Pharmacist, Mr C

A Pharmacy Company

A Report by the

Health and Disability Commissioner

(Case 04HDC10718)

Health and Disability Commissioner

Parties involved

Mrs A	Consumer
Ms B	Complainant/consumer's neighbour
Mr C	Provider/Pharmacist
A Pharmacy Company	Employer
Dr D	General practitioner
Dr E	House surgeon, a public hospital
Ms F	Registered nurse, a public hospital

Complaint

On 23 June 2004, the Commissioner received a complaint from Ms B about a pharmacy. The complaint was made on behalf of her neighbour, Mrs A, to the Pharmaceutical Society of New Zealand, which forwarded the matter to this Office. The following issues were identified for investigation:

Whether the pharmacy provided services of an appropriate standard to Mrs A on 15 June 2004, in particular:

- *The evening supply of quinapril was omitted*
- *Atorvastatin was doubled from the prescribed 40mg to 80mg each night*
- *Wrong instructions were given – medication to be taken on the evening of Tuesday 15 June 2004 was marked for "Tuesday morning".*

The investigation was commenced on 5 October 2004.

Information reviewed

- Ms B's letter of complaint to the Pharmaceutical Society of New Zealand, dated 21 June 2004
- The pharmacy company's Standard Operating Procedure for dispensing
- Copies of Mrs A's prescriptions written by Dr D and Dr E
- Information provided by:
  - Mrs A
  - Ms B
  - Mr C

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

Information gathered during investigation

Background
Mrs A is elderly and has poor eyesight. She also has a heart condition managed with the following ongoing medications prescribed by her general practitioner, Dr D:

Soluble aspirin 300mg ½ daily (to thin the blood)
Didyridamole 150mg capsule, one capsule daily
Accupril 20mg ½ daily (for the heart)
Selectol 200mg, three tablets daily (for blood pressure and heart)
Atorvastatin 40mg, one daily (cholesterol medication)
Zyloprim 100mg, one tablet daily (also known as Allorin – for gout)
Paradex one to two tablets four hourly or as required (pain relief).

In June 2004, Mrs A suffered a minor stroke and was admitted to a public hospital for treatment. She was prescribed the following additional medication by Dr E, house surgeon, on 14 June 2004:

Calcium carbonate (1.25mg) one in the morning (for osteoporosis)
Diltiazem (120mg) one in the morning (calcium antagonist)
Multivite Six Tablet, two tablets in the morning
Warfarin (1mg) 1mg to 5mg at dinner time (to thin the blood)
Quinapril (10mg) 15mg twice daily (also known as Accupril – for the heart).

Mrs A was required to take several new medications. Ms F, registered nurse, who had been involved with Mrs A's care in the public hospital, was concerned about Mrs A's ability to manage all her medications. To reduce the possibility of confusion, she suggested that Mrs A contact her local pharmacy to request that her medication be dispensed in blister packs. According to Ms F, Mrs A did not express any concerns about her medication during this discussion.

As warfarin was one of the new medications Dr E had prescribed, Ms F explained to Mrs A the effects of taking this medication. On 9 June 2004, she was given a booklet about warfarin.

On 14 June 2004, Mrs A was discharged from the public hospital. During the following morning, Ms B, who is a registered nurse, visited her to ascertain how she was managing. She found Mrs A very distressed as she had spent approximately five hours the previous evening sorting out the medication she was supposed to take. Mrs A was unsure whether she had sorted out that morning's medication correctly, and was concerned about her ability to cope with taking multiple medications correctly on an ongoing basis.

To assist Mrs A, Ms B contacted her regular pharmacy, which is owned by the pharmacy company. She spoke to Mr C, registered pharmacist, over the telephone to enquire whether Mrs A's medication could be dispensed in blister packs. As Mr C was unable to accede to the request, he suggested dispensing Mrs A's medication in stacker-trays (at an initial cost

of $17.00) which would be refilled weekly for a charge of $3.00. Mrs A informed Ms B that she was agreeable to managing her medications that way.

