Prescription and dispensing of incorrect dose of medication to child
15HDC01542, 16 December 2016

Paediatric registrar ~ Pharmacist ~ District health board ~ Pharmacy ~ Prescribing error ~ Dispensing error ~ SOPs ~ Rights 4(1), 4(2)

A young girl, aged two years and 11 months, experienced painful and difficult urination following bladder surgery. She was reviewed by a paediatric registrar at a public hospital. After discussion with a senior colleague, the paediatric registrar prescribed medication for her including oxybutynin, which is primarily indicated for the management of urinary urgency and incontinence.

The paediatric registrar chose an appropriate dose of 2mg oxybutynin, but instead of writing "oxybutynin 2mg" three times daily for ten days on the prescription form, wrote "oxybutynin 20mg", three times daily for ten days, which was a ten times higher dose.

The girl's father took the prescription forms to the pharmacy for the medications to be dispensed. The receiving pharmacist noticed that the oxybutynin dose seemed high but did not question it at the time. The prescription forms are not initialled to show who completed the dispensing. The medications were placed in a bag, and the bag was placed in the delivery basket at the pharmacy. A second pharmacist delivered the medication to the girl's mother. The second pharmacist said that she omitted to discuss the medication with the mother, but discussed a separate health issue.

The mother gave the girl the prescribed dose of oxybutynin after she had ongoing pain with passing urine. The girl experienced side effects and was taken to the hospital's Emergency Department, where she was monitored and discharged later that day.

It was the paediatric registrar's responsibility to ensure that she prescribed a clinically appropriate dose of oxybutynin. By failing to do so, she did not provide services with reasonable care and skill, and breached Right 4(1). It was considered that if electronic prescribing had been available when the medication was prescribed, it could have minimised the risk of this error occurring.

The first pharmacist failed to take steps to contact the prescriber when she noticed that the oxybutynin dose seemed high. She also did not sign on the date stamp to indicate that she had dispensed and/or checked the prescriptions in accordance with the pharmacy's Dispensing Prescriptions Standard Operating Procedure (SOP). It was held that the pharmacist did not provide services in accordance with professional standards, and breached Right 4(2).

It was found that the second pharmacist did not check the prescriptions, calculations and labels, did not ensure that the Dispensing Prescriptions SOP was followed, and missed an opportunity to check the appropriateness of the prescription at the time of delivery of the medications to the girl's mother. It was held that, in all the circumstances, the second pharmacist did not provide services with reasonable care and skill, and breached Right 4(1).

Non-compliance with the Dispensing Prescriptions SOP played a part in the girl receiving an inappropriate dose of oxybutynin. Accordingly, it was held that the pharmacy did not provide services with reasonable care and skill and breached Right 4(1).

The Commissioner recommended that the paediatric registrar, the two pharmacists and the pharmacy each provide a written apology to the girl's parents.

The Commissioner recommended that the DHB introduce systems to allow a specific space for the recording of a child's weight on prescriptions; give feedback to HDC on the implementation of its new electronic prescribing system, and use this case as an anonymised case study for education for paediatric medical staff.

The Commissioner recommended that the pharmacy undertake two audits of compliance with its Dispensing Prescription SOP, and use this case as an anonymised case study for education for future employees of the pharmacy.

The Commissioner recommended that the Pharmacy Council of New Zealand consider whether a review of the first pharmacist's competence is warranted.

The Commissioner recommended that the Ministry of Health actively continue to support the rollout of electronic prescribing across New Zealand's DHBs in both inpatient and outpatient settings, and work with the sector to progress an integrated approach to medicines management.