A Pharmacy

Pharmacy Owner, Mr E

Pharmacists, Ms C and Ms D

A Report by the

Health and Disability Commissioner

(Case 01HDC06336)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Parties involved

Master A	Consumer
Mrs A	Complainant / Consumer's mother
Dr B	Specialist Physician
Ms C	Provider / Pharmacist
Ms D	Provider / Pharmacist
Mr E	Provider / Owner of the pharmacy
Mr F	Lawyer for Ms D
Dr G	General Practitioner
Mr H	Independent pharmacist
Mrs I	Pharmacy technician
A Pharmacy	Provider

Complaint

On 20 June 2001 the Commissioner received a complaint from Mrs A about services provided to her son, Master A, by a pharmacy. The complaint was:

- *In April or May 2001 the pharmacy dispensed 20mg prednisone tablets for Master A. The prescription from Dr B had stated that Master A was to take two 20mg tablets once daily. The pharmacy placed incorrect instructions on the medication bottle, that Master A was to take two 20mg tablets twice daily. Master A became unwell as a result of taking twice the prescribed dose for approximately two months before the error was noticed.*

An investigation was commenced on 24 August 2001. On 17 January 2002 I extended my investigation to include pharmacist Ms C. On 18 February 2003 I extended my investigation to include pharmacist Ms D.

Information reviewed

- Complaint letter from Mrs A
- Response, incident book and prescription records from Mr E
- Response from Ms C
- Response from the lawyer, on behalf of Ms D
- Prescription records from HealthPAC
- Relevant medical records from Dr B
- Relevant medical records from Dr G
- Information from the Pharmaceutical Society

Independent expert advice was obtained from pharmacist Ms Eleanor Hawthorn.

Information gathered during investigation

Overview
This complaint concerns a dispensing error which resulted in Master A taking twice the dose of prednisone prescribed by Dr B. I have been supplied with conflicting information about when the error occurred, who was responsible for it, and what the cause was. In my view, the error was made by pharmacist Mr E on 28 February 2001, when he dispensed Master A's prednisone medication from Dr B's prescription. The error was then perpetuated when Master A was dispensed a repeat of the medication on 24 March 2001 without the original prescription being sighted. I do not accept Mr E's contention that the error occurred on a later date (24 March and in April) by other pharmacists. The evidence points to the error originally occurring on 28 February.

Background
Master A, who was 15 years old at the time of these events, suffers from mesangioproliferative glomerulonephritis, a serious medical condition affecting his kidneys. Master A is treated with prednisone (a steroid medication) at varying doses, under the supervision of his general practitioner, Dr G, and Dr B, a specialist physician in internal medicine and nephrology.

On 29 November 2000 Master A attended a clinic with Dr B at the Medical Outpatients Department at a public hospital. As Master A had completed a six-month course of prednisone with successful resolution of his symptoms, Dr B decided to cease prednisone and review Master A's progress in three months' time.

On 19 January 2001 Master A's general practitioner, Dr G, reintroduced prednisone treatment and prescribed 40mg once daily for one week followed by 30mg once daily for one week, reducing to 20mg daily thereafter (Appendix 1).

On 27 February 2001 Dr B reviewed Master A's progress. He noted that Master A was again experiencing problems relating to his medical condition, including significant leg oedema (swelling). Dr B prescribed prednisone 40mg daily. His prescription (Appendix 2), dated 28 February, stated that Master A was to take "40mg od [daily] for 8/52 [eight weeks]". Dr B arranged to review Master A in another three months.

Dispensing error
Mrs A, Master A's mother, took Dr B's prescription to the pharmacy on 28 February. As there are no 40mg prednisone tablets, it is necessary for pharmacists to dispense sufficient smaller dose tablets, for example 2 x 20mg tablets. Proprietor and pharmacist Mr E, who dispensed the prescription, endorsed it for two supplies of 56 tablets (ie, 2 x 20mg tablets) and dispensed the first 56 tablets, along with the final repeat of prednisone from Dr G's prescription of 19 January. The certified repeat copy from which Dr G's 19 January prescription was dispensed is attached as Appendix 3. The repeat copy document was generated by the pharmacy.

On 24 March 2001 the repeat from Dr B's 28 February prescription (again generated by the pharmacy) (Appendix 4) was dispensed at the pharmacy by pharmacist Ms D.

The pharmacy is registered as a company and has two directors, one of which is Mr E.

Error detected

Mrs A advised me that some time in April 2001 (she can no longer recall the exact date) she noticed that Master A was nearly out of prednisone. As he was not due to see Dr B she telephoned their general practitioner, Dr G, for another prescription. She told Dr G that the instructions on the pill bottle stated that Master A was to take two 20mg tablets twice daily and that the prescribing doctor was Dr B. Dr G advised her that this was the incorrect dose. According to his correspondence from Dr B, Master A was supposed to be taking 40mg once daily.

Dr G advised that he also spoke "to someone at the pharmacy", who confirmed that Master A had been incorrectly dispensed 40mg of prednisone *twice* daily. Dr G wrote a prescription for prednisone (Appendix 5) that stated Master A was to take two 20mg tablets once daily. However, because Master A had been inadvertently taking a high dose of prednisone, Dr G arranged with the pharmacist at the pharmacy a reducing regime until Master A reached the correct dose of 40mg daily. Dr G advised me that his conversation with Mrs A was on 5 April, and provided me with a copy of the contemporaneous note, recorded in Master A's medical notes on that day, which confirms this conversation.

Mrs A also telephoned the pharmacy about the error and advised that when she went to the pharmacy later that day to collect Master A's prednisone she was asked by "the Manager [Mr E] how [Master A] was". She told him that as a result of Master A being on the higher dose of prednisone, "he was having terrible pains in his stomach, very tired, lack of appetite, his eyes weren't able to focus, having blurred vision, wasn't feeling well, also a very pink, pink face". Mrs A stated that Mr E said: "My face is also pink." He told Mrs A that "they" had misread the dosage and the computer had not picked it up.

On 11 April Mrs A and Master A saw Dr B at the Outpatient Clinic. Following this consultation Dr B wrote to Dr G:

> "[Master A] was reviewed today having had a successful clinical response to a high dose of prednisone which was unfortunately prolonged at a very high dose for longer than I have planned and with your input he is now reduced down to 60mg and soon to be reduced to 40mg daily. He has suffered the usual and expected side effects of this prednisone therapy including a flare in his acne, some visual disturbance along with some epigastric discomfit, all of which have resolved with the dose reduction."

Advocacy Services South Island Trust

On 24 April 2001, after several discussions with Mrs A, an advocate opened a complaint file. The advocate advised me that she visited the pharmacy sometime after this date and before the end of May and spoke to Mr E. He told her that the woman who had made the error (pharmacist Ms C) had gone overseas and no longer worked there. He agreed to provide an apology. The advocate returned to the pharmacy to conduct an education session for staff on consumers' rights, and recalled that the staff member who Mr E alleged made the error was not present.

Apology letter
I asked Mrs A to provide me with her copy of Mr E's apology letter. She provided me with the following letter, dated 7 June 2001:

> "Dear [Mrs A]
>
> I am writing to say that I am very sorry to cause yourself and [Master A] distress. I hope that [Master A] is progressing well with his treatment and will soon be off his medication.
>
> I have tried to be totally upfront with you over the mix-up in [Master A's] dosage and I apologise again."

The letter was signed by Mr E but delivered personally to Mrs A's home by Ms C.

HealthPAC
HealthPAC, formerly called Health Benefits Ltd (HBL), funds pharmacies for prescription services. Whenever a prescription is dispensed the pharmacy claims payment from HealthPAC and sends it the original prescriptions. HealthPAC supplied a claim payment record for the prescription of 28 February (Appendix 6). This record shows that payment for Dr B's prescription, and its repeat, was submitted by the pharmacy for payment on 31 March 2001. The claims payment record then shows that the first dispensing (28 February) was altered between 1 and 15 April and re-submitted for payment on 15 April.

I was also provided with a copy of Dr B's original prescription of 28 February 2001, the certified repeat copy of Dr B's prescription dispensed on 24 March 2001, and Dr G's prescription of 5 April. The certified repeat copy of Dr B's prescription incorrectly states that Master A is to take two 20mg tablets of prednisone twice daily.

