General Practitioner, Dr B

A Report by the
Health and Disability Commissioner

(Case 19HDC00915)

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Executive summary

1. This case highlights the need for ensuring that the basic aspects expected in a medical consultation are performed adequately. A woman, who was 14 weeks pregnant at the time of events, presented to a medical centre with abdominal pain. She was reviewed by a general practitioner (GP). The GP did not identify the woman correctly, and during the consultation the GP believed that the woman was a patient who required treatment for gonorrhoea and chlamydia. The GP did not establish the woman's history and presenting complaint. When the woman denied that she had had an abnormal swab result, or received a notice to be recalled for treatment, the GP did not explore her responses. The woman was then administered an antibiotic incorrectly, when this was intended for another patient. The woman complained that the GP did not accept responsibility for the medication error, and blamed her for the error that occurred.

Findings

2. The Commissioner found the GP in breach of Right 4(1) of the Code. The Commissioner was critical that the GP did not establish the woman's identity before consulting with her, and did not obtain an accurate history of her presentation. The Commissioner was also critical that the GP did not question the woman when she denied a recall or an abnormal swab result, or document the identity error and medication error accurately in the woman's clinical records. The Commissioner noted that this case highlights the need for good communication and for taking responsibility for errors in such circumstances.

Recommendations

3. The Commissioner recommended that the GP undertake training on communication.

Complaint and investigation

4. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided to her by Dr B at the medical centre. The following issue was identified for investigation:

- *Whether Dr B provided Ms A with an appropriate standard of care in 2019.*

5. This report is the opinion of the Commissioner, Anthony Hill.

6. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
Dr B	Provider/general practitioner (GP)

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7. Further information was received from:

RN C	Registered nurse
Medical practice	

8. Also mentioned in this report:

Ms D	Other patient
Dr E	Complaints Officer

9. Expert advice was obtained from in-house vocationally registered GP Dr David Maplesden (Appendix A).

Information gathered during investigation

Introduction

10. At the time of events, Ms A, aged 24 years, was 14 weeks pregnant. This report concerns the care provided to Ms A by Dr B at the medical centre in 2019 when she presented with abdominal pain.

11. Dr B commenced employment as a GP at the medical centre in 2007 and has been practising as a GP for many years.

Attendance at medical centre

12. At around 6.30pm, Ms A, accompanied by her niece, sought medical assistance from the medical centre.[1] Ms A was experiencing sharp abdominal pains.

13. Dr B was the only doctor at the medical centre at the time of events. She was not Ms A's regular GP, and prior to these events had not provided care to Ms A.

14. RN C was the nurse on duty. Ms A told HDC that RN C confirmed her identity at this stage. RN C then performed an initial triage assessment of Ms A, and established that she was 14 weeks pregnant and had abdominal cramps and vomiting. Contrary to this, in response to the provisional opinion, Ms A stated that she did not present with vomiting. RN C recorded Ms A's history and vital signs in Ms A's notes, and placed her name on the electronic board queue to be seen by a GP. The electronic board queue is a system to manage the flow of patients in a general practice setting. Ms A returned to the waiting room with her niece. One other person was in the waiting room (a male).

Initial consultation with Dr B

15. Dr B told HDC that she was the only doctor in attendance, and there were two patient names on the electronic board waiting to be seen, Ms D and Ms A. The medical centre told HDC that Ms D was not present in the waiting room, but her name had been put in the patient

[1] Provides general medicine and urgent medical care.

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queue to be recalled by the nursing team. Dr B stated that she reviewed the clinical records for Ms D and noted a diagnosis of gonorrhoea[2] and chlamydia[3] and an urgent recall for treatment. Dr B noted that Ms D had been recalled a number of times previously, but had not responded to the recalls. Dr B entered the waiting room, noticed two females and a male, and called for the patient named "Ms D". Ms A stood up and followed Dr B to the consultation room. Contrary to Dr B's recollection, Ms A stated that Dr B called for "Ms A" in the waiting room.

