Dispensing of eye drops to child
17HDC00538, 9 March 2018

Pharmacist ~ Pharmacy ~ Dispensing ~ Eye drops ~ Checking ~ Right 4(1)

A woman and her eight-year-old daughter consulted an optometrist. At the end of the consultation the child was prescribed "[a]tropine drops 0.01%, 1 drop both eyes at night, 3 months supply".

The woman went to a pharmacy to have the prescription dispensed. There was only one pharmacist working, and he completed the processing and dispensing of the prescription. The pharmacist told HDC that during the dispensing he thought the strength of the atropine was unusual and he made attempts to verify it prior to dispensing. However he did not discuss his concerns with the prescriber, as the clinic was closed during the weekend. The pharmacist said that he told the woman that only 1% eye drops were available and believed there had been a mistake in prescribing. He offered to return the prescription to the woman if she was not comfortable proceeding with the dispensing. The pharmacist stated that as the woman had no apparent concerns, he dispensed atropine 1% instead of the prescribed 0.01%.

The woman followed the prescription instructions and administered her daughter one drop of atropine per eye. The woman looked at the label on the bottle and read "atropine 1% eye drops". She said that she remembered reading the prescription as "atropine 0.01%" and became confused and concerned.

The following morning, the woman rang the pharmacy and expressed her concern that the prescription said 0.01% instead of 1%. The pharmacist telephoned the optometry clinic and was told that the strength he had dispensed was incorrect.

The pharmacist called the woman to explain the situation. He asked whether the medication had been used and advised the woman to monitor her daughter closely and to contact him if she required any further assistance. The pharmacist did not specifically ask whether there had been any adverse effects from the atropine. The pharmacist advised that he posted and faxed the prescription to a pharmacy that specialised in pharmaceutical compounding, and then deleted the dispensing record from the dispensary software.

Findings

The pharmacist did not comply with a number of the Pharmacy's SOPs, as well as the Pharmacy Council of New Zealand's *Code of Ethics*. The pharmacist failed to provide services to the consumer with reasonable care and skill for a number of reasons, and was found in breach of Right 4(1). The pharmacy was not found vicariously liable for the pharmacist's breach of the Code.

Recommendations

It was recommended that the pharmacist review the Pharmacy Council of New Zealand's professional guidelines and identify improvements in his dispensing

practice. As part of this, it was recommended that the pharmacist undertake continued education on pharmaceutical products by keeping a written log of the Pharmacy Council of New Zealand's "Safety Alerts".

It was recommended that the pharmacy:

(a) Randomly audit, over a period of three months, its staff compliance with its "Dispensing 2 — Prescription assessment and clinical check" SOP.

(b) Incorporate into dispensary meetings, discussions around Pharmacy Council of New Zealand and/or Pharmacy Defence Association safety alerts and/or communications.