered an appointment with Dr A on Monday. Mrs B was also told to consult her general practitioner or an after-hours clinic if her condition worsened.

26. Throughout the evening, Mrs B applied a homemade remedy of yoghurt and egg white to the burn, used sunburn spray, and had cool showers to soothe the burns.

27. Around 5.00pm, Mrs B's skin was hot and sore, and her husband took her to an after-hours accident and medical clinic. She was seen by a nurse and a doctor, who diagnosed Mrs B with superficial but extensive burns across the body post-UVB treatment. Mrs B told HDC that the doctor attempted to contact Dr A at the clinic for an opinion, but was unable to

reach him, and instead spoke to someone from the Plastics Department at the public hospital for advice. Dr A told HDC that he received no message on his phone regarding this.

28. At the accident and medical clinic, Mrs B received moisturiser, pain relief, and a referral letter to go to the public hospital if the pain did not subside. She returned home at 9.00pm, applied the moisturiser, took the pain relief, and went to sleep.

29. At 3.00am on 25 July 2020, Mrs B woke up feeling sick and began to vomit and struggle to breathe. Her husband drove her to the Emergency Department at the public hospital. She arrived at approximately 3.30am, and a blood test was taken and her stomach was examined (the results were normal). Subsequently, Mrs B was discharged with pain relief and Sorbolene cream.[9]

30. Mrs B told HDC that throughout Saturday and Sunday (25 and 26 July 2020) she was in great pain and discomfort, and felt no improvement.

**Follow-up care from clinic**

31. Mrs B told HDC that when she attended the appointment on Monday 27 July 2020, Dr A appeared to be avoiding the topic of the burns. They discussed pain levels and medication. Mrs B said that she asked Dr A about how the burns occurred, but he wanted to focus on healing the burns first. Dr A's clinical notes for this consultation state: "[A]pologized will discuss how it happened when she is better." Dr A told HDC that at this appointment, he apologised for what had happened to Mrs B, but was not able to explain the reason why she had been burnt, as he did not yet know himself. In contrast, Mrs B told HDC that she did not receive a direct apology for what had happened to her.

32. Dr A told HDC that at the appointment on 27 July 2020, Mrs B had no evidence of temperature instability, shivering, significant skin blistering, or skin peeling. He prescribed prednisone (a steroid medication) to help with inflammation, and recommended cool baths and Locoid Lipocream[10] to be applied to tender areas.

33. Later that day, Mrs B received a text message from the clinic, which read:

> "[The clinic]: URGENT — NO UVB — the UVB phototherapy machine is not currently available and we do not have a time frame for when it will be available again. [W]e will contact you via text when it is available again. Our apologies, [the clinic]."

34. This text was sent to all UVB patients because at that point they thought the machine may have been to blame for the burns and considered it too unsafe to be used.

35. In response to the provisional opinion, the clinic stated that this text message was sent out due to the fact that they had a message on the control computer indicating to them that calibration of the machine was required. As such, they appropriately made the decision not

[9] An all-purpose cream commonly used as a moisturiser.
[10] A topical treatment for skin conditions.

to treat any further patients until they could confirm that the machine was functioning as it should.

36. Mrs B returned to the clinic for a follow-up appointment the following day (28 July 2020). Dr A told HDC that this appointment was organised when a small area of skin on her back had begun to peel and had become red and tender. He noted that there were also a few similar areas on the upper buttocks, and that the left breast was the most red and tender area. He noted that there were no other areas of significantly red skin. Mrs B told HDC that she was informed by Dr A that she would be better by Thursday, and she was encouraged to take cool showers. She stated that it was still not discussed how the burns had occurred. Dr A told HDC that he apologised again to Mrs B for what had happened to her, but was still unable to explain why it had happened as he had not yet established the cause. His clinical notes for this consultation do not make reference to an apology.

37. In response to the provisional opinion, the clinic explained that the 28 July appointment was organised not because small areas of the skin had begun to peel, but to ensure Mrs B's wellbeing and comfort. Additionally, Dr A noted that he did not tell Mrs B that she would be better by Thursday, as he would never have predicted such a rapid recovery, and he would never expect burns to settle within two days. He noted that he said that he would take care of her until she was comfortable, hence initially he arranged to see her daily.

