Doctor in Urgent Care, Dr B

Accident and Medical Clinic

A Report by the

Health and Disability Commissioner

(Case 12HDC01062)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. On 4 August 2012, Mr A (aged 60 years) attended an accident and medical clinic (the clinic), having been recently discharged from hospital with cellulitis.

2. Mr A is allergic to penicillin. An allergy to penicillins 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)[1] each time a doctor prescribed[2] medication for him.

3. Mr A was seen by Dr B. An intravenous (IV) dose of cefazolin[3] was administered by a nurse on Dr B's instruction. Mr A experienced no adverse reaction and was asked to return to the clinic the following day for review.

4. On 5 August 2012, Mr A returned to the clinic and was again seen by Dr B. Dr B considered that Mr A's leg appeared to be deteriorating, with the infected area looking more inflamed.

5. Dr B decided to provide another antibiotic to Mr A orally. Dr B administered 1g of flucloxacillin[4] to Mr A without prescribing it using the PMS, and so overlooked that he was allergic to penicillin. A further dose of IV cefazolin and probenecid was administered by a nurse on Dr B's instruction. Again, Mr A experienced no adverse reaction to the IV medication.

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

7. In the early morning of 6 August 2012, Mr A experienced an adverse reaction. He returned to the clinic at around 2.15am with symptoms of an allergic response. Dr C assessed Mr A as suffering from an allergic reaction likely due to the oral flucloxacillin dose he had been given the previous evening.

8. Dr C decided that Mr A would benefit from a period of observation in hospital to ensure the resolution of the allergic reaction, particularly in light of his other medical conditions. Mr A was kept in hospital overnight for observation and discharged the following day.

[1] Medical practice management software (PMS) is healthcare software that deals with the day-to-day operations of a medical practice.
[2] For the purposes of this opinion, prescribing refers to a formal prescription undertaken by using the prescribing module of the PMS.
[3] Cefazolin is an antibiotic mainly used to treat bacterial infections of the skin. It is clinically effective against infections caused by Staphylococci and Streptococci of gram-positive bacteria, which are common on normal human skin.
[4] Flucloxacillin is a narrow-spectrum antibiotic of the penicillin class.

Findings

9. Dr B missed several opportunities to become aware of Mr A's allergy, for example, by not reading the notes or asking her patient questions. Furthermore, she should have complied with the clinic's medication protocol and prescribed the flucloxacillin using the PMS system.

10. It was Dr B's responsibility to ask Mr A 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 of Health and Disability Services Consumers' Rights (the Code).[5]

11. Comment was made that although it was not unreasonable for Dr C to rely on information provided by the nurse, best practice would have been to review Mr A's consultation notes.

Complaint and investigation

12. The Commissioner received a complaint from Mr A about the services provided by Dr B and an accident and medical clinic (the clinic). The following issues were identified for investigation:

- *Whether Dr B provided an appropriate standard of care to Mr A between 4 August 2012 and 6 August 2012.*
- *Whether the clinic provided an appropriate standard of care to Mr A between 4 August 2012 and 6 August 2012.*

13. An investigation was commenced on 3 April 2013.

14. The parties directly involved in the investigation were:

Mr A	Consumer
Dr B	Provider
The clinic	Provider
Dr C	Provider

15. Expert clinical advice was obtained from general practitioner, Dr David Maplesden, and is attached as **Appendix A**.

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

Information gathered during investigation

Mr A

16. On 4 August 2012 Mr A, aged 60 years, was referred by a public hospital to the clinic in order for two infusions of antibiotics to be administered 24 hours apart to treat cellulitis in his leg.

17. In 2010 Mr A had informed the clinic staff of his allergies to vancomycin[6] and penicillins.

Dr B

18. Dr B[7] has been employed by the clinic for 13 years. Dr B advised that at the time of this incident she was working extra hours because the clinic was short staffed. She was working at other branches of the clinic in the region, as well as the clinic at which she usually works.

Consultations at the clinic

Consultation on 4 August 2012

19. On 4 August 2012 at 10.06pm, Mr A presented at the clinic. He was initially seen by a registered nurse, who discussed the administration of cefazolin with Mr A and noted "iv+ process discussed with pt. aware of cross over reaction posiblitiy [sic]: adverse reactions explained: call bell in reach any concerns: aware must remain in clinic 20mins post for safety".

