Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 21HDC01574)

Executive summary

1. This report concerns a pharmacist's failure to check that the correct medication had been dispensed before giving it to the consumer. The report also emphasises the importance of pharmacies having clear standard operating procedures containing step-by-step processes for dispensing and checking, and the need to highlight look-alike medications on dispensary shelves to alert dispensers to the potential error of dispensing incorrect medication.

Findings

2. The pharmacist accepted full responsibility for failing to check that the correct medication had been dispensed. The Deputy Commissioner considered this to be a breach of the pharmacist's professional standards, as set out by the Pharmacy Council of New Zealand | Te Pou Whakamana Kaimatū o Aotearoa (the Pharmacy Council). The Deputy Commissioner also noted that the pharmacist failed to inform the consumer's doctor promptly after the error was discovered. Accordingly, the Deputy Commissioner found the pharmacist in breach of Right 4(2) of the Code.

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

3. The Deputy Commissioner was also critical that the pharmacist failed to provide the consumer with a comprehensive explanation about the adverse side effects of taking the incorrect medication after the error had been discovered.

4. The Deputy Commissioner criticised the pharmacy's Dispensing and Checking standard operating procedures for not highlighting look-alike medications on the dispensary shelves and not having a step-by-step process for dispensing and checking in accordance with the Pharmacy Council's standards.

Recommendations

5. The Deputy Commissioner recommended that the pharmacist provide an apology to the consumer and complete a written report to HDC on the learnings from this case and the effectiveness of the changes implemented as a result.

6. The Deputy Commissioner recommended that the pharmacy undertake an audit of its existing standard operating procedures.

Complaint and investigation

7. This report discusses the care provided to Ms A by pharmacist Ms B at a pharmacy in April 2021. The following issues were identified for investigation:

- *Whether Ms B provided Ms A with an appropriate standard of care between 7 April 2021 and July 2021 (inclusive).*
- *Whether the pharmacy provided Ms A with an appropriate standard of care between 7 April 2021 and July 2021 (inclusive).*

8. This is the opinion of Deputy Commissioner Rose Wall and is made in accordance with the power delegated to her by the Commissioner.

9. I would like to thank Ms A for taking the time to bring her concerns to the Health and Disability Commissioner. I would also like to thank Ms B for her comprehensive responses, which have helped with the investigation process.

Background

10. On 7 April 2021, Ms A presented to her family GP, Dr C, regarding her acne. Dr C prescribed Ms A with isotretinoin (10mg x 30 capsules). This medication can have adverse side effects for pregnancy and is not recommended for women who plan to become pregnant.[1]

[1] Isotretinoin is used to treat severe acne. It belongs to a group of medications called retinoids. The medication works by reducing the amount of oil made by the glands in the skin, inhibiting the growth of bacteria, reducing pore clogging and decreasing inflammation. However, isotretinoin has been known to cause birth defects and can be harmful to unborn babies, so is not recommended for women who plan to become pregnant.

11. Ms A presented to the pharmacy later the same day to collect her prescription. The script was filled by pharmacist Ms B,[2] who provided Ms A with the medication inside a box. Ms A told HDC that the box was labelled 'isotretinoin'.

12. However, Ms B had placed acitretin[3] (25mg)[4] in the box instead of the isotretinoin. This dispensing error was unknown to both Ms A and Ms B at the time Ms A collected the prescription from the pharmacy. Ms B told HDC that she 'was the only person involved in preparing [Ms A's] medication'.

13. Ms B understood that this was the first time Ms A had been prescribed isotretinoin, so she explained to Ms A that it was 'important not to get pregnant' while taking isotretinoin. Ms B told HDC she also asked Ms A whether she was using a contraceptive (to which Ms A replied that she was), informed her to take extra precautions when outdoors (as her skin might be more sensitive to sun), and provided her with a patient information sheet about isotretinoin.[5]

14. Ms A told HDC that she was not provided with an information sheet about isotretinoin on 7 April 2021.

29 April 2021 — Discovery of dispensing error

15. On 29 April, Ms A returned to the pharmacy to collect a repeat of the isotretinoin. Ms A handed the box to the pharmacy technician, who discovered that acitretin had been dispensed instead of the isotretinoin. The pharmacy technician immediately went to inform Ms B about this.