Mr C explained that a stacker-tray is a plastic container with eight trays, seven of which are marked with the days of the week from Sunday to Saturday, and the eighth being an unmarked spare tray. Each respective tray has four compartments labelled morning, noon, evening and night. The labelling and compartments help patients to identify the medications they are required to take at a particular time of the day.

Dispensing – Tuesday 15 June 2004

After speaking to Mr C on 15 June, Ms B took all of Mrs A's medications to the pharmacy for Mr C to sort into the respective compartments in the stacker-tray. When she collected Mrs A's medication an hour later, Ms B discovered that Mr C had made several dispensing errors. First, he had omitted the evening supply of quinapril 15mg. Secondly, he had doubled the supply of atorvastatin by putting two 40 mg tablets (80mg in total) into the evening compartments, although Mrs A had been prescribed only one 40mg tablet each night. Thirdly, as Mr C had intended Mrs A to commence taking her medication from the stacker-tray the following day (Wednesday), he placed her medication for that Tuesday evening into a separate paper bag and explained this to Ms B. However, despite his verbal instruction, he mistakenly labelled the paper bag with "Tuesday morning" instead of "Tuesday evening". Ms B was alerted to this error as it was inconsistent with Mr C's verbal instruction. Furthermore, she was aware that Mrs A had taken her medication for Tuesday morning by the time Ms B brought her medications into the pharmacy. When she contacted Mr C again, he apologised for the dispensing errors he had made. Mr C then contacted Dr D to inform him of the dispensing errors. Because Ms B had discovered the errors before delivering the stacker-tray to Mrs A, she was not adversely affected.

Mr C informed me that Mrs A took about 10-12 different drugs. On 15 June 2004, Ms B had presented him two new prescriptions for Mrs A; one from Mrs A's general practitioner, Dr D, and the other from Dr E at the public hospital. He made the dispensing errors as a result of misinterpreting information from both prescriptions. He explained that he had looked at the medications in the trays but did not double check the contents of each respective compartment.

Mr C explained that when dispensing, it is his practice to work on one prescription at a time. However, as the pharmacy is located in close proximity to a medical practice (approximately 100 yards away), he is often interrupted by telephone enquiries where callers require immediate answers, as well as patients who require their prescriptions to be dispensed urgently. Being the sole pharmacist of the pharmacy, this necessitates him leaving the prescription he is working on and returning to it later. Due to the passage of time, Mr C could not recall whether the pharmacy was particularly busy at the time he dispensed Mrs A's medication into the stacker-tray.

Mr C stated:

> "I am the only pharmacist at the pharmacy and in fact the only person in the pharmacy.
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> As you can see from the prescriptions, [Mrs A] is on quite a number of medications. As well as the new prescriptions from the hospital, I was dispensing from ongoing ones from her doctor. In transferring the dose of each medication from the prescription forms to the daily card of the stacker-trays I work from, I made errors in the *quinapril* and *atorvastatin* doses. I gave [Mrs A] verbal instructions about the evening dose in the bag, but inadvertently labelled it Tuesday morning. [Mrs A] had already had her morning dose."

Checks introduced

Since the dispensing error on 15 June 2004, Mr C has taken greater care in his dispensing by introducing further checks throughout the dispensing process. After completing the dispensing of medication into a stacker-tray, he conducts a second check of that tray to ensure that its contents are consistent with the medication stated on the prescription. Before the customer is handed the stacker-tray, all respective trays are checked again by counting the number of tablets in each compartment to ensure that the total number of tablets being dispensed corresponds with the number stated on the prescription.

Mr C stated:

> "Since these dispensing errors I have increased the checks on the stacker-trays, the prescriptions and the transfer of the prescription information to the stacker-trays. The trays are now checked twice, daily and weekly, and the prescriptions and transfer of information to trays are double checked by me. I have been involved with blister packaging and the use of stacker-trays since 1994 and have had no other problems with errors.
>
> In the future every possible check at each stage of the dispensing process will be carried out.
>
> Being the sole pharmacist and employee at [the pharmacy], I realise I must be more diligent and careful in the dispensing of pharmaceuticals."

