Pharmacist

Report on Opinion - Case 98HDC11160

Complaint

The Commissioner received a complaint from a consumer that in late October 1997 a Pharmacy dispensed 100mg morphine tablets instead of 10mg morphine tablets as prescribed by the consumer's doctor.

Investigation

The complaint was received on 19 January 1998 from the consumer and an investigation was undertaken. Information was obtained from:

The Consumer
The Provider / Pharmacist
The Manager, Pharmacy

A copy of the prescription form was obtained from Health Benefits Ltd.

Outcome of Investigation

The consumer's doctor prescribed 10mg morphine tablets to the consumer in late October 1997. The consumer is unable to remember the exact date of seeing his doctor and picking up the prescription. The prescription was dispensed by the Pharmacy a few days after the consultation.

The day after the prescription was dispensed, the consumer telephoned the Pharmacy and spoke to a pharmacy technician, stating that when he opened the bottle of morphine tablets, he noticed the colour of the tablets was different to his usual tablets. The consumer queried whether he had received the correct morphine tablets and the pharmacy technician transferred the telephone call to the provider, the original dispensing pharmacist. After the consumer explained the situation, the provider checked the original prescription form. The prescription form confirmed that the consumer should have received 10mg morphine tablets, but appeared to have received 100mg morphine tablets. The difference in dose was identified by way of tablet colour over the telephone. No one had initialled the prescription form upon the dispensing of the medication.

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Outcome of Investigation, *continued*

The provider ensured that the consumer had not taken any of the 100mg morphine tablets and offered to bring the correct dosage tablets to him at his home address. The consumer advised that this would not be necessary, as he was coming to the Pharmacy later that morning.

When the consumer returned to the pharmacy, the provider retrieved the wrongly dispensed dosage of morphine tablets and dispensed the correct dosage and apologised for the error.

In his response to the Commissioner, the provider stated that he was unsure how this error had occurred, since he cannot remember dispensing this prescription. The provider stated he had personally apologised to the consumer and confirmed with him that he had not suffered any ill effects from the dispensing error.

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Code of Health and Disability Services Consumers' Rights

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

Professional Standards

The Pharmaceutical Society of New Zealand, Code of Ethics, December 1996 states:

Rule 2.12
"A pharmacist must dispense the specific medicine prescribed …"

The Pharmaceutical Society of New Zealand Pharmacy Practice Handbook, January 1998 states:

4.1 Prescription and Dispensing Services…

Checking the dispensing procedure:

- *the pharmacist is responsible for the final check of the prescription*
- *check for label accuracy - name, date, medicine strength and form, instructions, C & A labels and content accuracy – correct medicine, dose, form and quantity*
- *the dispenser and checker of the prescription must always be readily identifiable;…*

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Professional Standards, *continued*

The Pharmacy's dispensing procedures set out:

"Check the strength and quantity of the medicine against the prescription and check the expiry date."

Opinion: Breach

Right 4(2)

In my opinion, the provider pharmacist breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights.

The provider dispensed the incorrect dosage of medication to the consumer. This action did not comply with Pharmaceutical Society standards and therefore breached Right 4(2) of the Code of Rights.

Additional Comment

The provider signed the prescription as dispensed and checked, however his signature was not placed within the Pharmacy stamp on the prescription and was misleading. The position of the signature is not a requirement of the Pharmaceutical Society guidelines. In my opinion there is a need to establish nationally observed standards as to where, on the prescription form, the pharmacist annotates to confirm dispensing and checking procedures were followed. In the absence of such standards I believe it is common sense to sign within the "Pharmacy Dispensed and Checked" box.

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Actions

I recommend that the provider provide a written apology for his breach of the Code to the consumer. The apology should be sent to this office within one month and the Commissioner will forward it to the consumer.

A copy of this report will be sent to the Pharmaceutical Society of New Zealand to establish national guidelines regarding pharmacists annotating prescriptions as dispensed and checked.