Dispensary Technician, Ms B

Pharmacist, Mr C

A Pharmacy

Proprietor of the Pharmacy, Mr D

A Report by the

Health and Disability Commissioner

(Case 03HDC04264)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Miss A	Consumer
Ms A	Parent / Complainant
Ms B	Dispensary technician
Mr C	Pharmacist
Mr D	Proprietor, the pharmacy

Complaint

The Commissioner received a complaint from Ms A regarding the service her daughter, Miss A, received from staff at a pharmacy on 22 March 2003 and in the days that followed. The complaint was summarised as follows:

The pharmacy
In March 2003, the pharmacy did not provide Miss A with services of an appropriate standard and did not respond appropriately when notified by Ms A (mother of Miss A) of a dispensing error.

Ms B
On 22 March 2003, Ms B did not provide Miss A with services of an appropriate standard. In particular, Ms B:

- *dispensed the wrong medication. (Instead of dispensing prednisone, she dispensed diazepam.)*
- *dispensed the medication without a check by the duty pharmacist.*

On 22 March 2003, when the dispensing error was brought to her attention, Ms B did not advise Ms A (mother of Miss A) of her right to complain under the Code of Health and Disability Services Consumers' Rights.

Mr C
On 22 March 2003, Mr C did not provide Miss A with services of an appropriate standard. In particular, Mr C did not check the medication dispensed by Ms B, the pharmacy technician. (Instead of prednisone, Ms B dispensed diazepam.)

On 22 March 2003, Mr C did not respond appropriately when Ms A (mother of Miss A) initially raised the possibility of a dispensing error. In particular, Mr C:

- *did not take appropriate action to confirm whether a dispensing error had occurred*
- *did not advise Ms A of her right to complain under the Code of Health and Disability Services Consumers' Rights.*

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Mr D
On 24 March 2003, Mr D did not respond appropriately when Ms A (mother of Miss A) raised the dispensing error with him. In particular, Mr D:

- *did not adequately investigate and address the concerns raised by Ms A*
- *did not advise Ms A of her right to complain under the Code of Health and Disability Services Consumers' Rights.*

The complaint was received on 25 March 2003 and an investigation was commenced on 24 April 2003.

Information reviewed

- Information from Ms A, Mr C, Ms B, Mr D and Dr E (general practitioner)
- Miss A' records from Dr E
- Advice from Pharmac (Pharmaceutical Management Agency of New Zealand) and Medsafe (New Zealand Medicines and Medical Devices Safety Authority)

Information gathered during investigation

Background
On Saturday 22 March 2003, at 9am, Ms A took her 10-year-old daughter, Miss A, to a medical centre with exacerbation of her bronchial asthma. Miss A was seen by Dr E, the duty doctor, who prescribed prednisone tablets and Cefaclor (a broad-spectrum antibiotic). The prednisone prescription was for 5mg tablets, six (30mg) to be taken daily for three days.

Initial dispensing
On 22 March, at 9.45am, Ms A presented the prescription at the pharmacy. Ms B, the dispensary technician on duty, confirmed that she received the prescription from Ms A, processed it on the computer and dispensed the medications. In line with her standard practice, Ms B left the container containing the medications with the prescription form for the pharmacist, Mr C, to check. She said that Mr C checked the prescription and authorised her to give the dispensed medications to Ms A.

Ms A alleged that at no time did Mr C check the prescription.

Mr C advised me that while Ms B was entering the prescription information onto the computer, he selected the correct strength prednisone container and placed it next to the prescription label on the dispensing bench. The reason for doing so was to assist Ms B, who was new to the dispensary (it was her first day at the pharmacy). He thought Ms B

might have difficulty locating the stock bottle of prednisone, which was kept on the rotating shelves on the dispensing bench with other "fast-moving", regularly dispensed medications, rather than on the shelf where medications are stored in alphabetical order. Prednisone 5mg tablets and diazepam[1] were not stored in proximity to each other.

Mr C advised me that he first checked that the Cefaclor had been dispensed correctly by Ms B and then proceeded to check the prednisone part of the prescription. He checked that the instructions on the label of the container in which the medication was dispensed were correct and matched them with the prescription form. Mr C stated that it was his standard practice to check the contents of the container with the label, but could not recall whether he did so on this occasion. He also had no recollection of seeing the stock bottle of diazepam on the dispensing bench at the time.

