

**Dispensing error – incorrect strength of lithium carbonate
(15HDC01016, 23 June 2016)**

Pharmacy ~ Pharmacist ~ Dispensing error ~ Policy ~ Lithium carbonate ~ Professional standards ~ Right 4(2)

A 32-year-old woman had been taking lithium carbonate for approximately four years, and was on a regimen to wean her off the medication slowly. The woman saw her general practitioner who prescribed her with a 90-day supply of lithium carbonate, totalling 450 tablets of 250mg strength, with the instruction to take five tablets once daily at night.

The woman went to a pharmacy to get her prescription filled. A pharmacist assembled, checked and dispensed the prescription and, in doing so, mistakenly provided the woman with 400mg lithium carbonate tablets instead of the prescribed 250mg tablets.

When assembling the medication the pharmacist was interrupted by a dispensing technician enquiring about the medication of another consumer and, once the pharmacist had finished her conversation with the technician, the pharmacist picked up the lithium carbonate stock bottle (containing 400mg tablets) but did not check the strength of the bottle. The pharmacist also performed the two-stage checking process herself but did not open and check the contents of the bottle to be given to the woman against the original prescription or the stock bottle. The pharmacist then gave the medication to a shop assistant to hand to the woman.

The pharmacy's dispensing standard operating procedure (SOP) requires that the person assembling medication with multiple strengths (such as lithium carbonate) check the strength of the medication. At the checking stages, the dispensing SOP requires that the person checking the medication open the bottle to check the contents against the prescription and the stock bottle. The dispensing SOP also states that where more than one member of the dispensary staff is on duty, a dispensing should be checked by another appropriate person (eg, a pharmacist or dispensing technician).

It was held that the pharmacist breached Right 4(2) for failing to dispense the prescribed lithium carbonate correctly and ensure that her dispensing was checked appropriately. Adverse comment was made about the pharmacy regarding the time it took to document the error initially (eight days after being notified of the error).

It was recommended that the pharmacist provide the woman with an apology for her breach of the Code. It was also recommended that the pharmacy conduct an audit on staff compliance with its dispensing SOP and an audit on all errors and near misses in the last six months up until the date of this report.