Pharmacist

Report on Opinion - Case 98HDC15279

Complaint

The Pharmaceutical Society of New Zealand forwarded to the Commissioner a complaint by the consumer concerning dispensing procedures at the pharmacy. The complaint was that:

- *The consumer has deep concerns over the lack of identification procedures for the issuing of prescriptions at the pharmacy.*
- *The consumer was given another person's prescription by the pharmacist which caused both the consumer and his family much discomfort and distress.*

Investigation

The complaint was received by the Commissioner on 10 June 1998 and an investigation was undertaken. Information was obtained from:

The Consumer
The Pharmacist

Relevant clinical records were obtained and viewed. The pharmacy supplied a copy of its customer complaints procedure, the incident report form and a copy of the consumer's prescription.

Information Gathered During Investigation

The consumer is aged 84 years. In early June 1998 he consulted his general practitioner for acute diarrhoea. His general practitioner prescribed *loperamide*. The consumer went to the pharmacy, which was located next to the doctor's surgery, to have the prescription filled. The consumer told the Commissioner that he would not normally have prescriptions filled at the pharmacy but went there on this occasion because the weather was terrible.

The consumer stated that he was the only male customer in the pharmacy and that there were approximately three or four other customers present. He said that, once the prescription had been filled, the pharmacist motioned towards him and he went forward to collect a brown paper bag. He acknowledged that he did not hear his name being called but believes it might have been. The consumer said he is hard of hearing. He said the pharmacist neither asked for his address nor requested he confirm it.

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Information Gathered During Investigation, *continued*

The consumer advised that he took one of the pills he had been given as soon as he got home and another one the following morning. He could not remember if the general practitioner had explained how to take the medication. The consumer advised the Commissioner that he did not read the label before taking the pills.

The consumer's daughter telephoned on the following morning to check on him. The consumer told her he had been given some pills and that the pharmacist had told him there was a repeat available if he wanted it. He said he also told her that he was feeling "*woozy*" and not at all well. The consumer said that his daughter indicated it was unusual to have a repeat for that type of medication. She subsequently consulted a chemist friend, telephoned the consumer back and told him to stop taking the pills as she suspected he had been given the wrong ones.

The consumer's daughter visited the consumer that afternoon and ascertained, from the description of the pills printed on the label, that they were not meant for him. The consumer's other daughter took him to see the general practitioner that evening. The general practitioner told the consumer that his blood pressure had dropped by fifty percent. The general practitioner's clinical notes recorded, *"*[g]*iven hytrin for some reason from chemist, feeling tired and washed out all day. Stop it. BP is certainly down at present. BP 70/?, check cbc this pm too."*

The consumer's daughter swapped the pills and complained about the dispensing error. She did not advise the consumer of this in case it made him worse. Upon her return from the pharmacy she said to "*the chemist intimated that it was* [the consumer's] *fault for not answering his name when called*". The consumer called at the pharmacy the next day to pay the fee. He advised that he asked for his prescription and paid the fee to the woman behind the counter. He said he "*didn't want to blow it up*" so he said nothing about the error.

The pharmacist advised the Commissioner that he was the pharmacist on duty on the day the prescription was dispensed. He stated that he had been unable to identify the staff member who gave the consumer the incorrect prescription, or identify the procedure that was followed at the time the prescription was handed over.

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Information Gathered During Investigation, *continued*

The pharmacist said that the pharmacy is a very busy, principally dispensing, business that handles an average of 400 prescriptions per day. He advised that since the consumer's complaint he has studied the handling of prescriptions and become aware of a number of problems. He said that customers become impatient waiting for their prescriptions and, frequently, come forward to collect prescriptions as they are brought out, assuming the prescriptions are theirs. He said customers often answer to someone else's name and the address being mentioned is all that distinguishes their prescription from someone else's. He noted that customers who are in a hurry may not listen to the questions of identity being asked, which allows for a mistake such as the mistake in question to occur.

The pharmacist said that the consumer's prescription, and the one he took by mistake, were both uncomplicated and that it was unlikely he would have required further counselling about the medicine when the prescription was handed out. He believed the problem was exacerbated by the consumer not reading the label on the medication. He said the packaging and dosage on the medication he was given were very different from any anti-diarrhoea preparation. He stated that he did not believe the consumer queried the medication he was provided with at any stage before he took it.

The consumer said the name and address on the label were not legible as they had been typed over the pharmacy logo.

The pharmacist said he believed the mistake occurred through:

> *"…an "incomplete" operating procedure that has stood the test of time until now. It has caused the Pharmacy to criticise the procedure and review it to provide what we feel is a more complete identification section that is workable in the every-day function of the Pharmacy and satisfies the various legal and ethical requirements."*

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The Code of Health and Disability Services Consumers' Rights

The following 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.

3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

...

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including -

a) An explanation of his or her condition; and

b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option.

...

RIGHT 10
Right to Complain

1) Every consumer has the right to complain about a provider in any form appropriate to the consumer.

...

2) Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.

...

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*

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The Code of Health and Disability Services Consumers' Rights, *continued*

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; and
c) The consumer's complaint and the actions of the provider regarding that complaint are documented; and
d) The consumer receives all information held by the provider that is or may be relevant to the complaint.

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Report on Opinion - Case 98HDC15279, continued

Opinion: Breach

In my opinion the pharmacist has breached Right 4(2), Right 4(3), Right 6(1) and Right 10 of the Code as follows:

Right 4(2)

Rule 2.11 of the Pharmaceutical Society of New Zealand Code of Ethics states: *"A pharmacist must be responsible for maintaining and supervising a disciplined dispensing procedure that ensures a high standard is achieved."*

The pharmacist made enquiries of staff but was unable to ascertain who handed the consumer the incorrect medication in early June 1998. The pharmacist, as the pharmacist in charge, had vicarious liability for the actions of employees. He was responsible for ensuring that the entire dispensing process, from the time the prescription was received, until it was ultimately handed over, was in accordance with all legal and ethical requirements. This included ensuring that the consumer received the correct medication.

