A Pharmacy

A Report by the

Deputy Health and Disability Commissioner

(Case 06HDC17949)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer
Ms B	Complainant/Mr A's mother
Mr C	Provider/Pharmacist
Mr D	Provider/Pharmacy proprietor
Dr E	Mr A's GP
Ms F	Pharmacy manager
Ms G	Pharmacist
Mr H	A methadone client
Mr I	Current pharmacy proprietor

Complaint

On 13 November 2006 the Commissioner received a complaint from Ms B about the services provided by pharmacist Mr C. The following issues were identified for investigation:

- *The appropriateness of the care provided by Mr C to Mr A in 2006.*
- *The appropriateness of the care provided by the Pharmacy to Mr A in 2006.*

An investigation was commenced on 20 February 2007. Investigation into the care provided by Mr C was discontinued on 14 December 2007 because of health concerns. Mr C died in 2008.

This investigation has taken over one year. This was because of the need to obtain further information following the receipt of expert advice.

Information reviewed

Information from:

Ms B
Mr C
Mr D
Mr I (current Pharmacy proprietor)
Police
Pharmacy Council of New Zealand

Ms G (Pharmacist)
Ms F (Manager)
Chief Medical Officer, the District Health Board
Dr E (Mr A's GP)
Medsafe

Independent expert advice was obtained from pharmacist Maree Jensen.

Information gathered during investigation

Overview
A pharmacist mistook Mr A for another methadone client and provided him with a larger methadone dose than he had been prescribed. Mr A died after taking the methadone at his house later that day.

Background
Mr A, aged 27, was well known to the District Health Board (the DHB) mental health services. He had a long history of low mood, suicidal ideation, self-harm episodes, and alcohol and illicit drug usage. In 2006, Mr A self-referred to the DHB Community Alcohol and Drug Service (CADS) "with the hope of being placed on the methadone programme". Mr A had not previously been on the methadone programme. However, Mr A reported the regular use of illicit methadone of up to 200mg per week.

Later that month, a CADS Counsellor undertook a comprehensive assessment of Mr A. He was considered to fulfil the criteria for a diagnosis of opioid dependence. Mr A was therefore considered for the Interim Methadone Programme (IMP), as there was a "greater than two week" wait for an individualised Methadone Programme.

The main aim of the IMP is to reduce the risk of drug-related harm through the regular controlled supply of methadone prescribed by an authorised general practitioner (GP). There are a number of restrictions on people on the IMP, including the requirement to consume their daily methadone in front of a pharmacist. During the IMP there are no takeaway doses allowed. The methadone must also be dispensed by a nominated seven day/week pharmacy. In Mr A's case, this nominated pharmacy was the Pharmacy, which had a large methadone client base with a contract to provide services to up to 100 methadone clients per day.

A Pharmacy Company held the licence to operate the Pharmacy. At the time of this incident Mr D was a shareholder and director of the Pharmacy Company. He purchased the Pharmacy (with his business partner) in February 2005. Mr D advised that he was "almost singularly" responsible for developing the policies and procedures, including the standard operating procedures (SOPs) for methadone dispensing. However, Mr D had not worked as a dispensing pharmacist at the Pharmacy for "some years" and was no longer involved in the day-to-day running of the Pharmacy. Mr D was also shareholder, CEO and managing director of a group which has interests in a

number of pharmacies and provides consultancy and services management to a number of pharmacies.

Mr A provided CADS with his written consent to the IMP. The following month, Mr A's IMP was deferred owing to gaps in his use of illicit methadone. At the end of the month, following review by the CADS medical director and a case presentation to the CADS clinical team, Mr A was approved for the IMP. The plan was to start the methadone at 10mg, increasing up to 30mg over three days. The goal was to "achieve stability on IMP" and "stabilise [Mr A's] lifestyle".

At the beginning of the next month, Mr A saw his GP, Dr E, along with the CADS liaison nurse to arrange for the implementation of the IMP. The IMP was explained to Mr A and he was strongly advised against using other drugs. Dr E was provided with written authorisation to prescribe methadone, signed by the CADS medical director. Dr E was given specific dosage guidelines and a consumption schedule for Mr A. Dr E advised that he provided a prescription for Mr A's methadone to the CADS liaison nurse, who took the prescription directly to the Pharmacy.

Dr E prescribed 10mg of methadone to commence six days later, on Day 1, to be increased to 20mg on Day 2, and then 30mg on Day 3 with the instruction that "each of these doses to be verbally approved by [Dr E] — dose alterations may occur". The total period of supply was 28 days.

The IMP requires the client to see his or her GP after every dose increase in order to assess safety and dose effect. Mr A attended appointments with Dr E on Days 2 and 3. No issues were identified during these appointments and the doses were increased accordingly.

CADS advised that routine follow-up and monitoring of patients on the IMP is not normally provided. However, due to Mr A's "extensive past involvement with mental health services, and his recent emotional instability" ongoing counselling was planned with CADS. Mr A did not attend his first follow-up counselling appointment on Day 2.

Mr A received his daily doses as prescribed, except on Day 7 when he failed to attend the Pharmacy. CADS was not informed of the missed dosage. Mr D advised that it was normal practice to notify CADS of any missed doses. He is unsure why this did not occur in this case.

Day 11

At approximately 9.15am, Mr A went to the Pharmacy for his daily methadone dose (30mg). On the way to the pharmacy, Mr A met a friend, who accompanied him. Mr A's friend waited outside while he went into the pharmacy.

Mr C was the sole pharmacist on duty when Mr A arrived. There were also two other staff on the premises, one in the front/retail area and one in the prescription area. Mr C was a highly experienced pharmacist who had previously owned his own pharmacy for 30 years. Mr C was experienced in working with methadone clients. He had been

employed for approximately three years as a locum pharmacist and worked at the Pharmacy as a locum pharmacist manager. During the six weeks prior to this incident he had been working primarily at the Pharmacy.

Mr C was responsible for dispensing methadone, dispensing or checking other prescriptions, and assisting customers with other pharmaceutical needs. The records show that Mr C had dispensed methadone to Mr A on two previous occasions (Days 6 and 8).

Methadone dispensing procedure
The Pharmacy has a separate room where methadone clients can consume their methadone in private. When a patient arrives, he or she pushes a buzzer on an external door, which rings in the dispensing room. The pharmacist checks who is waiting and then opens the door by releasing an electronic catch on the external door. The patient walks into a room separated from the dispensing room by a counter and a window, which the pharmacist can open and close. The pharmacist remains on the other side of the counter from the patient and dispenses the methadone through the window hatch.