Subsequent events

Mrs A advised that she has a good relationship with Mr C and that he had continued to dispense her medication in a stacker-tray since these events. She did not want the pharmacy to "get into trouble" as a result of this complaint, although she supported the complaint being made.

I have been advised by the Pharmacy Council of New Zealand that Mr C ceased to practise as a pharmacist as of 1 April 2005 as a result of ill health.

Standard Operating Procedure

The pharmacy company, which owns the pharmacy, had a standard operating procedure in place when the dispensing errors occurred. The procedure had been reviewed on 31 December 2003, six months previously. Mr C supplied a copy of the standard operating procedure at the time, which stated:

"**STANDARD OPERATING PROCEDURE**

[The pharmacy company]

SUBJECT Page: 1 Document No: F7-1-4B

DISPENSING A PRESCRIPTION Issue Date: 01/12/1999 Supersedes:

1. Purpose: To ensure fast, accurate dispensing of prescriptions.

2. Responsibility of: Pharmacists, Dispensary technicians, (subject to limitations as per Schedule 'Dispensing Technicians Limitation')

3. Procedure:

1. On receipt of the prescription check name, address, age if necessary, and patient code. Clarify any details if necessary.

2. Check statutory details – date, signature, etc.

3. Record prescription on computer using S.O.P, checking past medication history for consistency, interactions, sensitivities, etc

4. Generate label and receipt

5. Stamp the prescription at the top with Pharmacy date stamp, and annotate the prescription if necessary.

6. Select the required medicine, checking the strength against the prescription. … If compounding, perform any calculations, weighing, etc.

7. After dispensing, transfer medicine to an appropriate container.

8. Pull the label off the computer label backing and attach the third part of the label to the prescription as close as possible to the item, preferably on the right hand side.

9. Place the main, larger label onto the container, checking the following against the prescription:

Patient name;
Quantity, name, form and strength;
Dose and frequency of dose;
Any warnings or cautionary labels;
Prescriber's name.

Attach label horizontally taking care not to obscure any relevant information for the patient.

9. On completion of prescription form, ensure number of items prescribed totals the number of items dispensed.

10. Total items to be claimed and write total inside a circle on the top right hand corner of the prescription.

11. Initial the prescription as being dispensed and/or checked.

12. Wrap the prescription items in brown paper, or pack inside available paper bags.

13. Attach receipt on front of parcel, checking name, address and prescription charges against original.

14. Place with prescription for collection in alphabetical order, or place on shelf for delivery.

15. If a compounded medication is dispensed, the expiry date of the product shall be on the label. This date shall either be 3 months ahead of dispensing, or the date of the shortest-dated ingredient.

HANDING OUT OF PRESCRIPTIONS.

1. Locate prescription parcel.

2. Check name and address of patient.

3. Collect monies owing.

REFER HANDBOOK OF PHARMACY PRACTICE Section 4 pg 73.

Created by: […], B.Pharm. M.P.S Date: 01/12/1999
Approved by: Date:
Review Date: 01/12/2000
31/12/2003"

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

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's *Code of Ethics*, states:

"Principle 2: Beneficence 2.6

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

The Quality Standards for Pharmacy in New Zealand Standard 6.2 states:

"A 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 C

Under Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code), Mrs A had the right to pharmacy services that met professional and ethical standards. The standards that apply in this case are determined by the Pharmaceutical Society of New Zealand (the Society).[1] Standard 6 of the Society's Quality Standards places a duty on the pharmacist to maintain a disciplined dispensing procedure, and Principle 2.2.6 of the Code of Ethics holds the dispensing pharmacist responsible for ensuring that the appropriate product is selected and dispensed correctly. These requirements have been incorporated into the pharmacy's dispensing policies.

