Informed consent for use of haloperidol (13HDC01252, 23 June 2015)

District health board ~ Public hospital ~ Antipsychotic medication ~ Dementia ~ Informed consent ~ EPOA ~ Complaints process ~ Communication ~ Rights 4(2), 7(1), 7(4)

An elderly woman was admitted to a public hospital after a review by her general practitioner suggested a diagnosis of pneumonia. The woman had a complex medical history including dementia. At the time of her admission, the woman was noted to have had a recent fall, and was confused.

The woman had previously appointed her daughter to be her Enduring Power of Attorney (EPOA) for personal care and welfare. However, the EPOA was not activated via medical certification.

At admission, sections of the hospital admission forms were left incomplete. A general physician reviewed the woman. An X-ray showed no evidence of pneumonia, and the physician considered that the woman might have a urinary tract infection. He performed a neurological examination but did not document it.

The daughter was advised that her mother's behaviour was disrupting the ward. The woman was thought to have delirium in addition to cognitive impairment, and the medical team sought a review by Psychiatric Services.

The woman was prescribed low dose (0.5mg) haloperidol (an antipsychotic), to be administered two-hourly as required. She was not assessed to ascertain whether she was competent to consent to the proposed treatment, and there is no evidence of any discussion with her or her daughter about the options for treatment, or the risks, side effects, and benefits of treatment with haloperidol, or consent having been obtained for the administration of haloperidol.

The woman was discharged and her GP stopped prescribing haloperidol. Prior to the hospital admission, the woman had been able to walk well without an aid, but following her discharge she shuffled, taking small steps, and was unable to get in and out of bed by herself. Her facial expression was blank. The daughter felt that the haloperidol was a major contributor to her mother's deterioration.

A short time later, the woman was readmitted to hospital, as she had not managed at home. A cognitive assessment was not fully completed at admission. The daughter requested that haloperidol not be administered to her mother. However, again it was administered on five occasions when the woman was agitated and non-compliant with cares. No consent was obtained for the administration of haloperidol. Haloperidol was ceased and, subsequently, the woman was administered low dose quetiapine (an alternative antipsychotic).

Hospital clinicians failed to be clear as to the legal basis on which haloperidol was being administered to the woman, either by consent from the woman or within the terms of Right 7(4). It was found that the DHB breached Right 7(1). In addition, the use of haloperidol during the second admission was unwise, and the issue of cessation of the haloperidol should have been considered earlier during that admission. Furthermore, the overall standard of communication between DHB staff, the woman, and her daughter, could have been much improved.

There was a pattern of suboptimal documentation by multiple DHB staff. The DHB failed to comply with legal standards and, accordingly, breached Right 4(2).

It was noted that the DHB should have updated the woman's daughter more regularly about its consideration of her complaint.