Incorrect dispensing of medication to child
16HDC00441, 21 June 2017

Pharmacy ~ Pharmacist ~ Epilim ~ Dispensing error ~ Professional Standards ~ Right 4(2)

An 11-year-old boy was prescribed, among other medications, sodium valproate (brand name Epilim). The child's prescription was for three Epilim 100mg tablets twice daily, with a total quantity of 180 tablets.

The child's mother visited a pharmacy to have a repeat prescription of Epilim filled. The same pharmacist carried out both the dispensing and checking of the medication. The pharmacist dispensed 200 Epilim 500mg tablets instead of 180 Epilim 100mg tablets. The child's mother discovered the error and returned to the pharmacy approximately one week later. The pharmacist explained that the pharmacy was busy and lacked staff.

Approximately one month later, another repeat prescription of Epilim was dispensed to the child's mother from the same pharmacy. The child's mother the received a full box containing 100 Epilim 100mg tablets and a 'broken' box which contained 50 Epilim 100mg tablets and 30 Epilim EC 200mg tablets. The pharmacy was unable to identify who carried out the dispensing, but was able to identify that a second pharmacist had carried out the checking of the dispensing.

The first pharmacist failed to dispense the correct medication and check her dispensing adequately. She also failed to complete an incident report form once her dispensing and checking error was identified. By doing so, the first pharmacist failed to provide the child with services in accordance with the professional standards set by the Pharmacy Council of New Zealand, and with the pharmacy's SOPs and, as such, breached Right 4(2).

While the pharmacy had in place appropriate SOPs, it had not ensured that there was a sufficient number of qualified staff supporting the first pharmacist in the dispensary on that day. It therefore did not take all reasonably practicable steps to prevent the acts or omissions of the first pharmacist's breach of the Code and, as such, the pharmacy was vicariously liable for the first pharmacist's breach of Right 4(2).

The second pharmacist failed to perform the final check for the dispensing adequately, in accordance with the professional standards set by the Pharmacy Council of New Zealand and with the pharmacy's SOPs. In doing so, and by replacing the 80 tablets returned by the child's mother with 100 tablets, she failed to provide the child with services in accordance with professional and other relevant standards, in breach of Right 4(2).

The pharmacy was not found in breach of the Code or vicariously liable for the second pharmacist's breach.

It was recommended that the pharmacy randomly audit, over a period of three months, its staff compliance with its SOPs for dispensing and checking medication.

It was also recommended that the pharmacy and both pharmacists provide a written apology to the child and his mother.