Overdose of paracetamol to acutely ill child (02HDC08949, 31 March 2005)

Nurse ~ Public hospital ~ Intensive care unit ~ District health board ~ ICU consultants ~ ICU registrar ~ Registered nurses ~ Burns ~ Dispensing of medication ~ Documentation ~ Infection ~ Investigations ~ Monitoring ~ Handover ~ Communication ~ Incident reporting ~ Continuity of care ~ Division of responsibilities ~ Vicarious liability ~ Rights 4(1), 4(2), 4(5), 10(6)

A three-year-old boy residing overseas received burns to 60–70% of his body from boiling water. He was transferred to a public hospital in New Zealand, where his burns were debrided three times under general anaesthetic. He was cared for initially in the hospital's intensive care unit (ICU) before being transferred to the children's ward four days later. He was readmitted to ICU the following day when he developed fluid resuscitation problems as a result of diarrhoea. He developed renal and liver failure and died the next day.

Retrospective analyses of the boy's blood revealed elevated ALT results, which indicated that one of the nurses had administered the incorrect dose of paracetamol. The Coroner concluded that this was not the cause of the boy's death. However, administering the incorrect dose, and repeatedly doing so, did not reflect services administered with the requisite skill and care and did not meet professional standards. This was a breach of Rights 4(1) and 4(2).

The test results indicated that a second nurse had not administered an incorrect dose. However, in the course of documenting her own administration of the drug, the second nurse became aware of the possibility of the other nurse's error and did not report the incident. This meant that the boy was not specifically monitored for any consequential effects of the overdose, nor could the overdose be explored as a contributing cause when the child's health went into sudden, unexpected decline. Her actions and omissions amounted to breaches of Rights 4(1), 4(2) and 4(5).

The doctors involved were found not to have breached the Code as the action taken in considering other diagnostic possibilities was reasonable.

The DHB was held vicariously responsible for the first nurse's breaches, as there were various measures it could have taken to prevent the error or reduce its likelihood. The DHB was found directly liable for failing to advise the boy's parents of the existence of HDC and independent advocates. Staff had the opportunity to do this at various meetings they had with the boy's parents after his death, and their failure to do so breached Right 10(6).

The two nurses were referred to the Director of Proceedings, who commenced proceedings in the Health Practitioners Disciplinary Tribunal. A charge of professional misconduct was upheld in respect of both nurses. The first nurse was censured, while the second nurse was ordered to practise under supervision for six months should she return to practise in New Zealand, and to pay costs of $5,000.

Link to Health Practitioners Disciplinary Tribunal decisions:
www.hpdt.org.nz/portals/0/nur0518dfindings.pdf
www.hpdt.org.nz/portals/0/nur0517dfindings.pdf