Pharmacist

Report on Opinion - Case 99HDC02414

Complaint

On 3 March 1999 the Commissioner received a complaint from the consumer about services provided by the pharmacist. The complaint was that:

- *In mid-February 1999 the pharmacist dispensed a prescription of thirty warfarin tablets to the consumer. Later when the consumer opened the bottle she discovered an additional fifteen unidentified white tablets as well as the thirty warfarin tablets.*

Investigation

The complaint was received by the Commissioner on 3 March 1999 and an investigation was undertaken. Information was obtained from:

The Consumer
The Pharmacist

Copies of relevant correspondence between the pharmacist and the consumer were obtained and a copy of the pharmacist's customer complaint record form was viewed.

Information Gathered During Investigation

In mid-February 1999 the consumer went to the pharmacy in a town to pick up a repeat prescription of thirty *warfarin* tablets. The consumer advised that there was no one at the dispensary so a shop assistant took the bottle from the consumer saying *"I'll give this to* [the pharmacist]*"*. The pharmacist then came into the dispensary and advised the consumer that her prescription would not be ready for at least ten minutes. The consumer sat down on a chair in the pharmacy and waited for her prescription to be prepared.

Continued on next page

Pharmacist

Report on Opinion – Case 99HDC02414, continued

Information Gathered During Investigation, *continued*

Several moments later the pharmacist said to the consumer that her original prescription was only dispensed on a date in early February and that she was not supposed to have a repeat dispensed for at least twenty days after that date. The consumer stood up and approached the counter. She explained to the pharmacist that she was originally prescribed 1mg of *warfarin* daily, but this had then been increased to 3mg per day. She advised that following a further blood test that afternoon the dose could be increased to 4mg per day, depending on the blood result. The pharmacist advised her that he would have to endorse her script. The consumer then saw him open a second bottle of *warfarin* tablets. The pharmacist counted out the number, picked up a bottle that was standing nearby, took off the cap and poured the w*arfarin* tablets into it. The consumer advises that she then saw the pharmacist take the label off the bottle. He moved over to the computer area and put the consumer's label on the bottle and gave it to her.

At approximately 5.00pm that night the consumer opened the bottle and shook the tablets into her hand. She discovered that there were some white tablets in the bottle, as well as her usual brown *warfarin* pills. The consumer tipped all the tablets out on the table and separated fifteen white pills. The consumer put all the white pills into a small bottle and then took her dose of four *warfarin* tablets.

At 1.00am the next morning the consumer advised that she woke up suffering from stomach pains and a burning sensation in her mouth. She attempted to get out of bed, but she felt sick and seemed unable to move. By approximately 3.00am the symptoms seemed to ease and the consumer went back to sleep. In the morning she felt very weak, shaky and her stomach was still sore.

At about 8.30am the consumer left a message for her general practitioner advising him of her reaction and asking whether her w*arfarin* dose should be reduced. The consumer later received a phone call advising her to reduce her *warfarin* dose to three and one half tablets (3.5mg) and to have a further blood test two days later.

Continued on next page

Pharmacist

Report on Opinion – Case 99HDC02414, continued

Information Gathered During Investigation, *continued*

At 9.30am the consumer rang the pharmacist and asked him if he was looking for fifteen small white pills. He advised that he was. The consumer asked the pharmacist if the tablets could have caused her symptoms during the night. The pharmacist replied that he did not think so but he offered to deliver thirty new *warfarin* tablets to the consumer to replace the earlier ones. Later that day the pharmacist went to the consumer's house and provided her with a replacement bottle of tablets. He asked the consumer to return the other pills to him, but she refused to do this. The consumer provided the pharmacist with one white and one brown tablet which he wrapped in a piece of paper and took away with him.

Later in the week the consumer took samples of the tablets to her GP who identified the white tablets as *buscopan* and advised the consumer that these would not have caused her stomach-ache. He also advised the consumer that *buscopan* was a coated pill that could not have contaminated her w*arfarin* tablet.

In early March the consumer wrote to the pharmacist informing him that she had decided to refer the matter to the Health and Disability Commissioner and requesting a written apology from him. In early March the pharmacist wrote to the consumer apologising for the incident.

