District Health Board

Emergency Department Consultant, Dr C

A Report by the

Health and Disability Commissioner

(Case 15HDC00100)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Ms A slipped and fell in the shower injuring her left foot and ankle.

2. The following day, Ms A saw general practitioner Dr E, who referred Ms A to the emergency department (ED) at the public hospital. In her referral letter Dr E queried a possible fracture of Ms A's left foot and distal fibula, and recorded Ms A's allergies as: "**Allergies:** 06 July 2006 pen[icillin], morphine, codeine, erythromycin" (emphasis in original).

3. Later that afternoon, Ms A presented to the ED. On arrival Ms A completed a patient admission form on which she documented under "any medical alerts or allergies?" that she was allergic to "morphine, codeine, penicillin, erythromycin".

4. Ms A was triaged at 1.16pm. At 2.12pm, she was seen by an ED consultant, Dr C, who noted Ms A's history and her current medications and requested an X-ray. It was later documented in the nursing notes at 2.18pm that Ms A was allergic to "penicillin, morphine, codeine, erythromycin".

5. Subsequently Ms A had an X-ray of her ankle. At 3.54pm Dr C reviewed Ms A, noting no obvious fracture on the X-ray. Dr C queried whether Ms A had a Lisfranc fracture and suggested a CT scan. Dr C discussed Ms A with the orthopaedic team and requested orthopaedic review. Dr C then prescribed Ms A Sevredol, which is the controlled drug morphine sulphate in tablet form, and discharged her home. He did not ask Ms A whether she had any allergies, nor did he give her any information about what medication he was prescribing her. Furthermore, Dr C did not document his management or discharge plan.

6. Following Ms A's return home, Ms A's mother, Ms B, a registered nurse, noted that Ms A had been given Sevredol. Ms B called the ED and spoke to an ED nurse. Subsequently Ms B went into the ED and spoke to an ED doctor, Dr D. Dr D apologised for the error and, after reviewing Ms A's notes, dispensed alternative pain relief for Ms A.

Decision

7. Dr C inappropriately prescribed Sevredol to Ms A, who had a known and well documented allergy to that drug. By not reading the notes and by not asking Ms A whether she had any allergies, Dr C missed opportunities to ascertain Ms A's allergy status. It was Dr C's responsibility to take the necessary steps to ensure that he prescribed medication to Ms A that was appropriate for her. By failing to do so, and by prescribing her medication to which she was allergic, Dr C did not provide services to Ms A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

8. By failing to explain that Sevredol is a form of morphine, Dr C failed to ensure that Ms A was provided with information that a reasonable consumer, in that consumer's circumstances, would expect to receive and, accordingly, he breached Right 6(1) of

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

the Code.[2] As a consequence, Ms A was unable to give her informed consent for this aspect of the treatment, and I find that Dr C also breached Right 7(1) of the Code.[3]

9. Dr C's failure to document a discharge plan and, in particular, his prescription of Sevredol, was a significant departure from professional standards and a breach of Right 4(2) of the Code.[4]

10. Dr C's failures in this case were considered to be individual clinical errors, and the District Health Board (DHB) was not found to be vicariously liable for Dr C's breaches of the Code.

Complaint and investigation

11. The Commissioner received a complaint from Ms A about the services provided by the DHB and emergency department consultant Dr C. The following issues were identified for investigation:

- *Whether the DHB provided an appropriate standard of care to Ms A in 2014.*
- *Whether Dr C provided an appropriate standard of care to Ms A in 2014.*

12. An investigation was commenced on 18 August 2015.

13. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
Ms B	Consumer's mother
DHB	Provider
Dr C	Emergency department consultant/provider

Also mentioned in this report:

Dr E	General practitioner

14. Information was also reviewed from:

Dr D	Medical Officer Special Scale/provider
A pharmacy	Provider

15. Independent expert advice was obtained from an emergency department consultant, Dr William Jaffurs (**Appendix A**).

[2] Right 6(1) states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive …".
[3] Right 7(1) states: "Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise."
[4] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

Information gathered during investigation

16. Ms A was 38 years old at the time of these events. Ms A has a history of chronic pain syndrome and a known allergy to morphine.

