Pharmacist

Report on Opinion - Case 98HDC14405

Complaint

The Commissioner received a complaint from ACC about a dispensing error made by a pharmacist. The complaint is that:

In late August 1997 the consumer presented a prescription for Chloramphenicol eye drops at a pharmacy. The pharmacist dispensed Kenacomb eardrops in the container instead of the Chloramphenicol eye drops. As a result, when the drops were administered, the consumer suffered a burn to his eye, requiring treatment at the public Hospital.

Investigation

The complaint was received by the Commissioner on 6 May 1998 and an investigation was undertaken. Information was obtained from the following:

The Complainant
The Provider/Pharmacist
Two Pharmacists
A representative, Pharmaceutical Company
A representative, second Pharmaceutical Company

Outcome of Investigation

In late August 1997 the consumer took a prescription for Chloramphenicol eye drops to a pharmacy.

The pharmacist dispensed Kenacomb ear drops instead of the prescribed eye drops. The consumer used the drops. As a consequence, he experienced a burning sensation and attended the Accident and Emergency Department of the public Hospital.

The doctor who prescribed the eye drops reports that when seen again in mid-September 1997 the consumer's vision was essentially normal.

The principal of the pharmacy provided copies of their standard operating procedure for checking prescriptions. This standard operating procedure was issued in January 1995 and has been reviewed annually each September since then.

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Outcome of Investigation, *continued*

This procedure requires that the medicine, its strength, and the quantity be checked against the prescription at three distinct stages during the dispensing process, the last check being when the consumer calls for the prescription.

The provider/Pharmacist in his response to the Commissioner dated 14 September 1998, wrote:

"Being a Friday afternoon the dispensary was extremely busy and unfortunately a container of Kenacomb Ear Drops was selected instead of a container of Chlorsig Eye drops which is a generic Chloramphenicol Eye Drop. The containers are both white and of the same size and are kept in the same section of the fridge. The container was dispensed in a tablet skillet so that the label could be properly displayed."

A representative from a Pharmaceuticals Company advised that Chlorsig is supplied in a white bottle with a yellow and white label reading "Chlorsig 0. 5%, 10ml . . ." The bottle is about 5cm high.

A representative from a second Pharmaceuticals Company supplied a bottle of Kenacomb Ear Drops. This bottle is also white, about 5cm high with a white label which has a narrow yellow band at the top. The words "Kenacomb Ear Drops 7.5mL . . ." are printed in black on this label.

As a result of this error in dispensing, the pharmacist informed the Commissioner that the pharmacy has segregated the medications in the dispensary fridge. Additionally the brand of eye drops customarily carried by the pharmacy has been changed to a brand "contained in a distinctive container".

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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.

...

4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

Opinion: Breach

In my opinion the pharmacist breached Right 4(2) and Right 4(4) of the Code of Health and Disability Services Consumers' Rights as follows:

Right 4(2)
The Code of Ethics of the Pharmaceutical Society of New Zealand provides a guide to the standard of professional conduct required to ensure members of the public receive an adequate level of service from pharmacists. Rule 2.1 states *"a pharmacist must safeguard the interest of the public in the supply of health and medicinal products"* and Rule 2.12 states *"a pharmacist shall dispense the specific medicines prescribed".*

It is for public safety reasons that a pharmacist is required to ensure that the contents of any dispensed medication correspond with the prescription. In my opinion, by failing to dispense the prescribed eyedrops, the pharmacist did not comply with the standards of the profession, exposed the consumer to a potential risk to his health and breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights.

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Opinion: Breach, ***continued***

Right 4(4)

In dispensing a medicine other than that prescribed, the pharmacist did not provide services that minimised potential harm to the consumer. If the pharmacist had followed the standard procedure laid down by the pharmacy, he would have checked the identity of the medicine against the prescription on three occasions. The pharmacist did not follow this procedure and as a consequence dispensed eardrops instead of eyedrops.

In my opinion, this failure to follow procedures resulted in a breach of Right 4(4) which necessitated an urgent visit to the Emergency Department for treatment.

Actions

I recommend that the pharmacist:

- Apologises in writing to the consumer for his failure to dispense the medicine prescribed. This apology is to be sent to my office and I will forward it to the consumer.
- Sends the consumer a cheque for $50 to reimburse him for the inconvenience in urgently attending the Emergency Department.
- Acquaints himself with and follows the Pharmacy's standard pharmacy operating procedures.

In addition I have decided to refer this matter to the Director of Proceedings for the purpose of deciding whether any action should be taken in accordance with section 45(f) of the Health and Disability Commissioner Act 1994.

A copy of this opinion will be sent to the President of the New Zealand Pharmaceutical Society. The Society will be asked to publish a copy of this opinion with identifying information removed for educational purposes.

A copy will be sent to the second Pharmaceutical Company for the purpose of reviewing their packaging or providing information to their customers which may avoid future errors in dispensing or application.

Pharmacist

Report on Opinion - Case 98HDC14405, continued

Response: The pharmacist, in his response to my provisional opinion, undertook to follow my recommendations and added:

"On the Friday afternoon in question I was the only qualified pharmacist in the Dispensary, the other qualified [pharmacist] having left at 2:30 pm. The incident having occurred later in the afternoon, and having done about 280 numbers that day [I] *consider the Dispensary to have been somewhat under resourced.*

Employing pharmacists has been an ongoing problem in [this town] *for several years. As of today the Shop has been advertising for a qualified pharmacist since before July 1997, but to no avail."*