Registered Nurse, RN B

Medical Centre

A Report by the

Deputy Health and Disability Commissioner

(Case 21HDC00756)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a woman by a nurse at a medical centre. The woman requested that a mole on her back be removed for biopsy. She complained that she consented to a punch biopsy, and not the wider excision that the nurse performed.

Findings

2. The Deputy Commissioner found that the nurse did not inform the woman that she was going to perform a wide excision and did not discuss the risks of the procedure adequately. The Deputy Commissioner considered that this was information that a reasonable consumer would expect to receive before giving consent to the procedure. Accordingly, the Deputy Commissioner found that the nurse breached Rights 6(2) and 7(1) of the Code.

3. In addition, the nurse failed to identify, and therefore remove, the specific lesion about which the woman was concerned and did not document the discussion with the woman at the initial consultation about the mole and the option of a punch biopsy. Accordingly, the Deputy Commissioner also found that the nurse breached Right 4(1) of the Code.

4. The Deputy Commissioner was critical that the medical centre did not have evidence that it had reviewed the nurse's competency to perform biopsies and suturing.

Recommendations

5. The Deputy Commissioner recommended that the nurse complete HDC's online training module on informed consent and the Code; provide HDC with evidence of further formal education and assessment for removing skin lesions if she intends to continue to undertake similar procedures; and provide a written apology.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided to her by RN B at the medical centre. In her complaint, Ms A said that she consented to a punch biopsy, but not to the wide excision that was performed. Ms A also had concerns about the appropriateness of the excision and how the histology results were reported to her.

7. The following issues were identified for investigation:

- *Whether the medical centre provided Ms A with an appropriate standard of care from December 2020 to January 2021.*
- *Whether RN B provided Ms A with an appropriate standard of care from December 2020 to January 2021.*

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

9. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
RN B	Registered nurse/provider
The medical centre	Medical centre
Mr C	Managing Director, medical centre

10. Independent clinical advice was obtained from Nurse Practitioner (NP) Jenny Phillips (Appendix A). RN B provided an opinion from RN D, a copy of which is included as Appendix B.

Information gathered during investigation

Introduction

Ms A (consumer/complainant)

11. Ms A is a medical professional and was a patient at the medical centre at the time of events.

RN B

12. RN B has been a registered nurse for many years. She started working for the medical centre in 2017 in the role of Practice Nurse/PRIME[1] Responder and resigned in 2021.[2]

Events leading to complaint

Initial appointment

13. Ms A attended the medical centre on 7 December 2020 for a cervical smear and was seen by RN B. Ms A stated that during the examination, she also mentioned to RN B a mole on her back that concerned her.[3] According to Ms A, RN B advised that the mole had suspicious features and offered a punch biopsy (a procedure in which a small circular piece of skin tissue is removed and examined at a laboratory).

14. RN B recalled that Ms A requested a punch biopsy, and that she asked Ms A to make an appointment for this. RN B acknowledged that she did not record their discussion about the mole in the clinical notes. She explained that the appointment took just over 20 minutes

[1] Primary Response in Medical Emergencies. The PRIME service utilises the skills of specially trained rural GPs and/or rural nurses in areas to support the ambulance service where the response time for assistance would otherwise be significant or where additional medical skills would assist with the patient's condition.
[2] RN B now works for another provider.
[3] The mole was adjacent to a mole that Ms A had had removed a year earlier. The histology for that mole confirmed that despite looking like a melanoma, it was a benign (non-cancerous) mole.

(when it was booked for 15 minutes), and she was likely to have been under pressure to see the next patient and intended to return to the documentation later.

15. Immediately after this appointment, Ms A booked a new appointment for the procedure. RN B told HDC that she recalled that the patient notes template showed that Ms A was booked for a 30-minute appointment (whereas punch biopsies usually take 15 minutes), and the reason recorded for the appointment was 'excision'. RN B said that she recalled the earlier discussion about the mole, but not that Ms A had requested a punch biopsy. She assumed, from the way the appointment had been booked, that Ms A wanted an excision instead. In response to the provisional report, Ms A told HDC:

> 'I wish to reiterate that at no point did I ask for anything other than a punch biopsy. … When I left her room after the smear test, I immediately went to the reception to book an appointment and explained it was for a concerning mole and a punch biopsy. The receptionist stated this would be a double appointment and together we went through our respective diaries and found a convenient time.'

16. The medical centre provided notes that show that on 7 December 2020 a 30-minute appointment was booked and coded as 'PB'. The medical centre told HDC that 'PB' stands for 'punch biopsy'. The medical centre also provided an image of the 'appointment audit' (which shows whether any changes were made to the appointment booking). The audit shows that the PB code was assigned to the appointment on 7 December 2020, when the appointment was first booked, and the code was not changed. The medical centre also told HDC that punch biopsy appointments are booked for 30 minutes, and it provided evidence[4] demonstrating that this was the case at the time of events.

Excision

17. On 18 December 2020, Ms A returned to the medical centre for the procedure. RN B performed a wide excision, and not a punch biopsy.

18. RN B told HDC that in the treatment room Ms A said that the spot was by the scar (from a previous mole removal) on her back. RN B said that she could see 'discolouration' by the scar and assumed that this was what Ms A wanted removed. RN B added that Ms A had told her that the previous mole had been irregular and, given the possibility that the lesion had arisen from this previous mole, she considered it best to re-excise the whole scar along with the discolouration. RN B told HDC that she did not explain the procedure in usual detail because Ms A is a clinician herself. In response to the provisional report, Ms A told HDC:

> 'I would like it known/recorded that at the time of the appointment I was a doctor with no experience of punch biopsies or wedge [shaped] resections. [When] I trained … at no point did I complete any runs/placements where I gained education or experience in these procedures.'

[4] An excerpt from the medical centre's Reception Manual (dated August 2020), which states that both punch biopsy and minor surgery appointments are 30 minutes, and a computer printout of other 30-minute punch biopsy appointments with different consumers from 2018–2020.

19. RN B said that she advised Ms A at the time that she could 'remove all the discolouration with the scar as then there would be only one scar', and that Ms A accepted this. However, in response to the provisional report Ms A stated:

> 'I do not recall this conversation. When I entered the procedure room [RN B] said she was going to remove the mole. I presumed this was a punch biopsy as that was what we had discussed.'

20. RN B also said:

> 'I don't believe there was any discussion at the 18 December appointment about a punch biopsy. Had this been mentioned I would not have proceeded with the excision and had a more detailed discussion with [Ms A] to confirm the procedure she wanted.'

21. In response to the provisional report and the above comment from RN B, Ms A told HDC:

> 'I am confused by this statement. At the initial meeting (smear test) I asked [RN B] to look at a mole of concern. She said the best course of action was a punch biopsy and I was happy with that and hence made the appointment. At no point was anything other than a punch biopsy discussed.'

22. Ms A said that when she attended her appointment on 18 December, '[a]gain [they] discussed that this was a punch biopsy for diagnostic purposes'. Ms A said that she did not consent to a wide excision and would have declined for a number of reasons.[5] She recalled that as RN B was infiltrating the anaesthetic, RN B said, 'If I make it a little bigger I can remove it all.'[6] Ms A said that she took this to mean that RN B was going to use a different-sized biopsy punch. Ms A stated:

> 'I was therefore quite taken aback when [RN B] showed me the very large piece of tissue removed and that the wound needed five sutures. I questioned this at the time, and she simply said that is what it required.'

23. RN B agreed that she showed Ms A the tissue sample, which was much larger than a punch biopsy.

24. RN B said that she documented that consent was obtained (see paragraph 27 below), but stated: 'Given [Ms A's] own knowledge I accept that my discussion about risks etc would not [have] been as detailed as for other patients.' She said that ordinarily she would discuss with a patient the difference between a biopsy and an excision before undertaking the procedure, but as she thought that Ms A was familiar with both, this discussion did not happen. Ms A said that RN B did not discuss any risks prior to performing the procedure. As noted above, in response to the provisional report, Ms A reiterated that at that time she did

[5] Her reasons were that her skin has a tendency to form keloid scarring (thick, raised scarring resulting from the overgrowth of scar tissue); she would have been concerned about the wound reopening when she picked up her young child; and she did not feel that wide excision was an appropriate choice to remove the mole.
[6] RN B told HDC that she agrees that she 'probably did say this'.

not have any experience in punch biopsy and excision procedures and so would not describe herself as having been 'familiar' with them.

25. RN B told HDC that she regrets that her communication with Ms A about the procedure was insufficient to alert either of them to her misunderstanding about the procedure wanted by Ms A. RN B acknowledged that she should have used a written consent process, which would have specified the procedure to be performed.

26. Ms A told HDC that RN B did not give her any safety-netting or aftercare advice in respect of the wound, aside from being told to return in seven days for removal of the sutures.[7] Conversely, RN B told HDC that she would have explained to Ms A how she had dressed the wound, and informed Ms A to keep the sutures in for 10–14 days. The medical centre told HDC that it has a minor surgery and punch biopsy patient information sheet (updated in 2018), which was not provided to Ms A.

Documentation

27. RN B documented the following information in the clinical notes:

> '**PROCEDURE:** Excision …
>
> **CONSENT:** Obtained with risks identified as infection, bleeding, ineffectual procedure, poor cosmetic result. …
>
> **EDUCATION:** [Patient] educated on signs and [symptoms] of infection (redness, drainage, purulence, fever) or dehiscence and to return immediately if occurrence. [Patient] should keep wound dry for 24 hrs after the procedure, then may shower and wash. Should keep dressed and change is needed for drainage.'

28. The medical centre told HDC that RN B's notes were written in a prepopulated template. It said that the above information (including the fact that consent was gained and that risks were discussed) was automatically included in the template text, ie, not necessarily written by RN B at the time.[8] The medical centre said that it 'has been very clear to the nursing staff that they are not to use prepopulated templates to write notes and obtain signed consent'. The Clinical Notes Policy (August 2020) states that only one notes template is to be used, which is not prepopulated.

29. According to the medical centre, the prepopulated template that RN B used also included the words, 'Also picture taken of lesion,'[9] which RN B deleted when completing her notes. However, RN B said that in December 2020 there was no prompt in the template to take a

[7] Ms A said she told RN B that she would probably arrange for a nurse at her work to remove the sutures, and RN B said that would be fine.
[8] The medical centre provided HDC with a copy of the template. The template includes the same words next to 'CONSENT' and 'EDUCATION' as those written in RN B's notes included at paragraph 27.
[9] The medical centre provided a print-out of the notes template, generated on 30 April 2021, which included the words 'Also picture taken of lesion'.

photograph of the lesion, and she understands that this prompt was added to the template subsequently. In response to the provisional opinion, the medical centre stated:

> 'If [RN B] used non-[medical centre] templates (which she was not authorised to do), then [the medical centre] cannot comment on whether they would have prompted her to upload a photograph to the clinical record. However, if she had used the [medical centre] template, then it would have prompted her to add a photograph.'

30. The medical centre's 'Transportation and Recording of Laboratory Specimens' policy (August 2020) included a subsection called 'Procedures for Biopsy/Minor Surgery' (the Biopsy/Minor Surgery Policy), which required a photograph to be taken of the lesion before the injection of local anaesthetic. RN B did not take a photograph of the lesion. She told HDC that she was not aware of a requirement to take a photograph of the lesion for the clinical file and said that it was not regular practice at the medical centre at the time. However, she recalled that at the time of the events, the medical centre was considering introducing the practice as part of Cornerstone[10] accreditation. In response to the provisional opinion, the medical centre told HDC that it is 'unsure why [RN B] made this statement … when all [medical centre] templates automatically include[d] the requirement to take a photograph for clinical records'.

Histology

31. The histology report was completed on 23 December 2020. The report stated:

> 'Sections show hypertrophic dermal scar, which appears completely excised. This is presumed to represent site of previous excision/surgery, however clinical correlation is required.'

32. On 5 January 2021, RN B wrote in Ms A's clinical notes: 'Emailed results.' The same day, RN B emailed Ms A a copy of the histology report. RN B wrote: 'Hi [Ms A] I enclose your histology result … all good.' RN B told HDC that because it showed scar tissue and nothing else, she 'considered this a result that showed nothing of concern'.

33. Ms A told HDC that her view is that the histology report actually just says that only scar tissue was removed. She said that she had the area examined by a colleague, who confirmed that the mole is still in situ. Ms A believes that the histology was reported to her incorrectly and said that this is possibly her most important concern.

Subsequent events

34. Following the procedure, the wound dehisced (opened up) when Ms A picked up her young child. Ms A told HDC that the wound has now possibly developed keloid scarring, and she will consult a plastic surgeon about this, and about getting the mole removed.

[10] A quality programme for general practices run by the Royal New Zealand College of General Practitioners.

Further information

Training, policies, and workload at the medical centre

35. RN B told HDC that 10 years prior to her employment at the medical centre, a doctor observed her undertaking a minor surgical procedure and signed her off as competent. She said that she was never observed by a practitioner at the medical centre for the purpose of assessing her competence.

36. The medical centre stated that prior to her employment, RN B told the medical centre that she was competent in performing biopsies and suturing, and that its Clinical Director assessed RN B as competent. The medical centre was unable to find paper training records of this but did provide evidence that as part of RN B's orientation in 2017, there was a timeslot for a 'minor surgery' session with a nursing colleague. In response to the provisional opinion, the medical centre further stated: '[RN B] also helped teach other nurses with minor surgery while at the medical centre. The medical centre would not have allowed her to do so if [it] had any concerns regarding her competency.' Nevertheless, the medical centre agreed that it should have maintained better records that appropriately record staff competencies, and it noted further changes it has made to address this (see the 'Changes made' section of this report).

