Phenoxymethylpenicillin dispensed instead of prescribed flucloxacillin 04HDC13191, 11 May 2005)

Pharmacist ~ Pharmacy ~ Dispensing error ~ Checking ~ Labelling ~ Procedures ~ Vicarious liability ~ Professional standards ~ Right 4(2)

A seven-year-old girl was prescribed flucloxacillin oral solution, to be dispensed every two weeks. When, unlike the original prescription, the medication was orange, rather than the usual pink, and tasted better than usual, the girl's mother, a registered nurse, became suspicious. She returned to the pharmacy and asked whether there had been a change in drug company, which might account for these discrepancies. The pharmacist said that there had been no change in supplier and checked the dispensed medication. It was discovered that phenoxymethlypenicillin had been dispensed in error.

The mixtures of these two medicines, stored alphabetically, were shelved close together and come in identical 100ml opaque plastic bottles with labels of identical colour and shape. The colour of the medication in powder form is the same. Until shortly before the dispensing error, flucloxacillin had been orange when mixed with water; it had only recently changed to pink, and so the pharmacist did not notice the error.

The pharmacist accepted that extenuating circumstances do not excuse the dispensing pharmacist from the professional obligation to dispense medicine correctly. It was held that she breached Right 4(2) in failing to meet professional and legal standards.

As there were systems in place, which had recently passed an independent audit, the pharmacy was not held vicariously liable for the pharmacist's breach.