Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 22HDC02825)

1. 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.

2. A man complained that a dermatology clinic (the clinic) administered an incorrect dose of phototherapy treatment to him in November 2022, which left him badly burned and in considerable pain. The report discusses the standard of care provided by the clinic and the actions it took in response to the injury.

3. The following issue was identified for investigation:

- *Whether the clinic provided the man with appropriate care and treatment on 4 November 2022.*

Information gathered during investigation

How the complaint arose

4. The man was undergoing a course of phototherapy at the clinic to treat eczema.[1] Phototherapy treats eczema and other skin conditions by exposing the skin to ultraviolet light for a fixed amount of time several times per week, for several weeks. The treatment is delivered in a specially designed cabinet of fluorescent lights. A patient's specific treatment protocol — the strength of light and exposure time — is prescribed by a doctor, typically a dermatologist.

5. On 4 November 2022, the man attended a treatment appointment at the clinic and was greeted by one of the clinic's employees. The man provided his name to check in. He said that the employee 'quickly' advised him that his treatment protocol had been loaded in the phototherapy system. The man was concerned that the employee may have accidentally chosen the incorrect patient profile, as he felt that she had found him in the system too quickly. The man said that he provided his name again to confirm his identity, and he perceived that the employee was annoyed that he had done so.

6. The employee, who is not a healthcare practitioner but was trained to operate the phototherapy system, selected the man's profile in the phototherapy system. She then checked with the dermatologist as the man said that his skin was still quite red from his last

[1] A chronic condition that causes areas of the skin to become dry, itchy, bumpy and inflamed.

phototherapy session. The dermatologist examined the man's skin and recommended that his treatment dose be reduced by 10% on that occasion. The man's treatment protocol was adjusted in the phototherapy system, and the man spent three minutes in the phototherapy cabinet. The man remarked afterwards that his treatment felt longer than usual.

7. The man told HDC that he received a call from the dermatologist around an hour after he left the clinic. The dermatologist advised the man that he had received the wrong treatment, and it was much stronger than his usual treatment.[2] The man said that the dermatologist told him that the employee 'had opened a folder for a different patient and loaded their treatment'. The dermatologist then apologised and told the man that he would develop bad burns, for which he prescribed aspirin and a topical steroid cream.

8. The man said that his skin became increasingly red and hot from around noon that day. By the next morning, the man had developed several blisters on the front of his body. Over the rest of that day and the next day (a weekend), the blistering became worse and covered most of the front of the man's body, from his chin to his waist. The man said that he had to take Monday and Tuesday off work as he was in so much pain and discomfort that he was bed-bound and unable to carry out daily tasks by himself. He said that while the blisters started to dry out on Monday, the skin around his torso started to crack and peel badly, leaving behind 'raw' skin, and he had to work from home for the rest of the week as it was difficult for him to put on, and wear, a shirt.

9. The man said that the severe burns and blisters caused him considerable pain, discomfort, and stress and left him unable to sleep and bed-bound for four days overall. The man said his wife had to help him carry out all his daily tasks during this time. He told HDC that every day over the period, the dermatologist checked in with him about his condition.

10. The dermatologist told HDC that he offered the man an urgent face-to-face review and/or a referral to another dermatologist, as well as the option to start an ACC treatment injury claim. The man opted to return to his usual dermatologist (who had referred him to the dermatologist for phototherapy).

The clinic's investigation

11. On behalf of the clinic, the dermatologist told HDC that he accepted that the man was given the wrong dose of phototherapy. The dermatologist said that it was a 'deeply unfortunate error', and he was sincerely sorry that it resulted in the man suffering burns. The dermatologist stated that the man's injury was recorded as an incident and investigated, and the clinic's practices and policies were updated to mitigate the risk of recurrence in future. The dermatologist said that the investigation had identified two key errors.

First error

12. The employee confirmed the man's name twice at his request and did not recall being annoyed when the man asked her to do so. The employee then closed the man's profile in the phototherapy system while the dermatologist examined him, as she thought the

[2] He was given treatment of 1900mJ/cm^2 (millijoules per square centimetre) rather than 577mJ/cm.^{2}

dermatologist might want to open the profile himself (it could be opened only by one user at a time). When the dermatologist's examination was complete, the employee went back into the phototherapy system. It appears that the employee mistakenly opened the profile of another patient with the same first name as the man. The dermatologist said that this was an 'unusual circumstance', which was 'certainly a learning experience'.

Second error

13. The clinic's separate practice management software (PMS) should also be updated with a patient's phototherapy dose, before treatment begins, as the PMS will raise an alert if the dose is more than 20% higher than the previous dose. That did not happen in the man's case as it should have, as the employee updated the PMS after the man completed his treatment.

