Pharmacy/Pharmacy Manager

Private Hospital/General Practitioner

A Report by the

Health and Disability Commissioner

(Case 01HDC03082)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Complainant
Mr B	Pharmacist, Provider
Dr C	General Practitioner, Provider
Mrs D	Manager, The private hospital, Provider
Mr E	Director, Heritage Health Group Ltd
Mr F	District Coroner
Dr G	Honorary Consultant Cardiologist

Independent expert advice was obtained from Ms H, nurse, and Mr I, pharmacist.

Complaint

On 12 March 2001 the Commissioner received a complaint from Mrs A concerning the services provided to Mr J by a private hospital and a pharmacy.

The investigation was expanded to include Mrs D, Manager of the private hospital, and Dr C, general practitioner. The complaint is that:

- *Prior to Mr J's death on 3 February 2001, the pharmacy dispensed 40mg frusemide in a bottle marked 500mg frusemide.*
- *Prior to his death on 3 February 2001, staff at the private hospital administered 20mg frusemide instead of 250mg frusemide to Mr J. In addition, once the dispensing error had been detected, Dr C and staff at the hospital failed to notify Mr J's welfare guardian, Mrs A.*

An investigation was commenced on 30 May 2001 and extended to include Mrs D and Dr C on 25 July 2001.

Information reviewed

- Complaint letter from Mrs A, received 12 March 2001.
- Response from Mr E, received 31 July 2001.
- Response from Mrs D, received 31 July 2001.
- The private hospital nursing policies and procedures.
- Response from Mr B, received 10 August 2001.
- Response from Dr C, received 17 August 2001.
- Report completed for the coroner by Dr G, received 7 September 2001.

Information gathered during investigation

Mr J was admitted to the private hospital in November 2000. At the time of his admission, Mr J suffered from dementia, chronic obstructive lung disease, congestive heart failure, hypothyroidism, seizures and atrial fibrillation. Mr J had a past history that included a cerebro-vascular accident, hyponatraemia (a lower than normal concentration of sodium in the blood), gout and anaemia. His daughter, Mrs A, held an enduring power of attorney for his affairs.

On the day of his admission to the private hospital Mr J was examined by Dr C, general practitioner. Dr C recorded that Mr J had signs of chest infection and congestive heart failure. Dr C noted atrial fibrillation and that Mr J was very frail. She prescribed Mr J Frusemide at a dose of 250mg daily. Frusemide is a diuretic that alleviates the swelling associated with heart failure. Although it can improve a patient's quality of life, it does not prolong life.

On 10 January 2001 Mr J suffered from a chest infection and was treated with antibiotics and prednisone (a steroid).

On the evening of 10 January 2001 Ms K, pharmacist at the pharmacy, reviewed the medication charts for patients at the private hospital.

On 11 January 2001, a repeat prescription for Mr J's frusemide was processed at the pharmacy, together with repeat prescriptions for other private hospital residents. Mr J's frusemide prescription was dispensed by an unidentified pharmacist. Frusemide tablets in a 40mg dose were placed in a bottle labelled "frusemide 500mg".

Mr J's medication was delivered to the private hospital the following morning.

After the medication had been delivered on 12 January 2001, Ms K decided to check that Mr J's medication had been dispensed correctly. Ms K stated that the high dosage of medication prescribed for Mr J caused a "red alert" in her mind because of the potential for error in dispensing and the possible clinical significance should an error occur. Ms K asked the other pharmacists at the pharmacy if they could recall dispensing or checking Mr J's frusemide medication. On the day the dispensing error occurred there were three pharmacists and three technicians rostered on. Any of these staff could have dispensed or checked Mr J's medication. Ms K advised that no staff member could say whether he or she had dispensed or checked Mr J's medication amongst the many others that morning.

Ms K stated that she telephoned the private hospital at around 7.00pm on 13 January 2001 and asked to speak to a nurse on duty. Ms K said she spoke to a nurse with a "Kiwi accent", whom my investigation has been unable to identify, and advised that she wished to check Mr J's medication. Ms K explained that Mr J was on an unusually high dosage of frusemide and asked the nurse to do a physical check of the bottle and the content to ensure the correct tablets were in the bottle. Ms K stated that she stressed that the size of the

tablet should be checked. She informed the nurse that the tablets should be large and white and looked different to the usual small white frusemide 40mg tablets.