16. Ms B was not familiar with acitretin, so she researched further before dispensing the correct medication, isotretinoin. She then went to Ms A, who was waiting in the pharmacy. Ms B said that she apologised and explained that she had 'inadvertently dispensed the wrong medication on the 7th April' and informed Ms A that she had been given 10mg of acitretin instead of isotretinoin. Ms B told Ms A that acitretin is a 'similar medication, that is often used for psoriasis'.

17. Ms B told HDC that she also asked Ms A whether she was 'okay' and whether she had experienced any side effects such as dry lips. According to Ms B, Ms A told her that she was 'fine' but wondered whether the wrong medication explained why her acne had not improved. Ms B agreed with Ms A that this was a possibility. Ms B told HDC: 'I recall that I checked again at this point that she was on birth control and determined that she had an IUD. I apologised to her, and she accepted.'

[2] Ms B was employed as a pharmacist at the pharmacy working four days a week. On 7 April 2021, she was the only pharmacist working at the pharmacy. Ms B continues to be employed at the pharmacy.
[3] Acitretin is a retinoid (vitamin A derivative) used to treat severe skin disorders such as psoriasis (abnormal growth of skin cells that causes red, thickened or scaly skin). However, acitretin is contraindicated for women who are pregnant or intending to conceive, as it can cause congenital disorders. Strict birth control measures must be used during treatment and for three years after stopping acitretin.
[4] Ms A informed HDC that she was given 25mg as advised by her family GP, Dr C.
[5] Ms B told HDC that the patient information sheet was provided by MIMS New Zealand.

18. Ms B said that at this time, she was not aware that patients taking acitretin were required to avoid pregnancy for three years, so this was not communicated to Ms A.

19. Ms A told HDC that when Ms B informed her of the dispensing error, she did not disclose the name of the medication (acitretin) nor discuss its possible side effects, including the time frame in which a person should avoid pregnancy.

20. Ms A stated:

> 'The pharmacist came out and apologised saying they had given me the incorrect medication and it may have delayed the treatment of my acne, but never mentioned what the drug was called that I had taken or raised any concern for myself, I was told to just continue taking my original medication that I was prescribed by [Dr C], so I did.'

21. Furthermore, Ms A told HDC that she felt that Ms B should have told her to consult her doctor as the foremost priority, which did not occur.

Dispensing error

22. Ms B told HDC that she accepts full responsibility for the error. She said that she had processed the isotretinoin prescription through her computer software correctly, but she had 'inadvertently dispensed acitretin 10mg in error' and did not identify the error in her final check.

23. Ms B said that she has since investigated how the dispensing error occurred. She stated that she was the only person involved in preparing Ms A's medication, and it is likely that she inadvertently selected the wrong medication, because both isotretinoin and acitretin are similar medicines with similar strengths.

24. According to Ms B, the isotretinoin may have been stored in the wrong place at the time, and potentially had been moved by another staff member in error. Ms B stated:

> 'Our medications are stored alphabetically, so should not be stored next to each other. However, both myself and another pharmacist remember seeing the isotretinoin in the wrong location next to the acitretin. We think this may have been moved in error, as we have staff members that work between two pharmacies, and the other pharmacy stores these two medicines together in a drawer. This change in location may have contributed to the selection in the wrong item.'

Ms B also explained that the dispensary was busy at the time at which the error occurred, with increased interruptions and only two rostered staff members working at any one time.

Dispensing and checking standard operating procedures (SOPs)

25. The pharmacy's Dispensing SOP at the time of the events did not contain a step-by-step process for dispensing medication.[6] The Dispensing SOP stated: '[L]ook alike/sound alike drugs are highlighted on dispensary shelves to alert dispensers to the potential for errors.'

26. Ms B told HDC that the Dispensing SOP has now been updated[7] to include 'the 2nd part of the label to the script (front or back), for the checker to check stock on hand. This label contains the drug name, and the current stock on hand details.'

