Pharmacist, Mr D

A Pharmacy Company

A Report by the

Health and Disability Commissioner

(Case 04HDC15595)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Mrs B	Complainant/Consumer's daughter
Mrs C	Complainant/Consumer's daughter
Mr D	Provider/Pharmacist
Mrs E	Pharmacy assistant
Mr F	Pharmacist
A Pharmacy	Pharmacy

Complaint

On 24 September 2004 the Commissioner received a complaint from Mrs B about services provided to her mother, Mrs A, by a pharmacy. The issue for investigation was summarised as follows:

- *Whether on 9 September 2004 the pharmacy correctly packaged and gave out Mrs A's blister pack medication.*

On 25 January 2005 the investigation was extended to include pharmacist Mr D and the following issue:

- *Whether on 9 September 2004 Mr D correctly packaged Mrs A's blister pack medication.*

An investigation was commenced on 3 December 2004.

Information reviewed

- Complaint received from Mrs B

- Information from:
  - Mrs A
  - Mrs C
  - Mr D
  - Mrs E, pharmacy assistant
  - Pharmacy Council of New Zealand
  - Pharmacy Society of New Zealand Incorporated

Information gathered during investigation

Medication error
On Monday 6 September 2004 Mrs A rang the pharmacy and requested that a repeat of her monthly blister pack medication be delivered to her room at a retirement village by Thursday 9 September. Mrs B (Mrs A's daughter) explained that Mrs A's medications were primarily for heart failure. She stated:

> "My mother is 85 years of age, and partially sighted having macular degeneration in one eye and a cataract and some macular damage in the other eye. She has a significant number of health issues having had two heart attacks and a stroke, with blood pressure that needs to be controlled. For this reason she has her prescriptions made up into blister packs. She takes something like seven tablets in the morning and one in the evening."

Around midday on Thursday 9 September Mrs A's medication had not yet arrived so she contacted the pharmacy again. The pharmacy informed her that they had overlooked her prescription but would ensure it was delivered later that day. At approximately 5pm, the pharmacy office manager, Mrs E, delivered a package of medication addressed to Mrs A care of the main desk at the retirement complex, as Mrs A was not in her room. Mrs E stated:

> "I am aware of the patient being visually impaired, and whenever I have delivered to her room, I always open the bag to check with her that the contents are what she is expecting, and that she has no further queries before I leave. This particular day, [Mrs A] … was not at home when I called."

Mrs A collected the medication from the reception desk as she made her way back to her room after dinner. She received a paper bag containing morning and evening blister packs together with separate containers of paracetamol and frusemide.

Mrs A's morning blister pack should have contained thyroxine 100mcg, pantoprazole 40mg, candesartan 2mg, allopurinol 100mg, Cartia 100mg, metoprolol 23.75mg and folic acid 5mg, as prescribed by her general practitioner. However, the morning pack delivered to her on 9 September 2004 contained multivitamin tablets, captopril 12.5mg, Solprin 300mg, calcium carbonate (Osteo) 1.25mg, potassium chloride (Span) 600mg and fluoxetine 20mg, and was marked for a different patient.

Mr D explained that this was an inadvertent error which, he believed, had occurred when the correctly dispensed blister packs for Mrs A and the second patient became mixed up at the time they were put into a bag for delivery to Mrs A:

> "As I was … the sole pharmacist on duty on 9 September, I must accept full responsibility for the incorrect medication pack being delivered to [Mrs A]. As you can see from the complaint report that was completed after the incident [see below] we have treated the matter very seriously and I must say that I am personally devastated that this has happened under my care.

…

> Due to the time that ha[s] elapsed I can only remember completing two patients' packs and leaving them on the packing bench ready for final check and delivery. I do not remember actually bagging the separate orders with receipts attached nor giving them to our delivery person. It is normal for me to complete the process to the point that the medication is bagged and ready for delivery and in a situation where I am sole pharmacist I must assume that in this case I did just this, as was my responsibility both ethically and in compliance with our SOPs [standard operating procedures]. Therefore, it is logical to assume that I must have made a collation error between the two orders and inadvertently swapped the patients' packs during the final check before bagging the packs."

On Friday 10 September Mrs A started taking the new blister pack medication. Mrs A explained that her blister packs are labelled, but due to her visual impairment she cannot read the list of medications and also has difficulty recognising the individual tablets/capsules. However, when she first took the morning blister pack tablets that she had received on 9 September, Mrs A noticed that there were the same number of pills, but some were a different shape/size than normal.