In the dispensing room there is a rack which holds an individual plastic bin for each methadone patient. Attached to each bin is a flag and a copy of the dispensing label for the client's daily dose. At the end of each working day, if a client is to receive a methadone dose the following day the flag is raised. Every day a pharmacist generates a daily methadone dispensing control sheet (MDCS) from the pharmacy's database.[1] Mr D explained that the MDCS is checked against the notes in the methadone dispensing programme and the original prescription.

Mr D advised that when the pharmacist dispenses a dose of methadone he or she initials the column "administered by" on the MDCS. Mr D explained that a "tick" is normally added by the pharmacist after pouring the dose, just prior to giving it to the patient. He stated:

> "During the administration process the patient's 'flag' which contains a copy of the current label is removed from the individual patient's box, checked against the [Methadone Dispensing Record] and placed into the dispensed doses box for that day after the doses have been given. The 'flag' would only be up if the patient was expected to receive a dose that day ... Absence of a flag would indicate a patient was not expected that day or had already been in. This is a double check that dosing details are accurate."

Mr D advised that when a methadone client comes into the Pharmacy the pharmacist is required to "positively identify" the client. The SOP for methadone dispensing stated: "The pharmacist confirms the identity of the patient. If the client is unknown to the pharmacist, the client must provide identification." Mr D stated:

[1] Mr C did not prepare the MDCS used on Day 11.

> "We have always been conscious of the inherent risks of positive identification of Methadone clients [where] a pharmacist is interacting with a patient on a daily basis. We had notices prominently displayed for both clients and pharmacists stating that positive identification was required. In addition to this, as detailed in both the [Standard Operating Procedure] and Incident Report, there were a series of separate and unavoidable steps in the process that required the pharmacist to verify that they had the correct person and the correct dosage."

Mr D provided copies of the notices referred to. One of the notices requested all methadone clients to "identify yourself by name to the pharmacist — you may be asked for ID". The other notice stated that the pharmacist should "always confirm identity — ask the client to identify themselves and if not known to you ask for ID". Mr D advised that these notices had been in place for "some considerable time", and he was confident that all pharmacists working at the Pharmacy would ensure that they identified each methadone client by asking them to state their name.

Ms F, manager of the Pharmacy, and Ms G, a pharmacist who was working one day a week at the Pharmacy, both confirmed that signs were in place prior to the incident. However, neither could recall any details of what was written on them. They advised that they believed that the notices asked the pharmacist to "identify patient". Further to this, Ms G advised that the procedures in place at the time of this incident only required the pharmacist to "clearly identify who the patient was, but it didn't specify how you should do that". Both Ms F and Ms G agreed that it was accepted practice, if clients were known, to greet them by saying hello and then stating their name. If clients were unknown they would be asked to state their name and, if necessary, provide photo identification. Ms F explained:

> "… you would greet each other, sort of, good morning or how are you today X, Y … if you didn't know them you'd obviously ask for ID. But most people you did know. And I'm not saying that they wouldn't say their names sometimes, but I think at that point really it was sort of a mutual identification process."

Mr D disagrees that it was considered acceptable to identify clients by recognition only. He advised that he had always been very clear with staff that they must "positively identify all patients" by asking the patient to state his or her address. Mr D also advised that the requirement for the pharmacist to ask patients to state their address was written in the pharmacy's general dispensing SOP ("Dispensing — Dispensing a prescription procedure").[2] This states that the client should be "positively identified by asking their address".

Mistaken identity

Mr C stated that on that day he thought Mr A was Mr H, and he greeted him by Mr H's first name. Mr C stated that Mr A must have known that he had been mistaken for

[2] Dated 15 May 2003.

another client. Mr C explained that Mr A and Mr H were "remarkably alike in appearance, build and mode of dress" and he had no reason to be concerned that he had not correctly identified Mr A. There were no "warning bells". Mr C explained:

> "I had seen [Mr A] about three times before the incident, but since I had seen him last he had had his hair shaven off. This made him appear to look even more like [Mr H]. I called him [Mr H's] name, and from his appearance he looked so much like [Mr H] I was certain he was [Mr H]."

Mr H was also a regular client at the Pharmacy. Mr H had been on the Methadone Programme since 7 November 2005. At the time of this incident Mr H was receiving 180mg a day as a "takeaway" dose. He had been receiving full-time takeaway doses for three days. Mr C had dispensed Mr H's takeaway dose the previous day. Mr H would generally pick up his dose between 2.30pm and 3.30pm each day.

Mr C let Mr A into the methadone room. He measured out Mr H's methadone dose of 180 mg. This was put into a 50ml bottle and diluted with water up to the 50ml level as was standard practice at the Pharmacy. The bottle was labelled with Mr H's name, the dose, and the total volume in the bottle. Mr C stated:

> "It is simply not possible that [Mr A] had not realised by this time I had misidentified him. [Mr A] was on a consume on premises dose and was not to get takeaway doses."

Ms F agreed that Mr A and Mr H looked very similar. Ms F advised that she had also recently made the same mistake in mixing up Mr A and Mr H. However, Ms F identified this mistake before she dispensed the methadone. Ms F did not report the incident and said that it was "just something that I made myself aware of and thought don't do it again".

Similarly, Ms G advised that she had also recently made a mistake of mixing up two methadone clients. Mr D advised that after this incident he reinforced to all staff the need to positively identify all clients.

Comment from Mr A's friend

Mr A's friend advised that when Mr A came out of the pharmacy he was in a hurry. Mr A told him that the pharmacist didn't ask him his name and "acted like he knew his face". He then said that the pharmacist made up the prescription and poured the methadone into a bottle. Mr A thought that was strange "as he normally has 30mg in the bottom of a cup and he has to drink it there". The pharmacist placed the bottle into a bag and gave it to Mr A. Mr A then left the pharmacy. Mr A's friend stated:

> "When we got away from the chemist [Mr A] pulled the bottle out and showed it to me. It was for someone with [a different surname]. I don't remember the first name but there was 180mgs of Methadone.

> I asked him what Methadone does to him and how much he normally has. He said it was like Opium and he normally had 30mg."

Mr A's death

Mr A returned to his flat by himself at approximately 1100 hours. Mr A's flatmate advised that when Mr A got home he went to bed and asked to be woken about half an hour later for his community service. His flatmate advised that when she tried to wake him he opened his eyes briefly, mumbled something, and then went back to sleep.

