Pharmacist, Ms C

Pharmacy

A Report by the
Deputy Health and Disability Commissioner

(Case 20HDC00036)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns two dispensing errors by a Charge Pharmacist at a pharmacy. On two separate occasions, the pharmacist mistakenly dispensed Ropin 1mg instead of Rolin 1mg to a woman (aged in her nineties).

2. The report highlights the importance of undertaking adequate checks and steps during the dispensing of medication and adhering to robust standard operating procedures (SOPs). The report also highlights the importance of pharmacy providers ensuring that staff are familiar with SOPs, and of monitoring compliance with policies and guidelines to ensure safe practice.

Findings

3. The Deputy Commissioner considered that the pharmacist failed to provide services in accordance with the relevant professional standards as set out by the Pharmacy Council of New Zealand and the pharmacy's SOPs. This included the failure to undertake adequate checks on 17 October 2019, resulting in the initial medication selection error not being identified. The failure to review the woman's dispensing history adequately on 6 January 2020 meant that the previous error was not identified, and a flag that a discussion with the woman or her daughter was required before the medication was handed over was omitted. In addition, the pharmacist undertook all parts of the dispensing and checking process on 6 January 2020 herself without breaking up the steps.

4. Accordingly, the Deputy Commissioner found that the pharmacist failed to provide services in accordance with professional standards, and breached Right 4(2) of the Code. The Deputy Commissioner was also critical of the pharmacist's incident management following the errors.

5. The Deputy Commissioner considered that on both occasions the failures were a result of staff failing to comply with the pharmacy's SOPs, and that the pharmacy had a responsibility to ensure that its staff adhered to its policies and guidelines. The Deputy Commissioner considered that the pharmacy failed to support its staff adequately in making them aware of the requirements of the SOPs, and that its response to the errors at an organisational level was inadequate. Accordingly, the Deputy Commissioner found the pharmacy in breach of Right 4(1) of the Code.

Recommendations

6. The Deputy Commissioner noted that both the pharmacist and the pharmacy had made several changes following these incidents.

7. The Deputy Commissioner recommended that the pharmacy undertake the following:

- An audit of staff compliance with the updated dispensing process SOP, and where any departures are identified, the pharmacy should provide details of what steps it has taken to address the issues identified.
- An audit of staff compliance with the updated dispensing errors SOP.

- Use an anonymised version of this report to educate staff.
- Provide HDC with a copy of its "near misses" log and details of steps taken to address any issues identified.
- Provide evidence of staff training logs, demonstrating training in the pharmacy's SOPs.
- Amend relevant policies to include keeping written records of staff meetings/discussions and required actions following dispensing errors.

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided to her mother, Mrs B, by a pharmacy. The following issues were identified for investigation:

- *Whether Ms C provided Mrs B with an appropriate standard of care between October 2019 and January 2020 (inclusive).*
- *Whether the pharmacy provided Mrs B with an appropriate standard of care between October 2019 and January 2020 (inclusive).*

9. This report is the opinion of Deputy Commissioner Deborah James, and is made in accordance with the power delegated to her by the Commissioner.

10. The parties directly involved in the investigation were:

Mrs B	Consumer
Mrs A	Complainant/consumer's daughter
Ms C	Pharmacist
Pharmacy	

11. Also mentioned in this report:

Mr D	Pharmacist
Ms E	Pharmacy technician
Ms F	Pharmacist

12. Further information was received from a medical centre and the Pharmacy Council of New Zealand.

13. Independent expert advice was obtained from pharmacist Mrs Catherine Keenan (Appendix A).

Information gathered during investigation

Introduction

14. On two separate occasions, pharmacist Ms C mistakenly dispensed Mrs B (in her nineties at the time of events) Ropin 1mg (generic name ropinirole), a medication used to treat Parkinson's disease and restless leg syndrome (RLS), instead of Rolin 1mg (generic name anastrozole), a medication used in the treatment of advanced breast cancer in post-menopausal women.

15. This report discusses the care provided to Mrs B by Ms C and the pharmacy in relation to the dispensing of Ropin, as well as Ms C's and the pharmacy's response to the errors.

Pharmacy

16. The pharmacy is owned and managed by pharmacist Mr D.[1]

Pharmacist Ms C

17. Ms C first registered as a pharmacist in 2018. At the time of these events, Ms C was the Charge Pharmacist at the pharmacy.[2] She had held this position since 2019.

18. Ms C told HDC that when she began working at the pharmacy she was shown around the pharmacy and shown how to use the online rest-home charting system, but did not receive any orientation or training on the Standard Operating Procedures (SOPs). Ms C said that she was supported in her role by Mr D and another experienced part-time pharmacist.

19. Mr D told HDC that Ms C was provided with general orientation to the pharmacy, but initially Ms C was not provided with a copy of the SOPs.

SOPs

20. A copy of the pharmacy's relevant SOPs that were in place at the time of these events was provided to HDC, and relevant extracts are included as Appendix B.

First dispensing error — 17 October 2019

21. Rolin 1mg was a regular medication for Mrs B. She had never been prescribed Ropin.

22. On 17 October 2019, Mrs B was prescribed 90 "Rolin 1mg Tab[lets]" by her general practitioner (GP), together with Mrs B's other regular medications. Mrs B presented to the pharmacy the same day and provided the prescription to pharmacy technician Ms E.[3]

[1] Mr D first registered as a pharmacist in 2010.

[2] The key responsibilities of Ms C's role included providing pharmaceutical services in accordance with all legislative, contractual, professional, and ethical obligations, including "ensuring prescriptions are safe and appropriate for patients" and "dispensing/compounding medicines in accordance with all standard operating procedures".

[3] Ms E qualified as a pharmacy technician in 2008. Ms E's key responsibilities, as set out in her job description, included assisting the pharmacist with the operation of the pharmacy, including dispensing.

23. In accordance with the pharmacy's SOP, the pharmacist or pharmacy technician processing the prescription should review the appropriateness of each prescribed medication and check the medication history, including for newly prescribed medications, and, in the case of a new medication, annotate the prescription with the letter "N" to indicate that the medication is new to the customer, and that extra counselling is required.[4] When dispensing a medicine, after selecting the correct medication, the pharmacist or pharmacy technician should double check the generated label against the original prescription.[5]

24. Ms E entered the prescription details into the computer system. She told HDC that there were nine items on the prescription. Ms E incorrectly typed in Ropin 1mg instead of Rolin 1mg. She then selected Ropin 1mg from the shelf and printed off the label to be attached to the medication, which stated: "30 [Ropin] Tablets 1mg … 2 repeats by 15 [January 2020]." Ms E did not review Mrs B's medication history, or annotate the prescription with an "N" to indicate that Ropin was a new mediation for Mrs B. Ms E told HDC: "There is always a Pharmacist in the Pharmacy to check my work."