In my opinion, the pharmacist breached Right 4(2) of the Code of Rights. By failing to correctly identify the consumer and ensure he received the prescribed medication, he did not provide the consumer with services of an appropriate standard.

Rule 9 of the Rules of the Pharmaceutical Society of New Zealand 1991 states, *"A pharmacist responsible for the dispensing or checking of a dispensed medicine shall ensure ... that the label is accurate, unambiguous and clear ..."* The pharmacist asserted that the consumer did not read the label on the medication bottle correctly and should have queried the medication he was given. However, the consumer had the right to assume he had received diarrhoea medication according to a prescription supplied by his general practitioner. Further, the consumer did not have a copy of his doctor's prescription, nor was he able to check whether this was his own medication because the identifying details on the label were obstructed by the pharmacy logo. In my opinion, this was a further breach of Right 4(2) of the Code of Rights by the pharmacist. By failing to ensure that the consumer could clearly read the label and identify whether he was the intended recipient he did not provide services of an appropriate standard.

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Opinion: Breach

Right 4(3)

Rule 2.7 of the Pharmaceutical Society of New Zealand Code of Ethics states, *"A pharmacist must take any necessary additional steps to ensure a consumer with special needs, eg with respect to ... age ... receives an appropriate, adequate level of pharmaceutical care".* The pharmacist acknowledged the pharmacy's dispensing procedure relied upon customers responding to their names as prescriptions were called. He conceded that this could be problematic as some customers would, in haste, respond affirmatively to whatever name was called. The consumer was 84 years old and hard of hearing. He was unsure whether his name was called at all. In my opinion, the pharmacist had a duty to take the consumer's special needs, by virtue of his age, into consideration when he handed out the medication or authorised it to be dispensed. By failing to do this he breached Right 4(3) of the Code of Rights by not providing the consumer with services appropriate to his needs.

Right 6(1)

Rule 2.5 of the Pharmaceutical Society of New Zealand Code of Ethics states, *"A pharmacist must provide professional advice and counselling to consumers and take all reasonable steps to ensure that the consumer has sufficient knowledge to enable optimal therapy."*

The pharmacist advised that the consumer's prescription was uncomplicated and that it was unlikely he would have required further counselling about the medicine when the prescription was handed out. However, the pharmacist had a duty to ensure the consumer understood how and when to take the medication. In my opinion, by failing to counsel the consumer the pharmacist breached Right 6(1) of the Code.

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Opinion: Breach, *continued*

Right 10

The consumer was entitled to complain to the pharmacy "*in any form appropriate*". In this instance his daughter was entitled to complain to the pharmacy on his behalf. I note that the consumer's daughter did not discuss with her father beforehand whether he wanted a complaint to be lodged and the consumer did not himself complain to the pharmacy at the time he paid the pharmacy fee as he did not want to further the issue.

The pharmacy is required to have a complaints procedure to ensure the fair, simple and speedy resolution of complaints. While the pharmacy had a complaints policy, the consumer's daughter's complaint was not formally documented by pharmacy staff and the pharmacist acknowledged that: *"until I received your letter in August which was some two months after the incident I was unaware there had been a problem".* I note that the policy documents "*official*" complaints, which are not defined. The pharmacist had an obligation to ensure his staff understood their obligations and gave effect to the consumer's complaint that day, so that the review of processes could have occurred much earlier.

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Future Actions

I recommend that the pharmacist takes the following actions:

- Provides a written apology to the consumer for his breach of the Code. This is to be sent to the Commissioner's office and will be forwarded to the consumer.
- Reviews the labelling process to ensure that all details, including the consumer's name and address, are clearly legible and are not obscured by the pharmacy logo before medication is dispensed.
- Forwards to the Commissioner's office a copy of the amended operating procedures for:
  (a) checking the identity of consumers prior to the handing over of medications;
  (b) explaining prescriptions and ensuring consumers understand; and
  (c) processing complaints.
- Advises the Commissioner of training that will be undertaken so all staff are familiar with such procedures in the pharmacy and ensures the procedures are actioned.
- Reads the Code of Health and Disability Services Consumers' Rights and confirms in writing to the Commissioner that he fully understands his obligations as a provider of health services.

A copy of this opinion will be sent to the Pharmaceutical Society of New Zealand with a request that this opinion, with identifying information removed, be published for distribution to all pharmacists to ensure identification of consumers and appropriate counselling always takes place.

Pharmacist

Report on Opinion - Case 98HDC15279, continued

Actions Taken

Following the investigation and in response to the Commissioner's provisional opinion dated mid-November 1998, the pharmacist confirmed he has taken the following actions:

- The Pharmacy has now amended its operating document to ensure customers are actively involved in the identification procedure. Staff now request address details from customers before prescriptions are handed out.

- Consumers will be counselled in the use and purpose of the medication prior to the prescription being released.

- The pharmacy has now amended its operating procedures for finished prescriptions and for handling customer complaints. Consumers wishing to register a complaint will also now be made aware of Right 10 of the Code of Health and Disability Services Consumers' Rights and supplied with the Commissioner's contact details.

- The pharmacist has reviewed his labelling procedure. He confirmed he has recently introduced a new computer system and the thermal printing employed prevents a reduction in print quality.