Another friend who was at Mr A's flat advised:

> "[B]ecause he did his programme we checked on [Mr A] every half hour. He appeared to be sleeping normally … I checked on him at about 2.30–2.45pm and he was shallow breathing. He was making sort of a gurgling noise. It all happened so fast. I just panicked and tried to help [Mr A]. He was not breathing."

The Police attended at approximately 2.50pm. CPR was commenced but discontinued as there were no signs of life.

Effects of methadone consumed

A toxicology report[3] later confirmed the presence of methadone at a level consistent with that reported for methadone-related fatalities in someone who had not developed a high level of tolerance. The toxicology report also confirmed the presence of moclobemide (an antidepressant) and zopiclone (a sleeping pill), which were detected at levels consistent with medicinal use. There was no evidence of any other drugs or alcohol.

The DHB advised that while Mr A would have had a degree of tolerance to methadone, this tolerance would not have extended to the consumption of a significantly larger dosage. The DHB Chief Medical Officer stated:

> "[The] (CADS Medical Director) notes that tolerance is not an all-or-nothing phenomena but occurs on a continuum, and in this respect [Mr A] would have a degree of tolerance to the actions of Methadone. A drug-naïve individual taking 30 mgs methadone a day would be likely to have excessive somnolence and appear drowsy. However, [Mr A], who was taking 30 mgs methadone a day on a regular basis through the Interim Methadone Prescribing Programme, had developed a tolerance to the sedative effects of methadone of that particular dose, in that there was no observable intoxication or sedation for the 30 mgs methadone. As was the case in this unfortunate situation, his tolerance did not extend to the consumption of methadone several times his usual daily dose."

[3] The toxicology report, dated 18 April 2006, was provided to the pathologist for the purposes of the Coroner's inquest. The report detailed those drugs detected in Mr A's blood.

Detection of error
Mr C recalled that Mr H attended the Pharmacy shortly after 3pm to collect his prescription. Another pharmacist served Mr H. Because Mr H's name had already been ticked off the MDCS as having received his dose, the pharmacist and Mr C questioned him. Once they were satisfied that Mr H had not already received his methadone dose, it was given to him. Mr C stated:

> "At the time I thought I must have ticked the wrong name off the list and made a mental note to check through the list. At this stage I did not connect this with [Mr A]. ... Before I had time to check the lists, the Police arrived to enquire about [Mr A's] death."

At approximately 4pm that day the Police attended the Pharmacy and questioned staff.[4] Police and pharmacy staff went through the video of clients from that morning. It was thought that Mr C had made an error in the identification of Mr H. However, as things were still unclear, a manual stocktake of methadone was carried out (Mr D stated that it was his suggestion to carry out the stocktake and that he subsequently carried this out). Mr C advised that to ensure they got an accurate picture as to what the stock should have been, he ticked Mr A's name off the MDCS.[5] Mr C stated:

> "As it was now obvious that [Mr A] had been in the morning, and to get as accurate picture as possible as to what our stock should have been, I would have then ticked off [Mr A's] name. The results of the stocktake were inconclusive.
>
> …
>
> As soon as I realised that an identification error had occurred I assumed full responsibility for that error."

Response from the Pharmacy
Following Mr A's death Mr D completed an incident report. In this report Mr D summarises his involvement immediately following the incident, including the completion of the stocktake. However, his report does not discuss any steps the Pharmacy took to prevent a similar incident from occurring again. The report states: "The Pharmacy has well documented procedures for methadone dispensing."

During an interview with this Office, Mr D confirmed that, following his review of the SOPs, he was confident that the systems in place at the time were sound and did not need to be changed. He stated:

[4] The exact timing of these events is unclear. However, the information we have received suggests that Mr H presented sometime between 3pm and 3.30pm and the Police arrived a short time later, at approximately 4pm.

[5] It is not clear whether Mr D was involved in the decision to tick Mr A's name off the MDCS.

> "… [M]y expectation was, and I am very clear about that, that when you are talking to somebody you are identifying them, how do you identify them. You ask their name. … I don't regard it as something that needs to be spelled out in minute detail in SOP. Identification, that is what the SOP says. What I have said is that you need to identify the person, so you get positive identification. …"

Mr D advised that all staff were reminded of the SOP and the "absolute need to positively identify all methadone clients".

Ms G advised that following this incident, while there was no formal analysis and review of the SOPs, all staff reviewed how they were dispensing methadone and were much more careful about asking every patient to identify themself. Ms F agreed, stating "… everyone was really quite shocked. So everyone was just far more careful."

Comment from Mr C
In light of this incident, Mr C reviewed his practice. He stated that he had always been very cautious in identifying clients but he changed his practice, always ensuring the client stated his or her name. If there was any question about the client's identity he asked for a date of birth and the methadone dosage, and might require ID. Mr C stated:

> "[the Pharmacy staff] always have required photo ID for new clients. We now require clients to state their names before dispensing for them. This has been written into our standard operating procedures."

Mr C advised that this incident had been extremely traumatic for him personally and professionally. He attended counselling and obtained support from family and friends. Mr C retired in 2007 and, after a period of poor health, died in 2008.

The DHB
On 4 May 2006 the DHB completed its sentinel event investigation. In its report the Chief Medical Officer concluded that there were no issues in relation to the care and treatment provided to Mr A for mental health issues or opioid dependence. He stated:

> "I consider the decision to place [Mr A] on the Interim Methadone prescribing programme was clinically justified and the process used to determine this outcome was consistent with the Ministry of Health publication Opioid Substitution Treatment: NZ Practice Guidelines 2003."

Medsafe review
Following this incident Medsafe audited the Pharmacy's standard operating procedures (SOPs).

The audit was completed on 10 May 2006 and it identified several concerns relating to the updating and clarification of procedures. It identified a high-risk area in relation to the identification of methadone clients. The report stated:

> "Almost 2 months after one client received another client's methadone takeaway dose the pharmacy has not instructed all pharmacists working with methadone clients on the steps now required to correctly identify each client.
>
> A report of the incident was written up but did not include what steps the pharmacy had taken to minimise the risk of this situation occurring again."

Medsafe required this issue to be addressed by 24 May 2006. Medsafe also identified that no changes had been made to the SOPs following this incident and requested that further detail was added to clarify the process of identifying a client. This was to be completed by 31 July 2006.

Ms G stated:

> "Medsafe raised the issue of clearly identifying each patient prior to giving out a dose. This recommendation was made immediately after the audit. I spoke to ALL pharmacists dispensing for us at the time and reinforced the need to get each patient to identify themselves and to never offer a name for confirmation. We put up signs to this end in the methadone room for both staff and patients.
>
> …
>
> When the full audit report came in we were asked to improve the section in the SOP that dealt with identifying the patient. This I did and forwarded a copy of the amended SOP to Medsafe."