On 15 June 2004, Mr C was the dispensing pharmacist who dispensed Mrs A's medication and the only attendant at the pharmacy. Mr C undertook to dispense all Mrs A's medication (those prescribed by her general practitioner and the new mediations prescribed by the public hospital) into a stacker-tray to reduce the possibility of her confusion when taking them. Although Mrs A's prescriptions read 15mg quinapril in the morning and evening, and 40mg atorvastatin in the evening, Mr C omitted the quinapril and dispensed two atorvastatin tablets of 40mg each into the respective compartments of the stacker-tray. As he intended Mrs A to commence using the stacker-tray only from the following morning (Wednesday), Mr C placed her Tuesday evening's medication in a separate paper bag and informed Ms B of this. However, he mistakenly labelled the bag for Tuesday morning instead of Tuesday evening.

Mr C has acknowledged that he made a "human error". He explained that he did not carry out a final check of the medications before he handed the stacker-tray to Ms B. He was the sole pharmacist, and as he was interpreting information about Mrs A's medications from two different sets of prescriptions, the chances of a mix-up were increased. Nevertheless, he has accepted that he needs to exercise care and diligence when dispensing medications, and to conduct checks at every stage of the dispensing process. I also note Mr C's explanation that he had provided the correct verbal instructions to Ms B for Mrs A to take the medications in the separate paper bag on Tuesday evening. However, the bag was wrongly labelled "Tuesday morning".

As Mr C was the sole pharmacist of the pharmacy, it was imperative that he conducted checks of each medication he dispensed, and that he exercised a high degree of care and diligence when doing so. Mr C informed me that he has since modified his dispensing procedure by implementing a triple checking system from the point where he physically dispenses the medication to counting the total number of tablets being dispensed at the completion of the process. I accept that he has been dispensing medication into stacker-trays and blister packs for over ten years and that the incident on 15 June 2004 is, to his knowledge, his first dispensing error.

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[1] The Society ceased to exist on 18 September 2004. However, as the dispensing error occurred before 18 September 2004, the standards prescribed by the Society are applicable.

Mr C's dispensing error in relation to the "double dose" of atorvastatin constituted a breach of section 18(2) of the Medicines Act 1981, in that he supplied medicine other than that prescribed by Mrs A's medical practitioners.[2]

It is clear that Mr C did not correctly dispense Mrs A's medication as prescribed, and that he therefore failed to provide pharmacy services in accordance with professional and ethical standards set by the Pharmaceutical Society of New Zealand. In these circumstances, Mr C 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's breach of the Code.

Mr C is a director of the pharmacy company, which owns the pharmacy. On learning of his error, Mr C reviewed the Pharmacy's procedures to determine whether the incident could have been avoided. Mr C acknowledged that on this occasion, he omitted to follow the double checking process in place at the time, in accordance with his usual practice.

Mr C was dispensing multiple medications into the stacker-pack trays and entering the new prescriptions into his database. Mr C was the only person in attendance at the pharmacy and may have been interrupted during the process. I have reviewed the standards of practice operating at the pharmacy company at the time the error occurred, and am satisfied that they comply with the standards set by the Pharmaceutical Society of New Zealand. I accept that the dispensing error in this case resulted from a human error by Mr C and was not a systems failure. Accordingly, in my opinion the pharmacy company is not vicariously liable for Mr C's breach of Right 4(2) of the Code.

[2] See *Re PR* (Decision of the Disciplinary Committee of the Pharmaceutical Society of New Zealand, 8 May 2002).

Non-referral to Director of Proceedings

Mr C has apologised to Mrs A through Ms B. I commend Mr C on his prompt and unreserved admission of responsibility.

Mr C has reviewed his practice and the pharmacy's dispensing policies following his dispensing error.

In light of these circumstances and taking into account Mrs A's express wish that she did not want him to be subjected to punitive measures, and that Mr C is no longer practising as a pharmacist, I have decided that there is no public interest in further proceedings, and have not referred this matter to the Director of Proceedings.

Follow-up actions

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

- A copy of my final report, with details identifying the parties removed, will be sent to the Pharmaceutical Society of New Zealand Incorporated, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.