

## Inadequate standard of care for increased oxycodone dosage 21HDC02991

Deputy Health and Disability Commissioner Dr Vanessa Caldwell has found a GP breached the <u>Code of Health and Disability Services Consumers' Rights</u> (the Code) in relation to an increased prescription of oxycodone.

The report concerns a woman who presented to the GP with significant chest pain. She had been taking oxycodone (an opioid pain reliever) for several years for chronic pain but had experienced increased pain due to her recently diagnosed lung cancer.

The women informed her GP that she had already increased her oxycodone dose herself and requested that her GP formally increase her dose to match this, as it had sufficiently relieved her pain. The GP agreed to increase the dose of oxycodone. Sadly, two days later the woman passed away from oxycodone toxicity.

The Case was referred to HDC by the Coroner.

Dr Caldwell found the GP breached the Code for failing to provide an appropriate standard of care when increasing the woman's oxycodone dosage and the rate at which this was undertaken. The breach also applied to the inadequacy of documentation associated with the increased dosage.

Dr Caldwell said, "I would have expected documentation outlining the woman's prior average daily dosage to have been recorded. This would have enabled the GP to review the risk of toxicity due to rapid up-titration and enabled a more accurate basis for calculating ongoing prescribing of the medication.

"Overall, I am concerned that the GP did not adequately account for the speed of increase and risks of accumulation."

Since the event, the GP has made changes to his practice including undertaking further education on opioid titration. Considering the subsequent education undertaken by the GP, Dr Caldwell made no further recommendations.

24 June 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 '<u>Latest</u> Decisions'.

Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name 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 <a href="here">here</a>.

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%.

## Read our latest Annual Report 2023

Health and disability service users can now access an <u>animated video</u> to help them understand their health and disability service rights under the Code.

Learn more: Education Publications

## For more information contact:

Communications team, Health and Disability Commissioner

Email: communications@hdc.org.nz, Mobile: +64 (0)27 432 6709