# Pharmacist, Ms C

# Pharmacy Technician, Ms B

# Pharmacy

## A Report by the

## Deputy Health and Disability Commissioner

## (Case 16HDC01515)

Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

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## Executive summary

1. Mr A was prescribed prednisone 20mg, with instructions to take 40mg orally for a week, and then to wean down 5mg each week for a month. Mr A's mother presented the prescription to a pharmacy on the afternoon of 29 July 2016.

2. Reducing dosages of prednisone are often dispensed as 5mg tablets, given the difficulty of quartering 20mg tablets. Pharmacy technician Ms B calculated that the prescription equated to 182 tablets of prednisone 5mg, and annotated the prescription accordingly. Ms B incorrectly entered the prescription into the dispensary software, and generated a label stating "182 Prednisone Tablets 20mg". The label directed Mr A to "take eight tablets once daily for one week, then reduce by one tablet (5mg) every week for one month".

3. The calculations and the label were checked by Ms C. Ms C initially calculated that 180 tablets were required and wrote this on the prescription. However, on checking her calculations, she realised that the correct number was 182. She did not amend the note she had made on the prescription. Ms C proceeded to dispense the tablets from the prednisone 20mg supply, and did not identify during her check that she had dispensed the incorrect strength of medication. Ms B then performed a further check, and also failed to identify the error in the label and strength of medication dispensed.

4. Ms B told HDC that, although the pharmacy has a spacious waiting area, the dispensary is set up in such a way that customers can stand right in front of the work bench and cause disruptions.

### Findings

5. Ms C failed to ensure that she dispensed the correct strength of prednisone to Mr A and, subsequently, failed to conduct an adequate check of the dispensed medication. Accordingly, Ms C failed to provide Mr A with services in accordance with professional standards, and so breached Right 4(2) of the Code.[1]

6. Adverse comment is made about Ms C for omitting to cross off her incorrect calculation of the total number of tablets on the prescription.

7. Adverse comment is made about Ms B, for her role in the incorrect dispensing of the prescription. In particular, Ms B did not cross out the "20mg" on the prescription to make the change to 5mg tablets clear, she generated a label with the incorrect strength, and, in the checking process, she failed to identify the error on the label and in the strength of the medication dispensed.

8. The pharmacy did not breach the Code; however, comment is made about the pharmacy's failure to review or update its standard operating procedure (SOP) within the timeframe outlined in the Health and Disability Services Pharmacy Services Standard. It is noted that, while customers can cause disruptions by standing in front

[1] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

of the work bench, dispensary staff are able to direct people waiting for prescriptions to the waiting area.

**Recommendations**

9. It is recommended that the pharmacy randomly audit, over a period of one month, staff compliance with the new SOPs for dispensing and checking, and provide the results of the audit, including any errors identified.

10. It is recommended that the pharmacy consider staff concern regarding the physical set-up of the pharmacy dispensary, and report back to HDC on any changes proposed.

11. Ms C and Ms B each provided a written apology to Mr A, in response to the recommendations set out in the provisional report.

## Complaint and investigation

12. The Commissioner received a complaint from Mr A about the services provided to him by the pharmacy. An investigation was commenced and the following issues were identified for investigation:

- *Whether Ms B provided Mr A with an appropriate standard of care in 2016.*
- *Whether Ms C provided Mr A with an appropriate standard of care in 2016.*
- *Whether the pharmacy provided Mr A with an appropriate standard of care in 2016.*

13. This report is the opinion of Meenal Duggal, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

14. The parties directly involved in the investigation were:

| | |
|---|---|
| Mr A | Consumer/complainant |
| Ms B | Provider/pharmacy technician |
| Ms C | Provider/pharmacist |
| The pharmacy | Provider/pharmacy |

## Information gathered during investigation

### Background

15. On 29 July 2016, Mr A was provided with a prescription for prednisone[2]. The prescription read:

> "**Rx:** Prednisone (Apo-Prednisone) 20 mg Tablets
> **Sig:** 40mg [by mouth once a day] for 1 week, then wean down 5mg each week
> **Mitte:** 1 month
> (New — Chrons)."

### Dispensing the medication

16. Mr A's mother presented the prescription to the pharmacy at approximately 12.33pm. Pharmacist Ms C and pharmacy technician Ms B were the only dispensary staff rostered on at the time.

