Pharmacist / Counter Assistant / Pharmacist

Report on Opinion - Case 97HDC8981

Complaint

The complainant complained that his daughter, the consumer received a quantity of drugs that were not prescribed for her from the pharmacy.

Investigation

The complaint was received on 26 September 1997 and an investigation was commenced. Information was obtained from:

The Consumer
The Complainant/Father of consumer
The Dispensing Pharmacist
The Pharmacist/Manager

The customer incident report prepared by the pharmacist/manager of the pharmacy was also viewed.

Information Gathered During Investigation

In late-September 1997 the consumer was discharged from hospital following a caesarian section and given a prescription for medication. Her father-in-law drove her to the pharmacy and went in to collect her medication while she waited in the car. He collected a package containing four types of medication from the dispensing pharmacist. The package had no name on it. The dispensing pharmacist gave the consumer's father-in-law some instructions regarding the medication, and the counter assistant took his payment. A man's name was printed on each of the instruction labels on the medication containers.

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Report on Opinion - Case 97HDC8981, continued

Information Gathered During Investigation, *continued*

The consumer read the instruction labels on the medication and noticed the name was incorrect. She assumed that this was the name of the doctor who had prescribed the medication as she had not previously consulted him and was not aware of his name. She took the medication dose. Later that evening, the pharmacist/manager telephoned the consumer to tell her that she had been given the wrong medication. He also telephoned the consumer's doctor to inform him that the medication that the consumer had taken had side effects. On her doctor's advice, the consumer was taken by ambulance to hospital, monitored and discharged three to four hours later.

The dispensing pharmacist subsequently telephoned and visited the consumer to apologise. This was followed by an apology letter in late September 1997. The pharmacy also reimbursed the consumer's husband for the cost of the ambulance.

In his letter to the Commissioner dated early December 1997, the pharmacist/manager explained that the dispensing pharmacist and the counter assistant had assumed the consumer's father-in-law was picking up medication for himself. The pharmacist/manager also said that following this incident the pharmacy had implemented an amended protocol for handing out medication, intended to prevent a recurrence of the incident, and had trained all staff on the amended protocol.

The protocol provides a procedure for verifying patient details before medication is handed over and requires pharmacy staff to follow the following procedure when handing out medication:

- Ask the customer whose medication they are waiting for.
- Locate prescriptions and repeat the name on the bag label.
- Ask the customer to repeat their name and address.
- If counselling is required, refer the pharmacist to the customer.
- Only then take payment and wrap the medication.

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Information Gathered During Investigation, *continued*

According to the incident report, the dispensing pharmacist called the name on the prescription when he had finished dispensing the medication and the consumer's father-in-law responded to this call. According to the consumer, the consumer's father-in-law had asked for a prescription under the consumer's maiden name or her married name when he entered the pharmacy and did not hear the other name being called.

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Report on Opinion - Case 97HDC8981, continued

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this case:

RIGHT 4
Right to Services of an Appropriate Standard

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

…

Opinion: Breach - The Dispensing Pharmacist

Right 4(1)

In my opinion the dispensing pharmacist breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights. Insufficient steps were taken to ensure that the medication he dispensed was provided to the correct customer. In providing the wrong medication to the consumer's father-in-law, the dispensing pharmacist did not demonstrate reasonable care and skill.

In making this finding I consider that it is unnecessary to decide whether the consumer's father-in-law responded when the name on the prescription was called. Whatever the case, I consider that steps should have been taken to verify that the medication was being handed over to the correct person. Although the consumer did not experience serious consequences from taking the incorrect medication, I consider that she was exposed to a serious and unacceptable level of risk as a result of the dispensing pharmacist's failure to ascertain the identity of the person to whom the medication was delivered and for whose use it was intended.

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Opinion: The Pharmacist/ Manager

Right 4(2)

In my opinion the pharmacist/manager of the pharmacy, breached Right 4(2) of the Code of Health and Disability Consumers' Rights.

The Code of Ethics of the Pharmaceutical Society of New Zealand provides a standard of professional conduct required to ensure members of the public receive an adequate level of service from pharmacists. Rule 2.1 states *"A pharmacist must safeguard the interest of the public in the supply of health and medicinal products."*

I consider that insufficient steps were taken to safeguard the interests of the public in the supply of medicinal products in the dispensing process and, particularly, that appropriate checking procedures were in place to ensure that medication was supplied to the correct consumer.

Opinion: The Counter Assistant

While the counter assistant at the pharmacy, was responsible for taking payment from the consumer's father-in-law when he collected the consumer's medication, she had no other role in respect of the error that occurred. In my opinion the counter assistant did not breach the Code of Health and Disability Services Consumers' Rights.

Future Actions:

Both the dispensing pharmacist and the pharmacist/manager have apologised to the consumer and to her father. An amended protocol has been put in place to ensure that the identity of consumers is verified prior to the medication being wrapped and handed to them. All staff at the pharmacy have been trained to implement this protocol.

I consider that reasonable actions have been taken to prevent any recurrence of this incident.

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