38. Mrs B returned to the clinic on Thursday 30 July 2020 for further follow-up. Dr A told HDC that Mrs B's skin had started to peel over large areas, and that her sleep pattern had been disturbed but was improving. He prescribed her with 1% menthol in non-ionic cream[11] to apply to the warmest areas.

39. Mrs B told HDC that during this consultation, she asked again how the error had happened. She stated that Dr A mentioned that the machine was having calibration issues, and that the clinic was trying to reach the USA manufacturer for more details. Mrs B said that she does not remember a discussion about an individual error.

40. Dr A initially told HDC that at this appointment, he apologised to Mrs B and informed her that a human error had been made in entering the data onto the computer program, resulting in her receiving a higher UVB dose than planned. However, in response to the provisional opinion, Dr A clarified that at the appointment on 30 July 2020 he still did not know that the wrong patient information had been entered for treatment, and he did not inform Mrs B of a human error at this appointment. Dr A said that he outlined to Mrs B the possibility of a machine malfunction after the machine alerted them to a possible calibration error. He stated that this could not be verified as there were no technicians based in New Zealand, and they were unable to enter due to COVID-19 restrictions.

[11] A light non-greasy moisturiser or emollient, used to treat dry skin conditions.

41. The clinical notes for this appointment were documented by Dr A as:

> "Discussed as much as I know about machine malfunction. Explained that service technicians are US and Australia based thus not able to enter NZ at present. See Monday."

42. Mrs B next saw Dr A on Monday 3 August 2020. He advised her that the skin was healing and would take a few more days, and that no further medication was required. Mrs B told HDC that Dr A told her that she could visit on Thursday if she felt it was necessary. Dr A told HDC that he asked Mrs B to provide a telephone update on the Thursday, but she did not call, so a secretary telephoned her and left a message, and she responded saying that she was feeling better.

43. In response to the provisional opinion, the clinic clarified that at the time of this appointment, Mrs B was no longer needing to take any painkillers, and was finding that the topical treatment provided by Dr A was making her much more comfortable. Dr A suggested that she discontinue the application of the topical steroid, and he ensured that she had sufficient supplies of emollient (moisturiser) on hand.

44. In response to the provisional opinion, Dr A stated that he informed Mrs B of the human error as soon as he became aware that the wrong patient's name had been entered, on 3 August 2020, and he apologised for the error at this appointment.

**Subsequent events**

45. An incident evaluation report was completed on 28 August 2020, shortly after Mrs B made her complaint to HDC, and over a month after the events. Dr A told HDC that this delay occurred because of short staffing and stretched resources due to COVID-19 disruptions. The report found that the cause of the incident was one of the clinic receptionists entering an incorrect patient's name into the UVB computer program. The report also highlighted that on the day of the event the most experienced staff member was on leave, and the remaining staff members were less experienced in managing a busy front desk. The practice manager noted that at times when there is a high patient volume, there should be another staff member responsible for entering the patient details for UVB treatments. She said that patients who arrive for treatment should be given a computer-generated slip containing their details, and this should be handed to the staff member who sets the treatment. The incident report lists this incident as a process and procedure error, and notes that it is possible that it could occur again.

46. Dr A told HDC that the staff member in question cannot remember exactly how she came to enter the wrong patient name into the UVB computer, but that she was under considerable pressure at the time of the event. He stated that the practice takes responsibility for this. He said that following the COVID-19 lockdown, the practice saw a large increase in appointments due to the backlog of patients, and they had limited administrative support, and, as such, the two least experienced staff members were managing the practice at the time of the event.

**Further Information**

*Mrs B*

47. Mrs B told HDC that at no time has the practice manager offered any apologies for these events directly to her.

48. Mrs B stated:

> "[Dr A] was slow to apologise, and only when I kept bringing up the fact that I had not been contacted or offered an explanation, he offered me a quick apology then moved the conversation on. I do not recall [Dr A] apologising at my subsequent visits. While I acknowledge that [Dr A] has recorded his apology to the HDC in his letter … I continue to await a direct apology."

49. Mrs B told HDC that the first time she received the information that the wrong patient name had been entered was when she read Dr A's statement to this Office.

*Clinic*

50. The clinic told HDC that when new reception staff are employed, they are given training on the UVB process and on how to operate the UVB machine. It stated that usually, only one person, the most experienced reception staff member, is principally involved with UVB treatments (and that this person was away on 24 July 2020) but that all reception staff are trained and available to take over care if required. The clinic said that the staff member who made the error had less experience but had been trained by the most experienced reception staff member.