On 29 July 1999 the pharmacist was informed of the Commissioner's investigation. In his response to the Commissioner, the pharmacist accepted that the consumer had received incorrect medication. The pharmacist advised that after receiving the consumer's phone call the day after he filled the prescription he contacted the consumer, replaced the tablets, verbally apologised and investigated the situation. He later sent the consumer a written apology in response to her request. The pharmacist advised that at 10.06am on the date in question he had dispensed fifteen *buscopan* tablets for another consumer. At 10.37am he dispensed thirty *marevan* (*warfarin*) 1mg tablets for the consumer. In the afternoon the other client came into the pharmacy to collect his *buscopan*. The tablets could not be located. The pharmacist clearly remembered checking the prescription when it was originally made up. A second bottle of *buscopan* tablets was dispensed to the consumer and pharmacy staff started looking for the lost bottle. The pharmacist discussed the matter with his dispensary technician and she also remembered dispensing the *buscopan*. By closing time that day the lost bottle had not been located.

Continued on next page

Pharmacist

Report on Opinion – Case 99HDC02414, continued

Information Gathered During Investigation, *continued*

On the next morning the pharmacist received a phone call from the consumer advising that she had found fifteen small white tablets in her bottle of w*arfarin*. The pharmacist advises that he apologised over the telephone and said that he would replace the tablets with new ones. He also advised the consumer not to take any more of her medication until she received the replacement bottle.

The pharmacist discussed the situation further with his dispensary technician. They both remember dispensing both lots of tablets, putting labels on bottles and on scripts. They remembered that the consumer brought in one bottle for a repeat of thirty m*arevan* 1mg tablets. When the pharmacist received the bottle he discussed with the consumer that it was early for the repeat and the consumer informed him that her *warfarin* dose had been increased and she was going through them more quickly.

He remembers suggesting to the consumer that she should ask her doctor for a larger initial prescription to cope with variant doses.

The pharmacist advises that the consumer has continued to collect her medication from the pharmacy since this incident occurred. He provided a copy of a customer complaint record form that set out details of the incident, and of the actions the pharmacist took in response. The pharmacist also provided a copy of his written apology to the consumer, dated early March 1999. The pharmacist advised that he did not have a written dispensing protocol at the time the incident occurred, but he is in the process of developing one.

Pharmacist

Report on Opinion – Case 99HDC02414, continued

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.

…

Other Relevant Standards

Pharmaceutical Society of New Zealand Code of Ethics.

Rule 2.1 states:

A pharmacist must safeguard the interest of the public in the supply of health and medicinal products.

Rule 2.11 states in part:

A pharmacist must be responsible for maintaining and supervising a disciplined dispensing procedure that ensures a high standard is achieved
…

Pharmacy Practice Handbook

Standard 4.1.1 - Checking the Dispensing Procedure:

-the pharmacist is responsible for the final check of the prescription
-check for label accuracy – name, date, medicine strength and form, instructions, Cautionary and Advisory labels and contents accuracy - correct medicine, dose, form and quantity
…

Pharmacist

Report on Opinion – Case 99HDC02414, continued

Opinion: Breach

In my opinion the pharmacist breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights. Dispensing of the correct medication is a basic professional standard. It is not entirely clear how the *buscopan* came to be present in the *warfarin* bottle, but it appears the consumer's prescription was put into a bottle containing another consumer's medication. The pharmacist did not check that the contents of the medication bottle were accurate before the prescription was dispensed to the consumer.

In particular, it is of concern that the pharmacist did not have written protocols in place for dispensing medication and without such protocols did not take active steps to "*safeguard the interest of the public*." In my opinion the services provided by the pharmacist did not comply with relevant professional standards.

Actions

The pharmacist has already apologised directly to the consumer for the dispensing error.

I recommend that the pharmacist introduce a written dispensing protocol including appropriate checking procedures. A copy of this protocol is to be forwarded to the Commissioner.

Other Actions

A copy of this opinion will be forwarded to the Pharmaceutical Society of New Zealand. The Society will be requested to undertake an audit of the pharmacy within six months.