27. The Checking SOP at the time of events did not contain a step-by-step process for checking the medication dispensed.[8] This SOP stated that the checking procedure should not include annotation, looking up the computer or checking details, as these tasks should have been completed at the dispensing stage. Ms B told HDC that the Checking SOP has been updated to 'include checking the stock on hand figure on the 2nd part of the dispensary label that is stuck onto the prescription'. This label acts as 'another place to check the medication dispensed against'.

28. Both the Dispensing and Checking SOPs required the pharmacist to ensure a gap between dispensing and checking if the pharmacist was working on their own. Ms B has not indicated whether she ensured that there was a gap between dispensing and checking Ms A's medication.

29. Both the Dispensing and Checking SOPs stated that the pharmacist was responsible for the final check for dispensing, and that there should be minimal distraction when counting or measuring to maintain high standards of accuracy. Although Ms B did not confirm whether she was distracted at the time of events, she told HDC that whenever she is interrupted, she will start the checking process again and will delegate phone calls to the shop staff if she is in the middle of dispensing or checking.

Management of dispensing error

30. After the dispensing error was discovered on 29 April 2021, in accordance with the Pharmacy's Error Reporting SOP,[9] Ms B filled out the Pharmacy Defence Association (PDA) Incident Notification Form about the dispensing error.[10]

[6] The Dispensing SOP (v6.2a4) was created and approved by Ms B. This version was issued in April 2019. The purpose of the SOP is to 'ensure that the actual dispensing process is carried out with accuracy, efficiency, and consistency and to reduce the workload of the checker'.

[7] Page 1 of the Dispensing SOP now includes the requirement that 'if room allows, stick 2nd part of the label on the script front or back for the checker to check stock on hand figure'.

[8] The Checking SOP (v6.2a5) was created and approved by Ms B. This version was issued in April 2019. The purpose of this SOP is to 'ensure that each prescription has been dispensed and checked in a systematic manner and that the persons responsible are easily identifiable'.

[9] Issued in April 2019.

[10] The Pharmacy Defence Association is a non-profit, pharmacist support organisation that provides pharmacists with support for professional indemnity, public liability, and statutory liability claims.

31. In terms of contacting Ms A's GP to inform him about the dispensing error, Ms B told HDC:

> 'At this point, I tried to contact [Ms A's] doctor, [Dr C], but he was not working that afternoon. I filled out an incident form and reflected on possible causes for the error. Unfortunately, I did not hear back from her doctor, and mistakenly forgot to set a reminder to follow up.'

32. Ms B said that she forgot to follow up with Dr C because at that time she was following up with a Ministry of Health spot audit, and she was feeling overwhelmed because of significant events happening in her family life. She was also planning to be on leave shortly afterwards, so was ensuring that 'everything was up to date and handed over to other dispensary staff members'. Ms B said that she was also affected by supporting another staff member with health issues at the time of events.

33. The Incident Notification Form documented the following:

- The incorrect medication was taken for 22 days.
- An apology was given by Ms B and accepted by Ms A.
- The error was explained to Ms A and she was asked if she had experienced any health issues. No change was noted from taking the incorrect medication.
- Ms B was unsure of the cause of the dispensing error, which possibly could have occurred because of distraction or by not double checking carefully.
- Ms A's GP was notified and is following up with a dermatologist. It was noted that Ms A had an IUD in place and had had a pregnancy test.[11]

34. The Incident Notification Form was sent to the PDA on 5 July 2021 (67 days after the error was identified). Ms B wrote to the PDA representative that the delay in sending the Incident Notification Form for the dispensing error was because of the Ministry of Health spot audit follow-up and because she was on leave from work.

Subsequent events after discovery of dispensing error

35. On 30 June 2021, Ms A presented to Dr C for a wrist injury. During the consultation, it emerged that Dr C was unaware of the dispensing error and had not been contacted by Ms B. Ms A described the error to Dr C, who then informed her that he would follow up with Ms B.

36. Following the GP consultation, Dr C emailed Ms B on 30 June to confirm the details about the dispensing error. Ms B replied and apologised for not having informed him of the error. Dr C also expressed concerns about the seriousness of the side effects of the medication and the side effects it could have on Ms A's planning for pregnancy.