Actions taken in response

14. The dermatologist said that the employee was a trained and experienced staff member in whom he had full confidence, and he discussed the error with her. The dermatologist found that the incident was the result of human error. He stated that following the man's experience, training and protocols were revised to 'absolutely minimise' the chance of the same error happening again. The changes included the following:

- The clinic's phototherapy standard operating procedure (SOP) was updated to emphasise that a patient must be re-identified if the phototherapy record is closed after identification has taken place.
- The patient's name must also be cross-checked with their PMS record.
- The phototherapy dose must be entered in the PMS before treatment is administered.
- The person using or changing a phototherapy record is responsible for ensuring that the correct patient profile is selected.
- The above guidance was pinned up in the clinic so that staff can refer to it, and the dermatologist personally checks on the phototherapy operation during clinics.

Notification of HDC investigation

15. On 13 March 2024, I notified the clinic of HDC's investigation of the complaint. I proposed that HDC find the clinic in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[3] based on its investigation of the case. I also proposed to make two recommendations and publish my anonymised final decision on the HDC website.

16. This option was proposed to the clinic because it accepted that the man had been given the wrong dose of phototherapy, that the error should not have happened, and that the man developed significant and painful burns as a result.

17. The clinic confirmed that it would accept the breach finding as proposed.

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

Responses to provisional opinion

18. The provisional opinion was shared with the clinic, and it was invited to respond to it. The clinic told HDC that it did not wish to comment on the provisional opinion.

19. The section of the provisional opinion containing the information gathered during the investigation was shared with the man for any comment he wished to make. The man sent HDC photographs of his burns, and clarified several details of his recovery period, which have been incorporated into this report.

Opinion: Clinic — breach

20. Having undertaken a thorough assessment of the information gathered, I am critical that two process-related failures culminated in the man suffering burns during phototherapy on 4 November 2022. However, the clinic responded to the incident appropriately by undertaking an investigation and making several process improvements. I have set out my decision below.

21. First, I acknowledge the impact of the phototherapy error on the man. It was a serious incident that caused him considerable, albeit temporary, harm, and his description and photographs of the burns and blistering he experienced are compelling. It is evident that the man suffered significant discomfort from the injury for at least a week, along with disruption to his daily life. I appreciate that the man also found the treatment error especially troubling given his initial efforts to ensure that the employee had selected his profile correctly. While the error did not occur at that point, it is clear that the man had proactively attempted to avoid such an error.

22. In my view, the injury was avoidable and should not have occurred. The clinic already had a system in place to avoid this type of error, with the PMS set to alert if the dose entered was more than 20% higher than the previous dose. If the man's phototherapy dose had been entered into the PMS prior to him beginning treatment, as it should have been, an alert would have been raised, and the incorrect dose would likely have been discovered. This alert alone was not a sufficient safeguard, however. To ensure that it was failsafe, the person administering the phototherapy should also have confirmed the man's identity after re-opening the patient record.

23. These two errors were identified by the clinic in its investigation. I am satisfied that its investigation was appropriate, in that it found the two points at which the phototherapy SOP was not followed, leading to the man receiving the incorrect dose of phototherapy.

24. In that respect, I commend the clinic's prompt investigation and its transparency about how the error happened. Equally, the clinic identified process changes that would mitigate the risk of the same error happening again and implemented those changes in the phototherapy SOP. The changes to the clinic's processes were specific and appropriate to reduce the risk of the same error happening again. As human error was central to what went wrong, it was fitting that additional training was provided to the employee for the same reason.

25. This complaint highlights how crucial it is for healthcare providers to have suitable processes and measures in place to identify patients correctly and ensure that they receive their own prescribed treatment. Likewise, it is important that staff are not only trained to follow a process, but also to understand the purpose and order of the steps in that process.

26. Ultimately, the clinic has a responsibility to provide a reasonable standard of care to its patients. That did not occur in this case, and the man quite reasonably felt let down by the error in his treatment. Accordingly, with the clinic in agreement, I find the clinic in breach of Right 4(1) of the Code for failing to provide services to the man with reasonable care and skill.

Recommendations

27. Taking into account that the clinic previously provided an apology to the man, I recommend that the clinic:

a) Provide confirmation that the changes indicated (above) have been implemented, and information about the impact of those changes, including confirmation that no further incidents of this nature have occurred since, or a record of any near misses/events and the incident reports relating to them.

b) Provide evidence that this case has been used as a case study in an educational session with peers of the dermatologist.

28. The above information should be provided to HDC within three months of the date of this report.

Follow-up action

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