Ms K said that she did not receive a return phone call, and assumed that the nurse went to check immediately and would have called her back if there had been a problem.

Ms K's telephone call was not documented in Mr J's nursing records. The nursing staff on duty at the time Ms K made the call were registered nurse Ms L, registered nurse Ms M, and registered nurse Ms N. Ms N was working in a wing of the hospital that is not easily reached by telephone, to which outside calls are not usually referred. Neither Ms L nor Ms M can recall having a telephone conversation with Ms K about Mr J's medication. Both nurses are Fijian-Indian and neither speaks with a New Zealand accent.

On or around 18 January 2001, Mr J was commenced on the incorrectly dispensed frusemide when he was administered half a 40mg tablet from the container purporting to contain 500mg frusemide. This dosage continued to be administered until 31 January 2001.

On 31 January 2001, Mr J was noted to appear very unwell. A registered nurse reviewing his medication noted that the tablets in Mr J's bottle were 40mg frusemide. The nurse checked Mr J's medicine chart and administered 6 tablets to the patient. In the notes she recorded that:

> "while giving medications found 40mg tabs frusemide in 500mg container. ? if he was getting only 20mg daily. Given 6 tablets this morning to make 240mg. Incident form filled. [Mr O] [care co-ordinator] informed. Generally unwell SOB++ [short of breath] coughing and febrile [feverish] temp 38º at 1040 hours 20ml pamol given. Seen by [Dr P] …"

An incident report was completed by the registered nurse and Mr O, care co-ordinator at the private hospital. This report stated that:

> "Rang pharmacist [Ms K] regarding the incident. According to [Ms K] she rang from 14/1 to 16/1 regarding the high dosage of tab frusemide which is 250mg daily.
>
> [Ms K] spoke to the nurse who has a Kiwi accent. *'I instructed the nurse to check that the frusemide is 500mg and supposed to dispense to resident 250mg only. I didn't follow up the investigation presuming if she didn't ring back, that the dosage was correct.'*
>
> Initial investigation reveals 2 ½ tablets of 40mg left in the frusemide container. Shown to Dr P. Confirmed by [S/N Q]and [S/N M] that a labelled frusemide 500mg container contained only 40mg tablets and not 500mg frusemide tablets.

Action:

Pharmacist [Ms K] has agreed to supply immediately container of tab frusemide 500mg.

[Dr P] has examined Mr J at 10.15am, medications prescribed.

At 3.15pm rang [Mrs A], advised of situation and diagnosis. Will inform family if any change of condition arises.

To investigate the dispensing frusemide from 14/1 till 30/1 2001.

[Dr P] will review resident on 2/2/2001.

Photocopies of progress notes and doctors notes attached."

Mrs A was telephoned by a staff member from the private hospital on 31 January 2001 and informed that her father's condition was not good.

Mrs A and other members of Mr J's family visited the private hospital on 2 February 2001. Dr C was not available to meet with Mr J's family members, and Dr P, general practitioner, attended in her place. Dr P did not inform the family of the dispensing error. Mrs D advised that she and Mr O had decided to ask Dr C to discuss the error with the family when she returned on 5 February 2001.

In the early hours of 3 February 2001, Mr J died.

On 5 February 2001, a meeting was held between Dr C, Mr O and Ms D. Notes of the meeting signed by Mrs D and Mr O recorded that Dr C advised them not to inform Mr J's family of the dispensing error.

On 7 February 2001, Dr C met with Mr O, Mrs D and Mr E, Director of the private hospital. At this meeting, Mrs D expressed her concern about concealing the dispensing error from Mr J's family. Mrs D advised me that she was also concerned that the Coroner had not been notified. Mrs D stated that after a discussion, Dr C agreed with her and recommended that the family should be informed and that the Coroner's office should be contacted immediately.

Mrs D rang Mrs A on 7 February 2001 and advised her of the dispensing error. Dr C rang Mr F, District Coroner, the same day and informed him of the dispensing error.

On 30 July 2001 Mr F sought the advice of Dr G, consultant cardiologist. In his report to Mr F, Dr G stated:

"I have read all the documents provided by you. I have not requested the full hospital records but I doubt that that would make any difference to my conclusions.