16. In response to the provisional opinion, Ms A stated that she was in the waiting room with her niece and another female, who she assumes was Ms D. Ms A said that a male entered the waiting room, spoke to the woman, and then left. Ms A stated: "[Dr B] clearly said [Ms A] otherwise [Ms D] would have stood up."

17. Dr B told HDC that she commenced the consultation by stating: "[Ms D], you have been recalled to be treated for gonorrhoea, which is a sexually transmitted disease." Dr B recollected that she asked Ms A if she had a sexual partner, and she replied that she had a husband. Dr B then asked Ms A if her husband was her only sexual partner, and she replied "yes". Dr B recollected that she told Ms A again that she had been recalled to be treated for gonorrhoea, and that Ms A told her that she had not been notified of the recall. Dr B stated that in response, she told Ms A: "Never mind, you are here now, and we will give you the treatment. But we will need to check your partner because he might need to be treated as well." Dr B explained that the treatment was an injection of antibiotics.

18. Ms A refutes that Dr B called her "Ms D" again during the consultation, and stated that had Dr B called her "Ms D", she would have alerted her to the error. Ms A reported that Dr B did not ask her to confirm either her name or date of birth at the beginning of the consultation. Ms A recalled that Dr B told her that she had gonorrhoea and chlamydia, and in response she told Dr B that a swab taken recently had been normal. Ms A then asked Dr B "what sort of tests were done and when". Ms A stated:

> "[Dr B] did not respond to my question, and instead just kept saying how urgent it was to have an injection otherwise my tubes would close and I wouldn't be able to have children."

19. Dr B told HDC that neither Ms A nor Ms D were known to her, and that they are of the same ethnicity and age group. Dr B acknowledged that on this occasion she treated the wrong patient. She told HDC that she should have been more careful to establish Ms A's identity before consulting with her, and should have elicited from her the history of the presenting complaint. Dr B also acknowledged that Ms A's denial for recall was a "red-flag" that was missed. Dr B stated that at this point, Ms A's denial should have prompted her to double-check that she was consulting the correct patient.

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[2] A sexually transmitted infection.

[3] A sexually transmitted infection.

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20. Ms A told HDC: "[Dr B] was very quick and didn't give me much room to speak." Ms A agreed to proceed with Dr B's recommendation to have the intramuscular injection of antibiotics. She told HDC:

> "I was already so worried about my sore tummy and now being told I had something that could potentially stop me from having kids, it was overwhelming so I went and had the injection."

Administration of medication

21. Dr B escorted Ms A to the nurses station and gave RN C a verbal order[4] to administer ceftriaxone, an antibiotic, by intramuscular injection. At this juncture, Dr B believed she was treating Ms D; in contrast, RN C, having performed the triage assessment, understood that she was treating Ms A.

22. RN C reviewed Ms A again and administered the antibiotic.

Identification of error

23. RN C recorded in the clinical notes that Ms A was administered an antibiotic, and noted that there was no record of Dr B's consultation. RN C stated that she then went to Dr B's consultation room and asked her why Ms A had been prescribed an antibiotic for abdominal cramps and vomiting. RN C said that it was at this point that both Dr B and RN C established that Ms A had been reviewed instead of a patient named Ms D. RN C said that Ms A had left the clinic, so a telephone call was made and she was asked to return to the clinic.

24. In contrast, Dr B told HDC that following her consultation with Ms A, she reviewed the electronic board and the notes for a patient named "Ms A". Dr B stated that she then entered the waiting room to call Ms A but the room was empty. Dr B then asked RN C where Ms A was, and RN C advised that she had seen Ms A earlier. Dr B stated that at this point she was alerted to the identity error, and she gave instructions to the receptionist to telephone Ms A and request that she return to the clinic.

25. In response to the provisional opinion, Ms A told HDC that when she left the clinic there was one patient waiting to be seen.

Further consultation

26. Approximately five minutes after leaving the practice, Ms A returned to the clinic and was examined again by Dr B. In response to the provisional opinion, Ms A stated that when she was re-examined, "[Dr B] pushed down on my tummy a couple of times and that was it," and then Dr B handed over a prescription.