37. RN B submitted that she had not previously seen the policies and procedures provided to HDC by the medical centre,[11] and that she became aware that the medical centre had manuals of policies and procedures only when the medical centre updated its policies during a Cornerstone auditing process in 2020. RN B cannot recall nursing staff being taken through new policies or advised of the new requirements under them. In its response to the provisional opinion, the medical centre said that it disputes RN B's statement above and supports the comments made at paragraphs 39 and 40 of this report, which it said 'accurately record that [RN B] was aware of the policies and procedures, and all staff were advised of updates'. RN B provided a statement from a former colleague at the medical centre, who said that they worked on updating a significant number of the medical centre's policies and procedures before a Cornerstone assessment. The colleague also said that those changes were not brought to the attention of staff, and in their time working at the medical centre, clinical staff were not informed of new policies via email.

38. RN B also said that she did not complete her orientation because she was working full time within a fortnight of starting at the medical centre. She added that there was never any training at the medical centre on treating other medical professionals.

39. However, the medical centre noted that in October 2019, the data manager sent staff an email[12] outlining that there was a new desktop link to the PDF version of its manual. It provided a screenshot of RN B's desktop, which showed the link to the policies manual (last modified June 2020). The medical centre said that RN B could also access its policies manual on the intranet or use the hard copy held in the data manager's office. The medical centre

[11] Specifically, the Clinical Notes Policy and the Biopsy/Minor Surgery Policy.
[12] The medical centre provided HDC with a copy of this email.

added that RN B's employment agreement required her to comply with the medical centre's policies.

40. The medical centre also told HDC that its staff meet weekly for training with the entire clinical team, and staff are encouraged to present cases for discussion or debrief, to raise clinical topics for review, and to discuss significant events. In addition, the medical centre said that medical staff provide feedback on current procedures and case management, and present topics for educational purposes. The medical centre also has a weekly nurse-only peer support group session. It acknowledged that it had not held specific training on treating clinical peers but said that such patients should be treated following the same guidelines as any other patient.

41. Finally, RN B submitted that the events occurred during a very busy period of work for her, given that it was in the weeks leading up to Christmas. She said that she was seeing up to 30 patients a day, rather than the usual 20. However, the medical centre disputed this. It conducted an audit of the number of patients seen by RN B for the period 1 October 2020 to 31 December 2020. It stated that the average number she saw in December was 11.95 patients a day, and that she saw 20 patients on 18 December (the day of the procedure).[13] In response, RN B told HDC that she did not have access to her appointment records when she gave her figures. However, she pointed out that the figures from the medical centre reflect only booked appointments, and not telephone calls or other non-contact interactions with patients. She also noted that some of the daily schedules included in the audit were when she was on call overnight, and so she would have been scheduled to see only a few patients on those days. In its response to the provisional opinion, the medical centre acknowledged that staff tasks do include tasks with patients that are not face-to-face, but it noted: 'However, [the medical centre] system has no records of [RN B] carrying out any of these tasks on the day she saw [Ms A].'

Further comment from RN B

42. RN B told HDC that she has reflected on this event considerably, and on how the miscommunication could have been avoided. She acknowledged that she could have taken further steps to confirm with Ms A the area that she wanted excised, including asking Ms A's husband to mark the spot, or taking a photograph on Ms A's phone. RN B apologised to Ms A for the distress that these events caused her.

43. RN B also provided two character references from former colleagues at the medical centre. The first colleague recalled that RN B had appropriate expertise and experience for the role at the medical centre, and that RN B practised in a conscientious manner. The second colleague stated that RN B was 'always an extremely professional RN of the highest standard'.

[13] The medical centre provided HDC with copies of RN B's patient lists for each day in December.

Responses to provisional opinion

44. Ms A was given a copy of the 'Information gathered' section of the provisional report for the opportunity to comment, and her comments have been incorporated into the report where relevant.

45. Ms A told HDC:

> 'I did not realise the size of the incision until I got home [on 18 December 2020] and showed my husband. He told me there were 5 stitches and took a photo … Honestly I was shocked. In hindsight I should have contacted the practice asap, and regret not doing so.'

46. RN B was given the opportunity to respond to relevant sections of the provisional report. She accepted the proposed findings and recommendations and had no further comments.

47. The medical centre was given the opportunity to respond to the provisional report and its comments have been incorporated into the report where relevant.

Opinion: RN B — breach

Introduction

48. Ms A attended the medical centre on 18 December 2020. At this appointment, RN B performed a wide excision to remove a lesion on Ms A's back. Ms A said that she consented to a punch biopsy, but not to a wide excision. This opinion will consider whether RN B complied with her obligations under the Code of Health and Disability Services Consumers' Rights (the Code) to uphold Ms A's right to informed consent. It will also consider the appropriateness of the services RN B provided to Ms A.

Excision — informed consent

49. RN B and Ms A agree that they discussed a punch biopsy of the mole on Ms A's back at the initial appointment on 7 December 2020. However, they have different recollections as to what they discussed prior to the procedure on 18 December 2020. Ms A recalled that they again discussed that the procedure was a punch biopsy for diagnostic purposes; RN B does not recall discussing a punch biopsy at that appointment (and did not, at the time, remember their earlier discussion). However, they agree that prior to performing the procedure, RN B said to Ms A something about making the excision/biopsy bigger to 'remove it all'.

50. RN B acknowledged that she did not discuss with Ms A the difference between a punch biopsy and wide excision because of Ms A's pre-existing knowledge (being a clinician herself) of the two procedures. RN B also acknowledged that her discussion about the risks would not have been as detailed as she would normally have with other patients. RN B's notes record that the risks of 'infection, bleeding, ineffectual procedure, poor cosmetic result'

were identified. However, these risks were already included in the prepopulated text of the notes template that RN B used. Accordingly, I am of the view that they are not necessarily an accurate reflection of what RN B discussed with Ms A, and therefore have limited evidential value. In addition, I note that Ms A said that RN B did not discuss any risks of the procedure. Ms A has submitted, and I accept, that she had several reasons not to consent to a wide excision.

51. RN B also submitted that her misunderstanding as to what procedure Ms A wanted was contributed to by the fact that the appointment was booked as an 'excision', and that it was for 30 minutes (rather than the usual 15 for punch biopsies). However, the medical centre has provided evidence showing that the appointment was coded as 'PB', for punch biopsy (and that this was not changed prior to the appointment), and that punch biopsy appointments took 30 minutes. The clinical notes template completed by RN B did record 'excision' as the procedure being undertaken; however, this template was generated by RN B herself. On the evidence before me, I do not accept that the appointment booking showed 'excision' as the reason for treatment. For the avoidance of doubt, even if it had, I would still have expected RN B to confirm with Ms A the type of procedure to be performed prior to the procedure being undertaken.

52. Before giving consent to health services, consumers are entitled to be given information that a reasonable consumer, in their circumstances, would expect to receive, and need to receive to give informed consent.[14] This includes information about the risks and benefits of having the treatment, and the other options available to them.

53. Taking into consideration all of the above, I find that on 18 December 2020 RN B did not inform Ms A that she was going to perform a wide excision, and RN B did not discuss the risks of the excision procedure adequately with Ms A. This is information that a reasonable consumer would expect to receive before giving consent to the procedure. I note that my independent advisor, NP Phillips, considers that a failure by RN B to have had a more detailed discussion with Ms A about the procedure to be performed, including ensuring that the correct procedure was to take place, and making time for Ms A to ask questions, would be considered a severe departure from accepted practice.

54. I therefore find that RN B breached Right 6(2) of the Code.[15] It follows that, without being adequately informed of the procedure to be undertaken or the associated risks, Ms A was not in a position to give her informed consent to the procedure. I therefore find that RN B also breached Right 7(1) of the Code.[16]

[14] Right 6(1) of the Code states: 'Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive …'
[15] Right 6(2) states: 'Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.'
[16] Right 7(1) states: 'Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent …'

55. I accept that in practice, when a clinician is treating another clinician, informed consent discussions may often become curtailed because the patient already has knowledge about clinical matters. That said, in my view this is unsafe and unwise, because it can lead to important conversations being missed and mistakes being made, as this case demonstrates. In addition, I expect that fundamental matters, such as the actual procedure to be performed, should always be discussed explicitly and confirmed, regardless of who the patient is.

Standard of care

56. A number of other issues regarding the care RN B provided to Ms A warrant further discussion.

Standard and appropriateness of excision

57. Both NP Phillips and RN D (the clinical advisor engaged by RN B) agree that the main issue with the excision procedure was that RN B identified the wrong area for excision and, as a result, the area Ms A was concerned about was not removed. NP Phillips considered this to be a severe departure from the standard of care, and RN D considered it to be a moderately significant departure. Both advisors were of the view that the actual procedure itself, including RN B's decision to excise following the line of the scar from the previous excision,[17] was not a departure from accepted practice.

58. I am guided by both sets of advice and, accordingly, I am critical of RN B's failure to identify, and therefore remove, the specific lesion that was concerning for Ms A.

Documentation

59. RN B did not document her discussion with Ms A on 7 December 2020 about the mole and a punch biopsy. RN Phillips considered RN B's documentation failure to be a severe departure from accepted practice and reasoned that the requirement to document care in the notes is 'drilled into nurses from Year one training onwards'. Conversely, RN D categorised it as a departure of low significance, although I note that she further commented: 'Irrespective of any earlier consultations, documentation, or requests, it would be usual and accepted practice to confirm prior to any procedure, at the time of the procedure, exactly what procedure was to be completed.'

60. I accept that the initial discussion around the punch biopsy happened at the end of an appointment for an entirely different matter (a cervical smear). I also accept that RN B was likely under pressure to complete the consultation and see the next patient. Taking this into consideration, I am moderately critical that she did not document the initial discussion about the mole and Ms A's request for a punch biopsy. As RN D noted, if she had recorded this discussion, the subsequent issues might have been avoided.

61. RN B also used a prepopulated template that was not approved by the medical centre to document the excision procedure. The medical centre told HDC that this is inconsistent with its Clinical Notes Policy, which states that only one notes template is to be used (which is

[17] As opposed to following 'skin tension lines' or 'Langer's lines' when making the excision.

not prepopulated). RN D commented that unpopulated and prepopulated notes templates are acceptable formats for clinical documentation in practice. I accept this; however, as NP Phillips pointed out and discussed above, the problem with using prepopulated templates is that it makes it difficult to determine whether the template words are an accurate reflection of the care that was actually provided to the consumer. Accordingly, I consider that RN B's use of a prepopulated template was unhelpful, in addition to being inconsistent with the policy. I also take this into account when discussing below other aspects of the care she provided.

Photograph of lesion

62. RN B did not take a photograph of the lesion prior to excising it. This was inconsistent with the Biopsy/Minor Surgery Policy. According to the medical centre, RN B also deleted from the notes template the words referencing a picture being taken. However, RN B stated that those words were added to the template after the events. She also told HDC that she was unaware of the policy and the requirement to take a photograph. As RN B herself acknowledged, if she had taken a photograph, it may have helped to clarify with Ms A which area was to be removed.

63. Given the conflicting accounts, I am unable to determine whether RN B did delete from the notes the reference to taking a photograph of the lesion. However, even in the absence of the prompt in the notes, the policy required RN B to take a photograph. I do not accept that RN B not being aware of the requirement to take a photograph is a reasonable justification for failing to do so. I acknowledge that there is some disagreement about whether staff were or were not informed of changes to policies. However, the medical centre has provided evidence that staff were informed of how to access its policy manual. And as NP Phillips noted, individual practitioners have a responsibility to become familiar with policies relating to the care they provide. In addition, I note NP Phillips' comment that she would expect a photograph to be taken of an area a patient could not see, regardless of any policy requirement. I am therefore critical that RN B did not take a photograph of Ms A's lesion prior to the procedure.

Standard of care — conclusion

64. As detailed above, I have a number of concerns about the standard of care provided to Ms A. Specifically:

- At the initial consultation, RN B did not document her discussion with Ms A about the mole and the option of a punch biopsy.
- RN B failed to identify, and therefore failed to remove, the exact area that Ms A was concerned about.
- RN B did not take a photograph of the lesion, which was a breach of the medical centre's policy.

65. In my opinion, these matters amount to a failure to provide services to Ms A with reasonable care and skill. I note RN B's submission that she was particularly busy and seeing a high number of patients at the time of events, which was disputed by the medical centre. While

RN D commented that RN B's workload was heavy, she and NP Phillips agreed that, regardless of workload, RN B's responsibility to meet the expected standards of care was not reduced. I agree. Accordingly, I find that RN B breached Right 4(1) of the Code.[18]

Aftercare advice — adverse comment

66. Ms A told HDC that RN B did not give her any aftercare advice (aside from advising her to return in seven days for removal of the sutures), whereas RN B said that she would have told Ms A how she had dressed the wound and when the sutures needed to be removed. The notes, however, record that much more detailed aftercare advice was given.[19] As noted above, the notes were written in a prepopulated template, which included the text of the advice given. Therefore, I consider that these notes do not carry the same weight as contemporaneously recorded notes and have limited evidential value. Accordingly, given the conflicting accounts and the limited evidential value of the notes, I am unable to determine whether, and to what extent, RN B gave Ms A aftercare advice.

67. NP Phillips advised: 'Any nurse providing minor surgery should provide their patient with information around possible signs of infection, bleeding and pain preferably in writing but if not verbally.' She noted that the medical centre had a patient information sheet available, which RN B did not give to Ms A. I agree that RN B should have given Ms A this sheet and am critical that she did not do so. I accept that RN B may have overlooked this step because Ms A is a clinician herself. However, as NP Phillips comments: 'All staff should always treat every patient as if they do not know anything … and most importantly by ensuring all patients are provided with the patient information sheet.'

Reporting of histology result — other comment

68. After the medical centre received the histology report, RN B emailed Ms A a copy of the report and wrote: 'I enclose your histology result … all good.' RN B said she considered that the result showed nothing of concern because it showed scar tissue and nothing else. However, Ms A felt that the results were reported to her incorrectly.

