HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Failures in care for woman experiencing anaphylactic reaction

23HDC01305

In a report released today, Deputy Health and Disability Commissioner Rose Wall found a paramedic officer and an emergency medical technician (EMT) breached the Code of Health and Disability Services Consumers' Rights (the Code) for care provided to a woman experiencing an anaphylactic reaction.

The paramedic administered an initial dose of 5mg adrenaline to the woman via a nebuliser. A neighbour who was an off-duty nurse administered a second dose of intramuscular (IM) adrenaline (0.5mg) under the supervision of the paramedic. A third dose was drawn up into a syringe by the paramedic and handed to the EMT, without instruction on the intended administration method (nebuliser). As the dose was intended for the nebuliser it was 4mg, which was significantly higher than the recommended dose for IM or IV. This third dose of 4mg was then administered intravenously (IV) by the EMT in error without the awareness of the paramedic, who was concurrently on the phone to the air desk.

Within approximately one minute of the 4mg IV adrenaline dose, the woman suffered a cardiac arrest and subsequently required resuscitation and defibrillation.

Ms Wall found the paramedic breached the Code for failing to provide services of an appropriate standard | Tautikanga for administering the IV adrenaline.

After reviewing the relevant evidence, Ms Wall concluded that the paramedic did not provide clear instructions to the EMT regarding the medication and dose that was in the syringe and the required route of administration (intended for the nebuliser), and she did not supervise the EMT adequately.

Ms Wall also found the EMT breached the Code for failing to provide services of an appropriate standard | Tautikanga.

By administering the IV adrenaline, the EMT acted outside her scope of practice. She also failed to adhere to the Clinical Practice Guidelines which stipulate that the person administering the medicine should ensure the medicine name, dose and route is said out loud as it is administered.

"No information has been provided to indicate that when faced with uncertainty, the EMT sought clarification or advice," Ms Wall said. "On the basis that EMTs are not authorised to administer any medication intravenously, I consider that she was aware the consumer could be compromised by administering medicine outside of her scope, and she should have sought clarification. I am especially critical of the EMT in this regard and consider this an egregious breach of the standards."

Ms Wall made an adverse comment about the EMT for failing to identify her error, which meant it took three hours for medical personnel to receive the correct information about the cause of the woman's cardiac arrest.

She made an adverse comment about the paramedic for the initial decision to use the nebulised adrenaline, rather than the IM adrenaline. She also made an adverse comment about the paramedic for failing to adequately identify the error.

“As the senior officer, the paramedic was responsible for the initial Ambulance Care summary submitted after the incident. The summary did not record that 4mg of adrenaline had been administered in any form. I consider that in completing this report, there was a missed opportunity for the paramedic to identify earlier that the 4mg of adrenaline she herself had prepared had not been accounted for adequately.”

Ms Wall expressed her condolences to the woman and her husband for the stress and trauma they experienced because of the event and the long-lasting impacts on their wellbeing.

Since the event, the paramedic, EMT and the ambulance service have taken steps to prevent a similar occurrence in future. Taking these into account, Ms Wall made further recommendations in her report.

2 September 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 group 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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