Having checked the instructions on the Cefaclor bottle and the prednisone container for the second time, Mr C initialled the prescription form and asked Ms B to give the medications to Ms A.

Ms A advised me that on her return home, before giving Miss A the tablets, she noticed that the tablets in the container marked "Prednisone 5mg" were "largish yellow" tablets and not the usual "small pink" tablets Miss A had had in the past.

Pharmac (the Pharmaceutical Management Agency of New Zealand) and Medsafe (the New Zealand Medicines and Medical Devices Safety Authority) advised me that yellow prednisone tablets have never been available or dispensed in New Zealand.

Ms A's telephone call to the pharmacy
Ms A advised me that at approximately 10.50am she telephoned the pharmacy and spoke to Ms B. She described the tablets to Ms B, who after a consultation with Mr C told her the tablets she had been dispensed were "just a different strength and that they would be alright to give to [Miss A]". Still unsure about giving Miss A six tablets as stated on the container label, Ms A said she gave her daughter two of the tablets as it was "[her] intention to take them into another chemist to see if they could ascertain what the tablets were …"

Ms B advised me that approximately half an hour after Ms A left the pharmacy (at about 10.20am) she received a call from Ms A, who questioned the colour of the prednisone tablets (the tablets being yellow rather than the usual pink). Ms B stated:

> "I immediately realized I had dispensed the wrong tablets i.e. – Diazepam 5mg instead of Prednisone 5mg. I then told the pharmacist I was fairly sure I had dispensed Diazepam instead of Prednisone."

Mr C independently confirmed that at about 10.20am Ms B received a telephone call from Ms A, who questioned the colour of tablets dispensed. He stated:

[1] Also known as Valium or Propam.

> "At this point [Ms B] informed me and I took the call and asked the mother **not to give** tablets to patient but to bring the original container and tablets immediately to the pharmacy for correction. [Ms A] then voiced her discontent and explained that the reason she had gone to the doctor early was to get it out of the way as her husband had other plans for the rest of their day. I apologised again and requested that the medication be brought back for verification and correction."

Mr C advised me that during this conversation he acknowledged to Ms A that an incorrect medication was dispensed because prednisone 5mg tablets are white. He refutes Ms A's allegation that he told her that the tablets she was dispensed were a different brand of prednisone and that it was safe to take them.

Ms A, on the other hand, stated that at approximately 11am she received a telephone call from Mr C, who asked her what the dispensed tablets looked like. After describing the appearance of the tablets, she said Mr C asked her to bring the tablets back to the pharmacy because he was not sure whether he had given her the correct strength of prednisone or a wrong medication.

Mr C advised me that when Ms A had not returned to the pharmacy within half an hour of her telephone call, he felt uneasy and contemplated calling her. As Ms A was an acquaintance of Ms B's family, Ms B offered to make the call. Ms B advised me that she telephoned Ms A who informed her that she had already given the tablets to Miss A and asked what the effect of the tablets would be. Ms B consulted Mr C, who then took over the conversation and advised Ms A to take Miss A to an Accident and Emergency clinic or hospital, but before doing so, to bring the tablets back to the pharmacy so he could confirm what they were.

Mr D, proprietor of the pharmacy, advised me that immediately after the dispensing error had been noted, he received a telephone call at home from Mr C, who gave him a full report on the incident. Mr D was satisfied that Mr C was treating the matter seriously and handling the incident professionally and in accordance with the pharmacy's documented procedures.

There is a discrepancy in the account provided by Ms A and that provided by Ms B and Mr C regarding what was said during the first two telephone conversations. Ms A stated that during the first call she described the tablets to Ms B who, after consulting Mr C, informed her that the tablets were just a different strength and would be all right to give to Miss A. Ms A stated that during the second call Mr C asked her what the tablets looked like and, when unsure what they were, asked her to return the tablets to the pharmacy for checking. Ms B, on the other hand, stated that during the first call she immediately realised that she had dispensed a wrong medication and informed Mr C of this. Mr C took over the call, acknowledged to Ms A that an error had been made, instructed her not to give the tablets to Miss A, and asked her to return the tablets to the pharmacy for correction. The second call was made by Ms B (when Ms A had not returned as asked within half an hour of the initial call), who learnt that the medication had already been given to Miss A.