25. The pharmacy's SOP requires the pharmacist undertaking the medication check to check that the prescription details are correct, check that the medication history has been reviewed, check the appropriateness of each prescribed medication, and check that each medication is correct against the medicine prescribed, including checking the generated label against the original prescription. Once all the checking steps have been completed, the pharmacist should then place all the medications, with the original prescription and any additional counselling notes, in a tray for collection.[6]

26. Ms C carried out the medication check, checking the label against the prescription to ensure the accuracy of the medication and dose. In relation to this accuracy check, Ms C told HDC:

> "Unfortunately, I did not pick up the incorrect dispensing of Rolin 1mg during the checking process. I incorrectly checked off Ropin (Ropinirole) 1mg as Rolin (Anastrozole) 1mg …"

27. Ms C told HDC that when she carried out her check she did not make sure that Mrs B's medication history had been reviewed by Ms E, and did not personally review Mrs B's medication history.

28. Mrs B was then dispensed 30 tablets of Ropin 1mg.

29. Ms C told HDC:

> "The initial error was not picked up when I checked the prescription. This was because I misread the brand name Rolin as Ropin at the final check. This error could have been avoided if I had annotated the prescription with the generic name as well as checking the brand names matched with that on the prescription."

[4] SOP "Dispensing 2 — Assessing and Processing a Prescription".
[5] SOP "Dispensing 3 — Dispensing and Checking a Prescription".
[6] SOP "Dispensing 3 — Dispensing and Checking a Prescription".

30. Further to this, Ms C said that had she completed all of the checking steps and ensured that the patient history had been reviewed, the error "may have been avoided".

Discovery of dispensing error — 26–27 November 2019

31. Mrs A told HDC that on 26 November 2019, she noticed a bottle of "distinctive green hexagonal tablets" on her mother's table, which she had not seen in her mother's medication previously. Mrs A said that when she asked her mother what they were for, Mrs B did not know.

32. Mrs A said that she then went to the pharmacy, spoke to Ms E, and asked what the tablets (Ropin) were for. Ms E printed out a Ropin patient information leaflet, which was given to Mrs A. Ms E also asked pharmacist Ms F to speak with Mrs A. While waiting to speak to Ms F, Mrs A read the leaflet and noted that Ropin is used to treat Parkinson's Disease and RLS. She told Ms F that her mother did not have either condition, but was experiencing a number of the side-effects mentioned in the information leaflet.

33. Ms F told HDC:

> "I then quickly looked at [Mrs B's] dispensing history and mistakenly read Rolin as Ropin [and] said she had been taking it for a few months.[7] This was incorrect. I also said [Mrs A] should go to the medical centre and ask why it had been prescribed for [Mrs B]."

34. Mrs A telephoned the medical centre and spoke with the practice nurse, who documented their discussion dated 26 November 2019 as follows:

> "Discussion with daughter. Picked up repeat for [Ropin] today. Is concerned that mother has been a bit confused, not eating properly and having funny turns. Was wondering what this drug was for. Looking at notes this patient is not on this medication. Has been taking this for 1 month. Was given at last [prescription] dated 17th October. Should have been Rolin not Ropin."

35. The practice nurse telephoned the pharmacy and spoke to Ms C and informed her of the medication error. Ms C told HDC that upon investigating Mrs B's dispensing history and original prescription, she realised that Mrs B had been given the wrong medication. Ms C stated that she told the practice nurse that they had made an error and would inform Mrs B immediately, and would inform her GP the next day.

Management of dispensing error

36. The pharmacy's SOP[8] stated that once an error has been identified, either the Dispensary Manager or Charge Pharmacist (in this case Ms C, as advised by Mr D) will assess the error to identify what occurred, and will record the details on an incident form. The pharmacist responsible for the error should advise the consumer of the error and apologise for the mistake, establish whether the consumer has taken any of the medication, and, if the consumer has, contact the prescriber to find out what should be done. The pharmacist

[7] In her complaint, Mrs A stated that she was told that her mother had been on Ropin "since at least April".
[8] SOP "Dispensing Errors".

should also deliver the correct medications as soon as possible, and ask the consumer to return the incorrect medication. Either the Dispensary Manager or the Charge Pharmacist will then follow up with the consumer the following day. The pharmacist involved in the dispensing error will write a letter of apology as soon as possible, which will be checked by the Pharmacy Manager and the Pharmacy Defence Association then sent to the consumer.

37. The SOP also stated that the Pharmacy Manager and Dispensary Manager will evaluate the error and ensure that appropriate corrective action will be taken to prevent a similar error occurring again. Serious errors will be reviewed immediately.

Notification to Mrs A

38. On 26 November 2019, Ms C telephoned Mrs A and apologised that there had been a dispensing error by giving out Ropin instead of Rolin, and told her that Mrs B should stop taking Ropin. Ms C said that she asked whether Mrs B was feeling okay and whether she was still taking Rolin 1mg, and Mrs A advised that Mrs B had still been taking Rolin 1mg "as she had some tablets left from her previous prescription". Ms C told Mrs A that she would contact her GP the next day to discuss the error.

Contact with GP

39. On 27 November 2019, Ms C telephoned the GP. They discussed the medication error and noted that Mrs B had continued taking Rolin. Ms C said that the GP reassured her that any side effects "[would] go away after [Mrs B] stop[ped] Ropin, but if not then [to] ask the patient to make an appointment with her".

Further contact with Mrs A and Mrs B

40. Ms C stated that she then called Mrs A to relay her discussion with the GP. Ms C told Mrs A that she would personally bring the correct medication — Rolin — to Mrs B's house and apologise. Mrs A suggested that late in the afternoon would be the best time for Ms C to deliver the medication, as Mrs B usually slept in the early afternoon.

41. Mrs A told HDC that later that day, when she asked her mother whether Ms C had delivered the medication, Mrs B said that "she had not seen anyone". Mrs A said that she then telephoned Ms C, who advised that "[the pharmacy's] delivery person had taken it around 5pm". Mrs A told HDC:

> "It transpires that [the delivery person] had given it to my mother's care assistant who had arrived about the same time. The care assistant had just put the tablets with the rest of my mother's medication."