51. In its response to the provisional opinion, the clinic commented that it believes that the staff members involved were trained and supported. They had been fully trained by their most experienced staff member in how to use the machine, and supervised until they had the necessary knowledge to do it themselves. The clinic told HDC that while it agrees that an error was made by a staff member who was less experienced than its senior receptionist, it would not classify the staff member as inexperienced.

52. The clinic told HDC that training provided to its staff consisted of a verbal explanation of how to use the machine, followed up by a step-by-step demonstration using a "dummy" patient profile. After the initial training, the new staff member would observe the UVB machine being operated, and would then operate it under supervision until both the new staff member and the supervisor felt comfortable. In addition to this training, once a year a technician attends the practice to provide a service visit and offer a refresher on how to use the machine. The UVB protocol was written to be consistent with, and to complement, the training provided by the technician. The clinic told HDC that the machine is now overdue a service because of COVID-19-related delays, and has not been in operation.

53. The practice provided a written protocol that details how to set up new patients for treatment, how to edit current patient treatment, and how to manage daily treatments. The clinic stated that this protocol is given to reception staff.

54. The UVB protocol that was in place at the time of the event states the following:

a) At each visit the patient must present to the front desk.

b) The patient's name is then entered into our Patient Management System (Profile).

c) Treatment details are then entered onto our UVB computer.

d) Once the details are confirmed, the patient is then given their protection goggles and proceeds to the treatment room.

55. The practice manager advised HDC that the protocol was updated following these events. The revised protocol is set out in paragraphs 89–90 below.

56. Dr A told HDC:

> "I would like to reiterate the clinic's apologies to [Mrs B] for the deficiencies in the care she received. We accept that these shortcomings resulted in [Mrs B] suffering superficial burns and also acknowledge the distress these events have caused her."

57. Dr A said that as a result of these events, he and the practice manager held a meeting with staff to discuss all protocols relating to the UVB machine and the key questions to ask patients when they attend. The clinic believes that it now has a system in place that will prevent a similar situation occurring again.

**Responses to provisional opinion**

*Mrs B*

58. Mrs B was given the opportunity to provide comment on the "information gathered" section of the provisional opinion, and had no comments to make.

*The clinic*

59. The clinic was given the opportunity to provide comments on the provisional opinion, and submitted a number of comments.

60. The clinic reinforced that Dr A is certain that he apologised to Mrs B during each appointment she had with him following the event. Dr A stated that initially he was not able to outline the exact cause of what happened, as at that point he did not know what had caused the error. He noted that he informed Mrs B of the cause as soon as he became aware of it, at the appointment of 3 August 2020.

61. The clinic commented that, as previously noted, the UVB machine was not made available for treatments over the period of the pandemic, as technicians were not able to enter New Zealand and, given that the last service had been in 2019, it felt it prudent to wait until a full service could be undertaken.

62. The clinic advised that on 7 June 2022 a full service was completed, and a meeting was held with the technician to ascertain how the error had occurred and how to prevent a similar error from occurring again. At this time, it became evident that the staff member who made

the error had failed to take note of three opportunities to ensure that the correct patient was about to be treated.

63. First, there would have been an on-screen alert that stated: "It has been zero hours since this patient was treated — are you sure you want to proceed?" This error message was dismissed without checking. The second opportunity was to check that the patient's name on the screen was correct, and the third opportunity was to check the proposed treatment time.

64. The clinic advised HDC that in order to reduce the likelihood of such an error occurring again, the technician suggested that the UVB computer be set up with restricted permissions, so that if an error message occurs it cannot be dismissed without intervention from either the practice manager or Dr A. The same restricted permissions apply if the computer detects an error in the dose to be administered if a manual change has been made by the user. The clinic said that these precautions bring a significant level of extra safety.

65. The clinic stated that from 2015 until Mrs B's event in 2020, it had never encountered an incorrect patient being loaded for treatment, so the cause of the event was not recognised immediately.

66. The clinic commented that it would like to assure HDC that it has taken this incident very seriously, and has implemented training and processes within the practice to ensure that such an error does not happen again. It reiterated that Dr A never hesitated to apologise for the error in the care Mrs B received at her 24 July 2020 appointment. Dr A again expressed his deep regret for the distress that Mrs B experienced as a result of the error.

