# Prescription and administration of Maxolon without complying with hospital policies (03HDC04005, 11 January 2005)

*Public hospital ~ District health board ~ Emergency department ~ Medical practitioner ~ Registered nurse ~ Maxolon ~ Anti-emetic ~ Adverse reaction ~ Allergy ~ Communication ~ Standard of care ~ Informed consent ~ Protocols ~ Systems ~ Vicarious liability ~ Rights 4(1), 4(2), 6(1)(a), 6(1)(e), 6(2), 7(1)*

A man complained that a hospital emergency department doctor and nurse prescribed Maxolon despite his medical notes recording he was allergic to it, and that they did not take remedial action in a timely manner. He claimed that they did not give him adequate information about his treatment or obtain his informed consent.

The man presented late in the evening at the emergency department, complaining of severe abdominal pain and frequency/urgency in passing urine. Tests were initiated and pain relief administered intravenously. When pain persisted, a different type of pain relief was administered, along with Maxolon, an anti-emetic. Upon asking what the second medication was, the man discovered it was a drug to which he had previously had an adverse reaction. He became agitated and asked to be given diazepam, which he knew would counter any adverse reaction. Diazepam was not administered for a further 80 minutes.

Upon admission, and again at the initial consultation with the doctor, the subject of allergies was raised. The man, who was in considerable pain, said that there were drugs he could not take, but did not mention Maxolon. While his paper-based hospital records contained a complete list of the medications to which he had allergies or adverse reactions, they were not available to staff until at least an hour and a half after admission. Neither the doctor nor the nurse knew that they could access the information in his files electronically.

Under hospital protocol, both the doctor and the nurse had a responsibility to identify allergies, although the doctor was ultimately responsible. Neither followed the DHB's minimum requirements to ascertain allergy status. While it was accepted that their ability to do so was hampered by a lack of access to previous records, or knowledge of how to access them electronically, the conflicting information they were receiving and recording in the patient notes made it all the more imperative to clarify the man's allergy status. Their failure to follow up with more detailed questioning and to record the outcomes in meaningful detail amounted to breaches of Rights 4(1) and 4(2).

They were also found in breach of Rights 6(1)(a), 6(1)(e), 6(2) and 7(1) for not informing the man about the drugs they were administering and making sure he understood and agreed to his treatment.

The DHB was held vicariously liable for the breaches, as members of staff were unaware of the electronic information system and had not been adequately trained in its use.