Dispensing of incorrect dose of medication
16HDC01515, 28 June 2017

Pharmacist ~ Pharmacy technician ~ Pharmacy ~ Dispensing error ~ Professional standards Right 4(2)

A man was prescribed prednisone 20mg, with instructions to take 40mg orally for a week, and then to wean down 5mg each week for a month. The man's mother attended a pharmacy to have the prescription filled.

Reducing dosages of prednisone are often dispensed as 5mg tablets, given the difficulty of quartering 20mg tablets. The pharmacy technician calculated that the prescription equated to 182 tablets of prednisone 5mg and annotated the prescription accordingly. The pharmacy technician incorrectly entered the prescription into the dispensary software and generated a label which stated "182 Prednisone Tablets 20mg". The label directed the man to "take eight tablets once daily for one week, then reduce by one tablet (5mg) every week for one month".

The calculations and the label were checked by a pharmacist. The pharmacist initially calculated that 180 tablets were required and wrote this on the prescription. However, on checking her calculations, she realised that the correct number was 182. She did not amend the note she had made on the prescription. The pharmacist proceeded to dispense tablets from the Prednisone 20mg supply, and did not identify during her check that she had dispensed the incorrect strength of medication. The pharmacy technician then performed a further check, and also failed to identify the error on the label and in the strength of medication dispensed.

The pharmacy technician raised concerns that the dispensary is set up in such a way that customers can stand right in front of the work bench and cause disruptions.

Findings
It was held that the pharmacist breached Right 4(2) by failing to ensure that she dispensed the correct strength of prednisone to the consumer and by failing to conduct an adequate check of the dispensed medication. In addition, adverse comment was made about the pharmacist for failing to cross out her incorrect calculation on the prescription.

The pharmacy technician was criticised for omitting to cross out the "20mg" on the prescription to make the change to 5mg clear; generating a label with the incorrect strength of prednisone; and failing to identify the error on the label or in the strength of medication dispensed when checking the medication before it was given to the man's mother.

The pharmacy was not found in breach of the Code. However, comment was made about the pharmacy's failure to review its standard operating procedures within the timeframe set out in the Health and Disability Standards: Pharmacy Services Standard.

Recommendations

It was recommended that the pharmacy complete an audit of staff compliance with the new SOPs for dispensing and checking, and that it consider staff concern regarding the physical set up of the pharmacy dispensary.

The pharmacist and pharmacy technician each provided the man with a formal letter of apology.