17. The prescription was processed initially by Ms B, who worked out the dosage for 5mg prednisone tablets and annotated the dosage and quantities on the prescription. Ms C told HDC that "reducing doses of prednisone are often dispensed as 5mg tablets instead of 20mg, as 20mg tablets are difficult to quarter given their small size".

18. Ms B correctly calculated that the prescription equated to 182 tablets of prednisone 5mg, but entered the incorrect strength (20mg rather than 5mg) into Toniq[3] when generating a label. Accordingly, the label she generated read:

> "**Do not stop taking this medicine**
> **182 Prednisone Tablets 20mg (APO)**
> TAKE EIGHT TABLETS ONCE DAILY FOR ONE WEEK, THEN REDUCE BY ONE TABLET (5MG) EVERY WEEK FOR ONE MONTH. TAKE EACH DOSE WITH FOOD IN THE MORNING."

19. Ms B then passed the prescription and the label to Ms C. Ms C told HDC that, before dispensing the prednisone, she double-checked the annotation on the prescription and reviewed the instructions on the label against the instructions on the prescription. After checking the annotation on the prescription, Ms C did a mental calculation of the number of 5mg prednisone tablets required. She reached the figure of 180, and wrote that number next to Ms B's calculations on the prescription. Ms C told HDC: "I then double-checked my addition for each subtotal using a calculator and realised it was 182. I then checked 182 against the label." However, Ms C did not cross off the inaccurate number on the prescription.

20. Ms C then circled 20mg on the prescription, which she said she did in order to reassure herself that she was dispensing the specified strength of medication. She proceeded to dispense the medication from the prednisone 20mg supply. Ms C told HDC:

[2] Prednisone is a corticosteroid that is used as an anti-inflammatory or an immunosuppressant medication.
[3] Computer software for the management of dispensary and retail operations.

> "Unfortunately after double-checking [Ms B's] annotation and calculation with the intention of dispensing 5mg tablets, I was somehow fixated on 20mg tablets for the rest of the dispensing and checking process."

### Checking the medication

21. Ms C then checked the dispensed medication, but failed to identify the error she had made in the strength of prednisone. In describing her checking procedure, Ms C said:

> "I opened the dispensed bottle of prednisone to check the strength of the tablets (20mg) as written on [the] prescription again.
>
> I read over the instructions on the label once more, using 5mg tablets in mind. I then checked the strength selected on the label against the prescribed strength (20mg) on [the] prescription. However, I got confused with the strength written by the prescriber against the strength used in the annotation. This is why I didn't pick out the clinical error of dispensing such a large quantity of 20mg prednisone tablets."

22. A further check was then completed by Ms B. Ms B stated that she followed her usual procedure of checking the label against the prescription, and then checking the label against the tablets dispensed, which she opened and checked.

23. The medication was then given to Mr A's mother. Ms B acknowledged that her login was used to scan out the prescription, but stated that she does not recall handing the medication over.

### Discovery of dispensing error

24. On 23 August 2016, Mr A's general practitioner informed the pharmacy of the dispensing error. The director of the pharmacy told HDC that the general practitioner had reported that Mr A had not experienced any ill-effects, and that Mr A had received a new prescription for the correct dose.

25. The director stated that he then called Mr A and provided him with an apology, as well as an assurance that the pharmacy would be carrying out a full review of its processes.

26. An incident reporting form was completed by Ms C, and a meeting was held with the entire dispensary team on 7 September 2016 to discuss the error.

### Additional information

*Ms B*

27. Ms B told HDC that, as a result of the incident, she has made a number of changes to her practice, including:

- The development of a three-step "check and mark" process, whereby she checks the label against the prescription and circles the name and strength of the medicine if the label matches the prescription. She then checks the name and strength of the medicine on the label against the name and strength of the dispensed medicine, and ticks both circles if these are correct. She also ticks the

instructions on the prescription once she has checked the generated label against the prescription.

- If she alters any part of the prescription, she will alert the pharmacist by crossing off the part of the prescription that has been changed, and annotate next to the crossed off part for clarity. In Mr A's case, the change in strength was recorded, but Ms B did not cross off "20mg" on the prescription.
- She is now more inclined to call for assistance from another pharmacy nearby if the pharmacy[4] is experiencing a busy period.

