

## **Identification of penicillin allergy prior to prescribing medication (12HDC01062, 30 May 2014)**

*Doctor in urgent care ~ Accident and medical clinic ~ Emergency care ~ Penicillin allergy ~ Right 4(1)*

A 60-year-old man attended an accident and medical clinic for two infusions of antibiotics, having been referred following his discharge from hospital with cellulitis in his leg.

The man had an allergy to penicillins, which had previously been entered into his records at the clinic. This meant that a medication alert would “pop up” in the patient management software (PMS) each time a doctor prescribed medication for him.

A doctor assessed him, and an intravenous (IV) dose of cefazolin was administered by a nurse on the doctor’s instruction. The man experienced no adverse reaction and was asked to return to the clinic the following day for review.

The following day the man returned to the clinic and was again seen by the doctor who considered that the man’s leg appeared to be deteriorating. The doctor administered 1g of oral flucloxacillin, a penicillin, to the man without prescribing it using the PMS, and so was not alerted to his allergy by the PMS. A further dose of IV cefazolin and probenecid was administered by a nurse on the doctor’s instruction.

The doctor typed up her handwritten consultation notes, but did not prescribe any of the medication using the PMS. She then left the clinic. A nurse subsequently asked another doctor to prescribe the cefazolin and probenecid, which he did, but he did not prescribe the flucloxacillin because he was not aware that the first doctor had administered it.

Early the following morning the man experienced symptoms of an allergic response, so at around 2.15am he returned to the clinic. The second doctor assessed the man as suffering from an allergic reaction, likely due to the oral flucloxacillin dose he had been given the previous evening. He decided to refer the man to hospital for observation, where he was kept overnight to ensure the resolution of the allergic reaction.

It was held that the first doctor missed several opportunities to become aware of the man’s allergy, for example reading the notes or asking him questions. Furthermore, she should have complied with the clinic’s medication protocol and prescribed the flucloxacillin using the PMS system.

It was the first doctor’s responsibility to ask the man whether he had any allergies, check the PMS system, and/or appropriately prescribe the medication she provided to him. By failing to do so, she did not provide services with reasonable care and skill and breached Right 4(1) of the Code.

Comment was made regarding the second doctor that, although it was not unreasonable for him to rely on information provided by the nurse, best practice would have been to review the man’s consultation notes.