69. RN D considered that it was reasonable that RN B interpreted this result as she did, and therefore it was appropriate for her to advise Ms A of the results in the way that she did. RN D also described RN B's action in sending the actual report to Ms A as 'thorough practice'. NP Phillips advised that RN B's actions were 'certainly not ideal' and had the potential to be more serious. However, NP Phillips agreed with RN D that because RN B sent the actual result to Ms A so that she could read and interpret it herself, there was no departure from the standard of care on this point.

70. I note that the histology report also stated: 'Sections show hypertrophic dermal scar, which appears completely excised. This is presumed to represent site of previous excision/surgery, however clinical correlation is required.' RN B was aware that Ms A's concern was about a mole next to the previous scar, which had led her to request the procedure. Given that the report clearly indicated that the tissue excised was scar tissue only, it is therefore surprising

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

[19] '[Patient] educated on signs and [symptoms] of infection (redness, drainage, purulence, fever) or dehiscence and to return immediately if occurrence. [Patient] should keep wound dry for 24 hrs after the procedure, then may shower and wash. Should keep dressed and change is needed for drainage.'

that RN B continued to convey that the findings were 'all good', as this information was likely to convey to Ms A that the mole had been examined and found to be non-cancerous. However, this action is mitigated somewhat, as RN B attached the actual histology report to her email, which enabled Ms A to read the report herself. I remind RN B of the importance of reading histology reports closely to ensure that no further investigation or consideration is required.

Opinion: Medical centre — no breach

71. At the time of events, RN B was employed by the medical centre and had been registered as a nurse for many years. I have concluded above that RN B breached Rights 6(2), 7(1) and 4(1) for a number of issues related to the care she provided to Ms A, including RN B's failure to obtain Ms A's informed consent to the wide excision.

72. It is the responsibility of an individual clinician who is to perform a procedure to obtain a consumer's informed consent to that procedure. RN B has submitted, and the medical centre has acknowledged, that the medical centre did not provide specific training to staff around treating peers and other medical professionals as patients. I acknowledge that training may have helped to reinforce the medical centre's expectation that clinical peers are to be treated following the same guidelines as any other patient, a position with which I agree. However, I do not consider that the lack of such training materially contributed to RN B's failure to inform Ms A that she was to perform a wide excision, and to obtain Ms A's informed consent to that procedure. In my view, it was reasonable for the medical centre to expect that RN B, with her significant clinical experience as a nurse, would obtain Ms A's consent appropriately. Accordingly, I do not find that the medical centre breached the Code in this respect.

Evidence of RN B's competency — adverse comment

73. First, I note that according to RN B, she was last signed off as competent for biopsies and suturing 10 years prior to her employment at the medical centre. She said that she was never observed undertaking such procedures at the medical centre. The medical centre stated that its Clinical Director confirmed that RN B was competent to perform these procedures, but was unable to provide evidence of this, although the medical centre did provide evidence that RN B's orientation included a 'minor surgery' session with a nursing colleague. Given the important role that biopsies play in the early detection and treatment of malignancies, it is crucial that staff who perform these procedures are adequately skilled to perform them accurately. With that in mind, I am critical that the medical centre was not able to provide evidence that it had reviewed RN B's competency appropriately in this regard. In response to the provisional opinion, the medical centre agreed that it should have maintained better records that record staff competencies appropriately, and it noted further changes it has made to address this (see 'Changes made' section below).

Changes made

RN B

74. RN B told HDC that she has reflected considerably on this event and, in particular, on her communication. She said that now she would always use a written consent process for these procedures, would ask the patient to mark the spot about which they are concerned, and would take a photograph to discuss and confirm the information with them. In addition, she stated that since these events she has not undertaken any further removals of skin lesions, and she plans to organise more formal education, assessment, and sign-off before doing any further such procedures.

Medical centre

75. The medical centre has made the following changes since these events:

a) It has improved its Minor Surgery and Punch Biopsy Patient Information sheet and updated its consent forms to record that the patient has read the information.

b) It has added into its procedure consent form a printout from DermNet.[20]

c) It has further developed its orientation and training package and has consolidated all of its clinical orientation material into one manual.

d) It has provided staff with expectations of informed consent and procedures.

e) It has instigated a new policy sign-off form for recording that staff are current and up to date with the policy and procedure manual, and now requires staff to sign off to confirm that they have read and understood new or updated policies.

f) It has undertaken a review of its staff's competency in procedures and has identified further assessments required for individual staff.

g) In response to the provisional opinion, the medical centre said that to further address the need for appropriate recording of staff competencies, all staff must now:

   i. List all procedures they complete as part of annual appraisals so that they can be (re)assessed and signed off in peer review.

   ii. Supply all certificates of training to the medical centre, which are filed electronically as well as in hard copy.

   iii. Maintain an individual portfolio of training and competency as per New Zealand Nurses Organisation guidelines.

[20] A free clinical resource website about dermatology and skin conditions.

Recommendations

76. In making the below recommendations for RN B, I acknowledge NP Phillips' positive comments around the steps RN B has taken following these events.

77. In my provisional opinion, I recommended that RN B:

a) Provide HDC with a written apology to Ms A for the issues identified in this report, for forwarding to Ms A. RN B has since sent the apology to HDC, and this has been forwarded to Ms A.

b) Complete HDC's online training module on informed consent and the Code, and report back to HDC with details of her learnings after completing this training. In response to the provisional report, RN B provided evidence of her completion of several HDC online training modules, including the informed consent module, and another informed consent module offered by Te Whatu Ora. In relation to this, RN B told HDC: 'Reflecting on my recent education on the consent process and communication I realise my practi[c]e was not up to standard. I am now much more robust with the consent process.' I am therefore satisfied that RN B has met this recommendation.

c) Provide HDC with a statement indicating whether she intends to continue to undertake similar procedures and, if so, provide evidence of the further formal education and assessment she has undertaken in respect of removal of skin lesions, and a description of what she has learnt following this education and assessment, within six months of the date of this report. In addition, I provisionally recommended that RN B, as part of this education, review her employer's workplace policies and procedures, as well as reliable resources like DermNet. In response to the provisional recommendation, RN B stated that currently she is not undertaking minor surgery, but she accepted the recommendation that she attend formal education on the subject. RN B also advised that she has agreed on a programme of education and assessment with her employer, which she is in the process of completing. However, as RN B advised that she will be on leave until October 2023, she requested that a further six months be allowed to complete and report on her training. In light of this, I agree to extend the time frame for this recommendation, and I look forward to receiving the necessary information for meeting this recommendation within 12 months of the date of this report.

78. I have made no further recommendations for the medical centre due to the findings of this report and the changes already made by the medical centre as outlined above.

Follow-up actions

79. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to Te Kaunihera Tapuhi o Aotearoa | Nursing Council of New Zealand, and it will be advised of RN B's name.

80. A copy of this report with details identifying the parties removed, except the advisor on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from NP Jenny Phillips:

'**Report for 21HDC00756**

The adequacy and appropriateness of [RN B's] record keeping and communication with [Ms A], particularly with regards to obtaining patient consent and discussing the risks and benefits of the punch biopsy and/or the excision procedure.

[RN B] failed to keep accurate records around her appointments with [Ms A] and also failed to follow the existing policies at [the medical centre]. The questions posed by the Health and Disability Commission have been measured against the Nursing Council of New Zealand competencies for Registered Nurses.

Domain 2 — management of nursing care — *please see attached document for further breakdown.*

2:1 Provides planned nursing care to achieve identified outcomes;

Accepted standards of care:

The main failure here was not treating the patient according to the policies available at [the medical centre].

While this had serious results many staff do not have time to update on policies within their clinical load, however, time is allocated at [the medical centre] for this type of activity. This would be seen as a moderate departure of care by many.

Recommendation: In future when policies are updated the practice ensures that nurses are made aware of this and a specific education, question and answer session factored in to ensure that all staff are made aware of changes. This should be signed off on the nurse's competency sheet.

2:3 Ensures documentation is accurate and maintains confidentiality of information

Indicator: Maintains clear, concise, timely, accurate and current health consumer records within a legal and ethical framework.

Accepted standard of care:

This is drilled into all nurses from Year one training onwards and there is the much-bandied adage — "if it is not written down, it did not happen". There would be many nurses who have not written in notes when they should have because of work load, but as soon as they are able, they retrieve the notes and write in them. Critically [RN B] failed to document her original conversation around a punch biopsy option.

This constitutes a severe departure from the standard of care.

Recommendation: None as all nurses know this is an absolute and not completing this is just not an acceptable level of practice.

2:4 Ensures the health consumer has adequate explanation of the effects, consequences and alternative of proposed treatment options

Accepted standard of care:

Indicator: Making professional judgement regarding the extent to which the health consumer is capable of participating in decisions relating to their care.

This is a key part of nursing and while new graduates may take a while to grasp how essential this is, an experienced RN should have this as a basis for all their practice. In this instance because the patient was a medical professional, [RN B] assumed that she had sufficient knowledge around procedures and what was happening. This is unfortunately not uncommon when treating other health professionals and as such would be a moderate to severe departure from the standard of care. The following is an excerpt from the letter [RN B] wrote following the complaint:

> "The punch biopsy would have required a further procedure if the biopsy results indicated full excision was required. Ordinarily I would have a discussion with a patient about the difference between a biopsy and a full excision before undertaking the procedure but as [Ms A] was familiar with both procedures this did not take place. I have documented that consent was obtained. Given [Ms A's] own knowledge I accept that my discussion about risks etc would not [have] been as detailed as for other patients."

Recommendation: [RN B] mentions a lack training around treating medical professionals and states that in her new role this was discussed at a meeting of staff. If there was a concern around this, [RN B] could have requested further information after her first appointment with [Ms A] and this could have generated discussion within the practice. All staff should always treat every patient as if they do not know anything and by questioning build from there as necessary, for example by asking [Ms A] if she had any questions and most importantly by ensuring all patients are provided with the patient information sheet.

Domain 3: Interpersonal relationships

3:2 Practises nursing in a negotiated partnership with the health consumer where and when possible

Indicator: Undertakes nursing care that ensures health consumers receive and understand relevant and current information concerning their health care that contributes to informed choice.

Accepted standard of care: As already discussed this would involve far more information and discussion with the patient, ensuring the correct procedure was taking place, obtaining written consent and providing the patient with information and allowing them time to ask any questions.

This was a severe departure from the standard of care.

2:9 Maintains professional development

Accepted standard of care:

This relates to taking responsibility and for [RN B] making herself familiar with updated policies, particularly any around competencies she would be performing and possibly recognising that her training in minor surgery procedures was some time ago, and could be in need of updating or at least having her competency re-assessed. Had she been up to date with the policies she should have known that written consent is needed for minor surgery and punch biopsy and would also have been familiar with the patient information sheet.

There is no guidance around this in terms of time lines either under Nursing Council or the Practice so could be considered a mild departure from care.

Recommendation: One recommendation I would make is that some timeline is introduced around extended skills such as minor surgery and punch biopsy as I note that [RN B's] training around this was in the 80s and 90s. When a new nurse is employed, before being able to perform these skills I would suggest a standard is set that they have either been observed completing the task and signed off as competent within the practice or that competency training/assessment is given every 2 years and has been signed off. This would include knowledge around policies and patient information as well as the actual procedure.

The adequacy and appropriateness of the clinical decision to perform an excision procedure (instead of the punch biopsy procedure) which failed to excise a mole sample

The problem here is that [RN B] identified the wrong area for excision. This was a result of failure to take a photo and share this with [Ms A] to ensure that she had got the correct area, or failing this, she could have sought a second opinion to make sure that she had the correct area. Taking the photo to clarify the mole with the patient is what is mandated in [the medical centre's] policy and she should have been aware of this. This again involves Domain 2.

Domain 2 — Management of nursing care

2:1 Provides planned nursing care to achieve identified outcomes.

Accepted standard of care

Once again this involves not planning care with the patient and a photo of the wound as per the policies at [the medical centre]. This resulted in her not involving the health consumer appropriately in care planning based on informed decisions or administering interventions within established policies.

This constitutes a severe departure from the standard of care as any nurse with the competency to complete this type of procedure should absolutely ensure that they are excising the correct area.

Recommendation: This would be as above, as if the nurse had had the whole competency signed off including the knowledge of the policy this should not occur.

Whether [RN B] carried out an excision procedure with reasonable skill and care.

In terms of how the procedure was carried out there was a reasonable amount of skill, however, her failure to follow skin lines — again as recommended in [the medical centre] policies was a breach in standard of care. Her reasoning was that she followed the lines of the previous scar — this was an occasion when she should have sought a second opinion as to where she should excise.

Domain 2: Management of nursing care

2:8 indicator — identifies one's own level of competence and seeks assistance and knowledge as necessary.

Accepted standard of care:

[RN B] failed to recognise that her skills needed updating including becoming familiar with relevant policies in the Practice. Normal practice for an excision would be to ensure that the area to be excised had been clearly identified with the patient, or with support from a second opinion. This is a severe breach in the standard of care. Her reasoning in not following body lines for the procedure is a moderate breach.

The adequacy of the safety netting advice provided to [Ms A] regarding post excision care.

From the complaint by [Ms A], it does not seem that any post excision advice was given. [RN B] stated that she told the patient how it was dressed and that the sutures should be removed in 10–14 days. There was no mention around infection, bleeding or any other possible post excision complications and again, the patient was not provided with the information sheet. [RN B] also put this in her letter of explanation following the complaint.

Accepted standard of care:

Once again this was not according to the [medical centre's] policy. Any nurse providing minor surgery should provide their patient with information around possible signs of infection, bleeding and pain preferably in writing but if not verbally.

