Pharmacy

Pharmacist, Ms B

A Report by the

Health and Disability Commissioner

(Case 15HDC01016)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of Contents

Executive summary

1. Mrs A (aged 32 years) had been taking lithium carbonate[1] for approximately four years, and was on a regimen to wean her off the medication slowly. On 16 June 2015, Mrs A saw a general practitioner who prescribed her with a 90-day supply of lithium carbonate, totalling 450 tablets of 250mg strength, with the instruction to take five tablets once daily at night.

2. On 16 June 2015, Mrs A went to a pharmacy to get her prescription filled. Pharmacist Ms B assembled, checked and dispensed the prescription and, in doing so, mistakenly provided Mrs A with 400mg lithium carbonate tablets instead of the prescribed 250mg tablets.

3. When assembling the medication Ms B was interrupted by a dispensing technician enquiring about the medication of another consumer and, once she had finished her conversation with the technician, she picked up the lithium carbonate stock bottle (containing 400mg tablets) but did not check the strength of the bottle. Ms B also performed the two-stage checking process herself but did not open and check the contents of the bottle to be given to Mrs A against the original prescription or the stock bottle. Ms B then gave the medication to a shop assistant to hand to Mrs A.

4. The Pharmacy's dispensing standard operating procedure (SOP) requires that the person assembling medication with multiple strengths (such as lithium carbonate) check the strength of the medication. At the checking stages, the dispensing SOP requires that the person checking the medication open the bottle to check the contents against the prescription and the stock bottle. The dispensing SOP also states that where more than one member of the dispensary staff is on duty, a dispensing should be checked by another appropriate person (eg, a pharmacist or dispensing technician).

Findings

5. Ms B failed to dispense the prescribed lithium carbonate correctly and ensure that her dispensing was checked appropriately on 16 June 2015. Accordingly, Ms B failed to provide Mrs A with services in accordance with professional standards, and so breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code).[2]

6. Adverse comment is made in respect of the Pharmacy.

Recommendations

7. It was recommended that Ms B provide Mrs A with a written apology for her breach of the Code. It was also recommended that the Pharmacy conduct an audit on staff compliance with its dispensing SOP and an audit on all errors and near misses in the six months up until the date of this report.

[1] Lithium carbonate is a psychotropic drug used to treat acute manic attacks in bipolar disorder and, when given on a maintenance basis, to prevent the recurrence of manic-depressive episodes.
[2] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

Complaint and investigation

8. The Commissioner received a complaint from Mrs A about the services provided to her by Ms B and the Pharmacy.

9. The following issues were identified for investigation:

- *Whether Ms B provided an appropriate standard of care to Mrs A between June 2015 and August 2015.*
- *Whether the Pharmacy provided an appropriate standard of care to Mrs A between June 2015 and August 2015.*

10. An investigation was commenced on 18 September 2015.

11. The parties directly involved in the investigation were:

Mrs A	Consumer/complainant
Ms B	Provider/pharmacist
Pharmacy	Provider

12. Further information was reviewed from:

Mr A	Husband of consumer
Mr C	Director of the Pharmacy /pharmacist
Dr D	General practitioner
Pharmacy Council of New Zealand	

Also mentioned in this report:

Ms E	Pharmacist
Ms F	Pharmacist

Information gathered during investigation

Background

13. In 2015, Mrs A (aged 32 years) had been taking the medication lithium carbonate[3] for approximately four years. Mrs A told HDC that she was on a regimen to wean her off the medication slowly.

14. On 16 June 2015, Mrs A's GP prescribed Mrs A a 90-day supply of lithium carbonate, totalling 450 lithium carbonate tablets of 250mg strength, with the instruction to take five tablets once daily at night. The prescription read as follows:

> "**Lithium Carbonate 250mg Cap**
> Sig: 5 caps, Nocte

[3] Lithium carbonate is a psychotropic drug used to treat acute manic attacks in bipolar disorder and, when given on a maintenance basis, to prevent the recurrence of manic-depressive episodes.

Mitte: 450 caps
(Generic Substitution Allowed)"

16 June 2015 — visit to the Pharmacy

15. On 16 June 2015, Mrs A went to the Pharmacy to have her prescription for lithium carbonate filled. The prescription was received by pharmacist Ms E and dispensed by pharmacist Ms B.[4]

16. Ms E processed the prescription on the Pharmacy's computer system (TONIQ) and generated a label. Ms E also annotated the prescription, noting that Mrs A's lithium carbonate dosage had been decreased from six 250mg tablets once a day, to five 250mg tablets once a day. The label and prescription were then placed in a basket on the dispensing bench to be dispensed.