28. Ms B said that, when the pharmacy is busy, both the pharmacist and pharmacy technician are constantly interrupted while performing dispensary duties. She said that they are also required to serve customers, deal with any over-the-counter or medicine queries, and answer telephone calls.

29. Ms B also stated that, while there is a spacious waiting area, the dispensary is set up in such a way that customers can stand right in front of the work bench and cause disruptions.

*Ms C*

30. Ms C said that the dispensing error is something she will never forget and that, to this day, she feels sorry and guilty when she sees Mr A in the pharmacy.

31. Ms C stated that she has reflected on her dispensing procedures and made changes to her practice, including:

- Crossing off the prescribed strength on the prescription and writing clearly and visibly the strength that she is substituting.
- Ensuring that she takes her time when checking and dispensing complex prescriptions, even when under time pressure.
- Walking away and resting for a few minutes if she feels overwhelmed.
- Counselling patients on complicated prescriptions herself to ensure that they fully understand what has been dispensed and how to take their medicines.

32. Ms C said that she will use this error as an opportunity to educate her peers and fellow staff members about the importance of checking prescriptions for anomalies and annotations. Ms C also said that she has enrolled in postgraduate study in clinical pharmacy to further expand her clinical knowledge.

*The pharmacy*

33. The dispensary time zone report for 29 July 2016 shows that 49 prescriptions were dispensed between 12pm and 1pm. This was significantly above the average volume of prescriptions dispensed between 12pm and 1pm in the period 1 May 2016–30 November 2016 (28).

[4] The two pharmacies share staff, cost centres, and administration.

34. The pharmacy said that it has added extra staffing at peak times since the incident, as it has become busier and peak times have changed over time. It also said that it has reinforced to staff that they are to contact the other pharmacy nearby and request help in excessively busy periods. According to the pharmacy, "the appropriate staff are always sent and can be on site within 3–5 minutes".

**Standard Operating Procedures**

35. The pharmacy told HDC that "the [standard operating procedures (SOPs)] concerning dispensing that were in use at the time [of the incident] were those created in July 2013 and have since been reviewed and updated where necessary".

36. The pharmacy stated that all staff are trained and made aware of the pharmacy's SOP folder when they commence employment, and that the SOP folder can be accessed at any point should there be a need. Ms B and Ms C confirmed that they received training on the SOPs.

37. The July 2013 SOPs instructed the person assembling the prescription to "retrieve the appropriate medicine from the shelf and before counting/pouring the medicine check you have the correct medicine, strength and brand against the prescription NOT the label".

38. In relation to dispensing checks, the SOPs stated:

> "FIRST DISPENSING CHECK (can be done by a dispensary technician or intern pharmacist or pharmacist)
>
> 1. Check that what is on the prescription is what is written on the label: drug, dose, quantity, instructions, patient name and address, prescriber.
> 2. Check that what is on the prescription is in the container — always open the container and look inside, do not assume the contents are correct.
>
> …
>
> FINAL CHECK OF PRESCRIPTION
>
> - Must be carried out by a Registered Pharmacist if initial dispensing is carried out by intern pharmacist or pharmacy technician.
> - The same pharmacist can do 1st and 2nd checks.
> - Initial on the right hand side of each third part dispensing label.
>
> 1. Clinical check
>
> …
>
> - Ensure dose is appropriate for patient's age, other medications or health. Any unusual or high doses are to be double checked, by the pharmacist, with the prescriber.
>
> …
>
> 2. Dispensing check

- Open all skillets, vials and missions to double-check the contents are correct
- Check the contents of the skillet/vial/mission off the prescription NOT the label
- Check the label off the prescription
- Check that the quantity is correct
- Double check the dose is correct if the product comes in multiple strengths".