Given the discrepancy between the two accounts, it is not clear at what point Ms A was advised not to give the medication to Miss A and at what point the tablets were given to her daughter. It is not clear why Ms A would have given the tablets to Miss A if she knew that she had been dispensed the wrong or incorrect strength medication, unless she had been told it was safe to do so.

Ms A's return to the pharmacy

Shortly after 11am Ms A returned to the pharmacy with two tablets in the palm of her hand. Mr C advised me that he took the tablets from Ms A and, after comparing them with tablets in the dispensary, concluded that they were diazepam 5mg. He informed Ms A of the dispensing error and advised her to take Miss A to an Accident and Emergency clinic or hospital for urgent medical attention. He apologised to Ms A for the error and offered to compensate her for any expenses she incurred in taking Miss A to a clinic or hospital.

Mr C noted that the two tablets were not sighted by him in the original container and that he has not sighted that container since. When asked whether he made a request to Ms A to see the container, Mr C said that he did not because at that time he was more concerned about Miss A's well-being.

Ms A advised me that Mr C told her to "keep an eye" on Miss A because she might become drowsy. He also told her that if Miss A "gets worse or is not responsive", to take her to the doctor.

Ms B advised me that she and Mr C apologised to Ms A for the error and again urged her to take Miss A to a clinic or hospital "as soon as possible". Ms B said that although Ms A indicated that she would be taking Miss A to hospital, she did not appear to be in a hurry to seek medical assistance. When Ms B asked where Ms A's daughter was, Ms A said Miss A was at home with her father.

Mr C advised me that Ms A left the pharmacy without taking the prednisone tablets that had been re-dispensed for her prior to her arrival at the pharmacy. When asked why she did not take the re-dispensed prednisone, Ms A said she was flustered and it was not her priority at that time. She was more concerned about going home and being with her daughter.

Mr C and Ms A advised me that the two tablets Ms A brought back to the pharmacy were retained by Mr C.

Subsequent telephone calls

Mr C advised me that upon Ms A's departure from the pharmacy he contacted Dr E, the general practitioner who prescribed the prednisone tablets, and informed her about the dispensing error. Dr E recommended taking Miss A to an emergency clinic or a hospital as she might require observation. Dr E asked Mr C not to send Miss A back to the practice as it would be closing shortly. Having already advised Ms A to take her daughter to an emergency clinic, Mr C did not call Ms A and pass on Dr E's advice. Because he remained concerned about Miss A's well-being and was unable to leave the pharmacy, Mr C telephoned a local general practitioner on duty for further advice. His advice was the same as Dr E's.

Ms A advised me that on her return home from the pharmacy she made Miss A vomit by putting her fingers down Miss A's throat. She said that Miss A vomited two or three times.

Mr C advised me that at approximately 1pm, before Ms B went off duty, he asked her to make another telephone call to Ms A to find out how Miss A was. When Ms B telephoned, she was informed by Ms A that her daughter was fine and that her husband was planning to take her to hospital. Ms B advised me that during the conversation Ms A informed her that the incident had ruined their pre-paid weekend away and that she wanted to be compensated for the costs incurred. Ms A also informed Ms B that it would have to be a reasonable amount, "not just $100 dollars or something" and if compensated she would not take the matter any further. Ms B informed her that she could not discuss this with her and that she would need to speak to the pharmacist and call her back. After discussing it with Mr C, Ms B called Ms A again and told her that she would not be compensated in any way other than for any resulting medical costs she might incur.

Mr C advised me that at approximately 3pm he received a call from Ms A, who asked him whether he had decided on an amount of compensation. He informed her that he could not make such an offer and that there were procedures in place if she wished to take the complaint further. Mr C said he informed Ms A that it was her right to make such a complaint. When Ms A asked for the name of the pharmacy proprietor and when he would be available to take her complaint, she was given Mr D's name and told that he would be at the pharmacy on Monday morning (24 March).

Ms A disputes the explanations provided by Ms B and Mr C about the matter of compensation. She advised me that after her return visit to the pharmacy, she received at least three phone calls from Ms B, who asked her whether she (Ms A) "would consider settling something between [them] rather than doing it legally". Ms A said Ms B informed her that "she would have to ask the chemist [Mr C] what he was prepared to pay, as they would have to halve the cost between them". Ms B told Ms A that after discussing the matter with Mr C she would call her back, but she failed to do so.

Ms A advised me that Miss A was not taken to see a doctor that day because she had vomited up the medication.

