Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Medication error leads to allergic reaction
21HDC00682

The Deputy Health and Disability Commissioner has found a GP in breach of the Code of Health & Disability Services Consumer's Rights (the Code) for incorrectly prescribing medication on two occasions to a young woman who had recorded allergies to the medications.

The young woman had a phone consultation with a GP at an accident and emergency clinic. Following the consultation she was prescribed amoxicillin, which she is allergic to. The woman alerted the clinic to the error and the prescription was changed.

However, the young woman was also allergic to the replacement medication (and did not recognise it by its abbreviated name as labelled by the pharmacy). After taking the medication, she was admitted to hospital with severe stomach pain and treated for erythromycin-induced gastritis with strong pain relief (morphine).

In prescribing the medications, the GP failed to check with the woman about her allergies, as was the normal practice with face-to-face consultations, and also failed to check the allergy section of the patient management system (PMS) record.

Deborah James found the GP breached Right 4(1) of the Code which gives consumers the right to services provided with reasonable care and skill.

Ms James says, "By not undertaking a check of the PMS or verbally checking with the young woman about allergies on two occasions, the GP did not adhere to the Medical Council of New Zealand "Good prescribing practice" standards. This is particularly concerning on the second occasion, given that the doctor was already on notice about having incorrectly prescribed amoxicillin."

The breach highlights the need for practitioners to take all reasonable steps to ensure that the risk of error is mitigated when prescribing medication to patients.

A second GP from the same clinic also incorrectly prescribed a medication the woman was allergic to at a later date. In light of actions taken by the GP, however, Ms James viewed this as an isolated error but reminded the GP of the importance of checking medical alerts on both the PMS and verbally with patients before prescribing.

In response to the breach Ms James recommended that both GPs provide a written apology to the young woman and her family. She also recommended that the first GP provide results of the next two consecutive cycles of her clinical notes audit.

Since the events, the clinic has taken a number of actions including having discussions with other doctors to check that the prescribing systems used are in line with other clinics. The clinic has also conducted a doctor's peer group to discuss how to minimise prescribing errors and has communicated with the PMS help-desk to check whether the alert system could be improved to help flag allergies to medications.

The GP who breached the Code has also made a number of changes including reflecting on her practice and taking extra care to verify that medication reactions are checked on the patient's record and with the patient. She has conducted audits of her medical records related to antibiotic prescribing and recording of allergies.

22 May 2023

Editor's notes

The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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