Pharmacist/Pharmacy

Report on Opinion - Case 98HDC20935

Complaint

The consumer complained to the Pharmaceutical Society of New Zealand about services provided to him by the pharmacy. The Pharmaceutical Society forwarded the complaint to the Commissioner. The details of the complaint are:

- *On or about mid-May 1998 the pharmacy incorrectly dispensed imdur medication to the consumer instead of plendil tablets.*
- *The consumer later discussed the incident with the governing director on two occasions. The consumer was not satisfied with the response he received.*

Investigation

The complaint was received by the Commissioner on 16 November 1998 and an investigation was undertaken. As the investigation progressed the Commissioner became aware that the pharmacist had dispensed the medication and the investigation was extended to include him. Information was obtained from:

The Consumer/Complainant
The Consumer's Wife
The Governing Director of the Pharmacy
The Pharmacist/Provider

Copies of relevant medical records were obtained from the consumer's general practitioner. A copy of the prescription form was obtained from Health Benefits Limited.

Information Gathered During Investigation

On or about mid-May 1998 the consumer went to the pharmacy to collect a prescription for *plendil* blood pressure tablets. A box of tablets was dispensed to the consumer and he returned home. The pharmacist has confirmed that he dispensed the consumer's medication on this occasion.

The consumer later took one of the tablets and started to feel unwell. He advises that his heart started pounding, he developed a headache and he became dizzy. When he checked the box of tablets he discovered that the pills were labeled *imdur* rather than *plendil*. The consumer did not take any further tablets.

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Information Gathered During Investigation, *continued*

The consumer advised the Commissioner that the day after he took the *imdur* tablet he consulted his doctor. Medical notes obtained from the consumer's general practitioner recorded:

> "[Mid] *May 1998*
>
> *Given Imdur in place of Plendil at last Pn* [prescription] *fill. Taken only 1 60 mg yesterday. Felt crook + dizzy + H/ache.*"

The consumer advised the Commissioner that he and his wife later returned to the pharmacy and complained to the governing director of the pharmacy. The date of this visit is not known. The governing director apologised to the consumer for the error and advised that the prescription had been prepared by another staff member. The consumer returned the remaining *imdur* tablets and the director provided the correct medication for the consumer. The consumer advised that during this visit he was not informed of his right to complain to the Commissioner about the services that he had received and the mistake that had been made.

The director advised the Commissioner that the staff member who had dispensed the medication to the consumer was the pharmacist. The pharmacist ceased working for the director in September 1998 and is currently practising in another country. The director advised that there were no written dispensing or checking policies in place at the pharmacy at the time that this incident occurred in May 1998. The director advised that before new policies were introduced in early April 1999 he expected his employees to dispense medication correctly and he noted that dispensing and checking techniques were taught during pharmacy training. The director advised that when two pharmacists are on duty they cross check each other's work. When only one pharmacist is working he or she should self check the prescriptions. At the time the incident occurred the pharmacist was in sole charge of the pharmacy.

The pharmacist confirmed to the Commissioner that he was the pharmacist who had dispensed the medication to the consumer. The pharmacist also confirmed that he had mistakenly dispensed *imdur* instead of *plendil* tablets. The pharmacist advised me that he believed the mistake occurred because the *imdur* tablet boxes had been mistakenly placed in the position where the *plendil* boxes were usually kept. The *imdur* boxes were a similar size to the *plendil* packets.

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Information Gathered During Investigation, *continued*

During the course of the investigation the person responsible for placing the *imdur* boxes in the wrong position on the dispensary shelf was not identified.

In response to the suggestion that the consumer was not satisfied with the pharmacy's response to his complaint the director advised the Commissioner that when he was informed of the mistake he apologised to the consumer and speedily rectified the problem. He noted that the consumer continued to have his medication supplied by the pharmacy after the incident occurred. The director stated that he regarded the error very seriously and all his efforts were spent trying to avoid this type of situation. The pharmacy did not have a written complaints policy in place during 1998.

A copy of the relevant prescription was requested from Health Benefits Limited. A prescription for *plendil* dated early April 1998 was obtained and details of a repeat prescription dispensed in early June 1998 were viewed. Health Benefits Limited were not able to provide details about any *plendil* tablets dispensed to the consumer during May 1998.

