Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 22HDC00897)

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Introduction

1. The Health and Disability Commissioner (HDC) received a complaint from Dr B, a general practitioner (GP), about the care provided to Mr A by a pharmacy. The complaint concerns medication dispensed to Mr A that was not prescribed for him.

2. The following issues were identified for investigation:

- *Whether the pharmacy provided Mr A with an appropriate standard of care between 22 December 2021 and 12 April 2022.*
- *Whether Ms C provided Mr A with an appropriate standard of care between 22 December 2021 and 12 April 2022.*

3. This report is the opinion of Deborah James, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

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4. The parties directly involved in the investigation were:

Mr A	Consumer
Dr B	Complainant/GP
Ms C	Pharmacist and pharmacy owner
Pharmacy	

5. Ms D, an intern pharmacist, is also mentioned in the report.

Background

6. Mr A went to the pharmacy on 22 December 2021 to pick up a prescription that had been faxed through from his doctor's practice. The fax included four pages, which had been printed double-sided. On the final page was a prescription for Sinemet,[1] which Mr A had not been prescribed previously.

7. The prescription was processed by intern pharmacist Ms D, who noted that Sinemet was a new medication for Mr A. This was then checked by Ms D's supervising pharmacist, Ms C, who made a note to discuss the new medication with Mr A. There is no record that this conversation occurred. Mr A took the Sinemet medication and returned for two further repeats over a period of three months.

8. Mr A presented to his GP, Dr B, on 31 March 2022, complaining of dizziness and feeling off balance. He showed Dr B the empty medicine containers, including the Sinemet tablets (100mg/25mg) with instructions to take '2 tablets at 9am, one tablet to be taken at 12 noon and 2 tablets to be taken at 5pm as directed'.

9. Dr B contacted the pharmacy that had dispensed the medication, as he had not prescribed Sinemet for Mr A.

10. An internal investigation completed by the pharmacy found that the last page of the printed fax used to dispense Mr A's medication included a prescription for Sinemet, intended for another patient from the same medical practice. This prescription had been dispensed to Mr A incorrectly.

Facts gathered

Consultation with Dr B — 31 March 2022

11. Mr A speaks English as a second language and uses translation software to understand written communication. He asked Dr B to assist him with making a complaint to HDC. Dr B told HDC that Mr A had come in for his usual appointment and prescription for his regular medications on 31 March 2022. At the appointment, he explained to Dr B that he was not feeling right and was dizzy and off balance.

[1] A medication used to treat Parkinson's disease.

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12. Dr B told HDC that he is familiar with the usual medications Mr A was taking and was aware that he had not prescribed him Sinemet. He checked his records and discovered that although he had not prescribed Sinemet, it had been dispensed to Mr A on 22 December 2021, with two repeats on 28 January 2022 and 27 February 2022 respectively. While Mr A was in the consulting room, Dr B contacted the pharmacy and asked staff to check the prescription dated 21 December 2021.

13. The pharmacy undertook an investigation and discovered that Mr A had been incorrectly dispensed Sinemet, which had been printed on the back page of his prescription but prescribed for a different patient of Dr B.

14. Although Mr A had been taking Sinemet for three months, he had not advised Dr B or the medical centre of any undue symptoms or side-effects during that time. Dr B advised Mr A to speak with the pharmacy about the incident. Mr A said that he wanted to complain, and Dr B advised him to discuss the matter with the pharmacist first. Dr B also provided Mr A with information about HDC and how to file a complaint and gave him a blood test form to check his liver and renal function.

Follow-up appointment 11 April 2022

15. Dr B told HDC that he saw Mr A for a follow-up appointment on 11 April 2022. Mr A told Dr B that he had spoken to Ms C at the pharmacy and had received a verbal apology. He was told that he would receive a formal apology letter, but one week had passed, and he had not received this. Mr A then asked Dr B for assistance to make a complaint with HDC.

16. On 12 April 2022, Dr B informed HDC of the incident and included information he had received in an email from Ms C, confirming that she had apologised to Mr A verbally and would follow up with a written apology. The email information included that the pharmacy had held an urgent dispensary meeting to investigate what had occurred and to develop a prevention plan involving retraining and process change. Ms C also offered to cover the cost of Mr A's medical appointments until the end of the year.

Information provided by pharmacy

17. Ms C provided HDC with a copy of an incident notification form she completed and filed with the Pharmacy Defence Association (PDA). The form details internal investigation findings and reflection on possible causes for the error.

18. Ms C told HDC that on 22 December 2021, four pages of prescriptions from Dr B were faxed at the same time to the pharmacy. The first three pages were prescriptions for Mr A, and the last page, prescribing the Sinemet, was for another of Dr B's patients.

19. Faxed prescriptions are received in the pharmacy's email inbox. The investigation found that prescriptions were printed double-sided on two sheets of paper, causing the prescription for the other patient to be on the back of Mr A's. The prescription was not an electronic prescription and therefore did not contain a barcode. The internal investigation noted that a barcode would have been beneficial.

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20. The prescription was processed by Ms D, who mistakenly assumed that the back page of the prescription was also for Mr A and therefore incorrectly loaded the Sinemet prescription into Mr A's file in the dispensing system, causing the two repeats to be under Mr A's name. Ms C told HDC that Mr A was on multiple medications, so it was not unusual to expect four pages of prescription for him. Ms D did identify that Sinemet was a new medication for Mr A and annotated this on the prescription as per the pharmacy's Standard Operating Procedure (SOP) dispensing section two, 'Dispensing and Processing a Prescription' (attached as Appendix B), which states:

> 'If the medicine is new to the customer, then the letter *"N"* is written on the left side of the medicine name to indicate that this medicine is new for the customer and extra counselling is required.'