After a few days Mrs A began to feel unwell with a "bloated stomach" and increasing anxiety. On Tuesday 14 September Mrs A asked her daughter, Mrs C, to check her medications. Mrs C found that the evening blister pack was correct but the medications in the morning blister pack were not for Mrs A and were therefore incorrect.

Mrs C telephoned a medical centre and was advised by a general practitioner that the incorrect medication her mother had taken should not be too harmful but that her blood pressure should be checked. Mrs C then took Mrs A to the medical centre, where she was seen by the practice nurse. Mrs A's blood pressure was recorded as elevated (200/110) and the family was advised to check it again in the morning at the hospital, where Mrs A was scheduled for a cataract operation. (Mrs A's family decided to cancel this operation because of their concerns about her blood pressure.) Mrs A's blood pressure gradually returned to normal over the next few days.

Pharmacy response to error

The pharmacy was informed of the error and it provided the correct medication to Mrs A later on 14 September. Mrs B's complaint was recorded on a pharmacy customer complaint form, as follows:

> "On 14/9/04 [Mrs B] called [the pharmacy] to advise that there was a problem and mix up with her mother's medication. This was promptly investigated and it was discovered that one of her packs had been inadvertently mixed up with another patient's pack."

On Friday 17 September Mrs B telephoned the pharmacy and discussed the error with the co-owners, pharmacists Mr F and Mr D. They apologised and advised her that this was the first time an event like this had occurred. They said the error was due to the fact that Mrs

A's original request for a repeat prescription was not processed, and they had needed to process her repeat quickly when she followed it up. The pharmacy also noted that Mrs A was not at home when the delivery was made. Mr F and Mr D assured Mrs B that the pharmacy reviewed procedures regularly and felt that there were no other precautions they could take in addition to their current practices.

Mrs A explained that Mr F sent her a letter of apology dated 8 October 2004 after they had an argument over her transfer to another pharmacy and after Mrs B made the complaint to my Office. Mr F wrote:

> "… I would like to also apologise for the recent mix-up in your foiled medication – we have been looking after you for a little while and hopefully you would agree that we do try and look after you especially closely with [Mrs E] always going through your medication with you. It was extremely unfortunate that the cross-over occurred (something we have looked into) – and I accept and understand your decision to go elsewhere for your future medication needs."

Mrs A was concerned that the pharmacy did not fully explain how the mix-up had occurred. Overall, she did not feel that the incident had been dealt with as if it was a "serious error". Mrs B commented:

> "It was because I did not believe I had received adequate reassurance from one partner that I spoke to the other, and it was because I felt their response was inadequate for the safety of future patients that I discussed this with my mother and sister, with a view to seeking assistance to ensure that they did take our concerns seriously.
>
> Their seeming lack of concern and lack of assurance of follow-up action was the major factor in our family's decision to take this matter up with the Health and Disability Commissioner."

The pharmacy report into what occurred was completed on 21 September 2004 by pharmacist Mr D. Mrs A and Mrs B were not informed of the results of the pharmacy investigation. The report stated:

> "As soon as the error had been discovered, following the phone call from [Mrs A's] daughter, we immediately contacted the second patient involved (where the switch had occurred) and picked up [Mrs A's] correct morning pack and delivered it to her straight away. The 'wrong' pack was collected from [Mrs A] and a full replacement given to the second patient who had not at that stage started using her packs as she still had other medication remaining. The correct pack that was delivered to [Mrs A] was delivered by one of our senior technicians as the pharmacist was unable to leave the business unattended. Our technician conveyed our full concern and apologies for the error and explained in detail what medications [Mrs A] had been taking and that they were not likely to cause any detrimental effects apart from the fact that she had not been having her blood pressure medication, which had subsequently resulted in an increase in her blood pressure. Mrs A's daughter was present at the time that the pack was delivered."

The report listed a number of follow-up actions to be taken by the pharmacy, including:

- Investigation into why the order (Mrs A's repeat prescription) was not processed when it was initially received.

  This was believed to be due to new staff being on duty, and was an oversight. Mr D and Mr F have since stressed with pharmacy staff the importance of acting on all patient requests promptly.

- Verbal apologies by both owners to Mrs B including an assurance that they would investigate the matter thoroughly.