## Opinion: Dermatology clinic

67. Mrs B had been receiving care from the clinic for four years. When she saw Dr A in March 2020 regarding treatment of her psoriasis, he suggested that she undergo narrowband UVB treatment. This is a form of light therapy that generally will improve the symptoms of psoriasis after 10 to 15 treatments.

68. Due to the COVID-19 Level 4 lockdown restrictions, the treatment could not begin until July 2020. Mrs B attended eight sessions without incident, with the final session before the event lasting two minutes 16 seconds.

69. This report concerns the session on 24 July 2020, the subsequent care Mrs B received after the error was identified, and the disclosure of information to Mrs B after the event. Mrs B was entitled to have services provided with reasonable care and skill, and to the information that a reasonable consumer in her circumstances would expect to receive.

**Care provided during and after event — breach**

*Care provided during event*

70. The preparation for the 24 July 2020 session did not deviate from the normal procedure. On 24 July 2020, Mrs B waited for the machine to become free and, once it was, she took goggles from reception and went to the machine. It was then the role of reception staff to enter Mrs B's name into the system to bring up the correct treatment time and therefore the dose of UVB. At this time, staff erroneously used the details of a different client, exposing Mrs B to a significantly higher dose of UVB than was planned — 3135mJ instead of 825mJ.

71. On the morning of 24 July 2020, the most experienced member of the reception staff was on leave, and the reception staff who were working were less experienced. Later, on 30 July 2020, following a review of the computer logs, it was determined that the treatment parameters for Mrs B were that of another patient, and that the incorrect patient details had been entered into the system by one of the reception staff.

72. During an internal review, the clinic found that the error occurred due to a large patient load, limited administrative support, and the inexperience of the staff members involved. In the incident evaluation report, the practice manager identified that at times when there is a high patient volume, there should be another staff member responsible for entering patient details for UVB treatment. She stated that patients who arrive for UVB treatment should be entered on a daily appointment schedule and be given a computer-generated slip with their details, which should be handed to the staff member who sets the treatment.

73. It is concerning that two less experienced staff members were tasked with ensuring that the correct treatment was given to the right patient, particularly — as noted by the clinic's investigation report — when the workload for the receptionist staff was high. In my view, it was the lack of support for staff to ensure the safety of patients that allowed this to happen to Mrs B, as identified by the clinic's internal review. Ensuring that a patient receives the correct treatment is a fundamental element of providing healthcare services. All staff involved in treatment provision need to be trained and supported appropriately in order to achieve this.

74. In its response to the provisional opinion, the clinic commented that it believes that the staff members involved were trained and supported, and it would not classify them as inexperienced. While this may be the case, I remain of the view that the clinic did not provide sufficient support to receptionist staff to ensure Mrs B's safety during her treatment.

*Care provided after event*

75. Immediately following the treatment, Mrs B informed the reception staff of the unusual length of treatment. Mrs B told HDC that the reception staff appeared confused and unsure of what had happened, with one looking at the screen and noting the time and informing Mrs B that the time would be corrected for the next time. Mrs B was told to report back if there were any problems.

76. Following the session, Mrs B's skin began to feel itchy and she noticed that her skin was reddening. She called the clinic twice that afternoon. On the second call, she informed a receptionist of the redness and asked to speak to a doctor. The clinic told HDC that since these events, it now advises patients to apply Aloe vera gel for any burn, and, if no doctors from the practice are available, to book an urgent appointment with their GP or attend an after-hours clinic. However, this process was not in place at the time of events and, as such, it did not specify clearly to the reception staff what they should do in such a situation. At 2.19pm, Mrs B was called back and told that she could not see a doctor at the practice because they had all gone home for the day. She was advised to apply Aloe vera gel and attend her GP or after-hours clinic if her condition worsened, and she was offered an appointment with Dr A for Monday 27 July 2020.

77. Dr A told HDC that the actions of the clinic staff did not follow the practice's usual process, which was that the practice manager would contact the patient and then Dr A. Dr A would then contact the patient that same day to discuss the issues. On the day on which Mrs B called, the practice manager was in a meeting, and did not speak directly with Mrs B, and advised the receptionist to add her to Dr A's calendar for Monday. The practice manager did not inform Dr A of the event at this time, and, as a result, Dr A was unaware of the event until Monday (three days later).