Assembling

17. Ms B removed the prescription from the basket. She told HDC that when reviewing the prescription she noted Ms E's annotation regarding the dosage change of the medication. Ms B then calculated the quantity needed to provide a month's supply of lithium carbonate, "as this medication is supplied on a monthly basis", and this equated to 150 tablets.[5] Ms B said: "I remembered what medication I wanted to select in my mind and walked to the shelf labelled 'L' in the dispensary to select the medicine."

18. Ms B stated that before selecting the lithium carbonate 250mg tablets she was interrupted by a dispensing technician enquiring about another consumer's medication. Ms B told HDC that after finishing her conversation with the technician:

> "I resumed the process to pick up the lithium carbonate. The lithium carbonate 250mg capsules (by [a pharmaceutical company]) were sitting beside the lithium carbonate 400mg tablets bottle on the shelf and I was so sure that I wanted to select the lithium carbonate tablets [400mg] not the capsules [250mg]. I picked up the lithium carbonate stock bottle labelled tablets, not checking the strength of the tablets."

19. At the assembling stage, the Pharmacy's standard operating procedure, "54 — Dispensing New Prescription" (the dispensing SOP), requires that when there is a medicine with multiple strengths (such as lithium carbonate) the pharmacist is to "check again that the correct strength has been chosen".

20. Ms B stated that when she assembled the medication she did not check the strength of the lithium carbonate tablets and proceeded to count out 150 tablets, and then placed the stock bottle of 400mg lithium carbonate tablets back on the medication shelf. Ms B then placed the tablets into a dispensing bottle and "returned back to the prescription to work through the final checking procedure".

[4] Ms B completed her bachelor of pharmacy degree in New Zealand and was registered as a pharmacist with the Pharmacy Council of New Zealand. At the time of these events, Ms B was employed by the Pharmacy as a pharmacist.

[5] On the generated label it was recorded that Mrs A was entitled to "2 Repeats by 14 Sept 15", which totalled 450 tablets prescribed overall.

Checking

21. At the checking stage, the dispensing SOP requires that each dispensing of a prescription is checked twice. The first check can be conducted by a pharmacist, dispensary technician or pharmacy intern. The second check must be conducted by a registered pharmacist, and can be done by the same pharmacist who conducted the first check. Ms B told HDC that she conducted both checks on her dispensing but did not carry out a number of steps required by the dispensing SOP. She further stated:

> "As my pharmacist colleague, [Ms E], had processed and annotated on the prescription and we were short of staff I decided to dispense and check off the medications myself."

22. Ms B said that at the first check she did not open the bottle to ensure that its contents (ie, the incorrectly dispensed 400mg tablets) matched what was on the prescription. Ms B also did not check the stock bottle to ensure that the correct strength of medication had been selected, as she had "put the stock bottle of lithium carbonate back [on]to the shelf shortly after dispensing it".

23. Ms B stated that she did check the prescription against what was written on the label, and placed the dispensary label onto the prescription. After completing the first check, Ms B said that she "did not initial in the checked box on the dispensary stamp" that is affixed to the original prescription.

24. Ms B stated that at the second check she did not open the bottle containing the dispensed tablets "to check against the stock bottle, which had already been put back on the shelf". Ms B also stated that she did not check the contents of the bottle against the prescription to make sure that what was contained in the bottle was what was prescribed, and said: "[I]n my mind I was so sure that I dispensed the correct strength and form of the lithium carbonate."

25. Ms B stated that she did check that the label on the bottle matched what was on the prescription, and that the quantity was correct. Ms B also said that she conducted the appropriate funding, legal and clinical checks required by the dispensing SOP, and initialled on the dispensary stamp affixed to the prescription that she had conducted the final check.

26. Ms B said that she then gave the lithium carbonate medication to a shop assistant to hand to Mrs A. Ms B stated that she also attached a red ticket to the dispensed medication. The purpose of the ticket is to prompt shop assistants to ask whether a consumer is aware of a dose change. If the consumer is not aware of the dose change, he or she would be referred to a pharmacist for counselling. Ms B stated that she was informed that Mrs A was aware of the dose change.