  Mr D and Mr F believed that these discussions explained and resolved the incident to the point that no further patient/caregiver follow-up was indicated apart from the future monitoring of pharmacy processes. They believed their apologies were "appropriate and sufficient".

- Review of systems to prevent reoccurrence of the error.

  The error was considered not to have been caused by pharmacy systems, but by human error on the part of Mr D in making a sorting error.

- Where possible, ensuring that all patients have their medications reviewed on receipt.

  In respect of this issue Mr D advised that the pharmacy had systems and policies in place to ensure medication review occurred at the time of delivery to a patient. Pharmacy procedures are discussed below (see Standard Operating Procedures).

Mrs A recalled that, five days after the error with her blister packs, she opened her door to a person from the pharmacy with a delivery. Mrs A refused to take the delivery as she was not expecting any further medication at that time. On checking with the delivery person, it was found that the delivery was intended for a different apartment at the retirement village. Mrs B also advised that two previous errors had occurred with Mrs A's prescriptions:

> "The first error was a simple mistake of including her [frusemide] tablets in the blister pack instead of dispensing separately; the second was a complete change in how the blister packs were made up without advising [Mrs A], which led to her being unable to take her medication until I could get to her apartment and check them."

Mrs B regarded the two previous errors as minor, and they were included only as background to her complaint. She emphasised that the 9 September error was the "most serious":

> "I cannot express how distressed and angry my sister and I are at this latest incident. We could so easily have lost our mother as a result of such carelessness. What I want to ensure by making this complaint is that the pharmacy, which has a significant clientele at

> the retirement complex where my mother lives, is forced to institute thorough processes and procedures to ensure that this type of incident cannot happen again."

Mr D responded to the "background" concerns raised by Mrs A and Mrs B, as follows:

> "It is very disappointing to read the other items … as I believe that these are not accurate nor true reflections of the care and overall level of service and competency we provide. … [Mrs E] who handles all deliveries to [the retirement village] … is aware that [Mrs A] is visually impaired and always endeavours to go through her medications with her to ensure that she is fully conversant with them. When we changed from the hot seal to cold seal [blister] packs, [Mrs E] spent time explaining in detail the format changes to avoid any confusion. The reason for the change in packs was to provide a superior quality product."

As noted above, Mrs B disputes that her mother was informed of the change in blister packs, and is certain that Mrs A would have recalled any such discussion.

Standard Operating Procedures
The pharmacy SOP 52 "Unit Dose Packaging" at point 6.2 states that a qualified pharmacist must complete the final check of the medication inside the unit dose packs against the patient medication folders and/or prescriptions. The blister pack medication is to be dispensed in accordance with SOP 18 "Dispensing Medication" and checked according to SOP 23 "Final Prescription Check".

The Pharmacy SOP 18 "Dispensing Medication" states:

> "8.0 Procedure
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> …
>
> 8.6 Allow a qualified pharmacist to check the prescription according to SOP 23 before placing both the prescription and medication in a bag and staple the receipt to it. Ensure that the number of items in the bag matches the number of receipts and the number of items on the prescription.
>
> 8.7 Place the bag on the shelf in alphabetical order in dispensary if the patient is not waiting for it or hand it on to the counselling pharmacist to give to any patients waiting."

The pharmacy SOP 23 "Final Prescription Check" describes the steps in the checking process and states:

> "6.0 Responsibility
>
> 6.1 It is the responsibility of all qualified pharmacists in the dispensary to ensure that each completed prescription is checked before it is handed out to the patient (or put away for delivery/postage).
>
> 6.2 It is the responsibility of the pharmacist checking the prescription to sign the prescription as having been checked and sign the patient's receipt."

The final step in the checking process (point 8.9 of SOP 23) is to place the prescription and medications inside the bag and attach the receipt to the outside.

Mr D explained that the dispensing pharmacist is responsible for placing the correct medication into the bags for delivery, which should then be noted in the delivery log. On checking the delivery log for 9 September, it is apparent that Mrs A's medication and delivery is not listed. Although it was his normal practice and occurred "99% of the time", Mr D cannot confirm without doubt that he bagged the medication for delivery, as two other staff members were present, a pharmacy technician and the office manager. However, he accepts that it should have been bagged by him as part of the final dispensing process. Mr D has reviewed his practice and will now only let medications go out when he has bagged them personally. Mr D accepts full responsibility, as the charge pharmacist and sole pharmacist on duty, for what occurred that day.

