Medication error contributing to patient's death (03HDC14692, 14 October 2005)

Public hospital ~ District health board ~ Medication charts ~ Documentation systems ~ Admission procedures ~ Prescription and administration of medications ~ Teamwork ~ Supervision ~ Patient identification label ~ Morphine ~ Diabetic ~ Rights 4(1), 4(2), 4(5)

The daughter of a 91-year-old rest home resident complained about the care her mother received at a public hospital. The elderly woman presented to the hospital's emergency department with a suspected lower respiratory tract infection. At some time during the clinical assessment or admission, a computer-generated patient identification "bradma" label, on which was printed her name, date of birth, sex, age, home address, admission date, GP, and unique hospital identification number, was affixed to the top of a completed medication chart intended for another patient.

The woman was admitted to a general medical ward and the mislabelled drug chart was attached to her file. Over the next few days she received several doses of morphine intended for the other patient, and did not receive any of her own regular medications. She deteriorated into a coma. Although the error was discovered and the correct medications administered, her condition deteriorated and she died as a result of pulmonary oedema secondary to acute cardiac failure and pneumonia.

The labelling error could not be attributed to any individual member of staff, although alert medical and nursing staff should have detected it earlier.

It was held that the DHB did not have adequate systems in place to prevent the mislabelling and incorrect filing of the drug chart, and to ensure effective co-operation between individual members of staff, in breach of Rights 4(1), 4(2), and 4(5). The fact that the hospital systems were not sufficiently robust contributed to the drug chart error remaining undetected, and the DHB breached Rights 4(1) and 4(5) in respect of these issues.

While the chart may have been accessible, had the doctors taken steps to find it, it is clear that they believed it was for all practical purposes "unavailable", since it was not immediately present with the medical records during the round. The DHB now requires that patients' notes and medication charts are present on all ward rounds, and has provided doctors with swipe-card access to dispensaries. It was held that in respect of these issues the DHB breached Rights 4(1), 4(2) and 4(5).

The DHB was also responsible for the nurses' shortcomings in consulting with the woman, her family, and other clinical staff, and the failure to determine the clinical suitability of the medications charted, because the systems and staff structures in place were inadequate to ensure continuity and quality of care was maintained and clinical reviews undertaken. In respect of these issues, the DHB breached Rights 4(1), 4(2) and 4(5).