> Briefly, the patient had known chronic respiratory disease and severely impaired cardiac function with congestive heart failure. From his daughter's comments [Mrs A] he had been in [a public hospital] with severe heart failure before admission to [the private hospital] in November 2000. In that [public hospital] admission, he was in severe heart failure and not expected to survive. It appears that there was an error in dispensing by pharmacists about 10 January 2001. [Ms K], a qualified pharmacist working for [the pharmacy], recognised the possibility of a wrongly dispensed size of frusemide tablets (40 mg instead of 500 mg) and contacted [the private hospital] on 13/1/01 to have the staff check the situation. It appears from the records given to me that this information was not acted upon until a nurse discovered the discrepancy on 31/1/01 and instituted the appropriate larger dose of frusemide (250 mg each morning). There appeared to be no improvement in the patient's condition despite the reinstitution of the correct dose and he died three days later on 3/2/01.
>
> There are two issues here. The first is the incorrect dispensing, recognised by [the pharmacy] at an early stage and then the apparent failure of [the private hospital] to follow up on the advice concerning that to make a correction. These are matters which no doubt the Health and Disability Commissioner will have views about.
>
> The second issue is whether the smaller dose of frusemide contributed to the patient's death. In chronic heart failure, the use of the diuretic has been shown in numerous studies to improve a patient's sense of wellbeing and quality of life but not to prolong survival. The one medication which appears to prolong survival is the use of one of the ACE inhibitors and [Mr J] was taking that together with other anti-heart-failure medication. The fact that his condition did not improve in the three days between the re-establishment of the appropriate high dose and his death, emphasised the point that it is improbable that the smaller dose in the preceding twelve to fourteen days was likely to have contributed to his death and it appears that he was in a rapidly declining state of cardiovascular health and had been for some time.
>
> My conclusion is that while the faulty dose of frusemide dispensed and the failure to correct that in [the private hospital] are regrettable events, it is most unlikely that this hastened his death but may have adversely affected his quality of life over the period before he died on 3/2/01."

On 31 August 2001 Mr F wrote to Mrs A and advised her that he would not be conducting an inquest into Mr J's death.

The pharmacy advised that since this incident it has refined its procedures to:

"1. Never expect a staff member at the institution to take responsibility for checking a medication for us. If we are concerned about what has been supplied, it is our duty to physically check it ourselves.

2. Always document significant discussions with the institutions we service, noting the name/s of the staff member/s concerned.
3. Highlight unusual doses or strengths in such a way as to alert the dispensing technician and checking pharmacist.
4. Review pharmacy procedures to ensure they are consistent with recommendations made by the Pharmaceutical Society of New Zealand, and the Pharmacy Defence Association of New Zealand."

Independent Advice to Commissioner:

The following expert advice was obtained from Mr Murray Guy, an independent pharmacist:

> "The information provided to me indicates that the dispensary procedures in place at [the pharmacy] are well organised in what is obviously a very busy pharmacy, however up until February of this year [2001] there does not appear to have been a recorded method of dispensing and checking, as least with repeat prescriptions.
>
> It is customary for pharmacies to have a stamp which franks the prescription or 'Certified Repeat Copy' (CRC), with the provision for name of pharmacy, date, dispensed by and checked by
>
> Eg [the pharmacy]
>
> 1st February 2001.
>
> Disp……Checked…
>
> The dispenser (technician or pharmacist) initials the fact that he/she has dispensed the medication and another pharmacist checks this.
>
> In the case referred to your office a repeat dispensing of frusemide 250mg (half a tablet) was required. I assume a computer generated 'Certified Repeat Copy' (CRC) was printed and the frusemide dispensed from that copy, or was it a label, but there is no recorded check? I am aware that this is practised in some pharmacies but I consider this practice undesirable. It should be noted that moves are afoot to require all pharmacies to dispense from ORIGINAL prescriptions and not from CRCs.
>
> [Mr B] in his letter to [the Commissioner] states:
>
> '… up until this incident, while repeat prescription receipts were automatically printed prior to dispensing, they were not retained and therefore were not

signed by the "checker" pharmacist as, with the introduction of electronic claiming, pharmacies no longer had an obligation to supply repeat prescription receipt copies to the funding authority.

This incident, however, highlighted the shortcoming in the process and repeat prescriptions are now printed, signed by the "checker" pharmacists and retained.'

I note that [Mr B] made contact with the Pharmaceutical Society of New Zealand and the Society Pharmacist, [Ms R], clarified that the standard operating procedure (SOP) should include the requirement for the pharmacist who checks a prescription (repeat or otherwise) to be identifiable.