The updated SOP is dated 25 August 2006. This states "confirm identity by asking client to give their name".

Pharmacy Council
On 19 June 2006, the DHB brought this incident to the attention of the Pharmacy Council, in accordance with the Health Practitioners Competence Assurance Act 2003.

In August 2006, the Pharmacy Council wrote to the Pharmacy requesting an update on the changes implemented since the incident. They also requested confirmation that all pharmacists involved in dispensing methadone at the Pharmacy were familiar with any new procedures implemented.

In response, the Pharmacy provided a copy of the new SOP for methadone dispensing. The Pharmacy also confirmed that all staff were familiar with the changes.

The Council then made additional recommendations to the Pharmacy's SOPs in accordance with the Opioid Substitution Treatment Guidelines. The recommendations related to clarifying the process of identifying the client, managing dispensing errors, tracking dispensed and missed doses, and managing changes to a methadone dose. The Pharmacy Council's report and recommendations were sent to the Pharmacy on 20

October 2006. Ms G advised that these recommendations were incorporated into the pharmacy's SOP at this time.

Mr C's competence
The Pharmacy Council was of the view "that the error made by Mr C is not an issue of competence, nor an issue to be referred for further investigation by a professional conduct committee". However, Mr C was reminded to be vigilant when identifying methadone clients and dispensing methadone.

Sale of pharmacy
In October 2006, Mr D sold the Pharmacy to Mr I. Mr D explained that the Pharmacy Council recommendations arrived after the sale of the Pharmacy but that he passed them on to Mr I. He stated:

> "[Mr I] was fully aware of the incident with [Mr A] and of the subsequent Medsafe and Pharmacy Council recommendations."

Mr D also added:

> "As this incident occurred several months before [Mr I] even approached me to purchase the Pharmacy I saw no reason to place any emphasis on this incident except to emphasise to [Mr I] the importance of pharmacists taking great care to positively identify methadone clients. I also informed him that I understood that [Mr A's] family had publicly indicated that they would refer the matter to HDC and that we may need to access both written and computer records relating to this incident."

Ms G advised that she discussed the incident with the new pharmacists working at the Pharmacy. Ms G said that she reinforced to them the need to be very careful about asking clients their name, rather than just greeting them with the assumption that you know who they are.

In contrast, Mr I advised that Mr D did not inform him of Mr A's death and he did not become aware of what had occurred until it became headline news in the newspaper. Mr I advised that he raised this with Mr D but that this was "brushed off as being inaccurate reporting by the [newspaper] and that the pharmacy has done nothing wrong — only an individual has".

Mr I advised that the Pharmacy is currently using SOPs not dissimilar to the updated SOPs used at the Pharmacy prior to its change of ownership. However, Mr I was updating this process, including the introduction of colour photographs for every existing and new client attached to the methadone prescription.

Response to provisional opinion

Mr D

In response to my provisional opinion, Mr D stated that he "emphatically denies" that it was acceptable to identify a client by recognition only. Mr D's lawyer stated that "every person who worked at the Pharmacy and who [Mr D] has been involved with, either as a student, a colleague or an employee, has had personal instruction from him on the vital importance of positive identification …". He advised that "[Mr D's] instruction, and method of practice, was to always seek to positively identify a patient; Mr D trained staff to ask each patient what their address was".

Mr D reiterated his belief that "all staff had been trained appropriately" in how to identify patients and that adding further detail to the SOP was unnecessary. He stated that the process for identifying the client was "self-evident" and he does not believe that "an SOP which spelled out the actual method of obtaining identification would have made the slightest difference in this case". Mr D said that "there is no substitute for good practice by pharmacists and for … one-to-one instruction on obtaining positive identification".

Mr D acknowledged that the written SOP lacked detail in the identification process but he argued that staff had been trained appropriately in this regard. He said that while it was not documented, clear guidance had always been provided.

Mr D's lawyer stated that they felt that the description of Mr D's incident report was "unfair and unnecessary". The incident report was written as a "report of the incident itself". He advised that following the incident Mr D did review the SOPs and "determined that the best way of ensuring that such an event did not occur again was to reiterate, in no uncertain terms, the necessity to get a methadone patient positively identified".

Mr D commented that it was Mr C's responsibility to identify the patient before giving the dose of methadone. He advised that Mr C was not following the steps that were standard practice in the pharmacy at the time.

In relation to the lack of handover to the new proprietor of the Pharmacy, Mr D reiterated that Ms G did discuss the incident with the new pharmacist. Mr D "emphatically denies brushing the incident off".

Mr C

Mr C's lawyer responded on behalf of Mr C and his family. Mr C's lawyer felt that as the actual sequence of events is unclear, expert advisor Ms Jensen's criticism that Mr C should have started checking the MDCS sooner may be unjustified. Mr C's lawyer brought to my attention Mr C's statement in which he said: "… I had just settled down to try and work out what had gone on and the Policemen came and it didn't take very long to figure out after that."

Independent advice to Commissioner

Expert advice was obtained from pharmacist Maree Jensen. See Appendix A.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with a reasonable care and skill.

Opinion

This report is the opinion of Rae Lamb, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

Opinion: Breach — The Pharmacy

Mr C mistook Mr A for Mr H. Both Mr A and Mr H were methadone clients of the Pharmacy but Mr H usually received a 180mg takeaway dose while Mr A received 30mg of methadone, which he was required to consume on the premises.

When Mr A presented to the Pharmacy at approximately 9am, Mr C did not ask him to identify himself and greeted him by a first name. It appears Mr C was mistaken because Mr A and Mr H looked similar. Mr C measured out the methadone dose of 180mg into a takeaway bottle and gave it to Mr A.

As indicated earlier, the investigation into the actions of Mr C was discontinued in December 2007, after taking into consideration his acceptance of responsibility for his mistake, his health, and Ms Jensen's advice. This report focuses on the responsibility of the pharmacy to provide Mr A with services with appropriate care.

Procedures

The safe and effective provision of prescription drugs encompasses several basic principles. While the competence of the pharmacist is vital, the system under which he or she is are operating also plays an important role. Written Standard Operating Procedures (SOPs) provide the minimum requirements for dispensing medication and are central to ensuring safe and effective dispensing. They are particularly important when dealing with patients on methadone because of the inherent risk associated with patients with a history of addiction.