Subsequent events

On Monday morning, 24 March 2003, Ms A telephoned the pharmacy and spoke to Mr D. She said that Mr D refused to meet with her to discuss compensation. She also alleged that Mr D did not inform her of the right to lodge a complaint.

Mr D advised me that when Ms A phoned him at approximately 8.50am on 24 March he enquired after Miss A and conveyed his apologies for the incident. He was informed that Miss A "had been spewing [her] guts out for hours" and that now she was "as well as could be expected". Ms A asked Mr D about the appropriateness of the number of calls made to her by Mr C and Ms B on 22 March. Mr D indicated to Ms A that he was not aware of the number of calls made to her but that he would conduct a full internal investigation into what happened and take disciplinary action if it was warranted.

Mr D advised me that after he had apologised to her again, Ms A wanted to know what he planned to do about compensation. He explained that if she wished to pursue compensation it was necessary for her to go through "the correct channels" and that she should make a formal complaint to the Pharmaceutical Society. He provided Ms A with contact details for the Society. Ms A told him that she had already contacted the Pharmaceutical Society and was advised to direct her complaint to the Health and Disability Commissioner's Office (this Office).

Mr C advised me that on 24 March he also contacted Ms A to find out how Miss A was. He again apologised to Ms A for the dispensing error and any inconvenience it had caused. He said Ms A acknowledged his apology and said that Miss A was fine and was at home recovering. Mr C informed Ms A that later in the week he would be writing her a formal letter of apology.

Late on Tuesday 25 March Ms A uplifted from the pharmacy the prednisone 5mg tablets Mr C had re-dispensed for her on 22 March.

On 25 March, Mr C wrote a letter of apology to Mr and Ms A in which he acknowledged the dispensing error, informed them of the steps taken to minimise the likelihood of a similar error being repeated, and provided the contact details for the Health and Disability Commissioner, should they wish to lodge a formal complaint. Mr C delivered the letter to Ms A in person on 28 March.

Review of incident

On 14 April 2003 Mr D conducted a review of the incident with Mr C and Ms B. While acknowledging that the incident should not have occurred and was preventable, Mr D was satisfied that once the error was discovered Mr C and Ms B acted appropriately according to the pharmacy's standard operating procedures. Nevertheless, after the review a recommendation was made that all new staff, particularly dispensary staff, be given an orientation period under supervision to assess their competence and any training needs. This was incorporated into pharmacy policy.

On 19 June 2003 Ms A provided this Office with the container and tablets dispensed to her by the pharmacy chemist. The label on the container reads as follows:

"Do not stop taking this medicine
<u>18 PREDNISONE 5MG Tabs (AP)</u>
Take SIX daily for THREE days or as
directed. Take with food
[MISS A]
[Dr E]
22 Mar 2003 […]"

There were 16 small, pale yellow tablets with a "DM" marking in the container. The tablets have been verified as diazepam 5mg.

Right to complain
Ms A alleged that during her visit to the pharmacy Mr C, Ms B and Mr D did not inform her of her right to complain.

Mr C advised me that during his conversation with Ms A she indicated that she wanted to lodge a complaint against him with the pharmacy management and the Pharmaceutical Society. He wrote his full name on a piece of paper, gave it to Ms A and informed her of her right to complain. Mr D advised me that during this conversation Ms A was also provided with his name and contact number, as well as that of the Pharmaceutical Society, if she wished to pursue the matter further.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*

2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

RIGHT 10
Right to Complain

6) *Every provider, unless an employee of a provider, must have a complaints procedure that ensures that –*

   …

   b) The consumer is informed of any relevant internal and external complaints procedures, including the availability of –

      …

      ii) The Health and Disability Commissioner; …

Professional standards

The following Pharmaceutical Society of New Zealand standards, set out in the *Pharmacy Practice Handbook 2003*, are applicable in this case:

2.2 Quality Standards for Pharmacy in New Zealand
Standard 6 Pharmaceutical Services
6.2 Dispensing, 6.2c:

"The pharmacist ensures that the dispensed medicine is selected correctly …"

6.2 Guidance:

"– all dispensing activities are undertaken or directly supervised by the pharmacist; …

– all prescriptions are finally checked for completeness and accuracy by the pharmacist; …"

4.1 Prescription and Dispensing Services
4.1.1 Dispensing

"Pharmacy graduates, dispensary technicians, pharmacy technicians, pharmacy students and pharmacy technician students may only dispense under the direct personal supervision of a pharmacist."