This is moderate departure from the standard of care and was in part because [RN B] assumed that [Ms A] did not need to be told this information.

[RN B] told HDC that on 5 January 2021, she noted that [Ms A's] laboratory results: "showed nothing of concern but [RN B] expected this and assumed [Ms A] was also aware of it". [RN B] subsequently informed [Ms A] that her results were "all good" without noting that the laboratory did not identify any mole particles. Please advise on the appropriateness of [RN B's] actions in this regard.

This had the potential to be a moderate breach, and was certainly not ideal, however, [RN B] did send the actual result to [Ms A] so that she could "read and interpret it herself" and this was a reasonable thing to do.

Accepted standard of care:

This was a mild departure from the standard of care.

Any other matters in this case that you consider warrant comment or amount to a departure from the standard of care/accepted practice.

Unfortunately, [RN B] has failed to tell the truth in her statement. There was the potential for a she said–she said with the differing accounts from [Ms A] and [RN B], however some of this was disclosed in the documentation from the Practice. The major factor here was [RN B] stating that [Ms A's] December 18th appointment was coded for an excision when in fact it was clearly marked as for a punch biopsy. [RN B] admitted that she did not fully remember the previous conversation and that "unfortunately, I had not documented our earlier interaction about the punch biopsy". This in itself should have resulted in further discussion with the patient to ensure they were both on the same page. She ended up performing a procedure which was not consented and which was not coded on her appointments. This is a severe breach in standards of care as is summarised in the questions already covered, and as previously stated the failure to document properly or to ensure that the area she was going to excise was the correct one were at the heart of this complaint.

Additionally, [RN B] tried to say she had an excessive work load at this time, but again the Practice records do not support this and show that on the 18th she had 20 patients not 30 as she stated. She has failed to fulfil some of her responsibilities/competencies under all of the NCNZ Registered Nurse Competencies as shown throughout this report and detailed below.

Domain 1: Professional responsibility; specifically 1.1 accepts responsibility for ensuring that their nursing practice and conduct meet the standards of the professional, ethical and relevant legislated requirement.

Domain 2: Management of nursing care — as detailed in the answers above

Domain 3: interpersonal relationships — as covered under question 1

Domain 4: interprofessional healthcare and quality improvement specifically 4:1 indicator — maintains and documents information necessary for continuity of care and recovery.

Recommendation: I realise that time is of the essence in Primary Health Care, but there needs to be some space for nurse to review upcoming appointments — whether the night before or on the day to ensure they have all their facts and documentation in place. Unfortunately, in this case it would not have made any difference as [RN B] had failed to document her discussion around punch biopsy with [Ms A].

[Medical centre].

A. The standard of the policies in place at [the medical centre] at the time of these events, particularly in relation to excision procedures performed by RNs, and informed consent for minor surgeries.

All of the policies/procedures provided by [the medical centre] are clearly written and were in place when [RN B] provided care to [Ms A]. They were fit for purpose and had been reviewed in 2020 in preparation for an audit; they have been reviewed since this incident and further updated as needed.

The relevant policies relating to this incident are as follows:

1. Procedure for biopsy and minor surgery (19/10/2020)

Specifically, this policy/procedure states that written consent must be obtained and if the procedure is upgraded, further consent is required. It also states that a photograph should be taken prior to any procedure to check with the client that what is to be done is correctly identified.

To support this policy there is also a patient information sheet for patient undergoing minor surgery or punch biopsy (3/7/2018) where one of the pointers for the patient is to inform the staff if they have had any problems with scarring with previous procedures.

2. Clinical notes policy (17/08/2020)

This policy clearly states that every time a member of staff talks to or attempts to talk to a client it is recorded in the clinical notes.

B. Whether [RN B] adhered to the policies in place at [the medical centre] during her appointment with [Ms A] on 18 December 2020.

[RN B] did not, unfortunately adhere to the policies above. She did not get written consent and so obviously did not upgrade any consent, but also failed to get verbal consent for the change of procedure. She failed to take a photograph of the area in question and consequently removed the wrong tissue. I note that in her reflection later she states that she should have taken a photo or diagram to show the patient to make sure they were talking about the same area.

She failed to provide the patient with the information sheet, which would have enabled [Ms A] to say she had had issues with scarring before and also this sheet pointed out problems that could occur post-surgery and which [Ms A] did not have access to at any time.

[RN B] did not document all her communications with [Ms A] which certainly contributed to the confusion around treatment options and what had been decided, as by her own admission, [RN B] did not remember everything around the first appointment when [Ms A] arrived for what she believed would be a punch biopsy.

C. Comment on the adequacy of training provided to [medical centre] RNs carrying out excision procedures.

The practice has a comprehensive induction competency documentation. Despite being very busy they allow time for staff training which is never easy in Primary Health Care and nurses also need to take responsibility around this in line with Nursing Council Competency for Registered nurses on professional practice which states:

Competency 1.1 Accepts responsibility for ensuring that their nursing practice and conduct meet the standards of the professional, ethical, and relevant legislated requirements.

Indicator: Practises nursing in accord with relevant legislation/codes/policies and upholds health consumers rights derived from that legislation

Indicator: Demonstrates knowledge of, and accesses, policies and procedural guidelines that have implications for practice.

Recommendation see also page 3: One recommendation I would make is that some timeline is introduced around advanced skills such as minor surgery and punch biopsy as I note that [RN B's] training around this was in the 80s and 90s. When a new nurse is employed, before being able to perform these skills I would suggest a standard is set that they have either been observed completing the task and signed off as competent within the practice or that competency training/assessment is given every 2 years. This would include knowledge around policies and patient information as well as the actual procedure.

10/08/2020
Jenny Phillips
Nurse Practitioner'

The following further advice was obtained from NP Phillips:

'**Response to further queries relating to 21HDC00756**

1. Severe departures identified for [RN B]

[RN B's lawyer] has raised a number of questions regarding the severe departures identified.

Would you mind providing a further discussion regarding the severe departures identified for [RN B] and comment on whether the further information provided by [RN B's lawyer] changes your original opinion.

The following were identified as severe departures from standards of care in the original report.

1. *Adequacy and appropriateness of [RN B's] record keeping: no change to this. In addition to the information below [the medical centre] made the point that they had had to remind [RN B] on previous occasions to complete her documentation.*
2. *Adequacy and appropriateness of the clinical decision to perform an excision procedure: No change*
3. *Whether [RN B] carried out an excision procedure with reasonable skill and care: Downgrade to moderate breach as she did have the knowledge and skills despite her shortcomings in the actual process.*
6. *Any other matters: This can be deleted as it is covered in the above sections.*

2. [RN B] maintains she has never seen policies provided by [the medical centre]

Considering the new information provided by [the medical centre], can you please provide an opinion on whether [the medical centre] has done enough to introduce its staff and especially [RN B] to its policies.

[RN B's lawyer] queries where the information in the original report was obtained around updating policies and procedures — this was from [the medical centre] in general terms, however they have now provided further evidence. They identified that there was no written record of staff being provided with policy updates and have remedied this in 2021, however, they did always provide individuals with an e mail around updating of policies, and in October 2019 informed all staff of the availability of policies and procedures in 3 separate places accessible on their computer log ins. Additionally, as there was an audit coming up, all staff were asked to become familiar with changes and [RN B] was in fact selected by the auditors to take part in the audit, where they could be questioned on any policy.

Based on evidence provided by [the medical centre] were there sufficient sources and opportunities to access the policies at [the medical centre]?

Yes

What is the standard practice for Medical Centres to introduce its staff to its policies?

Obviously, I cannot speak for all practices, so this is based on my experience and additionally I asked a Family Nurse NP working in a large practice which takes medical and nursing students and her response was the same as my experience, and is copied here: "These are written/updated by one person with input by others as needed. They are put on a shared drive and we are advised of any changes/updates to these policies at our regular 10-minute daily huddle or at the monthly clinical and full staff meetings". She also stated that other than this it would be the RN's professional responsibility to familiarise themselves with the policies and they would not expect additional time for this to be provided by the employer.

Is it usual for RNs not to be aware of its employer's policies and procedures?

No, all organisations have policies and procedures stored in central folders available to all staff.

Any further comment on this issue raised by [RN B's lawyer].

[The medical centre] state[s] that when a policy or procedure is updated on the main server, employees' desktops automatically update at which time all staff are sent a notification e mail. This is an additional insurance rather than just telling staff at meetings. [The medical centre] has checked [RN B's] computer to ensure the automatic e mail set up on her computer was installed and working, and they state that it would be fictitious if she stated she was not aware of updated policies. Additionally, she was sent an individual reminder on December 17th 2020 around failure to follow policies or procedures.

3. [RN B] not "telling the truth" comment in the report

[RN B's lawyer] has noted that [you] commented that [RN B] "did not tell the truth". [RN B's lawyer] stated that [RN B] could have just forgotten that [Ms A] was booked for an "excision" rather than "lying". In light of this, would you consider amending your report to reflect this?

The comment that [RN B] was not telling the truth may be too harsh and it is accepted that she could have forgotten how she recorded the appointment.

Any further comment on this issue raised by [RN B's lawyer] would be appreciated.

This in fact endorses the importance of checking on the appointment list on the day of the procedure to see what had been booked, and [RN B's] recollection that the appointment recorded excision cannot be correct as while appointments can be altered in the booking schedule the computer back up records that an alteration was made and by whom. [The medical centre] has checked this and no alteration was made to the original booking for a punch biopsy.

3. [RN B] was allocated time for "this type of activity" in relation to policy review. Could you please provide further explanation as to why you opine that staff at [the medical centre] were provided with allocated time to review policies.

This was provided in general terms by [the medical centre] as being discussed at staff meetings. They have further enforced this in their letter of September 5th 2022, by stating that that they have a weekly practice meeting for training and updates. During this time a whole policy or procedure could not be covered, but would be brought to the attention of the staff. Additionally on October 18th 2019 an e mail was sent to all users informing them of a new file on desktop containing a pdf of all manuals (see letter dated 20th September 2022). At the time of the incident, nurses were also allocated 7.25 paid nonclinical hours to "catch up on other tasks" and this is operated on an honesty system whereby it is expected that the nurses will use this time to do this. They do not state that this could be used to catch up on policies, but it seems an obvious time to do this, particularly if it is relevant to a specific procedure the nurse is undertaking.

Is it standard practice for employers to allocate time for RNs to review policies?

Not standard practice, see comment under point 2 around RN professional responsibility to update themselves on new policies and procedures.

Alternatively, if [the medical centre] did not allocate specific time for RNs to review its policies would your opinion about [RN B's] lack of knowledge about these policies change in any way?

No, because [the medical centre] in fact provide more time than some other surgeries for nurses as non-clinical hours and it is the RN's professional responsibility to update themselves.

4. "Minor surgical procedures are not within the basic competencies of an RN" according to [RN B]

[RN B's lawyer] stated that comment was made about [RN B's] responsibility for ensuring her training was up to date but, she said that there was no discussion about responsibility and accountability of [the medical centre] for ensuring its staff were adequately trained and accredited to provide such procedures.

Are minor surgical procedures within the basic competencies of an RN? How does this impact [RN B's] care of [Ms A]?

Minor surgical procedures come under expanded practice roles — document from the Nursing Council NZ forwarded with this response. It is absolutely correct that employers also have responsibilities for this (see page 14 of attached document) and these include but not exclusively:

Clear role descriptions for nurses and policies and quality and risk systems to support the RN in this role.

Ensuring nominated RNs have demonstrated a level of competence beyond "competent" level to perform expanded roles and to provide adequate education and clinical training for the provision of safe and competent care.

Ensuring the RN is supported and has been appropriately assessed as competent to undertake the expanded activity and this should be part of the PDRP process.

[The medical centre] had not supplied full information around this initially, but now have stated that [a doctor] assessed [RN B's] competence and also peer reviewed her work and that she and other nurses had frequently been involved in assisting [RN B].

Did [the medical centre] do everything it was required to do as an employer to ensure [RN B] was adequately trained and accredited to provide minor surgeries? What is the acceptable standard for Medical Centres to ensure its RNs were adequately trained and accredited to provide minor surgical procedures?

[The medical centre] appears to have carried out their responsibilities in this area and in line with the responsibilities shown above. The March and February 2017 appointment list for [RN B] show that she had several orientation sessions including on Feb 27th 2017 an hour time slot for minor surgery with one of the staff providing orientation. Additionally, they provided a screen shot of a punch biopsy performed by [RN B] the

week before the procedure on [Ms A] and this was completed correctly following all policy and procedure requirements, showing that she knew what these were.

5. [RN B's] procedural encounter on 10 December 2020

Any comments on this procedural encounter in regard to [RN B's] skill and [the medical centre's] comments would be appreciated.

This record shows that [RN B] knew how to correctly carry out the minor surgery procedure for a punch biopsy according to the policies and procedures — consent, photograph, risks pre and post procedure and recording how the procedure was carried out. I have to agree with [the medical centre] around their comment on the procedure carried out on [Ms A] and this is even more incomprehensible given that [RN B] knew the correct way to perform and document minor surgery.

6. [Medical centre]

In light of the further information provided, [do you] have any further comments to make about the standard of care [the medical centre] provided [Ms A]?

No, only that it is difficult to see why it occurred given all the additional information provided.

7. [RN B] Cornerstone accreditation

What is Cornerstone accreditation?

This is accreditation for GP practices based on providing quality and equity in health care. Education modules are provided to assist consumers to achieve the accreditation, and there are 3 levels, Bronze, Silver and Gold. Further information provided in the link below.

https://www.rnzcgp.org.nz/Quality/Cornerstone/Quality/Cornerstone.aspx?hkey=64ed2c77-cb06-4f23-a038-d44a97d326d6

What are the requirements on RNs and employers in regard to this accreditation and policy awareness/knowledge?

All employees would be expected to know the policies related to their area of work within the practice.

