Pharmacist

Report on Opinion - Case 98HDC18025

Complaint

The Commissioner received a complaint from the complainant regarding the standard of service her mother, the consumer, received from the pharmacist, at a pharmacy in a city. The complaint has been summarised as follows:

- *Twelve months ago the consumer was wrongly dispensed digoxin 0.0625mg tablets instead of the prescribed digoxin 0.25mg tablets by the pharmacist.*
- *In mid-August 1998 the pharmacist wrongly dispensed a three monthly prescription of warfarin tablets to the consumer. Instead of dispensing 1mg tablets, 3mg tablets were dispensed.*
- *On both occasions the consumer noticed the error before the tablets were taken. The consumer raised the concern with the Pharmacy on both occasions. The explanation given by the pharmacist was not satisfactory.*

Investigation Process

The Commissioner received the complaint on 25 September 1998 and an investigation was undertaken. Information was obtained from the following:

The Complainant, the Consumer's Daughter
The Pharmacist/Provider
The Dispensary Technician at the Pharmacy
The General Practitioner

Copies of the consumer's September 1997 prescription for *digoxin* and August 1998 prescription for *warfarin* were obtained. A copy of the label from the container of the *digoxin* tablets dispensed in early October 1997 was also obtained.

Pharmacist

Report on Opinion – Case 98HDC18025, continued

Information Gathered During Investigation

In early September 1997 the consumer obtained a prescription for *digoxin* (heart medication) from her general practitioner who works from a medical centre in the consumer's home city. The prescription was presented to the pharmacy, also in her home city in early October 1997. The copy of the general practitioner's prescription obtained by the Commissioner read:

"DIGOXIN TABLETS, 0.25MGS
Mitte: 90
1 DAILY"

The label on the box in which the medication was dispensed read:

"DO NOT TAKE WITH ANTACIDS, IRON OR CALCIUM
30 DIGOXIN TABS 0.0625MG [LAN]
TAKE ONE TABLET DAILY WITH FOOD
1 Repeat By [early]*Dec97*
[the consumer]
702626/2 [the date]*Oct97* […] [the consumer's address]*"*

After uplifting the medication the consumer went away on a holiday and did not realise the dispensing error until she opened the container and noticed that the tablets were a different colour than the ones she normally took. The consumer phoned her daughter who, after consulting with another pharmacist, advised her to take four of the 0.0625mg tablets she was dispensed which equated to one 0.25mg tablet (the strength of tablet that the consumer should have been dispensed).

The pharmacist said to the Commissioner that after the mistake had been brought to her attention that she ensured that the consumer had an adequate supply of the medication for the period prescribed by the general practitioner, apologised to the consumer for the error, offered to pay for the toll-call the consumer had to make and gave the consumer a gift-wrapped bar of soap in recognition of the error and inconvenience caused to the consumer. The pharmacist denied the complainant's suggestion that she did not take the error seriously.

Continued on next page

Pharmacist

Report on Opinion – Case 98HDC18025, continued

Information Gathered During Investigation, *continued*

The medication was prepared by the dispensary technician whose initials appear in the "*dispensed*" box on the prescription form. The medication was checked and dispensed by the pharmacist whose initials appear in the "*checked box*" on the prescription form. The pharmacist failed to pick up the error that the label on the stock bottle did not match the prescription and the label on the container in which the medication was being dispensed.

In mid-August 1998 the consumer was prescribed *warfarin* (an anticoagulant) by the general practitioner, now at another medical centre in the same city. The prescription read:

"WARFARIN (Marevan), tabs, 1 mg
take 3&1/2 daily (3.5mg)
Mitte: 3 MONTHS"

Instead of being dispensed *warfarin* 1mg tablets, the consumer was dispensed *warfarin* 3mg tablets. When the consumer realised that a dispensing error had been made, she phoned the pharmacist who acknowledged to her that an error was made and apologised for it. Keen to correct the mistake the pharmacist promptly dispatched a delivery person to collect the incorrectly dispensed medication and deliver the right strength tablets. The returned container confirmed that wrong strength medication was dispensed. The pharmacist was responsible for all stages of dispensing this prescription, as her dispensary technician was not involved.

The pharmacist acknowledged that errors were made on each occasion, that each was potentially dangerous and that they were essentially human errors. At the time the errors occurred the pharmacist did not have a formal complaints procedure in place.

Pharmacist

Report on Opinion – Case 98HDC18025, continued

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumer's Rights apply:

RIGHT 4
Right to Services of an Appropriate Standard

...

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

...

RIGHT 10
Right to Complain

...

6) Every provider, unless an employee of a provider, must have a complaints procedure that ensures that –

...

b) The consumer is informed of any relevant internal and external complaints procedures, including the availability of-

i. Independent advocates provided under the Health and Disability Commissioner Act 1994; and

ii. The Health and Disability Commissioner; and

c) The consumer's complaint and the actions of the provider regarding that complaint are documented.

...

