Reporting of dispensing error
(14HDC00439, 24 June 2015)

Pharmacist ~ Pharmacy technician ~ Pharmacy ~ Dispensing error ~ Incident report ~ Open disclosure ~ Information ~ Rights 4(2), 4(4), 6(1)

A man presented at a pharmacy to have a new prescription filled and to pick up a repeat of his regular medication. One of the medications for repeat was cyclosporine 50mg. Cyclosporine is an immunosuppressant used to prevent rejection following transplants. The man had previously had a kidney transplant. Cyclosporine capsules are white, sealed with foil, and dispensed in a cardboard box.

The prescriptions were processed by the pharmacy technician. Cyclophosphamide 50mg tablets were selected from the shelf instead of cyclosporine 50mg capsules. Cyclophosphamide is a chemotherapy drug used to treat certain types of cancer, and is dispensed as small pink tablets in a bottle. The pharmacist checked the medications and initialled the dispensing record for each repeat medication dispensed.

Approximately seven weeks later, the man presented at the pharmacy for a regular test. After the test, the man showed the cyclophosphamide tablets to the pharmacist, and enquired as to why the tablets were different from his regular cyclosporine capsules. The pharmacist told him that the tablets were a “discontinued product”, and that he should stop taking them. The man left the cyclophosphamide tablets with the pharmacist.

Following the consultation, the pharmacist immediately looked up who had dispensed the cyclophosphamide tablets and noted that the prescription had been processed by the pharmacy technician and the dispensing record signed off by himself. The pharmacist then changed the stock levels on the pharmacy’s computer system. The pharmacist did not complete an incident form or notify the pharmacy owner of the error. The pharmacy owner was away from the pharmacy at the time the pharmacist became aware of the error, but returned approximately 20 minutes later.

Later that same day, the pharmacy owner processed an order for medications, and noted that there was no remaining stock of cyclophosphamide tablets. The pharmacy owner questioned his staff about this, but the pharmacist did not disclose the error.

Two days later, the man returned to the pharmacy and asked to speak to the pharmacy owner in private. The man showed the pharmacy owner the remaining cyclophosphamide tablets in his possession, and outlined the pharmacist’s explanation for the tablets. The pharmacy owner told the man that he would look into the matter further.

Following the pharmacy owner’s conversation with the man, the dispensing error was discovered, and the pharmacy contacted the man and his GP to alert them to the incident. The pharmacy also undertook an internal investigation.

By making a serious dispensing error, the pharmacist did not comply with professional standards and was in breach of Right 4(2). The pharmacist also breached Right 6(1) by failing to disclose the dispensing error to the man as soon as he became aware of it. The pharmacist’s failure to report the error was in breach of the pharmacy’s policy, and professional standards, and a breach of Right 4(2). For failing to take appropriate actions to mitigate the risk of serious harm to the man, the pharmacist breached Right 4(4).

Adverse comment is made about the pharmacy technician's error in selecting cyclophosphamide 50mg tablets instead of cyclosporine 50mg capsules.

The Director of Proceedings filed a charge before the Health Practitioners Disciplinary Tribunal. Professional Misconduct was made out and the pharmacist was fined and had two conditions placed on his practice.