27. Dr B told HDC that she immediately apologised to Ms A and offered her an explanation of what had happened. Dr B stated that she explained to Ms A that she had called for "Ms D" in the waiting room, and when Ms A had followed her, she assumed she was Ms D. Dr B then told Ms A that there was nothing to arouse her suspicion that she had not identified the

[4] A prescriber gives verbal instructions to a nurse to document and administer medication.

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patient correctly. Dr B stated that she asked Ms A why she had responded to "Ms D" in the waiting room, but Ms A did not respond. Dr B told HDC that she apologised again and took Ms A's history, examined her, and prescribed paracetamol and metoclopramide for her symptoms.

28. Dr B recorded in the clinical notes:

> "Here for abdo pain, 14/40, found a midwife, no contraction, no bleeding. Afebrile, well hydrated and perfused, no meningism, no rashes, throat not cong, both TM clear, vbs nil added, soft non-tender abdo, dual sounds nil added, nausea. Script and back if any concern. Prescription provided for Maxolon[5] and Paracare[6]."

29. There is no reference to the medication error or why Ms A was administered IM ceftriaxone.

30. Ms A told HDC that on returning to the medical centre, she discussed the medication error with Dr B, but felt "pushed out" because the clinic was closing. Ms A further told HDC that Dr B offered no apology, and told her that it was her fault because she called for "Ms D" and not "Ms A". Ms A stated that she left the practice feeling upset, and that Dr B had not shown her empathy.

Subsequent events

31. The following day, Ms A returned to the clinic and saw Dr B. Ms A requested the name of the antibiotic that had been administered to her, so that she could inform her midwife, and Dr B gave this to her in writing. Ms A stated that Dr B told her that it was her fault, and again showed her no sympathy for what had happened. Dr B told HDC that she apologised again to Ms A and reassured her that ceftriaxone is safe in pregnancy, and there was no risk of harm to her baby.

Medical centre

32. On 23 May 2019, a Significant Event Investigation Report was completed, in accordance with the Practice's Incident Policy. The report identified the following improvements relating to verbal medication orders:

- All medications to be administered in the clinic need to be charted by the doctor in the patient's electronic medical record.
- The nurse will then document that the medication has been given as charted.

33. Dr E, the Complaints Officer of the medical centre, told HDC that all staff were advised of the changes to verbal medication orders, as recorded above. Dr E also told HDC that learnings from the case were discussed at a doctors' peer review meeting.

34. Dr E telephoned Ms A to offer an apology and reassure her that there would be no harm to her unborn baby, and advise her that the practice had made changes following these events.

[5] A medication for nausea and vomiting.
[6] A medication for pain relief.

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Further comment

Ms A

35. Ms A stated: "I also believe this case could've been easily resolved had [Dr B] been apologetic and also taken ownership of her wrong doing."

Changes made

36. Dr B told HDC that she has attended an MPS[7] Risk Management workshop, and has applied to attend further training on this topic. Dr B stated that before commencing any consultation with a patient whom she has not met previously, she will ask the patient to state their full name and date of birth. Furthermore, she will ask the patient to explain the reasons for the presentation.

Responses to provisional opinion

37. Ms A and Dr B were given the opportunity to respond to the relevant sections of the provisional opinion. Where appropriate, changes have been incorporated into the report.

38. Ms A told HDC that she felt that Dr B did not take responsibility for these events. Ms A also said that she is pleased that Dr B has since attended training on communication.

39. Dr B accepted the findings in the provisional opinion, and has provided a written apology for forwarding to Ms A.

Relevant standards

40. The requirement for doctors to prescribe medicines adequately is set out in the Medical Council of New Zealand's publication, "Good Prescribing Practice"[8]. The statement notes that doctors must:

> "Make the care of patients your first concern. You should only prescribe medicines or treatment when you have adequately assessed the patient's condition, and/or have adequate knowledge of the patient's condition and are therefore satisfied that the medicines or treatment are in the patient's best interests."