21. A copy of the prescription provided to HDC shows handwriting on the left side of the Sinemet medication. It appears to be annotated 'NW' or 'new'.

22. Ms D told HDC that for new prescriptions with a barcode, the barcode is scanned, and the prescription is automatically uploaded into the system, ensuring that the correct patient and medications are loaded. When there is no barcode, the information is input into the system manually. At the time of this event, the medical centre was not using electronic prescriptions or barcodes.

23. Ms C told HDC that staff at the pharmacy were becoming very used to electronic prescriptions and barcodes, which is available under the New Zealand ePrescription Service and being rolled out nationwide. ePrescriptions had become popular during the peak of the COVID-19 pandemic, as it offered a 'no contact' option. The system includes additional safety features that would have made it difficult to process an additional medication. An additional prescription would not be available to download in the system under the patient's name, prompting further investigation.

24. The medication was checked by Ms C, who also did not identify the error. Ms C made a note as a reminder to staff that a pharmacist needed to discuss the new medication with Mr A. The medication was bagged for collection, as it was past closing time.

25. The incident notification form documented that Ms C asked Mr A if he knew what the medication was for and why he was prescribed it, and that Mr A stated that he trusted his doctor and would take whatever he was told, and that he was aware that the medication was for Alzheimer's. It is unclear whether this conversation occurred when Mr A collected his 'new medication' or as part of the usual counselling process,[2] when he collected one of the repeat prescriptions. There are no records documenting the discussion.

26. The incident notification form also notes that during dispensing, the staff were 'in a rush to get it done' because it was past closing time and Mr A had been waiting for a while. The form documents: '[During dispensing,] we mentioned that there was a new medicine but did not show the patient what it looked like or what it was for.' It is likely that Mr A collected

[2] See Appendix D for the pharmacy SOP section Dispensing 4: Counselling of Dispensed Prescriptions.

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his prescription on 23 December 2021, as Ms C told HDC that she recalls staying behind late to clear the remaining prescriptions and remembers feeling pressure to get Mr A's prescription completed urgently, so that it was ready for him the next morning. In hindsight, she stated that she could have completed another check the next morning with fresh eyes.

27. The apology letter to Mr A, dated 9 May 2022, stated that Ms C's note, attached to the bag of medication, was to prompt a pharmacist to discuss the new medication with him when he returned to collect his prescription. None of the dispensary team members can recall this interaction occurring due to the time that has passed, and there is no documentation to support that this discussion occurred or to provide detail on the content.

28. The internal investigation identified a missed opportunity to identify the error on 23 December 2021, when the patient who had been prescribed Sinemet came into the pharmacy with a prescription stamped 'faxed' the day before. There is no evidence of any investigation into the discrepancy, and the incident notification form notes: 'We should have questioned why it was not processed or printed the day before.'

29. Subsequent dispensing checks for Mr A's repeat prescriptions also did not identify the error, as the original prescription had been loaded under Mr A's name incorrectly. The dispensing pharmacists told HDC that they check that the patient is due for the repeat medication and assume that the prescription has been processed correctly during the initial dispensing. Typically, they do not locate or check against the initial prescription. The pharmacy told HDC that when dispensing repeat medication, a certified repeat copy (CRC) is printed from the system and used, not the original prescription.

30. The Pharmacy Council of New Zealand (PCNZ) Competence Standards for the Pharmacy Profession (2015) provide that a pharmacist '[m]aintains a logical, safe and disciplined dispensing procedure' and '[m]onitors the dispensing process for potential errors'. Guidance included in the Standard maintains the '[pharmacy's] SOP's will also outline the technical aspects of the dispensing process'.

31. Ms C acknowledged that the pharmacy's SOPs[3] were not followed on 22 December 2021 as the staff failed to verify patient details on each prescription during the processing, dispensing, and checking steps.

Context of care

32. In her response to HDC, Ms C stated that several factors had an impact on staff at the time of dispensing the initial prescription, which was three days prior to Christmas. This included staff vacancies, additional pressure, and telephone calls concerning a government announcement the previous day regarding shortening of the COVID-19 booster gap from six months to four months, and providing vaccine passes and information on the COVID-19 vaccine rollout for 5–11-year-olds. In addition, there were a high number of requests for prescriptions.

[3] Included as Appendices A–D.

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33. Ms C explained that the staff were having to work long hours and overtime to meet the demand. She told HDC that when she checked Mr A's prescription, she was working past closing time to catch up on her workload.

34. Ms D recalled being extremely busy with vaccinations and Christmas extended hours. She stated that Mr A's prescription was processed after 5.30pm and she felt pressured to process all the prescriptions that had come in that day, so that the pharmacist in charge could generate an order from the supplier. This is done at the end of the day.

35. Ms C provided the following information to give HDC a picture of the workload on 22 December 2021:

- 322 prescriptions were dispensed (50 of which were processed between 5pm and 6pm);
- 242 transactions through the till;
- 107 phone calls;
- Approximately 50 vaccine passes processed;
- Approximately 70 vaccinations provided; and
- The dispensary stock received from the wholesaler was missing two boxes of medications and included a few packing errors, which needed to be rectified with the supplier.

36. Ms C also explained to HDC that although it was legal and appropriate to send prescriptions via fax, staff were becoming used to ePrescriptions, which may have resulted in a lack of vigilance. She specifically noted that this is not an excuse for the incident, and the staff should have identified that the prescriptions were for two separate patients, regardless of the form in which the prescriptions were received.