20. The registered nurse also recorded "allergy to penicillins". The allergy was entered into the notes as a medication alert that would "pop up" in the PMS each time a doctor prescribed a medication.

21. Mr A was then seen by Dr B, who noted that he had been previously treated with cefazolin without adverse reaction. Dr B prescribed an intravenous dose of cefazolin to be administered in the clinic. Mr A had no adverse reaction to this medication and was asked to return the following day for review.

Consultation on 5 August 2012

22. On 5 August 2012 Mr A returned to the clinic and was again seen by Dr B. Dr B advised that this consultation occurred just as she was leaving the clinic. She said that it had been a particularly busy shift, with long waiting periods of up to two hours and many disgruntled patients. She said that she recognised Mr A from the previous night and remembered his medical problem.

23. Dr B said: "Given I remembered him I thought I would make it easier for my medical colleagues by reviewing him before finishing my shift. I compared the extent of his infection with how it had been some 24 hours prior."

[6] Vancomycin is an antibiotic used to treat bacterial infections.
[7] Dr B is a general registrant of the Medical Council of New Zealand, and is not vocationally registered as a general practitioner.

24. At 10.17pm Dr B recorded that Mr A was experiencing more pain than the previous day, and that the redness of his leg remained but had not extended beyond the markings of the previous day. He reported that he had been walking a lot that morning but had elevated his leg in the afternoon.

25. Dr B decided that Mr A required a further dose of IV cefazolin, which would be administered by a registered nurse. Dr B stated that, on reviewing Mr A's leg, she considered that it might be deteriorating, with the infected area looking more inflamed, although the infection did not appear to be spreading. Dr B stated that she decided to "add in" another antibiotic, flucloxacillin, and for that treatment to be assessed before prescribing a full course of the antibiotic. In response to the provisional opinion Dr B stated that this is recommended "as the first line for cellulitis".

26. Dr B stated that, as it was a particularly busy night and the nursing staff were occupied, she thought that she would save time and get the medication herself. She said that she told Mr A what the medication was, and then provided him with 1g of flucloxacillin to be taken orally, "forgetting that he was allergic to penicillin".

27. In response to the provisional opinion, Dr B said she had two discussions with Mr A and his wife and she recalls mentioning the medication, the class of medication and its use. She stated she knew Mr A's wife was a practising nurse.

28. Mr A recalls that Dr B mentioned the name of the medication, but stated: "[S]he certainly did not say, or indicate in any manner, that the medication was penicillin based, I would have refused to take it".

29. Mr A said that the reference to the medication was made while his wife was in the room, but he cannot say what attention, if any, his wife[8] was paying to the conversation which was between Dr B and him, but if the conversation had raised alarm bells for his wife she would have intervened.

30. Dr B advised that she "verbally gave the nurse orders for the intravenous medication, [she] then typed up the consultation notes [that she had handwritten earlier] and left the clinic". Mr A again experienced no adverse reaction to the cefazolin.

Prescribing medication

31. The clinic's protocol "Clinical Practice Policy: Administration of Medications & Intravenous Infusions" states: "Medications that have been administered must be entered and 'signed' for immediately after administration, by the person administering the medication." The protocol requires: "*Documentation* that is timely, of what has been given and patient reaction including any adverse reactions in Profile prescription/medication section." As Mr A's allergy to penicillins had been entered in the PMS in the "adverse reactions" module, an alert would have appeared on the PMS when a provider used the prescribing module.

[8] Mrs A has since passed away.

32. Dr B did not use the PMS when administering the medications to Mr A on the evening of 5 August 2012 (IV cefazolin, oral probenecid and oral flucloxacillin), but charted[9] the medications in the handwritten consultation notes that she typed up prior to leaving the clinic that evening.

33. The notes state that Dr B's plan was:

> "[F]urther cefazolin + review in 24hrs — or sooner if gets worse
>
> fluclox 1g in clinic po — given 2230hrs
>
> strongly advised to rest and elevate foot."

34. Dr B's omission to prescribe the medications was noted by a member of the nursing staff after Dr B had completed her shift. The nurse asked the doctor on duty, Dr C, to prescribe the probenecid and cefazolin that had been administered intravenously to Mr A. Dr C completed the prescribing of the medication at 11.02pm. However, the prescribing of the flucloxacillin was overlooked because the nurse was not aware that Dr B had given it to Mr A, and so did not bring this medication to Dr C's attention.