I consider that if [Ms K] had sufficient concern over the dispensing of the frusemide 500mg and it worried her enough to discuss it with her employer, a phone call to the registered nurse at [the private hospital] may have clarified the issue. In this case there was no resolution. The Pharmacist's responsibility was to assure herself that the medicine supplied was correct and I believe that a visit to [the private hospital] immediately, would have resolved the issue.

[Mr B] in his letter to [Mrs D] at the private hospital dated 19th February 2001 outlined refined procedures in the pharmacy and I consider that would assist in preventing future dispensing errors.

All pharmacy staff must realise the responsibility they have when dispensing and the importance of recording the dispensing and checking of medicines.

I cannot see that further exploration by the investigation officer would achieve any useful purpose.

I am conscious that mistakes are made in dispensing and the simplest method we can take to eliminate these is to insist on the dispensing/checking procedures and perhaps, ask the Pharmaceutical Society to bring this to the attention of all members."

The following expert advice was obtained from Ms H, an independent registered nurse:

"*Background*

[Mr J] was admitted to [the private hospital] on 24 November 2000. At the time of his admission, [Mr J] suffered from dementia, chronic obstructive lung disease, congestive heart failure, hypothyroidism, seizures and atrial fibrillation.

[Mr J] was prescribed frusemide at a dosage of 250mgs daily.

On 12 January 2001, a repeat prescription for [Mr J's] frusemide was processed at [the pharmacy]. The medication was dispensed by an unknown pharmacist.

[Mr J's] frusemide prescription was incorrectly dispensed and the pills of a 40mg dose placed in a bottle labelled 'frusemide 500mg'.

On 13 January 2001, [Ms K] telephoned an unidentified nurse at the private hospital to ensure that [Mr J's] medication of frusemide was correct. The nurse informed [Ms K] that she would check that the dosage dispensed was correct.

On or around 18 January 2001, [Mr J] was commenced on the incorrect frusemide when half a 40mg tablet was given to him from the incorrectly labelled container.

On 31 January 2001, a nurse noted that the tablets being administered to [Mr J] appeared different from his normal dosage. This nurse realised that the tablets were of only 40mg level and commenced [Mr J] on the correct dosage.

[Mrs A], [Mr J's] daughter and welfare guardian, was called by the nurse and informed that her father's condition was not good.

On 3 February 2001, [Mr J] passed away.

In forming this opinion information viewed was:

- Complaint letter from [Mrs A]and attachments, 12 March 2001
- Phone call with [Mrs] A, 29 May 2000
- Phone call with [Mrs A], 5 June 2001
- Response from [the private hospital], 17 July 2001
- Response from [Mrs D], 27 July 2001
- Response from [the pharmacy], 9 August 2001
- Response from [Dr C], 13 August 2001
- Letter from [Mrs A], 11 June 2001 and attachments.

Registered Nurses are registered under the Nurses Act 1997 … by the Nursing Council of New Zealand.

Registered Nurses have an annual Practising Certificate which allows nurses to practise in that role for the year specified.

Codes and requirements which allow nurses to practise under include:

- Code of Conduct for Nurses and Midwives – Nursing Council of New Zealand 1995
- Standards for Registration of Nurses and Midwives in New Zealand 1994
- New Zealand Nurses Organisation – Standards of Nursing Practice 1993

Guidelines for medication dispensing are published. These include:

- Safe Management of Medications – Ministry of Health 1997
- Guidelines for Nurses on the Administration of Medications – New Zealand Nurses Organisation.

Policies and Procedures sufficient to ensure the safe administration of medication to consumers:

[The private hospital] has four policies which deal with the administration of medication. These include:

- Medication – Administration and Management of
- Medication – Acquisition and Dispensing
- Disposal of Pharmaceutical Waste
- Management and Reporting of Incidents/Accidents

Also viewed was the contract between [the private hospital] and [the pharmacy].

The policies and procedures provided by [the private hospital] are typical of aged-care providers and are in significant detail to ensure safe practice if followed. They include information in relation to dispensing medications from the original packs and the residents' own supply.

Section 5 details 'Administration of Medication'. It outlines what the Registered Nurses must check, eg the right medication, the right resident, right dose, right route, right time.

Within this policy it also outlines how patients should be administered medication.

