Reconciliation of correct dosage of methadone (11HDC00710, 28 June 2013)

District Health Board ~ Registrar ~ Methadone maintenance programme ~ Medicines reconciliation ~ Prescribing error ~ Professional standards ~ Rights 4(1), 4(2), 4(5)

A woman attended an Emergency Department (ED) in the morning, complaining of sudden onset epigastric pain, nausea and vomiting. She was on a local methadone maintenance programme (MMP) but had not had her usual daily dose for that day.

The woman was triaged, assessed by an ED registrar, and an ED care plan was completed. A surgical trainee intern and surgical registrar assessed the woman. The woman's usual daily dose of methadone was not established or recorded by various staff throughout the day. Her local community pharmacist recalled being contacted by a DHB doctor by telephone to discuss the dosage, but the doctor's identity could not be established, and no call was documented in the woman's hospital notes.

In the evening a surgical registrar reviewed the woman, discussed the methadone dosage and documented that the usual dose was 37mls. (It was in fact 37mgs of a 5mg/ml strength solution, equalling 7.4mls.) The registrar told the woman that she could not give her methadone for the night, but would be able to administer her usual methadone once reconciliation of the dose was confirmed by Community Alcohol and Drug Services (CADS). The registrar then prescribed and charted 37mls instead of 37mgs of a 5mg/ml strength solution of methadone (meaning it totalled five times the usual daily dose).

The registrar asked the on-call surgical house officer to contact CADS to confirm the usual dose. The registrar was made aware by the house officer that CADS was not contactable as it was after hours; however this communication was not documented for the morning team to follow. The woman was transferred to the surgical ward.

The (incorrect) dose was given as charted by a ward nurse the following morning. The ward stocked only 10mg/ml strength liquid methadone, so the woman was given 18.5ml, which equated to 185mg. The error was picked up by a rotational ward pharmacist around noon that day. Medical staff, a senior manager, and the woman were all promptly told of the error. The woman responded well to treatment and made a good recovery.

The registrar did not reconcile or confirm the appropriate dosage of methadone, and subsequently prescribed an incorrect dose. As the responsible and prescribing clinician, the registrar did not provide services with reasonable care and skill, and she therefore breached Right 4(1). By failing to effectively communicate with her colleagues that the methadone dosage had not yet been confirmed and required reconciling, the registrar did not ensure continuity of services and breached Right 4(5). The registrar took full responsibility for charting the incorrect dose of methadone, reflected on the incident, and made changes to her practice.

Appropriate investigation and review was initiated by the DHB. However, at the time of the events, the DHB did not have an organisational system for formal medicine reconciliation. As such, the DHB did not comply with relevant professional standards for medicine reconciliation and breached Right 4(2).