Selecting the correct medicine:

"– check the selected medicine against the prescription to ensure it is the correct medicine, dosage and strength …"

Checking the dispensing procedure:

"– the pharmacist is responsible for the final check of the prescription …"

"The prescriber should be contacted if there are any problems with the medicine prescribed."

Avoid Errors in Dispensing:

"Pharmacists must develop, and regularly take time to evaluate, systems that prevent or minimize errors in their dispensing of prescriptions. At each step of the dispensing operation – from receipt of the prescription to final prescription to the patient, a checking component must be part of the process. Adopting the following suggestions will help reduce the possibility of errors: … check the contents of the dispensed bottle or skillet are correct."

The Medicines Act

Section 18(2) of the Medicines Act 1981 states:

> "(2) No person may sell by retail any prescription medicine otherwise than under a prescription given by a practitioner, registered midwife, veterinarian, or designated prescriber."

Opinion: Breach – Mr C

Ms A complained that Mr C did not check the medication dispensed by Ms B, the dispensary technician and, as a result, she was dispensed diazepam instead of the prescribed prednisone.

Although Mr C did not sight the container in which the medication was dispensed after the medication was dispensed, on the basis of the two tablets Ms A returned to the pharmacy he accepted that an error was made.

As it was Ms B's first day at the pharmacy, and thinking that she might have difficulty locating the prednisone stock container, Mr C located the correct container and placed it on the dispensing bench next to the prescription label. After Ms B placed the tablets into the dispensing container Mr C checked that the instructions on the label of the container in which the medication was being dispensed were correct and matched them with the prescription form. While his standard practice was also to check the contents of the container with the label on the container, he could not recall whether he did so on this occasion.

Under Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) every consumer has the right to have services provided with appropriate care and skill, and in accordance with legal, professional, ethical and other relevant standards. The standards that apply in this case are determined by the Pharmaceutical Society of New Zealand and state that all dispensed prescriptions must be finally checked to ensure accuracy. The checking pharmacist is solely responsible for such checking.

Mr C was the checking pharmacist and it was his responsibility to check the dispensed medication for "completeness and accuracy" against the prescription. Although it is not clear how Ms B came to place diazepam into the dispensing container, in addition to other checks he performed Mr C should have checked the contents of the container before it was given to Ms A. He failed to do so and the wrong medication was dispensed. In these circumstances, Mr C breached Rights 4(1) and 4(2) of the Code and section 18(2) of the Medicines Act 1981 (since Ms A was supplied a medicine (diazepam) otherwise than pursuant to a prescription).

Opinion: No breach – Mr C

Ms A complained that Mr C did not respond appropriately when she initially raised the possibility of a dispensing error – in particular, that Mr C did not take appropriate action to confirm whether a dispensing error had occurred and did not advise her of the right to complain under the Code. Ms A's allegations about the actions of the pharmacy staff in relation to this issue are potentially very serious. If true, her allegations would amount to a serious breach of professional responsibilities. It would be negligent for a pharmacist alerted to a possible dispensing error to assert, without sighting the medication, that it was the correct medication but of a different strength, and that it could safely be administered to a child.

Response to error
I note the dispute as to what was said when Ms A called to notify the pharmacy of the alleged dispensing error. In her complaint, Ms A stated that she rang the pharmacy and informed Ms B that the tablets were a different colour than usual. Ms A stated that Ms B informed her, after checking with Mr C, that the tablets were only a different strength, and that she could give them to her daughter. Ms A said that 10 minutes later she was telephoned by Mr C, who enquired further about the tablets.

Ms B and Mr C gave a very different version of events. Both stated that Ms B received the initial call from Ms A and handed the call to Mr C, who acknowledged that a dispensing error might have occurred and instructed Ms A not to give the dispensed tablets to her daughter. Mr C also stated that he asked Ms A to return the medication for correction. Some time later, when Ms A had not returned to the pharmacy with the medication, Ms B telephoned her (at Mr C's request) to see what was happening.

It is not clear why Ms A would have given the tablets to her daughter if she knew that she had been dispensed the wrong or incorrect strength medication, unless she had been told it was safe to do so. It is also not clear why Ms A returned to the pharmacy with only two tablets rather than with all the tablets in the original container, as requested by Mr C.

