The Pharmacy

Report on Opinion - Case 98HDC15773

Complaint

The Commissioner received a complaint from a mother about the services provided to her daughter ("the consumer") by a pharmacy. The complaint is that:

- *The complainant's daughter was prescribed Dexamethazone 4mg tablets by her GP. Instead of dispensing Dexamethazone 4mg tablets, the pharmacy dispensed Betamethasone 0.5mg tablets on a date in mid-June 1998 in a container labelled Dexamethazone 4mg tablets.*
- *The error resulted in the deterioration of the consumer's medical condition necessitating medical intervention and admission to hospital.*
- *The error was discovered three days later by hospital staff on the consumer's admission to hospital.*

Investigation

The Commissioner received a letter on 1 July 1998 addressed to the pharmacy. At the time of writing to the pharmacist, the complainant wrote to the Commissioner. Although the Commissioner knew the matter was resolved between the parties, she decided to commence an investigation on her own initiative. An investigation was undertaken and information was received from:

The Complainant/Consumer's mother
The Pharmacist/Provider

A copy of the prescription was obtained from Health Benefits Ltd Wanganui and the consumer's medical records were obtained from the hospital.

Outcome of Investigation

On a Monday in mid-June 1998 the complainant and her husband took their daughter to her general practitioner. Their daughter ("the consumer") had been diagnosed with Glioblastoma Multiforme of the brain. Following the consultation the doctor prescribed Dexamethazone 4mg tablets. The complainant took the prescription to the pharmacy to be dispensed.

Continued on next page

The Pharmacy

Report on Opinion - Case 98HDC15773, continued

Outcome of Investigation

The consumer commented that the tablets were different from those she had taken previously. These tablets were a different colour and left a bitter after-taste. The family thought the drugs dispensed were a different pharmaceutical brand and did not consider it further at the time.

Over the next few days the consumer's condition worsened. On the Thursday of that week the complainant took her daughter to hospital for relief of the pain. The consumer was admitted to a ward where the nurses and medical professionals drew the complainant's attention to the fact that Betamethasone 0.5mg tablets were enclosed in her daughter's medications box but labelled Dexamethazone 4mg tablets.

The pharmacist advised the Commissioner that:

> *"On Monday* […] *I incorrectly dispensed a prescription for* [the consumer] *giving 30 Betamethasone 0.5mg in a packet correctly labelled as per the prescription, 30 Dexamethazone 4mg. The mistake occurred while filling the foil wrapped tablets into the packet (probably as a result of a momentary distraction between typing the label and filling the prescription). The error was not detected during final checking, before being given out.*
>
> *I believe the prescription was presented and collected by a third party.* [The consumer] *was not a regular patient and as such I was unaware of her medical condition, which may have contributed to my not noticing the mistake, by not realising the medication was not normal for her type of illness.*
>
> *Because she did not respond to the incorrect corticosteroid dispensed, even after increasing the dose, she was admitted to hospital on Thursday* […] *for pain relief. It was at this time my error was discovered and I was notified by a hospital staff member, at which time I apologised to* [the consumer] *via this person for the mistake.*

Continued on next page

The Pharmacy

Report on Opinion - Case 98HDC15773, continued

Outcome of Investigation, *continued*

> *About a week later I received a letter of complaint from* [the consumer's mother] *requesting a personal meeting with myself for an explanation and apology for the shock, upset, anger and stress this mistake had caused the family.*
>
> *I decided the correct procedure was to meet with* [the complainant] *and her family to explain my situation and offer my sincerest apology. I promptly contacted* [the complainant] *by phone and arranged to personally call at the family home to apologise."*

The pharmacist met the complainant, the consumer and family, offered an explanation of how the dispensing error occurred and his sincere apology. To the best of the pharmacist's knowledge the matter was resolved.

On 6 August 1999, in response to the Commissioner's provisional opinion, the pharmacist advised that:

(a) The medication was dispensed into a cardboard skillet, after which the correct label was attached, by the sole pharmacist.

(b) The pharmacist checking the medication was the same sole pharmacist that took the prescription from the patient's agent, typed the label on the computer, counted the tablets, filled and labelled the packet, and has already stated that the error may have been caused by a monetary distraction during [the] *dispensing/checking process, which in a busy sole pharmacist dispensary* [is] *almost simultaneous and may occur at a rate of up to two hundred or mores times a day.*

Continued on next page

The Pharmacy

Report on Opinion - Case 98HDC15773, continued

Code of Health and Disability Services Consumers' Rights

Right 4
Right to Services of An Appropriate Standard

2) Every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards.

Relevant Standards

The Pharmaceutical Society of New Zealand, Code of Ethics, December 1996 states:

Rule 2.12 - The Pharmacist must dispense the correct medicine prescribed.

The Pharmaceutical Society of New Zealand Practice Handbook, January 1998 states:

Rule 4.1 – Prescription and dispensing services, checking the dispensing procedure:

Check for label accuracy name, date, medicine, strength and form, instructions C & A labels and content accuracy– correct medicine, dose, form and quantity.

The Pharmacy Dispensing Procedure Manual states:

Selecting the correct medicine:
- *check the selected medicine against the prescription to ensure that it is the correct medicine, dosage form and strength.*

Attaching the label to the container;
- *label each medicine as they are put into the container.*

Checking the dispensing procedure;
- *the pharmacist is responsible for the final check of the prescription.*
- *check for label accuracy – name, date, medicine strength and form, instructions, C&A labels and content accuracy- correct medicine, dose, form and quantity.*

Continued on next page

The Pharmacy

Report on Opinion - Case 98HDC15773, continued

Opinion: Breach

In my opinion the pharmacist breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights:

The pharmacist received a prescription for Dexamethazone 4mg and he mistakenly dispensed Betamethasone 0.5mg. The error was not detected on the final check before the tablets were given to the consumer. The dispensing procedure failed on two counts: an error occurred when the wrong medication was dispensed into a container labelled with the name of the medication prescribed; and the pharmacist checking the medication did not detect the error before the medication was given to the consumer.

Actions

I recommend that the pharmacist:

- Report to the Commissioner on the steps taken to ensure that a similar error does not occur again in the future.

Other Actions

A copy of this opinion will be forwarded to the Pharmaceutical Society of New Zealand.