The pharmacy's response
The proprietor of the pharmacy, Mr E, denied that the dispensing error occurred from Dr B's prescription of 28 February. He stated that the error resulted from Dr G's prescription of 5 April and was subsequently discovered on 17 April, when Mrs A called into the pharmacy.

Mr E identified the pharmacist who had made the dispensing error on 5 April as Ms C. Mr E confirmed that Ms C was aware that she had made the error, and that she had worked with him to resolve the situation. He advised that Mrs A was sent a personal letter (of apology) "which was delivered in person by [Ms C]". Mr E did not have a copy of this letter but provided me with a computer reprint of an earlier letter he had sent to Mrs A on 25 May 2001, which stated:

> "Dear [Mrs A]
>
> I am writing to let you know that we have thoroughly reviewed our dispensing and checking procedures. I hope [Master A] is progressing well and please keep in touch."

Mrs A did not receive this letter.

Mr E advised that he was unsure how to contact Ms C, as she was overseas, but said he would check with her parents for a contact address "should one exist".

Mr E supplied me with a photocopy of Dr G's prescription of 5 April for "Prednisone 20mg ii daily – ie 40mg/day". The prescription is initialled with what appear to be Ms C's initials. Mr E also provided a photocopy of a page from the pharmacy's incident book, in which Ms C recorded the following:

> "5/4/01 Rx 1019015/1 – [Master A] dispensed 60 Prednisone 20mg with dosage instructions of 2 tablets twice daily instead of 2 tabs daily as scripted by [Dr G].
>
> 17/18 – phone call from [Mrs A].
> – Checked with [Dr G]
> – Corrected dosage – decreasing dosage of Prednisone 20mg as discussed with [Dr G] and given to [Mrs A] (written) from 4 tabs per day to 3 per day for X days then 2 per day to continue. (X = week.)"

Mr E explained that the numbers 17/18 "should read 17/18 April".

Mr E engaged the services of an independent consultant pharmacist, Mr H, to independently investigate the dispensing error. Mr H advised me via his report:

> "On 4 September 2001 I visited the pharmacy and was provided with free access to computerised prescription records, dispensing quality assurance procedures, dispensing records, and a copy of the original prescription written for [Master A] by [Dr G] and dated 5/4/01."

Mr H stated that he interviewed the pharmacy technician who was on duty on 5 April, Mrs I, and Mr E. He was unable to interview Ms C as she had left the country. He spoke to Dr B and confirmed that it was his intention for Master A to be on 40mg prednisone daily.

Mr H described the sequence of events as advised to him by Mrs I and Mr E. He stated that on 17 April 2001 Mrs A had come in to the pharmacy to collect a repeat of Master A's prednisone. She spoke to Mrs I, who was "alerted … to a possible problem since [Master A] should have sufficient for a month". Mrs I therefore advised the pharmacist, Ms C, who investigated the situation. Ms C contacted Dr G and recorded her discussion in the incident book.

Mr H commented that he thought that while Dr G's writing may not have been clear (the number 20 was written over the number 40), his instruction of "ie 40mg/day" should have been clear enough to ensure correct dispensing. The fact that 60 tablets were dispensed indicated to Mr H that the pharmacist had interpreted the prescription correctly as two 20mg tablets once daily. Mr H advised that the following matters may have contributed to the error occurring:

- The computer automatically generates a label in accordance with the medication last dispensed.

- As Master A had previously been on 80mg, the computer would have automatically generated this dose. Therefore, the pharmacist had to be alert to changes in dosage and enter any changes in the "directions" field.

- The majority of prescriptions do not involve a dose change and it is possible to overlook this if it occurs.

- Dr G's handwriting was not clear. The strength had been overwritten and followed by the Latin numeral ii (two).

- The format of the prescription was not strictly conventional in that there was no standard frequency instruction such as OD (once daily). The dose level was not excessively high in the circumstances and therefore would not have alerted the pharmacist to a problem.

- The dispensed prescription label was not checked against the original by a second person, which Mr H noted was common practice.

Mr H further advised that the pharmacy had been audited on 26 June 2000 by the Ministry of Health and had satisfactory dispensing practices. Since this incident the pharmacy had taken steps to prevent repeat errors by introducing the policy of dispensing repeat prescriptions off the original prescription rather than off the certified copy.

I was supplied with additional information from the pharmacy:

- An illness prescription report listing all medications dispensed to Master A for the period 20 December 1999 to 25 May 2001.

- A computer-generated list of medicine labels (the typed instructions that are placed on the medication bottles) covering the period 23 May 2000 to 25 May 2001. However, the label for 24 March 2001 was not supplied.

The pharmacy prescription records confirm that Master A had been on varying amounts of prednisone, including 40mg twice daily in May 2000.

Mr E advised me that he had contacted HealthPAC for a copy of Dr B's prescription of 28 February, "but they were unable to trace it". However, he supplied the label for 28 February which correctly stated the dose as two 20mg prednisone tablets once daily.

I asked Mr E to forward to me the label from the medication dispensed on 24 March and the name of the staff member who had dispensed the medication. Mr E sent me the label, which states "take 2 tablets twice daily with food" and advised that the pharmacist on duty was Ms D. On 17 April 2003 Mr E's lawyer, Mr F, advised the following:

> "The medical records suggest a prescription error was identified on 5 April 2001. This does not fit with the recollection of the technician involved and some of the other staff members. They consider the error was discovered when a repeat was requested. This view is also contrary to the report provided to the pharmacy by [Mr H].
>
> The pharmacy records display a dispensing error, which took place on 24 March 2001. [Ms D] dispensed a return prescription following the wording of a CRC [certified repeat copy]. [Ms D] has no actual recollection of the dispensing which took place. Her practice was to print off the CRC and dispense according to the details outlined. There was no opportunity for her to view the original script and ensure the CRC reflected it."

Mr F noted that the CRC generated on 24 March differed from the instructions of the original prescription of 28 February. He stated that it was possible that there was "some kind of corruption" in the computer system whereby the computer system defaulted to an earlier dose. Mr F also stated that it was possible that the computer record had been altered after the original dispensing but that this was not common and would normally only occur after "a conversation with the doctor or something similar". Another possible reason for the CRC to be changed was to ensure that future repeats did not perpetuate the same error. He advised that the pharmacy had had a number of problems with the computer system, which had been "eventually replaced".

In response to my questions about the nature of the computer problems being referred to, Mr F subsequently advised me that "the description of the computer system corrupting may not be accurate". He advised that the default settings in the computer had possibly brought up instructions for a previous dosage (a point also raised in Mr H's report). Mr F noted that the pharmacist was still required to check the prescription and then accept or edit the instructions.

Mr F advised that when Master A's prescription of 28 February had been presented at the pharmacy, the person processing the prescription would have typed Master A's name into the computer and, as he was an existing customer, his details would have been displayed on the screen. The details from the prescription would then have been imputed into the fields on the screen. The label would have been printed and taken with the original prescription to the dispensing bench, the tablets counted and put into a bottle, and the bottle labelled.

Mr F advised that it was possible that a pharmacy technician or one of the "other pharmacists" may have imputed the prescription data into the computer. However, he confirmed that Mr E was the pharmacist on duty on 28 February and that Mr E had dispensed prednisone both from Dr B's prescription and from Dr G's repeat prescription (within minutes of one another). He advised:

> "[Mr E] was the pharmacist who dispensed the original prescription and a repeat on 28 February 2001. He is also the proprietor of the pharmacy. He has no actual knowledge or recollection of what took place."

Mr F advised that after the prescription had been imputed into the computer, "[Mr E] would have checked the script against the label and the medicine and signed the original script."

In relation to the dispensing of the repeat medication on 24 March, Mr F explained the pharmacy's usual process for dispensing medication from a CRC. He stated that when a person returns for a repeat prescription, his or her details are entered into the computer. A label and a CRC are printed off and the label and medicine are checked against the CRC. Mr F advised that the script label and dispensed medicines would have been checked "two to three times" by two separate pharmacists and/or a technician before being dispensed. He advised that dispensing from the CRC was accepted practice in pharmacies at the time of the incident. The error that subsequently occurred "was an isolated human error".