17. Ms A slipped and fell in the shower, injuring her left foot. The following day, Ms A saw general practitioner (GP) Dr E, who referred Ms A to the emergency department (ED) at the public hospital. In her referral letter to the ED, Dr E queried possible fractures of the left foot and distal fibula.[5] On the referral, Ms A's allergies are recorded as: "**Allergies:** 06 July 2006 pen[icillin], morphine, codeine, erythromycin" (emphasis in original).

18. Later that afternoon Ms A presented to the ED and completed a patient admission form. She documented on the admission form under "any medical alerts or allergies?" that she was allergic to "morphine, codeine, penicillin, [erythromycin]".

19. Ms A was triaged at 1.16pm. It is recorded in the triage notes:

> "… Referral from GP with Painful (L) foot and lower leg difficulty weight bearing, swelling and pain distal fibula region referred for X-ray."

Initial assessment by Dr C

20. At 2.12pm, Ms A was seen by locum ED consultant Dr C.[6]

21. Following his initial assessment, Dr C noted: "[F]ell in shower and body fell on her foot. Unable to weight bear."

22. Dr C noted that Ms A had a history of chronic pain syndrome, depression and asthma. He noted that she was currently on quetiapine, sertraline, nortriptyline clonidine, lorazepam,[7] ibuprofen,[8] gabapentin,[9] zopiclone,[10] omeprazole,[11] Flixotide, Serevent and salbutamol.[12]

23. At 2.18pm, Ms A's history was documented in the ED nursing notes. It is noted that she had been referred by her GP, that she had slipped in the shower one day ago and was now experiencing difficulty weight bearing, with bruising and swelling of her left

[5] Sometimes referred to as an ankle fracture.
[6] Dr C has been practising medicine since 2008. He has held general scope New Zealand Medical Council registration since this time. Dr C is not vocationally registered. Dr C is no longer practising in New Zealand and does not currently hold a New Zealand practising certificate.
[7] Quetiapine, sertraline, and nortriptyline are antidepressant medications. Clonidine and lorazepam are used to treat anxiety.
[8] An anti-inflammatory, used for relieving pain and/or reducing fever.
[9] Originally developed to treat epilepsy, gabapentin is currently used to relieve neuropathic pain and restless leg syndrome.
[10] A sedative, often used in the treatment of insomnia.
[11] Used to treat reflux.
[12] Flixotide, Serevent and salbutamol are used for the treatment of asthma.

foot. The notes then record that she had pain around her distal fibula and "? Lisfranc injury[13] — referral for X-ray". Under "Allergies/Alerts" at the bottom of the page (written in the same handwriting as the other notes) is documented "penicillin, morphine, codeine, erythromycin", although there is no time documented next to this entry.

Prescription

24. Subsequently Ms A had an X-ray of her ankle. Dr C reviewed the X-ray and at 3.54pm documented:

> "[N]o fracture obvious to me
>
> given [Tubigrip] and needs [orthopaedic] review please. If still tender perhaps a CT may be warranted to rule out a Lisfranc
>
> discussed with [an orthopaedic surgeon] for symptomatic [treatment] — crutches and [orthopaedics] will review films … "

25. There is no further documentation in the clinical records regarding Dr C's proposed discharge plan.

26. Dr C prescribed Sevredol for Ms A. Sevredol is morphine sulphate in tablet form and it is a controlled drug. However, there is no record in the clinical records that this was prescribed, and a copy of the prescription was not retained in the clinical records.

27. Dr C told HDC:

> "… I always discuss what analgesia should be used with the patient before prescribing it. At no point during the consultation, did [Ms A] alert me that she was allergic to morphine."

28. Ms A told HDC that Dr C asked her about what medications she had taken in the past, and she recalls telling him that she could take ibuprofen, Panadol or fentanyl[14] patches. She said that he noted that she had a long history of chronic pain syndrome and told her he would give her some "strong pain killers". Ms A advised HDC that Dr C did not tell her what he was going to prescribe or that it was morphine. She also said that he did not ask her about any allergies.

29. Ms A was then discharged from the public hospital with the prescription for Sevredol.

Discovery of error

30. Ms A told HDC that she filled the prescription at a pharmacy before returning home.

31. After she arrived home, Ms A's mother, Ms B (a registered nurse), arrived to check on Ms A. Ms B told HDC that when she arrived Ms A was just about to take the

[13] A Lisfranc injury is an injury of the foot in which one or more of the metatarsal bones (bones in the mid foot) are displaced from the tarsus (upper foot).
[14] An opioid used for analgesia.

medication she had been prescribed by Dr C. Ms B said that she asked what the medication was, and was "horrified" to find that it was Sevredol.