Allergic response

35. On 6 August 2012 Mr A awoke with severe itchiness on his hands, chest and torso, and a developing red rash. He returned to the clinic at around 2.15am with symptoms of a cutaneous[10] allergic response.

36. Dr C assessed Mr A as suffering from an allergic reaction likely due to the oral flucloxacillin dose he had been given the previous evening. He was given ranitidine hydrochloride, promethazine hydrochloride and prednisone in the clinic. Mr A stated that Dr C "looked at [him], looked at the notes, and said [he] had some kind of allergic reaction". Mr A stated that Dr C did not tell him what the reaction was to. Dr C stated: "Although not documented, I told the patient that the allergy is most likely due to the Flucloxacillin."

37. Dr C decided that Mr A would benefit from a period of observation in hospital to ensure the resolution of the allergic reaction, particularly in light of his other medical conditions. He was offered transport to the hospital by ambulance, but decided to go home first before presenting to the hospital.

38. Mr A stated that he was kept in the hospital overnight for observation, and discharged the next day at around 11.45am. He told HDC that he was concerned about being given a drug to which he is allergic, particularly as he had alerted the clinic to the allergy, and because he had not been told by Dr C that the allergic response was due to the flucloxacillin.

39. In response to the provisional opinion Mr A commented that he has been told that his allergic response to the flucloxacillin was reduced because he takes antihistamines

[9] Charting means recording freehand instructions in the patient clinical file (usually to nursing staff) requesting administration of medication to the patient.
[10] Relating to or affecting the skin.

each day. He said that he has been advised that if that were not the case there would have been a real possibility of anaphylaxis.

The clinic

40. The clinic advised HDC that Mr A's allergies had been recorded correctly in his records in 2010.

41. With regard to the induction and orientation of Dr B, the clinic advised that, as part of the training for the Profile[11] software and the orientation meeting, all doctors are shown how to use the prescribing module in the PMS and are expected to use it when prescribing medication either for in-clinic use or for use at home. This ensures that the medication is prescribed using the current MIMS (Medical Information Management System) data, and alerts the doctor to any medication alerts that may have been recorded at triage or during the consultation. The clinic has advised that, although it does not have a formal record of it, Dr B had formal training and was aware of how to use the prescribing module correctly. Nurses and doctors are instructed how to create an alert in the PMS for an adverse reaction. This recording is done at triage and checked again by the doctor prior to prescribing or administering any medication.

42. The clinic stated that staff are expected to record allergies. As part of the clinic's administration of medications and IV infusions policy, checking allergies is required before administering medications.

43. As a result of this case, the clinic formalised its Medication Policy to include:

- Prescribing of medications — in clinic and for discharge.
- Recording of allergies.
- Dispensing medications.

44. On 24 June 2013, the clinic advised HDC that, as a result of the medication error, it had undertaken a performance review of Dr B and believed that the error was a result of fatigue due to night shifts rather than a process issue. Dr B has also been provided with further training. The clinic stated that, as a result of the review, Dr B's night shifts have been reduced by one shift a fortnight. In response to the provisional opinion the clinic stated it will be reviewing the workload of nightshift doctors and will develop a policy that demonstrates a consistent approach for all staff to acknowledge errors.

Actions by Dr B

45. Dr B has acknowledged her error. She stated that she takes full responsibility for the mistake, which may have been contributed to by the work demands on her at that time. Dr B has advised HDC that since this incident she rechecks verbally for adverse reactions to medication during the history-taking part of a consultation and immediately before prescribing medication.

[11] Practice management and electronic medical record for general and specialist practice.

46. Dr B stated that she now advises the patient what class of medication the medicine belongs to and gives generic and commonly known trade names for the same medication in case the patient is unfamiliar with the medication or knows it by another name.

47. Dr B said that she now prints out the consultation notes for the patient or caregiver/guardian with the adverse drug name highlighted in bold, so that patients have a copy for themself. She advises patients to keep the information in their wallet or with their driver's licence, and to inform their GP on the next occasion they visit. She also now discusses and recommends that patients with allergies obtain a medical alert bracelet/neck chain.

