Fluoxetine dispensed instead of prescribed Tramadol (15HDC01810, 14 June 2016)

Pharmacist ~ Pharmacy ~ Dispensing error ~ Checking ~ Professional standards ~ Right 4(2)

A 32-year-old woman was prescribed 30 "TRAMADOL 50mg tabs" for pain relief following a wisdom tooth extraction. Her mother presented the prescription to a pharmacy for dispensing.

The pharmacist interpreted the prescription as being for Arrow-Tramadol 50mg capsules, but mistakenly selected from the shelf 30 fluoxetine 20mg capsules, rather than 30 tramadol 50mg capsules. The fluoxetine capsules were repackaged out of the manufacturer's packaging into a plain white packet, which was then labelled as containing tramadol capsules. The pharmacist became distracted while labelling the packet and so did not check the contents, as done usually and as is required by the pharmacy's Standard Operating Procedures (SOPs).

The dispensing was checked by a second pharmacist, who did not identify the dispensing error. The pharmacy told HDC that the second pharmacist's normal practice was to open packets to make sure the correct medicine and strength had been selected, as is required by the pharmacy's SOPs. However, the second pharmacist advised that, on this occasion, the packet may have been opened, but, because the strips of capsules were the same size as that of tramadol capsules, the medication may not have been removed from the packet for a more thorough check.

The dispensing error was discovered by the woman's mother a week later. The woman took up to 20 fluoxetine capsules over the space of one week, and took six capsules (totalling 120mg) on at least one day during this time.

It was held that the first pharmacist failed to ensure that the correct medication was dispensed, in accordance with the professional standards set by the Pharmacy Council of New Zealand and with the pharmacy's SOPs. The pharmacist therefore failed to provide the woman with services in accordance with professional and other relevant standards, in breach of Right 4(2).

The second pharmacist failed to check the dispensed medication adequately, in accordance with the professional standards set by the Pharmacy Council of New Zealand and with the pharmacy's SOPs. The pharmacist therefore failed to provide the woman with services in accordance with professional and other relevant standards, in breach of Right 4(2).

The dispensing error was the pharmacists' alone. The pharmacy had appropriate SOPs in place, as well as a sufficient number of trained staff working at the time. The pharmacy did not breach the Code, and was not vicariously liable for the pharmacists' breach of the Code.

It was recommended that the pharmacy randomly audit its staff compliance with SOPs (for dispensing and checking medications) over a one-month period and report back to HDC. Both pharmacists had already apologised to the woman.