37. On 2 July 2021, Dr C arranged a further appointment with Ms A to discuss that the medication given to her in error was acitretin, and to explain the possible adverse side

[11] This information was handwritten into the Incident Notification Form for the PDA following Ms B's correspondence with Dr C from 1 July 2021, so it was not originally included in the form on 29 April 2021.

effects of taking it. Dr C advised Ms A that she should not conceive children within the time frame of three years. Ms A told HDC:

> 'After three and a half weeks of taking Acitretin, I was never warned about the side effects after taking it, I was never told by the pharmacist what the drug I was taking was until I saw [Dr C] on Friday 2nd July, but as a result of this I have been told I cannot conceive children for the time frame for 3 years.'

Further information

Ms A

38. Ms A told HDC that the dispensing error has had 'a huge effect' on her and her family with the delay in starting her family. She feels that this error has taken her choices away alongside the trauma and stress this has caused her and her partner. Ms A said that she is concerned about the competence of Ms B, as she provided her with the wrong medication and failed to follow up with her about the error and the adverse side effects.

Ms B

39. Ms B told HDC that she had not been aware that Ms A wanted a further explanation of how the dispensing error had occurred. Ms B said that she had no communication with Ms A following the identification of the error on 29 April 2021.

40. Ms B told HDC that following the dispensing error, she reflected on her dispensing and checking practices and made further changes (discussed below).

Pharmacy Council of New Zealand | Te Pou Whakamana Kaimatū o Aotearoa

41. HDC wrote to the Pharmacy Council of New Zealand|Te Pou Whakamana Kaimatū o Aotearoa to determine whether the Council would undertake a competence review and/or disciplinary actions against Ms B based on the information gathered.

42. The Pharmacy Council told HDC that it was 'unlikely to undertake a competency review or disciplinary action' for Ms B. However, the Pharmacy Council said that because of the serious nature of the incident and the adverse outcome for the patient, it undertook a practice visit as part of its preliminary enquiries process.

43. The Pharmacy Council noted that Ms B has taken full responsibility for the incident and shown genuine remorse and empathy. She has also taken remedial steps to investigate the cause of the error and has made improvements to her practice to avoid a similar incident occurring. The Pharmacy Council said that accordingly, it 'does not have any information to suggest [Ms B] lacked clinical competence', and the incident appears to have been 'the result of poor dispensing and checking process for this case, with work and personal stressors contributing'.

44. The Pharmacy Council concluded: 'As stated above, it is the Council's preliminary view that this incident is a result of work, personal and systems pressures rather than incompetence.'

Responses to provisional opinion

Ms A

45. Ms A was provided with the opportunity to comment on the 'information gathered' section of the provisional opinion, and her comments have been incorporated into this report where relevant.

46. Ms A told HDC that she was not provided with an information sheet on the acitretin once the wrong medication had been discovered. She said that approximately 12 months after the incident, she received an information sheet from the pharmacy for an anti-inflammatory medication that was unrelated to the events.

47. Ms A told HDC that she is concerned that Ms B was not familiar with the serious side effects of acitretin, which were not communicated to her. Ms A stated:

> 'I would assume a pharmacist has a very extensive and in-depth program to locate information on medication they dispense given their responsibility. I struggle to understand how that was missed at the time that [Ms B] researched further into Acitretin before attending to me in the pharmacy to notify me of the mistake of [the] incorrect medication given to me.'

48. Ms A concluded:

> 'It is vital that processes are put in place and followed in dispensing medication so this severe error that happened to me, does not happen to someone else. At the time of dispensing my medication; if there were processes in place they unquestionably failed me.'

Ms B

49. Ms B was provided with the opportunity to comment on the provisional opinion and had no further comment to make.

Pharmacy

50. The owner of the pharmacy at the time of the events was provided with the opportunity to comment on the provisional opinion and had no further comment to make.

51. The current owner of the pharmacy was provided with the opportunity to comment on the provisional opinion. In accordance with the recommendations made in the provisional opinion, the current owner advised that it has now undertaken an audit of the standard operating procedures and actioned the changes 'being used as standard operating procedures'.