Actions taken following incident

37. Dr B informed Ms C of the error on 31 March 2022. The incident notification form was dated 1.29pm 31 March 2022, indicating that an investigation was started that day.

38. By 4 April 2022, when she emailed Dr B, Ms C had verbally apologised to Mr A on Friday (1 April 2022) and provided him with a brief explanation on what had caused the error. She planned to follow the verbal apology with a formal written apology. Ms C also stated that she had 'touched base with [Mr A] on Sat[urday] to check on how he was feeling and to update him of the ongoing work done in regard to this matter'.

39. Ms C told Dr B in her email that the pharmacy had held an urgent dispensary meeting on Friday morning to investigate what went wrong and how to ensure that it would not happen again. She also said that the pharmacy had an extensive plan involving retraining and changing processes, and she would provide details of this if Dr B wished.

40. Ms C informed Dr B:

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> 'I would like to cover the costs of all [Mr A's] medical appointments at [the medical centre] until the end of the year, regardless of what pharmacy he chooses to get his scripts from in the future. But I need to have [Mr A's] permission to do so first.'

41. Ms C told HDC that she discussed the error with the dispensary staff in depth and has made changes to systems, which are outlined in the 'changes made since events' section of this report.

42. A written apology letter, dated 9 May 2022, was sent to Mr A. Ms C acknowledged that there was a delay in writing the apology letter and told HDC that she has apologised to Mr A for the delay. She explained that April and May 2022 were extremely busy due to both personal and professional pressures, which resulted in a longer than expected timeframe to complete the internal investigation and write the apology letter.

43. Ms C told HDC that she maintained continuous communication with Mr A between 1 April 2022 and 14 April 2022. During this time, she checked on how he was feeling and spoke to him about his blood test.

Responses to provisional report

Mr A

44. Mr A was provided with a copy of the 'facts gathered' section of my provisional report, which was translated into his first language. Mr A told HDC that he has experienced ongoing issues with his health since he was dispensed Sinemet; in particular, he has suffered from dry eyes and a dry nose, for which he now requires ointments, and he has a dry mouth. Mr A said that his sleep and physical activity have also been affected, and he suffers from dizziness and numbness in his hands and feet.

Ms C

45. Ms C was provided with a copy of the provisional report and given an opportunity to comment. Ms C is the owner of the pharmacy and was also given the opportunity to respond in this capacity. Ms C confirmed to HDC that she had no comments, and that Ms D had been given an opportunity to review the sections of the report that relate to her. Ms D confirmed to HDC that she had no comments.

Opinion: Ms C — breach

46. In her response to HDC and apology to Mr A, Ms C expressed genuine remorse for the dispensing error. She also made the effort to engage with Dr B to ensure that Mr A was not affected financially by any additional medical care required because of the error, and she checked on Mr A's wellbeing when he came into the pharmacy.

47. I acknowledge the pressures staff were under at the time of these events, due to understaffing during the COVID-19 vaccination roll-out and the Christmas season. Further, I acknowledge that the way the prescription was sent to the pharmacy (two prescriptions for different people faxed at the same time) increased the risk of an error occurring. I also note

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that staff were transitioning to ePrescribing and becoming used to the additional safety features associated with barcodes.

48. However, SOPs are in place to provide a safety net and prevent medication being dispensed to the incorrect consumer. It is particularly critical for staff to be vigilant in following SOPs during periods of high demand and additional stress, as the environmental factors affecting staff increase the risk of distraction and error.

49. Mr A had difficulty communicating in English, as this was not his first language, and he had a high level of trust in health professionals, including his doctor and community pharmacy. The staff at the pharmacy had a responsibility to ensure that Mr A understood what his medications were for and why he was taking them. Mr A told Ms C that it was his understanding that the new medication was for Alzheimer's. This response should have prompted further investigation, as Sinemet is used for the treatment of Parkinson's disease, not Alzheimer's. Due to a lack of documentation, it is unclear when this discussion occurred.

50. Ms C, as the owner of the pharmacy, was supervising Ms D, who was an intern at the time, and Ms C was the checking pharmacist when Mr A's medication was dispensed on 22 December 2021. As the supervising pharmacist, Ms C has taken responsibility for the error and agreed that a breach of the Code of Health and Disability Services Consumers' Rights (the Code) had occurred. I commend her for her professionalism and willingness to work with HDC.

51. By failing to verify patient details on each of the pages of the prescription during the checking process, Ms C did not follow the pharmacy's Dispensing and Processing a Prescription SOP or the PCNZ Competence Standards (2015) correctly. Accordingly, I find that Ms C breached Right 4(2)[4] of the Code in failing to provide services in accordance with professional standards and the pharmacy's SOPs.

Opinion: Ms D — adverse comment

52. On 22 December 2021, Ms D was an intern pharmacist at the pharmacy working under the direct supervision of Ms C. Ms D was an experienced intern and had completed her final examinations to become a newly registered pharmacist on 27 January 2022.

53. Ms D explained that she was under pressure to complete the prescriptions that had come in on the evening of 22 December 2021. I acknowledge the pressure she was under and that a barcode on the prescription would have been preferable to manual entry into the system. However, I am critical that Ms D failed to verify patient details on each of the pages of the prescription during the processing and dispensing process. I trust that Ms D has learnt from this experience and will carry this learning forward in her career as a pharmacist.

[4] Right 4(2): The right to services of an appropriate standard. 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

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Opinion: Pharmacy — adverse comment

Dispensing error — adverse comment

54. I note that a growing familiarity with the ePrescribing system and its additional safety features meant that the dispensing staff were manually processing fewer prescriptions that required an additional level of vigilance. I also acknowledge that having more than one process in place increases the chance of error.