48. Dr B stated:

> "I am deeply passionate about medicine and remain mortified and very sorry that I allowed such an error to happen. The error has been salient in making me look carefully at my work, my medical practice and work/life balance. I have made a number of changes to minimise any risk of repetition in the future."

Relevant standards

49. The Medical Council of New Zealand publication *Good Prescribing Practice* (April 2010) provides that doctors should:

- "Take an adequate drug history of the patient, including: any previous adverse reactions to medicines; current medical conditions; and concurrent or recent use of medicines (including non-prescription, complementary and alternative medicines).
- Keep a clear and accurate patient record containing all relevant clinical findings; decisions made; information given to the patient and the medicines and any other treatments prescribed.
- Remain vigilant regarding possible adverse effects of medicines and inform the Centre for Adverse Reactions Monitoring (CARM) of any severe, uncommon or unanticipated adverse reactions to medicines reported by [their] patients."

Opinion: Breach — Dr B

50. Under Right 4(1) of the Code, Mr A had the right to have services provided by Dr B with reasonable care and skill. Dr B was aware that she was expected to prescribe medications using the prescribing module in the PMS. This ensures the medication is

prescribed using current MIMS data and alerts the doctor to any medication alerts that may have been recorded at triage or during the consultation.

51. In this case the facts are clear. Mr A's allergy to penicillin was appropriately entered into the PMS in the "adverse reactions" module. Accordingly, an alert would appear on the PMS when a provider prescribed penicillin using the PMS.

52. On 5 August 2012 Dr B assessed Mr A's response to his IV antibiotic treatment and decided that an additional antibiotic, flucloxacillin, given orally, was desirable. Given the nurses were occupied, she obtained the medication herself and administered it to Mr A. However, Dr B did not follow the clinic protocol[12], as she did not prescribe the flucloxacillin. Accordingly, the automatic medication alert on the PMS was not activated.

53. Dr B did not recall that Mr A had a penicillin allergy despite having seen him the previous day. I accept that Dr B would not be expected to have remembered specific information about Mr A from the previous day.

54. However, Dr B did not review the records. In addition, while Dr B submitted in response to the provisional opinion that she mentioned the medication and its use to Mr A and his wife, I confirm my finding that Dr B did not check with Mr A whether he had any allergies prior to the administration of flucloxacillin. As a result, Mr A was administered a penicillin based antibiotic and suffered an allergic reaction some hours later. As noted by my expert clinical advisor, Dr David Maplesden, "there was potential for a life threatening situation had Mr A suffered an anaphylactic response to the flucloxacillin".

55. In addition, on the evening of 5 August 2012, Dr B did not use the PMS to prescribe the medications she administered to Mr A. Had she done so, the alert would have "popped up" and she could have taken appropriate action to contact and assist Mr A.

56. The failure to prescribe the probenecid and cefazolin was noted by the nursing staff after Dr B had completed her shift, and so Dr C prescribed these two medications. However, he did not prescribe the flucloxacillin as the nurse was not aware that the flucloxacillin had been given to Mr A, and so had not passed on that information to Dr C.

57. Dr B has acknowledged the error and suggested that a factor that may have contributed to her making the mistake was the work demands placed on her at that time. However, she agrees that she has full responsibility for the error.

58. I have previously noted the importance of reviewing the risk factors and discussing medication with patients.[13] Furthermore, the Medical Council of New Zealand's standards require a doctor to take an adequate drug history of the patient, including any previous adverse reactions to medicines, current medical conditions, and concurrent or recent use of medicines.

[12] "Clinical Practice Policy: Administration of Medications & Intravenous Infusions".
[13] 10HDC00753 (15 June 2012) at page 12. Available at www.hdc.org.nz.

59. Dr B missed several opportunities to ascertain Mr A's allergy status, including reading the notes and asking her patient about allergies. In addition, if she had complied with the clinic's expectations with respect to prescribing using the prescribing module in the PMS, and with the clinic's administration of medicines protocol, she would have become aware of the allergy. In my view, it was Dr B's responsibility to ask Mr A about 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.

Opinion: No Breach — The clinic

Clinical care — no breach

60. Under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), employers are responsible for ensuring that their employees comply with the Code. Pursuant to section 72(5) of the Act, it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the acts or omissions leading to an employee's breach of the Code. Aside from this vicarious liability, the clinic may also be held directly liable for the inadequate care provided to Mr A.

