Registered General and Obstetric Nurse

Report on Opinion - Case 98HDC14753

Complaint

The Nursing Council of New Zealand forwarded a complaint from the consumer about the standard of service she received from the nurse. The complaint was that:

- *When the consumer attempted to inform the nurse that her leg was going numb, the nurse did not take her concern seriously.*
- *The nurse had administered the injection in the wrong place which has left the consumer with an ongoing disability.*
- *The nurse has denied that she was at fault in any way*.

Investigation

The complaint was received on 15 May 1998 and an investigation was commenced. Information was obtained from:

The Consumer
The Registered General and Obstetric Nurse / Provider
A Locum General Practitioner/Provider
The General Practitioner

Relevant clinical records were obtained and viewed. The Commissioner obtained verbal advice from an independent general practitioner. A copy of the consumer's ACC file was obtained and viewed.

Registered General and Obstetric Nurse

Report on Opinion – Case 98HDC14753, continued

Information Gathered During Investigation

The consumer and her son consulted the locum GP at a medical clinic in a town on 8 April 1998. The locum attended to the consumer's son's health needs and then the consumer raised concerns about her irregular periods. The locum advised the consumer to have a further contraceptive injection and asked the nurse to administer it. The nurse advised the consumer to call her when she was finished with the locum.

At the conclusion of the locum's consultation the consumer went to the treatment room. She took her trousers down and leaned against a bed situated in the room. The nurse inserted the needle in the consumer's right buttock. The consumer advised the Commissioner that she felt her leg going numb and twice mentioned this to the nurse. The consumer then realised the nurse had removed the needle. The consumer said that when the nurse re-inserted the needle her leg was totally numb and without feeling. The consumer said she again told the nurse her leg was numb, to which the nurse responded, *"I'll give you an Easter Egg"*. The consumer declined the offer. She leaned against the bed for three or four minutes, but the feeling in her leg did not return.

During the investigation the nurse indicated at the interview that while she was administering the injection the consumer moved and the needle came off the barrel. She said she removed the needle, put the barrel back on and re-inserted the injection. She said the consumer told her that she had "*pins and needles*" and stated that the consumer was upset. She was unable to recall the consumer mentioning numbness on the two earlier occasions. The nurse said she did not think the numbness was serious and offered the consumer a lolly as a gesture of comfort.

The nurse's clinical entry recorded:

> *"IM Depo-Provera given. 1st injection became dislodged owing to sudden movement of patient. Re-inserted ® buttock.*
>
> *Patient has severe pain in leg. Referred back to* [the locum]*."*

The nurse advised the Commissioner that the locum was in consultation with another consumer and did not see the consumer.

Continued on next page

Registered General and Obstetric Nurse

Report on Opinion – Case 98HDC14753, continued

Information Gathered During Investigation, ***continued***

The consumer left the clinic and accompanied her son to Medlab for tests. She advised the Commissioner that she had difficulty walking there and said *"the lady in the Medlab got worried as she wanted to know what happened and I told her as I was in a lot of pain as I couldn't walk let alone use my right leg which was numb"*.

The Medlab worker arranged for the consumer to see the locum. The locum advised the Commissioner that the consumer had no focal neurology present. She told the consumer she could be experiencing either post injection pain, or sciatic nerve injury. The locum sent the consumer home with instructions to return the next day if the pain worsened.

The consumer advised the Commissioner that the pain became so great her husband telephoned the clinic and arranged for her to see a GP who was covering the evening practice. The GP telephoned the on-call neurosurgeon at a Crown Health Enterprise. The consumer said the GP then told her that the needle had been inserted four inches too low and had gone into a nerve. An appointment was made for the consumer to attend the hospital the next morning. At that time an assessment was carried out to compare the differences in leg power, reflexes and sensation. Clinical records indicated:

> *"Sciatic nerve damage secondary to injection. Recovering. Nearly to normal in 12 hours."*

When the consumer returned home she received an answerphone message from the nurse. The nurse indicated at the interview that she had telephoned to see how the consumer was, and to apologise to her. She confirmed that, in the message, she had stated her belief that the consumer had moved during the procedure. The consumer returned the nurse's telephone call. The consumer disputed that she had moved during the procedure, and told the nurse that she would not be returning to the clinic.

The consumer complained of on-going pain and disability. She required ACC assistance with housework and other chores until September 1998.

Continued on next page

Registered General and Obstetric Nurse

Report on Opinion – Case 98HDC14753, continued

Information Gathered During Investigation, *continued*

The nurse did not dispute that she gave the consumer an injection of *depo-provera* that touched a nerve. She advised the Commissioner:

> *"Human error does occur from time to time and in my 30 years of practising as a registered general and obstetric nurse, nothing like this has ever happened to me."*

The nurse disputed the consumer's view that she had not taken the consumer seriously. She said she thought initially that the consumer was reacting to the actual soreness of the injection, but realised, after the consumer's evening consultation with the on-call GP, *"the seriousness of what I was accountable for"*. The nurse said she had been in telephone and letter contact with the consumer and had apologised to the consumer's husband during a brief telephone conversation with him.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

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.*

…

3) *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.*

…

Code of Conduct for Nurses and Midwives

Principle Two
The nurse or midwife acts ethically and maintains standards of practice.

Criteria
The nurse or midwife:
…
2.4 *Demonstrates expected competencies in the practice area in which currently engaged;*
…

Registered General and Obstetric Nurse

Report on Opinion – Case 98HDC14753, continued

Opinion: Breach

In my opinion the nurse breached Right 4(2) and Right 4(4) of the Code as follows:

Right 4(2) and Right 4(4)
My advisor informs me that sciatic nerve involvement is a well recognised complication of injections administered in the buttock, including *depo-provera*. In order to minimise the possibility of sciatic nerve damage it is important to insert the needle, and to pause momentarily to see if there is a reaction from the consumer to its insertion. If the consumer complains of pain or numbness the needle must be withdrawn prior to fluid being injected.

The nurse was able to recall only one occasion in which the consumer complained of leg numbness and her response was to offer "*a sweet to make it better*". Whether or not the consumer moved during the initial procedure, I accept that she expressed concern to the nurse that her leg was going numb. The nurse did not heed this warning and administered an injection which damaged the consumer's sciatic nerve. In my opinion the nurse did not provide services of an acceptable standard and breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights.

The nurse's failure to address the consumer's concerns caused the consumer to suffer on-going pain. While the public hospital clinical records indicated the subsequent sciatic nerve damage was expected to resolve within 12 hours, the consumer continued to experience numbness and required ACC assistance with housework and other duties until September 1998. In my opinion the nurse failed to minimise the potential harm to the consumer and breached Right 4(4) of the Code of Health and Disability Services Consumers' Rights.

Registered General and Obstetric Nurse

Report on Opinion – Case 98HDC14753, continued

Actions

I recommend that the nurse take the following actions:

- Provide a written apology to the consumer for her breach of the Code. This is to be sent to the Commissioner's office and will be forwarded to the consumer.
- Read the Code of Health and Disability Services Consumers' Rights.
- Ensure she pays close attention to a consumer's reaction when administering *depo-provera* and withdraws the needle without injecting fluid if a consumer complains of pain or numbness following its insertion.

A copy of this opinion will be forwarded to the Nursing Council of New Zealand.