55. In the days following the dispensing of Mr A's original prescription, opportunities were missed to identify the dispensing error and prevent a further two repeat prescriptions from being issued. I agree with the findings of the pharmacy's internal investigation, and I am critical that further action was not taken to reconcile the discrepancy in documentation when the consumer who had been prescribed Sinemet came in to collect his prescription on 23 December 2022.

56. There is no documentation of the counselling conversation that was to occur following the initial dispensing of Sinemet, and I am unable to determine exactly what was said given the passage of time. I am cognisant of Mr A's difficulties with communicating in English and the impact this would have when complex medical information is discussed. I acknowledge that in this situation it may not have been reasonably practicable for an interpreter to be engaged. However, Mr A's communication difficulties should have resulted in additional efforts to ensure that he understood what his medication was for and was not just taking it on trust.

Resolution of complaint — other comment

57. Mr A asked Dr B to assist him to make a complaint to HDC on 11 April 2022 because he had been expecting a written apology that had not eventuated. A written letter of apology was sent to Mr A on 9 May 2022.

58. Right 10(3) of the Code requires a provider to facilitate the fair, simple, speedy, and efficient resolution of complaints. Right 10(4) of the Code requires a provider to inform a consumer about the progress on the consumer's complaint at intervals of not more than one month.

59. I have considered Ms C's actions outlined in her email to Dr B on 4 April 2022 (four days after she was informed of the complaint) and find that her acknowledgement of the error, verbal apology, brief explanation of what had occurred, and offer to cover medical costs, is a reasonable effort to facilitate a fair, simple, speedy resolution.

60. Although 9 May 2022, when the written apology was provided, is slightly longer than one month since Ms C acknowledged the complaint and apologised verbally, it is not an excessive delay. Ms C was in contact with Mr A up to 14 April 2022 and has provided HDC with information on extenuating circumstances that were affecting her ability to complete the letter. I also consider it reasonable for Ms C to have waited until the internal investigation had been completed, prior to writing an apology, so that the investigation findings and actions taken to prevent a recurrence could be included. I therefore find that the pharmacy did not breach Right 10 of the Code.

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Changes made since events

61. After completing its internal investigation into the cause of the dispensing error, the pharmacy made the following changes:

- The settings on the pharmacy printer were changed to print each page of a prescription on a single page.
- All dispensing staff were retrained on the pharmacy SOPs for processing, dispensing, and checking prescriptions and will focus on carrying out thorough checks on patient information written on the prescription against each medication and pharmacy label.
- Staff were reminded of the importance of documenting discussions with patients or any relevant additional information when processing new medications.
- Pharmacists were reminded to slow down and ensure that their full attention is given to each task, especially when dispensing is busy.
- Recruitment of new staff was underway and there are now two qualified pharmacists in addition to Ms C. A full-time pharmacy technician was employed but has since left (in July 2023). Additional vaccinators were contracted to help ease the workload during times of high demand.
- Staff were to be retrained on accuracy and clinical checks using a workbook developed by one of the pharmacy professional bodies.
- The pharmacy's SOPs were updated to include a new documenting practice utilising 'quick note' on the dispensing system to document any change of dose, strength, quantity or brand, new medication, regular medications that are missing from the prescription, and other issues such as expired special authority. A copy of the note is printed and included with the patient prescription, indicating to staff that a dispensing staff member must talk to the patient. Screenshot examples of this system in use have been provided to HDC.
- A system of printing New Zealand Formulary patient information leaflets for new medications has been implemented.
- The repeats section of the SOPs was amended to include conducting a brief clinical check against dispensing history. When dispensing a repeat prescription, the processing pharmacist now checks the first dispensing against the patient's history for appropriateness.

62. Ms C also completed a clinical checking reflection workbook and provided a copy of this reflection to HDC.

63. In addition, the process of faxing prescriptions to a pharmacy has been discontinued and replaced with either emailed prescriptions or the New Zealand ePrescription Service. The medical centre currently emails prescriptions to the pharmacy. Examples have been provided to HDC and show that each prescription is attached separately and the patient's NHI number is in the subject line. If more than one prescription is sent in an email, both NHI numbers are in the subject line.

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Dr B

64. Dr B told HDC that the medical centre is upgrading its patient management system. Included with the upgrade will be ePrescribing, and this will replace the email system.

Recommendations

65. I acknowledge the changes that have already been made to improve systems at the pharmacy and prevent medication being dispensed to a consumer for whom it was not intended.

66. Taking into account the changes already made by the pharmacy, I recommend that Ms C:

a) Provide records of completion of dispensing staff training utilising the clinical checks workbook. A copy of each workbook is to be provided to HDC within three months of receiving this report.

b) Audit the last 15 prescriptions where a new medication has been dispensed, for compliance with the pharmacy SOPs and the newly introduced 'quick note' process for recording discussions of new medication. The result of this audit, including any corrective actions, is to be provided to HDC within six weeks of receiving this report.

Follow-up actions

67. A copy of this report with details identifying the parties removed will be sent to the Pharmacy Council of New Zealand, and it will be advised of Ms C's name.