32. Ms B said that she immediately telephoned the ED at the public hospital and spoke to a registered nurse (RN). Ms B told HDC that the RN confirmed that Ms A's allergies were clearly recorded in her records. The RN's retrospective records state: "Mother of above [Ms A] rang re medication script that was prescribed [and Ms A's] allergy to morphine. Upset by error. I apologised and advised her to represent to ED so we could give another script. …".

33. Ms B presented to the ED at the public hospital and at 8.39pm spoke with a medical officer special scale (MOSS)[15] in ED, Dr D.[16] Dr D recorded in the clinical notes that Ms B told him that her daughter had been given Sevredol and that she was allergic to morphine. Ms B returned the Sevredol to Dr D and subsequently it was disposed of. Dr D recorded that Ms B asked him for a different analgesia for her daughter and told him that previously paracetamol and ibuprofen had had little effect on Ms A's pain. Dr D recorded:

> "[A]llergy to morphine and codeine is recorded on this am ED triage sheet. I have apologised openly to the mother for the mistake. Mother says that the only analgesia that is effective and that has been effective in the past is fentanyl. I have agreed to dispense one fentanyl patch of 25 [micrograms] (mother has returned the Sevredol to nurses)."

34. With regard to the care that he provided, Dr D told HDC:

> "… [Ms B] told me she was a nurse and that she would monitor [Ms A] closely through the night. I felt I had been put in a difficult position. I thoroughly read [Dr C's] notes, who had assessed [Ms A] in ED earlier that afternoon. I was made aware of the distress that this woman was currently suffering as a result of her pain and lack of analgesia. I carefully weighed the pro[s] and cons of complying with [Ms A's] mother's request versus denying it. I thought that if my ED colleague had elected to prescribe an opioid analgesic, that must have been because [Ms A] was in severe pain.
>
> …
>
> I felt it would have been unduly harsh on [Ms A] to require her to come back and be reassessed in ED so that I could prescribe a different opiate to the one she was originally given. I opted for issuing a single patch of a low dose Fentanyl and advised that she should attend the GP within the next 48 hours to be reviewed …"

35. Dr D recorded in Ms A's medication chart that he had provided a "Fentanyl Patch to take home". Dr D told HDC that because of the late hour, no pharmacies were open, so a prescription would have been no use to Ms B or her daughter.

[15] A MOSS is doctor who is not in a training programme and who has not yet specialised or gained a postgraduate qualification.
[16] Dr D is vocationally registered in general practice.

Further information provided

The DHB

36. In a letter to Ms A, the DHB's quality coordinator stated:

> "I want to reassure you that we do have a robust system in place to record patient allergies. Any allergy is recorded in our electronic patient information management system and is also noted at the front of the patient's clinical file.
>
> …
>
> We would like to apologise for the distress this experience has obviously caused you …"

37. In relation to why a copy of Dr C's prescription was not retained in the clinical records, the DHB explained that controlled drugs (such as Sevredol) are required to be prescribed on individually numbered triplicate scripts (H572 forms produced by the Ministry of Health). All three copies of the scripts are required to be given to the patient to be presented to the pharmacy, in order to be a legal prescription.

38. In relation to this, the DHB stated:

> "Although the prescribing doctor must record the medication prescribed in the patient notes, [Ms A's] concerns have highlighted to us that unless the script is photocopied prior to being given to the patient, we have no way of seeing exactly what was prescribed. [An] emergency consultant has been tasked with talking with the other ED Doctors to set up a process to ensure that a copy of any controlled drug prescription is also placed in the patient's clinical file."

39. In response to the provisional opinion, the DHB advised that it has now changed its process relating to the management of controlled drug prescriptions. It advised that when a controlled drug is prescribed staff are now required to photocopy the triplicate form before it is given to the patient. The photocopy is retained on the patient's medication chart. This change has been communicated to staff and a reminder has been placed on the controlled drug safe in the ED.

Dr C

40. In response to this investigation, Dr C told HDC:

> "… I do realise that I should have gone through all of [Ms A's] notes before prescribing her a morphine based analgesia however I feel that patients should accept some responsibility in knowing what medications they can and cannot have especially if they have had an adverse reaction to them in the past.
>
> …
>
> I have certainly learnt from this and now check the hospital records to ascertain if any previous allergies have been documented. However, I believe the best prevention to such a situation is for the patient to take an active role and interest in their healthcare. If the patient is unable to do this due to any impairment, a responsible carer should come to the hospital to assist them especially if there are competency issues."