Each pharmacy is responsible for developing its own SOPs in accordance with the relevant standards. Therefore the SOPs in place at the Pharmacy were unique to that pharmacy. At the time of this incident, the SOP for methadone dispensing required that the pharmacist "confirms the identity of the patient". In the event that the client was unknown to the pharmacist, the client was required to provide identification. This SOP document did not include any further detail about how this should be established, although the SOP for general dispensing stated that clients should be identified by asking for their address.

In addition to the SOPs, Mr D advised that he had always made clear to staff the need to "positively identify" all clients by asking their name or address. He advised that all staff had recently been reminded of this requirement following an error by another staff member. Mr D advised that signs were also in place reminding the pharmacist of the process to identify clients by asking them to give their name. However, while it has been confirmed that signs were in place prior to the incident, staff who worked at the Pharmacy at the time of the incident, including Mr C, did not recall whether they stated how identification should be confirmed.

Mr D may believe that the requirement to identify clients by asking them to state their name or address had been made clear to staff. However, I have been advised by three senior staff members that it was accepted practice to identify the client by recognition, and it was only necessary to ask clients to identify themselves when they were unknown to the pharmacist. In the circumstances, I am not convinced that pharmacy staff had been given clear enough guidelines or instruction on how to confirm the identity of the patient.

My expert advisor, Ms Jensen, had similar concerns. She did not consider the Pharmacy had adequate procedures in place for the identification of methadone patients. She stated:

> "It is generally accepted that best practice is to ask the patient whose medication they are waiting for, and to be asked the address, or date of birth as a more reliable indicator of patient identity."

She viewed the lack of clear direction regarding patient identification in the Pharmacy's SOPs with moderate disapproval.

Conclusion
When dispensing methadone, a pharmacist must ensure they are dispensing it to the correct patient and that it is appropriate for that patient. However, it is the responsibility of the pharmacy to ensure the relevant professional standards are met. This is in part achieved through the development and implementation of SOPs. It is not enough to rely on reminders to staff to be vigilant, particularly in a busy pharmacy dispensing methadone to up to 100 clients. Clear written guidance and instruction is needed, with systems for identifying patients to reduce, as much as possible, the potential for human error.

It has been said that "all systems are perfectly designed to achieve the results they get".[6] The Pharmacy's system largely relied on individual staff determining, in the first instance, whether they recognised someone. The fact that both Ms G and Ms F had also previously mixed up methadone clients, testifies to the need to remove any subjective judgement from the system and provide detailed written instruction.

In this case, Mr D has argued that while it was not documented, clear guidance was given to staff. He has acknowledged that the SOP for methadone dispensing lacked detail regarding the identification process but he maintains that staff had been appropriately trained. Nevertheless, it appears that Mr C and two other similar staff had a different understanding of the requirements.

In light of this, and having carefully considered the advice of my expert, the Medsafe audit findings, and the Pharmacy Council's review, I consider that the Pharmacy did not have an adequate SOP for methadone dispensing at the time of this incident. In particular, the Pharmacy did not have adequate procedures in place for identifying patients, or for ensuring staff were given appropriate guidance and instruction about how to ensure the identity of patients. Therefore, in my view, the Pharmacy breached Right 4(1) of the Code.

Other comment

Actions taken by pharmacy
Following the incident, Mr D completed an incident report. He did not make any changes to the Pharmacy SOPs, as he was confident that there had not been a systems error. He stated:

> "[W]e believe that our Standard Operating Procedures and policies were complete and effective … there were a series of separate and unavoidable steps

[6] Dr Don Berwick, CEO, Institute for Healthcare Improvement, Boston.

> in the process that required the pharmacist to verify that they had the correct person and correct dosage."

However, the Medsafe audit completed on 10 May 2006 raised concern that "[n]o changes had been made to SOP following a serious incident on [Day 11]". Medsafe recommended that more detail for identifying clients be incorporated into the Pharmacy's SOPs. This recommendation was required to be completed by 31 July 2006. The report also stated:

> "Almost 2 months after one client received another client's methadone takeaway dose the pharmacy has not instructed all pharmacists working with methadone clients on the steps now required to correctly identify each client.
>
> A report of the incident was written up but did not include what steps the pharmacy had taken to minimise the risk of this situation occurring again."

In accordance with these recommendations, the Pharmacy changed the SOP for methadone dispensing so that the pharmacist was required to "confirm identity by asking client to give their name". This was completed on 25 August 2006. Ms G confirmed that she ensured that all dispensing staff were clear about the process for identifying clients.

I am disappointed to see that the Pharmacy was not proactive about improving the SOP covering methadone dispensing procedures following the death of Mr A. While an incident report was completed, there was no analysis of the reasons for the incident or recommendations for improvement by the pharmacy. I am concerned that Mr D still does not consider that there was anything wrong with the SOP. Mr D's statement (in response to my provisional opinion) that the SOP was "self-evident" leaves me with some disquiet that he still does not fully grasp the point being made about the importance of having clear written guidelines and detailed instruction in place for staff. However, I agree that it needs to be backed up by training, and note Mr D has indicated that the SOP will now be amended.

Handover of pharmacy

At the completion of the Pharmacy Council review, further recommendations for clarification of the Pharmacy's SOPs were made. These were based on the 2003 Opioid Substitution Treatment New Zealand Practice Guidelines (the Opioid Substitution Treatment Guidelines). These recommendations were sent by the Pharmacy Council to the Pharmacy in October 2006, at the same time that the Pharmacy was going through a change of ownership.

The new proprietor of the Pharmacy advised me that he was unaware of the incident involving Mr A until it became headline news. Mr D denies this. He advised that he discussed the matter with the new proprietor, emphasising the importance of positive identification — although he "saw no reason to place any emphasis on this incident". He also stated that Ms G had detailed discussions with the pharmacist in charge of the

new business and considered she had made them aware of the problems. I am unable to establish what information was discussed between Mr I and Mr D. However, Mr D had a clear responsibility to ensure that the new owner was aware of these events and knew of the changes that needed to be made.

Preparation of methadone
Ms Jensen advised that the Opioid Substitution Treatment Guidelines state that nothing should be added to the commercial preparation of methadone before giving the dose to the client. The Pharmacy SOPs stated:

> "The dose is measured into a cup and diluted to approximately 50ml with water."

Mr D advised that colouring is added as a safety consideration to ensure that it is not mistaken for water.

Ms Jensen advised that, while this may have been the accepted standard for CADS in the area or the Pharmacy, it is not accepted practice under the Opioid Substitution Treatment Guidelines. However, Mr D believes that adding the colouring for safety reasons is "more important".