68. A copy of this report with details identifying the parties removed will be sent to the Health Quality & Safety Commission, the NZ Pharmacovigilance Centre, Medicines Control, and the Pharmaceutical Society of New Zealand, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: SOP — Dispensing 1: Prioritising and validating a prescription

Dispensing 1 – Receiving, Prioritising and Validating a Prescription

Review Status: Reviewed

Local updated on: 23/05/2022

Author	Activated On	Update Frequency
	21/06/2019	Yearly
Next Update	**SOP Management**	**Responsibility**
23/05/2023	Pharmacy Manager	Dispensary Manager, Pharmacist, Technician

Purpose

To ensure all required details on new prescriptions are checked and confirmed

General Information

To ensure all required details on new prescriptions are checked and confirmed

Procedures

- Greet the customer in a kind and friendly manner. Always smile.
- Accept the prescription from the customer or the customer's agent and check that the following is recorded on the prescription:
  - A legible name.
  - A legible residential address (Post Office Box numbers and Rural Delivery addresses are not acceptable).
  - A daytime phone number or cellphone number.
  - The address and phone number(s) on the prescription(s) are correct.
  - Patient coding is filled in, i.e. A3, A1, A4, J3, Y1, etc.
  - If the customer has a Community Services Card (CSC). If they do ask to view the card and write down the number and the expiry date on the top of the prescription. If the customer does not have the Community Services Card (CSC) available to view, obtain the customer's date of birth (if not

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5/24/22, 4:07 PM Dispensing 1 – Receiving, Prioritising and Validating a Prescription

recorded on the prescription) and phone the Community Services Card line on 0800-999-999 to obtain the card number and expiry date.

- If the customer has any other relevant cards, i.e. Higher User Card (Z) or Prescription Subsidy Card (X3, X1, X4).
- A date of birth if the customer is a child.
- The weight of the child. If the weight is unknown by the parent or caregiver, then ask to weigh the child with the Pharmacy scales. If the child is not present, then estimate the child's weight using information from the NZ Formulary for Children.
- If the customer has allergies to any medicines.
- A Prescriber's signature.
- The date of the prescription. Prescriptions expire if not presented within 3 months of the original date, except for Controlled Drug prescriptions, which expire 7 days after the date the Prescriber has written it.

- Ask the customer or the customer's agent when they would like to pick up the prescription(s). If they are confused ask what is the most convenient time for them to pick up their prescription(s).

- If the customer or customer's agent has opted to wait for their prescription(s) notify them approximately on how long it will take, assessing from the work load already in the Dispensary.

- If the customer or the customer's agent has opted to come back, ascertain from them what time they wish to come back for their prescription(s), e.g. morning teatime, tomorrow lunchtime, etc. and note it down on the top of the prescription.

- Confirm whether the Dispensary will be able to fulfill the prescription(s) in the desired timeframe by checking with the staff in the Dispensary.

- Ask the customer or the customer's agent if they need anything else from the Pharmacy and would like some assistance.

- Hand the prescription to a Pharmacist or Technician in the Dispensary to be dispensed and mention any special information that the customer or the customer's agent has conveyed.

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In the Dispensary (Pharmacists, Technicians, Interns):

- Where queried, check the customer's eligibility for funded prescriptions on the Ministry of Health website.
- If required, explain non-eligibility and medicine(s) costs to customer or their agent. If the customer is not prepared to pay, refer back to the Prescriber.
- Where anomalies need noting, e.g. medicine missing from usual regime, early, late or infrequent dispensing, or duplicated therapy, ensure a note is attached to the prescription to draw the Pharmacists' attention to relevant points.

N/A

References

MOH Website - Guide to Eligibility

http://www.moh.govt.nz/moh.nsf/indexmh/2011-eligibility-guide

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Appendix B: SOP — Dispensing 2: Assessing and processing a prescription

Dispensing 2 - Assessing and Processing a Prescription

Dispensing 2 - Assessing and Processing a Prescription	Review Status: Reviewed	Local updated on: 06/12/2023
Author	Activated On 21/06/2019	Update Frequency Yearly
Next Update 06/12/2024	SOP Management Pharmacy Manager	Responsibility Dispensary Manager, Pharmacist, Technician

Purpose

To ensure all prescriptions are assessed for validity, safety and clinical appropriateness

General Information

To ensure all prescriptions are assessed for validity, safety and clinical appropriateness

Procedures

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12/6/23, 8:59 PM Dispensing 2 - Assessing and Processing a Prescription

- Ideally all annotations made by a Pharmacist or Technician should be done in green pen, however annotations in blue or black pen are accepted. No annotations should be carried out with red pen.
- When **processing** a prescription, the Pharmacist or Technician shall:
    - Check that each prescription complies with the MOH Sector Services contracts and legislative prescription controls and requirements and that the following are recorded on the prescription:
    - A legible name.
    - A legible residential address (Post Office Box numbers and Rural Delivery addresses are not acceptable).
    - A daytime phone number or cellphone number.
    - Patient coding is filled in, i.e. A3, A1, A4, J3, Y1, etc.
    - If the customer is eligible for funding of medicines – use the Ministry of Health Checking Eligibility and Eligibility Checklist for further information.
    - If the customer has a Community Services Card (CSC), Higher User Card (Z) or Prescription Subsidy Card (X3, X1, X4).
    - A date of birth if the customer is a child.
    - The weight of the child. If the weight is unknown by the parent or caregiver, then ask to weigh the child with the Pharmacy scales. If the child is not present, then estimate the child's weight using information from the NZ Formulary for Children.
    - If the customer has any allergies to any medicines.
    - A Prescriber's signature.
    - The date of the prescription. A prescription is eligible for subsidy if it is dispensed within 3 months of the date of the prescription. After this time period, a prescription medicine is still able to be dispensed if first presented within 6 months of the date of writing or 9 months for an oral contraceptive, however no subsidy is payable. Prescriptions expire if not presented within 3 months of the original date, except for Controlled Drug prescriptions, which expire 7 days after the date the Prescriber has written it.
    - The Prescriber's address.
    - The name of the medicine.
    - The dose and frequency of the dose, for an internal medicine.
    - The method and frequency of use for an external medicine.