The DHB's Medicines Management Policy

41. The DHB's medicine management policy relevant at the time of these events states:

> "5.1 Prescribing
>
> The role of the Medical Practitioner/Nurse Practitioner/Midwife
>
> A Medical practitioner, nurse practitioner or midwife is to prescribe within their professional scope of practice.
>
> Prescribers must prescribe medicines in accordance with the National Medication Charting Standards which give stringent and clear guidelines for prescribing medications.
>
> …
>
> 5.4 Receiving
>
> The Patient's role
>
> The patient's role is as a participant and the time of receiving medication provides an opportunity for ensuring that the patient understands the treatment and consents to receiving the medication …".

Response to Provisional Opinion

Dr C

42. In response to the provisional opinion Dr C stated that he accepted that Ms A's allergy to morphine was documented in three different places in her clinical records. He also accepted that he could have obtained this information by questioning Ms A directly and that "[i]t follows that I accept Dr Jaffurs' advice that a prudent practitioner would verify no allergy status before prescribing medicine."

43. Dr C stated that he is not sure how the error occurred in this case. He reiterated that he always discusses with the patient what analgesia should be used before prescribing and "during that discussion [Ms A] did not alert [Dr C] to the fact that she was allergic to morphine." Dr C stated: "… I am confident that had I known at the time of [Ms A's] allergy I most certainly would not have prescribed Sevredol." However, he accepted that there was no documentation of a discussion with Ms A regarding allergies or analgesia.

44. Dr C stated: "I cannot now be certain that all the documentation was actually in [Ms A's] file box in the doctors' working station when I saw her." He submitted that the ED is very busy and that there were times when he would see patients without all the relevant information being available. He stated that his usual practice was to review a patient's record prior to seeing the patient. However, he accepts that he is "ultimately responsible" and that he "made an error in this case."

45. Dr C also accepted that he did not document his discharge plan or any discussion he had with Ms A. Dr C stated that he is usually "very particular" about his record keeping and suggested that his failures were the result of being very busy.

The DHB

46. The DHB advised that it accepted the findings of the provisional opinion.

Ms A

47. In response to the information gathered section of the provisional report Ms A stated that she was not aware of the different medication names. Ms A said that she only found out that she had been prescribed morphine because her mother, who is a nurse, stopped her before she took the medication.

Opinion

Introduction

48. Ms A has a known allergy to morphine. She presented to the ED at the public hospital with a suspected fracture of her left foot and ankle and was prescribed Sevredol, which is the controlled drug morphine sulphate in tablet form. This opinion considers the actions of the doctor who prescribed Sevredol to Ms A.

Opinion: Dr C — Breach

Standard of care

Assessment and management

49. Ms A was referred by her GP, Dr E, to the ED for assessment of a suspected fracture of her left foot and ankle. In her referral letter Dr E recorded that Ms A's allergies included "pen[icillin], morphine, codeine, erythromycin".

50. On arrival at the ED Ms A completed a patient admission form. On this form under "any medical alerts or allergies?" Ms A listed that she was allergic to morphine, codeine, penicillin, and erythromycin".

51. At 1.16pm, Ms A was triaged and at 2.12pm she was seen by ED consultant Dr C. Dr C noted the history of Ms A's presenting complaint, in that she had fallen onto her foot and was unable to weight bear. Dr C also noted Ms A's relevant past medical history, which included chronic pain, and documented her current medications, which included the pain relief medications gabapentin and ibuprofen, as well as a number of medications used to treat depression and anxiety. Dr C carried out an initial assessment and requested an X-ray.

52. The nursing notes documented at 2.18pm also record Ms A's allergy to morphine.

53. At 3.54pm, Dr C reviewed Ms A's X-ray. He documented that no fracture was visible, Ms A had been given a Tubigrip, he had requested an orthopaedic review, and he queried the possibility that a CT scan was needed to rule out a Lisfranc injury.

54. I note the opinion of my specialist emergency medicine expert, Dr William Jaffurs, that the care Ms A received in the ED was "timely, sensitive, and skilful". Dr Jaffurs specifically notes that Dr C identified Ms A's history of chronic pain and recorded her complex list of medications, and advised that "[t]hese issues would have demanded and received an added level of caution in dealing with [Ms A's] foot injury". Dr Jaffurs advised that the suggestion of a CT scan was appropriate for this type of injury.

