Patient hospitalised after wrong medication dispensed (13HDC01413, 19 December 2014)

Pharmacist ~ Pharmacy ~ Dispensing error ~ Checking ~ Generic substitution ~ Standard operating procedures ~ Professional standards ~ Right 4(2)

A woman visited a pharmacy to collect a prescription for mesalazine (Pentasa) which is used to treat ulcerative colitis, and atorvastatin (Lipitor) which is a cholesterol-lowering medication. The sole pharmacist on duty at the pharmacy that day dispensed her medications, intentionally replacing Lipitor with another brand of atorvastatin, Zarator. The pharmacist mistakenly dispensed Salazopyrin instead of Pentasa. Salazopyrin is another medication used to treat ulcerative colitis, but it can cause liver abnormalities. The pharmacist did not speak directly to the woman when she enquired with a shop assistant about the change from Pentasa as he mistakenly believed she was querying the change from Lipitor.

The woman started taking the medications dispensed by the pharmacist. She began to feel extremely fatigued and took time off work. Her blood test results were markedly deranged, and her GP discovered that she had been taking Salazopyrin in place of Pentasa for approximately three weeks. The woman was admitted to hospital with a primary diagnosis of deranged liver function. The overall opinion was that her condition was caused by a reaction to Salazopyrin. The woman was discharged from hospital after five days.

The pharmacy had relevant Standard Operating Procedures in place at the time, and the pharmacist accepts that he did not follow the checking procedure required by the Standard Operating Procedure. The pharmacist failed to ensure that he dispensed the correct medication and failed to counsel the woman effectively about her medications, resulting in a missed opportunity to identify the error at the outset. It was held that the pharmacist did not comply with professional standards and breached Right 4(2).

The error occurred as a result of the pharmacist's individual conduct as opposed to systemic issues at the pharmacy. Therefore, the pharmacy was not held vicariously liable for the pharmacist's breach.

Adverse comment was made about another pharmacist at the pharmacy in relation to a later interaction with the woman when she raised concerns about changes to her medication.