52. The current owner also interviewed Ms B about the matter and is satisfied with the steps she has taken since the incident. The current owner told HDC:

> 'Since we took over, our observation of [Ms B's] quality of work has been very good. We did not find issues with her professional capabilities. If anything, looking back during that period of COVID pressure to the physical and mental state of any frontline medical

staff, we were impressed with her resilience to still turn up daily and perform her duties as a professional while under investigation.'

Relevant standards

53. The Pharmacy Council of New Zealand Competence Standards for the Pharmacy Profession (2015) (the Pharmacy Competence Standards) state:

> 'O3: Supply and administration of medicines
>
> Competency O3.2 Dispense Medicines
>
> O3.2.1 Maintains a logical, safe and disciplined dispensing procedure.
>
> O3.2.2 Monitors the dispensing process for potential errors and acts promptly to mitigate them.
>
> …
>
> O3.2.5 Accurately records details of medications incidents and actions taken, including clinical and professional interventions, to minimise their impact and prevent recurrence.'

54. The Pharmacy Council issued a Writing Standard Operating Procedures (SOPS) guideline in August 2008, which was updated in December 2017. Page 3 states:

> '*Dispensing SOP*
>
> Pharmacists are accountable for the dispensing process, but in developing and working to SOPs, should be able to benchmark current practice and ensure that systems of practice operating within their pharmacy is safe. SOPs should cover all aspects of the dispensing process, including the delivery of the medicine or product to the patient, and must comply with professional requirements applying to the dispensing process. The added-value of the pharmaceutical service i.e. the pharmacist's professional input into the assessment of the safety and appropriateness of a prescription and, in the provision of information and counselling when completed prescriptions are transferred to patients, should be explicit.
>
> The dispensing process should be clearly defined in the SOP and it should specify which activities must be carried out personally by a pharmacist, including the clinical check (see Council Newsletter August 2016), which activities can be delegated to [identify] competent support staff and how the checks for accuracy are to be carried out. It is good practice for SOPs to incorporate an audit trail so that the pharmacist can determine who is responsible for each aspect of the process i.e. for each item on the prescription, the dispenser and the checking pharmacist should be clearly identified.'

Opinion: Ms B

55. Ms B is a registered pharmacist and was employed at the pharmacy at the time of events. As a healthcare provider, Ms B had an obligation and responsibility under the Pharmacy Competence Standards to dispense the correct medication to Ms A.

56. It is a fundamental patient safety and quality assurance step in the dispensing process to check the accuracy of the medication being dispensed against the prescription. However, in this case, Ms B inadvertently selected and dispensed the wrong medication, and subsequently failed to inform Ms A's GP of her error.

Dispensing error — breach

57. On 7 April 2021, Ms A presented to Ms B at the pharmacy for a prescription of isotretinoin to treat her acne. As the only pharmacist present at the time, Ms B was responsible for filling the script, which included processing, selecting, dispensing, and checking the medication.

58. Instead of providing Ms A with isotretinoin, Ms B mistakenly provided her with acitretin inside a box labelled isotretinoin. The dispensing error was later discovered by a pharmacy technician when Ms A returned for a repeat prescription on 29 April 2021.

59. First, I acknowledge that Ms B has accepted full responsibility for the dispensing error and has since undertaken a review of how the error occurred. Ms B told HDC that she processed the isotretinoin prescription through her computer correctly but 'inadvertently dispensed acitretin in error' and did not identify the error in her final check.

60. Ms B suggested that the isotretinoin may have been stored in the wrong place at the time, as she remembered seeing the isotretinoin in the wrong location next to the acitretin. I am concerned that Ms B did not proactively correct this issue when it was first identified.

61. I am unable to determine with certainty how Ms B picked the wrong medication, but, as acknowledged by Ms B, most likely she selected the acitretin in error and did not double check the medication before putting it into the box for Ms A.

62. The Pharmacy Competence Standards state that a pharmacist must maintain a logical, safe, and disciplined dispensing procedure for potential errors. In this case, Ms B did not comply with this standard, as she dispensed acitretin instead of isotretinoin, and failed to double check that the correct medication had been dispensed.