Ms C's response
Ms C denied that she had ever incorrectly dispensed Master A's prednisone. She stated: "As far as I was concerned I had found the discrepancy and corrected the situation …" When Ms C left New Zealand in June 2001 she was unaware that she was being held responsible for the error. Ms C advised that she was "so upset" by this complaint that she returned to New Zealand and met with Mrs A at her home on 17 March 2002.

She stated:

> "Although I knew when I left New Zealand that a complaint had been received by my employer [Mr E], I was confident that my work was not the subject of the complaint and no indication otherwise has ever been given to me by my employer. … I understand that [Mr E] has responded to you with details of a specific prescription and the standard operating procedures for the pharmacy. I also understand an independent report has been written by [Mr H] and forwarded to the Commissioner. All these things have been carried out without my knowledge and involvement despite [Mr E] having my e-mail address and my parents' address. In fact in December 2001 I received [overseas] an e-mail message from [Mr E] in which he made no mention of the complaint or the fact that he had stated, 'The Dispenser, [Ms C] …' in his letter to the Health and Disability Commissioner dated 11 October 2001. …"

Ms C confirmed that she was the pharmacist who was on duty when "[Mrs A] came into the pharmacy with a query about her son's medication". Ms C stated that she remembered finding the original prescription and a repeat dispensing where "… it appeared the patient had received a different dose from that intended by the doctor". Ms C can no longer recall whether the prescription was Dr B's or Dr G's.

Ms C telephoned Dr G and told him that it appeared Master A had been receiving 40mg of prednisone twice daily instead of 40mg once daily. Ms C wrote down Dr G's instructions for a reducing dose regime for Master A and gave this, along with the prednisone dispensed from Dr G's prescription, to Mrs A. Ms C stated that when Mrs A left the pharmacy she analysed the prescription that the error had been made from. She is adamant that she signed neither the original prescription nor the repeat dispensing. "I made a note in the pharmacy incident book and advised my employer immediately on his return to the pharmacy later that day." Ms C confirmed that the handwritten note in the pharmacy incident book was hers. However, she was unable to recall what "17/18" referred to.

Ms C recalled that Mrs A called into the pharmacy again a few days later and spoke to Mr E. Mr E later told Ms C that Mrs A had become more upset as he had talked to her, and he thought Ms C should talk to her as "she didn't seem to like him".

Ms C resigned from the pharmacy to travel overseas. She recalled that approximately four weeks before she left the pharmacy (sometime in May) "a woman" visited the pharmacy and spoke to Mr E. Ms C did not know who the woman was but assumed she was investigating the incident. Mr E told Ms C that as a result of this visit he had agreed to write a letter of apology to Mrs A.

Before leaving New Zealand, on 20 June, Ms C made a social call to the pharmacy. She stated that "at [Mr E's] insistence" she agreed to make a delivery for him to Mrs A's home as he had "no one else to do it". Ms C subsequently found out, through her meeting with Mrs A on 17 March 2002, that the delivery was Mr E's letter of apology dated 7 June. Ms C stated: "I feel very strongly that it was entirely inappropriate for me to have been asked to deliver this to [Mrs A] – [Mr E] should have delivered it in person."

Ms D's response
Ms D responded via her lawyer, Mr F, that she could not recall the details of the 24 March dispensing.

Independent advice to Commissioner

The following expert advice was obtained from Ms Eleanor Hawthorn, an independent community pharmacist:

> "I have reviewed the documents from the above complaint file which were supplied to me by HDC on 22 May 2003.
>
> The complaint is specifically with regard to dispensing of Prednisone tablets from [the pharmacy] to [Master A] on 28 February 2001 and 24 March 2001. It is claimed that on each of these occasions [Master A] received twice the dose of Prednisone that was prescribed by [Dr B], Specialist Physician in Internal Medicine and Nephrology at [the public hospital].
>
> [Master A] had a history of Mesangioproliferative glomerulonephritis and had been treated with Prednisone for a period of time and the dose had varied over the previous year.
>
> [Dr B] had seen [Master A] in December 2000 and it is recorded that at that stage [Master A] was on no Prednisone therapy and that further observation and review would take place in 3 months' time. [Dr B] writes that in March 2001 [Master A] had developed recurrent symptoms and urinary abnormalities and that Prednisone was re-introduced at 40mg daily. The prescription, which was presumably written on that

occasion, is dated 28 February 2001 and was dispensed that day at [the pharmacy]. The prescription was clearly written 'Prednisone 40mg od (daily) for 8/52 (eight weeks' supply)'. As no 40mg tablet is available, this would have been interpreted as 2 x 20mg tablets and the prescription has been endorsed in [the pharmacy] for 2 supplies of 56 tablets, which is correct.

However, it appears that the instructions given on the label were not 40mg once daily, but 40mg twice daily. I suspect that when the prescription was processed into the computer, the programme defaulted to a previous prescription dispensed for [Master A] on 23 May 2000 for 56 Prednisone tablets 20mg when the dose was Prednisone 20mg, two tablets twice daily (40mg twice daily). This is a feature that would have been in the Toniq programme at that time and is designed to act as a prompt when a new prescription is processed. The change in dose was not identified when the prescription was processed into the computer. Neither was the error picked up in the final checking of the prescription.

I also suspect that [Master A's] condition deteriorated between his visit to [Dr B] in December and the visit on 28 February, as another prescription from [Dr G] was dispensed by [the pharmacy] on 19 January 2001. This prescription was written for Prednisone and the dose prescribed was for 40mg per day for one week then 30mg per day for one week then 20mg per day for the balance of 3 months. The prescription is annotated as 39 + 30 + 30 (I would have expected it to be annotated 40.5 + 30 + 30) and if this dose had been observed this prescription should have lasted [Master A] at least until the middle of April. It is possible that the dose of 40mg per day was maintained for longer than a week as a repeat was collected early, on 31 January.

On 28 February the final repeat of [Dr G's] prescription was dispensed along with the first supply of the new prescription from [Dr B]. Whoever processed the prescription would have been aware of this as the computer prompts you to make a decision whether to dispense if another similar prescription has been dispensed within the previous 20 days. It is unclear whether this was discussed with [Mrs A] when the prescription was collected, as a double supply with different doses creates another potential problem. This may account for the fact that although the label on the new prescription may have said to 'take two tablets, twice daily' the quantity of tablets lasted for nearly a month, until 24 March. If the number of Prednisone tablets dispensed was right and the instructions were wrong, and [Master A] was taking two tablets twice daily, the medication should have lasted only half the time (2 weeks).

I have viewed the labels for these prescriptions and accept that all but one (the label for the repeat of the prescription in question) were reprinted from [the pharmacy's] computer system at the same time. This is evidenced by the number that appears on the lower right hand corner of the label under the prescription label. You will note that on each label the number is 108/9. These numbers are the 'stock in hand' (108) and Cautionary and Advisory Label (9) information. This was the stock figure for Prednisone held in [the pharmacy] at the time the labels were reprinted for your file. The repeat label for prescription 1016057 is submitted out of sequence and has been printed

(or reprinted) at a different time. Note that the stock figure is 364. They also appear in different files (B and E). The label matches the Certified Repeat Copy for this prescription. I am not sure what significance I should place on this as I do not know how or when the information was obtained.

[The pharmacy] apparently replaced [the pharmacy] computer system in 1999 and has since been operating on Toniq. There is some discussion in the file that suggests that the computer system was responsible for the apparent difference in the instructions between the original dispensing on 28 February and the repeat dispensing on 24 March. As I operate the same system in my own pharmacy, I am unable to support this contention.

I accept that some problems may have occurred when the files were converted from the old system to the new one but these were 'one-off' problems. I cannot accept that the computer system was responsible for this particular error. I have discussed this matter with the people at Toniq and neither can they support this view.

As a consequence, and with your permission, I have sought further information from Health Benefits Ltd [HBL]. The printout of their claim for payment from [the pharmacy] (attached) [Appendix 6] indicates that the original prescription, submitted for payment on 28 February 2001, and its repeat, submitted for payment on 31 March 2001, were paid according to the claim. The printout then records that the first dispensing was altered between 1 April and 15 April 2001 and re-submitted for payment on 15 April. Note that on 15 April the HBL computer records 56 Prednisone 20 mg 'out' and 56 Prednisone 20mg 'in'. I believe that this confirms that the prescription record was altered in [the pharmacy's] computer, after the error in the instructions had been discovered, otherwise I can see no reason for the prescription to be re-submitted. Any change in the record requires an electronic notification to HBL. A change in dose is handled in this way. Unfortunately HBL does not record the dose and frequency. I cannot say who in the pharmacy was responsible for this alteration.

