Dispensing error: tenoxicam instead of tamoxifen (13HDC01235, 4 June 2014)

Pharmacy ~ Pharmacist ~ Dispensing medication ~ Selection error ~ Insufficient measures ~ Standard operating procedures ~ Inadequate care ~ Right 4(1)

In 2012 a woman underwent a bilateral mastectomy and chemotherapy due to breast cancer. Consequently, she was prescribed a five-year course of tamoxifen, a drug for the treatment of breast cancer. She started the course in mid-2012.

In 2013, she presented a repeat prescription at the pharmacy for a further three-month supply of tamoxifen. She noticed that the tablets she was dispensed were different from previous ones. However, she attributed the difference in appearance to funding changes and took the tablets for three months.

Five months later, the woman returned to the pharmacy to collect a further supply of tamoxifen tablets. Upon collecting the tamoxifen tablets, she noticed a return to the round white pills she was used to.

The woman queried with staff at the pharmacy about the changes in the medication. It was then established that she had been dispensed tenoxicam instead of tamoxifen five months earlier. Tenoxicam is described as an antirheumatic, anti-inflammatory and analgesic agent.

The pharmacy undertook an investigation to determine how the error occurred. It was noted that the woman's prescription was correctly entered into the computer, as a label for 20mg tamoxifen was generated. However, tenoxicam 20mg was incorrectly selected from the shelf and dispensed to the woman.

At the time of the error, the pharmacy's standard operating procedures (SOPs)required that the dispenser and checker must be able to be identified at all times. However, the pharmacy was unable to identify the pharmacist responsible for the dispensing error, as the woman's prescription was not initialled by the dispenser.

It was held that the pharmacy's failure to have sufficient measures in place within the pharmacy environment to ensure knowledge of, and compliance with, its SOPs played a significant part in the woman receiving the incorrect medication. In particular, the pharmacy failed to place an alert or precaution notice near the tamoxifen and tenoxicam, did not regularly review and update its SOPs, was unable to demonstrate that staff read the SOPs and, despite being aware of ongoing non-compliance with the dispensing SOP, failed to enforce compliance. Accordingly, the pharmacy did not provide services to the woman with reasonable care and skill and breached Right 4(1).