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12/6/23, 8:59 PM Dispensing 2 – Assessing and Processing a Prescription

- Stamp each prescription form with the Pharmacy Stamp. The dispensary stamp is to be placed in such manner and place that no part of the prescription is obliterated. Stamp should include date prescription is processed, pharmacy name and address.

- Review the appropriateness of each prescribed medicine with respect to its therapeutic use, appropriateness for the customer's parameters, e.g. age, weight, renal function, possible adverse effects, contraindications, dosage, route of administration, duration of treatment, and possible interactions with other medication(s) or food.

- Check the recorded medication history for newly prescribed medicines, consistency of treatment, different strengths or frequency, duplication of medicines, e.g. different brands of the same medicine, regular medicines not prescribed, interactions with other prescribed medicine(s), evidence of misuse, allergies, e.g. calling for repeats too early or too late.

- If the customer has had the medicine before "AB" (As Before) is written on the left side of the medicine name to indicate that the customer has had this medicine before. If the medicine is new to the customer, then "New" is written on the left side of the medicine name to indicated that this medicine is new for the customer and extra counselling is required. Print Patient Info Leaflet when prompted (with the entery of a new medicine) when appropriate. This will be given to the patient. It will also be documented in the patient's diary.

- Note any relevant discrepancies, changes or amended prescription details in "quick Note" (Patient Diary on Toniq) and on the prescriptions to alert other dispensary staff members involved in the process. Print "Quick Note" to attach it to the parcel for the patient to take home as a record.

- Select the brand of medicine that best serves the interest of the customer, i.e. maintains continuity of treatment and bioavailability, and complies with the Sole Supplier Brand scheme of Pharmac. This is done with reference to the legislative requirements covering substitution.

- Key in relevant information into the dispensary computer system and calculate the quantity to be dispensed from the prescription directions and in accordance to type of medicine, the rules of the Pharmac Pharmaceutical Schedule and the Pharmacy Procedures Manual, and the type of Prescriber, e.g. Doctor, Dentist, etc.
- Any changes in the quantity or presentation of a medicine dispensed must be annotated on the prescription. If there is a change in the quantity prescribed, regardless of whether it results in a financial implication to the DHB or not, a Pharmacist cannot increase the quantity of the prescription without the change being endorsed by the prescriber. A Pharmacist can however change the presentation of a medication, as long as the change is clearly annotated.

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12/6/23, 8:59 PM Dispensing 2 - Assessing and Processing a Prescription

- If it is not possible to determine the medicine the Prescriber intended to be dispensed or there is a choice of strengths of the medicine, then the Prescriber must be contacted to confirm the medicine and/or correct strength and the prescription must be annotated and signed accordingly by a Pharmacist. Should a prescriber be contacted for whatever reason, a diary entery is to be made by generating a quick note. Details of the interaction are to be recorded. This quick note is then printed and placed with the original script.
- If emailing a prescriber regarding a script, the email is to be copied and pasted into a diary entery. the same is true for the prescriber's response. This ensures there is a communication trail in case of change of shifts.
- If the medicine is to be supplied all at once then the total quantity supplied must be annotated on the prescription.
- If the medicine is to be supplied on more than one occasion the prescription must be annotated with the following information:
  - The number of times the medicine can be supplied AND
  - The quantity to be supplied at each time of dispensing.
- If a 'non-STAT' medicine is to be dispensed in greater than one month's supply, then the dispensary computer system 'Stat Disp' function is used to make a note in the dispensary computer records and the Access Exemption Stamp or 'STAT' stamp is stamped on the prescription for the customer or the customer's agent to declare and sign.
- If the Pharmacy is unable to supply the full amount of the medication ordered for the treatment period, a Pharmacist or Technician can borrow or medication from the other local Pharmacies in the correct manner.
- If the other local Pharmacies do not have enough stock to fulfill the prescription the dispensary computer system 'Drugs Owing' function will be used to make a note in the customer's Patient File in the dispensary computer system and the amount owing will be indicated on the medicine label.
- If the medicine is to be put on hold to be dispensed at a later date, then the dispensary computer system 'Held Rx' function is used and an "*H*" is annotated on the left of the medicine to indicate that the medicine has been placed on hold in the dispensary computer system. Once the customer or customer's agent has collected the prescription items they require, the prescription needs to be photocopied and the photocopy of the original prescription will be placed in the dedicated 'Held Prescriptions' file.

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- If the medicine is a liquid form of an antibiotic to which a diluent must be added in an amount that does not coincide with the amount contained in one or more standard packs, then the dispensary computer system "Claim Wastage" function is used to claim for the remaining antibiotic not used in the dispensing.

- If a manufactured Bulk Extemporaneous product has to be used the batch number and expiry date of the manufactured Bulk Extemporaneous product must be included on the medicine label.

- Produce medication dispensary label(s) that are legible and complete in the information that they provide. Labels should be prepared in accordance with the recommendations of the Pharmaceutical Council of New Zealand and the NZS 8134.7:2010 Health and Disability Services Pharmacy Services Standard and appropriate Governmental Acts and Regulations, and should ensure that the intentions of the Prescriber are properly represented.

- Where possible, adapt labeling instructions to address communication barriers such as literacy level and cultural background.

- Generate enough dispensary labels for each container dispensed. Place a "more than one container of the same medicine" note on multiple containers of same medicine to alert the customer.