55. I accept Dr Jaffurs' advice that up to that point Dr C's assessment and management of Ms A, and his documentation, were appropriate.

Prescription of Sevredol

56. Despite Ms A's allergy to morphine being clearly recorded on Dr E's referral, Ms A's patient admission form, and in the nursing records, Dr C prescribed Ms A Sevredol, which is morphine sulphate in tablet form.

57. Dr C told HDC that he did not review Ms A's clinical records before prescribing her Sevredol, but stated: "I always discuss what analgesia should be used with the patient before prescribing it … [and at] no point during the consultation did [Ms A] alert me that she was allergic to morphine." Ms A said that while Dr C did ask her about medications she had taken in the past, he never discussed what medication he was going to prescribe or mention that it was morphine. Ms A said that Dr C told her only that he was going to give her some "strong pain killers".

58. There is no documentation of any discussion regarding analgesia or allergies. Therefore, given the lack of evidence to support Dr C's account, I do not accept that he had an adequate discussion with Ms A in relation to Sevredol; in particular, I find that he did not advise Ms A that Sevredol was morphine in tablet form. Furthermore, I find that Dr C did not ask Ms A about her allergies.

59. I note that Dr C accepts that he should have reviewed Ms A's clinical records before prescribing Sevredol. However, he goes on to state:

> "… I feel that patients should accept some responsibility in knowing what medications they can and cannot have especially if they have had an adverse reaction to them in the past.
>
> …
>
> I believe the best prevention to such a situation is for the patient to take an active role and interest in their healthcare. If the patient is unable to do this due to any impairment, a responsible carer should come to the hospital to assist them especially it there are competency issues."

60. I find Dr C's comments concerning. In my view, the onus is on the clinician to elicit an adequate history. This is a basic medical skill. The Medical Council of New

Zealand outlines the basic requirements for prescribing medications in its guideline *Good Prescribing Practice* (April 2010), which states:

> "… To ensure that your prescribing is appropriate and responsible you should:
>
> Take an adequate drug history of the patient, including: any previous adverse reactions to medicines; current medical conditions; and concurrent or recent use of medicines …"

61. The Medical Council of New Zealand publication *Good Medical Practice* (April 2013) provides:

> "When you assess, diagnose or treat patients you must provide a good standard of clinical care. This includes:
>
> - adequately assessing the patient's condition, taking account of the patient's history and his or her views, reading the patient's notes and examining the patient as appropriate
> - providing or arranging investigations or treatment when needed."

62. In this case, Dr C failed to read the notes adequately and talk with his patient. Previously I have noted the importance of reviewing the risk factors and discussing medication with patients.[17] By failing to do the basics right, Dr C missed several opportunities to ascertain Ms A's allergy status.

63. Ms A's allergy to morphine was information that was easily accessible to Dr C in Ms A's clinical records, where it was clearly documented in three different places, including on the patient admission form completed by Ms A. Information about Ms A's allergies could also have been obtained directly from Ms A.

64. I note Dr Jaffurs' advice: "A prudent practitioner would verify no allergy status before prescribing medicine." In Dr Jaffurs' view, Dr C's error in prescribing Sevredol to Ms A in the circumstances was a "significant" departure from accepted standards. I agree.

65. I note that in response to the provisional opinion Dr C's accepted these findings.

Documentation

66. Dr C's documentation of Ms A's past medical and presenting history, and his assessment of Ms A's injury, were, in Dr Jaffurs' view, complete and orderly up to the point of the orthopaedic referral. However, Dr C did not document his discharge plan for Ms A, or any discussions he had with Ms A in relation to discharge. In particular, Dr C did not document that he had prescribed Sevredol to Ms A.

67. It is a fundamental requirement of good clinical practice that a health provider keep clear and accurate records of the care provided. The Medical Council of New Zealand publication *Good Medical Practice* (April 2013) states:

[17] See opinions 12HDC01062 (30 May 2014) and 13HDC01041 (25 May 2015), available at www.hdc.org.nz.

"You must keep clear and accurate patient records that report:

- relevant clinical information
- options discussed
- decisions made and the reasons for them
- information given to patients
- the proposed management plan
- any drugs or other treatment prescribed.