61. The clinic had systems and policies in place for the management and documentation of allergies, and trained staff on its expectations with respect to prescribing medications using the prescribing module in the PMS. Had Dr B prescribed the medication in accordance with the clinic's policies and expected processes, the PMS alert would have "popped up".

62. I have been advised by Dr Maplesden that there do not appear to be any particular deficiencies in the clinic's policies and expected processes, including the staff orientation process. I accept that the clinic provides training to staff on using the prescribing module in the PMS.

63. In this case, I accept that the error was an individual clinical error by Dr B. However, I note that Dr B has stated that she was working extra hours at the time of the incident, and saw Mr A at the end of her shift to try to improve continuity of care, as she had reviewed him on the previous day. I note that the clinic has subsequently adjusted Dr B's night shift workload in an attempt to minimise the risk of her being fatigued.

64. In my opinion, the clinic's systems were adequate and it took reasonable steps to ensure that its policies and the Code were complied with by its staff. Accordingly, I find that the clinic is not directly liable for the inadequate care provided to Mr A, or vicariously liable for Dr B's breaches of the Code.

Open disclosure — other comment

65. Under Right 6 of the Code, Mr A had the right to information that a reasonable consumer, in his circumstances, would expect to receive. This includes information about any adverse events in the care provided to a consumer (often referred to as "open disclosure").

66. Mr A expressed his concern that the clinic did not openly acknowledge or make the error known to him. Mr A said that Dr C advised him that the reaction was most likely related to the medications prescribed earlier that evening, but did not specifically advise him that he had been given medication to which he had a known allergy. In contrast, Dr C stated: "Although not documented, I told the patient that the allergy is most likely due to the Flucloxacillin." I am not able to make a finding as to which account of events is correct.

67. The clinic had no policy on open disclosure. I suggest that the clinic develop an appropriate policy in this regard, to ensure that a consistent approach is taken to acknowledging errors.

Other comment — Dr C

68. On the evening of 5 August 2012, after the nursing staff noted that Dr B had not prescribed any of the medications administered to Mr A, Dr C prescribed the probenecid and cefazolin but overlooked the flucloxacillin because he was not aware that Dr B had administered it. Dr Maplesden is mildly critical that Dr C did not review Mr A's notes before prescribing his medication or, if Dr C did review the notes, he failed to detect that oral flucloxacillin had also been administered. However, Dr Maplesden advises that the context must be considered, which was "that nursing staff requested only that Dr C prescribed the usual cellulitis protocol medications in retrospect rather than to actually review Mr A's management". I accept that it was not unreasonable for Dr C to rely on the information provided by the nurse; however, best practice would have been to review Mr A's consultation notes.

69. Mr A was concerned that in the early hours of 6 August 2012 Dr C advised him that the reaction was most likely related to the medications prescribed earlier in the evening, but did not specifically advise him that he had been given medication to which he had a known allergy. In contrast, Dr C stated: "Although not documented, I told the patient that the allergy is most likely due to the Flucloxacillin." As stated above, I am not able to make a finding as to which account of events is correct.

Recommendations

70. I recommend that Dr B take the following actions:

- Provide a written apology to Mr A for her breach of the Code. This should be sent to HDC within three weeks of the date of the final opinion, for forwarding to Mr A.
- Undergo further training on good prescribing practice, and report to my Office within three months of the date of the final opinion on the outcome of the training.

71. I recommend that the clinic take the following actions:

- Develop an appropriate policy to ensure that a consistent approach is taken by all staff with regard to acknowledging errors.
- Review the workload of all clinicians it employs.
- Report to HDC the outcome of these recommendations, within three months of the release of the final opinion.

Follow-up actions

72.
- A copy of this report with details identifying the parties removed, other than the expert who advised on this matter, will be provided to the Medical Council of New Zealand and the District Health Board, and they will both be advised of Dr B's name.
- A copy of this report with details identifying the parties removed, other than that of the expert who advised on this matter, will be provided to the Health Quality and Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Clinical expert advice to the Commissioner

The following expert advice was obtained from Dr David Maplesden.

