Pharmacists / Pharmacy

Report on Opinion - Case 97HDC9405

Complaint

The Commissioner received a complaint from a consumer concerning dispensing errors that occurred at a pharmacy. The complaint was that:

- *In October 1996 the consumer was incorrectly dispensed 5mg tablets of prednisone in a bottle marked 1mg tablets.*
- *On a separate occasion the consumer was dispensed her husband's gout medication instead of her own medication.*
- *When she telephoned the chemist to request a prescription item be made up, she was told the chemist was not holding a prescription. When she insisted a prescription had been presented, it was located "in a drawer" and had not been entered on the computer.*
- *The consumer's Digoxin and Diltiazem tabs were incorrectly dispensed – both being labelled "1 tab three times a day" when the Digoxin dosage should have been three tablets in one dose.*

Investigation

The complaint was received on 20 October 1997 and an investigation was commenced. Information was obtained from:

The Consumer
The Pharmacist / Owner
A second Pharmacist

Relevant documents viewed as part of the investigation included the confirmation of procedures form, incident report form and shop display notice form from the pharmacy. The Commissioner obtained copies of most of the prescriptions in question from Health Benefits Limited. The Commissioner obtained independent advice from a practising pharmacist.

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Outcome of Investigation

The consumer is 70 years old. She suffers from chronic rheumatoid arthritis, osteoporosis, paroxsysmal atrial fibrillation, has autoimmune problems and a history of pericarditis and peptic ulcers. She advised the Commissioner that her conditions are managed well medically.

The first pharmacist is the owner of the pharmacy. She employs three pharmacists who have over 50 years' collective experience in community pharmacy.

Prednisone

In October 1996 the consumer was prescribed 1mg tablets to be taken as a 3mg dose in the morning and a 2mg dose in the evening. The consumer advised the Commissioner that the second pharmacist was the pharmacist on duty at the pharmacy and that she dispensed 5mg tablets of prednisone in a bottle marked "1mg tabs". The consumer said she took the tablets for two days (25mg in total per day) and then noticed the different size. The consumer telephoned the pharmacy and spoke with the pharmacist who had dispensed the medication. The tablets were exchanged for the correct ones and the consumer said she received an apology. The pharmacist advised the Commissioner that *"we immediately phoned her doctor to let him know what had happened and a pharmacist rectified the mistake that day."* The Commissioner was unable to obtain a copy of the prednisone prescription. It was therefore not possible to identify the relevant doctor or confirm that this conversation took place.

Allopurinol

Some weeks later the consumer made a telephone request for repeat medication for herself. The consumer stated that on occasion she would order repeats for her husband by telephone but would specify that the prescription was for him and would state the medication she required. On this occasion the consumer was dispensed her husband's gout medication (Allopurinol) instead of her own. The pharmacy owner acknowledged that the consumer was given this medication by mistake and said the error occurred because it had been dispensed to the wrong person (with the same initial) at the same address.

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Outcome of Investigation, *continued*

The consumer also complained that she made a telephone request for a prescription item to be made up and was told that pharmacy did not hold the prescription. She said she insisted she had handed one over and it was discovered in a drawer.

The pharmacy owner advised that not all items on consumers' prescriptions are required immediately and that the consumer would leave prescriptions at the chemist for items she did not yet require. She said these items would not always be entered into the computer because prescriptions expire after three months and to enter them on presentation of the prescription would mean they expired sooner. She said this could cause confusion when people asked for their prescription because the prescriptions could have been made up, on the computer, not yet dispensed and not on the computer or coming by fax or phone from the doctor.

Digoxin

In October 1997 the consumer's doctor changed her heart medication from Socator to Digoxin in conjunction with Diltiazem. She was advised by her doctor to take three tablets of Digoxin in one dose and one tablet of Diltiazem three times per day. However, both bottles were marked "three daily". The second pharmacist, who was responsible for checking the prescription, accepted that this was an oversight on her part. When it was brought to her attention, the second pharmacist said she checked that the consumer knew how to take the tablets, apologised to her and corrected the dosage on the computer.

The pharmacy owner acknowledged the pharmacy's policies and advised that practices had been reconfirmed since the consumer' complaint and that new policies and practices had been designed to remedy past mistakes.

The consumer advised the Commissioner that she had been a customer of the pharmacy for about 20 years. She has since changed to another chemist.

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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.