42. In relation to why she had not delivered the medication in person herself, Ms C told HDC:

> "[A]fter finding out that [Mrs B] will only be free in the late afternoon, I thought that it would be more convenient for our trusted delivery person to deliver the medication as she usually does all the deliver[ies] around that time. The reason why I did not deliver it personally was because it got busy in the afternoon. I know this shouldn't be an excuse as [Mrs B] was expecting me. I should've checked with [Mrs A] whether it was okay for our delivery person to deliver instead of myself or suggest some other time more

suitable but at that time I did not think of it and I did not want to delay the delivery of the correct medication."

43. The next day, Ms C emailed Mrs A a letter apologising for the medication error, explaining how it had occurred, and noting the actions that had been taken as a result to ensure that it would not happen again.

Incident reporting

44. On 27 November 2019, Ms C completed an Incident Notification Form noting the details of the error. Ms C recorded the steps she had taken, including contacting Mrs A, apologising and advising Mrs B to stop taking Ropin, notifying Mrs B's GP, and retrieving and replacing the Ropin.

45. The form recorded that the following steps should be taken to reduce the likelihood of a similar incident occurring again:

- Review checking processes, e.g., "always check brand or annotate medication name on prescription".
- "Print [information] sheet for every new medication, will pick up at counselling as this was a new medication for the [patient]."
- Hold dispensary staff meeting.

Actions taken by pharmacy

46. Ms C informed Mr D of the incident at the time. Mr D told HDC that when he was made aware of the error, he encouraged Ms C to call Mrs B to ensure that she was all right.

47. Mr D said that following this incident, all staff were asked to review the SOPs in place to "make sure [they are] clear and practical".

Second dispensing error — 6 January 2020

48. On 6 January 2020, Mrs B was given a new prescription at the medical centre. Mrs A took the prescription, which included three separate medications, none of which were Ropin or Rolin, to the pharmacy to be filled.

49. Ms C told HDC that the pharmacy is divided into two sections — the front dispensary, which deals with community prescriptions and is staffed by one pharmacist and one technician, and the back dispensary, which deals with rest-home prescriptions and is staffed by one pharmacist and two technicians.

50. The pharmacy's SOP stated that it is best practice to have different members of the dispensary team involved in the dispensing and checking of a prescription. If this cannot be achieved, it is recommended that the pharmacist undertake another task in between the dispensing and checking steps so that they come back to the checking step with a "fresh set of eyes".

51. Ms C stated that at the time she received Mrs B's prescription she was the only front dispensary staff member on duty, as the technician was busy with other tasks. Ms C said that she processed, dispensed, and checked the medications herself. She said that when she was entering Mrs B's new prescription into the computer, she carried out a review of her dispensing history and noted that there was an outstanding repeat for Ropin 1 mg (the incorrect medication that had been dispensed previously). Ms C told HDC that the computer system did not prompt her that previously there had been an error with that medication, nor did she remember the error at that time. She stated:

> "I saw there was a repeat still active for Ropin 1mg. I was going to ask the patient at the time before I processed the repeat through. However, she wasn't there at the time. I thought I would put it through and un-dispense it if the patient didn't need it."

52. Ms C then selected and checked the three items on the prescription, as well as the repeat for Ropin. Ms C told HDC that she did not break up the checking and dispensing with a break.

53. Ms C said that if a pharmacist wants to have a discussion with the patient, a coloured label is attached to the medication and, upon collection, this flags that the pharmacist needs to speak to the patient or person collecting the medications before they are handed out. Ms C stated that it was her "intention" to add a "see a pharmacist" label to the medications so that she could discuss whether the repeat for Ropin was still required, but she "failed to do this". As such, the bagged medications were handed over to Mrs A when she came to collect them, without Ms C discussing with her the need for the repeat Ropin.

54. Ms C told HDC that she was the only pharmacist in the front dispensary at the time. She stated:

> "As I identified there was a repeat prescription for Ropin outstanding on her file, I processed the repeat, dispensed and carried out the final check using the Certified Prescription Copy (as opposed to the original prescription) and the label. I believe the main reason for the repeat being dispensed in error was because the original incorrect dispensing of Ropin from 17 October was not inactivated on [Mrs B's] file and did not have a clear prompt note that [Mrs B] was not meant to be on Ropin. … The error could have been avoided if there was a clear prompt note on [Mrs B's] file or a discussion occurred with [Mrs B]/[Mrs A] regarding the medication at the time of collection. I accept that I could have added a more obvious note to [Mrs B's] file following the initial dispensing error in October."

Discovery of second dispensing error

55. Mrs A told HDC that when she unpacked the package of medications at her mother's home, she found that there were four items, despite the GP having prescribed only three. She stated: "This turned out to be another bottle of [Ropin]."

56. Mrs A went back to the pharmacy and spoke to Ms C. Ms C told HDC that she apologised for the error and asked Mrs A to bring back the medication so that they could discard it for her.

Actions taken following second dispensing error

57. Ms C told HDC that after the second error had been identified, she recorded the incident on a pharmacy incident form, which was placed on Mrs B's electronic file as a diary note the same day, and a warning prompt was also placed on Mrs B's file, which appears in a red box noting clearly that she was not on Ropin.

58. Mr D also contacted Mrs A and apologised for the error. Ms C said that she also visited Mrs B to apologise in person and gave her a bouquet of flowers.

59. Mr D told HDC that following the second incident he met with Ms C to discuss and learn from the errors, and suggested that she review the SOPs and double check her work. Mr D said that he also suggested to Ms C that "if she is not confident, she can ask either for a Pharmacist or technician working in the pharmacy to double check her work to give her a second checking procedure".

60. Ms C said that Mr D held a staff meeting to discuss the error and ways to prevent a similar error from occurring again in the future, including inactivating any incorrect repeat medications and putting warning notes on the patient file. Ms C stated that staff were also told to re-read the SOPs and to make sure they followed every step. The details of this meeting were not recorded.

Further comment

Ms C

61. Ms C told HDC:

> "I am very sorry for the errors that occurred with [Mrs B's] medication, it was not my intention to provide her with the incorrect medication. I have learned a lot from these incidents."

Mrs A

62. Mrs A told HDC:

> "[The errors were] human error, which could be fatal for some people. The first person who looked into the issue back in October said that my mother had been taking the medication since at least April [2019], which was incorrect. This suggests to me that their systems are not robust enough."

63. Mrs A said that she would like the pharmacy's procedures to be reviewed to ensure that these dispensing errors do not happen to other patients in the future.

Responses to provisional opinion

Mrs A

64. Mrs A reviewed the "information gathered" section of the report and had no comments to make.

Ms C

65. Ms C agreed with the provisional opinion and had no further comment to add.

The pharmacy

66. In response to the provisional opinion, the pharmacy told HDC:

> "We have certainly all learned a great deal from this case and we have set measures in place to prevent such [an] incident from happening again. As a business owner I have been looking after a small community … for years and [have] certainly never had to deal with such [a] situation."