78. I am critical that Dr A was not alerted to Mrs B's adverse reaction on the same day she had informed the staff.

79. The significant increase in the length of Mrs B's session should have alerted the reception staff that something had gone wrong, and yet it did not. I acknowledge that reception staff were trained on how to operate the machine, but it appears that their training did not extend to the risks of overexposure or how to respond if it occurred. The staff appear not to have realised that the extra time spent in the narrowband UVB machine could mean that Mrs B would suffer burns, and they did not have the requisite knowledge to provide Mrs B with appropriate advice on what signs to look for, how to treat any burns should they arise, or when to seek medical attention. Further, when Mrs B rang the clinic approximately four hours later with reddening skin, she was not given medical advice because the practice manager did not follow the usual procedure and notify Dr A of her condition.

*80.* The clinic's narrowband UVB fact sheet notes the potential side effects, including the potential for burns. The reception staff should have been alert to this risk and been familiar with how to work with equipment that potentially can cause harm. Staff need to be supported adequately to provide advice to patients in the case of an adverse event, and to have in place a clear line of escalation so that the patient can receive appropriate follow-up care. I consider that the reception staff were not supported or trained adequately by the clinic to deal with an adverse event such as this.

*Conclusion*

81. As noted above, I consider that the reception staff at the clinic were not supported or trained in their role adequately in order to provide safe care. As a result, Mrs B was given another patient's dose of 3135mJ, and was not provided with medical advice on how to

treat her resulting redness and burns. It follows that the clinic failed to provide Mrs B with services of an appropriate standard of care, in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[12]

**Open disclosure — adverse comment**

82. When the provision of a health service is not as expected, it is understandable for a consumer to have questions and to seek a clear explanation of what went wrong. As per Right 6(1) of the Code, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive. This includes details of how the adverse event occurred.

83. As noted above, Mrs B raised concern about the unusually long session and her side effects with reception staff on the day of treatment. She then attended four consultations with Dr A, who provided treatment for her burns. Across these appointments, Dr A discussed treatments for the burns with Mrs B. While there was discussion about the increase in the dosage of UVB, the cause of this was not discussed.

84. Dr A and Mrs B have differing recollections as to exactly what was discussed. Dr A initially told HDC that during the 30 July 2020 appointment they discussed the potential for human error having caused the burns, and the potential calibration error of the machine. Dr A's clinical notes from that appointment make no mention of the human error, only the potential machine fault. Mrs B recalls being told of an increase in dosage and the potential calibration error of the machine, but does not recall any discussion of the cause of this being human error. In response to the provisional opinion, Dr A stated that he told Mrs B of the human error during the 3 August 2020 appointment, after he became aware that the wrong patient's name had been entered. Dr A's clinical notes from the 3 August 2020 appointment make no mention of human error, nor any mention of having informed Mrs B about the cause of the burns.

85. Mrs B told HDC that the first time she was made aware of the reason for the error was when she read Dr A's response to HDC, and not during the 30 July or 3 August 2020 appointments, as Dr A told HDC. The internal investigation was undertaken on 28 August 2020, after Mrs B had complained to HDC. Taking into account the above evidence including Dr A's clinical notes, which are consistent with Mrs B's recollection, I find it more likely than not that Mrs B was not told about the cause of the error during the follow-up appointments.

86. In addition, Mrs B told HDC that she is yet to receive a direct apology from Dr A or the practice manager for these events.

87. I am critical of the clinic for failing to investigate the cause of the machine error in a timely manner. It appears that the clinic was prompted by this complaint to undertake a review, despite Mrs B having asked many times about how the error happened, across multiple appointments following the event. I am also critical of the clinic for not informing Mrs B of

[12] Right 4(1) of the Code stipulates that "[e]very consumer has the right to have services provided with reasonable care and skill".

either the cause of the event or the outcome of the investigation, and for failing to apologise to her in a timely manner.

88. In addition to the right to know what has happened, consumers have a right to know the circumstances of how an adverse event occurred. Internal review of any adverse event is also vital to ensure that changes can be made to prevent a similar event. Whilst the clinic undertook an investigation and did advise Mrs B of the cause of the error, I am critical that this was not carried out in a timely way. An error of this type should be notified to senior staff/managers immediately for investigation in order to avoid recurrence and to provide surety of safety to consumers.