In a busy pharmacy there will often be occasions where two prescriptions are being dispensed at one time, such as when a pharmacist is dispensing a retirement village prescription and receives an urgent prescription. Mr D explained that there is often a delay before medication is bagged while a patient is counselled. It is Mr D's practice to complete all the checking steps required in the pharmacy SOPs regardless of interruptions. Mr D further explained:

> "Prescriptions that are being dispensed in tandem are kept separate on the bench, by allowing a space between them. They will be moved to allow space between each prescription form. The same applies if a technician is assisting and has scripts along the bench ready for checking. In the case of Compliance (blister) packaging, it is undertaken in relation to other dispensing, in a separate dedicated area in the dispensary to allow for better continuity. The packs that had been correctly dispensed for [Mrs A] were left on the back of the bench in this dedicated area ready for bagging/delivery."

Mr D explained that Mrs A's prescription was a repeat blister pack. The pharmacy SOP 16 "Repeat Prescriptions" (now amended) stated that certified repeat copies of prescriptions were printed from the computer and used as the prescription form before filing in batches. However, actual practice at the time of the error was not to dispense from a certified repeat copy of the prescription. A new process had been introduced whereby the third part of the

dispensary label was collated onto a daily repeat log, which was annotated by the dispensing pharmacist as an audit trail. Mr D provided a copy of the relevant daily repeat log, which confirmed that he had initialled Mrs A's prescriptions as correct. On 21 February 2005 Mr D amended the pharmacy SOP 16 "Repeat Prescriptions" to reflect this change in the dispensing of repeat prescriptions, which now states:

> "8.0 Procedure
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> …
>
> 8.6 The repeat prescription is dispensed as per SOP 18 and follows the regular prescription flow chart from this point onwards. The 3rd part of the dispensary label is attached to the daily repeat log and is initialled by the dispensary pharmacist as checked."

Mr D informed me that deliveries must be given to the patient or a caregiver rather than left in a letterbox or on a doorstep. This policy is "strictly adhered" to by delivery staff and, if a patient is not home, the medication is returned to the pharmacy. The pharmacy SOP 27 "Delivery/Postage" states:

> "6.0 Responsibility
>
> 6.1 It is the responsibility of the dispensary manager to ensure that all deliveries are made in a timely fashion and that they are recorded appropriately.
>
> 6.2 It is the responsibility of the person making the delivery to ensure that if the person is not available the delivery is not made and the person is made aware that it was attempted by leaving an 'Unable to Deliver' note."

However, the pharmacy has an arrangement with the retirement village for medications to be left with staff at the main office if the patient is not available. Mr D stated:

> "[Mrs A] lives at a retirement village and as such there is a main office and the staff at the main office are deemed to be the caregivers of the patients at the retirement village. It was deemed to be safe and normal practice in this retirement village for us to leave the medication with caregiver staff at the main office and for them to deliver to [Mrs A] when she returned to her unit."

Mr D commented that it was most unfortunate that Mrs A was not available when the medications were delivered, as if the packs had been delivered to her directly he is certain the error would have been identified.

Mrs A confirmed that Mrs E normally checks that it is the correct delivery for her, but disputed that Mrs E goes through the medication with her as a matter of course. In addition, Mrs B doubted that it was Mrs E who delivered the medication, as it was her understanding that Mrs E was on holiday.

Actions taken
Mr D advised that as a result of this incident he has reviewed the relevant SOPs but has found no specific changes that could be implemented to avoid a recurrence. Mr D has concluded that the error in bagging Mrs A's prescription was due to workload and human error, which occurred during the final checking and collation process. He commented that the incident highlights the need to ensure appropriate separation of each patient's dispensed medication, and completion of each order sequentially, and all staff have been made aware of this requirement. He advised that the last full audit of the pharmacy SOPs was carried out by Medsafe on 4 July 2002, and the pharmacy demonstrated full compliance in all aspects of pharmacy practice and quality standards. In addition, the pharmacy SOPs had been reviewed and updated by him shortly prior to this incident.