The medication acquisition and dispensing policy outlines the correct charting of medications, telephone orders and medication and Pharmaceutical ordering. Section 5 of the policy outlines Pharmacy Deliveries. Section 5.2 states that 'Both the Pharmacist and the Registered Nurse will check the delivery against

the order form.' Section 5.3 'Both the Pharmacist and the Registered Nurse will sign the order form.'

Section 6 Outlines the dispensing of Medications.

Section 7 'Safe Storage of Medications'

Disposal of Pharmaceutical waste policy is adequate enough to ensure safe practice.

All policies and procedures are signed and dated and are less than two years old. It is my opinion that Policies and Procedures as stated do provide for safe practice.

[The pharmacy] has policies and procedures and a signed contract.

The signed contract is typical of contracts signed with aged-care providers.

The policies list the service and responsibilities and include what is required to meet an aged-care facilities medication requirements.

What actions should nursing staff have taken on 13 January when [Ms K] rang:

There is documented a statement from [Ms K] that she rang the private hospital on 13th January at approximately 7pm. [Ms K] states she spoke to the nurse on duty and discussed the unusually high dosage of frusemide. She asked the nurse to check the bottle to ensure the medication was the correct dose.

Nursing staff did not phone back hence [Ms K] assumed that the correct dose was dispensed.

Nursing staff should have checked the bottle of tablets at the time or as soon as possible after [Ms K] phoned. Any phone call such as this would have alerted staff that there was concern.

Staff rosters would demonstrate who was on duty that evening.

It is assumed that [Ms K] spoke to a Registered Nurse. This is not confirmed by her. If a caregiver had answered the phone then they might not have realised the consequences of such a call and not passed the message on.

It is noted that [the private hospital] has reviewed its policies and has now included 'Section 4' – Discussions with Pharmacy Staff:

> All significant discussions with pharmacy staff must be confirmed in writing by fax.

Including this statement in policies will ensure that communication between Pharmacists and nursing staff will be documented.

Policies and procedures in place at the time of the incident did not specifically outline that all communication between the Pharmacist and nursing staff be documented, but it does state that 'the Registered Nurse on duty in ward or wards, is responsible for the supervision of medication for residents in his/her care.'

It is my opinion that the nurse who took the call should have acted on the Pharmacist's concerns and checked the patient's medications.

In reviewing the process which was followed after the incident was noted, it is my opinion that correct and appropriate action was taken by the Hospital Manager. The family was notified, a meeting held and minutes and correspondence from these meetings kept.

The incident of dispensing 40mg tablets instead of 500mg tablets is acknowledged that the hospital was made aware of the potential for error and did not act on it.

Frusemide is a common tablet used as a diuretic. It is accepted practice that the Pharmacist is responsible for dispensing the correct dose and ensuring the labelling is correct on the bottle.

Experienced Registered Nurses would have, in my opinion, recognised the order of 250mg as being larger than normal and have questioned the tablets, as was the case at [the private hospital].

Junior staff may not have had the experience or knowledge to question.

There is a discrepancy in the information provided as to when [Mr J] did start on the incorrect dose.

Aged-care facilities should have a clear accountable system when medication is reissued as it is unclear when the newly-delivered medication was started. The medications were dispensed on 12 January 2001.

RN [S] is unsure when she commenced the new supply of frusemide but thinks it may have been on 22 January 2001, approximately 10 days after the new bottle was delivered to the Pharmacy.

[The private hospital] in conjunction with the Pharmacy, needs to review the ordering and dispensing systems. There should be a very clear and auditable

system in place to know when new deliveries of drugs should be started or stopped.

Many aged-care facilities dispense medications from blister packs. This does allow clear accountable systems and clearly shows when drugs are reissued."

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 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –
a) An explanation of his or her condition; …

RIGHT 7
Right to Make an Informed Choice and Give Informed Consent

…

4) Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where –

a) It is in the best interests of the consumer; and

b) Reasonable steps have been taken to ascertain the views of the consumer; and

c) Either, –

i. If the consumer's views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of

the services is consistent with the informed choice the consumer would make if he or she were competent; or

ii. If the consumer's views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.

Other Relevant Standards:

The Pharmaceutical Society of New Zealand 'Code of Ethics' (December 1996):

RULE 2.12

"A pharmacist must dispense the specific medicine prescribed …"

RULE 2.13

"The pharmacist responsible for a dispensed product must always be readily identifiable."