41. The Medical Council of New Zealand's statement, "The maintenance and retention of patient records"[9] states that doctors "must keep clear and accurate patient records that report relevant clinical findings; decisions made; information given to patients [and] any drugs or other treatment prescribed".

[7] Medical Protection Society.
[8] Available from https://www.mcnz.org.nz/assets/standards/eeccbbf5a1/Statement-on-good-prescribing-practice.pdf
[9] Available from https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Maintenance-and-retention-of-records.pdf.

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Provisional opinion: Dr B — breach

42. This case is concerning in that the basic aspects expected in a medical consultation were not done. Dr B did not identify Ms A correctly or establish her history and presenting complaint. Dr B did not pay sufficient attention to Ms A's responses and relevant concerns. Subsequently, Ms A was administered a medication incorrectly when this was intended for another patient.

Consultation

Establishing identity

43. On 23 May 2019, Ms A presented to the medical centre with abdominal pains. She was triaged by RN C and her name was placed on the electronic board to be seen by Dr B. Dr B noted that two patients were in the patient queue waiting to be seen, Ms D and Ms A. Dr B stated that Ms D and Ms A are of the same ethnicity and age group, and that at the time, neither were known to her. Dr B reviewed the notes for a patient named "Ms D" and noted a diagnosis of gonorrhoea and chlamydia and an urgent recall for treatment.

44. Dr B called for "Ms D" in the waiting room, and Ms A followed her to the consultation room. Dr B stated that she called Ms A "Ms D" again in the consultation room. However, Ms A disputes this, and stated that Dr B did not call her "Ms D" in the waiting room or during the consultation, or ask her to confirm her identity.

45. I note that Dr B reviewed the notes for Ms D, the next patient for review. I consider it more likely than not that Dr B, having reviewed the notes for Ms D, then called for Ms D in the waiting room.

46. Regardless, as identified by my in-house clinical advisor, Dr Maplesden, Dr B failed to establish Ms A's identity adequately before consulting with her. He advised that this is a basic aspect of medical practice if the patient is previously not known to the clinician.

47. I agree with Dr Maplesden's advice. While I note that Dr B stated that she called Ms A "Ms D" on two occasions, I also note the similarities in age and ethnicity, and that neither patient was known to Dr B. In these circumstances, Dr B should have exercised caution and taken further steps to establish Ms A's identity clearly before consulting with her.

Presenting complaint

48. Dr B initiated the consultation by advising Ms A that she needed to be treated for gonorrhoea and chlamydia. Dr B did not ask Ms A to explain her presenting complaint, and did not establish that she was presenting with abdominal pains.

49. Dr Maplesden advised that Dr B failed to ask Ms A why she was attending, to obtain an accurate history of the presenting complaint. He said that this is a basic element of a medical consultation if the patient is not previously known to the clinician.

50. I am critical that Dr B failed to obtain Ms A's patient history of her presentation for abdominal pain. Ms A expressed her frustration that Dr B did not offer her the opportunity

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to explain her presenting complaint. It is unacceptable that Dr B did not ask Ms A to explain her presentation. Had Dr B obtained Ms A's history, this may have raised some doubts about her identity. This is a basic element of a medical consultation, and I am highly critical that this did not occur.

Response to Ms A

51. Ms A told Dr B that she had had no notification of an abnormal swab result and was not aware of a recall for treatment. Despite this, Dr B proceeded with her initial treatment plan of an antibiotic to treat gonorrhoea and chlamydia. Dr B acknowledged that Ms A's comments were a "red flag" that should have prompted her to check again that she was treating the correct patient.

52. Dr Maplesden advised that Dr B failed to question Ms A further when she stated that she had had no notification of an abnormal swab result or a recall for treatment. Dr Maplesden commented:

> "[Dr B] did not take adequate account of [Ms A's] responses or concerns, or give [Ms A] adequate opportunity to question the diagnosis she was being given, taking into account such issues as health literacy, and the power/knowledge imbalance inherent in a clinical consultation."