The situation is further complicated by the fact that at the time of the error, this pharmacy relied upon dispensing off a Certified Repeat Copy, rather than the original prescription. Prior to a date in 2000, the version of the programme that all pharmacies used for claiming payment from HBL, required the original prescription to be sent to them after the first dispensing. This was part of HBL's own audit procedure and was known as Version 1.5. Many pharmacies relied upon the accuracy of the Certified Repeat Copy when dispensing repeats. Other pharmacies photocopied the original prescription so that there was a copy on the premises for verification. The accuracy of the Certified Repeat Copy depends on the correct processing into the computer of the original prescription. If an error is made at this stage and is not picked up in the checking process, the error is perpetuated through the repeats. More recently under Version 2.2 the original prescriptions are held in [the pharmacy] and submitted for audit five months later. I can only be approximate in the date of change because different pharmacies changed at different times.

It is clear from information provided by [Ms C] that although the pharmacy would have been using Version 2.2 when the dispensing error occurred, dispensing was still being

done from the Certified Repeat Copy. [Ms C] was able to retrieve the original prescription which was on the premises. I note that the pharmacy has reviewed its dispensing protocols since this incident.

Your request for advice asks the following questions:

What are the relevant standards that apply?

The standards that applied are those contained in the Code of Ethics of the Pharmaceutical Society of New Zealand which were current at that time, specifically Standard 6 Pharmaceutical Services. Section 6.2 of the Code requires the pharmacist 'to maintain a disciplined dispensing procedure which ensures that the appropriate product is selected and dispensed correctly and efficiently'. Guidance notes to this section require 'all prescriptions (to be) finally checked for completeness and accuracy by the pharmacist'.

It is unclear who checked the original dispensing for accuracy as I do not recognise the initials of the dispensing pharmacist.

The pharmacy has its own quality standards and these are recorded as Standard Operating Procedures. These documents are appropriate for the purpose.

Were the pharmacy's dispensing procedures in place at the time of this incident appropriate?

I have reviewed the pharmacy's quality documents and they are appropriate. As the document entitled Dispensing Procedures – A Guide To Eliminating Errors is undated and the document entitled Dispensing Procedure was revised in March 2002, it is difficult to say if adequate procedures were in place at the time of the incident. If these documents were current at the time of the incident then the dispensing/checking procedures [undertaken by the dispensing pharmacist] fell short of the requirements. The incident reporting meets standard practice requirements.

Were the actions that [Mr E] took to resolve [Mrs A's] complaint appropriate?

I think that it is unfortunate that [Mr E] was not more prompt in responding to [Mrs A's] concerns. It seems that his letter of apology to [Mrs A] was delivered to her by [Ms C] two weeks after [Ms C] left [the pharmacy] at the end of May. I note that the letter is dated 7 June. I believe that this is an unacceptable time delay and that having [Ms C] deliver the letter to [Mrs A] rather than delivering it himself, has not helped the situation.

Please describe the process involved with entering details of a prescription into the computer. Can any one else amend the record once it is entered?

The process of entering the details of a prescription into the computer can be done only by staff qualified for that purpose i.e. pharmacists or pharmacy technicians. Once the information has been processed into the computer it can be changed at any time. As

indicated above, I believe the information originally recorded was altered after both dispensings had taken place. I attach two labels for a fictional patient which pertain to the same prescription, to illustrate this capability. Note that the first two labels have the same prescription number but the heading is presented differently. I have also attached 2 Certified Repeat Copies, again for the same repeat, where the dosages have been changed. It must be noted though, that to make any change in the information that is keyed into the computer at the time of the original processing, the 'Edit' mode in the programme must be engaged. This is an essential facility as in any pharmacy, many times a day, alterations need to be made to the originally processed information. There may be a number of reasons for this to happen – a change in dose or quantity, a change in address, a misspelling of a name, the patient producing a Community Service Card or a Prescription Subsidy Card that the pharmacy was not aware of etc. The change cannot be made without a conscious decision to do so. A change cannot happen by accident.

Please explain how a Certified Repeat Copy is obtained.

A Certified Repeat Copy is generated automatically by the dispensing programme if a repeat has been authorised on the original prescription and that repeat (or repeats) has been processed into the computer at the time of the original dispensing.

Please advise whether it is possible to make changes to a Certified Repeat Copy after it has been created. If so, how, and in what circumstances would this occur?

Yes it is possible to make changes to a Certified Repeat Copy (see above). This would happen when it was realised, on the dispensing of a repeat, that perhaps a different quantity was prescribed on the repeat than had been entered into the computer when the original was dispensed, or the instructions had changed on the repeat which hadn't been recognised when the original was entered. This would not be uncommon. The Certified Repeat Copy of the prescription in question was, I believe, a true reflection of what had been entered into the computer when the original was dispensed.

In your experience, is it possible that a computer corruption or default generated the incorrect repeat copy? How likely is this?

I believe a default in the computer programme could have led to the incorrect dose on the record and label of the original dispensing as [Master A] had been dispensed 56 Prednisone 20mg (with a dose of two tablets twice daily) on a previous occasion. This was not picked up in the checking process. The Certified Repeat Copy was a true reflection of what had been entered originally on 28 February. I do not believe that there was any computer corruption of the information. In my view it is impossible for the computer to automatically generate a Certified Repeat Copy that does not reflect the original information. Manual intervention would need to have taken place.

What are the possible reasons for the Certified Repeat Copy stating the incorrect dose of Prednisone?

To the best of my knowledge, the only reason that the Certified Repeat Copy stated the incorrect dose of Prednisone is that the original prescription was entered incorrectly.

The format of the label 28 February 2001 for Prednisone differs from all the other labels. How would this happen?

The format of the label on the prescription dispensed on 28 February 2001 (and its repeat) differs from the other labels only insofar as for that particular prescription the generic form of Prednisone has been selected (lower case with the brand APO in brackets). For all the other labels the brand name APO-PREDNISONE (expressed in capital letters) has been selected (see above). There is nothing to be concerned about.

[Ms D] dispensed from the Certified Repeat Copy on 24 March. Were her actions reasonable in the circumstances?

Dispensing from the Certified Repeat Copy would have been common practice in many pharmacies for some years leading up to this time. It was a practice that concerned me at the time and in my own pharmacy I ensured that none of my own staff were put into a situation where they were required to sign off as being correct, a repeat prescription for which they had not sighted the original. It was obviously a policy of this pharmacy at this time to dispense off the Certified Repeat Copy, although by March 2001 I am surprised that the original prescription instead was not kept on file. According to [Ms C's] evidence, the original prescription was on the premises and was readily available. Therefore it could have been on file for verification. [Ms D] dispensed off the Certified Repeat Copy. This was standard practice for the pharmacy at that time and I believe her actions were reasonable in the circumstances.

I can understand [Mrs A's] concern. As a parent of a young man requiring ongoing treatment with Prednisone she would have wanted him to receive the lowest dose required to control his symptoms. [Master A] might have exhibited the classical side-effects of worsening acne, weight gain, flushing and typical 'moon face' etc at any dose, but certainly the dose he was dispensed would not have helped. I note that [Dr G] suggested a reducing dose of 20mg daily per week when he spoke to [Ms C] and that by 1 June 2001 [Master A] was down to 40mg per day with the dose further reducing to 10mg. This dose seems to have given him good symptom control without undue side-effects."

Responses to Provisional Opinion

Mr E submitted the following response via his lawyer, Mr F:

- Adverse comments made about Mr E in relation to his initial interpretation of events are "not correct and unfair" and "suggest a deliberate attempt by [Mr E] to mislead and conceal an error". Mr F submitted that Mr E had limited information available to him and did not know exactly when the error occurred. Accordingly the entry in the incident book and the numbers "17/18" took on greater significance. Mr F advised that Mr E no longer holds this view and accepts that the initial error was made on 28 February 2001 and was perpetuated when a repeat was dispensed on 24 March. Furthermore, Mr E does not accept that he "denied" that the dispensing error occurred on 28 February as his initial response was based on limited information which suggested the error had occurred on 5 April.