Subsequent events

Pharmacy notified of error 7 July 2015

27. Mrs A told HDC:

> "I noticed the mistake after taking only 3–4 of the [400mg] tablets mixed with the last of my 250mg tablets and feeling ill. The only difference in 400mg tablets is

> that they are a little bigger and I noticed this on the third day of me going to take the tablets when I compared them to the last of the old tablets I had."

28. On the evening of 7 July 2015,[6] Mrs A returned to the Pharmacy with her husband, and informed the pharmacist on duty, Ms E, of the dispensing error and that Mrs A had taken the incorrect strength of lithium carbonate tablets. Mrs A stated that she remembers being asked to return the incorrect medication, and being told that it "would be swapped over with no questions asked". Mrs A did not supply Ms E with the medication that night.

29. The Director of the Pharmacy, Mr C, told HDC:

> "[Ms E] advised the patient, [Mrs A], that she should visit her doctor as soon as possible, even an after hours doctor tonight [7 July 2015], and also get a blood test done to check the lithium levels in her blood. The patient, [Mrs A] advised [Ms E] that she had already made an appointment to see her Doctor for tomorrow (that is 8th July 2015) and was going to get a blood test done also at this visit."[7]

30. Mrs A stated that she does not remember being advised on 7 July 2015 to seek medical assistance. She said that she requested that a manager call her for an explanation. Mr A told HDC that the pharmacist (Ms E) stated that they could see a doctor, but it was communicated with no sense of urgency.

31. Ms B stated that Ms E notified her of the error that evening, and that she (Ms B) asked if Mrs A was "OK" and if she had taken any of the tablets. Ms B recalls that Ms E reported that Mrs A was "OK" but had ingested the incorrect medication and experienced diarrhoea.

Events of 8 July 2015

32. Pharmacist and acting manager Ms F documented[8] that on 8 July 2015 she telephoned Mrs A and spoke to Mr A. Ms F recorded that she "asked him if [Mrs A had] had her blood test done and [said that the Pharmacy felt] obliged to cover any medical costs as it is [the Pharmacy's] responsibility". Mr C documented[9] that on 8 July 2015 Ms F also "apologised profusely [to Mr A] for the error". Mr A told HDC that he does not remember this telephone conversation.

33. On 8 July 2015, Ms B contacted the Pharmacy Defence Association (PDA). The TONIQ dispensing incident report form dated 12 August 2015 documents that Ms B received "advice [from PDA] on how to write an apology letter and [the correct] course of action".

34. Ms B then wrote a letter to Mrs A dated 8 July 2015 apologising for her error. In the letter Ms B stated:

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[6] Mrs A told HDC that typically she has a 3–4 week supply overlap of lithium carbonate to ensure that she does not run out of her medication, and this is the reason why she first noticed the dispensing error in July 2015 and not June 2015 when the lithium carbonate was first dispensed.
[7] Ms E told HDC that Mr C's recounting of the facts was "true [and] accurate".
[8] The Pharmacy's incident report form dated 16 July 2015.
[9] TONIQ dispensing incident report form dated 12 August 2015.

> "I have notified [Dr D], as [the GP who initially prescribed the lithium carbonate] is currently away, of this error and any costs related to this medication error … will be covered by our pharmacy …
>
> If you are not satisfied with the way I have handled the situation you have the right to contact the Health and Disability Commissioner …"

35. Mrs A told HDC that she received Ms B's apology letter a day or two after she made a complaint to HDC.

36. Dr D told HDC that he advised Ms B to tell Mrs A "to do blood tests for lithium levels and if unwell to come in to seek medical attention". Ms B told HDC: "[After talking with Dr D I felt that] it would be easier for [Mrs A] to talk to my colleague than myself. I asked the dispensary manager [Ms F] to apologise to her profusely on my behalf."

37. Mrs A had blood tests performed on 8 July 2015, and the result for lithium was 0.5mmol/L, which was within the normal range.[10] In light of the result, Mrs A told HDC that she did not see a doctor in relation to the dispensing error.