- Label font size should not be compromised by adding too many cautionary instructions. Where required, use additional coloured Cautionary Advisory labels instead.

- Never overwrite corrections on dispensary labels - edit the dispensary label on dispensary computer system and reprint.
- If a generated dispensary label is not needed or is wrong, cross through with pen and discard in the confidential bin so it is not inadvertently used.
- Collate the prescription, generated dispensary labels into a plastic tray and place on the dispensing bench for the dispensing and checking of the prescription process.

N/A

References

MCNZ website

https://www.mcnz.org.nz/

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Appendix C: SOP — Dispensing 3: Dispensing and checking a prescription

1/11/24, 7:27 PM Dispensing 3 – Dispensing and Checking a Prescription

Dispensing 3 – Dispensing and Checking a Prescription	Review Status: Active	Local updated on: 06/12/2023
Author	Activated On 21/06/2019	Update Frequency Yearly
Next Update 06/12/2024	SOP Management Pharmacy Manager	Responsibility Dispensary Manager, Pharmacist, Technician

Purpose

To ensure label generation and medicine dispensing and checking follows a safe and logical process.

General Information

To ensure label generation and medicine dispensing and checking follows a safe and logical process.

Procedures

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- Ideally all annotations made by a Pharmacist or Technician should be done in green pen, howeverannotations in blue or black pen are accepted.
- It is best practice to have different members of the dispensary team involved in the dispensing andchecking of a prescription. If this cannot be achieved, it is advised that the Pharmacist undertake anothertask in between the dispensing and checking steps so that they come back to the checking step with a"fresh set of eyes".
- Attach the third-part of the dispensary label to the prescription next to the corresponding medicine itcorrelates to for the recording of the unique Pharmacy prescription number.
- Assemble all of the prescription items, with the original prescription and the receipt in a plastic basket.
- Once items have been dispensed the basket should be placed on the bench to be checked by the pharmacist.
- Once checked the item should be bagged up with the patient reciept or collection information on theoutside of the bag and place on the "todays shelves" which are organised into alphabetical order to awaitcollection by the customer or the customer's agent.
- If there are medicines that require refrigeration or are controlled drugs, place these medicines in the appropriate area and place a note with the other medicines as a reminder to retrieve them before handingto the customer or customer's agent.
- Ensure any additional documentation and products, such as counselling notes, cards, samples, areincluded in the plastic basket.
- For detailed information on other restrictions and rules that apply to dispensing of prescriptions and making claims for payment from MOH Sector Services please refer to the Pharmac Pharmaceutical Schedule and its current monthly updates and the Pharmacy Procedures Manual.
- Any Medicinal Near Misses are recorded on the Near Misses Log on the day that the Medicinal Near Misswas identified in the correct manner
- When dispensing cytotoxic medicines, e.g. Cycloblastin, Methotrexate, etc., the dedicated Cytotoxi ccounting tray and spatula labelled "For Cytotoxic Use Only" is used. You can find this in the first drawer below the sink. The dedicated Cytotoxic countingtray and spatula are cleaned with 70% methylated spirits and a disposable tissue or cotton wool aftereach use. If there is any chance of a staff member coming in contact with the cytotoxic medicine, then disposable examination gloves are used.

When dispensing a medicine, the Pharmacist or Technician shall:

- Select each medicine from the dispensary shelf at one time using the original prescription, makingsure the correct medicine, strength and brand has been chosen. Never use the generateddispensary label to select the medicine.
- Check the expiry date of the stock medicine.
- Count or pour the selected medicine and transfer to a suitable clean container (bottle, mission, vial or skillet) and use child resistance safety caps when required.

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1/11/24, 7:27 PM Dispensing 3 – Dispensing and Checking a Prescription

- Where possible, label the medicine, rather than an outer box, e.g. label inhalers or ointment tubes as opposed to their containers.
- Ensure the dispensary label is straight and at an appropriate height on the container.
- If the original container is used, the label should be affixed so that no important information on the label is obscured.
- Attach the appropriate Cautionary and Advisory (C&A) labels if required.
- Attach the third-part of the dispensary label to the prescription next to the corresponding medicine it correlates to for the recording of the unique [name of pharmacy] Pharmacy prescription number.
- Annotate on the prescription next to the corresponding medicine if the Pharmacy owes any medicines.
- Repeat the process until all of the medicines on the prescription are dispensed.
- Leave the prescription (and any attached notes), all stock containers and dispensed medicines in a plastic tray to be checked by a Pharmacist.
- Initial in the DISPENSED box on the dispensary stamp to indicate that you have assembled the prescription.

When checking the prescription, the pharmacist shall:

- Check the prescription details are correct, including the customer's details, statutory details and the suitability of the prescribed medicine(s) in terms of the quantities prescribed, funding and the prescribers scope of practice.
- Check that the medical history has been reviewed and that there is consistency of treatment and compliance.
- Check the appropriateness of each prescribed medicine with respect to its therapeutic use, appropriateness for the customer's parameters, e.g. age, weight, renal function, possible adverse effects, contraindications, dosage, route of administration, duration of treatment, and possible interactions with other medication(s) or food.
- Check that each medicine dispensed is correct against the medicine prescribed on the prescription. This includes checking the generated dispensary label and dispensed medicine(s) against the original prescription for the:

1. Correct customer's name;
2. Correct instructions for use;
3. Correct formulation, strength and quantity of medicine;
4. Correct prescription number;
5. Correct prescriber;
6. Correct directions, which are clear and concise.