- Mr E was not at the pharmacy on 5 April and the "error and its aftermath were dealt with by other staff". He accepts that he did speak to Mrs A "at a later stage" but states that their conversation, as described in my provisional opinion, is not "a verbatim transcript". In particular, Mr E "may have said that he had a pink face in an attempt to provide some comfort to [Mrs A] …"

- Mr E did not restrict Mr H's investigation in any way. The conclusions reached were reasonable given the limited information initially available about when and how the error occurred.

- There were difficulties in obtaining the original prescription from HBL. Ms C and Mrs I made numerous requests but were told that the prescription could not be located. The problem may rest with HBL rather than with the pharmacy.

- Mr F advised that his suggestion that the computer information was possibly "corrupted" was based on a "limited understanding of the error being discussed". He confirmed that the correct term was "default setting" and noted that this was confirmed by the independent advisor. Mr F stated that there was no attempt to mislead and further commented that "correspondence between myself and your office … are not appropriate to be included in this way".

- Mr F stated that Mr E "has not deliberately attempted to mislead your Office or to delay the investigation" and submitted that my opinion "should be amended accordingly".

- Mr E has "always understood" that he was responsible for the error as the owner of the pharmacy. However, "he did not realise that he had made the error personally until the medical notes confirmed the date it occurred". Mr E denies that he attempted to hide from the error or to suggest other staff were responsible.

- In relation to Mr E's apology to Mrs A, Mr F advised that although Mrs A had stopped using the pharmacy, her husband, Mr A, continues to do so and discusses Master A's condition with Mr E. "It was [Mr E's] understanding as a result of those discussions

that [Master A] had fully recovered; that [Mr A] understood the reason for the error and that he had accepted the initial verbal apologies offered and the fact that systems have changed to prevent a repeat incident occurring."

- Mr F commented that the "question of vicarious liability is somewhat artificial … as [Mr E] is the effective principal of the pharmacy. However, your independent advisor has confirmed that the protocols in place were appropriate. [Mr E] is an experienced pharmacist who has practised for over 30 years without a similar complaint. It was appropriate for the owners of the pharmacy to rely on [Mr E's] expertise and experience to follow the protocols which were in place".

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 reasonable care and skill.

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

Other relevant standards

Rule 2.11 of the Pharmaceutical Society's *Code of Ethics* states:

"A pharmacist must be responsible for maintaining and supervising a disciplined dispensing procedure that ensures a high standard is achieved. The pharmacist's responsibilities include … ensuring that the label is accurate, unambiguous and clear, contains the relevant information required by the consumer and complies with all statutory requirements."

Standard 6.2 of the Quality Standards for Pharmacy in New Zealand states:

"… [D]ispensing procedures must ensure that … labels are applied to the container which will inform and advise the patient and which meet legal and professional requirements: all prescriptions are finally checked for completeness and accuracy by the pharmacist …"

Opinion: Breach – Mr E

Under Right 4 of the Code Master A had the right to have services provided with reasonable care and skill in compliance with legal, professional, ethical and other relevant standards.

Mrs A complained that the pharmacy dispensed double the prescribed dose of prednisone to her son Master A. As a consequence, Master A suffered unnecessary side effects caused by exposure to a higher than intended dose of this medication.

Date of dispensing error – 28 February 2001
Mr E submitted conflicting information to me about when the dispensing error occurred and who was responsible. Initially he advised that the dispensing error occurred on 5 April as a result of Dr G's prescription, and that the error was discovered on 17 April when Mrs A came into the pharmacy. He identified employee Ms C as the person responsible for making the error and informed me that Ms C was aware of having made the error and had been fully involved in rectifying it.

Mr E submitted as evidence a copy of a page from the incident book in which Ms C had recorded her actions. Two dates appear on this page, 5 April and "17/18". Mr E's initial interpretation was that the error was made on 5 April and was discovered on 17/18 April. Ms C disputes that she made any error with Master A's prednisone prescription, advising me that she merely responded to the concerns outlined by Mrs A when she visited the pharmacy on 5 April, taking steps to rectify the dispensing error in consultation with Dr G. Further, she is unable to recall what "17/18" means.

Although the pharmacy incident record of Ms C's discovery is confusing (eg, her reference to Dr G's prescription rather than Dr B's and "17/18"), Dr G's record of his discussion with Mrs A and the pharmacy dated 5 April, and his instigation of a reducing dose on that date; Dr B's clinic note of 11 April referring to Master A being on a "higher than intended" dose of prednisone; and Dr G's reducing regime, all point to the error being discovered on 5 April. In addition, Ms C stated that she alerted Mr E to her discovery of the error on his return to the pharmacy the day she discovered the error (that is, 5 April) and Mrs A recalls speaking "to the Manager" about the dispensing error when she picked up Dr G's prescription dispensed on 5 April.

Although Mr E and his employee, Mrs I, recall the error being discovered when Mrs A came into the pharmacy on 17 April for a "repeat" of Master A's prednisone, no medication was dispensed to Master A that day. I am satisfied that Mr E's and Mrs I's recollections about when the error was discovered are not correct.

Mr E advised me that he was unable to provide a copy of Dr B's prescription from 28 February as it had "been mislaid by HealthPAC". However, I was able to obtain a copy of this prescription from HealthPAC.

I asked Mr E to provide a copy of all the labels for the period 23 May 2000 to 25 May 2001. The label from the 24 March dispensing (with the incorrect instructions) was initially omitted.

It was only after examining Dr G's records, and responding to my second request to forward the label from 24 March, that Mr E conceded through his lawyer, Mr F, that the error appeared to have occurred not on 5 April but on 24 March. He identified Ms D as the pharmacist who made the dispensing error.

My advisor believes that the dispensing error actually occurred on 28 February from the prescription written by Dr B, which was dispensed by Mr E. She explained that the CRC from which Ms D dispensed on 24 March reflected the original instructions of 28 February (which must have therefore been incorrectly imputed and dispensed). She advised that while it is possible for a CRC to be altered, it would require manual intervention to do so.

Mr E, through his lawyer, Mr F, confirmed that he was the pharmacist who dispensed the 28 February prescription. However, he can no longer recall what took place. I note here that, although Mr E has stated that another member of his staff may have imputed the data into the computer from which the medication label and CRC were generated, he was responsible for the dispensing and therefore for checking that the correct drug, dose and instructions were provided to the patient. As my advisor noted, this was particularly important given the nature of prednisone and the fact that two prescriptions of it for Master A were being dispensed on the same day.

Mr F also raised the possibility that the CRC had been changed in response to a "conversation with the doctor or something similar". However, had this occurred, I would expect there to be a record on the CRC, in the pharmacy incident book, or in Master A's medical records held by Dr B and Dr G. There is no such record. Furthermore, both doctors have confirmed that Master A was supposed to take 40mg prednisone once daily. Therefore I consider it is highly unlikely that either Dr B or Dr G initiated an increase in Master A's prednisone dose via the dispensing pharmacist on 24 March 2001. Although Ms D can no longer recall the circumstances surrounding her dispensing of the repeat prescription, there is no evidence that anything would have caused her to manually alter the prescription dose.

In addition to the above evidence, I note that the prescription of 28 February was resubmitted to HealthPAC after being altered at the pharmacy sometime between 1 and 15 April, presumably after the error was discovered.

I am satisfied, therefore, that a dispensing error occurred from Dr B's prescription of 28 February 2001, which was dispensed by Mr E on 28 February. This error was perpetuated in the repeat dispensing by Ms D on 24 March. The dispensing errors were subsequently discovered by Ms C on 5 April.

Reasons for error

Mr E submitted various explanations for how the dispensing error occurred. He obtained a report by pharmacist Mr H, which supported Mr E's position that the dispensing error

occurred on 5 April. However, from the outset of Mr H's investigation he was told that Ms C had made the error on 5 April from Dr G's prescription. Unsurprisingly, Mr H confined his investigation to this time-period and concluded that the illegibility of Dr G's prescription had contributed to the error, along with the computer's defaulting system, and the failure in not having the prescription checked by a second person.

