Inappropriate prescription of narcotic medication (12HDC01608, 10 November 2014)

Public hospital ~ District health board ~ House officer ~ Registrar ~ Consultant ~ Renal impairment ~ Documentation ~ Rights 4(1), 4(4)

An elderly man with complex co-morbidities including chronic renal impairment was admitted to hospital for the management of an acutely ischaemic leg. The man underwent an angioplasty and the man's pain was noted to have improved postoperatively. The man was reviewed by the surgical registrar and the decision was made to discharge the man home on either the Sunday or Monday.

The registrar reviewed the man on the Sunday morning and changed his medication from fentanyl to Sevredol. The ward round book records "discharge + script". The registrar did not document a discharge management plan, any details of the decision to prescribe Sevredol, or the plan with regard to monitoring and reporting the man's Sevredol requirements.

Later that day, the on-call surgical house officer was contacted by a nurse who requested that the house officer write a prescription for antibiotics for the man so that he could be discharged. The house officer prescribed an appropriate antibiotic taking into account the man's renal impairment. As the house officer was leaving the ward the nurse requested a prescription for analgesia for the man. The house officer noted that the man had been prescribed Sevredol earlier that day by the registrar, so wrote a prescription for the same dose that had already been prescribed. The house officer did not complete the discharge documentation.

The man was then discharged and returned home. He took his medications as prescribed, including a total of five 10mg Sevredol tablets. The following morning the man was found unconscious by his daughter. He was later admitted to hospital and treated for opioid toxicity. Sadly, the man died a short time later.

Adverse comment was made that the registrar failed to critically assess the appropriateness of prescribing Sevredol to the man, given that his pain was already well managed and he had renal impairment. It was held that having made the decision to prescribe such medication the registrar should then have proceeded with caution. The registrar's failure to document a discharge plan and the decision to prescribe Sevredol, and its monitoring requirements, demonstrated a lack of caution that placed the man at unnecessary risk of harm. Accordingly, the registrar was found to have breached Right 4(4).

The house officer was not found to have breached the Code. However, criticisms were made of aspects of the care the house officer provided, in particular the failure to critically question the prescription of Sevredol in a man who had renal impairment, and the failure to complete any discharge documentation. The consultant was found not to have breached the Code in light of the fact that the consultant was not informed that the man had been prescribed Sevredol, and there was no expectation that the consultant should be involved in the man's discharge.

The DHB was found to have breached Right 4(1) for failing to ensure that its staff provided services with reasonable care and skill. Adverse comment was made about a retrospective change being made to the man's medication chart.