Incorrect identification of patient when dispensing methadone (06HDC17949, 5 May 2008)

Pharmacist ~ Pharmacy ~ Identification ~ Methadone client ~ Dispensing error ~ Standard operating procedures ~ Right 4(1)

A methadone client attended a pharmacy for his daily methadone prescription. The pharmacist mistook him for another methadone client and provided him with a much larger dose than he had been prescribed. The client consumed the dose and died a short time later.

The licence holder and owner of the pharmacy advised that his expectation was that pharmacists would identify all clients, whether they knew them or not, by asking them to identify themselves. However, pharmacists who worked at the pharmacy said that it was common practice to identify clients they knew by physical recognition. If the client was unknown to the pharmacist, he or she would be asked to produce some form of identification. The standard operating procedures in place at the time of the incident required that the pharmacist "confirms the identity of the patient".

It was held that the pharmacy did not have adequate procedures in place at the time of the incident, in particular for identifying patients, or for ensuring staff were given appropriate guidance and instruction about how to confirm the identity of patients. Accordingly, the pharmacy breached Right 4(1).