53. Dr Maplesden advised that several factors contributed to this medication error, and that overall he is moderately critical of Dr B's management of Ms A's care.

54. Dr B did not pay sufficient attention to Ms A's comments about the diagnosis of gonorrhoea and chlamydia, especially when Ms A stated that she had had no notification of an abnormal swab result or recall for treatment. This should have alerted Dr B to question Ms A further, and I am highly critical that this did not occur. I am also concerned that there was a lack of opportunity for Ms A to participate in the consultation and discuss the new diagnosis. Had Dr B paid sufficient attention to Ms A's comments and questioned her further, this error could have been avoided.

55. Dr Maplesden also advised that Dr B's clinical notes for Ms A do not reflect the identity error and subsequent medication error accurately, and this represents a mild departure from the standards of expected care.

56. I am critical that Dr B did not document the circumstances of her error in Ms A's clinical record. In my view, it is concerning that Dr B omitted the relevant circumstances around the administration of the antibiotic.

57. The Medical Council of New Zealand's statement, "Good Prescribing Practice"[10] sets out the requirement for doctors to prescribe medicines adequately. The statement notes that doctors must:

[10] Available from https://www.mcnz.org.nz/assets/standards/eeccbbf5a1/Statement-on-good-prescribing-practice.pdf

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"Make the care of patients your first concern. You should only prescribe medicines or treatment when you have adequately assessed the patient's condition, and/or have adequate knowledge of the patient's condition and are therefore satisfied that the medicines or treatment are in the patient's best interests."

58. Dr B failed to assess Ms A's condition adequately and obtain sufficient information about her presentation, prior to prescribing an antibiotic. In my view, Dr B failed to comply with the Medical Council of New Zealand's statement for "Good Prescribing Practice".

Conclusion

59. In summary, I consider that Dr B failed to provide appropriate care to Ms A for the following reasons:

a) Dr B failed to establish Ms A's identity before consulting with her.
b) Dr B failed to obtain an accurate history of Ms A's presentation.
c) Dr B failed to question Ms A further when she denied a recall or an abnormal swab result.
d) Dr B failed to document the identity error and medication error accurately in Ms A's clinical notes.

60. These failures resulted in the incorrect administration of an antibiotic to Ms A, which was intended for another patient. Taking into account these deficiencies, in my opinion Dr B did not provide services to Ms A with reasonable care and skill, and I find that Dr B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[11]

Communication — other comment

61. Ms A was seen by Dr B immediately after the error and the following day. Ms A asserts that Dr B blamed her for the medication error, offered no apology, and showed no sympathy for the error that occurred. In contrast, Dr B stated that she offered an apology and further explanation about how the error of identity occurred. On the evidence available to me I am unable to make a finding on this issue. However, I remind Dr B of the need for good communication and for taking responsibility for errors in such circumstances. In my view, an empathetic apology to Ms A would have been appropriate.

Recommendations

62. Dr B has provided a written letter of apology to Ms A for the deficiencies identified in this report, and the apology has been forwarded to Ms A.

63. I recommend that Dr B undertake further training on communication, and provide HDC with evidence that the training has been completed, within four months of the date of this report.

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

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Follow-up actions

64. 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 B's name.

65. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Royal College of General Practitioners and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: In-house expert advice to the Commissioner

The following expert advice was obtained from Dr David Maplesden, GP:

"**CLINICAL ADVICE**

…

1. Thank you for providing this file for advice. To the best of my knowledge I have no conflict of interest in providing this advice. I have reviewed the available information: Complaint from [Ms A]; response from [Dr B]; response from [clinical director] at [the medical centre]; statement from [RN C]; clinical notes for [Ms A] from [the medical centre].