Given Ms A's expressed concern for the well-being of her daughter, it is not obvious why Ms A or her husband did not take Miss A to an emergency clinic or hospital for medical assessment as advised by Mr C. Nor is it clear why Ms A did not take the re-dispensed prednisone when she initially returned to the pharmacy with the wrong tablets, although her explanation is that she was flustered. It does seem surprising that she did not uplift the correct medication from the pharmacy (a short drive away) until three days later.

On balance, I am not satisfied that Ms A's serious allegations about how Ms B and Mr C responded to the error can be substantiated.

First, the numbers do not add up. Ms A was dispensed 18 tablets. It is not in dispute that she took two tablets back to the pharmacy for identification. My Office was subsequently provided by Ms A with a container of the dispensed tablets, which contained 16 tablets. Yet Ms A says she gave two tablets to her daughter.

Secondly, I have been advised by Pharmac and Medsafe that yellow prednisone tablets have never been available in New Zealand. It is not in dispute that Ms A told Ms B (in her initial telephone call) that the tablets were yellow. It is inconceivable that pharmacy staff would have advised her that yellow tablets were simply a different strength of prednisone.

Although the wrong medication was dispensed to Ms A, I am satisfied that Mr C's response to the error was timely and appropriate. He took prompt and necessary steps to ensure that the patient came to no harm, sought medical advice, and appropriately informed Ms A of the steps she should take. He took the necessary corrective measures and re-dispensed the appropriate medication at the earliest opportunity. Accordingly, in my opinion, Mr C did not breach Right 4(1) of the Code in responding to the error.

Right to complain
With respect to Ms A's allegation that Mr C did not advise her of the right to complain under the Code, I am satisfied that the possibility of lodging a complaint was raised and discussed with Mr C. Mr C's letter of 25 March 2003 to Mr and Ms A specifically refers to their right to complain to the Health and Disability Commissioner and includes the relevant telephone number. Accordingly, this allegation is not substantiated and Mr C did not breach Right 10(6)(b) of the Code.

Opinion: Breach – Ms B

Ms A complained that Ms B dispensed the wrong medication, diazepam instead of prednisone.

Under Right 4(1) of the Code Ms A had the right to services provided with reasonable care and skill. Ms B was a dispensary technician and her role was to assist the pharmacist in dispensing prescription medicines. She was required to exercise reasonable care and skill to ensure she dispensed the medicine correctly.

The dispensing of a prescription medicine should be carried out according to a disciplined dispensing procedure which incorporates self-checks during all aspects of the operation. Ms B should have taken care to check that the container that Mr C had selected for her, and placed next to the prescription on the dispensing bench, was the correct one and matched the prescription. When she stuck the label onto the dispensing container, she should have checked that the label was correct and matched the medication inside it. Ms B should then have carried out her final check of the medication to be dispensed before passing it to Mr C for his final check, prior to giving the medication to Ms A.

While I accept that Ms B acted under Mr C's supervision and that Mr C had the ultimate responsibility for the dispensing of the medication, Ms B also had a duty of care to ensure that the right medication was selected and placed in a correctly labelled container. By placing the wrong medication in the container and by failing to carry out adequate checks that would have detected and prevented the error, Ms B breached Right 4(1) of the Code.

Opinion: No breach – Ms B

Ms A alleged that Ms B dispensed the medication without having it checked by Mr C, the duty pharmacist. She also alleged that when the dispensing error was brought to Ms B's attention, Ms B did not advise her of the right to complain under the Code.

Checking process
Mr C stated that while Ms B was entering the prescription information into the computer, he selected the prednisone container and placed it next to the prescription label on the dispensing bench. Ms B then placed the medication into the dispensing container and left it next to the prescription form for Mr C to check. Mr C then checked that the instructions on the label of the container in which the medication was being dispensed were correct and matched the prescription. I am satisfied that Mr C was involved in the checking process and that Ms B gave the medication to Ms A after the prescription form had been initialled by Mr C and he had asked her to give it to Ms A.

Ms A's allegation that Ms B dispensed the medication without having it checked by Mr C cannot be substantiated. Accordingly, Ms B did not breach the Code in this regard.

Right to complain
Regarding the allegation that Ms B did not inform Ms A of her right to complain to this Office, I am satisfied that this issue was appropriately dealt with by Mr C. There was no obligation on the part of Ms B to separately inform Ms A about the avenues of complaint open to her. Accordingly, Ms B did not breach Right 10(6)(b) of the Code.