Subsequently, through Mr F, I was told that the instructions on the CRC generated on 24 March differed from the instructions on the original prescription of 28 February because of a possible "corruption" of the system and that problems with the computer program had led to its eventual replacement. In response to my enquiry about the nature of the computer problems, Mr F explained that the description of the computer system corrupting "may not be accurate". Rather, the computer may have defaulted to an earlier prescription dose. Mr F also alerted me to the possibility of the "unusual" occurrence of the dispensing record having been altered perhaps in response to "a conversation with a doctor" or to "ensure future repeats did not perpetuate the error".

In responding to my provisional opinion, Mr F submitted that, in his view, it is not appropriate to refer to his interpretation of how the error may have occurred (with its attendant terminology difficulties). However, I can only conclude that, as Mr E's legal representative, Mr F was making such comments with his client's knowledge and approval.

My advisor stated that she believes the dispensing error may have occurred as a result of the program defaulting to an earlier (higher) dose of prednisone that Master A had been on. However, this was a feature of the program at the time, not a fault, and was intended to act as a prompt to the person imputing the prescription details. She stated:

> "I believe a default in the computer program could have led to the incorrect does on the record and label of the original dispensing as [Master A] had been dispensed 56 prednisone 20mg (with a dose of two tablets twice daily) on a previous occasion. *This was not picked up in the checking process* [emphasis added]. The Certified Repeat Copy was a true reflection of what had been originally entered on 28 February. I do not believe that there was any computer corruption of the information. In my view it is impossible for the computer to automatically generate a Certified Repeat Copy that does not reflect the original information. Manual intervention would need to have taken place."

My advisor also stated that when the prescription details were imputed on 28 February the repeat dispensing details (the CRC) were created simultaneously. A CRC is an exact reflection of the original prescription. Therefore, for the CRC to have been incorrect on 24 March, the instructions on 28 February would have to have been incorrectly imputed in the first place. My advisor stated:

> "There is some discussion in the file that suggests that the computer system was responsible for the apparent difference in the instructions between the original dispensing on 28 February and the repeat dispensing on 24 March. As I operate the same system in my own pharmacy, I am unable to support this contention. … I can not accept that the

> computer system was responsible for this particular error. I have discussed this matter with the people in Toniq and neither can they support this view."

Although an error occurred on 28 February, the computer label for this date does not reflect this (unlike the 24 March label). The only conclusion I can draw – and I note my advisor has come to the same conclusion – is that the label for 28 February was changed once it was known that an error had occurred.

My advisor stated:

> "The print out of their claim [HealthPAC] for payment from [the pharmacy] (attached) indicates that the original prescription, submitted for payment on 28 February 2001, and its repeat, submitted for payment on 31 March 2001, were paid according to the claim. The printout then records that the first dispensing was altered between 1 April and 15 April 2001 and resubmitted for payment on 15 April. Note that on 15 April the HBL [HealthPAC] computer records 56 Prednisone 20mg 'out' and 56 Prednisone 20mg 'in'. I believe that this confirms that the prescription record was altered in [the pharmacy's] computer, after the error in the instructions had been discovered, otherwise I can see no reason for the prescription to be re-submitted."

Although Mr E states that any of his staff could have imputed the prescription details of 28 February, it was ultimately his responsibility to ensure that the medication dispensed was correct. I note Mr F's comments in relation to the actions Mr E would have taken following the prescription details being imputed into the computer: "At this time, [Mr E] would have checked the script against the label and the medicine and signed the original script." However, I am satisfied that these steps did not occur, and that Master A received incorrect doses of prednisone on 28 February and 24 March.

Conclusion

In my opinion, by failing to adequately check Master A's prescription details and dispensing the incorrect dose of prednisone on 28 February 2001, Mr E did not observe a reasonable standard of practice and breached Rights 4(1) and 4(2) of the Code. While I accept that the computer automatic default system may have contributed to such an error occurring, in my view, pharmacists must always maintain the highest level of vigilance when dispensing medications. Mr E dispensed prednisone from *two* prescriptions on 28 February, and vigilance was therefore especially important. Prednisone is a powerful medication and particular care needs to be taken in dispensing it.

I have noted Mr E's response to my provisional opinion and, in particular, his denial that he attempted to mislead my investigation and blame others for his error.

Mr E submits that he initially had insufficient (and confusing) information from which to determine when and how the error occurred. However, I am not persuaded by Mr E's comments. The evidence suggests that Mr E was well aware the error occurred on 5 April. I note that Ms C advised that she brought her discovery of the error to his attention on 5 April. Furthermore, Mrs A spoke to Mr E following her discovery of the error, when she picked up the medication dispensed from Dr G's prescription dispensed on 5 April. Thus

two parties independently stated that they spoke to Mr E about the error on 5 April. In addition, both the CRC and the medication label of 24 March were incorrect, which indicated that the original dispensing on 28 February was therefore incorrect.

Mr E failed to provide me with an explanation for not providing *all* copies of the medication labels when I initially requested them (the label for 24 March was omitted). Nor has he explained why the label of 28 February does not reflect the error that occurred and why the original prescription details were altered and reclaimed between 1 and 15 April 2001.

Opinion: No breach – Ms C

As discussed above, I am satisfied that the dispensing error occurred from Dr B's prescription that was incorrectly dispensed on 28 February and again on 24 March. I accept that Ms C's involvement was limited to discovering the error on 5 April. My advisor commented that the actions Ms C took to resolve the complaint were entirely correct and appropriate in the circumstances. In my opinion Ms C did not breach the Code.

Opinion: No breach – Ms D

Ms D could not recall any details of the dispensing of Master A's prednisone on 24 March. However, as discussed above, I am satisfied that a dispensing error occurred on 28 February and that the CRC that Ms D dispensed from on 24 March reflected this original error. The only way for Ms D to have avoided making the error was for her to refer to the original prescription.

My investigation was not able to establish whether the original prescription was available for Ms D to refer to on 24 March. Ms C's evidence suggests that the original prescription was still in the pharmacy when she checked on 5 April. Nonetheless, I accept that Ms D's "practice … to print off the CRC and dispense according to the details outlined" was an accepted practice within the pharmacy at that time. The pharmacy has now altered its practice and dispenses from the original prescription rather than the CRC.

My advisor concluded that Ms D's action of dispensing off a CRC was reasonable in the circumstances. Furthermore, I note that the amount of prednisone that Master A was dispensed on that date was not such that she should have been alerted to an error being made. Accordingly, in my opinion Ms D did not breach the Code.

Opinion: Breach – The Pharmacy

Employers are vicariously liable under Section 72(2) of the Health and Disability Commissioner Act 1994 (the Act) for ensuring that employees comply with the Code of Health and Disability Services Consumers' Rights (the Code). Under Section 72(5) it is a defence for an employing authority to prove that they took such steps as were reasonably practicable to prevent the employee from breaching the Code.

Furthermore, under Section 72(3) of the Act an employing authority is liable for acts or omissions by an agent of that employing authority. Section 72(3) states:

> "**Liability of employer and principal** –
> (3) Anything done or omitted by a person as the agent of an employing authority shall, for the purposes of this Act, be treated as done or omitted by that employing authority as well as by the first-mentioned person, whether or not it was done or omitted with that employing authority's knowledge or approval."

As set out above, Mr E breached the Code by incorrectly dispensing Master A's prednisone on 28 February 2001. As a result, a CRC was generated, which led to Master A's repeat prescription of prednisone being incorrectly dispensed on 24 March 2001.

It is unclear whether Mr E, in his capacity as dispensing pharmacist on this occasion, was acting as an employee of the pharmacy Ltd (the company) or as an agent of the company. Nevertheless, I am satisfied that his actions as dispensing pharmacist on 28 February 2001 fall within the parameters of section 72.

Although my advisor has identified appropriate standards in place in the pharmacy, there do not appear to have been adequate systems in place to ensure that dispensing pharmacists routinely followed the standards.

Mr E, as pharmacy manager and company director, must have been aware of the pharmacy's standards. He was in a position to ensure that the standards were carefully adhered to and that there were adequate systems in place in the pharmacy to ensure that such an error could not occur. As dispensing pharmacist in this case, I am satisfied that Mr E was acting with the employing authority's knowledge and authority.

In my opinion, the pharmacy is vicariously liable for Mr E's breaches of the Code.

Other comment

Apology letter
Mr E provided a computer generated copy of a letter apparently written to Mrs A on 25 May 2001, advising her that the pharmacy had reviewed its procedures. Mrs A appears never to have received it and was only able to provide me with a copy of a letter dated 7

June. In my view, an aggravating feature of this complaint is the way in which Mr E responded to Mrs A's concerns. The letter dated 25 May 2001 does not apologise for the mistake or provide any detail to assure Mrs A in a tangible way that the same error would not happen again.