Mr D commented that in almost 30 years of pharmacy practice this is the most serious incident he has had to deal with personally, and admits full responsibility. He offers his sincere apologies to Mrs A and her family for the distress and inconvenience it caused them. Mr D stated:

> "This incident has had a major impact on my life and practice as a pharmacist. I am extremely concerned about the ramifications this could have on my pharmacy and on my future. I have also found this whole situation very stressful and have commenced professional counselling to assist me through the process so that I may hopefully continue working effectively as a community pharmacist within my community."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

Other relevant standards

The Pharmaceutical Society of New Zealand *Code of Ethics* (June 2001) Principle 2.6 stated:

> "The pharmacist who is responsible for the dispensing of a prescription must verify its authenticity, interpret and evaluate the prescription, ensure it is correct and complete, assess its suitability for the patient within the limitations of available information, and dispense it correctly."[1]

The Pharmaceutical Society of New Zealand *Quality Standards for Pharmacy in New Zealand* Standard 6.2 states:

> "The pharmacist maintains a disciplined dispensing procedure which ensures that the appropriate product is selected and dispensed correctly and efficiently."

The Medicines Act 1981, section 18, states:

> "(2) No person may sell by retail any prescription medicine otherwise than under a prescription given by a practitioner, registered midwife, veterinarian, or designated prescriber."

Opinion: Breach – Mr D

Under Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code), Mrs A had the right to have pharmacy services provided that met professional and ethical standards. The standards that apply in this case are determined by the Pharmaceutical Society of New Zealand (as it then was).[2] Under principle 2.6 of the Pharmaceutical Society of New Zealand *Code of Ethics* (June 2001), and as a matter of good practice, prescriptions must be dispensed correctly. In addition, standard 6.2 of the Pharmaceutical Society of New Zealand's *Quality Standards* places a duty on a pharmacist to maintain a disciplined dispensing procedure that ensures that the appropriate product is dispensed. The Pharmaceutical Society of New Zealand has issued the following definition of dispensing:

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[1] After 18 September 2004 the Pharmacy Council of New Zealand *Code of Ethics 2004* is applicable, which is to be read in conjunction with Current Acts and Regulations and Codes of Practice.

[2] On 18 September 2004 the Pharmaceutical Society of New Zealand was dissolved, and the Pharmacy Council of New Zealand was established as the registration/complaint body for pharmacists in New Zealand. In addition, the Pharmaceutical Society of New Zealand Incorporated (the Society) was established as an independent non-statutory professional body responsible for professional support, education, training and career development for all pharmacists. The Society has retained responsibility for professional Codes of Practice.

> "Dispensing includes all processes which occur from receipt of the prescription, medicine order or request at the pharmacy to the prescribed item being collected or delivered to their patient or their representative."[3]

The standard operating procedures (SOPs) in place at the pharmacy were required to comply with the above professional standards. The SOPs for blister packs required that they be dispensed according to SOP 23 (final prescription check) and SOP 18 (dispensing medication). The last step of the dispensing process required the medication to be placed in a bag, normally by the dispensing pharmacist.

It is not disputed that Mrs A received another patient's blister pack. As a result Mrs A not only took someone else's drugs, but also was without her correct medication for four days, which was potentially very serious. Fortunately, she asked her daughter, Mrs C, to check whether her medication was correct as she was feeling unwell. Although Mrs A did have an increase in her blood pressure, she did not experience any permanent adverse consequences. However, Mrs A and her family are understandably distressed that she received the wrong medication from the pharmacy. Medication is put into blister packs as an explicit safety precaution to ensure that patients take their correct medications in the correct doses, and Mrs A had her medication dispensed in blister packs because she is partially sighted and is required to take a number of medications.

Mrs A's blister packs were correctly prepared by pharmacist Mr D. The other patient's blister packs were also correctly prepared. Mr D explained that in a busy pharmacy there are often occasions when more than one prescription is being prepared, and medications are not necessarily bagged as soon as the prescription is dispensed. He cannot recall whether he bagged the orders on this occasion, although this was his normal practice and occurred "99%" of the time.

Clearly there are occasions when different prescriptions are being dispensed in the pharmacy, and often more than one staff member will be involved in the dispensing process. However, it is critical that pharmacy staff exercise caution and ensure that prescriptions are properly separated throughout the entire dispensing process. The pharmacy SOPs make it clear that the bagging of medication is the final step in the dispensing process. In this case, it appears that human error or haste on the part of Mr D (or another pharmacy staff member) caused Mrs A's prescriptions to be bagged incorrectly. Mr D has appropriately accepted full responsibility for the error, as the dispensing/charge pharmacist on duty that day.