67. The pharmacy also told HDC that Ms C has learned a lot from these events and carries herself very professionally and "in a manner that is [appreciated] by [the pharmacy's] staff and patients".

68. The pharmacy shared the relevant section of the provisional report with Ms E and Ms F, and they had no further comments to make.

69. The pharmacy told HDC: "I can assure you that I have done all it takes to prevent such [an] incident from happening again in the pharmacy."

Opinion: Ms C — breach Right 4(2)

70. As a registered pharmacist, Ms C was required to comply with all professional and other relevant standards, including the Pharmacy Council of New Zealand's *Competence Standards for the Pharmacy Profession (2015),* the Pharmacy Council *Code of Ethics*, and the pharmacy's SOPs (appended to this report).

Dispensing error — 17 October 2019

71. Ms E, the pharmacist technician, incorrectly entered the medication into the computer system, selected the medication Ropin 1mg from the shelf, and then printed the label and attached it to the medication to be checked by Ms C. However, ultimately, Ms C, as the qualified pharmacist in charge, was responsible for ensuring that the correct medicine was dispensed. This responsibility is clearly set out in both the relevant professional standards and the pharmacy's SOPs.

72. The relevant SOP in place at the time required Ms C to check that Mrs B's medical history had been reviewed, and to check that the medication was correct against the medication prescribed on the original prescription.

73. Ms C checked the label against the prescription, but failed to identify the error. Ms C told HDC that she did not complete all of the required checking steps on this occasion, including checking that Mrs B's dispensing history had been reviewed.

74. My expert advisor, pharmacist Mrs Catherine Keenan, advised:

> "The expectation is that prescriptions will be accurately **and** clinically checked and the SOPs from [the pharmacy] do spell out quite clearly the process to follow. Any deviation from the accepted practice can have severe consequences. In my opinion, missing the clinical check was a moderate to severe departure from standard practice."

75. I accept Mrs Keenan's advice. The pharmacist's check is an important part of the dispensing process, and failing to complete this step adequately, and consequently dispensing the incorrect medication to Mrs B, was a departure from professional standards[9] and the Pharmacy's SOPs.

76. I note that Ms C accepts that she failed to carry out all of the required checking steps adequately and acknowledged that had she made sure that Mrs B's patient history had been reviewed, the error may have been avoided.

Dispensing error — 6 January 2020

77. On 6 January, when processing a prescription for a new medication for Mrs B, Ms C noted that there was a repeat of Ropin available (the incorrect medication that had been dispensed on 17 October 2019).

78. Because Mrs A was not present at the time for Ms C to check whether Mrs B required the medication, Ms C decided to dispense the repeat medication, noting that she could "un-dispense" it if it was no longer needed. However, Ms C did not flag this to the dispensary staff, who then later dispensed the medication to Mrs A without checking whether Mrs B still required the Ropin.

79. On this occasion, Ms C undertook each step of the dispensing and checking herself. She advised HDC that at the time, she was the only dispensary staff member in the front dispensary. Ms C said that while she reviewed Mrs B's dispensing history, she did not identify that the Ropin repeat was an error, and did not recall the previous error. There was also no prompt notifying her that Mrs B should not be receiving the Ropin, and she did not look at the diary note made following the first incident. Ms C then selected, checked, and dispensed the repeat for Ropin, and Mrs B was again provided with the same incorrect medication.

80. Mrs Keenan advised that a number of factors appear to have contributed to the error on this occasion. In particular, Mrs Keenan noted that Ms C's review of Mrs B's dispensing history was not thorough and failed to identify the error, there was no clear notification of the previous error on the file, the incident reporting and follow-up of the previous incident was inadequate, and the medications were bagged up, so there was no opportunity to discuss the medications with Mrs A in the pharmacy.

81. The SOP states that it is best practice to have another dispensary staff member involved in the process and, if this cannot be achieved, to have a break between the dispensing and

[9] 03.2.1 of the Pharmacy Council of New Zealand's *Competence Standards for the Pharmacy Profession (2015)* requires that a registered pharmacist "[m]aintains a logical, safe and disciplined dispensing procedure".

final check. However, Ms C undertook every step of the checking and dispensing process herself, and did not break up the dispensing and checking.

82. I accept Mrs Keenan's advice:

> "All of these points together contribute to a moderate to severe departure from accepted practice when dealing with the initial notification of the dispensing error in November 2019."

Conclusions

83. As the Charge Pharmacist at the pharmacy, Ms C's role included providing pharmaceutical services in accordance with all legislative, contractual, professional, and ethical obligations, including "dispensing/compounding medicines in accordance with all standard operating procedures".

84. Ms C had graduated as a pharmacist only recently, and was relatively new to her role. Nevertheless, she had a professional responsibility to ensure that the right medication was dispensed to Mrs B. I would also expect her to have familiarised herself with the Pharmacy's SOPs.

85. As outlined above, Ms C failed to provide services in accordance with the relevant professional standards as set out by the Pharmacy Council of New Zealand and the Pharmacy's SOPs, in the following ways:

- She failed to undertake adequate checks on 17 October 2019, which meant that the initial medication selection error was not identified.
- She failed to review Mrs B's dispensing history adequately on 6 January 2020, which meant that the previous error was not identified.
- She failed to flag that discussion with Mrs B or Mrs A was required before the medication was handed over.
- She undertook all parts of the dispensing and checking process on 6 January 2020 herself without breaking up the steps.

86. As a result of the above failures, Ms C dispensed the same incorrect medication on two occasions. Accordingly, she failed to provide Mrs B with services in accordance with professional standards, and breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code).[10]

Incident management — adverse comment

87. As Charge Pharmacist, Ms C was responsible for several steps in the incident management process required by the pharmacy's SOP, most of which she completed adequately. After the initial error of 17 October 2019 had been identified, Ms C took steps to record the

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

incident, notify Mrs A, and apologise for the error. However, my expert advisor identified that two aspects were lacking. First, although Ms C originally planned to deliver the correct medications in person, eventually she delegated to a delivery person, which Mrs Keenan advised "would be deemed inadequate". I acknowledge Mrs Keenan's view that it would have been best practice for Ms C to have delivered the correct medication to Mrs B in person, rather than to have delegated the task. This would have been an important opportunity for Ms C to have checked on Mrs B's health, as required by the SOP.