39. The pharmacy told HDC that a review of the existing dispensing and checking SOPs, conducted as a result of the events outlined in this report, had revealed "inconsistencies with current practice as a result of the rapid rate of change in pharmacy", and completely new SOPs for dispensing and checking were implemented on 18 October 2016. The new SOPs include the following steps:

> "If the medicine, strength or dosage prescribed is complicated and needs to be clarified, annotate clearly what has been calculated and highlight relevant details.
>
> …
>
> Note any relevant discrepancies, changes or amended prescription details on attached notes or in the prescription margins to alert other dispensary staff members involved in the process.
>
> …
>
> If … there is a choice of strengths of the medicine, then the Prescriber must be contacted to confirm the medicine and/or correct strength and the prescription must be annotated and signed accordingly by a Pharmacist. All prescriptions changed must be sent back to the Prescriber to be authorised and annotated.
>
> …
>
> - It is best practice to have different members of the dispensary team involved in the dispensing and checking of a prescription. If this cannot be achieved, it is advised that the Pharmacist undertake another task in between the dispensing and checking steps so that they come back to the checking step with a 'fresh set of eyes'.
> - When **dispensing** a medicine, the Pharmacist or Technician shall:
> Select each medicine from the dispensary shelf at one time using the original prescription, making sure the correct medicine, strength and brand has been chosen. Never use the generated dispensary label to select the medicine.
>
> …
>
> - Count or pour the selected medicine and transfer to a suitable clean container (bottle, mission, vial or skillet) …
> - Double check the generated dispensing label(s) against the original prescription before attaching to the container, making sure that the dispensary label contains what is written on the prescription, e.g. correct medicine, dose, quantity, instructions, customer's name, and prescriber
>
> …

- When **checking** the prescription, the Pharmacist shall:
  - Check the prescription details are correct, including … the suitability of the prescribed medicine(s) in terms of the quantities prescribed …

  …

  - Check the appropriateness of each prescribed medicine with respect to its therapeutic use, appropriateness for the customer's parameters, e.g. age, weight, renal function, possible adverse effects, contraindications, dosage, route of administration, duration of treatment, and possible interactions with other medication(s) or food.

  - Check that each medicine dispensed is correct against the medicine prescribed on the prescription. This includes checking the generated dispensary label and dispensed medicine(s) against the original prescription for the:
    - Correct patient name;
    - Correct instructions for use;
    - Correct formulation, strength and quantity of medicine;
    - Correct prescription number;
    - Correct prescriber;
    - Correct directions, which are clear and concise.

  - Check that each medicine dispensed [is correct] against the bulk stock container of the medicine for the correct strength, form, brand …

  - Open up each dispensed bottle or skillet to compare the contents with stock supply and the prescription — never assume that the contents is correct.

  - If a calculation is involved, this is rechecked and if possible checked by another Pharmacist or Technician."

40. The pharmacy said that the new SOPs have been discussed in one-on-one meetings and in staff meetings.

**Response to provisional opinion**

41. Mr A was provided with an opportunity to comment on the "information gathered" section of my provisional opinion. He had no further information to add.

42. Ms C, Ms B, and the pharmacy were provided with the opportunity to respond to my provisional opinion.

43. In response to the recommendations set out in my provisional opinion, Ms B and Ms C each provided HDC with a letter of apology for forwarding to Mr A.

44. The pharmacy accepted the findings and recommendations set out in my provisional opinion. It stated:

"The whole Pharmacy team has been involved in the process and our systems reviewed and revised where necessary. We have all learnt a lot from this and believe we have more robust processes for dispensing and checking."

## Relevant professional standards

45. The Pharmacy Council of New Zealand publication *Safe Effective Pharmacy Practice* (2011) provides in its "Code of Ethics" that pharmacists must:

"1.2 Take appropriate steps to prevent harm to the patient and the public.

…

5.1 Be accountable for practising safely and maintain and demonstrate professional competence relative to your sphere of activity and scope of practice."

46. The Pharmacy Council of New Zealand *Competence Standards for the pharmacy Profession* (2015) include the following requirements for pharmacists:

"O3.2.1 Maintains a logical, safe and disciplined dispensing procedure

O3.2.2 Monitors the dispensing process for potential errors and acts promptly to mitigate them …"

## Opinion: Ms C — breach

### Selection and checking errors — breach

47. Mr A was prescribed prednisone 20mg, with instructions to take 40mg orally for a week, and then to wean down 5mg each week for a month. Ms B calculated that this equated to 182 tablets of prednisone 5mg, and annotated the prescription accordingly. However, Ms B incorrectly entered the prescription into Toniq, and generated a label stating "182 Prednisone Tablets 20mg". The label directed Mr A to "take eight tablets once daily for one week, then reduce by one tablet (5mg) every week for one month".