Clinical advice dated 4 December 2012

"1. The history of the complaint has been well summarised in [the clinic's] response which is consistent with the contemporaneous clinical notes. It is apparent [Mr A's] allergy to penicillins was appropriately entered into the PMS on 4 August 2012 in the 'Adverse Reactions' module. As explained in the response, an alert then appears on the PMS when a provider is using the prescribing module. [Mr A] explains he also informed staff of an allergy to vancomycin. While this drug is rarely used in primary care, it should still have been recorded in the 'Adverse Reactions' module and the failure to do this, while not relevant to the current incident, was a departure from expected standards.

2. Treatment of [Mr A's] cellulitis on 4 August 2012, and his medication reaction on the early hours of 6 August 2012, was consistent with expected standards.

3. On 5 August 2012 [Dr B] assessed [Mr A's] response to his IV antibiotic treatment and determined an additional antibiotic (flucloxacillin) given orally might improve his response. Had [Mr A] not had a recorded allergy to penicillins (flucloxacillin being penicillin based), this was a reasonable therapeutic strategy.

4. [Dr B] did not follow [clinic] policy in that she did not formally prescribe the flucloxacillin before administering it from the surgery supply. Despite having attended [Mr A] the previous day, she did not recollect his penicillin allergy (which is not in itself unusual) but her failure to 'prescribe' the medication initially meant the automatic medication alert on the PMS was not activated. An additional precaution when administering drugs on-site is to verbally check with the patient whether they have any allergies immediately prior to administration, and I presume this is also part of [clinic] protocols (administration usually being undertaken by nursing staff). The end result was that [Mr A] was administered a penicillin based antibiotic (orally) to which he suffered a reaction some hours later. This was the result of human error and a failure to follow [clinic] policies by [Dr B]. There was potential for a life threatening situation had [Mr A] suffered an anaphylactic response to the flucloxacillin. It is not clear whether he wears a MedicAlert bracelet but perhaps consideration should be given to this if he does not.

5. As the prescriber and administrator, [Dr B] had full responsibility for ensuring that the medication she was administering was suitable and safe for [Mr A] to take. This responsibility was not fulfilled, and the likely contributing factors have been noted above. Prescribing errors are not uncommon in primary care. A 2009 prospective study in the UK[14] documented errors in prescriptions from 28 general practitioners as they occurred over a 3-day period in 12 community pharmacies. From a total of 3,948 prescriptions, 491 (12.4%) contained one or more errors. From a total of 8,686 drug items, 546 (6.2%) contained one or more errors. Of the

[14] Sayers YM et al. *Prescribing errors in general practice: A prospective study* Eur J Gen Pr 2009;15

errors the majority were minor (398, 72.9%), a smaller number (135, 24.7%) were major nuisance errors, and there were 13 (2.4%) potentially serious errors. The most common errors related to drug directions and dosage. I would regard the error made by [Dr B] as being in the 'potentially serious' category. While prescribing errors are not uncommon, they cannot be regarded as acceptable practice. I must determine therefore that the prescribing error made by [Dr B] was a severe departure from accepted practice, although the circumstances do not raise concern at her clinical competence otherwise.

6. [Dr B] has apologised to [Mr A] and this was appropriate. She has initiated changes to her practice as outlined in the [clinic's] response and these too are appropriate. It would be reasonable to seek a copy of relevant policy documents from [the clinic] (recording of medication allergies, prescribing policy, on site medication administration policy) to ensure their robustness, and for [the clinic] to use this incident (in an anonymised form) in the orientation of new staff and education of existing staff to emphasise the importance of compliance with facility policies."

Further expert advice dated 2 September 2013

"1. I have reviewed the additional information provided on this file: further responses from [the clinic] dated 1 May and 24 June 2013; statement from [Dr C] dated 3 May 2013; response from [Dr B] dated 5 June 2013; additional information from [the RN] who administered [Mr A's] Cefazolin on 5 August 2013. I note [the clinic's] management have confirmed that both the penicillin and vancomycin allergies suffered by [Mr A] were recorded on his electronic file at a visit in 2010.