88. Second, I also note Mrs Keenan's view that Ms C should have retrieved the incorrect medications herself, instead of asking the family to bring them back. However, I acknowledge that the SOP was vague on this point, and advised to "kindly ask the customer for the incorrect medication back".

89. Ms C considers that the main cause of the second dispensing error relates to management of the initial error — in particular, the failure to inactivate the Ropin and the lack of a clear prompt on Mrs B's file to indicate that she should not be on Ropin (discussed further in the following section). Ms C stated:

> "Without this information at the time, there was no way of me knowing this repeat dispensing was processed in error. The error could have been avoided if there was a clear prompt note on [Mrs B's] file or a discussion occurred with [Mrs B]/[Mrs A] regarding the medication at the time of collection."

90. Ms C acknowledged that she could have added a clear note on file for the first error. However, I accept that under the SOPs, the Pharmacy Manager and Dispensary Manager had primary responsibility for evaluating the error and ensuring that appropriate corrective action was taken to prevent a similar error occurring again. I have discussed this below in respect of the pharmacy.

Opinion: Pharmacy — breach Right 4(1)

Introduction

91. While there is no dispute that Ms C had an individual responsibility in relation to the two dispensing errors, the pharmacy also had a duty to ensure that it provided services to Mrs B with reasonable care and skill. This included ensuring that its staff provided safe and accurate dispensing services.

92. I have considered whether any organisation-level factors contributed to the errors. I have also considered the pharmacy's response once it was notified of the errors.

Oversight and support

93. Mrs Keenan advised that the SOPs "seem thorough and follow a full and complete process". I accept Mrs Keenan's advice and am satisfied that the SOPs in place at the time of these

incidents were appropriate. However, I have concerns about the failure of staff to comply with these SOPs, as set out below.

94. First, when pharmacy technician Ms E entered Mrs B's prescription into the computer system, she did not review Mrs B's medication history and annotate the prescription with an "N" to ensure that counselling was provided — a requirement in the SOPs for any newly prescribed medications.

95. I note Mrs Keenan's advice that "on entering the drug [Ropin] into the software system it would have been clear that this item had not been dispensed to [Mrs B] in the past". Mrs Keenan advised that the failure to follow the steps set out in the SOP would be considered a moderate departure from accepted standards.

96. Next, Ms C carried out her check, but, as outlined in the previous section, failed to follow a number of steps that were clearly set out in the SOPs, including completing the accuracy check adequately, and checking that Mrs B's medication history had been reviewed.

97. Then, when Mrs A presented to the pharmacy after the initial error and questioned pharmacist Ms F about Ropin, Ms F made an error in advising Mrs A that Mrs B had been on Ropin for some time. I accept Mrs Keenan's advice that this would be viewed as a moderate to severe departure from "best practice".

98. Lastly, when processing Mrs B's second prescription on 6 January 2020, Ms C undertook all steps of the dispensing process herself and did not break up the dispensing and checking with a break. Ms C failed to check the dispensing adequately, and bagged up the medications without first ensuring that the need for the repeat Ropin was discussed with Mrs A.

99. A pharmacy's SOPs are a central part of ensuring safe and consistent dispensing of medications. As noted by Mrs Keenan: "Reading the SOP and understanding it, are different from actually following the set process every single time." As the employer, the pharmacy has a responsibility to ensure that all its staff are orientated to its SOPs, and that staff understand them and follow them consistently. As outlined above, there were a number of instances where the staff involved in dispensing the medications failed to comply with the dispensing and checking SOPs. I note that Ms C was not given a copy of the pharmacy's SOPs when she started working there. As noted by Mrs Keenan:

> "No pharmacist comes to work to make mistakes. [Ms C] is at the very early part of her career and deserves to be fully supported in establishing a high standard of checking (both clinical and accuracy) and not just be left to read a procedure and then follow it without guidance and support."

100. Mrs Keenan advised that had the correct SOP processes been followed, then the risk of errors would have been reduced. I agree. In my view, multiple departures by staff from the SOPs in the dispensing and checking of Mrs B's medications on two occasions is evidence of inadequate systems in place at the pharmacy for the oversight and monitoring of staff adherence to its SOPs and safe clinical practice.

Incident management

101. The SOP required the Pharmacy Manager and Dispensary Manager to evaluate any errors and ensure that appropriate corrective action was taken to prevent a similar error occurring again.

102. Although an incident form was completed soon after the initial incident, and immediate steps taken to address the error, including a review of the checking procedures and a reminder of the need to flag new medications, a full review of the error does not appear to have been carried out adequately.

103. My expert, Mrs Keenan, noted that no clear prompt was put on Mrs B's file after discovering the error, and that repeat prescriptions for the incorrect medication were not inactivated. In my view, and having regard to the requirements of the Pharmacy's SOP, ultimately the responsibility for these failures lay with pharmacy management.

104. Further, the SOP required further training for staff following a dispensing error. While both Ms C and Mr D told HDC that following the incident a staff meeting was held and checking processes reviewed, there is no documentation to show that the staff meeting occurred and to record the outcome and how the review was carried out. Mrs Keenan advised: "This process has not been completed adequately and is a moderate departure from accepted practice."

105. I accept Mrs Keenan's advice. A comprehensive and thorough response to errors and near misses is central to identifying the cause and preventing the error from occurring again. As noted by Ms C, had further steps been carried out following the first error, it is likely that she would have been alerted to the error at the time of dispensing Ropin on 6 January 2020.

Conclusions

106. A pharmacy is required to ensure the provision of services that are safe and appropriate, which includes having adequate policies and guidelines in place. It also has a responsibility for ensuring that staff adhere to these policies and guidelines.

107. The dispensing errors on both occasions were the result of staff failing to comply with the SOPs. While there is individual accountability for the errors, I am concerned that staff failed to comply with the SOPs in multiple respects, which I consider is evidence of a failure by the pharmacy to support its staff adequately in making them aware of the SOP requirements and actively encouraging and supporting staff to follow them.

108. I also consider that the response to the errors, at an organisational level, was inadequate. In particular, it appears that a comprehensive review was not carried out following the identification of the first error. No clear prompt was placed on Mrs B's file flagging the error, and the repeat medication was not inactivated. In my view, this contributed to the second error. Furthermore, any staff meetings, discussions, and training following either the first or second error, including steps taken to prevent a similar error from occurring again, were not recorded.

109. Overall, for the reasons set out above, I consider that the pharmacy failed to provide services to Mrs B with reasonable care and skill, and breached Right 4(1) of the Code.[11]

Bagging of dispensed items — other comment

110. I note Mrs Keenan's advice that placing finished items in baskets or clear plastic bags to be given out is best practice and is required by the SOP. Ms C stated that the medication was "bagged up", but it is not clear what kind of bag was used.