How much participation is required from RNs in this accreditation?

They can be randomly selected by the auditors and asked about any relevant policy and procedures

Would you expect RNs participating in Cornerstone accreditation to be aware of its employer's policies and procedures?

Absolutely, [the medical centre] state that this was a requirement to pass Cornerstone accreditation and also that they provided compulsory education sessions around some policies and [RN B] signed that she had attended these.

Was [the medical centre's] approach to Cornerstone accreditation standard practice?

I would say yes, they kept policies up to date and reviewed them before the audit and informed all staff of the updates.

8. Number of patients seen by [RN B]

[The medical centre] has provided updated records of how many patients were seen by [RN B] around the time of [Ms A's] appointment. Does this change [your] opinion on [RN B's] workload?

[The medical centre] states that the average seen per day by [RN B] in December 2020 was 11.95 and that administration staff allocate catch up appointment times if needed. This appears to be a reasonable workload for onsite appointments.

Jenny Phillips
Nurse Practitioner

September 28th 2022.'

The following further advice was obtained from NP Phillips:

'Report for 21HDC00756

1. *The adequacy and appropriateness of [RN B's] record keeping and communication with [Ms A], particularly with regards to obtaining patient consent and discussing the risks and benefits of the punch biopsy and/or the excision procedure.*

[RN B] failed to keep accurate records around her appointments with [Ms A] and also failed to follow the existing policies at [the medical centre]. The questions posed by the Health and Disability Commission have been measured against the Nursing Council of New Zealand competencies for Registered Nurses.

Domain 2 — management of nursing care — *please see attached document for further breakdown.*

2:1 Provides planned nursing care to achieve identified outcomes;

Accepted standards of care:

The main failure here was not treating the patient according to the policies available at [the medical centre].

While this had serious results many staff do not have time to update on policies within their clinical load, however, time is allocated at [the medical centre] for this type of activity. This would be seen as a moderate departure of care by many.

Recommendation: In future when policies are updated the practice ensures that nurses are made aware of this and a specific education, question and answer session factored

in to ensure that all staff are made aware of changes. This should be signed off on the nurse's competency sheet.

2:3 Ensures documentation is accurate and maintains confidentiality of information

Indicator: Maintains clear, concise, timely, accurate and current health consumer records within a legal and ethical framework.

Accepted standard of care:

This is drilled into all nurses from Year one training onwards and there is the much-bandied adage — "if it is not written down, it did not happen". There would be many nurses who have not written in notes when they should have because of work load, but as soon as they are able, they retrieve the notes and write in them. Critically [RN B] failed to document her original conversation around a punch biopsy option.

This constitutes a severe departure from the standard of care.

Recommendation: None as all nurses know this is an absolute and not completing this is just not an acceptable level of practice.

2:4 Ensures the health consumer has adequate explanation of the effects, consequences and alternative of proposed treatment options

Accepted standard of care:

Indicator: Making professional judgement regarding the extent to which the health consumer is capable of participating in decisions relating to their care.

This is a key part of nursing and while new graduates may take a while to grasp how essential this is, an experienced RN should have this as a basis for all their practice. In this instance because the patient was a medical professional, [RN B] assumed that she had sufficient knowledge around procedures and what was happening. This is unfortunately not uncommon when treating other health professionals and as such would be a moderate to severe departure from the standard of care. The following is an excerpt from the letter [RN B] wrote following the complaint: Downgrade to moderate and also see comment below.

> "The punch biopsy would have required a further procedure if the biopsy results indicated full excision was required. Ordinarily I would have a discussion with a patient about the difference between a biopsy and a full excision before undertaking the procedure but as [Ms A] was familiar with both procedures this did not take place. I have documented that consent was obtained. Given [Ms A's] own knowledge I accept that my discussion about risks etc would not have been as detailed as for other patients."

Recommendation: [RN B] mentions a lack of training around treating medical professionals and states that in her new role this was discussed at a meeting of staff. If there was a concern around this, [RN B] could have requested further information after

her first appointment with [Ms A] and this could have generated discussion within the practice. All staff should always treat every patient as if they do not know anything and by questioning build from there as necessary, for example by asking [Ms A] if she had any questions and most importantly by ensuring all patients are provided with the patient information sheet.

Domain 3: Interpersonal relationships

3:2 Practises nursing in a negotiated partnership with the health consumer where and when possible

Indicator: Undertakes nursing care that ensures health consumers receive and understand relevant and current information concerning their health care that contributes to informed choice.

Accepted standard of care: As already discussed this would involve far more information and discussion with the patient, ensuring the correct procedure was taking place, obtaining written consent and providing the patient with information and allowing them time to ask any questions.

This was a severe departure from the standard of care.

No Change in this. [RN B] herself admits that she did not discuss issues in enough detail. I note that [RN D] (19) says that verbal or written communication can be used as "accepted usual practice" but how can anyone know if verbal information occurred unless it is at least recorded in the notes along the lines of "all options discussed with patient and queries answered".

2:9 Maintains professional development

Accepted standard of care:

This relates to taking responsibility and for [RN B] making herself familiar with updated policies, particularly any around competencies she would be performing and possibly recognising that her training in minor surgery procedures was some time ago, and could be in need of updating or at least having her competency re-assessed. Had she been up to date with the policies she should have known that written consent is needed for minor surgery and punch biopsy and would also have been familiar with the patient information sheet.

There is no guidance around this in terms of time lines either under Nursing Council or the Practice so could be considered a mild departure from care.

No change around updating on policies as a mild departure. I note that [RN D] makes the point that there was no signed document indicating that [RN B] had read the policies and this is both a personal and practice responsibility to ensure this is done.

Recommendation: One recommendation I would make is that some timeline is introduced around extended skills such as minor surgery and punch biopsy as I note

that [RN B's] training around this was in the 80s and 90s. When a new nurse is employed, before being able to perform these skills I would suggest a standard is set that they have either been observed completing the task and signed off as competent within the practice or that competency training/assessment is given every 2 years and has been signed off. This would include knowledge around policies and patient information as well as the actual procedure.

2. *The adequacy and appropriateness of the clinical decision to perform an excision procedure (instead of the punch biopsy procedure) which failed to excise a mole sample*

The problem here is that [RN B] identified the wrong area for excision. This was a result of failure to take a photo and share this with [Ms A] to ensure that she had got the correct area, or failing this, she could have sought a second opinion to make sure that she had the correct area. Taking the photo to clarify the mole with the patient is what is mandated in [the medical centre's] policy and she should have been aware of this. This again involves Domain 2.

Domain 2 — Management of nursing care

2:1 Provides planned nursing care to achieve identified outcomes.

Accepted standard of care

Once again this involves not planning care with the patient and a photo of the wound as per the policies at [the medical centre]. This resulted in her not involving the health consumer appropriately in care planning based on informed decisions or administering interventions within established policies.

This constitutes a severe departure from the standard of care as any nurse with the competency to complete this type of procedure should absolutely ensure that they are excising the correct area.

No change in this as she did fail to identify the area clearly and regardless of the policy stating a photograph should be taken, I would expect that to occur with an area the patient could not see. I accept that [RN B] has identified and accepted that her practice did not meet standards of care (25–27).

Recommendation: This would be as above, as if the nurse had had the whole competency signed off including the knowledge of the policy this should not occur.

3. *Whether [RN B] carried out an excision procedure with reasonable skill and care.*

In terms of how the procedure was carried out there was a reasonable amount of skill, however, her failure to follow skin lines — again as recommended in [the medical centre] policies was a breach in standard of care. Her reasoning was that she followed the lines of the previous scar — this was an occasion when she should have sought a second opinion as to where she should excise.

Domain 2: Management of nursing care

2:8 indicator — identifies one's own level of competence and seeks assistance and knowledge as necessary.

Accepted standard of care:

[RN B] failed to recognise that her skills needed updating including becoming familiar with relevant policies in the Practice. Normal practice for an excision would be to ensure that the area to be excised had been clearly identified with the patient, or with support from a second opinion. This is a severe breach in the standard of care. Her reasoning in not following body lines for the procedure is a moderate breach.

I accept the comments made by [RN D] (40) and while there is no change in the need for skills updating, the failure to follow body lines can be removed as she did follow the line of the old scar.

4. *The adequacy of the safety netting advice provided to [Ms A] regarding post excision care.*

From the complaint by [Ms A], it does not seem that any post excision advice was given. [RN B] stated that she told the patient how it was dressed and that the sutures should be removed in 10–14 days. There was no mention around infection, bleeding or any other possible post excision complications and again, the patient was not provided with the information sheet. [RN B] also put this in her letter of explanation following the complaint:

Accepted standard of care:

Once again this was not according to the [medical centre's] policy. Any nurse providing minor surgery should provide their patient with information around possible signs of infection, bleeding and pain preferably in writing but if not verbally.

This is a moderate departure from the standard of care and was in part because [RN B] assumed that [Ms A] did not need to be told this information.

I have not concluded that no post excision advice was given (45) I simply stated that it did not seem that any was given. Again there was information on the standard template for excision included in the notes, but as there is doubt around how much of this was discussed or conveyed to [Ms A] — see comment above.

In the scenario that [RN B] did not give any post-excision advice, in my opinion this would be a moderate departure and only because she is dealing with another health professional, as in fact they should have some of this knowledge and be able to ask any questions around it. Advice should have included: When sutures due for removal ([RN B] said she did say this) and where to get this done. Signs of infection, inflammation, excess swelling, pain — ideally someone to look at the wound for her once a day to see if any of these changes. If any of these occurred to return to surgery for check. Post excision pain relief if needed (although this could probably be excluded for a [medical

professional] who would know this) avoiding any activity which would stretch the area and put it under strain, and if any gaping or breakdown in the suture line occurred to return to surgery. Most of this was in the standard template, but as above it is difficult to say if it was discussed with the patient, just putting it in the notes does not confirm this. If the patient had to sign that they had read it this would be different. In the scenario that [RN B] did give post-excision advice as per her statement, in my opinion this would be normal standard practice.

What is to be commended is [RN B's] actions since the complaint. In her May and June 2021 responses she admits to having reflected on the incident and the miscommunication. She acknowledges where she could have improved her communication and states that she will not do any more excisions until she has further education and assessment and sign off before completing any more. If she has followed through with this, it shows a commitment to improving her practice to an accepted standard of care.

5. *[RN B] told HDC that on 5 January 2021, she noted that [Ms A's] laboratory results: "showed nothing of concern but [RN B] expected this and assumed [Ms A] was also aware of it". [RN B] subsequently informed [Ms A] that her results were "all good" without noting that the laboratory did not identify any mole particles. Please advise on the appropriateness of [RN B's] actions in this regard.*

This had the potential to be a moderate breach, and was certainly not ideal, however, [RN B] did send the actual result to [Ms A] so that she could "read and interpret it herself" and this was a reasonable thing to do.

Accepted standard of care:

This was a mild departure from the standard of care.

I accept that as she forwarded the results to the patient this can be discounted as a departure from the standard of care. (52)

6. *Any other matters in this case that you consider warrant comment or amount to a departure from the standard of care/accepted practice.*

There are differing accounts around this complaint. There was the potential for a she said–she said with the differing accounts from [Ms A] and [RN B], however some of this was disclosed in the documentation from the Practice. The major factor here was [RN B] stating that [Ms A's] December 18th appointment was coded for an excision when in fact it was clearly marked as for a punch biopsy. [RN B] admitted that she did not fully remember the previous conversation and that "unfortunately, I had not documented our earlier interaction about the punch biopsy". This in itself should have resulted in further discussion with the patient to ensure they were both on the same page. She ended up performing a procedure which was not consented and which was not coded on her appointments. This is a severe breach in standards of care as is summarised in the questions already covered, and as previously stated the failure to document

properly or to ensure that the area she was going to excise was the correct one were at the heart of this complaint.

I accept the comments around changes in this and [RN B] failing to tell the truth (20) in [RN D's] report, and have amended this. I see that the software is to be audited, but this issue does also return to the lack of documentation around the previous visits. The departure of care remains severe. She states that [Ms A] paid for the longer appointment, but that does not mean that she realised the significance of this. There was a standard template included and completed on December 18th, however this states that it was for an excision, yet [RN B] in her reply of May 2021 stated there was no discussion around a punch biopsy otherwise she would not have proceeded with the excision. Equally if she had discussed excision with [Ms A], as on the template, it is to be assumed that [Ms A] would have picked up on this and corrected it to punch biopsy.

Additionally, [RN B] tried to say she had an excessive work load at this time, but again the Practice records do not support this and show that on the 18th she had 20 patients not 30 as she stated. She has failed to fulfil some of her responsibilities/competencies under all of the NCNZ Registered Nurse Competencies as shown throughout this report and detailed below.

Domain 1: Professional responsibility; specifically 1.1 accepts responsibility for ensuring that their nursing practice and conduct meet the standards of the professional, ethical and relevant legislated requirement.

Domain 2: Management of nursing care — as detailed in the answers above

Domain 3: interpersonal relationships — as covered under question 1

Domain 4: interprofessional healthcare and quality improvement specifically 4:1 indicator — maintains and documents information necessary for continuity of care and recovery.

Recommendation:

I realise that time is of the essence in Primary Health Care, but there needs to be some space for nurses to review upcoming appointments — whether the night before or on the day to ensure they have all their facts and documentation in place. Unfortunately, in this case it would not have made any difference as [RN B] had failed to document her discussion around punch biopsy with [Ms A].

I accept that Practice Nurses can get overloaded with phone calls and these are not recorded. I think [RN D] has a good point around an 8 hour day and catch up time which the practice might like to take on board. However, as information is recorded, [RN B's] statement that she had 30 patients that day is not supported by the records. Additionally as [RN D] states, regardless of work load [RN B's] accountability to meet expected standards of care is not reduced (62).

