Pharmacist

Report on Opinion - Case 99HDC0660

Complaint

The Commissioner received a complaint from a consumer with respect to services provided by a Pharmacist. The complaint is that:

- *In mid-December 1998 a doctor prescribed the consumer Paroxetine (Aropax). However, when the consumer took the prescription to the Pharmacy, she was provided with Prozac, which resulted in the symptoms of her illness becoming worse.*

Investigation

The Commissioner received the complaint on 14 January 1999, and an investigation was undertaken. Information was obtained from the following:

The Consumer
The Pharmacist / Provider

Outcome of Investigation

The Prescription
In mid-December 1998 a doctor prescribed the consumer Paroxetine (Aropax) 20mg nocte.

Dispensing the Medication
The same day the consumer took the prescription to the Pharmacy where she was attended to by the Pharmacist.

The consumer states that the pills in the container had the same appearance as Paroxetine pills prescribed to her previously. The consumer proceeded to take the medication prescribed in accordance with the instructions on the pharmacy label. However, the symptoms of her illness worsened and after an extreme anxiety episode the consumer became concerned about her medication. On checking the label she discovered that the medication within the container was not the medication prescribed. The consumer realised that the Pharmacist had dispensed Prozac in error.

Accordingly, in early January 1999, the consumer went to the Pharmacy to advise of the mistake and exchange the Prozac for the correct medication.

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Pharmacist

Report on Opinion - Case 99HDC0660, continued

Outcome of Investigation, *continued*

In a letter dated early March 1999, the Pharmacist advised the Commissioner that although she did not remember filling the consumer's prescription in December 1998, she felt that she must have confused the drug Paroxetine with Prozac and that the error was not corrected in the final check. She advised that this error could have occurred because Paroxetine and Prozac are both in the same drug group and are used to treat similar conditions.

The Pharmacist further advised the Commissioner that the Pharmacy has a *"very low dispensing error rate"* and has a written standard operating procedure for dispensing prescriptions. She provided the Commissioner with a copy of the written procedure. The procedure states its purpose is to *"ensure the correct person gets the correct medication and understands the dosage, instructions, storage requirements, possible side effects and possible drug interaction".* The procedure is as follows:

- *"Check prescription thoroughly to ensure correct name, address, GMS status of patient. Signature and date and authenticity of prescription including Doctor's address.*
- *Check medicine strength and dosage and interactions. Where there are any calculations (especially CD's and alkaloids) calculate and check. Do something for 5 minutes then come back and recalculate and recheck.*
- *Enter into computer generate labels and patient medication notes.*
- *Count or pour or repackage appropriate medicine.*
- *Attach correct label to medicines.*
- *Give final check of labels and ensure they are on the correct items.*
- *Initial the prescription to identify the pharmacist responsible for dispensing and checking.*
- *Place all items and medication notes in a paper bag, seal and attach receipt.*
- *When a patient comes in ask their address and go through their medication ensuring they understand how to use or take their medication, explaining possible side effects and drug interactions."*

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Pharmacist

Report on Opinion - Case 99HDC0660, continued

Outcome of Investigation, *continued*

Actions Taken

The Pharmacist apologised to the consumer personally in early January 1999. She also apologised in writing by letter dated early March 1999. In that letter she acknowledged that she did not handle the consumer's complaint well when the consumer came in to the pharmacy to advise of the mistake which had been made. She also said that if the consumer was willing, she would like to discuss the matter further with her.

The Pharmacist advised the Commissioner that she thought her verbal apology had been accepted by the consumer. She also advised that following notice of the complaint from the Commissioner she rang the consumer's GP in early March 1999 to discuss the incident. She advised that the doctor cited the Privacy Act and refused to speak to her about the consumer on account of it.

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

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

Professional Standards

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

Rule 2.12
"A pharmacist must dispense the specific medicine prescribed …"

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Pharmacist

Report on Opinion - Case 99HDC0660, continued

Opinion: Breach, Pharmacist

Right 4(2)

In my opinion, the Pharmacist has breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights. She erroneously dispensed Prozac to the consumer instead of Paroxetine as prescribed, in breach of Rule 2.12 of the Pharmaceutical Society of New Zealand's Code of Ethics and the procedure adopted by the Pharmacy.

The Pharmaceutical Society views the dispensing of the correct medicine as a basic professional standard.

The Pharmacist had an obligation to meet professional standards by correctly dispensing medication in strict accordance with the prescription. The Pharmacist did not meet her obligations when she dispensed Prozac rather than Paroxetine to the consumer. In my opinion this is a breach of Right 4(2).

Actions

The Pharmacy and the Pharmacist are to review the dispensing procedures in place at the Pharmacy to safeguard against further errors such as this and confirm to the Commissioner that this has been done.

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