Make these records at the same time as the events you are recording or as soon as possible afterwards."

68. Dr Jaffurs advised that "[b]est practice would be to have prescriptions noted in some manner in the medical record both for reasons of safety and to assist subsequent health care providers with decision making".

69. I agree. In this case it is fortunate that Ms A did not take the prescribed Sevredol. However, had she done so and an adverse reaction resulted, the fact that she had been prescribed Sevredol was significant information that would be required by the treating clinician.

Conclusions

70. While I accept that Dr C undertook a good assessment of Ms A's injury, he prescribed Sevredol to her inappropriately, despite her well documented allergy to the drug. In my view, Dr C failed to do the basics and missed several opportunities to ascertain Ms A's allergy status, by not reading the notes and by not asking Ms A whether she had any allergies. It was Dr C's responsibility to take the necessary steps to ensure that he prescribed medication to Ms A that was appropriate for her. By failing to do so, and prescribing her medication to which she was allergic, Dr C did not provide services to Ms A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

71. Furthermore, by failing to explain that Sevredol was a form of morphine, Dr C failed to ensure that Ms A was provided with information that a reasonable consumer, in that consumer's circumstances, would expect to receive and, accordingly, he breached Right 6(1) of the Code. As a consequence, Ms A was unable to give her informed consent for this aspect of her treatment, and I find that Dr C also breached Right 7(1).

72. Dr C's documentation was complete and orderly up to the point of the orthopaedic referral. However, I consider that Dr C's failure to document his discharge plan and, in particular, his prescription of Sevredol, was a significant departure from professional standards and a breach of Right 4(2) of the Code.

Opinion: The DHB — No breach

Vicarious liability

73. Under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority may be vicariously liable for acts or omissions by an employee.

74. As Dr C was an employee of the DHB, consideration must be given as to whether the DHB is vicariously liable for his breaches of the Code. Under section 72(5), it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent acts or omissions leading to an employee's breach of the Code. Previously this Office has found a provider not liable for the act or omission of its staff when the act or omission clearly relates to an individual clinical failure made by the staff member.[18]

75. The DHB has a system whereby a patient's allergies are recorded on the electronic patient management system, as well as in the patient clinical records. In Ms A's case, her allergies were recorded clearly in her clinical records, but Dr C failed to review the records and identify Ms A's allergy. As stated above, this failure was a clear departure from accepted standards.

76. The DHB advised that when prescribing a controlled drug it is the prescribing doctor's responsibility to document this in the clinical records. I agree.

77. The DHB was entitled to rely on Dr C, as a consultant, to provide an appropriate standard of care. In my view, Dr C's failures in this case were individual clinical errors and cannot be attributed to the system within which he was working. Accordingly, I conclude that the DHB is not vicariously liable for Dr C's breaches of the Code.

78. I note that following this incident the DHB identified a gap in its system for retaining a copy of the prescription in the case of controlled drugs, and currently is addressing the issue.

Recommendations

Dr C

79. In accordance with the recommendations of the provisional opinion Dr C has agreed to provide a written apology to Ms A for his breaches of the Code. The apology should be sent to this Office within three weeks of the date of this report, for forwarding to Ms A.

80. I recommend that Dr C undertake further training in relation to history taking in a clinical setting and safe prescribing practices. Dr C should provide evidence of his

[18] Opinion 11HDC00521.

attendance or enrolment in an appropriate workshop or seminar within three months of the date of this report.

The DHB

81. In accordance with the recommendations of the provisional opinion, the DHB has agreed to share its learnings and the actions it has taken in relation to prescribing controlled drugs and the maintenance of records, through the National DHB CMO Group. Confirmation of this action should be provided to this Office within three months of the date of this report.

Follow-up actions

82.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr C's name.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Health Quality & Safety Commission, and the New Zealand Pharmacovigilance Centre, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from an Emergency Medicine specialist, Dr William Jaffurs:

"Thank you for your request to review the above complaint.

In doing so I have reviewed the documents sent to me including:

Your letter

List of Relevant documents enclosed with listed documents verified included

HDC summary of facts

Expert advice requested

Guidelines for independent advisors effective 14 July 2014

ED Notes from visit [date]

I am currently a Fellow of the Australasian College of Emergency Medicine (since 1998) and work full time as an Emergency Medicine Specialist at Whangarei Base Hospital (since 1997). I was Director of the Emergency Department for my first seven years. I also hold Fellowship with the American College of Emergency Medicine. Having reviewed the persons and entities in this case I can see no conflict of interest on either a personal or professional level. I have read your guidelines for expert advisors.

