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## Nurse / Medical Centre

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### Report on Opinion - Case 98HDC15806

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**Complaint**

The Commissioner received a complaint from the Accident Rehabilitation and Compensation Insurance Corporation about services provided to a consumer in early May 1997 at a medical centre. The complaint is that:

- *The consumer received burns or skin depigmentation following the application of phenol solution to warts on his right arm and left axilla.*
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**Investigation**

The Commissioner received the complaint from the Accident Rehabilitation and Compensation Insurance Corporation on 2 July 1998 and an investigation was undertaken. Information was obtained from the following sources:

The Consumer  
The Consumer's mother  
The Consumer's father  
Practice Nurse 1/Provider, Medical Centre  
The Practice Nurse Co-ordinator, Medical Centre  
Practice Nurse 2/Provider, Medical Centre  
A General Practitioner, Medical Centre

The consumer's medical records were obtained and viewed.

The report of the Medical Misadventure Unit of the Accident Rehabilitation and Compensation Insurance Corporation was also reviewed.

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## Nurse / Medical Centre

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### Report on Opinion - Case 98HDC15806, continued

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**Outcome of Investigation**

In early May 1997 the consumer attended the medical centre to have his molluscum lesions (warts) treated. At the time of the incident the consumer was 14 years old and was alone when he received the treatment. The consumer had warts on his right arm and left axilla. The consumer's warts were treated with phenol solution at the centre by a practice nurse. The treatment resulted in the consumer sustaining chemical burns and skin depigmentation to his right arm and under his left axilla. In order to sustain chemical burns the phenol solution must have been spilt and not neutralised by the practice nurse.

There is some uncertainty as to the identity of the practice nurse who treated the consumer. The practice nurse co-ordinator advised the medical misadventure unit of the name of the nurse involved (practice nurse 1). Practice nurse 1 advised the Commissioner that there was no documentation or record of who saw the patient. She stated that she cannot recall the incident but acknowledged that the consumer was on her nursing schedule for that day.

The consumer was asked to describe the nurse who had applied the phenol solution to his arms. He was unable to clearly describe the nurse who had administered the phenol. However, the consumer's mother believed she had seen the nurse who administered the phenol at the reception area of the medical centre. The consumer's mother considered that the nurse she saw was the nurse who had administered the phenol, because she was the nurse working with the family's general practitioner at the time.

The consumer's mother described the nurse's physical characteristics.

The description given matches the appearance of practice nurse 1. The general practitioner at the medical centre advised the Commissioner that she could not recall any other female staff members who fitted that description working at the centre at that time.

Practice nurse 1 advised the Commissioner in her letter of November 1998 that: "*the only evidence that the person responsible could be me is my nursing schedule for that day.*"

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## Nurse / Medical Centre

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### Report on Opinion - Case 98HDC15806, continued

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**Outcome of  
Investigation,  
*continued***

There were no written clinical notes indicating that practice nurse 1 was the health professional who applied the phenol solution to the consumer. The Commissioner requested the consumer's medical records from the medical centre. The medical records that the Commissioner received indicated that out of six consultations which the consumer had attended only two consultations had clinical notes entered on his medical records. The consumer's consultation in early May 1997 was not recorded. However, practice nurse 1 confirmed that it was her handwriting where the consumer's name was written on the nursing schedule.

The nurse co-ordinator advised the Medical Misadventure Unit that phenol solution was applied to the consumer's skin using cotton tipped applicators and that she was unaware of any attempt to neutralise the phenol on healthy skin.

The general practitioner stated that practice nurse 1 had received extensive instruction from senior nursing and medical staff on routine and commonly performed procedures. At all times she had medical staff close at hand if she required assistance, and it is expected that if a nurse is inexperienced in a procedure that she will notify senior staff and seek assistance.

The Commissioner was advised by practice nurse 1 that she used orange sticks to apply phenol solution and would not have used a cotton wool tipped applicator. Orange sticks are simple sticks with no cotton wool at all. She also stated that the practice nurse co-ordinator taught her the technique and never once informed her that a neutralising agent may be needed or that phenol solution can burn the skin. Practice nurse 1 confirmed that she "[applied] *phenol solution to numerous patients, as I was taught [by the co-ordinator] and I was led to believe by those who taught me my technique, that it was the standard of care and skill to be expected in the circumstances of applying phenol solution.*"

Practice nurse 1 sent the Commissioner a letter written by practice nurse 2, who she trained in the application of phenol solution. Practice nurse 2 considered that the usual technique used at the medical centre involved applying a sparse amount of phenol solution via an applicator or 'orange stick'. She also stated that she and practice nurse 1 discussed having alcohol on hand to neutralise the phenol solution should it be necessary.