Medicines Regulations 1984

"42(3)(h) On each subsequent occasion of dispensing (if any), there shall be printed or stamped on the back of the prescription the number or code … and a further endorsement that, together with any earlier endorsement, clearly indicates –

…

(ii) The date on which the prescription or any indicated part or portion of the prescription is dispensed

… "

Opinion: Breach – The pharmacy

Dispensing error
My expert pharmacist advisor noted that on 12 January 2001 there did not appear to have been a system for recording the dispensing and checking of repeat prescriptions at the pharmacy. On that day an unidentified member of staff at the pharmacy dispensed the incorrect dosage of frusemide into the bottle for Mr J. A pharmacist should have checked that the correct medication had been dispensed.

The Pharmaceutical Society of New Zealand 'Code of Ethics' states that "A pharmacist must dispense the specific medicine prescribed …". Pharmacists must always maintain the highest level of vigilance when dispensing medicines. Accurate dispensing is essential to ensure a safe community pharmacy. The profession and the community expect pharmacists to be constantly vigilant when dispensing medications, because of the potential harm from a dispensing error. A careful check by a pharmacist who records that he or she has checked that the correct medication has been dispensed and implicitly accepts professional responsibility for the accuracy of the dispensing is critical.

In this instance, because of the failure to record the details of the individual pharmacists involved in the dispensing and checking of Mr J's medication, I am unable to identify those individuals responsible. In my view those individuals failed to exercise reasonable care and skill in the performance of their duties and thus breached Right 4(1) of the Code. I consider dispensing errors of such seriousness that, had I been able to identify the responsible individuals, I would have referred the matter to the Director of Proceedings for further action. It is probable that disciplinary proceedings would have ensued. However, because I am unable to identify the individuals involved, I am unable to determine who breached the Pharmaceutical Society 'Code of Ethics' and therefore the Code of Rights.

I accept my expert's advice regarding the importance of recording the dispensing and checking of original and repeat prescriptions. Rule 2.13 of the Pharmaceutical Society 'Code of Ethics' states that the pharmacist responsible for a dispensed product must always be readily identifiable. The facts of the present case demonstrate why such records are essential. In my opinion, the pharmacy's failure to have an appropriate method in place to record who dispensed and checked medication amounted to a failure to comply with Rule 2.13 of the Pharmaceutical Society 'Code of Ethics' and therefore constituted a breach of Right 4(2) of the Code of Rights.

I acknowledge that once the pharmacy became aware of the incident involving Mr J, it immediately conducted a review of its dispensing procedures and contacted the Pharmaceutical Society of New Zealand to assist in overcoming the shortcomings in its system. As a result of this review, new procedures have been implemented to ensure that all medicines dispensed are checked and that the dispensing pharmacist and the checker are recorded.

I note that in June 2001 the Pharmaceutical Society issued an amended 'Code of Ethics'. The Code now includes a new rule that states: "The pharmacist manager shall ensure that

every prescription bears an annotation which identifies which pharmacist has taken responsibility for the dispensed medication."

Regulation 42(3)(h) of the Medicines Regulations 1984 states that, for repeat prescriptions:

> "42(3)(h) On each subsequent occasion of dispensing (if any), there shall be printed or stamped on the back of the prescription the number or code … and a further endorsement that, together with any earlier endorsement, clearly indicates –
>
> …
>
> (ii) The date on which the prescription or any indicated part or portion of the prescription is dispensed
>
> … "

This means that repeat prescriptions should be dispensed from the original prescription. I note that the pharmacy 'Standard Operating Procedures: Dispensing a Repeat Prescription' does not specify this and may result in breaches of Regulation 42(3)(h).

Follow-up action

Ms K, pharmacist at the pharmacy, stated that the high dosage of frusemide prescribed for Mr J caused a "red alert" in her mind when reviewing, on 12 January 2001, the medication that had been dispensed from the pharmacy the previous day. Her concern prompted her to ask staff at the pharmacy if they could recall dispensing or checking Mr J's frusemide medication. No one could remember having done so. Ms K was sufficiently concerned to telephone the private hospital and ask a nurse to check Mr J's tablets.

I accept my expert advice that "if Ms K had sufficient concern over the dispensing of the frusemide 500mg and it worried her enough to discuss it with her employer", she had a responsibility "to ensure herself that the medicine supplied was correct". My advisor noted that "a visit to [the private hospital] immediately would have resolved the issue".

In my opinion, Ms K acted appropriately in her initial follow-up, but failed to ensure – either by a further telephone call to the private hospital, when she received no call back from the nurse she had spoken to, or by a personal visit – that Mr J did have the correct medication.