Case summary:

[Ms A] presented to the Emergency Department of [the public hospital] at 1315 hours on [date]. She was triaged immediately. The nursing note timed 1418 appears to include allergies to penicillin morphine erythromycin and codeine. There is a later note added in above the allergy section, but the allergy note appears to be the handwriting of the original notation. She was seen by [Dr C] at 1412 hours. I do not see a triage code in the record but this time frame is reasonable for the problem. She was referred from [Dr E] as a possible LisFranc fracture of the left foot and the letter is attached to the medical record. The letter specifies that she is allergic to 'pen, morphine, codeine, erythromycin'.

[Dr C's] notes are orderly and complete to the extent of including past medical history and medications. Allergies are not included. His attention is appropriately focused on her injury. Her x-ray does not show a fracture. Her case is apparently discussed with [an orthopaedic surgeon] who agrees to review her films. There is a suggestion of a CT scan to detect the otherwise difficult to see possible LisFranc fracture in her foot. She is given crutches and a compressive tubigrip. There are no notes from the Orthopaedic doctor and it is not clear from the record what her discharge and follow up plans were. She was not referred to the fracture clinic according to the notes. There is a copy of a prescription for ibuprofen and paracetamol from [Dr C].

There is a further note added at 2039 hrs from [Dr D] indicating that [Ms A's mother] who is a Nurse has presented to ED to 'flag up' that her daughter was given a Sevredol prescription by [Dr C] and that she is allergic to it. The tablets are returned to the ED staff. [Dr D] receives this information, apologizes, identifies that fentanyl has been used safely in the past, and dispenses a single fentanyl patch which is a long acting slow release pain reliever of the synthetic narcotic type. This is correctly documented in the medication chart.

In response to your questions:

[Dr C]

1) The appropriateness of the care provided by [Dr C] to [Ms A] based on the information that he had available to him at the time.

The care provided to [Ms A] in the Emergency Department was timely, sensitive, and skilful. Her issues with chronic pain are identified objectively and complex medication list included in his clinical notes. These issues would have demanded and received an added level of caution in dealing with her foot injury. Available x-rays showed no fracture and Orthopaedic advice was sought. The suggestion of a CT scan is appropriate for the type of fracture suggested, although this is not usually done in an urgent timeframe. She is given prescriptions for pain medicine. It would be customary to have the follow up instructions provided by the Orthopaedic staff in some manner and I cannot tell exactly what advice was given for this item. In a busy Emergency Department as this would have [been on a Sunday] this information would not always make it back to the supervising ED consultant to be included in the ED record prior to the patient's discharge.

2) The appropriateness of [Dr C's] documentation of his consultation with [Ms A], including documentation of his prescription for [Ms A].

As discussed in section 1) documentation is complete and orderly up to the point of Orthopaedic referral. There is a copy of a prescription for ibuprofen and paracetamol attached to the record. There is no mention of a prescription for Sevredol. Best practice would be to have prescriptions noted in some manner in the medical record both for reasons of safety and to assist subsequent health care providers with decision making. In this situation it appears that all three copies of the controlled substances prescription are by necessity given to the patient to take to pharmacy and the usual practice of retaining a prescription copy for the record was overlooked. I consider this a minor departure from the expected standard of care, and forgivable in a busy weekend ED with too many tasks to accomplish with limited time and human resource.

An unfortunate prescribing error clearly occurred. [Dr C] did not see the clearly visible and legible information provided by the Referring GP and his nursing staff according to his letter of 13 May 2015. He notes there was some discussion of 'pain relief medications', without recalling details of this discussion. A prudent practitioner would verify no allergy status before prescribing a medicine. Therefore I find this a significant departure from the expected standard of care for prescribing of medication.

[Dr D]

1) The appropriateness of [Dr D] issuing for [Ms A] to [Ms A's] mother, based on the circumstances and the information that he had available to him at the time. […]

[Dr D] acted appropriately in all matters relating to this case in my opinion. He responded compassionately to [Ms A's] mother's concern, recognized the apparent error, apologized, and sought a reasonable solution. He was told that fentanyl was effective for [Ms A] and this was not one of her allergies. It was too late on a Sunday night to have a prescription filled so he dispensed a single fentanyl patch from the ED stock. This action is well documented in his note and on the medication chart, and is consistent with the DHB's medication policy (Section 5.2 Medicine management policy 2012 version). I do not see where this is an element of the complaint in any of the other attached materials. I do not see any departure from the expected standard of care for any of these items.