The letter of 7 June was prompted, it appears, by the visit from an advocate, and was not delivered by Mr E himself, but by Ms C. I consider that Mr E showed an unfortunate lapse of judgement in not delivering this letter himself.

Response to incident
From the beginning, Mr E has endeavoured to focus my investigation initially on the dispensing of Dr G's prescription on 5 April, and then the repeat dispensing of 24 March. His actions in initially blaming Ms C and then Ms D, constitute a significant breach of trust between employer and employee and again show unfortunate lapses in judgement. His actions could have resulted in serious professional consequences for both Ms C and Ms D.

Mr E's conduct delayed and unnecessarily complicated my investigation, and significantly added to the anguish of his two employees.

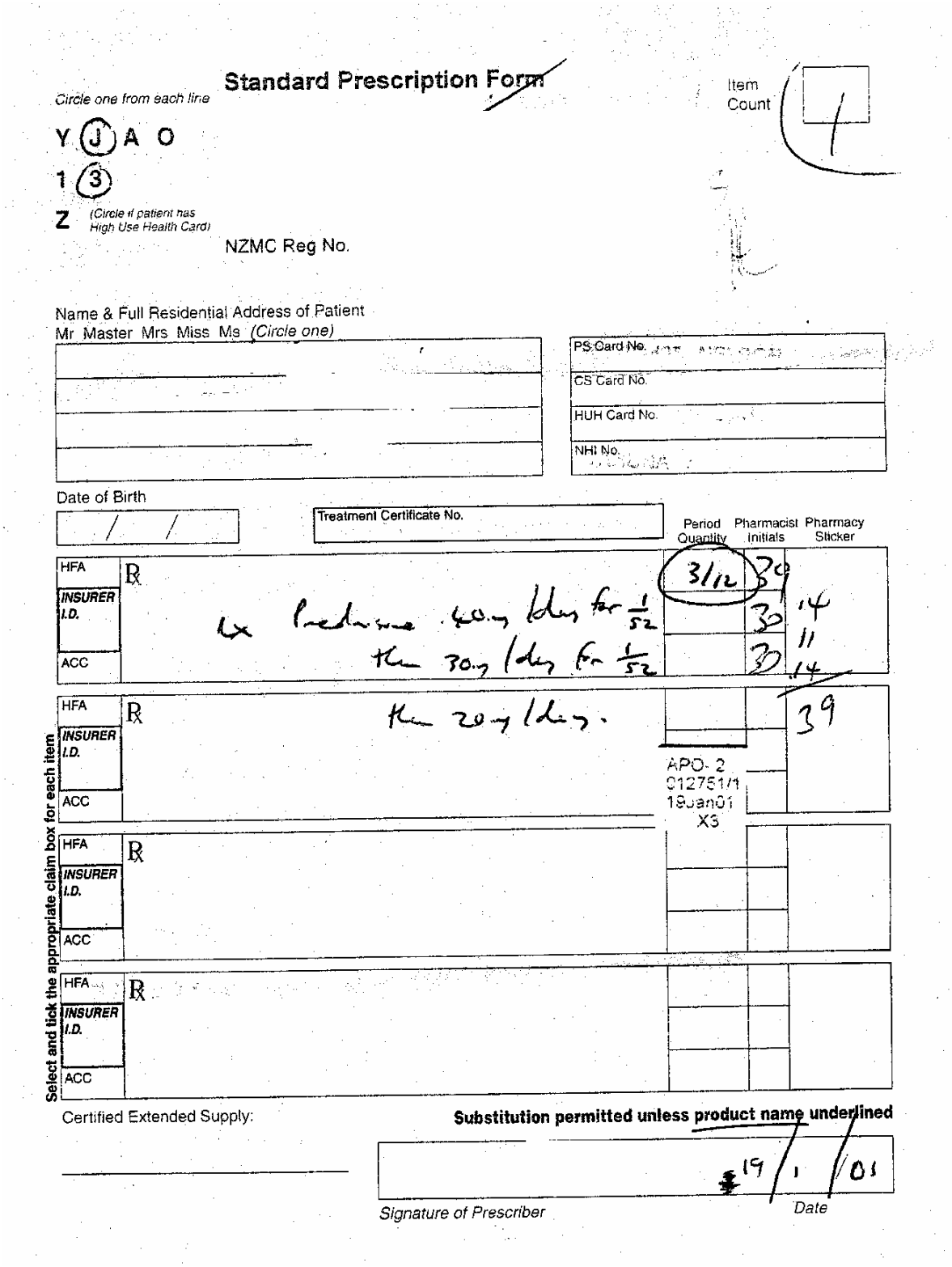
Actions

- A copy of this report will be sent to the Pharmaceutical Society of New Zealand.
- A copy of this report, with details identifying the parties removed, will be sent to the Pharmaceutical Society of New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.
- This matter will be referred to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

Addendum

The Director of Proceedings considered this matter and decided not to issue proceedings before the Human Rights Review Tribunal or the Pharmaceutical Society Disciplinary Committee.

Appendix 1



Standard Prescription Form

Circle one from each line

Y (J) A O

1 (3)

Z (Circle if patient has High Use Health Card)

Item Count 1

NZMC Reg No.

Name & Full Residential Address of Patient

Mr Master Mrs Miss Ms (Circle one)

PS Card No.

CS Card No.

HUH Card No.

NHI No.

Date of Birth / /

Treatment Certificate No.

Period Quantity | Pharmacist Initials | Pharmacy Sticker

HFA INSURER I.D. ACC

℞ Lx Prednisone 40mg 1day for 1/52 then 30mg 1day for 1/52

3/12 30 14 30 11 30 14

℞ then 20mg 1day.

39

APO-2 012751/1 18Jan01 X3

Select and tick the appropriate claim box for each item

Certified Extended Supply:

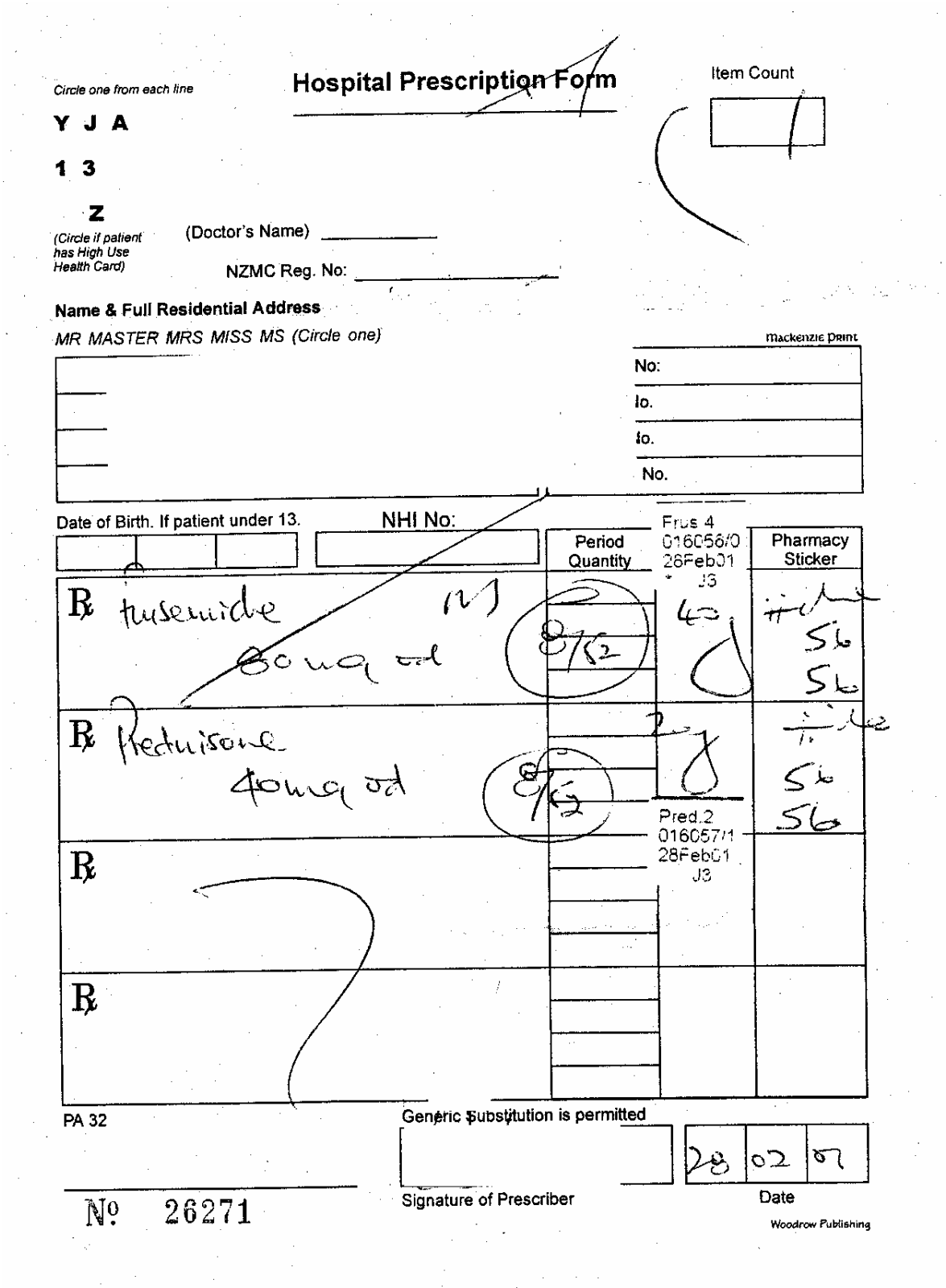
Substitution permitted unless product name underlined