In these circumstances, the pharmacy (acting through one of its pharmacists) failed to fulfil its organisational duty of reasonable care in following up a suspected dispensing error, and therefore breached Right 4(1) of the Code.

Opinion: No Breach – The Private Hospital

Failure to check medication
My nursing advisor stated that when the telephone call from Ms K was received on 13 January 2001, the nurse who took the call should have checked the bottle of pills as soon as possible. The nurses on duty at the time the call was made were registered nurse Ms L, registered nurse Ms G, and registered nurse Ms N. None can recall speaking to Ms K. I am therefore unable to identify the staff member at the private hospital who took the telephone call from Ms K. Had I been able to identify that person, I would have treated the failure to respond appropriately to Ms K's concerns very seriously.

The question remains whether there was any systemic failing on the part of the private hospital that could have prevented such inaction on the part of its staff. In my view there was no such failing. Instead, it appears that the nurse simply responded in a way that lacked professional judgement. The private hospital could not reasonably have been expected to prevent such a lack of professionalism by a registered nurse. Accordingly, I do not consider that the private hospital breached the Code.

Other comment – Mrs D

Failure to notify family of dispensing error
Mrs D became aware of the dispensing error on 31 January 2001. Mr J was suffering from dementia and was not competent to manage his own affairs; his daughter, Mrs A, held an enduring power of attorney and was entitled to give consent on his behalf. Accordingly, under clause 4 of the Code, Mrs A was entitled to be treated as if she was the consumer, Mr J.

On 2 February 2001 Mrs D met with care co-ordinator Mr O and decided to ask Dr C to discuss the dispensing error with Mrs A when she returned to the private hospital on 5 February 2001. Dr C subsequently advised Mrs D not to inform Mr J's family of the error. Initially, Mrs D simply told Mrs A that Mr J's condition had deteriorated. Mrs D was clearly uncomfortable with the decision not to fully inform Mr J's family and on 7 February 2001 she met with Dr C and expressed her concern. After the meeting, Mrs D telephoned Mrs A and informed her that Mr J had received the wrong medication.

Under Right 6(1)(a) of the Code, a consumer is entitled to receive, without asking, an explanation of his or her condition. That explanation should include the information that a reasonable consumer, in that consumer's circumstances, would expect to receive.

Mr J was a consumer who had suffered an adverse event because of a medication error. He was legally – and morally – owed a prompt explanation about what had happened. In light of his diminished competence, his legal representative, Mrs A, was entitled to receive that explanation on his behalf.

Mrs A was kept in the dark as a result of the intervention of Dr C and the reluctant acquiescence of Mrs D.

I accept that Mrs D intended to inform Mrs A of the dispensing error as soon as it was recognised, but was talked out of doing so by Dr C. After reflecting on Dr C's advice, Mrs D acted in an entirely appropriate manner, calling a second meeting to discuss her concerns and subsequently contacting Mrs A.

In the circumstances I am satisfied that Mrs D should be reminded of her obligations under the Code, in particular Right 6(1)(a), but consider that further action is not appropriate.

Other comment – Dr C

On 5 February 2001, two days after Mr J's death, Dr C met with Mr O and Mrs D and advised them not to inform Mr J's family of the dispensing error. As Dr C was not providing a health service at this point, the matter falls outside of my jurisdiction. However, in my opinion Dr C's decision to withhold information from Mr J's family was totally inappropriate and demonstrates a serious lack of judgement on her part.

Actions

I recommend that the pharmacy:

- Apologise in writing to Mrs A for breaching the Code. This apology is to be sent to the Commissioner and will be forwarded to Mrs A.
- Review its practice in light of this report.
- Ensure that an accurate record is kept of the name of the staff member who dispenses a medication and of the pharmacist who checks that the correct medication has been dispensed.
- Arrange with the private hospital (and with other rest homes and hospitals for which the pharmacy supplies prescription medicines) a contact person with whom any medication issues related to residents and patients can be discussed.

Other Actions

A copy of this opinion will be sent to the Medical Council of New Zealand. Additional copies will be forwarded to Medsafe and the Pharmaceutical Society of New Zealand with a recommendation that these two agencies co-ordinate an audit of dispensing procedures at the pharmacy.

A copy of this opinion, with all identifying details removed, will be sent to the New Zealand College of General Practitioners, for educational purposes.