Opinion: No breach – Mr D

Ms A alleged that Mr D did not adequately investigate and address her concerns about the dispensing error and did not advise her of the right to complain under the Code.

I note that Mr D was not on duty at the time the medication was dispensed to Ms A and that he had no direct involvement in the incident. He was contacted on 24 March 2003 by Ms A, who appeared to be pursuing the issue of compensation. Mr D advised Ms A to contact the Pharmaceutical Society (and provided contact details) if she wanted to pursue the issue of compensation. I note that Ms A contacted this Office after contacting the Pharmaceutical Society.

In respect of the allegation that Mr D did not adequately investigate Ms A's concerns about the dispensing error, I note that on 14 April 2003 Mr D conducted a review of the incident with Ms B and Mr C and made a number of changes to reduce the likelihood of a similar error recurring.

In my opinion Mr D responded to the incident, and to Ms A's telephone call, appropriately and did not breach the Code.

Opinion: No breach – The Pharmacy

Ms A complained that the pharmacy did not respond appropriately when she notified its staff of the dispensing error.

Vicarious liability
Employers are vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code. Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from doing or omitting to do the thing that breached the Code.

Having reviewed the pharmacy's Standard Operating Procedures (SOPs) in respect of its dispensing procedure, I am satisfied that adequate measures were in place to prevent a dispensing error. Accordingly, the pharmacy is not vicariously liable for Ms B and Mr C's breaches of the Code. I note that the pharmacy has reviewed its dispensing procedures to prevent the recurrence of a similar error. I commend the pharmacy and Mr C on its timely and appropriate response.

Other comment

Fairness and honesty in making complaint
The evidence in this case suggests that Ms A has given inaccurate information to the pharmacy staff after the incident and to my staff during the investigation. In my opinion Ms A has misrepresented key facts. Ms A appears to have tried to aggravate the situation for the pharmacy by making potentially damaging allegations about Mr C's initial response when alerted to the error, and by trying to create a picture of a distressed and very sick child. For the reasons outlined above, many of her allegations cannot be substantiated. Consumers have a responsibility to act fairly and honestly when making complaints about providers. Ms A has failed to fulfil that responsibility.

Compensation
The matter of compensation for the dispensing error appears to have featured highly and raises the question whether it was the primary reason for the complaint. While Ms A alleged that the issue of compensation was raised by Ms B, Ms B stated that the matter of compensation was raised by Ms A. As the matter of compensation was also raised separately with Mr C and later with Mr D, and as Ms A indicated to my investigation staff that compensation was the outcome she was seeking from the complaint, I am inclined to believe that it was Ms A, and not the pharmacy staff, who initiated and pursued the matter of compensation. Ms A's criticism of the pharmacy's alleged offers of compensation when "my main concerns were for my daughter not for any money I was being offered" in this context lacks credibility and further adds to my concerns about the truthfulness of her allegations.

Actions taken

- Ms B acknowledged that she made a dispensing error and apologised to Ms A for the mistake. As a result of this incident, Ms B resigned from her position at the pharmacy.

- Mr C acknowledged that the dispensing error occurred under his supervision and that he was ultimately responsible for it. On a number of occasions he apologised to Ms A and her family for the error and any distress and inconvenience it caused, including a formal letter of apology dated 25 March 2003.

- After the dispensing error was discovered, Mr C contacted the prescribing doctor and sought advice from her. The advice he received from the doctor was the same as the advice he gave Ms A. Mr C also sought advice from another local doctor.

- As soon as the dispensing error was noted Mr C contacted Mr D at home and briefed him on the incident. Mr C made several further calls to Mr D and kept him informed of the developments.

- Since the incident Mr C has reviewed his dispensing and checking procedures and re-familiarised himself with the pharmacy's Standard Operating Procedures (SOPs) to minimise the likelihood of such a mistake being repeated.

- Since the incident the pharmacy's SOPs regarding dispensing and checking, and customer complaints, have been reviewed and some changes have been made to reduce the likelihood of a similar error being repeated.

- Mr C advised Ms A of her right to complain to this Office and provided her with contact details.

- Mr D apologised to Ms A and her family for the dispensing error and for any distress and inconvenience it caused.

Further actions

- A copy of my final report will be forwarded to the Pharmaceutical Society of New Zealand.

- A copy of my final report, with identifying features removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.