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## Nurse / Medical Centre

### Report on Opinion - Case 98HDC15806, continued

**Outcome of Investigation, continued**

The Commissioner requested a copy of written policies or procedures which the centre had in place on the application of phenol solution. The Commissioner was advised that no written protocol or policy on phenol application was in place at the centre in May 1997. However, the general practitioner advised the Commissioner that the practice tips textbook written by John Murtagh recommends the use of phenol solution to treat warts. This textbook is in current use by general practitioners. In that textbook Murtagh states, "*there are several simple treatments available to treat [warts], ... [such as] pricking the lesion with a pointed stick soaked in 1% or 2.5% phenol.*"

According to the general practitioner the normal procedure at the medical centre to treat warts is to apply a dilute solution of phenol with an orange stick, which is a simple stick with no cotton wool on it. Only a small amount of solution is applied and precautions are taken to avoid contact with the normal surrounding skin. The general practitioner also advised the Commissioner that nurses at the clinic are employed by a company whose directors are the general practitioners at the medical centre.

The nurse consultant who advised the Medical Misadventure Unit noted that a nurse using phenol solution should be fully aware of the dangers associated with it, because phenols include carbolic acid, cresol and creosote. Contact with the skin produces an immediate necrosis (localised tissue death) of tissues and often large chemical burns that can ultimately ulcerate and may become infected. As phenol solution is extremely toxic, correct guarding of the area under treatment must be employed in order to prevent any splashing or dripping of the solution onto healthy skin. Should there be a spillage the phenol solution should be neutralised immediately.

**Code of Health and Disability Services Consumers' Rights**

*RIGHT 4*

*Right to Services of an Appropriate Standard*

- 2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*
- ...
- 4) *Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.*

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**Nurse / Medical Centre**

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**Report on Opinion - Case 98HDC15806, continued**

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**Opinion:  
Breach,  
Practice  
Nurse 1/  
Provider****Right 4(2) and Right 4(4)**

In my opinion, practice nurse 1 breached Rights 4(2) and 4(4) of the Code of Health and Disability Services Consumers' Rights.

The Commissioner was advised by practice nurse 1 that she was unable to recall the incident. However, in the light of all the evidence before me, it is my opinion that it was this nurse who incorrectly administered the phenol solution to the consumer.

The consumer was entitled to receive services of an appropriate professional standard. The consumer received chemical burns and skin depigmentation as a result of the phenol solution being applied incorrectly. There is no evidence of an attempt to neutralise the area of healthy skin that the phenol solution was spilt on. For this reason the consumer was not provided with services of an appropriate standard.

Practice nurse 1's response to my investigation reveals she has little fundamental understanding of the risks associated with the use of phenol solution. Her response indicates she blindly followed a procedure as per training without any underlying understanding of the treatment issues.

When phenol solution is applied to a wart the surrounding area of healthy skin should be protected. If phenol solution is spilt on the healthy skin this should be neutralised. In the consumer's treatment neither of these precautions were taken. In my opinion this treatment did not meet professional standards and did not minimise the potential harm to the consumer.

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**Nurse / Medical Centre**

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**Report on Opinion - Case 98HDC15806, continued**

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**Opinion:  
Breach,  
Employer  
Company****Right 4(2) and Right 4(4)**

In my opinion the company breached Right 4(2) and Right 4(4) of the Code of Health and Disability Services Consumers' Rights.

The nurses at the medical centre are employed by a company whose directors are the general practitioners. Under section 72 of the Health and Disability Commissioner Act 1994 an employer is responsible for a breach of the Code by an employee unless the employer took reasonable steps in the circumstances to prevent those breaches of the Code by the employee.

Practice nurse 1 received training in the application of phenol solution and there was supervision available. However, the medical centre did not have a protocol on this procedure and there was some uncertainty as to the correct method of its application. It is my opinion that the company as employer did not take reasonable steps and, therefore, is vicariously liable for practice nurse 1's breaches of the Code of Health and Disability Services Consumers' Rights.

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**Opinion:  
Breach,  
Medical  
Centre****Right 4(2)**

In my opinion the medical centre breached Right 4(2) of the Code of Rights.

The centre had no written policies or procedures in place outlining the application of phenol solution to treat patients with warts. The consumer was entitled to have services provided that complied with professional standards. The centre failed to meet those standards by not ensuring that clear policies on administering phenol solution to treat patients with warts were in place.

Furthermore, documentation of medical and nursing consultations were inappropriate. The consumer's medical records indicate that from six consultations which the consumer attended, the medical centre failed to note any action or inaction for four of those consultations on the consumer's medical records. The consumer's consultation on the day of the phenol incident in May 1997 was also not recorded.

Appropriate documentation of consultations is an important professional standard which was not sufficiently met by the centre.

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## Nurse / Medical Centre

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### Report on Opinion - Case 98HDC15806, continued

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**Actions**

I recommend that practice nurse 1 and the employer company take the following action:

**Practice Nurse 1/Provider**

- Apologises in writing to the consumer for breaching the Code of Rights. This apology is to be sent to the Commissioner who will forward it to the consumer.

**Employer Company**

- Apologises in writing to the consumer for breaching the Code of Rights. This apology is to be sent to the Commissioner who will forward it to the consumer.
- Implements clear written policies on application of phenol solution and other procedures where no policy exists.
- Evaluates its recording of consultations and ensure that records are kept of each consultation.
- Undertakes training of all health professionals in the centre regarding maintaining appropriate medical records.

**Other Actions**

A copy of this opinion will be sent to the Health Funding Authority and Nursing Council of New Zealand. If practice nurse 1 was practising in New Zealand, I would have referred this matter to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act.

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