Patient dies after fax blunder at hospital

Health Commissioner finds staff committed a chain of errors

by Errol Kiong
health reporter

An Auckland man died after a hospital mixed up a fax from his GP giving details of his medication with those of another patient, resulting in his receiving a fatal combination of the wrong drugs.

Auckland City Hospital has apologised for the blunder after the Health and Disability Commissioner found it had committed a chain of errors causing Mervin McAlpine's death.

Mr McAlpine, a diabetic, died at Auckland City Hospital after a letter from his GP was mistakenly attached to another patient's medication records and lab results, faxed to the hospital at the same time.

The 82-year-old — who had lost both legs and was sent to hospital because he was not coping at home — was then prescribed two drugs he was not supposed to have.

The Auckland Coroner found that Mr McAlpine died of complications from the administration, in error, of metformin and glipizide.

In a report made public today, Health and Disability Commissioner Ron Paterson says the hospital committed a chain of errors in Mr McAlpine's care in August 2004:

- Staff did not check where the records of the other patient had gone after finding them missing from his file.
- The house surgeon did not check Mr McAlpine's current medications, which he brought with him as requested, but was never asked to produce.
- The nursing assessment left the medications part of the form incomplete.

Mr Paterson says Mr McAlpine's death was a result of "systemic weaknesses" in the hospital's referral and prescribing processes.

"Hospital staff need to ensure that a complete and accurate list of a patient's current medication is compiled, checked and reconciled to ensure that the patient is prescribed the appropriate medication at the appropriate dose, in secondary care.

"The series of events that led to [Mr McAlpine's] death could occur at other hospitals. There is therefore a need to highlight these systemic weaknesses to other district health boards."

A friend of Mr McAlpine, Peter Larkin, lodged the complaint after the hospital acknowledged prescribing the wrong drugs.

"I was quite disgusted at how easy it was for him to have been given wrong medicine and the fatal consequences of it.

"At the end of the day, whatever we are doing now is not going to affect Mervin.

"He's dead, he's died from it, but this needs to be brought to the public's attention — how easy it is to be given the wrong medicine.

> 'Nobody bothered to read anything, [they] paperclipped it together and just put it in.'
>
> Peter Larkin, dead man's friend

"... Nobody bothered to read anything, [they] paperclipped it together and just put it in."

Mr Larkin had known Mr McAlpine since childhood, and helped look after him in his later years. The former council worker lived alone in a pensioner village in Mt Eden, but had family in Hawkes Bay.

Mr Larkin hopes the report will prevent something like this happening again.

"What I'd really like to see is the report making changes."

The hospital acknowledged the commissioner's findings. The chief medical officer, David Sage, said: "The patient's recovery was so compromised by the administration of incorrect medication for diabetes that we hastened his death."

Dr Sage said the hospital had since taken steps to correct the situation, including altering GPs' software to add patient ID and pagination to faxes. The hospital had found that 86 per cent of faxes from GPs were now marked with patient data, compared with 23 per cent in 2004.

The number of administration staff processing the paperwork has also been increased.

Dr Sage said he supported the commissioner's call for a national approach in developing a system to reconcile medications — a move also supported by the Royal College of GPs.

At present there is no centralised system for doctors at different levels of care to gain access to patient records.

The problem is compounded by the lack of a standardised software system among GPs and hospitals, which can hinder sharing of patient information.

A Ministry of Health committee is looking at improving the communication between patients moving from GP care to the hospital and back again.

Communication errors have been linked to the deaths of at least three other patients in the past three years.

Inadequate communication, documentation and monitoring contributed to the death of a 50-year-old man who died 40 hours after admission to Wellington Hospital with pneumonia.

A heart patient with chest pain, breathlessness and lethargy was sent home from Wanganui Hospital three times in 11 days after she was referred by her doctor.

Each time, the GP was not told the patient had been discharged. She died at home in January 2004 the day after the final discharge. Hospital doctors said they did not fully realise her doctor's level of concern.

Inadequate medical record-keeping was blamed when an asthma sufferer with a migraine was prescribed medication to which she was allergic by a doctor at an unnamed North Island medical centre.

The patient usually saw a different doctor at the centre but her file had no record of her allergy. The woman stopped breathing, suffered severe brain damage and later died.

1 Mervin McAlpine, an 82-year-old diabetic, is referred to Auckland City Hospital. His doctor faxes a one-page referral notice.

2 About the same time another doctor sends a three-page fax about another patient.

3 The second patient's fax is mistakenly attached to Mr McAlpine's notes in the hospital.

4 The notes are sent to Mr McAlpine's ward, where a house surgeon uses them to prescribe a combination of two wrong drugs.

5 The mistake is discovered when Mr McAlpine's health worsens. He dies on August 14, 2004, two days after admission.

HERALD GRAPHIC

NOTIFICATION THAT INQUEST UNDER CORONERS ACT 1988 WILL NOT BE OPENED OR RESUMED

To the Secretary for Justice
WELLINGTON

I HEREBY notify you that, pursuant to section 28 (6) of the Coroners Act 1988 I have decided that the inquest in respect of Mervyn Reginald McAlpine, late of 24/126 Landscape Road, Mt Eden, Auckland will not be resumed.

The Health and Disability Commissioner received a complaint, in November 2005, from Mr P Larkin, about the events which occurred at Auckland City Hospital concerning the death there of Mr McAlpine on 14 August 2004.

The Health and Disability Commissioner has completed his report (Case 05/17139/WS) and I have examined it carefully and **enclose** it.

The report of the Health and Disability Commissioner WAS THAT:

'My final decision is that, in light of the significant investigation already undertaken into this complaint by Auckland District Health Board (ADHB), ACC and this office, together with the steps already taken by ADHB to remedy the situation, further investigation is unnecessary.'

Dated at Auckland 28 September 2005

Coroner

Encl.

FINDING: I, Dr Murray Jamieson, Coroner at Auckland FIND THAT:

Mervyn Reginald McAlpine, late of 24/126 Landscape Road, Mt Eden, Auckland, retired person, aged 82 years, died on 14 August 2004 at Auckland City Hospital, Auckland of complications of the administration, at that hospital, in error, of Metformin and Glipizide (metabolic acidosis, acute on chronic renal failure, congestive heart failure and acute bronchopneumonia).

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

22 May 2007

Mr Peter Larkin
17 Roosevelt Avenue
Onehunga
AUCKLAND 1061

Dear Mr Larkin

Complaint: Auckland City Hospital and Mervyn McAlpine

Thank you for your letter of 10 May.

I would like to take this opportunity to express my admiration for the way you have pursued this complaint. I believe that it is your perseverance and your refusal to accept the status quo which has led to the very positive results we have seen in recent weeks.

The publicity surrounding Mr McAlpine's death has highlighted the problems which can arise from a failure to have an adequate system for medication reconciliation and will provide a focus for the work being undertaken by the Quality Improvement Committee (QIC) into this area.

On 29th April 2007, DHB chief executives agreed that the Safe and Quality Use of Medicines group (SQM), together with Chief Information Officers, should take a leading role in the DHB's involvement in medicines reconciliation, including any work developed by QIC. My report into Mr McAlpine's death is to be on the agenda for SQM's next meeting, for the development of a work programme.

Yours sincerely

Ron Paterson
Health and Disability Commissioner

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