Mr D failed to comply with the Pharmaceutical Society of New Zealand *Code of Ethics* (June 2001), the *Quality Standards*, and the pharmacy SOPs, which required him to

[3] See page 101, *Pharmacy Practice Handbook 2003*, Pharmaceutical Society of New Zealand.

dispense Mrs A's blister pack prescription correctly. In addition, Mr D had responsibility under SOP 27, 6.1 to ensure the delivery was appropriately recorded in the pharmacy records, and failed to do so.

I note that the dispensing error also probably contravened section 18 of the Medicines Act in that Mrs A was supplied medicines otherwise than under a prescription. As noted above, the dispensing process is not restricted to the actions taken by pharmacy staff to prepare medications, and is defined in the *Pharmacy Practice Handbook* as including the bagging and delivery of medication.

Accordingly, in failing to comply with these legal and professional standards, Mr D breached Right 4(2) of the Code.

Opinion: No Breach – The Pharmacy Company

Vicarious liability
In addition to any direct liability for a breach of the Code, employers may be vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for any breach of the Code by an employee. Under section 72(5), it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from doing, or omitting to do, that which breached the Code.

Mr D, a director of the pharmacy company, breached Right 4(2) of the Code. Mr D has carefully scrutinised his practice and the pharmacy SOPs following this incident and has not found any specific changes that could be implemented. He has reminded all staff of the importance of carefully carrying out every step in the dispensing process. There is no evidence to suggest that the pharmacy SOPs were not appropriate. I note that a full Medsafe audit was performed on 4 July 2002 and the pharmacy SOPs were fully compliant with pharmacy practice and quality standards.

It is not ideal that the SOP for repeat dispensing had not been amended to reflect the new system of collating the third part of the label onto a daily repeat log for annotation rather than using the certified repeat copy. Nevertheless, the error was not due to any inadequacy of the pharmacy's repeat dispensing practices or other systems errors. Accordingly, no issue of vicarious liability arises in relation to the pharmacy.

Other comment

Delivery practice
Pharmacy SOP 27 "Delivery/Postage", paragraph 6.2 requires deliveries to be made directly to a customer, otherwise an "Unable to Deliver" sign is to be left. Mr D has advised that this procedure is strictly adhered to, but there is an arrangement with the retirement village for medications to be left with main office staff, who are deemed to be the patient's "caregivers". However, Mrs B has been told by the retirement village that they have no role in checking delivered medication. In my view, leaving medication in the possession of the retirement village staff to be handed to residents is a satisfactory arrangement only when the pharmacy has taken action to ensure the patient will receive appropriate information about the medication, together with the correct medication.

Other incidents
Mrs B also mentioned two other alleged errors that she believed had occurred, by way of background to her complaint. I understand that these matters were not previously drawn to the attention of the pharmacy. Mr D disputes that these matters are a true reflection of the service provided by the pharmacy. Staff were aware that Mrs A was visually impaired and, in Mr D's view, took appropriate steps to ensure she understood her medications. Because of the discrepancy between Mrs A's recollections and the response by the pharmacy I am unable to determine what occurred.

Actions taken

Mr D, as the dispensing pharmacist, has accepted responsibility for the error in packaging Mrs A's medications and expressed his remorse about what occurred. Mr D has carefully reviewed his practice and now ensures that he always bags the medication he has dispensed personally. He has also reminded staff of the importance of completing every step in the dispensing process. He has sought professional counselling to assist him with his practice following the error.

Mr D and Mr F verbally apologised to Mrs B on behalf of the pharmacy on 17 September. (As noted above, Mrs B was not satisfied with their explanation.) On 8 October Mr F wrote to Mrs A about her decision to go elsewhere for pharmacy services and apologised for the error. The pharmacy has reviewed the relevant SOPs (but has made no amendments).

I note that Mrs A and her family considered the matter was not dealt with seriously by the pharmacy, which led to their complaint, and it appears they were not informed of the outcome of the internal investigation. This was an unfortunate omission by the pharmacy. In all other respects, I consider that Mr D and the pharmacy have taken appropriate steps to review processes in response to the medication error.

Recommendations

I recommend that Mr D:

- Apologise to Mrs A for breaching the Code. This apology is to be sent to the Commissioner and will be forwarded to Mrs A.

- Review the pharmacy's medication delivery practice in light of this report.

Follow-up actions

- A copy of this report will be sent to the Pharmacy Council of New Zealand.

- A copy of this report, with details identifying the parties removed, 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.