Pharmacist

Report on Opinion - Case 98HDC15748

Complaint

The Commissioner received a complaint from parents about the services provided to their daughter by a Pharmacy.

The complaint is that:

- *In May 1998 the Pharmacy dispensed Serenase instead of the prescribed Sandomigran for the consumer.*

Investigation

The Commissioner received the complaint on 30 June 1998 and an investigation was undertaken. Information was received from:

The Complainants/Parents of the Consumer
The Provider/Pharmacist
A General Practitioner

A copy of the prescription was obtained from Health Benefits Ltd.

Outcome of Investigation

In late May 1998 the complainant took her daughter ("the consumer") to her general practitioner. The GP wrote a prescription for Sandomigran tablets. The complainant took the prescription to the Pharmacy to be dispensed. The pharmacist incorrectly dispensed Serenase tablets. The consumer took the drugs as directed on the label.

Four weeks later the complainant and her daughter again attended the GP. During the consultation the complainant asked the GP why her daughter's headaches had returned and why the tablets she was giving her daughter were a different colour. The GP had previously prescribed Sandomigran and the complainant was familiar with the medication. Sandomigran are small white tablets. The tablets dispensed by the Pharmacy were green with "Searle" stamped on them.

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Report on Opinion - Case 98HDC15748, continued

Outcome of Investigation, *continued*

The GP phoned the pharmacy immediately and the error was discovered. The proprietor of the pharmacy prepared the correct medication for the complainant to collect but the complainant decided to return to her normal pharmacy to have the drugs dispensed. The GP wrote out a new prescription.

The proprietor of the pharmacy advised that three qualified pharmacists were on duty that day; two others, and himself. The Pharmacy stamp appears on the dispensed prescription form, but the dispensing pharmacist cannot be identified as the form was not signed. The proprietor pharmacist included a copy of protocols for the dispensing and checking of prescriptions that had been in operation for approximately 5 years. The protocols were reviewed in August 1998.

The proprietor pharmacist advised that:

"analysis of the circumstances surrounding the mistake in light of the procedures we employ leaves us at a total loss for an explanation. While both preparations are situated fairly close to each other on the shelf, they are separated, have different manufacturers labelling and differ greatly in colour, Sandomigran 1mg tablets being white and Serenase 0.5mg is green. We have deliberately laid out our dispensary stock on the shelves in such a fashion as to separate preparations prone to mistake through a similar name or the availability of multiple strengths. As a result of this mistake, we have introduced further stamps to act as a prompt for qualified staff to re-appraise prescriptions before being made available to counter staff. There is repeated reinforcement for all dispensing to use the checking stamp effectively and not let it become another automatic routine action. Counter staff have been instructed to return to dispensing staff any prescription not endorsed with the signed checking stamp.

We sincerely regret the dispensing error with respect to [the consumer], and sympathise and understand [the complainants'] concern. We hope they can accept that what has occurred is something that we do our utmost to avoid. It would be our wish on completion of your investigation to provide an apology to [the complainants and their daughter] for the anger, concern and disillusionment they have suffered".

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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, Code of Ethics, December 1996 states:

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

Rule 2.13
"The pharmacist responsible for a dispensed product must always be readily identifiable. Unless there is only 1 pharmacist on duty at one time and a diary record is sufficient to identify that pharmacist, each prescription must be annotated with the initials of the person dispensing the prescription and the initials of the pharmacist responsible for the dispensed product."

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

4.1 Prescription and Dispensing Services…

Checking the dispensing procedure:

- the pharmacist is responsible for the final check of the prescription check for label accuracy

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

- the dispenser and checker of the prescription must always be readily identifiable

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Pharmacist

Report on Opinion - Case 98HDC15748, continued

Opinion: Breach

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

I was unable to identify which pharmacist dispensed the medication as the prescription form was not signed. The manager and proprietor of the Pharmacy must therefore take responsibility for the actions of the dispensing pharmacist.

The Pharmacy dispensed the incorrect medication and the dispensing pharmacist did not sign the prescription form. These actions did not comply with Pharmaceutical Society standards and therefore breached Right 4(2) of the Code of Rights.

Furthermore, the Pharmacy protocols for dispensing medicines require the dispensing pharmacist to initial a prescription form once the medication is dispensed. Failure to identify the dispensing pharmacist is also a breach of the Pharmacy's internal standards and is therefore also a breach of Right 4(2) of the Code of Rights.

Actions

I recommend that the proprietor pharmacist and the Pharmacy:

- Apologise to the complainants and the consumer for breaching the Code of Health and Disability Services Consumers' Rights. This apology is to be sent to the Commissioner who will then forward it to the family.

- Confirm that all dispensing pharmacists sign prescription forms and audit this in February 1999.

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