2. [Ms A] complains about her management by [Dr B] at [the medical centre] [in] 2019. [Ms A] was pregnant (14 weeks) and had developed abdominal pain. She presented to [the medical centre] and was seen initially by [RN C] who took her history and some recordings. She returned to the waiting room with [her niece] who had accompanied her to the appointment. There was one other person in the waiting room. She understood [Dr B] then called her into the waiting room ([Dr B] apparently has a 'thick accent' according to [Ms A]). … [Ms A] states that [Dr B] *straight away went into details of* [me] *being diagnosed with chlamydia and gonorrhea. Had there been any mention of '[Ms D]' I would've immediately told her that wasn't me but in saying that I did advise her that I had already done a urine and swab test [months prior] when I had gone into the doctors [clinic]) to see if I was pregnant. A doctor from [the medical centre] had already called me to let me know that my results were fine I had nothing abnormal. So when [Dr B] told me that she had positive tests of chlamydia and gonorrhea I asked what sort tests were done and when. She didn't say anything she just kept saying how urgent it was to have an injection otherwise my tubes would close and I wouldn't be able to have children. Not once did she ask me why I had come into the clinic*. [Ms A] states [Dr B] asked her if she was sexually active and she confirmed she was pregnant but only ever had one partner — her fiancé. The misdiagnosis of a sexually transmitted infection caused distress for herself and her partner before the error was disclosed. [Ms A] was fearful that the infections she was told she had might damage her baby and agreed to the intramuscular injection of antibiotics recommended by [Dr B]. The injection was administered by [RN C] and [Ms A] then left [the medical centre]. Shortly afterwards she was contacted by [the medical centre] to say she had received the injection in error and to return for review which she did. On this occasion [Dr B] examined her abdomen and prescribed medication. [Ms A] states her perception that [Dr B] blamed her for the medication error because the patient she had called was named '[Ms D]' and [Ms A] had stood up when this name was called.

3. [Dr B] includes the following comments in her response:

(i) There is an electronic 'board' of patients waiting to be seen at [the medical centre]. At the time of the events in question [Dr B] was the only doctor in attendance and there were two names on the board with the first names [of Ms D] and [Ms A]. [Dr B] opened

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the notes for [Ms D] and established she had been recalled by nursing staff for urgent treatment of culture confirmed gonorrhea and chlamydia. She had not responded to previous recalls. (NB the clinical notes for [Ms D] have not been provided.)

(ii) [Dr B] states there were two women and a male in the waiting room. She called the name [Ms D] and [Ms A] got up and followed her into the consulting room. [Dr B] recalls saying: *[Ms D], you have been recalled to be treated for gonorrhea, which is a sexually transmitted disease. May I ask if you have a sexual partner?* [Ms A] responded that she had a husband and noted she had not received any notification of the diagnoses of gonorrhea and chlamydia. [Dr B] advised that [Ms A's] partner might need to be treated but the priority was to treat [Ms A].

(iii) [Dr B] then accompanied [Ms A] to the nurses station and instructed [RN C] to administer ceftriaxone by IM injection. [RN C] recorded the injection in [Ms A's] notes. [Ms A] then left the premises.

(iv) [Dr B] then went to call the last patient on her list ([Ms A]) and was surprised to find the waiting room empty. On checking with [RN C], [Dr B] established the patient she had just seen was [Ms A]. [Dr B] arranged for [Ms A] to be immediately informed of the error and for her to return for review. [Dr B] apologised to [Ms A] for the error, examined her and prescribed paracetamol and metoclopramide for her symptoms.

(v) That evening and when [Ms A] returned to discuss the incident the next morning, [Dr B] attempted to explain how the error occurred. [Dr B] reassured [Ms A] that ceftriaxone is safe in pregnancy and there was no risk of harm to her baby. The incident was subsequently dealt with through the practice incident/complaints management system.