63. The Pharmacy Competence Standards also state that a pharmacist should monitor the dispensing process for potential errors and act promptly to mitigate them. I remind Ms B that she has a duty to identify risks to her practice in order to mitigate harm to her patients, as part of her professional responsibility.

64. I note that the pharmacy's Dispensing and Checking SOPs do not set out clearly the steps for the pharmacist to follow to ensure that the correct medication is selected. I have made further comments about this in my opinion about the pharmacy.

Failure to inform GP – breach

65. After discovering the dispensing error and disclosing this to Ms A, Ms B did not ensure that Ms A's GP, Dr C, was informed of the dispensing error promptly. It was only after Ms A told Dr C about the dispensing error on 29 June (two months after discovery of the acitretin error) that Dr C contacted Ms B and was informed by her about the incident.

66. Ms B told HDC that various factors (see paragraph 32 above) made her forget to follow up with Dr C. I acknowledge that these factors would have had an impact on Ms B at the time. However, acitretin is a medication with serious side effects, and it was essential for Dr C to be informed of this to enable him to advise Ms A appropriately and avoid any further harm to her. Ms B's omission to do so is unacceptable.

Conclusion

67. Ms B had a professional responsibility to ensure that the right medication was dispensed to Ms A. Ms B's dispensing error had a serious impact on Ms A's ability to start a family.

68. As outlined above, Ms B failed to provide services in accordance with the relevant professional standards as set out by the Pharmacy Council, and with the Pharmacy's SOPs. As a result, Ms B dispensed the incorrect medication to Ms A. Ms B then failed to inform Ms A's GP of her dispensing error promptly. Accordingly, Ms B failed to provide Ms A with services in accordance with professional standards and breached Right 4(2) of the Code.[12]

Explanation of side effects — adverse comment

69. After the acitretin error was discovered, Ms B dispensed the correct medication and apologised to Ms A. Ms B told HDC that she informed Ms A that she had been given acitretin in error, and asked Ms A if she was experiencing any side effects and whether she was on birth control. Ms B then provided Ms A with information about isotretinoin.

70. Ms B told HDC that at the time of disclosing the error to Ms A, she was unaware that patients who have taken acitretin were required to avoid pregnancy for three years. Accordingly, this was not communicated to Ms A when the error was discovered. Following the error, Ms B had no communication with Ms A and was unaware that she had wanted a further explanation of how the dispensing error had occurred.

71. In contrast, Ms A told HDC that she was not informed by Ms B of the name of acitretin, nor about the adverse side effects. Ms A said that Ms B only told her to take the isotretinoin. Ms A stated that she was informed that the incorrectly dispensed medication was called acitretin, and about the adverse side effects, only after seeing Dr C on 2 July 2021.

72. I note that there is a conflict of evidence in whether the medication name 'acitretin' was disclosed to Ms A by Ms B on 29 April 2021. I am unable to determine whether this occurred at the time. In terms of side effects, Ms B has acknowledged that at the time of discovering her error she was unaware of some of the side effects of acitretin, and I consider it more

[12] Right 4(2) of the Code states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

likely than not that Ms A received a full explanation of all the adverse side effects of acitretin only once she saw Dr C on 2 July.

73. In my view, a reasonable pharmacist should conduct a thorough and comprehensive review about an incorrectly dispensed medication and inform the affected patient immediately about any potential adverse side effects. It is clear that at the time of discovering her error, Ms B checked for information about acitretin, but did not appreciate that there were serious side effects. Accordingly, I am critical that Ms A did not receive a comprehensive explanation from Ms B about the adverse side effects of taking acitretin.

Opinion: Pharmacy — adverse comment

74. The pharmacy had a duty to ensure that it provided services to Ms A with reasonable care and skill. This included ensuring that its pharmacists provided safe, accurate, and efficient dispensing services. The pharmacy also had an obligation to ensure that it had in place adequate policies and SOPs to facilitate safe dispensing and checking.

75. At the time of events, Ms B was the main pharmacist and was responsible for dispensing Ms A's prescription. Ms B accepts that she did not identify that she had dispensed the incorrect medication, and I have found her in breach of Right 4(2) of the Code. The Pharmacy Council told HDC that potential 'systems pressures' may have contributed to Ms B's error. Accordingly, I have also considered whether there were systemic issues at the pharmacy that contributed to the error.

