Crown Health Enterprise/House Surgeon

Report on Opinion - Case 98HDC15093

Complaint

The Commissioner received a complaint from the complainant concerning a house surgeon and a Crown Health Enterprise. The complaint is that:

- *In mid-May 1997 the house surgeon did not write a prescription for the consumer for cartia 100mg, imdur 120mg, atenolol 25mg in accordance with his discharge notice.*
- *Further to this the house surgeon incorrectly prescribed warfarin as 500mg instead of 5mg.*
- *In addition, the complaint is that when the consumer was again discharged from the hospital the house surgeon did not include atenolol 50mg on his prescription, in accordance with his discharge notice.*

Investigation

The complaint was received on 2 June 1998 from the complainant and an investigation was undertaken. Information was obtained from:

The complainant
The house surgeon
The Crown Health Enterprise
The pharmacist
The Medical Council of New Zealand

Information Gathered During Investigation

In May 1997 the consumer was admitted to the public hospital for a femoropopliteal bypass operation. On his discharge from hospital in mid-May 1997 the house surgeon completed a prescription for *augmentin* 500mg, *dilacor* 120mg, *warfarin* 1mg and *warfarin* 500mg.

In addition to these medicines the consumer's discharge sheet indicated that he should also be taking *cartia* 100mg, *imdur* 120mg and *atenolol* 25mg.

At the time he saw the consumer, the house surgeon was employed on the neurosurgical ward at the hospital. Outside of ordinary hours and over weekends he was on the "first on" roster providing cover for all the surgical wards. In this role the house surgeon was not responsible for the general, routine or administrative tasks provided by the normal team caring for the complainant. The medical team caring for the complainant made discharge decisions and was responsible for completing the discharge summary.

Continued on next page

Crown Health Enterprise/House Surgeon

Report on Opinion – Case 98HDC15093, continued

Information Gathered During Investigation, *continued*

In mid-May, as "first on", the house surgeon was asked to complete a prescription for the consumer by a nurse. The CHE reported that when a patient is admitted details of medication currently prescribed are recorded on their clinical notes. If, during the period of admission, amendments are made to a patient's medication, or the prescription runs out, a new prescription is written. The new prescription is recorded on a yellow medication card. Where no amendments are made, no new prescriptions are given. The consumer's clinical notes stated that on admission the consumer was receiving *cartia, atenolol* and *imdur*. Therefore, when the house surgeon completed the prescription for the consumer he did not include *cartia* 100mg, *imdur* 120mg and *atenolol* 25mg as the consumer already had a prescription for these medicines.

The consumer presented his prescription at the pharmacy the same day. As *warfarin* comes only in doses of 1mg, 2mg and 5mg the pharmacist did not fill the prescription for *warfarin* 500mg. The pharmacy has a written procedure for dealing with prescriptions that appear to have been completed incorrectly. This procedure complies with the Pharmaceutical Society of New Zealand "Code of Ethics" and involves contacting the prescriber in all cases, except for emergencies and "cases of obvious error". Where the pharmacist does spot an obvious error and that error is in dosage, then the procedure requires that he/she try to establish the correct prescription from the complainant by asking whether it is a repeat prescription and, if it is, establishing the previous dosage.

In this case the pharmacist correctly amended the prescription and provided a supply of *warfarin* 5mg.

The consumer was readmitted to the hospital eight days after he was first discharged and discharged again two days later. The house surgeon was on leave at this time and did not take any part in the discharge of the consumer. On the consumer's discharge another doctor completed a prescription for *augmentin* 500mg, *flagyl* 400mg, *cartia* 100mg and *diltiazem* 120mg. In addition to these medicines the consumer's discharge sheet indicated that he should also be taking *atenolol* 50mg.

Crown Health Enterprise/House Surgeon

Report on Opinion – Case 98HDC15093, continued

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

…

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

…

4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

…

Opinion: No Breach The House Surgeon

Right 4(2)

In my opinion the house surgeon and the doctor who completed the second prescription did not breach Right 4(2) of the Code of Health and Disability Services Consumers' Rights as they took reasonable care and skill in prescribing only those medicines which had not been prescribed prior to the consumer's admission.

The CHE's practice is that prescriptions are only filled for those medicines listed on a discharge sheet which were prescribed while the patient was admitted to the hospital. Where a patient has received a prescription prior to admission no new prescription is issued.

Opinion: Breach The House Surgeon

Right 4(4)

In my opinion the house surgeon breached Right 4(4) of the Code in failing to prescribe the correct dosage of *warfarin*. *Warfarin* is a particularly dangerous medicine and administering it in incorrect dosages could have had unfortunate effects. In this instance, the prescribing error was very obvious and was dealt with by the pharmacist at the pharmacy in the correct manner.

Opinion: No Breach The CHE

In my opinion the CHE had appropriate policies and procedures in place and were not in breach of the Code.

Crown Health Enterprise/House Surgeon

Report on Opinion – Case 98HDC15093, continued

Actions

I recommend that the house surgeon provide a written apology to the complainant's family. This apology should include details of the procedures implemented since this incident and should be sent to the Commissioner who will forward it to the family.

Other Actions

A copy of this opinion will be sent to the Medical Council of New Zealand. The Medical Council will be requested to include an article in the *New Zealand Medical Journal* discussing the need to ensure correct details when prescribing medicines, particularly *warfarin*.

Other Comments

This investigation was delayed due to a lack of response by the CHE to my inquiries regarding its policies. I suggest the Chief Executive Officer remind staff of the requirement to meet requests by the Commissioner in a timely manner.