Further conversations with the Pharmacy in July 2015

38. On 9 July 2015, Ms F spoke with Mrs A in person at the Pharmacy. Mr C reported that at this meeting:

> "[Ms F] asked how [Mrs A] was feeling and whether she had seen her GP and had her blood tests done to check on her lithium level. [Mrs A] told [Ms F] that she has blood tests on a regular basis and so far she is fine …
>
> [Mrs A] was advised by the charge pharmacist, [Ms F], of the pharmacy's complaint process. [Ms F] explained to the patient, [Mrs A], how the pharmacy will deal with her specific complaint and make sure there is a thorough investigation and that this error does not occur again. [Ms F] then advised the patient [Mrs A] that if she is not happy with the way the pharmacy has dealt with her complaint that she is well within her rights to contact the Health and Disability Commissioner to escalate the matter further."

39. Mrs A told HDC that she remembers "being pulled aside" on approximately 9 July 2015, and that Ms F told her that a "pharmacy association" had been notified of the error and that there was nothing further required from her. Mrs A stated that this made her feel like she did not have a voice and was excluded from being a part of the process. Mrs A also remembers being told by Ms F that the Pharmacy would pay for her medical costs relating to the error, and that she told Ms F that she had received a blood test and that the result was normal. Mrs A stated that during this conversation she was not informed of her right to contact HDC.

40. On 13 July 2015, Mrs A returned to the Pharmacy to give back the incorrectly dispensed lithium carbonate tablets. Mr C told HDC:

[10] The laboratory results record the normal range as being between 0.5–1.0mmol/L.

> "I spoke at length [with Mrs A] and again apologised for the [distress] caused to her and told her that we take dispensing errors very seriously and that we shall do everything in our power to ensure it doesn't happen again … I reminded her also to be expecting a letter from [Ms B] personally and also that we had planned a meeting with all dispensary staff to discuss and review our procedures …"

Changes made since the incident

41. Ms B told HDC that as a result of the dispensing error she has made changes to her practice, including:

> "[I]f I am the one dispensing and final checking the medications, I will undertake another task in-between to ensure I will final check with 'fresh eyes'. I will always open the package to verify the contents against the prescription to ensure I [have] dispensed the correct medicines."

42. The Pharmacy also reported that as a result of the dispensing error the different strengths of lithium were moved to separate shelves, and the dispensing shelves are now labelled with bright red STOP signs to remind dispensing staff to double check that they are selecting the correct strength of medication.

43. The Pharmacy's standard operating procedures relating to dispensing of new prescriptions, dispensing errors and near misses, and incident procedures were also reviewed but not changed.

Further information received from the Pharmacy

44. On 16 July 2015, an incident report detailing the error was completed.[11] On 24 July 2015, the Pharmacy convened a meeting with all dispensary staff to review and discuss the factors that led to the error. Mr C stated: "[At this meeting] we discussed at length on how we can improve our processes and systems to ensure that such a mistake doesn't happen again." Dispensing staff also received further training on the Pharmacy's standard operating procedures relating to dispensing a new prescription, dispensing errors and near misses, and incident procedures.

45. On 27 July 2015, Ms F and Mr C conducted a systems review. The changes suggested as a result of the review (listed above) were implemented and, on 10 August 2015, Mr C documented: "[I]t has been 2 weeks since changes came into effect and it is working."

46. A number of documents were generated in relation to the error, including (but not limited to) TONIQ incident reports, documentation regarding Ms B's self-assessment of the dispensing error, and a dispensing error review conducted by Mr C and Ms B.

47. Mr C also told HDC that on 16 June 2015, "at the relevant time" there were four registered pharmacists, two dispensing technicians and one pharmacy intern on duty, but that he was "unsure which staff members were on a paid break or at lunch at this time of day".

[11] On 12 August 2015 a TONIQ dispensing incident report was also completed.

Dispensing SOP

48. The Pharmacy's Dispensing SOP states:

"Assembling the prescription (Count/ Pour and label)

…

- Retrieve the appropriate medicine from the shelf and before counting/pouring the medicine check you have the correct medicine, strength and brand against the prescription, NOT the label. If it is a medicine with multiple strengths check again that the correct strength has been chosen.

…

- Place counted medication with the stock bottle or box and prescription on dispensary bench in a basket/container to be checked.
- Initial in the DISPENSED box on the dispensary stamp to indicate that you have assembled the prescription.

