

**Error in packaging and delivery of medication
(04HDC15595, 19 August 2005)**

Pharmacist ~ Pharmacy ~ Blister pack medication ~ Retirement village ~ Packaging error ~ Standard operating procedures ~ Right 4(2)

A woman complained about the services provided by a pharmacy to her elderly, visually impaired mother. The elderly woman rang the pharmacy and requested a repeat of her monthly blister pack medication. Medication is put into blister packs as an explicit safety precaution to ensure that patients take their correct medications in the correct doses, and the woman had her medication dispensed in blister packs because she was partially sighted and was required to take a number of medications.

The prescription was delivered to the main desk at the woman's retirement complex, and the following day she started taking the new blister pack medication. A day later it was discovered that she had been taking another patient's morning blister pack.

The pharmacist explained that this was an inadvertent error which, he believed, had occurred when the correctly dispensed blister packs for the woman and the second patient became mixed up at the time they were put into a bag for delivery to the woman.

It was held that, by failing to comply with legal and professional standards, the pharmacist breached Right 4(2). It is critical that pharmacy staff exercise caution and ensure that prescriptions are properly separated throughout the entire dispensing process. It was also held that the error was not due to any inadequacy of the pharmacy's repeat dispensing practices or other systems errors. Accordingly, no issue of vicarious liability arose in relation to the pharmacy.