I plan to draw this to the attention of CADS.

Action taken

- Following the Medsafe review, the Pharmacy made changes to the SOPs to ensure that a pharmacist always asks the patient his or her name. Under the new ownership, photo identification is requested if the patient is unknown to the pharmacist.
- The Pharmacy Council recommendations were implemented into the SOPs of all pharmacies owned by the Group.

Recommendation

I recommend that Mr D apologise to Mr A's mother, Ms B, for the Pharmacy's breach of the Code. The apology is to be sent to this Office and will be forwarded to Ms B.

Follow-up actions

- A copy of this report will be sent to the Pharmacy Council of New Zealand, the Ministry of Health, and the District Health Board.

- A copy of this report, with details identifying the parties removed, will be sent to the Pharmaceutical Society of New Zealand and the Pharmacy Guild of New Zealand, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

APPENDIX A

Report by pharmacist Maree Jensen — First report

I have been asked to provide a report to the Health & Disability Commissioner on case number 06/17949 as an independent advisor.

I have read, and agree to follow the Commissioner's Guidelines for Independent Advisors.

I have no personal or financial connection with the provider or the consumer making the complaint. I have not worked with the provider or with the pharmacists named in the complaint.

I am a registered pharmacist, Pharmacy Council registration number: 4620, and registered with the Pharmaceutical Society of New Zealand in 1974.

Currently I am the proprietor of a community pharmacy in Mt. Roskill, Auckland; which has a large number of clients under the Auckland Regional Alcohol & Drug Service (Methadone Clients). My Pharmacy has been dispensing Methadone to opioid addicted clients in Auckland for several years. I completed a post graduate certificate in Opioid addiction at the Auckland School of Medicine in 2000. I also taught General Practitioners, Pharmacists & Practice Nurses in the Goodfellow Unit Opioid Substitution training programme which ran from 2001–2005.

I am also employed (0.8 FTE) at the School of Pharmacy, University of Auckland as a senior tutor in Pharmacy Practice. My teaching commitments are coordinating a 4th year paper: Professional Pharmacy Studies, and teaching the dispensing laboratory component of the Integrated Pharmacy Studies Paper, also for 4th (final) year students.

[At this point Ms Jensen refers to the information provided by this Office. This information has been omitted for the sake of brevity. Ms Jensen then asks a number of questions. The questions and answers are set out in her subsequent report after additional information had been obtained. Accordingly, this section has been omitted to avoid repetition.]

…

Answers to the Commissioner's Questions:

In your professional opinion were the services provided by [Mr C] and [the Pharmacy] appropriate?

The services provided by [Mr C] were of an appropriate level, given that he was working under the SOPs that operated in [the Pharmacy] at that time. [Mr C] was not employed full-time by this pharmacy, and could not be expected to remember the name and appearance of all the methadone clients at this pharmacy.

The services provided by [the Pharmacy] were not, in my opinion, of an appropriate level. It appears from the reports and documentation provided that the systems and SOPs in place were not of an adequate level to provide a safe working environment for the pharmacists employed by [the Pharmacy], or to provide a safe service to the clients of this pharmacy, for methadone dispensing services. Staff training and implementation of SOPs were not complete or carried out with all staff. It would be appropriate for staff involved in providing services such as methadone dispensing to be involved in the maintenance and development of SOPs to be used in that pharmacy. [The Pharmacy] did not seek input from the pharmacists involved in providing a significant part of the operations of [the Pharmacy] in developing their SOPs.

Training sessions for regular pharmacists should be mandatory to detail existing SOPs and develop new and revised SOPs. A manual of changes & SOPs to be initialled once sighted would be useful at commencement of a shift for locum or new pharmacists.

Providing methadone services appeared to be a significant part of the business of [the Pharmacy], therefore training about systems for safety should have been optimised.

The 'rack' system described sounds as if it could have been modified to include a copy of the photo ID of the client, plus the prescription (or a photocopy of them both) to aid in determining both the correct dose of methadone and ensuring that the correct dose goes to the correct client.

What standards apply in this case?

The standard that applies in this case is the responsibility of the pharmacist to ensure the identification of the patient before giving the dose of methadone, according to the 'Opioid Substitution Treatment: New Zealand Guidelines 2003'.[7]

Other standards that apply in this case are from the Pharmacist Code of Ethics:[8]

Principle 2: Optimise Medicines Related Health Outcomes

Principle 3: Prevent Harm to patient and the Public

Were those standards complied with?

The Opioid Substitution Treatment Guidelines were not complied with as the pharmacist did not clearly identify the patient before supplying the methadone to [Mr A].

I note that these guidelines also state that nothing should be added to the commercial preparation of methadone before giving the dose to the client. [The Pharmacy] added dye to the mixture, and also diluted the volume to 50ml before dispensing or issuing to

[7] Refer to the Ministry of Health website: www.moh.govt.nz

[8] This refers to the Pharmacy Council of New Zealand, Code of Ethics, 2004.

the patient. This may be local standards for CADS in [the area], but is not accepted by these guidelines.

In my opinion, Principles 2 and 3 of the Pharmacist Code of Ethics were also breached.

Patients will often agree with any name when addressed as they may not hear the name called when initially spoken to. It is generally accepted that best practice is to ask the patient whose medicine they are waiting for, and to be asked the address, or date of birth as a more reliable indicator of patient identity. I note that the amended [the Pharmacy] SOP discusses asking the patient their date of birth, which is a useful second means of identifying the client.

Did [Mr C] take appropriate steps to identify [Mr A]?

No, [Mr C] did not clearly identify [Mr A] before issuing [Mr H's] methadone. In my opinion, however, [Mr C] took the steps that were standard practice in [the Pharmacy] at that time.

What responsibility should a patient take to ensure they receive the appropriate medications?

The patient does have responsibility to ensure that they take medicine that is intended for him. It would seem from [Mr A's] medical history that he may well have had impaired judgement, and impulse control. The history also mentioned suicidal ideation, so that may have further preventing him from pointing out to the pharmacist that he had received the incorrect medication.

In my opinion [Mr A's] responsibility was diminished because of his state of health at the time.

Did [Mr C] respond appropriately when he became aware of the error?

[Mr C] appears to have acted inappropriately in ticking off the wrong name immediately before the stock check. However in his statement he clearly admits that he made an error and takes responsibility for that error. In my opinion he did respond in an appropriate manner when he became aware of the error.

Should [Mr C] have identified the error with [Mr A's] methadone earlier?