FIRST CHECK (can be done by a Pharmacist, Dispensary Technician or Intern)

- Check that what is on the prescription is what is written on the label: drug, dose, quantity, instructions, patient name and address, prescriber.
- Check that what is on the prescription is in the container — always open the container and look inside, do not assume the contents are correct.
- Check the stock bottle or box to make sure the correct strength of medication has been selected and is within date.
- Highlight changes to the medicines or directions on the prescription.
- Place the dispensary label generated by Toniq listing interactions onto the front of the prescription for the checking pharmacist to reference.
- Initial in the CHECKED box on the dispensary stamp.

FINAL CHECK OF PRESCRIPTION

- Must be carried out by a Registered Pharmacist
- The same Pharmacist can do first and final checks
- Initial final CHECK box on dispensary stamp.

1. Clinical Check
   - PSS G 5.2.4 guidance states that the clinical check includes, but is not limited to:
     - Appropriate dose form and route of administration
     - Dosage is within therapeutic range

     …
2. Dispensing Check
   - Open all skillets, vials and missions to double check the contents are correct against the stock bottle or box.
   - Check the contents of the skillet/vial/mission off the prescription, NOT the label.
   - Check the label off the prescription.
   - Check that the quantity is correct.

- Double check the dose and brand is correct if the product comes in multiple strengths and brands.
- Initial the prescription on the dispensary stamp to identify you as the Pharmacist responsible for the prescription.

…

4. Safety Systems
   - In the interest of safety we ask that a Pharmacist does not type into the computer, count and check a prescription on their own if other staff are also working.
   - We ask that if two or more people are working (e.g. Pharmacist and a Technician) that they check each other's work.

..."

Responses to provisional opinion

49. The parties were given an opportunity to comment on the relevant sections of the provisional opinion. These responses have been incorporated into the report where appropriate. Further responses have been outlined below.

Mrs A

50. Mrs A told HDC that she remembers the conversations she had with the Pharmacy staff regarding the medication error, "including exactly where they took place", but does not remember being informed of her right to complain to HDC. She stated that another pharmacy told her about the HDC complaints process.

Ms B

51. Ms B told HDC that she did not wish to comment on the provisional opinion and that she accepts the findings, recommendations and proposed course of action.

The Pharmacy

52. In his capacity as co-owner and director of the Pharmacy, Mr C told HDC that the company accepts the provisional opinion and recommendations.

Relevant professional standards

53. The Pharmacy Council of New Zealand (PCNZ) *Safe Effective Pharmacy Practice Code of Ethics* (2011) provides that a pharmacist should:

"1.2 Take appropriate steps to prevent harm to the patient and the public.

…

5.1 Be accountable for practising safely and maintain and demonstrate professional competence relative to your sphere of activity and scope of practice.

…

7.6 Ensure that you are able to comply with your legal and professional obligations and that your workload or working conditions do not compromise patient care or public safety."

54. Furthermore, the PCNZ *Competence Standards for the Pharmacy Profession* (2015) state that a pharmacist should:

"*Domain M1: Professionalism in Pharmacy*

Comply with ethical and legal requirements. Follows legal, ethical, professional and organisational policies/procedures and codes of ethics.

M1.2.4 Complies with the obligations created by the code of ethics.

Domain 01: Health and medicine management

01.1.4 Advises patients when and in what circumstances to seek further medical intervention.

01.4.3 Acts to optimise health outcomes by identifying and mitigating potential sources of error in service delivery.

01.4.5 Participates in ongoing incident analysis (including 'near misses') and adopts recommendations for resolution or change that come from that analysis.

Domain 03: Supply and administration of medicines

03.2.1 Maintains a logical, safe and disciplined dispensing procedure.

03.2.2 Monitors the dispensing process for potential errors and acts promptly to mitigate them.

03.2.5 Accurately records details of medication incidents and actions taken, including clinical and professional interventions, to minimise their impact and prevent recurrence.

03.4.2 Follows relevant policies, procedures and documentation requirements for the administration of medicines.

Domain 04: Leadership and organisational management

04.4.5 Monitors the workplace and work practices to identify and minimise security risks and ensure compliance with workplace safety policies and procedures."

Opinion: Ms B — Breach

Dispensing and checking errors

55. Ms B accepts that she dispensed Mrs A's medication on 16 June 2015 and that, in doing so, she mistakenly dispensed 400mg lithium carbonate tablets instead of the prescribed 250mg tablets. Ms B stated that at the assembling stage she was interrupted by a dispensing technician enquiring about the medication of another consumer and, once she had finished her conversation with the technician, she "picked up the lithium carbonate stock bottle labelled tablets, not checking the strength of the tablets".