Signature of Prescriber

19/1/01 Date

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 2



Hospital Prescription Form

Circle one from each line

Y J A

1 3

Z

(Circle if patient has High Use Health Card)

Item Count

(Doctor's Name) _____

NZMC Reg. No: _____

Name & Full Residential Address

MR MASTER MRS MISS MS (Circle one)

Mackenzie Print

No:

No.

Date of Birth. If patient under 13.

NHI No:

	Period Quantity	Frus 4 01605670 28Feb01 J3	Pharmacy Sticker
℞ frusemide 80mg od (N)	8/52	40	56 56
℞ Prednisone 40mg od	8/52	2	56 56
℞		Pred.2 01605771 28Feb01 J3	
℞			

PA 32

Generic substitution is permitted

Signature of Prescriber

28 02 07

Date

№ 26271

Woodrow Publishing

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 3

Certified Repeat Copy

Initial dispensing: 19 Jan 01 15:08
Repeat dispensing: 28 Feb 01 13:01
Print date: 28 Feb 01

Rx: 1012751/3 Quantity: 30 Qty changed
Med: APO-PREDNISONE 20mg Tablets
Sig: Take ONE TABLET DAILY WITH FOOD

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 4

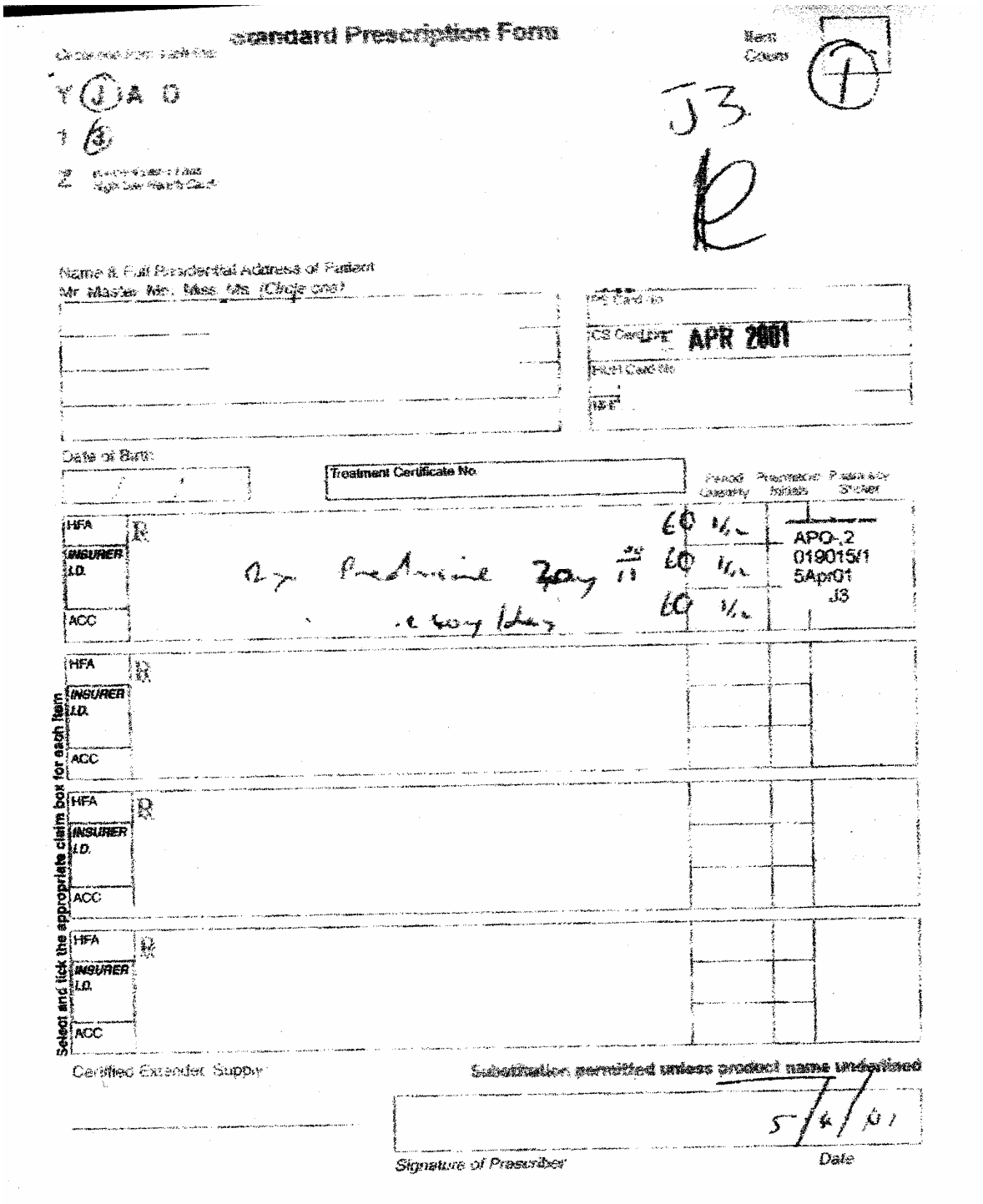
Certified Repeat Copy

Initial dispensing: 28 Feb 01 13:02
Repeat dispensing: 24 March 01 10:53
Print date: 24 March 01

Rx: 1016057/2 Quantity: 56
Med: Prednisone 20mg Tablets
Sig: Take TWO TABLETS TWICE DAILY with food

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 5



Standard Prescription Form

Item Count 1

J3

Name & Full Residential Address of Patient
Mr Master Mrs. Miss Ms (Circle one)

PHO Card No

ICS Card No DATE APR 2001

PHO Card No

NHI

Date of Birth

Treatment Certificate No.

Period Quantity | Prescriber Initials | Pharmacist Initials

HFA INSURER I.D. ACC

℞ Prednisone 20mg tds x 3 days
then 20mg bd x 3 days
then 20mg od x 3 days

60 ½
60 ½
60 ½

APO-2
019015/1
5Apr01
JB

HFA INSURER I.D. ACC

HFA INSURER I.D. ACC

HFA INSURER I.D. ACC

Select and tick the appropriate claim box for each item

Certified Extended Supply

Substitution permitted unless product name underlined

5/4/01

Signature of Prescriber Date

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 6

831	28-Feb-01	28-Feb-01	16057	1	2	I
831	31-Mar-01	24-Mar-01	16057	2	2	I
831	15-Apr-01	15-Apr-01	16057	1	0	C
831	15-Apr-01	28-Feb-01	16057	1	2	R

56	56	Prednisone	Tab 20 mg	tab	J
56	56	Prednisone	Tab 20 mg	tab	J
-56	-56				
56	56	Prednisone	Tab 20 mg	tab	J

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