2. [Dr C] notes that [Dr B] had not charted any of the medications administered to [Mr A] (as authorised by [Dr B]) on the evening of 5 August 2012 — those medications being IV Cefazolin, oral probenecid and oral flucloxacillin. This was contrary to [the clinic's] policy. I note the medications were listed freehand in [Dr B's] consultation note. As discussed previously, this was individual human error and the policies and processes in place at [the clinic] appear appropriate and robust with respect to requirements for medication management. [Dr B's] omission was noted by nursing staff soon after she completed her shift, and [Dr C] charted the probenecid and Cefazolin as requested by nursing staff. However, formal charting of flucloxacillin was overlooked most likely because nursing staff were not involved in its administration. I am mildly critical that [Dr C] evidently did not review [Mr A's] notes before charting his medication, or if he did review the notes he failed to detect that oral flucloxacillin had also been administered. However, the context of the 'consultation' must be considered — that nursing staff requested only that [Dr C] prescribe the usual cellulitis protocol medications in retrospect rather than to actually review [Mr A's] management.

3. [Dr C] states that in the early hours of 6 August 2012 he advised [Mr A] that the reaction being experienced was most likely related to the medication he had been prescribed earlier that evening. [The clinic] does not have a formal open disclosure policy but it does not appear there was any attempt to conceal the error that had occurred in this case. I would not regard the absence of a formal open

disclosure policy as being a departure from expected standards. There is no specific requirement in the RNZCGP Cornerstone accreditation process to have such a policy. However, consideration should be given to [the clinic] developing an appropriate policy to ensure a consistent approach is taken to acknowledging errors. In my own PHO, development of an Open Disclosure Policy before the end of June 2014 is a requirement of all member practices.

4. There do not appear to be any particular deficiencies in [the clinic's] policies and expected processes including the staff orientation process. [Dr B] had apparently followed the expected processes for prescribing of medication in the past and since the incident in question, with that incident being the result of a lapse in her usual practice. [The clinic's] management have considered whether fatigue might have been a contributing factor in the lapse and [Dr B's] night shift workload has been adjusted accordingly. In her response, [Dr B] has stated she was working extra hours at the time of the incident and had seen [Mr A] at the very end of her shift (rather than leaving his assessment to one of her colleagues) to try and improve continuity of care as she had reviewed him on the previous two days. [Dr B] has altered her practice to safeguard against unintended medication errors by getting verbal confirmation of presence or absence of medication allergies prior to prescribing even if there is no computerised alert.

5. As noted in my initial advice, medication errors are common in medical practice at all levels and do not necessarily imply a deficiency in clinical acumen or poor processes. However, while such errors may be an accepted part of medical practice, this does not make them acceptable and providers should be striving at all times to minimise the risk of harm through such errors. In this case, the error appears to have been the result of a lapse in concentration at the end of a busy shift when [Dr B] attempted, in the best interests of the patient, to provide continuity of care under some pressure of time. In hindsight this was an unwise decision. Both [Dr B] and [the clinic's] management have treated this incident with the priority it deserves and I am confident the risks of a further incident of this type involving [Dr B] have been minimised. An apology has been made to [Mr A] for any distress caused to him through this episode, and he should be reassured that his complaint has led to relevant practice changes at an individual and facility level. I have no further comments or recommendations."

Further expert advice dated 23 December 2013

"My intention in my advice was for the terms to represent as follows:

1. prescribing — formal prescription undertaken by using the prescribing module of the PMS. It is the use of this module that automatically activates any warnings with respect to allergies, potential drug interactions etc although drug allergies can also be found by proactively 'opening' that component of the PMS before prescribing. By using the prescribing module of the PMS, the drug details and instructions are automatically transcribed into the patient notes in a dedicated area and format obvious to anyone reviewing the notes. The main use of the prescribing module is when supplying the patient with a hard copy prescription which they then take to a pharmacy to have filled. However, its use in the

situation described under ‘charting’ below would represent ‘best practice’ (although not necessarily common practice) and was evidently the policy in place at the [clinic] in question.

2. charting — recording freehand instructions in the patient clinical file (usually to nursing staff) requesting administration of medication to the patient. This usually applies in primary care when a ‘one off’ medication, generally from medications the surgery holds, is to be administered to a patient eg charting instruction might be ‘please administer diclofenac 75mg IM + Stemetil 12.5mg IM’ to a patient with severe migraine. In this case, the medication may not be ‘prescribed’ in the sense the PMS prescribing module is not used, which makes it important to check manually for any medication alerts and to ask the patient regarding any allergies prior to administering the medication (or use the prescribing module!).
3. administration — physically giving the patient the medication (whether orally or by injection).”