Relevant Standards

The Pharmaceutical Society of New Zealand's Code of Ethics

Rule 2.12 states that "*a pharmacist must dispense the specific medicine prescribed…"*

Rule 9 states that *"a pharmacist responsible for the dispensing or checking of a dispensed medicine shall ensure… that the label is accurate…"*

Rule 2.11 states that *"a pharmacist must be responsible for maintaining and supervising a disciplined procedure that ensures a high standard is achieved".*

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Report on Opinion - Case 97HDC9405, continued

Opinion: Breach The second Pharmacist

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

Right 4(2)

Prednisone

The Pharmaceutical Society of New Zealand views the dispensing of the correct medication as a basic professional standard. The pharmacy owner advised me that, because the prescription was unable to be located, she was unable to determine which pharmacist dispensed 5mg, instead of 1mg, tablets of prednisone in a bottle marked "1mg tabs". Nor was the pharmacy owner able to identify which pharmacist checked it. However, I am satisfied with the consumer's account that the second pharmacist investigated was the pharmacist on duty at the time and that she did not dispense the specific medicine prescribed. In my opinion, by not doing so, the pharmacist did not provide the consumer with services that complied with the professional standards set out in the Pharmaceutical Society of New Zealand's Code of Ethics.

Digoxin

The second pharmacist was the one responsible for checking the consumer's prescription. In my opinion she breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights by failing to correctly label the medication or to recognise that the Digoxin bottle was incorrectly labelled "one three times daily".

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Report on Opinion - Case 97HDC9405, continued

Opinion: No Breach, Pharmacy Owner

In my opinion the pharmacy owner did not breach Right 4(2) of the Code and Health and Disability Services Consumers' Rights as follows:

Right 4(2)
Prednisone
I am satisfied that the pharmacist in charge at the time the consumer's prednisone was dispensed was responsible for ensuring that the entire dispensing process, from the time the prescription was received, until it was ultimately handed over, was carried out in accordance with all legal and ethical requirements. The pharmacy owner has demonstrated that her dispensing process requires prescriptions be checked by a qualified pharmacist prior to being dispensed. In my opinion, the pharmacy owner had appropriate policies in place and was not vicariously liable for her employee's actions.

Opinion: Breach, Pharmacy Owner

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

Allopurinol
The pharmacy owner admitted that the consumer's husband's gout medication was dispensed to the consumer in error but stated that it was not a dispensing error as such because the right medication was dispensed to the wrong person. However, staff at the chemist had an obligation to ensure that identification details were confirmed at the time of contact. The pharmacy owner said that, as a result of the consumer's complaint, staff are instructed to double check names, and the medication is explained at the time of the pick up, to ensure that such incidents are not repeated. In my opinion, the pharmacy owner's failure to ensure procedures were in place so that the intended recipient of the medication could be correctly identified amounts to a breach of Right 4(2) of the Code of Rights.

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Opinion: Breach, Pharmacy Owner, *continued*

Multiple Prescription Items

The pharmacy owner admitted that there had been difficulties locating prescriptions when items not required at the time of initial presentation were required later. She advised that new practices have been instituted to remedy the situation. She said staff are now instructed to question customers more carefully when they collect their prescriptions. However, I do not think that questioning customers at the time of collection adequately addresses the issue raised by the consumer. She complained that her prescription was not easily located at the time of the initial telephone contact.

The pharmacy owner explained why some prescriptions are held over and my advisor has informed me that it would not be considered unprofessional to delay entering an as yet unwanted prescription item in the computer. However, in my opinion, as owner of the pharmacy, she has direct responsibility to ensure that appropriate systems and policies are in place to efficiently and effectively address the problem, including a system which enables prescriptions to be swiftly discovered. While the pharmacy owner explained that held over prescriptions are kept in a metal filing cabinet, in my opinion, the system in place at the pharmacy does not allow specific items recorded in held-over prescriptions to be efficiently located and amounts to a breach of Right 4(2) of the Code of Rights.

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Actions

I recommend that both pharmacists take the following actions:

- Provide a written apology to the consumer for their breaches of professional standards. This is to be sent to the Commissioner's office and will be forwarded to the consumer.
- Read the Code of Health and Disability Services Consumers' Rights.

I recommend that the pharmacy owner take the following additional actions:

- Reviews her procedure regarding telephone requests for repeat prescriptions, including (a) checking the identity of the intended consumer and (b) explaining prescriptions and ensuring consumers understand.
- Reviews her procedure regarding prescription items that are not required immediately.
- Advises the Commissioner of training that will be undertaken so staff are familiar with the procedures in place at the pharmacy.

A copy of this opinion will be forwarded to the Pharmaceutical Society of New Zealand with the request that it oversees the review of the procedures and policies to ensure they are appropriate and that the Society determines any other action it considers appropriate.