48. Ms B then passed the prescription and the label to Ms C. Ms C told HDC that, before dispensing the prednisone, she double-checked the annotation on the prescription and reviewed the instructions on the label against the instructions on the prescription. However, she failed to identify the error on the label, and proceeded to dispense from the 20mg prednisone supply rather than the 5mg supply. Ms C told HDC:

"Unfortunately after double-checking [Ms B's] annotation and calculation with the intention of dispensing 5mg tablets, I was somehow fixated on 20mg tablets for the rest of the dispensing and checking process."

49. Ms C then checked the dispensed medication, but failed to identify the error she had made in the strength of prednisone selected. She told HDC:

> "I opened the dispensed bottle of prednisone to check the strength of the tablets (20mg) as written on [the] prescription again.
>
> I read over the instructions on the label once more, using 5mg tablets in mind. I then checked the strength selected on the label against the prescribed strength (20mg) on [the] prescription. However, I got confused with the strength written by the prescriber against the strength used in the annotation. This is why I didn't pick out the clinical error of dispensing such a large quantity of 20mg prednisone tablets."

50. As a registered pharmacist, Ms C is responsible for complying with the professional standards set by the Pharmacy Council of New Zealand. She failed to ensure that she dispensed the correct strength of prednisone to Mr A and, subsequently, failed to conduct an adequate check of the dispensed medication. Had Ms C performed a thorough check, she would have identified that 182 tablets of prednisone 20mg was inconsistent with both the prescriber's instructions and the instructions on the label generated by Ms B. Ms C should also have identified that such a large quantity of prednisone 20mg was not appropriate for a one-month supply. Accordingly, I consider that Ms C failed to provide Mr A with services in accordance with professional standards and breached Right 4(2) of the Code.

51. I note that Ms C has told HDC that in future she will take care to ensure that she takes her time when checking and dispensing complex prescriptions, and will walk away and rest if she feels overwhelmed.

**Annotation on prescription — adverse comment**

52. When checking the requisite number of prednisone 5mg tablets, Ms C mistakenly calculated the total to be 180 and recorded this figure on the prescription. Ms C told HDC that she then reached the correct figure of 182 when she used a calculator to add up the total, and that she used the correct figure when checking the label against the prescription.

53. I am concerned that Ms C did not cross off the "180" figure on the prescription after recognising that it was incorrect. This omission created a risk that an inaccurate number of tablets would be dispensed.

## Opinion: Ms B — adverse comment

54. Mr A's prescription read:

> "**Rx:** Prednisone (Apo-Prednisone) 20 mg Tablets
> **Sig:** 40mg [by mouth once a day] for 1 week, then wean down 5mg each week
> **Mitte:** 1 month."

55. Ms B annotated the prescription as requiring 182 tablets of prednisone 5mg, but entered a 20mg strength when generating the label. The label read:

> "**182 Prednisone Tablets 20mg (APO)**
> TAKE EIGHT TABLETS ONCE DAILY FOR ONE WEEK, THEN REDUCE BY ONE TABLET (5MG) EVERY WEEK FOR ONE MONTH. TAKE EACH DOSE WITH FOOD IN THE MORNING."

56. Prednisone 20mg tablets were then dispensed by Ms C. Ms C checked the medication but did not identify the error in the label or that the wrong strength of medication had been dispensed. Ms B then performed a further check, and also failed to identify those errors. Ms B told HDC that she followed her usual procedure of checking the label against the prescription, and then checking the label against the tablets dispensed.

57. I acknowledge that pharmacy technicians are directly supervised by pharmacists, and that professional standards stipulate that it is the pharmacist in charge of the dispensing (in this case, Ms C) who is ultimately responsible for the safe dispensing of medication.

58. However, I am critical that Ms B:

a) Did not cross out "20mg" on the prescription to make the change to 5mg clear;
b) Generated a label with the incorrect strength of prednisone; and
c) Did not identify the error on the label or in the strength of medication dispensed when checking the medication before it was given to Mr A's mother.

59. I note that Ms B has said that she has amended her practice so that, when she changes a prescription, she will cross off the part of the prescription that has been changed, and annotate next to it for added clarity. She has also implemented a more robust checking process.