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1/11/24, 7:27 PM Dispensing 3 – Dispensing and Checking a Prescription

- Check that each medicine dispensed against the bulk stock container of the medicine for the correct strength, form, brand and that is it within an appropriate expiry date. If more than one stock bottle has been used, check the dispensed medicine against all sources of supply.
- Open up each dispensed bottle or skillet to compare the contents with stock supply and the prescription– never assume that the contents is correct.
- If a calculation is involved, this is rechecked and if possible checked by another Pharmacist orTechnician.
- Attach any additional appropriate Cautionary and Advisory (C&A) labels if required.
- Check that the cautionary label 'External Use Only' and/or 'Caution: Not to be Taken' is on all external products.
- Sign their initial on the third-part of the dispensary label for each medicine to confirm that each medicine has been fully checked as per the process above.
- Check that all required information and annotations are documented on the prescription to meet contractual requirements.
- Check the receipt to ensure that the dispensed prescription complies with all funding requirements and the medicines are the correct price
- After reviewing all of the medicines on the prescription and receipt initial in the CHECKED box on the dispensary stamp to indicate that the entire prescription has been checked and that the dispensing is complete and correct
- Put away all bulk stock container in their correct positions in the Dispensary.
- It is the Pharmacy policy that at all times the prescription must be kept with the dispensed medicine(s) until the customer or the customer's agent has collected the items as it allows the dispensary staff member giving out the prescription to double check what they are giving out with the prescription and provide the appropriate counselling. In addition, if the customer queries what they are being given, the dispensary staff member has the prescription immediately right in front of them to discuss with thecustomer.
- Assemble all of the prescription items, with the original prescription and the receipt in a plastic basket. Call out and if the patient is not waiting to collect the item, items are bagged with the reciept, printed diary notes, new medicine information leaflets, or collection infromation on the outside of the bag. The bag is then placed alphabetically on the shelf.
- If there are medicines that require refrigeration or are controlled drugs, place these medicines in the appropriate area and place a note with the other medicines as a reminder to retrieve them before handing to the customer or customer's agent.

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Appendix D: SOP — Dispensing 4: Counselling of dispensed prescription

1/11/24, 8:55 PM Dispensing 4 - Counselling of Dispensed Prescriptions

Dispensing 4 - Counselling of Dispensed Prescriptions	Review Status: Reviewed	Local updated on: 10/12/2023
Author	Activated On 21/06/2019	Update Frequency Yearly
Next Update 10/12/2024	SOP Management Pharmacy Manager	Responsibility Dispensary Manager, Pharmacist, Technician

Purpose

To ensure that patients or their agent are offered appropriate counselling about their medicines when they com to collect them.

General Information

To ensure that patients or their agent are offered appropriate counselling about their medicines when they com to collect them.

Procedures

- The Pharmacy takes responsibility for providing its customers with sufficient information so that they can derive maximum therapeutic benefit and encounter minimum untoward side effects from their medicatior
- It is preferred that a Pharmacist will hand out the dispensed medicine(s) to the customer or the customer's agent and counsel them on their medicine(s), however at busy times this cannot always be possible.
- If the pharmacist deems it essential that they give out the prescription or they require the patient to have specific information, a printed "quick note" will be placed on the outside of the sealed script. This will ensure that retail staff know to get a pharmacist before handing out the medication.
- Counselling of customers will always be held in a suitable area away from the customer traffic flow to ensure the customer's privacy. If complete privacy is required, the Consultation Room can be used.

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1/11/24, 8:55 PM Dispensing 4 - Counselling of Dispensed Prescriptions

Handing out Medication to Patients

Objective: To ensure that medication is dispensed accurately and safely to patients.

Equipment Required:

- Patient medication list - Toniq Dispensary
- Medication
- Prescription labels
- Paper bags
- Patient information sheet (if applicable) , Printed notes.

Procedure

1. Verify patient information including the patient's name and address.
2. Ask the patient for their address and confirm that it matches the information on the medication label
3. Hand the bag to the patient along with any additional instructions or warnings.
4. Record the dispensed medication on the patient's Dispensary Toniq file when collected (Automatically collected when scanning bag label on Retail Toniq)

Note: If there is a "Pharmacist Note" or a "Medicine Info Leaflet" attached to the prescription, shop staff must get one of the dispensary staff members to hand out the prescription. This ensure clear communications regarding any changes, discrepancies, issues relating to the prescription.

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- The Pharmacist or Technician will advise the customer or the customer's agent if any approved substitutions have been made and the reasons for them. The Pharmacist or Technician will also advise the customer or the customer's agent if there are any medicines owing to them and when the medicine(s) will be available.

- In the case of new medicines being prescribed, the Pharmacist or Technician will ensure that the customer or customer's agent understands the answers to the following questions for each of their medicines:
  - Why is the medicine being prescribed for me?
  - How do I take the medicine?
  - When do I take the medicine?
  - How do I know if I have a side effect and what should I do?
  - What special precautions should I take?
  - Are there any foods or other medicines I should avoid with this medicine?
  - Should I avoid alcoholic drinks while taking this medicine?
  - How will I know the medicine is working and when should I call the Prescriber?
  - How should I store the medicine?
  - How do I know when to and how to dispose of any unwanted unused medicine(s)?
  - Do I have a repeat prescription to collect, and if so, how and when should I collect it?
  - What do I do if I think the medicine is not working?
  - When is it appropriate to contact the Prescriber?

- The Pharmacist or Technician will always check that the customer or the customer's agent understands the advice given.

- If the customer or customer's agent indicates that any medicine(s) that the Prescriber has prescribed are incorrect then a Pharmacist will contact the Prescriber to confirm the details.

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