HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Missed opportunities to ensure man understood risks of taking nitrofurontoin for an extended period

20HDC01462

In a report published today, Deputy Health and Disability Commissioner Carolyn Cooper found several health professionals missed opportunities to ensure a man understood the serious risk of taking the antibiotic nitrofurontoin for more than six months.

Sadly, the man died from the lung disease pulmonory fibrosis caused by long-term use of the medication.

The man was a paraplegic who managed his neurogenic bladder (lack of bladder control) with intermittent self-catheterisation. Due to ongoing urinary tract infections, he was initially prescribed nitrofurantoin by a specialist at a spinal unit of a district health board (now Health NZ).

The medication was successful in treating his symptoms and both his GP and a urology registrar at another public hospital continued to prescribe the medication without ensuring the man understood the risks of long term usage. The pharmacy also dispensed the medication without advising the man of the risks.

The man took the medication for around 28 months over a three-year period and was never made aware of the known risk of pulmonary disease from its long-term use. Consequently, he did not have the opportunity to make a fully informed decision about whether the potential benefits outweighed the risks of continuing to take the medication.

The man's wife made a complaint to HDC. "In concluding this investigation, I acknowledge and support her wish to prevent any further avoidable deaths that may be due to the adverse effects of nitrofurantoin," said Ms Cooper.

She found the health professionals shared responsibility for missed opportunities to inform the man of the risk of long-term use of the medication.

"Although I am very critical that none of the health service providers who cared for the man ensured that he understood the risks, I consider that no single individual or service was significantly more responsible," Ms Cooper said.

"All the healthcare providers who had a role in the prescribing and dispensing of nitrofurantoin to the man could have checked whether he was aware of the long-term risk at appropriate times, and it is concerning that this did not occur."

Ms Cooper said the complaint has highlighted that some practitioners who prescribe and dispense nitrofurantoin, including those who treated this man, were not aware of the potential for serious lung damage from long-term use beyond six months.

“It has shone a light on a very important issue and prompted necessary improvements and education to reduce the chances of a similar situation in future,” she said.

In recognition of the seriousness of this case, the providers involved have made significant changes and improvements. These include a request being made by the pharmacy to the Pharmacy Defence Association to request dissemination of the appropriate information to all community pharmacists. The spinal unit at Health NZ is creating an information document to be shared via the Royal New Zealand College of General Practitioners (RNZCGP). The medical centre has conducted an audit of all patients prescribed this medication for monitoring and to ensure the side effects are reiterated to them.

In addition to the changes already made, Ms Cooper listed follow up recommendations in her report for the RNZCGP, Te Tāhū Hauora|Health Quality & Safety Commission, Medsafe and the Medical Protection Society, Pharmac, and Health NZ.

26 August 2024

Editor’s notes

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC’s website - see HDC's 'Latest Decisions'.

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 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

Health and disability service users can now access an animated video to help them understand their health and disability service rights under the Code.

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