## Changes since event

89. Dr A told HDC that since the event, the clinic has reviewed the protocols that related to this episode, and has made the following changes:

a) Added to the patient information sheet that is given to patients at their initial consultation that the UVB treatment can be ended at any time by opening the door of the UVB machine. A warning notice has been placed in the UVB room that states that if the proposed time of the treatment has been increased significantly, then the patient should be alerted and not proceed with the treatment until the proposed dose has been double-checked with the front office staff.

b) The clinic planned to install an intercom between the treatment room and reception, but following discussions with an electrician it was determined that this was impractical. Staff now ensure that patients take their mobile phone into the UVB room, and instruct them to call the front desk if there are any issues.

c) The UVB protocol now states that reception staff should "tell the patient if they experience any burning or stinging to let us know immediately and we will check with the doctor". The clinic told HDC that staff have been advised that in response to any patient complaints of an adverse reaction, they are to advise the patient to apply Aloe vera gel for any burns, and, if no doctor from the practice is available, to make an urgent appointment with their GP or attend an after-hours clinic.

90. The clinic also advised that following these events it introduced a "double-check" system to ensure that reception staff enter the correct patient's name into the UVB treatment schedule. The clinic provided an updated protocol for the new process, which comprises the following steps:

"a. At each visit the patient must present to the front desk.

b. The patient's name is then entered into our Patient Management System (Profile).

c. Once entered on our system each patient is given an identifying slip and is asked to check their details.

d. Once the patient is called for their treatment, they provide reception staff their slip.

e. Treatment details are then entered onto our UVB computer using the name on the slip as a double check safeguard.

f. Once the details are confirmed, the patient is then given their protection goggles and proceeds to the treatment room."

91. In response to the provisional opinion, the clinic advised that front desk staff will no longer be involved in setting up UVB treatment. As the demands on the receptionists have increased, it has been decided to train two non-front-desk staff to take over this task under supervision by the practice manager until such time as she is confident that they are fully competent to perform all required tasks safely. The two staff appointed to set up treatments will work together so that the details of the patient to be treated are checked against the patient slip by both staff members.

92. Also in response to the provisional opinion, the clinic advised that in order to reduce the likelihood of staff members making errors entering information into the UVB computer, the UVB computer has been set up with restricted permissions so that if an error message occurs it cannot be dismissed without intervention from either the practice manager or Dr A. The same restricted permissions apply if the computer detects an error in the dose to be administered if a manual change has been made by the user.

## Recommendations

93. I acknowledge that the clinic has taken this issue seriously and commend them on the improvements to their service outlined above. Further to this, I recommend that the clinic:

a) Ensure that all individuals involved in the event provide a written apology to Mrs B for the failures outlined in this report. The apologies are to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs B. Following receipt of the final report one staff member involved in the error refused to provide an individual apology to Mrs B.

b) Develop a comprehensive policy for adverse events and the role of each staff member in each scenario, as well as clear advice to provide to the patient. The clinic is to provide HDC with a copy of this policy within four months of the date of this report.

c) Provide training to reception staff for managing an adverse event (based on the above policy) and first aid training to ensure that they have the skills to assist if a similar event occurs. The clinic is to provide HDC with evidence that this has been done within four months of the date of this report.

d) Amend the UVB set-up policy to include a more comprehensive double-checking protocol further to the policy it has created. I recommend reviewing the "Five Rs of

Medical Administration"[13] and following a similar approach. The clinic is to provide HDC with a copy of this policy within four months of the date of this report.

e) Develop an open disclosure policy to ensure that patients are kept up to date with the status of internal investigations and the changes made as a result. I recommend that before doing so, the clinic review HDC's open disclosure policy,[14] and provide HDC with a copy of the clinic's open disclosure policy within four months of the date of this report.

f) Report to HDC on the implementation of the changes to the UVB process, as listed at paragraph 93, within four months of the date of this report.

## Follow-up action

94. A copy of this report with details identifying the parties removed will be sent to the Australasian College of Dermatologists and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[13] Right patient, Right drug, Right dose, Right time, and Right route of administration: https://www.nzno.org.nz/Portals/0/publications/Guideline%20-%20Guidelines%20for%20Nurses%20on%20the%20Administration%20of%20Medicines%20(002).pdf?ver=72ENNovqJ9HlYkn-7-Fcjw%3d%3d.

[14] https://www.hdc.org.nz/media/5372/guidance-on-open-disclosure-policies.pdf.