Hospital practice is different from other practice structures in that doctors are often required to prescribe or administer drugs to patients who are not technically their own. This happens frequently on Wards, in Theatre, and in the Emergency Department. Doctors satisfy the expected standard of care by verifying the indication and safety of the prescribed drug, and documenting the prescription and administration appropriately. Although [Dr D] did not personally examine [Ms A], I think he had an appropriate request from a mother who also happened to be [a nurse], and sufficient information to dispense the fentanyl patch to her for her daughter's use. The Sevredol tablets were returned to the nursing staff for disposal. The controlled drug registry and documentation of disposal procedure were not provided to me for review, and I do not feel this information is pertinent to the question posed.

Several additional points can be made with regard to this case:

The dispensing pharmacy that provided you with a copy of the Sevredol prescription missed an opportunity to detect an allergy to a prescribed medicine. As an ED Consultant, I occasionally get calls from Pharmacists who are dealing with hospital prescriptions written by our doctors and detect an allergy to a prescribed medicine. I always appreciate this procedure for double checking our doctors, but am not sure if this is a standard routine for them. I am not in a position to comment on the standard of practice for Pharmacists.

Generic prescribing is often cited as a means of avoiding confusion when prescribing or dispensing medication. For instance in one audit of our nursing staff several years ago, only one third realized that Augmentin was a form of penicillin. Morphine has many formulations and is marketed under a variety of names including Sevredol, LA Morph, MS Contin, and others. These medications are so common, that I would expect doctors, nurses, and pharmacists to recognize them as morphine. This item has not been raised in this investigation, but I will raise it to suggest that these morphine preparations and names are so common that I do not think generic prescribing would have made a difference in this case.

I have attached several articles regarding morphine allergy with pertinent statements highlighted. Listed patient allergies are notoriously inaccurate. True allergy to morphine is unusual with one publication citing only one out of ten patients who list this allergy as actually being allergic (attachment 1).[19] Narcotics fall into one of several classes depending on their structure and synthesis. Attachments 2 and 3[20] are examples of the information available to practitioners on line to guide their choice of narcotic pain medicines in the situation of morphine allergy. Both documents represent what I think is a consensus that Fentanyl is different enough from morphine to be used in the setting of suspected morphine allergy.

Finally, I would like to comment on the frequency of prescribing errors in our hospitals. Published estimates are that one in three patients in modern hospitals experience medication prescribing or administration errors despite multiple strategies in place to prevent this. Attachment 4[21] indicates prescribing errors in 1.5% of hospital prescriptions. Attachment 5[22] suggests errors of this type with potential for adverse effects occur in 4 of 1000 prescriptions written. An unsafe working environment, complex and undefined procedures and inadequate communication are cited as important contributing factors. The causes for these errors are analysed and described in the two articles. Numerous strategies are suggested for catching what appear to be inevitable errors. The most effective means of preventing errors are standardized drug charts, as in place at [the DHB], and on site pharmacists in clinical areas to double check all prescriptions written. The cost of onsite pharmacists in smaller hospitals is prohibitive and therefore not commonly used. Errors persist despite elaborate systems to prevent them and are blamed primarily on rushed human behaviour in difficult work situations. I think this is what happened to [Dr C] who otherwise displayed a high level of expertise in the care he provided to [Ms A]. He has acknowledged his mistake, is clearly mortified that he made it, and apologized."

[19] Saljoughian, M. (2006). Opioids: Allergy vs. Pseudoallergy, *U.S. Pharmacist*, 7:HS-5-HS-9.
[20] Pain Management in Adults with a Morphine Allergy, Glouestershire Hosptials, NHS Foundation Trust, December 2008.
Hayes, B. (2008). Opioid Allergies and Cross-reactivity, University of Maryland.
[21] Barber, N., Rawlins, M., Franklin, B. (2003) Reducing prescribing error: competence, control, and culture, *The international Journal of Healthcare Improvement*, 12: 29-32.
[22] Giampaolo, V., and Minuz, P. (2009). Medication error: prescribing faults and prescription errors, *British Pharmacological Society*, 67(6): 624-628.