Incorrect dose of citalopram administered to elderly woman
16HDC00072, 28 June 2017

Public hospital ~ District health board ~ Transcribing error ~ Medication ~ Standard of care ~ Right 4(1)

An 88-year-old woman was admitted to the orthopaedic ward at a public hospital following a fall at her rest home.

Documentation from the woman's rest home showed her daily dose of citalopram (an antidepressant) as 10mg per day, half of a 20mg tablet. An orthopaedic house officer prescribed the woman citalopram 10mg daily by writing this on a paper medication chart. However, initially he wrote "20mg" and then immediately realised that the dose was half of a 20mg tablet, so changed the prescription to "10mg" by writing over the "2". The house officer did not rewrite the prescription, as required by the DHB's policy.

The hospital ward pharmacist undertook a medicine reconciliation for the woman's medication. The pharmacist documented the daily dose of citalopram as 10mg and annotated the paper medication chart by writing "½ x 20mg" underneath the prescription of citalopram, to indicate that each dose was to be half of a 20mg tablet. Throughout the woman's admission to hospital, no staff rewrote the house officer's prescription of citalopram or asked him to do so.

The woman was transferred to another hospital. Another orthopaedic house officer completed the electronic discharge summary, listing the woman's dose of citalopram as 40mg. The house officer used the paper medication chart dose and misread the altered dose of citalopram as 40mg.

A geriatric house officer admitted the woman to the second hospital and electronically prescribed her citalopram 40mg daily. The geriatric house officer told HDC that she took this dose from the discharge summary. Following the woman's admission, a ward pharmacist reviewed the woman's medication. The pharmacist compared the medication entry to the discharge summary from the previous hospital. The pharmacist thought that the dose of citalopram was high for an elderly person, but not unusual, so it was not a red flag for her.

The woman was given 40mg citalopram daily for over a week. During this time, she had periods of suspicion, paranoia, delusion, and confusion. None of the staff caring for the woman identified the citalopram dosage error. A nurse practitioner reviewed the woman for a mental health assessment, and identified the error. The woman's citalopram dose was immediately reduced to 10mg.

Findings

An accumulation of apparently innocuous actions or inactions added up to a failure on behalf of the DHB in that the woman received 40mg instead of the intended 10mg of citalopram. Opportunities to avoid or correct this error were missed, and there was a lack of critical thinking exhibited in this case. It was held that the DHB failed to provide services with reasonable care and skill in relation to the prescribing and administration of citalopram, and breached Right 4(1).

Recommendations

It was recommended that the DHB use this case as an anonymised case study for the education of staff, and conduct a random audit of the transfer reconciliations performed by pharmacists at the receiving service.

As recommended in the provisional opinion, the DHB reported on the implementation of electronic prescribing and also provided a letter of apology to the woman's family.