Pharmacy dispensing and labelling errors
(13HDC01718, 26 August 2015)

Pharmacist ~ Pharmacy ~ Dispensing ~ Labelling ~ Documentation ~ Professional standards ~ Code of Ethics ~ Rights 4(1), 4(2)

A woman was prescribed Effexor-XR 37.5mg capsules by her general practitioner and presented her prescription at a pharmacy. About one month later, the woman returned to the pharmacy to collect her first repeat for Effexor-XR, but was dispensed 75mg capsules instead of 37.5mg capsules. She brought this to the attention of a pharmacist who apologised and provided the correct capsules. The pharmacist did not complete an incident report form at the time.

Approximately one month later, the woman was prescribed nadolol 40mg tablets. She presented her prescription at the pharmacy the same day, and collected her medication. It was later discovered that a second pharmacist incorrectly dispensed the woman propranolol 40mg tablets.

Approximately two months later, the woman was prescribed Konsyl-D powder. The woman presented the prescription at the pharmacy and was dispensed the correct medication by the pharmacist, but the label did not include the complete dosage instructions. The computer records were subsequently updated to document incorrectly that the woman had two repeats available on the prescription.

One month later, the woman obtained a prescription for further Konsyl-D powder. She presented her prescription at the pharmacy on the same day and was incorrectly advised that she had a repeat for Konsyl-D remaining on her previous prescription. The pharmacist dispensed the Konsyl-D powder as per her new prescription. The dosage instructions on the label were consistent with the new prescriptions but the incorrect prescriber was recorded on the label.

Approximately one month later the woman collected Konsyl-D from the pharmacy. The woman was given a repeat, accurately documented in the pharmacy's computer records as owing from her second prescription. However, the incorrect prescriber was again recorded on the label. On this occasion, the woman was also dispensed a repeat incorrectly documented in the pharmacy's computer records as owing to her.

It was held that the first pharmacist failed to ensure that he dispensed the correct strength of Effexor-XR to the woman, incorrectly labelled the Konsyl-D medication on three occasions, and failed to complete incident report forms in a timely manner. Furthermore, by amending the records without ensuring that he kept a record of those amendments, the pharmacist acted in an unprofessional and misleading way, and failed to minimise the potential harm to the woman, contrary to the Pharmacy Council of New Zealand's Code of Ethics. Accordingly, the pharmacist failed to provide services that complied with professional standards and breached Right 4(2).

The second pharmacist failed to ensure that she dispensed the correct medication to the woman and failed to provide services that complied with professional standards, and breached Right 4(2).

The pharmacy's failure to ensure staff compliance with its SOPs played a significant part in the woman receiving the incorrect medication on two occasions, and her medication being labelled incorrectly on three occasions. Accordingly, the pharmacy did not provide services to the woman with reasonable care and skill and breached Right 4(1). Adverse comment was made with regard to the pharmacy not having a system in place to ensure that any amendments to documentation were recorded.