111. In my view, the material of the bag (plastic or paper) in which checked prescriptions are placed and handed to customers is not relevant to the dispensing error that occurred in this case. As this Office has stated previously,[12] the important components when handing over medication are checking a patient's identity, reviewing medications with the consumer to ensure that they are correct, and ensuring that the consumer has an understanding of the use of the medication. I do not consider the bagging of the dispensed medication to be material to performing adequate dispensing checks or undertaking appropriate discussions with a consumer.

112. However, I am mindful of Mrs Keenan's advice that the SOP should reflect the pharmacy's actual practice. I encourage the pharmacy to review its staff's standard practice in this regard and ensure that its SOP reflects that accurately.

Changes made

Ms C

113. In relation to changes made following these incidents, Ms C told HDC:

> "I appreciate the feedback provided by the [HDC] expert advisor and in addition to the existing changes I implemented, I have further implemented changes based on their recommendation into my practice to ensure a similar incident does not occur. I will endeavor to constantly review and improve my practice to ensure the safety of my patients."

114. Ms C told HDC that since this incident she now "always make[s] sure the patient history has been or is checked and the prescriptions are annotated to show that the patient medicine history has been reviewed". In addition, she now only ever dispenses repeat medications after she has had confirmation from the patient first, and if they are not present in the pharmacy, she places a "to see pharmacist" label on the prescription so that she can speak to them when they come to collect their prescription.

[11] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[12] Opinion 19HDC00059, 1 July 2020.

115. Ms C also said that she will now always make clear notes on the patient file when an incident occurs, and will ensure that any incorrect repeat medications are inactivated.

116. Ms C stated that when the dispensary is busy, she feels pressured to undertake her tasks more quickly. She told HDC:

> "As I have become aware of this, I have reviewed my checking processes to ensure there were no gaps and that I am able to follow robust processes when it becomes busy. I have discussed with the retail staff that realistic waiting times need to be given to customers and I will not rush my processes in order to ensure my processes are followed correctly."

The pharmacy

117. Mr D said that recently Ms C completed a one-year leadership programme designed for pharmacy managers and owners.

118. Mr D told HDC that, as a pharmacy, it has also made a number of changes, including:

- Adding warning stickers to medications with similar names.
- The introduction of a prompt to flag new medications and print a medication information sheet for the patient.
- All staff meetings are now documented.
- The introduction of a near-miss log.
- Adding the [computer software] incident recording system to the SOP, which includes incident reports on a patient file being highlighted (purple) to make them visible to anyone opening the patient file.
- Updating its SOPs, including adding the requirement for any repeats that are not needed or incorrect to be inactivated immediately.
- Ensuring that new staff are provided with a copy of the most important SOPs when they start work at the pharmacy.

119. The medical centre was asked to use the generic name "anastrozole", rather than the trade name "Rolin", when prescribing the medication, to avoid confusion in the future.

120. Mr D said that the medical centre and many of the other medical centres in the area are starting to use e-prescribing, which will reduce the risk of errors occurring when medications are being entered into the system.

Recommendations

121. I recommend that within three months of the date of this report, the pharmacy:

a) Undertake an audit of staff compliance with the updated dispensing process SOPs. Where any departures are identified, the pharmacy should provide details of what steps it has taken to address the issues identified.

b) Undertake an audit of staff compliance with the updated dispensing errors SOP.

c) Use an anonymised version of this report for providing education to its staff on the issues identified in the report.

d) Provide a copy of the pharmacy's "near misses" log from 17 October 2019, up until three months after the date of this report. Where any issues are identified, the pharmacy should provide details of what steps it has taken to address those issues. This is to be provided to HDC within three weeks following the end of the three-month period noted above.

e) Provide evidence of staff training logs, demonstrating training in the pharmacy's SOPs.

f) Amend relevant policies to include keeping written records of staff meetings/ discussions and required actions following dispensing errors.

Follow-up actions

122. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Pharmacy Council of New Zealand, and it will be advised of Ms C's name.

123. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Health Quality & Safety Commission, the NZ Pharmacovigilance Centre, and the Pharmaceutical Society of New Zealand, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from pharmacist Mrs Catherine Keenan:

"I have been asked to provide an opinion to the Commissioner on case number 20HDC00036. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors, and I am not aware of any conflicts of interest.

Complaint: [The pharmacy]

Reference: 20HDC00036

Having read over the documents provided by … the office of the Health and Disability Commissioner I can provide the following information.

1. The adequacy of the dispensing service provided by [the pharmacy's] staff on 17 October 2019.

[Mrs B] has been dispensed the incorrect medication on 17 October 2019 when [the pharmacy] technician ([Ms E]) has keyed the prescription into the computer as Ropinirole (Ropin) instead of Anastrozole (Rolin) and then subsequently the pharmacist ([Ms C]) has not accurately checked the prescription. The dispensing service would be deemed inadequate because this dispensing error has occurred.

On entering the drug Ropinirole into the software system it would have been clear that this item had not been dispensed to [Mrs B] in the past. According to the SOP (Assessing and Processing a Prescription) there are clear steps to be taken to check the medication history, assess safety and appropriateness of the medicine and place the letter N beside the medicine name to indicate it is a new medicine.

[Ms C], in her response to the HDC complaint, says that 'this usually happens but did not happen on this occasion'. This is a moderate departure from standard practice (for the technician keying the prescription into the computer) and deviates from the SOP of the business.

Also, in [the] SOP (Dispensing and Checking a Prescription) it states that the pharmacist shall (among other things) 'Check that the medical history has been reviewed and that there is consistency of treatment and compliance'. [Ms C] states in her response that she unfortunately did not follow this step in her process of checking as she only did an accuracy check of the label against the prescription. So, as well as not adequately completing the accuracy check, she has not undertaken a clinical check at all (or made sure that a clinical check has occurred). This is a moderate to severe departure from standard practice.

'Slips and lapses' in checking can occur so her pharmacist peers may have some sympathy for [Ms C]. She seems to have adequate support in the dispensary with other

staff available and the prescription items for the day do not appear to be at an extreme level.

The expectation is that prescriptions will be accurately **and** clinically checked and the SOPs from [the pharmacy] do spell out quite clearly the process to follow. Any deviation from the accepted practice can have severe consequences. In my opinion, missing the clinical check was a moderate to severe departure from standard practice.