4. [RN C] includes the following points in her response

(i) [RN C] took a history from [Ms A] as part of the triage process and established she was 14 weeks pregnant and had abdominal cramps and vomiting. The history and vital signs were documented in [Ms A's] notes and [Ms A's] name was placed on the electronic board to be assessed by the GP. [RN C] states: *there were no other patients waiting to be seen, but the consultation queue had two patient's names awaiting the attention of the doctor — patients [Ms A] and [Ms D]. [Ms D] was a recall patient who was not physically present in the clinic.*

(ii) [Dr B] later brought [Ms A] to the nurses' station and gave a verbal order for administration of ceftriaxone IM. *The usual practice in the clinic at that time was that the medications were given as per the doctors' verbal or written instructions.* [RN C] checked the medication and dose again with [Dr B] and asked [Ms A] twice if her name was [Ms A] and *confirmed with her if she had seen the doctor and what the doctor had advised her.* [RN C] also noted [Ms A] had a prescription in her hand for additional antibiotics (although I presume the script has '[Ms D's]' name and surname on it). After administering the medication, [RN C] then consulted [Ms A's] notes to record the drug administration and noted [Dr B] had not recorded any consultation notes. She checked

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[Ms A's] inbox records and could not find any test results positive for sexually transmitted infections. She then spoke with [Dr B] to clarify *why patient [Ms A] needed the antibiotic injection and oral antibiotics prescription, as she was 14 weeks pregnant and came for abdominal cramps and vomiting.*

5. [Dr E] in his response said that it is assumed nursing staff are competent in the process of administering medications and there is no specific policy/process document in this regard. However, since this incident a memo has been sent to all staff informing them that medications for administration in the clinic are now required to be prescribed in the prescribing module of the PMS (F10) rather than freehand in the clinical notes section.

6. Clinical notes review

(i) As discussed, I am unable to view the notes made in relation to [Ms A's] initial consultation with [Dr B] as these were recorded in the notes of another patient and have not been supplied.

(ii) [RN C's] triage notes include: *14 weeks mat pt complaining of abdo cramps. Nauseated …* Vital signs were documented and were unremarkable. [RN C] has also recorded the administration of ceftriaxone 500mg IM prior to any recorded GP notes.

(iii) [Dr B's] notes do not refer to the medication error or any explanation visible from reading the clinical notes as to why [Ms A] was administered IM ceftriaxone. Notes include: *here for abdo pain, 14/40, found a midwife, no contraction, no bleeding. Afebrile, well hydrated and perfused, no meningism, no rashes, throat not cong, both TM clear, vbs nil added, soft non-tender abdo, dual sounds nil added, nausea. Script and back if any concern.* Prescription provided for Maxolon and Paracare.

7. Comments

(i) There were several factors contributing to this significant medication error (as is often the case):

- [Ms A] having a first name very similar in sound to that of the other patient on the waiting list
- the other patient apparently (according to the response) being of the same ethnicity and age group as [Ms A]
- [Dr B's] failure to adequately establish [Ms A's] identity before consulting with her. This is a basic aspect of medical practice if the patient is not previously known to the clinician
- [Dr B's] failure to ask [Ms A] why she was attending for review ie obtain an accurate history of the presenting complaint — this also is a basic element of the medical consultation. Both [Dr B's] account and that of [Ms A] indicate [Dr B] initiated the consultation with the assumption [Ms A] was attending for treatment of STI without confirming this assumption and without giving [Ms A] the opportunity to convey her

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presenting symptoms. The Medical Council of New Zealand state, in the publication *Good Prescribing Practice* (2016)[12]: *Make the care of patients your first concern. You should only prescribe medicines or treatment when you have adequately: assessed the patient's condition, and/or have adequate knowledge of the patient's condition and are therefore satisfied that the medicines or treatment are in the patient's best interests*