[Mr C] should have identified the error when [Mr H] presented at 3pm and his dose had already been ticked as given out. The 'flag' in the racking system should have also been lowered. This should have alerted [Mr C] to the fact that he needed to clearly check who had been given a dose, and who had not. In my opinion [Mr C] should have started checking actual doses (perhaps from the dispensary computer, unless the label & prescription was actually dispensed off the system at the start of shift, or some other time as to make checking difficult). It would be better practice to only put the methadone prescription through the dispensary computer when the client presented, to enable a time check as to what was dispensed and to whom.

Please comment on whether [the Pharmacy] SOPs were adequate?

In my opinion [the Pharmacy's] SOP with respect to Methadone Dispensing procedures was inadequate at the time of the incident. It appears that standard practice was the de facto SOP for identifying methadone clients.

Do you consider the action [the Pharmacy] took following this incident was adequate?

[The Pharmacy] did not take adequate steps to ensure safety of clients (and staff) following this incident. When SOPs had been changed, they were not fully implemented as they were not disseminated to all staff.

[Mr C] did not provide an appropriate standard of care to [Mr A]. I view his conduct with mild disapproval in that he did not follow up sooner the possibility of a dispensing or identification error.

[The Pharmacy] did not provide an appropriate standard of care to [Mr A]. I view this conduct with moderate disapproval.

I severely disapprove of the lack of follow up of SOP change implementation following the seriousness of the outcome for [Mr A], and the lack of communication to the new proprietor of this business about the incident.

…

[At this point Ms Jensen makes further comments in relation to the methadone dispensing sheets. Ms Jensen has addressed these issues in her additional report. Accordingly, this section has been removed to avoid repetition.]

In my opinion, this process of dispensing methadone and recording what was dispensed to whom and when is not appropriate for safe and effective provision of methadone to clients.

Further advice from Ms Jensen

[The following are questions Ms Jensen raised in her initial report. The answers are Ms Jensen's responses to these questions following the receipt of additional information.]

Further Comment with Respect to Additional Information Provided:

1. *[Mr A] was admitted to the 'Interim Methadone Programme' at CADS in [the area]. (In future, referred to as CADS). I am unsure as to what level of service this provides with respect to [Mr A] and his Methadone treatment.*

   (From information provided by [the] DHB) The interim methadone prescribing programme is a means of stabilising patients whilst awaiting a place on the MMT programme with [the local] CADS. This programme is administered, and prescriptions are provided by a named GP, who is the GP for that patient, and also is responsible for the day-to-day health needs of the patient.

2. *[Dr E], the prescriber of methadone for [Mr A], is authorised to prescribe as a GP under the supervision of the specialist service of CADS. Did [Dr E] also prescribe other medicines to [Mr A]? The toxicology report stated presence of several psycho-active drugs, Moclobemide and possibly Zopiclone. These medicines also taken by [Mr A] could have contributed to the toxicity of the methadone.*

   As above, [Dr E] was the GP for [Mr A]. According to [a record of [Mr A's] prescription medications], [Mr A's] regular medications included moclobemide & zopiclone. The medical records for [Mr A] from [Dr E] indicate that the last prescription for [Mr A], apart from methadone, was for 14 zopiclone tablets on 10th February 2006, for 14 tablets (7 days supply). This would have been exhausted by the time of [Mr A's] death, I did not find any records of recent prescriptions for moclobemide from [Dr E].

3. *Was [Dr E], as prescribing GP, given guidelines for [Mr A's] dose and treatment regime, or was he asked to prescribe a specific dose, for a specific period of time, to be consumed under observation only? Was [Mr A] a 'stable' or 'unstable' patient? I shall assume that he was regarded as unstable as he had only been prescribed methadone for a period of 10 days before this incident, and no takeaways were listed on the methadone dispensing sheet provided by [the Pharmacy]. [Mr A] may or may not have had a degree of tolerance to methadone because of his addiction history — what his consumption of opioids was when he presented to CADS.*

   [Dr E] was given very clear, explicit guidelines as to the range of doses and consumption schedule for [Mr A]. My question as to the 'stability' of [Mr A] was because of my lack of knowledge about the Interim methadone programme in place in [the area]. [In [[another]] CADS, patients are scripted from CADS until deemed to be 'stable' and capable of being managed safely in the community by their GP.] As [Mr A] was not a daily opiate injector (due to lack of funds, possibly also to lack of opportunity) according to his notes, he had a low tolerance to a large dose of methadone. His stated history was that of a regular, opportunistic opioid user, rather than regular daily use.

4. *Was [Day 1] the first dose of prescribed methadone for [Mr A], or the first dose at that pharmacy? I shall assume that [Day 1] was the first dose, for this treatment episode ([Mr A] may have been in methadone treatment at an earlier time).*

   It appears from the information provided that [Mr A] was given his first dose of oral methadone on [Day 1]. His dose increased quickly from 0mg to 30mg over 3 days, in 10mg per day increments, with a missed dose on [Day 7] (3 days before his death). It takes 3 days to establish a regular blood level of methadone after a missed dose, so [Mr A's] tolerance to even the 30mg dose would still be less than expected.

On [Day 11], it appears that no staff was present in [the Pharmacy], apart from [Mr C], until the afternoon. This would not appear to be safe practice, as the methadone dispensing area is separate from the main pharmacy, and if [Mr C] was busy dispensing methadone then [the Pharmacy] would be unattended.[9]

5. *[Mr C] should have had the opportunity to sight a photo, or some other form of identification for methadone clients, as he did not work in [the Pharmacy] every day … [Mr C] said that he was employed 20 to 30 hours a week by the […] group of pharmacies, and that his main place of employment was [the Pharmacy]. From this I assume that [Mr C] had dispensed to [Mr A] on several occasions between [Day 1 and Day 11]. If [Mr C] was involved in preparation of the methadone dispensing sheets, hopefully he would have had the opportunity to see some sort of photo identification of [Mr A].*[10]

   [Mr C] dispensed methadone to [Mr A] on 2 previous occasions, [Days 6 and 8], and should have been made aware of [Mr A's] missed dose on [Day 7]. It would be best practice for pharmacies dispensing methadone to clients using an Interim Methadone Programme such as this to contact the prescriber or Interim Programme manager when a client misses a prescribed dose of methadone.

6. *Were both [Mr A] and [Mr H's] name ticked off the signing sheet at the time of the stock check, at 4pm, or was [Mr H's] name ticked when his dose was given to [Mr A]? It would not be good practice to tick names off the signing sheet at a time different to the time of dispensing. I find that producing a label or dispensing the item in the dispensary computer is a useful check of the time that someone actually collects their dose of methadone.*

   [Mr D] indicated in his letter that the 'ticks' on the MDS were done when a dose was poured prior to consumption.

