Pharmacist

Report on Opinion - Case 98HDC14229

Complaint

On 27 April 1998 the Commissioner received a complaint from the Medical Misadventure Unit, Accident Compensation and Rehabilitation Insurance Corporation (ACC). The complaint was that:

- *In mid-July 1997 the provider, a pharmacist, incorrectly dispensed Prednisone to the consumer. The dispensed medication instructed 2 tablets were to be taken 4 times a day. The script instructed 2 tablets once a day.*

Investigation

The complaint was received by the Commissioner on 28 April 1998 and an investigation was carried out. Information was obtained from:

The Consumer
The Provider/Pharmacist
The Provider's Employer/Pharmacist

The Medical Misadventure Unit ACC file was obtained.

The Commissioner sought advice from the Pharmaceutical Society of New Zealand.

Outcome of Investigation

In late June 1997 the consumer was admitted to hospital with acute sinisitis. Following discharge she attended the Otolaryngology Clinic where a doctor saw her in mid-July 1997.

The doctor wrote a prescription for the consumer for Prednisone 20mgs, 2 tablets OD (once daily) for one week and Augmentin 500mgs 1 tid (three times a day) for two weeks. The doctor did not record the number of tablets he wanted dispensed.

Two days later the prescription was dispensed to the consumer at the pharmacy where the provider works, by the provider/pharmacist. The provider incorrectly interpreted the "OD" on the doctor's prescription to read "QID". "QID" is the abbreviation for the Latin *quart in dies* - four times a day.

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Outcome of Investigation, *continued*

The provider drew the Commissioner's attention to an inconsistency in the manner of writing the prescription that made it easy for her to interpret the "O" of "OD" with a "Q" for "QID"

The provider noted that the dosage of Prednisone prescribed was more than she was used to dispensing and added that:

"...I accept that the dosage of Prednisone in this instance was high but not above the maximum daily dosage of 250mg which can be given to an adult."

The provider referred to *New Ethicals Compendium* 6th Edition, Vol II, p1611 which refers to the maximum dosage of Prednisone for an adult patient. The provider advised that in a previous case she had researched a similar dosage in several pharmaceutical publications and notified the prescription writer and all confirmed the high dose as correct. She *"had no details relating to [the consumer's] condition and to enquire further could have given rise to patient objection and a possible prosecution under the Privacy Act... [In this case] I dispensed what I genuinely and honestly believed the doctor had written and from my considerable experience I had no reason to query it."*

The provider dispensed Prednisone 20mgs, with the instruction "take 2 tablets four times a day." She further advised that:

"in regard to the OD abbreviation I understand that it has been recommended to doctors that it not be used because of its ambiguity.

There is ample evidence that he [the doctor] *has not written what he intended, (one has only to read the script to see this) he has used an abbreviation which is not recommended, and his script is not written in a consistent fashion."*

The consumer took the drug as instructed on the bottle for approximately one week. She suffered severe pains in the legs, pain in the knees and increased difficulty in walking. She was taken to an emergency doctor where the mistake was discovered.

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Outcome of Investigation, *continued*

The Commissioner sought confirmation from the Pharmaceutical Society of New Zealand (the Society). A Representative of the Society confirmed that the use of "OD" for "once daily" is an abbreviation used mostly in America and has been used recently in New Zealand. The use of "OD" is a concern because it can so easily be mistaken for "Q" and subsequently "QID". The Society is about to publish a newsletter to alert its members of this danger.

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.

Professional Standards

The Code of Ethics of the Pharmaceutical Society of New Zealand, Rule 2.11 states that:

"A pharmacist must be responsible for maintaining and supervising a disciplined dispensing procedure that ensures a high standard is achieved. The pharmacist's responsibilities include:

- *Interpreting a prescription;*
- *Verifying the authenticity and appropriateness of prescriptions"*

The *Pharmacy Practice Handbook*, January 1998 provides guidelines for meeting the Code of Ethics. Part 4 Practice Advice states:

"The prescriber should be contacted if there are any problems with the medicine prescribed."

The Medicines Regulations 1984 define the legal requirements for prescriptions. Regulation 41(f) states:

*41 **Form of prescription**- Every prescription given under these regulations shall-*
(f) Indicate the total amount of the medicine that may be sold or dispensed on the one occasion, or on each of the several occasions, authorised by that prescription;…

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Professional Standards, *continued*

This regulation is reflected in the "Standard Operating Procedure" for dispensing medication operating at the pharmacy where the provider works, which states:

"4. Check script for legibility, dosages, interactions, doctor recommendations etc. IF IN ANY DOUBT CONTACT DOCTOR…
5. Annotate script for quantities, repeats etc."

Opinion: Breach

In my opinion the provider breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights in relation to dispensing Prednisone for the consumer.

The provider noted the high dose of Prednisone prescribed and referred to the appropriate reference manual. The provider noted the "OD" on the script appeared to be "QD" and was aware that the Society had concerns about the use of that abbreviation. The provider did not confirm the dose with the doctor before dispensing the drug in accordance with the Society's standard of practice. The prescription did not indicate the total number of tablets in accordance with the Medicines Regulations. The provider's failure to verify the dose of Prednisone with the prescribing doctor was a breach of Right 4(2) of the Code.

Actions

I recommended that the provider apologise in writing to the consumer for the breach of the Code. I have received the letter of apology from the provider and sent it to the consumer. A copy was retained on the Commissioner's file.

I have sent a copy of my final opinion to the Pharmaceutical Society of New Zealand and the provider's employer for their information.

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Other Actions I have written to the doctor involved in this case to bring to his attention the events that occurred and suggest he alter his prescribing practice to avoid future confusion, and comply with current requirements for filling out prescription forms.

A copy of this opinion, with all identifying features removed, will be sent to the Medical Council of New Zealand, the New Zealand Medical Association and all Hospital and Health Services to draw their attention to this matter and request that health professionals are reminded of the current requirements for filling in prescriptions.