[Medical centre]

A. The standard of the policies in place at [the medical centre] at the time of these events, particularly in relation to excision procedures performed by RNs, and informed consent for minor surgeries.

All of the policies/procedures provided by [the medical centre] are clearly written and were in place when [RN B] provided care to [Ms A]. They were fit for purpose and had been reviewed in 2020 in preparation for an audit; they have been reviewed since this incident and further updated as needed.

The relevant policies relating to this incident are as follows:

1. Procedure for biopsy and minor surgery (19/10/2020)

Specifically, this policy/procedure states that written consent must be obtained and if the procedure is upgraded, further consent is required. It also states that a photograph should be taken prior to any procedure to check with the client that what is to be done is correctly identified.

To support this policy there is also a patient information sheet for patient undergoing minor surgery or punch biopsy (3/7/2018) where one of the pointers for the patient is to inform the staff if they have had any problems with scarring with previous procedures.

2. Clinical notes policy (17/08/2020)

This policy clearly states that every time a member of staff talks to or attempts to talk to a client it is recorded in the clinical notes.

B. Whether [RN B] adhered to the policies in place at [the medical centre] during her appointment with [Ms A] on 18 December 2020.

[RN B] did not, unfortunately adhere to the policies above. She did not get written consent and so obviously did not upgrade any consent, but also failed to get verbal consent for the change of procedure. She failed to take a photograph of the area in question and consequently removed the wrong tissue. I note that in her reflection later she states that she should have taken a photo or diagram to show the patient to make sure they were talking about the same area.

She failed to provide the patient with the information sheet, which would have enabled [Ms A] to say she had had issues with scarring before and also this sheet pointed out problems that could occur post-surgery and which [Ms A] did not have access to at any time.

[RN B] did not document all her communications with [Ms A] which certainly contributed to the confusion around treatment options and what had been decided, as by her own admission, [RN B] did not remember everything around the first appointment when [Ms A] arrived for what she believed would be a punch biopsy.

C. *Comment on the adequacy of training provided to [medical centre] RNs carrying out excision procedures.*

The practice has a comprehensive induction competency documentation. Despite being very busy they allow time for staff training which is never easy in Primary Health Care and nurses also need to take responsibility around this in line with Nursing Council Competency for Registered nurses on professional practice which states:

Competency 1.1 Accepts responsibility for ensuring that their nursing practice and conduct meet the standards of the professional, ethical, and relevant legislated requirements.

Indicator: Practises nursing in accord with relevant legislation/codes/policies and upholds health consumers' rights derived from that legislation

Indicator: Demonstrates knowledge of, and accesses, policies and procedural guidelines that have implications for practice.

Recommendation see also page 3: One recommendation I would make is that some timeline is introduced around advanced skills such as minor surgery and punch biopsy as I note that [RN B's] training around this was in the 80s and 90s. When a new nurse is employed, before being able to perform these skills I would suggest a standard is set that they have either been observed completing the task and signed off as competent within the practice or that competency training/assessment is given every 2 years. This would include knowledge around policies and patient information as well as the actual procedure.

Jenny Phillips
Nurse Practitioner

10/08/2022

Amendments following [RN D's] report made on April 20th 2023'

Appendix B: Advice from RN D

The following advice was obtained by RN B from RN D:

'1. Thank you for the request that I provide an independent report in relation to the complaint from [Ms A] on 8 April 2021 about the care provided to her by [RN B] at [the medical centre] in December 2020. In preparing my 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 Health and Disability Commissioner's Guidelines for Independent Advisors and the High Court Code for expert witnesses.

2. I have been asked to review the provided documentation and advise whether I consider the care provided to [Ms A] by [RN B] was reasonable in all the circumstances, and why. In particular, I have been asked to comment on:

a. The adequacy and appropriateness of [RN B's] record keeping and communication with [Ms A], particularly with regards to obtaining consent and discussing the risks and benefits of the punch biopsy and/or excision procedure.
b. The adequacy and appropriateness of the clinical decision to perform an excision procedure (instead of a punch biopsy procedure) which did not excise a mole sample.
c. Whether [RN B] carried out an excision procedure with reasonable care and skill.
d. The adequacy of the safety netting advice provided to [Ms A] regarding post excision care.
e. [RN B] told HDC that on 5 January 2021, she noted that [Ms A's] laboratory results: "showed nothing of concern but [RN B] expected this and assumed [Ms A] was also aware of it". [RN B] then informed [Ms A] that her results were "all good" without noting that the laboratory did not identify any mole particles. Please advise on the appropriateness of [RN B's] actions in this regard.
f. Any other matters in this case that you consider warrant comment or amount to a departure from the standard of care/accepted practice.

3. For each question, I have been asked to advise:

a. What is the standard or care/accepted practice?
b. If there has been a departure from the standard of care or accepted practice, how significant a departure I consider this to be (minor, moderate, severe)?
c. How would it be viewed by my peers?
d. Recommendations for improvement that may help to prevent a similar occurrence in the future.

4. I have also been asked to note that if there are different versions of events in the information provided, to provide advice in the alternative. For example, whether the care was appropriate based on scenario (a), and whether it was appropriate based on scenario (b).

5. …

6. I have reviewed the following documentation: [Ms A's] complaint to [the medical centre], [Ms A's] complaint to HDC, clinical notes, HDC letter to [RN B], [RN B's] first response to HDC May 2021, [RN B's] second response to HDC June 2022, Report for the HDC by Jenny Phillips, Nurse Practitioner (NP), [medical centre] Policies and Procedures, work schedules, position descriptions, [RN B's] orientation records, transcript of [Ms A's] meeting with [the medical centre], and [the medical centre's] responses to [Ms A] and HDC.

7. In addition, to prepare my advice, I have reviewed the New Zealand Nursing Council's (NZNC) Scope of Practice and Competencies for Registered Nurses, the New Zealand Nursing Council's "*Expanded Practice Guidelines*", the New Zealand Nurses Organisation's (NZNO) "Documentation 2021" and "Standards of Professional Nursing" Practice Guidelines, and Dermnet New Zealand (www.dermnetnz.org). I have also undertaken literature reviews about a range of topics identified in this case to aid in preparing my advice.

8. In determining significance of findings, I have assessed these against the Joint Commission's "*SAFER* Matrix" (attached). This is a peer reviewed and researched assessment tool widely used to stratify risk during quality improvement activities within health organisations.

9. **Adequacy and appropriateness of [RN B's] record keeping and communication with [Ms A], particularly with regards to obtaining consent and discussing the risks and benefits of the punch biopsy and/or excision procedure.**

Standard of care / accepted practice

The NZNO has practice guidelines that outline the accepted standards of record keeping and clinical documentation. This document was updated in 2021, however the principles have not substantively changed from the guideline that was in place in 2020. I have also reviewed [the medical centre's] comprehensive policies and the NZNC Competencies for Registered Nurses.

10. Clinical documentation is a formal record of patient care and essential for effective and safe clinical communication. It is a core requirement of the NZNC within the competencies of the RN scope of practice and applies to all forms and formats (both paper and electronic), including clinical notes, emails, texts, and letters. Clinical documentation serves multiple purposes but, in my view, the main ones that are relevant in this case are to accurately reflect treatment, care planning and delivery, and to support good continuity of care.

11. [RN B] states in her response to the HDC, she does not recall reviewing any [medical centre] policies either at her orientation or during the Cornerstone auditing process in 2020. I have reviewed [RN B's] induction check list and note a tick beside the policies and procedures section. As outlined in the document, it appears this confirms [RN B] was advised of the location of the policies, procedures, and guidelines manual. However, I also note the induction checklist requires new staff to have "reviewed all

policies and procedures and signed a declaration of acknowledgment and understanding".

12. [The medical centre] states that staff are fully aware of, and provided with, opportunities to familiarise themselves with all [medical centre] policies and procedures. I have not been provided with either a declaration signed by [RN B] (per the [medical centre] induction process), or with documents that confirm whether policies and procedures were discussed at any time during team or practice meetings.[1] As there are inconsistencies between statements by [RN B] and [the medical centre], I have based my comments on the professional documentation guidelines and Standards of Practice of the NZNO, and the NZNC competencies for Registered Nurses, and not on any requirements identified within [medical centre] policies.

13. [RN B] used templates to record care provided at both consultations with [Ms A]. In the response from [the medical centre] to the HDC, [Mr C] refers to the use of prepopulated and non-prepopulated templates. The NZNO guidelines discuss the use of Focus Charting, checklists, and flow sheets, all of which are types of pre- and non-prepopulated templates. These guidelines make no specific comments about or against the use of other types of templates. In clinical practice across all settings including general practice, templates are accepted as appropriate formats for clinical documentation and can be prepopulated and non-prepopulated. The key factors irrespective of documentation format, are that records accurately reflect the substance of the consultation and would be easily understood by another provider or the patient.

14. In the first consult with [Ms A], [RN B] appropriately documents the cervical smear procedure using a template, in line with NZNO guidelines and accepted practice. There are no other documented comments linked to this consultation that relate to discussions about either blood tests or biopsy/excision of a lesion, however the fact blood tests (and what these were) were ordered is recorded in a laboratory test form.

15. In my experience, women presenting for cervical screening will often use this visit as an opportunity for a general health check and wish to discuss other issues or concerns. [RN B] comments in her first letter to the HDC, she would usually not be able to manage (or would allow) discussion of other issues within a 15-minute cervical screening consultation. In my experience this would be a common approach in general practice (single appointment/single issue) as time is limited. However, because [Ms A] is a health professional, [RN B] felt she could accommodate additional discussions, and recalls [Ms A] did request a punch biopsy as well as some blood tests.

16. [RN B] states that she would usually document all interactions fully, but was under time pressure, and intended to return to complete the note later. In my experience this

[1] This is a footnote added by HDC (not included in RN D's original advice). In response to the provisional opinion report and this comment from RN D, the medical centre stated: '[The medical centre] has previously provided evidence of the [Cornerstone Accreditation] Audit to the HDC. [The medical centre] confirms that [RN B] would not have been able to have been involved with the Audit if she were not aware of [the medical centre's] policies and procedures and attended all team meetings when these were discussed in detail.'

would be quite common in general practice. Frequently documentation is not fully completed at the time of consultation and will be completed at the end of the session or clinic list. It is often difficult to complete a consultation including thorough documentation, and any referrals for example, within a 15-minute consultation. The NZNO guidelines accept this can occur and outline processes for RNs to use when adding to or completing notes after patient interactions. In this case, [RN B] did not return to complete her documentation. Therefore, there is no record of the content of the discussion with [Ms A] about the procedure planned for the management of this lesion. [RN B] did appropriately communicate the result of the cervical screening to [Ms A].

17. At [Ms A's] second consultation on 18th of December 2020, [RN B] recorded the procedure using a prepopulated template ([Mr C's] letter to the HDC). As I stated previously, in my view this was a reasonable approach and is an accepted way to document care. I do note there are discrepancies between [Ms A's] statements, and [RN B's] statements/clinical note, about the discussion of and consent to a procedure at the consultation on 18th of December 2020. However, it cannot be inferred that just because the basis for the documentation comes from a prepopulated template, what is documented is inaccurate or did not occur. Therefore, I do not agree with [Mr C's] comments in his response to the HDC (4th of May 2021, Pg 2), where he states clinical notes based on a pre-populated template do not "prove" a practitioner's care.

18. Further, in my experience practitioners will review and amend templates to ensure what is documented reflects the details of a consultation. I note as stated by [Mr C] (response to the HDC), a software audit shows the template was amended and the phrase "*also a picture of a lesion*" was removed. This shows that [RN B] must have reviewed and did amend the template as no picture was in fact taken. However, within the clinical documentation related to both consultations, there is a lack of detail recorded about the substance of the discussions with [Ms A], what options were requested and then discussed, what types of procedure(s) may have been appropriate, and the resulting decision by [Ms A] about the procedure she consented to have completed.

19. In general practice we commonly communicate advice both verbally and via written resources and both are accepted usual practice. In addition, a literature review about written vs verbal information showed advantages and disadvantages for both formats. However, both have a body of evidence to support their use. It is reasonable that the post procedure information was provided verbally and not via a handout. The [medical centre] policy "Informed Decisions About Care" (Pg 174/634) also supports the use of either format.

20. There are discrepancies in accounts regarding the booking of [Ms A's] appointment on the 18th of December. [RN B] states the schedule showed [Ms A's] appointment had been made as a double appointment of 30 minutes and the reason for the consultation was "excision". [The medical centre] states the appointment was booked as a punch biopsy, and the schedule provided to me shows "pb" which appears to refer to a punch biopsy. I understand an audit of the software has been requested and I would expect

this to clarify this issue. However, I disagree with NP Phillips who states, "unfortunately [RN B] failed to tell the truth in her statement" (Pg 6, Report). In my view this cannot be concluded. Irrespective of any audit information, at the time, [RN B] states she approached this consultation with the understanding an excision was booked. She comments that this would fit with the fact a double appointment (30 minutes) was booked as a punch biopsy would usually only be booked for a 15-minute consultation. [RN B] also states that she noted an excision fee was charged and paid for by [Ms A].[2]

21. [RN B's] assumption about the purpose for the consultation was confounded by the lack of documentation at the earlier consultation. This would have clarified for [RN B], that the procedure requested and discussed with [Ms A] in the first consultation, was a biopsy. [RN B] acknowledges this in her initial response to the HDC. In my view, during the first consult with [Ms A], [RN B] tried to extend a professional courtesy to a clinical colleague. Unfortunately, by allowing other health concerns to be raised by [Ms A], [RN B] increased the complexity of the consultation which would have exacerbated any time pressures, and directly contributed to the subsequent events in this case.