76. Ms B provided HDC with the Dispensing and the Checking SOPs that applied at the time of events. SOPs provide important guidance to staff to support them to comply with professional and practice standards. I have reviewed both SOPs, including the updated versions, and neither contained step-by-step processes for dispensing and checking.[13] I consider that a lack of clear guidance in the SOP contributed to the error occurring.

77. I have also identified that the Dispensing SOP required look-alike medications to be highlighted on dispensary shelves to alert dispensers to the potential for errors. Ms B told HDC that at the time of events there were no labels to alert the dispenser of the potential risk of selecting the wrong medication, despite them being stored alphabetically. Whilst I acknowledge that this appears to have been rectified following Ms A's complaint, I am critical that this was not in place at the time of events, as required by the SOP.

78. Accordingly, I am critical of the adequacy of the pharmacy's Dispensing and Checking SOPs that were in place at the time of events, and for not highlighting look-alike medications on the dispensary shelves, and I will make recommendations to address my concerns.

[13] See relevant Pharmacy Council of New Zealand Writing Standard Operating Procedures (SOPs) in the 'relevant standards' section of this report.

Changes made since events

79. Ms B told HDC that following the dispensing error, she made several changes to both her practice and the pharmacy's systems to prevent a similar error from happening, including the following:

- Ensuring that both acitretin and isotretinoin are separated on the dispensary shelves and adding warning stickers to dispensing staff to double check these medicines.
- Reminding staff that all medications are to be stored alphabetically.
- Underlining of the name and strength of the medicine on the prescription in the final checking procedure.
- Writing both the brand name and generic name on the prescription.
- Not rushing her processes and taking her time while dispensing and checking.
- Utilising a dispensing diary to prevent the oversight of overlooking any follow-up, and making notes to follow up if an issue has not been resolved.
- Having meetings with her employer and colleague to discuss her work pressures and workload.
- Discussing with her technician the double checking of prescriptions prior to the final check, in order to reduce the pressure on her to dispense.
- Updating the Dispensing SOP to include attaching the second part of the label to the script (front or back) for the checker to check.
- Updating the Checking SOP to include checking stock on hand on the second part of the dispensary label that is on the prescription. The Checking SOP has also been updated to utilise the technician for an 'in-between' second check if they are available.
- Updating the Error Reporting SOP to include information regarding contacting the prescriber.
- Familiarising herself with acitretin by reading the Medsafe datasheet for it and adding a note to the dispensary software to remind staff to warn patients not to consume alcohol while taking acitretin.
- Taking the 'Error Prevention' topic as part of her continued professional development cycle and purchasing the 'Improved Accuracy and Self-Checking Workbook' to complete her learnings.

Recommendations

80. Taking into account the comprehensive changes made by Ms B, and the information provided by the Pharmacy Council, I recommend that Ms B:

a) Provide a written apology to Ms A for the breach of the Code identified in this report. The apology is to be sent to HDC, for forwarding to Ms A, within three weeks of the date of this report.

b) Provide a written report to HDC on the effectiveness of the changes she has implemented as a result of this case, and on the learnings she has implemented from the 'Error Prevention' learning module. The report should be provided to HDC within three months of the date of this report.

81. In response to my recommendation made in the provisional opinion, the pharmacy undertook an audit of its existing SOPs (ie, the Dispensing SOP and Checking SOP) and updated them to ensure that they are in accordance with the Pharmacy Competence Standards.[14] Having completed this, I now recommend that the pharmacy provide HDC with a report containing further details on the audit and evidence of any changes made as a result, including copies of the Dispensing and Checking SOPs. The report should be provided to HDC within three months of the date of this report.

Follow-up actions

82. A copy of this report with details identifying the parties removed will be sent to the Pharmacy Council of New Zealand|Te Pou Whakamana Kaimatū o Aotearoa, and it will be advised of Ms B's name in the covering correspondence.

83. A copy of this report with details identifying the parties removed will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[14] For the Dispensing SOP, the dispensing process should be clearly defined and should specify which activities must be carried out personally by a pharmacist, including the clinical check.