Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Northland DHB and staff members breach Code when woman with penicillin allergy dies following medication error

20HDC01979

Northland District Health Board (DHB) (now Te Whatu Ora Te Tai Tokerau), a senior medical officer, house officer and registered nurse breached the Code of Health & Disability Services Consumer's Rights (the Code) in the prescribing and administering of antibiotics to a consumer with a severe penicillin allergy.

The woman, in her eighties at the time, was admitted to Whangārei Hospital following earlier elective surgery. Her severe penicillin allergy was clearly documented. Following the woman's transfer to a different ward, the senior medical officer directed the house officer to change her antibiotic to Augmentin (a penicillin-based antibiotic). The doctors did not inform the woman of the antibiotic change, and there was inadequate checking of whether she had any adverse reactions or allergies before prescribing or administering the antibiotic. The consumer suffered a severe anaphylactic reaction and died.

Health and Disability Commissioner Morag McDowell found the three health professionals involved in prescribing and administering the medication in breach of Right 4(1) of the Code, which gives consumers the right to have services provided with reasonable care and skill.

Ms McDowell also found Te Whatu Ora Te Tai Tokerau breached Right 4(1) of the Code for a lack of policies and failing to adhere to existing procedures. She was also critical of a lack of flexibility to enable adequate staffing during a busy weekend with a number of high acuity patients, and of the handover process which did not consistently support the sharing of important information such as medication allergies.

Ms McDowell reflected on the devastating impact of the error on the woman's family. She also noted that this was human error by clinical staff who were also clearly affected by outcome.

Te Whatu Ora Te Tai Tokerau accepted that systemic factors contributed to the error and agreed electronic prescribing is key to preventing medication errors and that it had been requesting for this to be prioritised for many years. Ms McDowell recommended that Te Whatu Ora National office liaise with Te Whatu Ora Te Tai Tokerau (Northland District) in respect of how it can support Te Tai Tokerau to implement electronic prescribing.

Ms McDowell also recommended Te Whatu Ora Te Tai Tokerau :

- consider how it can improve recognition of documented drug allergies and implement improvements that mitigate the risk of inadvertent administration of a drug to which the patient is allergic,
- improve the process and documentation of handing over information important for safe care between staff and teams,
- amend policy to make it clear that prescribers must inform consumers of changes to their medication and ask about allergies,
- consider amending policy to ensure the National Medication Chart is completed in full,
- provide evidence that staff use electronic clinical information at the bedside.

11 September 2023

ENDS

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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