22. Irrespective of any earlier consultations, documentation, or requests, it would be usual and accepted practice to confirm prior to any procedure, at the time of the procedure, exactly what procedure was to be completed. Because of this, in my opinion, the omissions in documentation for the first consultation are not highly significant.

23. However, at the second consultation, whilst [RN B] believed the appointment was for an excision, the clinical notes do not adequately reflect the contents of [RN B's] discussions with [Ms A] around informed consent for a procedure on that occasion (patient request for a biopsy, the options, or benefits of biopsy versus a full excision, or confirmation of the final decision about what procedure would be provided as agreed with [Ms A]). The only documentation made by [RN B] which shows clear consent to any procedure, is on the 18th of December 2020 for an excision, and [Ms A] states she would not have consented to this.

24. It is an expected standard of practice, that the health practitioner and not the patient, has full responsibility for clarifying treatment plans, obtaining consent relevant to this, and then completing documentation. I note that [RN B] has identified her responsibility for this in her response to the HDC (page 3).

25. <u>Departure from the standard of care or accepted practice</u>

a. The lack of adequate documentation about [RN B's] communication in the first consultation with [Ms A] is a **Low significance limited in scope departure from usual and accepted practice standards.**

[2] This is a footnote added by HDC (not included in RN D's original advice). In response to the provisional opinion, the medical centre stated: '[Ms A] was charged $50, which is the price of a punch biopsy, and minor surgery charges (such as an excision) are $100.'

b. The lack of adequate documentation about the process and details of discussions in obtaining informed consent at the second consultation is a **Moderately significant limited in scope departure from usual and accepted practice standards.**

26. How would this be viewed by peers

All RNs working in general practice would agree that the documentation/evidence, particularly reflecting the discussion and detail around obtaining informed consent, is not at the expected standards in this case.

27. Recommendations

a. I have no recommendations as to the appropriateness of documentation formats used by [RN B].

b. In both response letters to the HDC, [RN B] has identified and accepted where her practice has not met expected standards. She has commented about the challenges of treating another health professional, and the deficiencies in her practice around communication, documentation, and informed consent. Through reflection, [RN B] has identified specific strategies and actions she should have taken in her consultations with [Ms A] (Page 3, Initial Response, Page 4, second response). I agree with all the strategies and actions [RN B] has identified as these would meet the expected standards of care if implemented. If [RN B] had not already done so, I would have recommended she undertake a process of practice reflection and review of relevant standards of practice, to consider in detail the areas of practice deficiencies highlighted. I would have expected [RN B] to be able to identify how and where she can make practice improvements going forward and I see that she has done this. In my view this recommendation has been achieved.

c. The documentation policies at [the medical centre] are comprehensive, appropriate, and helpful in supporting good practice and [the medical centre] states they do ensure staff are familiar with and practise in accordance with relevant policies. However, NZNO documentation guidelines also recommend that RNs should receive regular and ongoing education and support, related to their responsibilities and the expected standards of documentation. I have reviewed no information that confirms whether this occurs for RNs working at [the medical centre]. If not, I recommend that this occur. [3]

[3] This is a footnote added by HDC (not included in RN D's original advice). In response to the provisional opinion, the medical centre stated that all its staff have weekly training and mentoring sessions that they are required to attend and provide feedback on, and that following this complaint all staff members are required to sign each updated policy and procedure.

28. **The adequacy and appropriateness of the clinical decision to perform an excision procedure (instead of a punch biopsy procedure) which failed to excise a mole sample.**

Standard of care/accepted practice

Notwithstanding the issues discussed above related to consent, patient expectations and documentation, I will answer this question focusing on [RN B's] decision between excision or biopsy.

29. In my experience and as an accepted practice, it is usual to consider a range of factors when deciding what procedure is most appropriate. These include patient preference, location of the lesion, previous history related to lesions and excisions/ biopsies, and suspicions about the type of lesion in question.

30. In this case, [RN B] states she was aware from [Ms A] that the area of concern was "by the previous scar" (first response to the HDC). [RN B] assessed the area and noted a "discolouration" beside the previous scar and thought this was the lesion of concern to [Ms A]. [RN B] states she was aware from [Ms A] the previous lesion "had been irregular" and considered the possibility that the new area could have arisen from the previous lesion. Therefore, [RN B] considered it best to re-excise the whole scar along with the discolouration. [Ms A] states [RN B] said, "if I make it a little bigger I can remove it all". [Ms A] states she understood this to mean [RN B] would take a larger biopsy. [RN B] accepts she probably did say this referring to removing the whole scar and appears to have assumed implied consent when [Ms A] didn't question or discuss this further. "I advised I could remove all the discolouration with the scar as then there would be only one scar. [Ms A] accepted this" ([RN B], second response to HDC, Pg 2).

31. In my view a decision to excise the area of discolouration along with the whole scar would be a common approach taken in the general practice setting for several reasons. These include reducing the need for further procedures and follow-up. But most importantly, to ensure its prompt removal for patient safety. Especially where it is suspected a new lesion might relate to the site of an earlier excision with an abnormal or irregular histology. In my view [RN B's] decision to excise the scar was reasonable.

32. Regarding correct identification of the area of [Ms A's] concern, there is no documentation made by [RN B] that describes in more detail how she established the correct location of the lesion. In retrospect, the lesion was not adequately identified, however [RN B] did make both verbal and visual attempts to identify the site of concern, and in good faith believed she had.

33. In my experience, sometimes practitioners do not adequately remove part or all of lesions they intend to excise. Usually, as part of good practice, practitioners will try to excise as little tissue as possible. On occasion this results in a sample that shows incomplete histological margins. However, in this case, as [RN B] did not adequately identify the correct lesion, the lesion [Ms A] was concerned about was not excised.

34. Departure from the standard of care or accepted practice

The lack of evidence that [RN B] took adequate steps to correctly identify the lesion to be removed is a **Moderately significant limited in scope departure from accepted practice standards.**

35. How would this be viewed by peers

All RNs working in general practice, as either practitioners providing or assisting with excision or biopsy, would agree that correct identification of the lesion or site for procedure is an expected standard of care in clinical practice.

36. Recommendations

a. I have no recommendations as to the decision to excise vs biopsy.

b. [RN B] in her responses to the HDC has identified several appropriate and specific actions she would utilise in the future to address the deficiencies in her practice. Several of these relate specifically to correct identification of lesions. I would have recommended that [RN B] complete a review of her actions in this case and articulate specific actions she will implement around correct identification of lesions had she not already done this.

c. I also recommend that before [RN B] provides any further excisions or biopsies, she undertakes a thorough review of her employer's workplace policies and procedures, in addition to reviewing reliable resources like Dermnet NZ, to support appropriate clinical practice.

37. **Whether [RN B] carried out an excision procedure with reasonable care and skill.**

Standard of care/accepted practice

There are many resources available that outline good clinical practice for excisions. In general, these will reflect several steps that practitioners should take to progress through the procedure logically and appropriately. These include cleaning the site, choice of anaesthesia, performing the procedure, appropriate wound closure method and suture selection (if used), initial wound care, advice about follow up wound care/ self-care, post procedure advice and when to return for suture removal if relevant. In answering this question, I have focused on the performance of the procedure itself.

38. As documented in the clinical notes and supported by [RN B's] responses to the HDC, in my view the processes and approach undertaken in performing the excision meet accepted standards of practice. This includes [RN B's] site preparation, choice of and infiltration of local anaesthetic, choice of and application of suture, post-procedure wound care, planned timing of suture removal and post procedure advice. The photo provided by [Ms A] after the excision (attached to her complaint to [the medical centre]) appears to show a clean linear wound, which is well approximated without puckering, and with secure intact evenly spaced sutures.

39. I note in the HDC letter to [RN B], and in [Mr C's] letter to the HDC, specific questions have been raised about [RN B's] approach to the orientation of the excision. The resource mentioned is known as "Langer's lines". Importantly, whilst often quoted as a "gold standard" guideline, as stated by Dermnet NZ (a widely used New Zealand clinical reference website developed by New Zealand specialist medical practitioners), Langer's lines were not intended as a guide for surgical excisions. This is because they do not always correspond to the best orientation for these and often run perpendicular to skin folds. Dermnet NZ identifies other preferred resources they recommend are used instead.

40. Whatever resources or previous experience a practitioner may use, they will assess the individual patient to determine the most appropriate direction in which to excise tissue, with the aim of improving wound closure, healing, and cosmetic results. In my experience, individuals differ significantly in their skin and body habitus, and practitioners will decide about which way they will orient their approach considering a wide range of factors. This practice is supported by Dermnet NZ, therefore I disagree with NP Phillips' comments in her report (pg. 5), that [RN B's] "failure to follow skin lines … was a breach in standard of care".

41. In this case, a practitioner who was a medical specialist ([Ms A's] letter of complaint), had previously removed a lesion. In my view, it was appropriate and reasonable that [RN B] would follow the same orientation as the previous practitioner, and as previously stated, [RN B] intended to remove the scar. To do this, she would need to follow the line of the old scar. In addition, [RN B] assessed the site of the excision (i.e. skin pinch) and noted the site was in an area of the body where skin tension can change. In my view [RN B's] practice meets expected standards of care.

42. Unfortunately, [Ms A] experienced a breakdown of the excision site and development of a hypertrophic scar, which was what [Ms A] had been concerned could happen. These are known possible complications of any surgical intervention. Rates of post-procedure wound dehiscence and hypertrophic scarring vary widely in the literature. Correlations or risks are linked to a lengthy list of factors that include type of procedure, previous surgical intervention, and location. The upper back/shoulder region is an area with a higher risk of wound breakdown, and even a large punch biopsy at this site might have opened up post-procedure and scarred.

43. Departure from the standard of care or accepted practice

I have found no departure from expected practice in terms of the provision of an excision.

44. **The adequacy of the safety netting advice provided to [Ms A] regarding post excision care.**

Standard of care/accepted practice

It is expected and usual practice that RNs/practitioners provide post procedure advice to patients about what they may expect and/or what to do about it if something does

occur. This advice could be related to the identification of expected or unexpected effects (i.e., infection, delayed healing, deterioration), and what, and/or how, the patient can seek support or review (i.e., return to the practice, after-hours contact information).

45. I disagree with the comment from NP Phillips (Pg 5) that "From the complaint by [Ms A], it does not seem that any post excision advice was given". In my view this cannot be concluded. [Ms A's] complaint identifies concerns about the fact an excision was completed instead of a biopsy, and that she experienced an adverse outcome due to this (wound breakdown and hypertrophic scarring), without the removal of the lesion. In her letter of complaint, no concerns about safety netting advice provided by [RN B] post procedure are identified.

46. In this episode of care, [RN B's] clinical notes include a description of not only when and how to identify issues, but also, what to do if any problems arose, and how the excision site should be cared for by the patient at home. It is acceptable that safety netting advice can be provided verbally (as in this case), and/or through written resources. As always, evidence of either what was communicated verbally, or provided in written format, should be included in the clinical documentation. In my view, what is documented in the clinical record is appropriate and adequate.

47. Departure from the standard of care or accepted practice

In my opinion there are no departures from the expected standard of care.

48. **[RN B] told HDC that on 5 January 2021, she noted that [Ms A's] laboratory results: "showed nothing of concern but [RN B] expected this and assumed [Ms A] was also aware of it". [RN B] subsequently informed [Ms A] that her results were "all good" without noting that the laboratory did not identify any mole particles. Please advise on the appropriateness of [RN B's] actions in this regard.**

49. Standard of care/accepted practice

Informing patients of results is an expected duty of care. However, in my experience it is also widespread practice that in some situations, particularly for normal or stable results, practitioners do not always specifically or actively relay every result. In many instances practitioners and patients may agree that "no news is good news" with regards to result notification. In addition, increasingly in general practice settings, patients have access to their own results via on-line portals. Therefore, a patient can view their results, at any time, and whether results are normal or abnormal. Frequently practitioners will make comments about results that can be seen in the portal to provide patients with further clarification as to the significance of the result. However, there are certain types of results where it would be usual and expected that practitioners would always actively advise patients. This would include results related to potential or actual significant diagnoses, results that will affect or change a plan of care and as in this case, histology.

50. [RN B] had intentionally excised scar tissue and an area of discolouration. I have reviewed the histology result and note the macroscopic result comment refers to the presence of "an irregular slightly raised skin coloured hard lesion". On microscopic examination, the tissue represented a hypertrophic scar which appeared completely excised.

51. In my view, it is reasonable that [RN B] interpreted this result as she did, which was that the result reflected nothing abnormal microscopically and contained a fully excised scar. [RN B] expected to see scar tissue, and as is usual practice, would be checking to ensure that the sample held no cells of concern. This is important especially given the comment that a lesion was seen in the macroscopic tissue sample. Therefore, [RN B's] email ("all good") to [Ms A] was appropriate in reassuring [Ms A] that there was no microscopic histological evidence of any cells/cell changes of concern, in a sample that held a lesion evident macroscopically. [RN B] also took the further step of forwarding the actual result via email, which is likely in my view to reflect the fact [Ms A] was herself a health professional. In my opinion it could reasonably be assumed [Ms A] would appreciate reviewing the result herself. This shows thorough practice.

52. Departure from the standard of care or accepted practice

In my view there are no departures from the expected standard of care.

53. **Any other matters in this case that you consider warrant comment or amount to a departure from the standard of care/accepted practice.**

I have several other comments to make.

54. Workload

I have reviewed the work schedules for [RN B] in the days around the 18th of December 2020, [RN B's] comments in her letter of 6th of May 2021 to the HDC, and the comments made in NP Phillips' report (Section 6). I note NP Phillips has concluded that the work schedules do not support [RN B's] comments about how busy she was during the time around [Ms A's] consultation on the 18th of December 2020. I also note NP Phillips makes no further comments about other workload shown in the work schedules, or about the broader issues in the working environment that were a factor at this time.