Plendil is used to treat high blood pressure while *imdur* is used for the treatment of angina and chest pain. The adverse effects of *imdur* can include headache, nausea and dizziness, and increased heart rate.

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Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumer's Rights apply:

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.

...

RIGHT 10
Right to Complain

...

6) Every provider, unless an employee of a provider, must have a complaints procedure that ensures that -

a) The complaint is acknowledged in writing within 5 working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period; and

b) The consumer is informed of any relevant internal and external complaints procedures, including the availability of -

i. Independent advocates provided under the Health and Disability Commissioner Act 1994; and

ii. The Health and Disability Commissioner;

...

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Other Relevant Standards

Pharmaceutical Society of New Zealand Code of Ethics

Rule 2.1 states:

A pharmacist must safeguard the interest of the public in the supply of health and medicinal products.

Rule 2.11 states in part:

A pharmacist must be responsible for maintaining and supervising a disciplined dispensing procedure that ensures a high standard is achieved…

Rule 2.28 states:

A pharmacist must ensure that a documented procedure is followed for handling complaints so that a satisfactory resolution is reached. Consumers must be informed as to where they can further complain if a satisfactory resolution is not reached and of their rights under the Code of Rights for Consumers of Health and Disability Services.

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.

Standard 6.2(a) states:

Procedures for dispensing and supply of pharmaceuticals are developed, documented and approved by the pharmacist.

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Opinion: Breach The Pharmacist

Right 4(2)

In my opinion the pharmacist breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights. *Imdur* tablets were incorrectly dispensed to the consumer instead of the *plendil* tablets that had been prescribed by his doctor. The dispensing of correct medication is a basic professional standard. Although the incorrect placing of the *imdur* boxes may have contributed to the mistake occurring, it does not excuse the pharmacist's failure to identify the mistake either at the time of selecting the box from the shelf, or before dispensing the medication.

Opinion: Breach The Pharmacy

In my opinion the pharmacy breached Right 4(2) and Right 10(6) as follows:

Right 4(2)

In my opinion the pharmacy breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights. In May 1998 the pharmacy had no written protocols for the dispensing and checking of prescriptions. Standard 6.2 of the Quality Standards for Pharmacy in New Zealand requires the pharmacist to maintain a disciplined dispensing procedure that ensures that the appropriate product is selected and dispensed correctly and efficiently. Standard 6.2(a) requires the pharmacist to develop, document and approve procedures for the dispensing and supply of pharmaceuticals. In 1998 the pharmacy did not have any clear, written protocols governing the dispensing process. In my opinion the pharmacy did not comply with appropriate professional standards and breached Right 4(2) of the Code.

Right 10(6)

In my opinion the pharmacy breached Right 10(6) of the Code of Health and Disability Services Consumers' Rights. There was no written complaints procedure in place at the time the incident occurred. When the consumer complained to the director about the dispensing mistake there appears to be no evidence that the consumer was informed of his right to complain to my office. I note that Rule 2.28 of the Pharmaceutical Society Code of Ethics also requires that a documented complaints procedure be present and that consumers be informed of their rights under the Code and of where they can further complain if a satisfactory resolution is not reached.

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Actions: The Pharmacist

I recommend that:

- The pharmacist provide a written letter of apology to the consumer for breaching the Code of Rights. This apology is to be sent to the Commissioner's office and will be forwarded to the consumer.

Actions: The Pharmacy

I recommend that:

- The pharmacy ensures that all pharmacists working in the pharmacy are aware of, and familiar with, the Standard Operating Procedures for checking and dispensing prescriptions that were introduced by the pharmacy in early April 1999.

- The director reads and familiarises himself with Right 10 of the Code of Health and Disability Services Consumers Rights. Confirmation that this has taken place is to be provided to the Commissioner within fourteen days.

- The written complaints policy introduced in April 1999 at the pharmacy is to be amended to specifically reflect the provider obligations included in Right 10(6) of the Code of Rights. A copy of the amended policy is to be forwarded to my office within fourteen days and a copy will be kept on the file.

A copy of this opinion will be forwarded to the Pharmaceutical Society of New Zealand. A copy will also be sent to the Pharmacy Board of the country in which the pharmacist is currently practising.