# Dispensing error to child
# (15HDC00183, 22 June 2016)

*Pharmacy ~ Pharmacist ~ Pharmacy technician ~ Dispensing medication ~ Selection error ~ Professional standards ~ Paediatric registrar ~ Rights 4(1), 4(2)*

A woman visited a Pharmacy to have a prescription filled for her child, aged seven, who has cerebral palsy and was prescribed baclofen (a muscle relaxant and antispastic agent). A pharmacist processed the prescription, a pharmacy technician compounded the baclofen, and a second pharmacist checked it. The Pharmacy dispensed 10mg/ml of baclofen instead of the prescribed 10mg/10ml, meaning that the child was dispensed ten times the strength prescribed.

Following the dispensing error, the child presented to the Emergency Department at a hospital on three occasions with increased seizures, shortness of breath and deep breathing with salivation, and was assessed on each occasion by a paediatric registrar. On the third presentation the dispensing error was identified by a pharmacist at the hospital and reported to the Pharmacy. The Pharmacy apologised to the woman and undertook an investigation.

It was held that by failing to process and check the correct strength of baclofen and failing to check the appropriateness of the dose, both the processing pharmacist and the checking pharmacist failed to provide the child with services in accordance with professional standards and, as such, breached Right 4(2).

Non-compliance with the Pharmacy's Standard Operating Procedures (SOPs) by multiple staff played a significant part in the child receiving the incorrect medication. Accordingly, the Pharmacy did not provide services to the child with reasonable care and skill and breached Right 4(1).

Adverse comment is made about the pharmacy technician's failure to check the strength of the medication against the prescription, and failure to identify that the strength of the baclofen she selected and compounded was different to the strength listed on the prescription.

Adverse comment is made about the paediatric registrar's failure to perform further investigations having been aware that the child was receiving 40mg of baclofen daily. This was especially concerning given that previously, the paediatric registrar believed that the child was having an adverse reaction to as little as 6mg baclofen daily.

It was recommended that: the two pharmacists each undertake assessments through the New Zealand College of Pharmacists and apologise to the woman and her child for their breaches of the Code; the Pharmacy conduct an audit of staff compliance with dispensing SOPs and apologise for its breach of the Code; and both the pharmacy technician and the paediatric registrar review their practice in light of the comments in this report.