Dispensing error
(02HDC04619, 10 February 2004)

Pharmacy ~ Pharmacist ~ Trainee technician ~ Dispensing error ~ Rest home ~ Standard of care ~ Medication checks ~ Rights 4(1), 4(2)

An 82-year-old rest home resident had her medication prepared into blister packs by a pharmacy. Blister packs involve the medication being prepared and dispensed at the pharmacy from a doctor's prescription. Each dose of medication is placed into a tray and checked by the pharmacist, then the pack is sealed with a foil overlay. In this case, the blister packs were prepared by a trainee technician and checked by a pharmacist. A nurse at the rest home then checked the medication listed on the blister pack against the medication prescribed by the resident's general practitioner.

The resident was given two blister packs per day, one in the morning and one at night. The nurse on duty gave the blister pack to the resident who, upon opening it, noticed that one of the pills was green, and looked different from the one she normally took. She alerted a staff member, who checked it and told the resident she could take it.

Soon after swallowing the tablet the resident vomited. Her GP visited and treated her for side effects of taking pergolide (a treatment for Parkinson's disease), which had been dispensed instead of perhexiline (treatment for angina). The blister pack was corrected by the pharmacy manager that morning. However, that evening the resident was again given a blister pack containing the incorrect tablet. She did not take the tablet and, next morning, alerted her daughter, who ensured that the pharmacy manager changed her mother's evening blister packs as well. The resident's daughter complained about the service provided by the pharmacy.

It was held that the trainee technician who prepared the blister pack was in breach of Rights 4(1) and 4(2) of the Code as, even though she was working under supervision, she was still accountable for her actions, and was required to follow professional standards.

The pharmacist breached of Rights 4(1) and 4(2) of the Code in not checking the contents of the blister pack, and failing to detect the medication error. When advised of the error, the pharmacy manager acted promptly, but failed to ascertain whether all the resident's blister packs were correct, so compounding the error.

The registered nurse on duty in the rest home was responsible for checking that the blister pack medication was correct, and failed to do so. Contrary to the rest home's policy and good nursing practice, she relied on the integrity of the checking process within the pharmacy, and thus breached Rights 4(1) and 4(2).

The pharmacy and rest home both had adequate policies and procedures for the dispensing and checking of medication, and it was reasonable to expect staff to adhere to such protocols.