2. The adequacy of the dispensing service provided by [the pharmacy's] staff on 6 January 2020.

When [Mrs B's] daughter, [Mrs A], came in to get a prescription for [Mrs B] on this date the Ropinirole tablets were again given out to [Mrs A], for [Mrs B] to take. This was a further dispensing error and therefore the service was not adequate on this date.

[Ms C] has stated in her response that she was solely responsible for all aspects of that dispensing (data entry, dispensing and checking). The notes state that there were less dispensary staff available on that day. SOP (Dispensing and Checking a Prescription) states that it is best practice to have another dispensary staff member involved in the process and gives guidelines on what to do if this cannot be achieved. It is unclear if [Ms C] followed the guidelines. This is a mild departure from accepted practice.

There seem to be a number of factors that contributed to this error:

- The pharmacist did every step of the process herself (mild departure)
- The medication history was looked at but not thoroughly checked during the dispensing process (moderate departure)
- There was no ***clear indication*** on the patient file that a previous error had occurred (moderate departure)
- The incident reporting and follow up on previous error had not been adequate (moderate to severe departure)
- The items were 'bagged up' and not left in a plastic tray (as stated in [the] SOP) so no opportunity to discuss with client in [the pharmacy] (moderate departure)

All of these points together contribute to a moderate to severe departure from accepted practice when dealing with the initial notification of the dispensing error in November 2019.

3. The pharmacy's management of these incidents and follow-up actions taken.

The pharmacy was initially asked by [Mrs A] why [Mrs B] was taking the Ropinirole. The pharmacist ([Ms F]) has looked at the history and not read it correctly, giving the false information that [Mrs B] had been on this medication for some time. I do not have a record of the dispensing history for [Mrs B] so it is difficult to know why this would have occurred. This initial response was not ideal and is a moderate to severe departure from best practice.

The next day the doctor has contacted [the pharmacy] to speak to [Ms C] and it is then discovered that the Ropinirole has been dispensed (and taken) instead of the Anastrozole. [Mrs B] had continued to take some Anastrozole that she still had at home.

[Ms C] spoke to [Mrs A] over the phone once this was discovered. [Ms C] offered a verbal apology to [Mrs A] and said she would personally take the correct medication to [Mrs B]. This did not happen. [Ms C] states that she got busy and let the usual delivery person take the correct medication. She states that in hindsight this was not ideal.

The SOP (Dispensing Errors) mentions often that the errors are taken seriously. In my opinion there were some steps in the procedure that were missed by [Ms C] and management on both occasions. These are outlined here:

- While the PDA form appears as a template in the [computer software] system and would be loaded in the Patient diary, it does not flag in the Patient file immediately that a past error has occurred.
- [Ms C] showed clear concern for the patient and did offer a verbal apology to [Mrs A] and a written apology to [Mrs B]. The letter is dated the 28th of November, only 24 hours after the incident has been identified. [Ms C] says they have reviewed their checking process and had a staff meeting to discuss the measures. There is no documentation showing what was discussed at the meeting or any documentation regarding how the review was carried out. This process has not been completed adequately and is a moderate departure from accepted practice.
- The SOP also states the steps the Pharmacist must take, including delivering the medication. This was not done by the Pharmacist so the response would be deemed inadequate.
- The SOP also states the Dispensary Manager or Charge Pharmacist will follow up with the patient the following day and determine the health outcome. This does not appear to have been done.

A full review of the dispensing error on 17 October does not appear to have been done when it was identified on 27 November. No ***clear note*** was put on the file, the repeats were not inactivated, and any further training was not documented. The PDA form filled out on 27 November 2019 states that [Ms C] will always check brand or annotate medication name on the prescription. Is this now happening? Is there evidence?

Following a dispensing error, the SOP mentions further training in procedures which should have happened and been documented. A dispensing log or peer review as evidence would be helpful.

Minutes of a staff meeting and evidence of a dispensing log (with no errors) may have helped give the family some comfort that a full review had happened.

After both errors the pharmacist should have made it her top priority to retrieve the medications herself, instead of asking the family to bring them back. She should also

have taken the parcel on the 27th of November to the patient instead of getting the delivery person to do this. This is a moderate departure from accepted practice.

4. The adequacy/appropriateness of [the pharmacy's] SOPs.

The SOPs from [the pharmacy] seem thorough and follow a full and complete process. If the processes had been followed as per the SOPs, then the risk of any errors would have been reduced.

The SOPs include many steps that seem to have been missed on both instances of dispensing error. If [the pharmacy] has decided that those steps are not important, they should be removed from the SOP.

The clinical check is a vital part of the process, whereby the pharmacist looks at the full dispensing history and previous medications to highlight any issues with the items prescribed on the day. This is spelt out in the SOP and did not happen.

Placing finished items in baskets or clear plastic bags to be given out is best practice and stated in the SOP but from the notes [Ms C] says the items were 'bagged up', so this should be removed from the SOP if it does not happen.

In the [computer software] system there is a way to record Incidents in the Patient file that are then highlighted in a different colour (purple). This is easy to spot when you open the patient file. This step should be added to the SOP.

There is an option in the [computer software] system for a Prompt to print a medicine information leaflet for all new medicines. This should be activated as an 'alert' for new medicines and can give an indication if the wrong medication has been entered or that the dispensing history should be further checked.

5. Any changes [the pharmacy] has undertaken since the events and if further changes may be appropriate.

The pharmacist has asked the medical centre to always prescribe the Anastrozole as the generic name, rather than the brand name Ropin, to avoid further errors. This was a good way of mitigating any further issue. Also ensuring that near misses are recorded and reviewed and provide the evidence of this.

The pharmacy and [Ms C] do appear to have made some changes to the dispensing practice since this has occurred. They have talked about putting warning notes in patient files and inactivating repeats for any future errors. These steps should be added to the SOP and everyone on the dispensary staff should be trained and have that documented.

Producing evidence of staff training logs, accuracy checking logs and minutes of staff meetings, in my opinion, would give some comfort to [Mrs A] and [Mrs B] that changes have happened. Ensuring the clinical check occurs each time is vital, and [the pharmacy]

may need to review their dispensary layout or computer availability to ensure this can happen.

6. Any other matters warranting comment.

To be noted: In my opinion there is a slight difference in the departure from accepted practice between the October dispensing and the January dispensing. The October situation is more to the severe side as the pharmacist has not looked at the dispensing history on the computer at all, whereas in January the pharmacist did look at the history in relation to the dispensing. Even though checking the computer records did not stop the error occurring in January, at least the pharmacist did have that step in her process.