55. In my view, context plays a role in considering this case. The weeks leading up to Christmas are always a busy time for general practice with increased demand. In addition, in July 2020, significant changes occurred to the national childhood immunisation schedule and general practices were managing the impact of programme adjustments across multiple vaccines and eligible age groups during the rest of 2020. It is also important to note this was at a time when New Zealand was experiencing a global pandemic. In my experience of working during this time, the impact and disruption of Covid-19 upon the health sector, and general practice more specifically, cannot be overstated.

56. Further, in my experience, many phone contacts are not logged or recorded on work schedules. These can be from patients, but also from other providers, and often require some degree of post contact follow-up i.e., documentation, liaison with other practitioners within and outside the practice, referrals, and patient or family contact.

57. I note in the work schedules there are multiple appointment times reserved for what I assume based on [the medical centre's] "Results, Referrals and Tasks" policy (Pg 331/669), is non-face to face workload. These are identified as "results and recalls" and "standing orders list". In [the medical centre's] policy, 60 minutes in divided 15-minute slots, are provided every day for "paperwork". In the policy "paperwork" includes a list of activities:

i. Electronic correspondence
ii. Electronic inbox messages
iii. External emails
iv. Recalls
v. Follow up on lab results and investigations
vi. Tasks
vii. Referral management and follow up

58. These terms are commonly used within general practice settings to refer to a range of clinical services that are usually provided by RNs. These include contacting patients to discuss test results and further management plans, providing health education and advice, triage, self-care advice for sick patients, long term condition management and follow up, annual diabetes reviews, cardiovascular risk assessments, cervical and breast screening recalls, recalls for child and adult immunisations, and patient assessment and supply of medicines/treatments under the Standing Order Guidelines.

59. In my experience, non-face-to-face workload is as demanding, as time consuming, and requires the same rigor (if not more), as face-to-face patient consultation, including relevant documentation. I also note it appears in the schedules I reviewed that not all allow for 60 minutes during the day for these activities in line with [the medical centre's] policy. In addition, appointments start at 0800 hours and the last patient appointment is 1645 hours (finishing at 5pm). I do not know from the documents reviewed what the usual or agreed roster is for RNs working at [the medical centre]. It may be that there is paid time provided (and agreed to by RNs) for nurses to complete their work (including documentation) outside of an 8-hour working day. However, I cannot find any other administration or "catch up time" allocated for unexpected time and workload pressures within the 8-hour working day schedules reviewed.[4]

60. I understand that at the time [RN B] initially responded to the HDC, she had left [the medical centre] and had not reviewed the work schedules. Therefore, her comments were based on her recall of the situation at the time. In the week of the 18th

[4] This is a footnote added by HDC (not included in RN D's original advice). In its response to the provisional opinion, the medical centre provided information regarding its nurses' patient contact time and non-contact time and how it supports its staff in their work.

of December 2020, [RN B's] schedules show she had 17, 17, 19, 20 and 20 patients booked for face-to-face appointments on Mon-Fri respectively, in addition to scheduled time for non-face to face work as discussed previously.

61. I agree that [RN B's] workload both on the 18th of December 2020 and during that week was heavy. Further, it would have placed her, or any RN, under pressure to fully complete in the given scheduled time. I cannot see evidence in the documents that [the medical centre] as an employer provided additional support or time to [RN B] during this time to assist with managing a heavy workload. In my experience, it is almost certain that she would have been in contact with as many patients on those days as she says in her response to the HDC (30), between her face-face and non-face-to-face workload. Therefore, I disagree with NP Phillips that "[RN B] tried to say she had an excessive work load at this time … the practice records do not support this and show that on the 18th she had 20 patients and not 30 as she stated" (Pg 6, Report).

62. I also want to re-iterate that whilst a heavy workload does not ultimately reduce the accountability of [RN B] to meet expected practice standards, in my view, it certainly plays a significant role in increasing the likelihood of error, missed care, and deficient care. Any RN working in general practice in similar circumstances would be at considerable risk of similar deficiencies occurring in their practice. A simple literature review provides a large volume of evidence to support this.

63. <u>Expanded Practice</u>

I note in NP Phillips' report (page 8, section C) and in [Mr C's] letter to the HDC, they comment on the area of expanded roles/activities undertaken by RNs. It is important to note that the NZNC has an established process that can be utilised to incorporate clinical care activities into the practice of an RN, that might have previously or traditionally not been provided by nurses.

64. Essentially, the NZNC prescribed Expanded Practice process requires both the RN and their employer, to work through several steps aimed at ensuring not only that the RN has developed and maintains the competencies required, but that they are supported in their workplace to be able to safely undertake the activity to the expected standard at all times. The responsibility of employers does not end after the initial stages of expanded practice development, and NZNC clearly describes its expectations of ongoing employer accountabilities.

65. In my experience, general practice employers/businesses, and enrolled patients, greatly benefit from RNs who are proficient and able to provide expanded care, including minor procedures like lesion removal. It is also quite common in general practice, especially non-urban general practice such as [the medical centre], that RNs are engaged in expanded practice activities.

66. [RN B] in her first response to the HDC, outlines the process she and her employer originally completed during the 1990s, and later with other employers over time. She states she was "signed off" and I understand this reference to mean she completed a

process of training, followed by competency assessment by medical colleagues. In my view, this would certainly be in line with the NZNC expanded practice process. Further, [RN B] outlines several earlier workplaces in which she provided excisions or biopsies, and this shows her ongoing familiarity with performing this activity. In addition, [RN B] states in her response to the HDC that she was utilised by [the medical centre] for the training or education of colleagues related to minor procedures. In my view, this implies that [the medical centre] was comfortable with her proficiency.

67. Like all nurses, [RN B] is required when renewing her Annual Practising Certificate (APC) every year (at risk of legal penalty), to declare to the NZNC, she has maintained competency in all areas of her clinical practice. I disagree with NP Phillips that a "timeline is introduced around advanced skills … as I note [RN B's] training was in the 80s and 90s". This is not a requirement by NZNC within the expanded practice process and the accountabilities for maintenance of competency are already provided for within the current APC process.

68. However, I do agree with NP Phillips that as an employer [the medical centre] have a responsibility under the NZNC Expanded Practice Guidelines to ensure they meet their obligations. Not only to monitor that [RN B] was competent, but that she had the support and time to provide these services to the expected standard. **I recommend [the medical centre] undertake a review of these obligations**, to ensure they have the appropriate systems and processes in place, to support RNs they employ to provide expanded practice services.

69. Learning through complaint review

In her letter of complaint to [the medical centre], and as documented in the notes of her subsequent meeting with [Mr C], [Ms A] comments that an intention of her complaint was to "have this complaint received with an educational review of practice" and "I think HDC cases can be incredibly supportive and useful, you know cementing things like procedures and policies".

70. I agree with [Ms A] that complaints are opportunities for learning and practice improvement. [RN B's] responses to the HDC, in my view, shows she has taken this complaint seriously, and has indeed used this process as a learning opportunity to review her practice. [RN B] accepts her responsibilities and makes an "unreserved apology" to [Ms A]. Further, [RN B] acknowledges the significant distress she caused to [Ms A], and details a range of specific and appropriate actions she will implement, to improve her practice so that similar errors don't occur in the future. In my view, [Ms A] should feel assured that her intentions through making this complaint have been achieved for [RN B] as a practitioner.

71. However, I also agree with [Ms A] that [the medical centre] as the employer have an opportunity to consider improvements to their policies and processes, and the working environment for their staff, as these played a role in this case in my opinion. **I recommend this occur.**

72. Timing and Management of the Complaint Process

[Ms A's] complaint was made to [the medical centre] on 5th February 2021. The initial response letter to [Ms A] from [the medical centre] is not dated, but [Mr C] apologised for the delay in replying to [Ms A]. [Mr C] confirms that [RN B] had left [the medical centre] before the complaint investigation was finalised and could be discussed with her (letter to the HDC). It is unclear from the documents, but the fact the investigation was not completed before [RN B] left, may have been related to the delay in starting an investigation. Subsequently a meeting between only [Ms A] and [the medical centre] occurred on 22nd March 2021.

73. In my view it is unfortunate that the timing in this case did not allow for communication between [Ms A] and [RN B] before [RN B] had left employment at [the medical centre]. The documentation I have reviewed indicates [RN B] was only aware of the complaint shortly before her employment concluded. Therefore, [RN B] did not have an opportunity to fully review and respond to what occurred and personally discuss this with [Ms A]. In my opinion had this happened, there might have been a better outcome. Firstly, in terms of the practitioner addressing or resolving [Ms A's] concerns directly, and secondly, more explicit reassurance for [Ms A] about [RN B's] practice learnings going forward. The complaint might also not have been escalated to the HDC with all that is entailed in this process for both the patient and practitioner.

74. Concerns about Statements Made by [the medical centre]

I note [Mr C] makes comments in relation to [RN B's] actions in seeking representation from her professional organisation (letter to the HDC on 4th May 2021). In my view it appears [Mr C] implies the involvement of the NZNO should be viewed in a negative light. However, this is standard usual practice for practitioners following notification of a complaint, and nothing adverse should be inferred from this. I find it unusual that an employer would comment on this at all.[5]

75. Further, and more problematic in my view, is that [Mr C] raised a pre-existing employment/disciplinary dispute between [the medical centre] and [RN B] in responding to this complaint. [Mr C] states this in his letter to the HDC, and directly refers to this to [Ms A] in the meeting on the 22nd of March.[6]

76. I find this concerning. In my opinion, based on accepted human resource management standards, and New Zealand privacy and employment legislation, this is

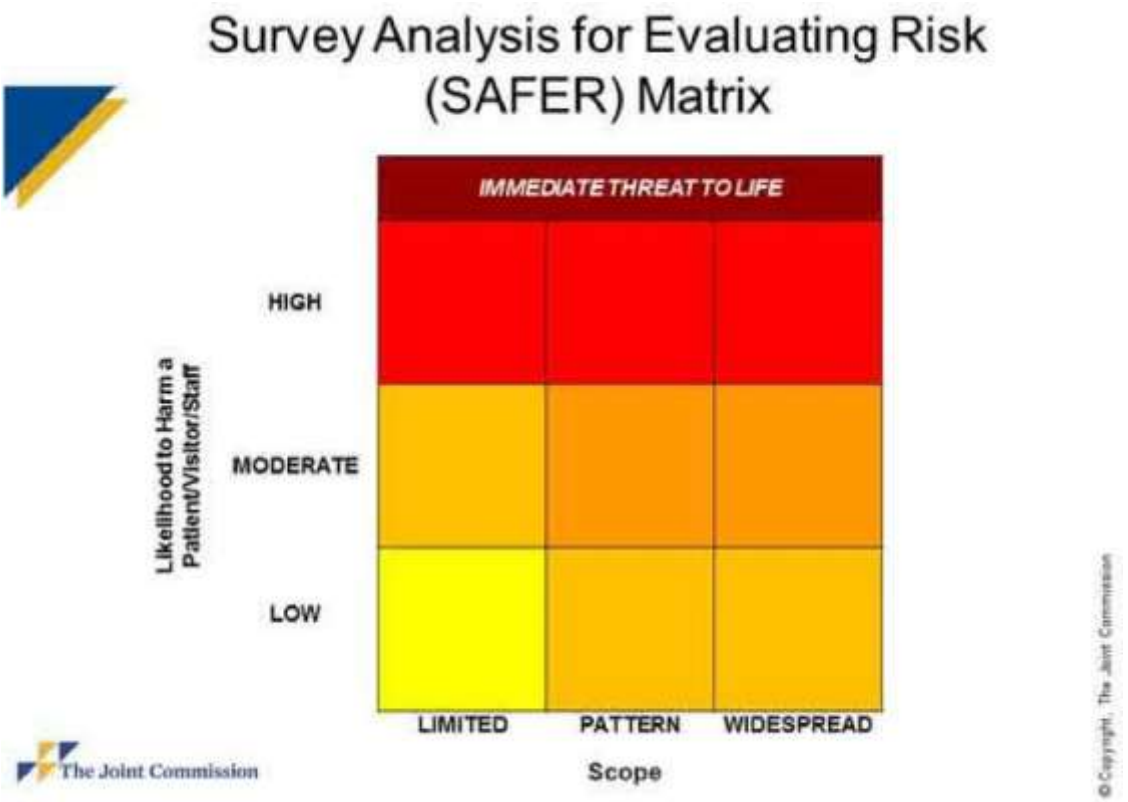
[5] This is a footnote added by HDC (not included in RN D's original advice). In response to the provisional opinion, the medical centre stated: '[Mr C] apologises if there has been a misunderstanding in relation to his correspondence in this regard. To be clear, [Mr C] did not intend to imply that NZNO's involvement should be viewed in a negative light. To the contrary: [Mr C] strongly encourages all nursing staff to be members of NZNO. The reason he mentioned NZNO was because he was optimistic that NZNO would also encourage [RN B] to improve her apology letter to [Ms A].'

[6] This is a footnote added by HDC (not included in RN D's original advice). In response to the provisional opinion, the medical centre provided further context that the comments in relation to the employment/ disciplinary dispute related to Official Information Act requests about which HDC had consulted the medical centre, and that the employment matter was raised with the intention to ensure that the medical centre did not inadvertently breach any of its legal obligations concerning that process.

highly inappropriate and should not have occurred. Doing so contravenes good faith principles, fairness, and due process. In addition, this constitutes a breach of privacy and is prejudicial to the outcomes of this complaint investigation process.

[RN D]'

The Survey Analysis for Evaluating Risk® (SAFERTM) Matrix is a transformative approach for identifying and communicating risk levels cited during surveys. The SAFER Matrix provides one, comprehensive visual representation of survey findings to help organizations prioritize and focus corrective actions by measuring the likelihood to harm and scope for each finding.



Names have been removed (except the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.