To Err is Human

When investigating complaints, HDC assesses after the fact whether there has been a failure to provide services of an appropriate standard. However, it is evident that in many cases the providers concerned operated in a routine manner and did not foresee that the circumstances were out of the ordinary. As stated by Sidney Dekker, (Ten Questions about Human Error: A new view of human factors and system safety), accidents and the drift that proceeds them are associated with normal people during normal work in normal organisations. The resultant complacency may then result in a lack of critical thinking. HDC has considered a number of matters recently in which this thesis is clearly demonstrated.

In 13/00903 (4 February 2016) a woman with a history of high grade cervical abnormality, with two cervixes and a bicornuate uterus enrolled at a medical clinic. Initially when performing smears the GP sent two samples to the laboratory but only one form and only ever received one result. Four years later, after the woman had inter-menstrual bleeding the GP performed a smear test on each cervix and noted the larger left cervix bled when touched and appeared lumpy. The GP sent two specimen referral forms and two specimens to the laboratory for testing and received a smear test result which documented that the result was normal, but did not identify which cervix the result related to or if the result was one of two.

Because of the woman's symptoms the GP sent a referral to a gynaecology clinic for a colposcopy with the normal result attached and the woman was rated as semi-urgent.

The medical clinic then received a second smear test result. The report did not indicate which specimen site it related to or that it was the second of two results. The result was abnormal but was mistakenly filed as a duplicate and no action was taken regarding the abnormal smear result. Subsequently, the woman was diagnosed with cervical cancer and underwent a hysterectomy.

It was held that the GP breached Right 4(1) of the Code because she failed to discuss with the woman an option of specialist involvement and failed to ascertain whether there should have been two results after sending two specimens with two forms.

It appears that the GP did not anticipate receiving two results as previously only one result had been received and did not factor in that two specimens and two forms had been sent.

In 14/00471 (7 January 2016), a registered nurse failed to think critically when caring for an elderly rest home resident. The nurse found the man lying on the grass outside the rest home at around 7am on a winter morning. He was wearing pajamas, his feet were bare and he was cold to touch and shivering. He told the registered nurse that he had been there for about half an hour.

The registered nurse instructed that the man was to be returned to his room, kept warm and put back to bed. Two night shift caregivers cared for him. No registered nurse assessment was carried out.

After handover he was left in the care of an enrolled nurse (EN) who, at 7.30am, recorded his temperature as 34.4^{o}C. The EN told the nurse, but the nurse still did not assess the man. At around 8am the man was found dead. The post-mortem report concluded that he had died of hyperthermia complicating pre-existing ischemic heart disease and chronic obstructive

respiratory disease. The Deputy Commissioner found that by failing to recognise the man required a comprehensive nursing assessment, leaving two caregivers in charge of his care and then delegating his assessment to EN who continued to monitor him, even after the vital signs suggested he had hypothermia, the RN breached Right 4(1) of the Code.

Prescription of paracetamol to patients following surgery is relatively commonplace. However, in 13/00306 (23 June 2015) the patient concerned was 77 years old, frail and underweight. She underwent bowel surgery without complications and following surgery she was charted paracetamol 1g PRN for pain relief with a maximum of 4g per day. She was being considered for discharge when blood tests indicated that her liver function tests (LFTs) were abnormal. That night a house officer crossed paracetamol off the PRN medication chart and charted regular paracetamol at 1g x 4 times a day. Over the next few days nursing staff withheld the woman's prescribed regular paracetamol owing to her deranged LFTs.

The woman was reviewed by a consultant gastroenterologist who was unable to specify a specific cause for her deranged LFTs and noted "no specific recent drugs to explain LFTs but drug induced hepatitis most likely". The woman's medications were re-charted by a house officer who again charted paracetamol 1g x 4 times daily as a regular medication. The house officer was unaware of any request to stop paracetamol. Over the next few days the woman was administered paracetamol as a regular medication. She began to deteriorate and was transferred to the high dependency unit where the plan included searching for the cause of her acute liver deterioration. The woman received no further paracetamol, and died a short time later.

It was found that the prescribed paracetamol dose was too high. Staff did not think critically and adjust the woman's paracetamol prescriptions in light of her circumstances. As the DHB did not provide services to the woman with reasonable care and skill it breached Right 4(1) of the Code.

It was noted that there was inadequate communication between the nursing and medical teams regarding the withholding of paracetamol and inadequate recording of communications, and accordingly the DHB breached Right 4(5) of the Code.

In each of these cases providers followed processes that, at first sight, may have appeared routine and ordinary. However, the individual circumstances that moved the situation away from the ordinary were not sufficiently considered. In addition, poor communication and unclear lines of authority between providers contributed to the failings.

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