Pharmacist

Report on Opinion – Case 98HDC18025, continued

Relevant Standards

Pharmaceutical Society of New Zealand Code of Ethics, December 1996:

Rule 2.1
"A pharmacist must safeguard the interest of the public in the supply of health and medical products".

Rule 2.11
"A pharmacist must be responsible for maintaining and supervising a disciplined dispensing procedure that ensures a high standard is achieved".

Rule 2.24
"A pharmacist must ensure the safe and efficient delivery of medicines in accordance with legislation and Council guidelines and policies".

Rule 2.28
"A pharmacist must ensure that a documented procedure is followed for handling complaints so that a satisfactory resolution is reached. Consumers must be informed as to where they can further complain if a satisfactory resolution is not reached and of their rights under the Code of Rights for Consumers of Health and Disability Services".

Pharmaceutical Society of New Zealand Pharmacy Practice Handbook January 1998:

2.2 Quality Standards for Pharmacy in New Zealand
Section 6.2 Dispensing
6.2a *"Procedures for dispensing and supply of pharmaceuticals are developed, documented and approved by the pharmacist."*

Pharmacist

Report on Opinion – Case 98HDC18025, continued

Opinion: Breach

In my opinion the pharmacist breached Right 4(2) and Right 10(6)(b) and (c) of the Code of Health and Disability Services Consumers' Rights.

Right 4(2)

In early October 1997 the consumer was dispensed *digoxin* 0.0625mg tablets rather than *digoxin* 0.25mg tablets as prescribed by her general practitioner. If the consumer had followed the instructions on the medication container label, she would have taken only a quarter of the dose prescribed by her doctor.

In mid-August 1998 the consumer was dispensed *warfarin* 3mg tablets rather than *warfarin* 1mg tablets as prescribed by her general practitioner. The prescription was for a three-month period. If the consumer had taken the dispensed medication she would have taken a triple dose of the anticoagulant prescribed by her doctor.

The Pharmaceutical Society regards the dispensing of a correct medicine as a basic professional standard. The pharmacist breached Rules 2.1, 2.11 and 2.24 of the Code of Ethics of the Pharmaceutical Society of New Zealand (December 1996).

At the time of the dispensing errors were made, the pharmacist did not have a documented procedure for dispensing medications. In its "*Pharmacy Practice Handbook*" the Pharmaceutical Society of New Zealand issues "*Quality Standards*" guidelines to its members in relation to the dispensing of medicine. Standard 6.2a instructs the pharmacist to ensure that procedures for dispensing and supply of pharmaceuticals are developed, documented and approved by the pharmacist. The pharmacy did not have a documented dispensing procedure in place at that time and therefore did not comply with standard 6.2a.

In my opinion the pharmacist did not provide services of an appropriate standard. She did not ensure that the correct medication was dispensed or have a dispensing procedure in place that would have alerted her to a wrong medication being dispensed. As a consequence the pharmacist did not comply with appropriate professional standards.

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Pharmacist

Report on Opinion – Case 98HDC18025, continued

Opinion: Breach, *continued*

Right 10(6)(b)(c)

At the time the dispensing errors were made, the pharmacy did not have a documented complaint procedure. In my opinion the pharmacist therefore was in breach of Right 10(6)(b) and (c) and also did not meet Rule 2.28 of the Code of Ethics of the Pharmaceutical Society of New Zealand (December 1996).

Actions

The pharmacist forwarded a copy of her newly drafted Dispensing Procedure dated 26 August 1998 and Complaints Procedure dated 30 July 1998. The Procedures were due for review on 26 August 1999 and 30 July 1999 respectively.

The pharmacist indicated she would take steps to delegate more of her workload, repeat a stress management course and consider taking a counselling option provided by the Pharmaceutical Society should other measures taken prove inadequate.

The location of different *digoxin* stock bottles on the pharmacy shelf has been rearranged to reduce the likelihood of wrong dosage being dispensed.

The pharmacist apologised again, through the Commissioner, for the stress and inconvenience caused to the consumer and for exposing her to potential harm.

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Pharmacist

Report on Opinion – Case 98HDC18025, continued

Actions, *continued*

I recommend that the pharmacist:

- Apologises to the consumer in writing. The letter is to be sent to the Commissioner who will forward it to the consumer.
- Confirms she has read the Code of Rights, has viewed the video ("*The Health and Disability Commissioner, the Code of Rights and the Advocacy Service – An Introduction for Providers*") and understands her obligations under the Code.
- Regularly reviews her dispensing procedure to ensure that the possibility of similar dispensing errors is minimised. Procedures must be reviewed periodically and should show the date of such review.
- Confirms that the dispensing procedure was reviewed in August 1999 and that it complies with the standards set by the Pharmaceutical Society.
- Confirms that her complaint procedure was reviewed in July 1999 and that it complies with the Pharmaceutical Society of New Zealand Code of Ethics Rule 2.28.

Other Actions

A copy of this opinion will be sent to the consumer and the Pharmaceutical Society of New Zealand.