7. *It would be useful if [the Pharmacy had] produced a copy of their notice requesting 'Positive Identification' as then I would know what this actually meant — were examples, such as 'photo ID' or similar used, or merely the term 'positive identification', as this is not a precise phrase.*

   [Mr D] has supplied copies of notices used in [the Pharmacy] at the time of the incident. The methadone checklist says to confirm identity, and ask for ID if the client is not known to you. Future notices could include a mention of type of ID. The methadone dispensing procedure (for the client) asked the client to identify themselves by name. It would appear that this did not happen.

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[9] There were two other staff present in the pharmacy; Mr C was the only pharmacist in the morning.

[10] Mr C was not involved in the preparation of the methadone dispensing sheets.

8. *How many pharmacists were employed in [the Pharmacy] when the SOPs were changed, after the incident? It would have been good practice to have a list of those pharmacists that attended the training or implementation session where new SOPs were introduced to the staff. This could have ensured that all pharmacists employed in [the Pharmacy] had been made aware of changes or new policies and procedures.*

   Mr D states in his letter of 11th July 2007 that he is not able to ascertain when the notice about enquiring about date of birth as a means of identification was displayed in [the Pharmacy]. He states in his letter of 15th August 2007 that [Ms G] discussed with the pharmacists at [the Pharmacy] that dispense methadone that patients must identify themselves. He has made no comment about introducing changes to SOPs with staff pharmacists.

9. *It remains unclear whether [Mr D] notified the new proprietor of [the Pharmacy] about the recommendations made to him subsequent to this incident.*

   [Mr D] states in his letter of 15th August that he discussed the incident with [Mr I] at the time of the incident, but not at a later stage. He also indicated that he discussed positive identification of methadone clients with [Mr I] at the time of the incident.

10. *There is a space on the top right hand corner for a signature — did this person take responsibility for all the dispensings on the sheet — it is only present on the top sheet.*

    The copy of the prescription shows the dispensing dates, the patient charge report shows the dispensing dates as recorded on the dispensary computer and the letter from [Mr D] (dated 15th August 2007) indicates who dispensed the methadone doses for [Mr A] from [Day 1 to Day 11] inclusive.

11. *What happened to the sheets — is the total filled in to the controlled drug book. Where were the sheets stored once they were completed?*

    [Mr D], in his letter of 15th August does not refer to the Controlled Drug register. I assume that the pharmacist who was working a particular shift would enter out of the CD register the methadone that they had dispensed during their shift. Consequently I assume that [Mr C] signed the methadone out of the register. [Mr D] states that the MDS sheets are stored in monthly groups, and would be easily accessible for further sighting or checking purposes, if necessary. I would like to remind [Mr D] of a recommendation from the Pharmaceutical Society of some years back advising storage of documentation regarding controlled drugs that included patient names to be stored under lock and key, preferably in the controlled drug safe, in order to [keep] this information remaining confidential.

12. *The doses initialled and ticked by '[C]' (I assume [Mr C]), did he also sight the original prescriptions?*

    I note [Mr D] reports that [Mr C] worked off the MDS record, prepared by a pharmacist working off the original prescription, but that [Mr C] would sight the original prescription if there were any questions. As there was no report of any question until the presentation of [Mr H] for his methadone dose, I assume that the original prescription was sighted by [Mr C] at that stage.

13. *Changes on the MDS were not countersigned by anyone.*

    Only one pharmacist was present so countersigning by a second 'pair of eyes' not carried out, or part of protocol.

14. *When were the MDS sheets prepared — the previous day? Did that person sight all the original prescriptions?*

    The person preparing the MDS sighted the original prescriptions, according to [Mr D].

15. *The SOP (S22.07 on the Methadone SOP) for preparing the MDS was not provided. It is unclear as to who had responsibility for this.*

    No comment from [Mr D] with respect to preparation of MDS SOP.

16. *When were prescriptions for methadone entered into the dispensary computer system? It is not clear from the reports or the SOP provided what the usual practice was with respect to this.*

    It appears from the computer record patient charge report that the prescriptions were put through the dispensing computer, but it is not clear from [Mr D's] letter who did this, or when. Ideally this would happen at around the time of the dispensing or consumption of observed dose.

Further advice from Ms Jensen

[Ms Jensen was asked to provide further comment following the completion of interviews with relevant parties. Following is Ms Jensen's report.]

Further Advice to the Commissioner after reading further information provided. (Transcripts of 4 interviews — [Mr D], [Mr C], [Ms G] & [Ms F].)

I wish to confirm my opinion on this matter, with respect to [Mr C]: I view his conduct with mild disapproval.

[Mr C] did not provide an appropriate standard of care to [Mr A] on the day of this unfortunate incident. It appears clear from the transcripts of the interviews that [Mr C] provided a service that was common practice in this pharmacy. It may have been a

deviation from the Standard Operating Procedure (SOP) of [the Pharmacy] (if one were to assume that 'positive identification' included sighting a photograph or photo-identification of the client), but this does not appear to have been expressly stated in the SOP.

[Mr C] clearly regrets this dispensing error. I note that further investigation into the care provided by [Mr C] has been discontinued, with which I concur.

I wish to confirm my opinion with respect to [the Pharmacy]. I view with moderate disapproval the conduct of [the Pharmacy] with respect to the reliance of standard practice as compared to best practice with respect to the SOP for identifying a methadone client. The SOP for this should state 'photo' identification if this is the intention.

However, I view with major disapproval the conduct of [Mr D] with respect to the handling of the process and staff issues after [Mr A's] death. It would have been appropriate for the designated 'owner' of [the Pharmacy] to take responsibility for the processes as the responsible pharmacist. [Mr D] should have contacted all staff members as soon as possible after he was aware of the incident and called a staff meeting to discuss the incident. At this staff meeting there would have been opportunity for all staff to be aware of the intent of the SOP and to amend the processes to include photo identification as [Mr D] stated that was his intention.

I also view with severe disapproval that [Mr D] did not see fit to inform the new purchaser of [the Pharmacy] of the 'incident'. [Mr D] left discussing issues around methadone dispensing and this dispensing error to the employees of his pharmacy, instead of taking responsibility of 'handing over' [the Pharmacy] and any outstanding issues to the new owner. I find this attitude does not fit into what I see as a duty of care for a pharmacist. I am disappointed that he finds this to be acceptable behaviour.