56. Ms B also accepts that when she conducted the first and final checking stages she did not take all the steps required by the dispensing SOP, which included checking the strength of the stock bottle, and prescription, against the contents of the bottle to be dispensed. Ms B then signed the prescription as completed and gave the medication to a shop assistant to hand to Mrs A. Ms B told HDC that at the time of these events they "were short of staff" so she decided to check the medication dispensing herself. I note that upon being informed of the medication error Ms B appropriately informed Mrs A of her right to complain to this Office in her apology letter dated 8 July 2015.

57. As a registered pharmacist, Ms B is responsible for ensuring her adherence to professional standards. The Pharmacy Council of New Zealand's (PCNZ's) *Competence Standards for the Pharmacy Profession (2015)*, outlined above, requires registered pharmacists to ensure that they:

- follow legal, ethical, professional and organisational policies/procedures and codes of ethics;
- follow relevant policies, procedures and documentation requirements for the administration of medicines;
- maintain a logical, safe and disciplined dispensing procedure;
- monitor the dispensing process for potential errors and act promptly to mitigate them;
- advise patients when and in what circumstances to seek further medical intervention;
- accurately record details of medication incidents and actions taken, including clinical and professional interventions, to minimise their impact and prevent recurrence; and
- participate in ongoing incident analysis (including "near misses") and adopt recommendations for resolution or change that come from that analysis.

58. The PCNZ *Code of Ethics (2011)* also requires registered pharmacists to be accountable for practising safely and maintaining and demonstrating professional competence relevant to the pharmacist's sphere of activity and scope of practice. The *Code of Ethics* further requires that pharmacists comply with legal and professional obligations, and that their "work load or working conditions do not compromise patient care or public safety".

59. The Pharmacy has a detailed standard operating procedure, "54 — Dispensing New Prescription" (the dispensing SOP), which was in operation in June2015. The dispensing SOP requires that at the assembling stage and where there is a medicine with multiple strengths, such as the lithium carbonate prescribed to Mrs A, the pharmacist is to "check again that the correct strength has been chosen". Ms B told HDC that after finishing her conversation with the dispensing technician she did not check the strength of the tablets.

60. The dispensing SOP then has a two-step checking process. The first check requires a pharmacist, dispensary technician or pharmacy intern to conduct a number of actions, including checking that what is on the prescription matches the contents of the container to be dispensed, and checking the stock bottle to make sure that the correct strength of the medication has been selected. Once all the checks have been completed, the person conducting the first check is to sign the dispensary stamp affixed to the prescription. Ms B failed to conduct any of these steps.

61. The final check must be conducted by a registered pharmacist, and can be done by the same pharmacist who conducted the first check. At the final check, the pharmacist must conduct a number of actions, including checking that the contents of the bottle to be dispensed are correct against the stock bottle. The pharmacist must also check that the contents of the bottle are correct against the prescription. Again, Ms B failed to conduct any of these steps.

62. This is unacceptable. Checking that the correct strength of medication has been dispensed is a fundamental aspect of pharmacy practice in New Zealand, and is also a requirement of both the Pharmacy's dispensing SOP and PCNZ's professional standards.

63. I further note that whilst the Pharmacy's dispensing SOP allows for a pharmacist to conduct both checks on a dispensing, it also states that "in the interests of safety" a pharmacist is not to "count and check a prescription on their own if other staff are working", and that it asks that "if two or more people are working (e.g. Pharmacist and a Technician) that they check each other's work".

64. At the time the error occurred, there were other dispensary staff on duty, including another registered pharmacist (Ms E) and a dispensing technician (who interrupted Ms B). Yet Ms B dispensed the medication and also conducted both checks on her dispensing. I am critical of the fact that Ms B did not follow the dispensing SOP and ask another dispensary staff member to check her dispensing. I note that had such a check occurred, the error may have been identified before the medication was supplied to Mrs A.

65. I also note that the *Code of Ethics* requires that a pharmacist's workload or working conditions do not compromise patient care or public safety. Notwithstanding the fact that Ms B was interrupted before selecting Mrs A's medication, or that other members of the dispensary staff may have been busy, Ms B was required to ensure that she dispensed medications safely and in accordance with her professional obligations.