- [Dr B's] failure to question [Ms A] further when [Ms A] stated she had had no notification of abnormal swab results, or recall for treatment, when the clinical notes apparently indicated there had been contact for recall on several occasions (which presumably must have been successful if the patient was attending for treatment). The impression I get from the responses on file is that [Dr B] did not take adequate account of [Ms A's] responses or concerns, or give [Ms A] adequate opportunity to question the diagnosis she was being given (taking into account issues such as health literacy and the power/knowledge imbalance inherent in a clinical consultation)
- The practice evidently in place at [the medical centre] at the time of allowing medication administration to occur prior to written confirmation of the medication and dose (whether that was in the narrative portion of the notes or the prescribing module) and excluding standing orders
- The fact [RN C] had already established [Ms A's] identity (from the triage process) and therefore questioned her regarding this identity rather than '[Ms D]'
- The failure by [RN C] to consult [Ms A's] clinical notes prior to administering the ceftriaxone (which would have been undertaken if the practice policy was to require a written record or prescription for the medication before it could be administered)
- The failure by [RN C] to question [Dr B] regarding the indications for antibiotic administration (based on the triage she had undertaken) rather than taking this step after administration of the antibiotic

(ii) I feel [Dr B's] management of [Ms A] departed from accepted practice to a moderate degree taking into account the factors discussed. While there was no apparent harm caused on this occasion, there was certainly a potential for harm in administering parenteral antibiotics to a patient whose identity has not been adequately confirmed, meaning details on the clinical notes open at the time (including historical notes, medication alerts and allergies) other than any contemporaneous history established, were not actually relevant for that patient. While there were some mitigating factors (similar sounding name to which [Ms A] responded, apparently similar age and ethnicity of the two patients confused), had [Dr B] followed accepted practice in obtaining a clinical history from the patient before assuming the reason for the presentation, or taken account of the verbal cues provided by [Ms A] (according to her response and that of [Dr B]) that might have raised some doubt regarding the assumptions already made, the identity error and subsequent treatment error might have been avoided. I am mildly critical that [Dr B's] clinical notes for [Ms A] did not accurately reflect the

[12] https://www.mcnz.org.nz/assets/standards/eeccbbf5a1/Statement-on-good-prescribing-practice.pdf Accessed 16 September 2019

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circumstances of her receiving the injection of ceftriaxone. I recommend [Dr B] consider attending a relevant MPS Risk Management workshop, and it would be a reasonable expectation that [Ms A] is provided with an unconditional written apology from [Dr B] given the dissatisfaction [Ms A] has expressed with the verbal apologies provided.

(iii) I recommend expert advice is sought from a practice nurse regarding [RN C's] role in the medication error.

(iii) The NZNO publication 'Guidelines for Nurses on the Administration of Medicines (2018)'[13] states: *Acceptance of verbal orders for the administration of medicines is not specifically provided for under legislation. Many individual health care institutions have their own policies to cover this. However, the MOH has provided some guidance for ARC [Aged Residential Care] settings. This indicates, if the RN records the name of the authorised prescriber, recipient, date, and medicine order (where possible the prescriber faxes/ scan and emails a copy of the order to the pharmacy and facility), and the order is signed by the prescriber within 48 hours, then this is acceptable (Ministry of Health, 2011). This documentation process can also be applied in general hospital wards and Primary health care settings. The documentation requirements for verbal orders (e.g. time frame within which the prescriber is required to subsequently sign the medicine chart) should be described in an organisational policy.* The RNZCGP Foundation Standard & Interpretation Guide (2016)[14] does not specifically refer to any requirement for a practice to have a policy on 'in-house' administration of medications although practices are expected to comply with Ministry of Health regulations regarding medications administered under standing orders (which was not the case in this incident). The previously cited MCNZ document on good prescribing practice does not specifically address the issue of verbal orders for medication administration. In my own practice, a prescription to be administered by nursing staff outside of standing orders is required to be documented in the notes before administration can occur. I think this is safe practice and while I am unable to state that the process in place at [the medical centre] in relation to nurse administration of medications prior to this incident was a departure from accepted practice, the changes made since the incident should reduce the risk of a similar medication administration error in the future."

[13] https://www.nzno.org.nz/get_involved/consultation/artmid/4775/articleid/1554/guidelines-for-nurses-on--the-administration-of-medicines-2018 Accessed 16 September 2019
[14] https://oldgp16.rnzcgp.org.nz/assets/Foundation-Standards-Interpretation-Guide-APR-2016.pdf Accessed 16 September 2019

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