## Opinion: The pharmacy — other comment

60. Pharmacy technician Ms B and pharmacist Ms C are employees of the pharmacy. When Mr A's prescription was presented to the pharmacy, Ms B entered the incorrect strength of prednisone into Toniq, and Ms C dispensed prednisone 20mg (rather than 5mg). Both Ms C and Ms B then checked the medication but failed to identify the error on the label or that the incorrect strength of prednisone had been dispensed. In recognition of the fact that it is the pharmacist who carries overall responsibility for the dispensing process, I have found that Ms C breached Right 4(2) of the Code.

61. Section 72(2) of the Health and Disability Commissioner Act 1994 provides that an employing authority is vicariously liable for any act or omission by an employee. However, a defence is available under section 72(5) if the employing authority can prove that it took such steps as were reasonably practicable to prevent the act or

omission. As a provider itself, the pharmacy can also be held directly liable for breaching the Code.

**SOPs**

62. Written SOPs assist staff to comply with their legal and professional obligations, and are central to ensuring safe and effective dispensing. Of note, the pharmacy's SOPs at the time of the dispensing error required:

- Dispensers to check the name, strength, and brand of the medicine dispensed against the prescription; and
- Those checking dispensed items to check the label and dispensed medicine against the prescription.

63. While both Ms B and Ms C performed checks of the dispensed medication, their checks were not sufficiently thorough, and they did not identify the error in the label or the fact that the wrong strength of prednisone had been dispensed. In my view, the dispensing error resulted from individual mistakes and cannot be attributed to any deficiency in the pharmacy's SOPs.

64. However, I note that the Health and Disability Services Pharmacy Services Standard (NZS 8134.7:2010) provides that "[a] staff policy and procedures manual shall be available. It shall be regularly reviewed and updated at least every 2 years." I am critical that, at the time the dispensing error occurred (29 July 2016), the SOPs had not been reviewed or updated since 1 July 2013. It is imperative that pharmacies ensure that their SOPs are up to date and reflective of current practice.

65. I note that the pharmacy implemented a new set of SOPs on 18 October 2016.

**Staffing**

66. At the time of dispensing, the pharmacy was staffed by Ms C and Ms B. The dispensary time zone report shows that an unusually large number of prescriptions (49) were dispensed between 12pm and 1pm on 29 July 2016. The average number of prescriptions dispensed between 12pm and 1pm for the period of 1 May 2016 to 30 November 2016 was 28.

67. However, I note that staff were able to request help from another pharmacy in particularly busy periods. Accordingly, I am satisfied that the pharmacy had taken reasonable steps to ensure that staff had sufficient time to carry out their responsibilities.

**Layout of dispensary area**

68. Ms B said that, when the pharmacy is busy, both the pharmacist and technician are constantly interrupted while performing dispensary duties. This situation is not unique to this pharmacy, and I consider that it is the responsibility of dispensary staff to manage interruptions appropriately while maintaining safe dispensing procedures.

69. Ms B also raised the concern that the dispensary is set up in such a way that the customer can stand right in front of the work bench and cause disruptions. However,

Ms B acknowledged that there is a spacious waiting area, and I consider that it is reasonable for dispensary staff to direct people waiting for prescriptions to that area.

**Conclusion**

70. While I am critical that, at the time of the incident, over two years had elapsed since the last review of the pharmacy's SOPs, I do not consider that this failure contributed to the dispensing error. Overall, I consider that the pharmacy took all such steps as were reasonably practicable to prevent the acts and omissions that led to Ms C's breach of the Code. Accordingly, I do not consider that the pharmacy is vicariously liable for Ms C's breach of Right 4(2). I also do not consider that the pharmacy breached the Code directly.

## Recommendations

71. In response to the recommendations made in my provisional report, Ms C and Ms B each provided a written apology for Mr A.

72. I recommend that the pharmacy:

a) Randomly audit, over a period of one month, staff compliance with the new SOPs for dispensing and checking, and, within three months of the date of this report, provide to HDC the results of the audit, including any errors identified.
b) Consider staff concern regarding the physical set-up of the pharmacy dispensary, and report back to HDC on any changes proposed, within two months of the date of this report.

## Follow-up actions

73. A copy of this report, with details identifying the parties removed, will be sent to the Pharmacy Council of New Zealand and the district health board, and they will be advised of Ms C's name.

74. A copy of this report, with details identifying the parties removed, will be sent to the Pharmaceutical Society of New Zealand, the Health Quality and Safety Commission, and the New Zealand Pharmacovigilance Centre.

75. A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.