The use of e-prescribing by the medical centre is an extremely useful tool in reducing data entry errors at [the pharmacy]. I would recommend that [the pharmacy] discuss this with [the medical centre] if they are not already doing this. If this system is already up and running it would be advisable to communicate this to [Mrs A] and [Mrs B] as a positive step towards reducing future errors.

All staff should read through the SOPs again and management should ensure they are fully understood and that processes are being followed at every dispensing. This training should be documented and followed up in staff reviews. This includes locum staff."

Further expert advice:

"I have read over all of the material a few times. I am impressed with the steps both the employer and the employee have taken in regard to altering their workplace and practice following this error.

Both have identified the improvements and acted on them. This is admirable and will go a long way to mitigating any further errors, one would hope.

The fact that these changes have happened do not change my advice on the departures from accepted practice. [Ms C] mentions that she usually does the clinical check but didn't on the first occasion. Keeping to a process of fully checking (both clinical and accuracy) is essential for every prescription item. By not doing this clinical check and a 100% accuracy check, this was a moderate to severe departure from practice and in this instance did have the serious consequence.

Reading the SOP and understanding it, are different from actually following the set process every single time. Even though the employer has amended the policies and given them to the staff, is he observing and noting evidence that they are being followed? By not assessing this, corners may still be being cut in busy times when there is less support in the dispensary that [Ms C] mentions.

No pharmacist comes to work to make mistakes. [Ms C] is at the very early part of her career and deserves to be fully supported in establishing a high standard of checking

(both clinical and accuracy) and not just be left to read a procedure and then follow it without guidance and support. She appears to have learnt a lot from this situation and acknowledges the improvements she needed to make. The hard work she has put in should give comfort to the complainant and the HDC."

Appendix B: The pharmacy's SOPs

Standard Operating Procedures

The pharmacy's standard operating procedure (SOP) "Dispensing 2 — Assessing and Processing a Prescription" stated that when processing a prescription, the pharmacist or technician should:

> "Review the appropriateness of each prescribed medicine with respect to its therapeutic use …
>
> Check the recorded medication history for newly prescribed medicines, consistency of treatment, different strengths or frequency, duplication of medicines, e.g. different brands of the same medicine, regular medicines not prescribed, interactions with other prescribed medicine(s), evidence of misuse, allergies, e.g. calling for repeats too early or too late.
>
> If the customer has had the medicine before a tick '✓' is written on the left side of the medicine name to indicate that the customer has had this medicine before. If the medicine is new to the customer, then the letter '*N*' is written on the left side of the medicine name to [indicate] that this medicine is new for the customer and extra counselling is required."

The SOP "Dispensing 3 — Dispensing and Checking a Prescription" stated that it is best practice to have different members of the dispensary team involved in the dispensing and checking of a prescription, and, if this cannot be achieved, it is recommended that the pharmacist undertake another task in between the dispensing and checking steps so that they come back to the checking step with a "fresh set of eyes".

It also stated that when dispensing a medicine, the pharmacist or technician shall:

> "Select each medicine from the dispensing shelf one at a time using the original prescriptions, making sure the correct medicine, strength and brand has been chosen. …
>
> Double check the generated dispensing label(s) against the original prescription before attaching to the container, making sure that the dispensing label contains what is written on the prescription, e.g, correct medicine, dose, quantity, instructions, customer's name, and prescriber."

It also stated that when checking the prescription, the pharmacist shall:

> "Check the prescription details are correct, including the customer's details, statutory details and the suitability of the prescribed medicine(s) in terms of the quantities prescribed, funding and the prescriber's scope of practice.
>
> Check that the medical history has been reviewed and that there is consistency of treatment and compliance.

> Check the appropriateness of each prescribed medicine with respect to its therapeutic use …
>
> Check that each medicine dispensed is correct against the medicine prescribed on the prescription. This includes checking the generated dispensary label and dispensed medicine(s) against the original prescription for the:
>
> - Correct customer's name;
> - Correct instructions for use;
> - Correct formulation, strength and quantity of medicine;
> - Correct prescription number;
> - Correct prescriber;
> - Correct directions, which are clear and concise.
>
> ...
>
> Assemble all of the prescription items, with the original prescription and the receipt in a plastic tray and await collection by the customer or the customer's agent."

The SOP "Dispensing Errors" states:

> "The Pharmacist shall deal with the customer in the following way … Deliver the correct medicine as soon as possible and counsel the customer. … Kindly ask the customer for the incorrect medication back.
>
> …
>
> The Dispensary Manager or Charge Pharmacist will follow up with the customer the following day and determine the health outcome of the customer. They will explain that the Pharmacy is investigating how this happened so that a similar incident will not happen again and are taking all steps necessary to prevent any similar dispensing errors occurring in the future.
>
> A letter of apology will be written by the Pharmacist involved in the dispensary error as soon as possible and checked by the Pharmacy Manager and the Pharmacy Defence Association. Once checked the letter of apology will be sent to the customer.
>
> The Pharmacy Manager and Dispensary Manager will evaluate each dispensing error using the dedicated Incident Review Form every month and discuss in the regular staff meetings and appropriate corrective action will be taken with the aim of preventing future similar dispensing errors and to facilitate staff education.
>
> Any serious dispensary errors will be reviewed by the Pharmacy Manager and Dispensary Manager immediately and appropriate corrective steps taken to prevent further occurrences. An urgent dispensary meeting will be called to discuss the incident and to alert them of the consequences of such an error.

With each review of a dispensing error the Pharmacy Manager and Dispensary Manager and staff members (when appropriate) will:

- Establish if any similarities between other medicinal incidents of its type.
- Review the employee and the working environment using the employee self-assessment form and system review sheet.
- Outline how the medicinal incident was dealt with and highlight any problems.
- Document any changes required to the Pharmacy's policies, procedures, and/or training.
- Identify any ways that the medicinal incident could have been handled better.
- Identify if any further action needs to be taken.
- Identify what was learnt from handling the medicinal incident."

Appendix C: Relevant standards

The Pharmacy Council of New Zealand's *Competence Standards for the Pharmacy Profession (2015)* require that a registered pharmacist:

> "03.2.1 Maintains a logical, safe and disciplined dispensing procedure.
>
> 03.2.2 Monitors the dispensing process for potential errors and acts promptly to mitigate them.
>
> …
>
> 03.2.5 Accurately records the details of medication incidents and actions taken, including clinical and professional interventions, to minimise their impact and prevent recurrence."

The Pharmacy Council of New Zealand's *Code of Ethics (2018)* requires that a pharmacist:

> "Principle 1F Acts to prevent harm to the patient and the public.
>
> …
>
> Principle 6C Be accountable for practising safely and providing professional services only within their scope of practice."