Multiple dispensing errors with repeat prescriptions but pharmacist unable to be identified (01HDC11910, 31 May 2002)

Pharmacist ~ Pharmacy ~ Dispensing error ~ Standard Operating Procedures ~Rights 4(1), 4(2)

A woman complained that pharmacy staff:

1 dispensed her prescription for folic acid with the instruction that she take one tablet daily, when the prescription stated one tablet weekly;
2 dispensed methotrexate with the instruction that she take one tablet weekly, when the prescription stated four tablets per week;
3 dispensed Surgam tablets with the instructions "one tablet twice daily", even though the prescription stated "two tablets daily"; and
4 incorrectly dispensed Premarin 0.625mg, instead of the prescribed 1.25mg.

The Commissioner stated that the identity of the dispensing pharmacist must be ascertainable, and highlighted the need for pharmacy staff to adhere to the pharmacy's SOPs, ensuring the prescriber's instructions are properly represented. Checks must occur with each new prescription. This is particularly important when prescriptions are presented as repeats, as these are generated automatically, and the opportunity to check may be reduced.

The identity of the dispensing pharmacist was not established. The key issue was how the dispensing error occurred. It was held that:

1 the manager of the pharmacy breached Rights 4(1) and 4(2) by not ensuring that there was a means of establishing the identity of the dispensing pharmacist, through the signing of the prescriptions by dispensing staff, and by failing to take appropriate steps to minimise the risk of repetition of errors;
2 the pharmacist breached Rights 4(1) and 4(2) because:
   (a) she incorrectly dispensed the woman's medication in that she labelled the medication correctly but supplied the incorrect strength;
   (b) she did not sign the woman's Premarin prescription;
   (c) it could be established on the balance of probabilities that she failed to initial, and failed to correctly label, the woman's Surgam prescriptions; and
   (d) she failed to inform herself about the relevant SOPs at the pharmacy, and failed to sign her prescriptions; and
3 the pharmacy breached Rights 4(1) and 4(2) by failing to ensure that the systems in place were operating effectively to minimise the risk of repeat errors in that:
   (a) it failed to properly identify the dispensing pharmacist;
   (b) it failed to check the labelling of prescriptions; and
   (c) the quality of the incident reports, and the investigation into the incidents, was poor.