66. Accordingly, by failing to dispense the prescribed medication correctly and ensure that her dispensing was checked appropriately, I consider that Ms B failed to provide Mrs A with services in accordance with professional standards, and so breached Right 4(2) of the Code.

Opinion: the Pharmacy — Adverse comment

67. In the course of this investigation, I have carefully considered the extent to which the dispensing error that occurred indicates broader systems or organisational issues at the Pharmacy. As this Office has stated previously, "a pharmacy has a responsibility to ensure that all pharmacists working in the pharmacy are appropriately trained and experienced, and aware of the pharmacy's expectations, including the SOPs".[12]

68. I further note that under section 72(2) of the Health and Disability Commissioner Act 1994, an employing authority may be vicariously liable for acts or omissions by any employee. Under section 72(5), it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent acts or omissions leading to an employee's breach of the Code. In addition, the Pharmacy may also be directly liable for the services it provides.

69. The Pharmacy's dispensing SOP specifically requires the pharmacist to retrieve the appropriate medicine from the shelf and, before counting/pouring the medicine, check the medicine, strength and brand against the prescription. For medicines with multiple strengths the dispensing SOP requires the pharmacist to check again that the correct strength has been chosen. The dispensing SOP states that the pharmacist is to check that what is on the prescription is in the container, and to "always open the container and look inside, not assume the contents are correct".

70. The Pharmacy's dispensing SOP also requires that in "the interests of safety" a pharmacist "does not type into the computer, count and check a prescription on their own if other staff are also working". The dispensing SOP also states: "[W]e ask if two or more people are working (e.g. Pharmacist and a Technician) that they check each other's work."

71. When Ms B dispensed Mrs A's medication on 16 June 2015 she dispensed 400mg lithium carbonate tablets instead of the prescribed 250mg tablets. Ms B stated that at the assembling stage she did not check the strength of the tablets. When Ms B conducted the first and final checking stages she did not take all the steps required by the dispensing SOP, which included checking the strength of the stock bottle and prescription against the contents of the bottle to be dispensed. Ms B then signed the prescription as completed and gave the medication to a shop assistant to hand to Mrs A.

[12] Opinion 13HDC00819, 23 June 2014.

72. Ms B stated: "[W]e were short of staff [so] I decided to dispense and check off the medications myself." Mr C told HDC that at the time of these events, there were four pharmacists, two dispensary technicians and one pharmacist intern on duty, although he was unsure which staff members were on a break at the time the dispensing error occurred. I note that, at the very least, the pharmacist who generated the prescription label (Ms E) was on duty and available to check the medications assembled by Ms B. I further note that Ms B acknowledged that she did not carry out a number of steps required by the dispensing SOP.

73. In light of such facts, I find that the error occurred as a result of Ms B's individual error, and is not attributable to systemic issues at the Pharmacy. Accordingly, I do not consider that the Pharmacy is vicariously liable for the actions of Ms B or directly liable for any breach of the Code.

74. However, I remind the Pharmacy of its responsibility to ensure that its dispensing staff are appropriately trained and aware of its SOPs. I also note that an incident report was not completed until 16 July 2015, eight days after the Pharmacy was first notified of the dispensing error. Whilst the Pharmacy subsequently took proactive steps in reviewing and learning from this error, I am critical of the time it took to document the error initially.

Recommendations

75. In my provisional report I recommended that Ms B provide a written apology to Mrs A for her breach of the Code. In response to my provisional report, Ms B supplied HDC with an apology letter for forwarding to Mrs A.

76. I recommend that the Pharmacy conduct an audit on the following matters:

a) All errors and near misses in the six months up until the date of this report, and common themes or patterns found; and

b) Staff compliance with SOP "54 — Dispensing New Prescription" over the last six months, including, where appropriate, that dispensary staff check each other's work,

and report back to HDC within three months of the date of this report.

Follow-up actions

77. A copy of this report, with details identifying the parties removed, will be sent to the Pharmacy Council of New Zealand and the district health board, and they will be advised of Ms B's name.

78. A copy of this report, with details identifying the parties removed, will be sent to the New Zealand Pharmacovigilance Centre and the Health Quality and Safety Commission.

79. A copy of this report, with details identifying the parties removed, will be placed on the Office of the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.