Pharmacist

Report on Opinion - Case 98HDC15457

Complaint

The complainant complained to the Commissioner about services provided to her late father, the consumer, by the pharmacy.

The consumer was prescribed "*0.0625 mg Digoxin tablets – take 2 tablets daily*." In mid-April 1998 the pharmacy dispensed 0.25mg *digoxin* tablets. The label on the bottle of tablets stated "*Digoxin 0.0625 mg*".

Investigation

The complaint was received by the Commissioner on 22 June 1998 and an investigation was undertaken. Information was obtained from:

The Complainant
The Manager of the Pharmacy

The bottle of *digoxin* tablets was acquired and a copy of the prescription obtained from Health Benefits Limited.

Information Gathered During Investigation

The consumer was prescribed "[d]*igoxin 0.0625 mg - take two tablets daily"*. In mid-April 1998 the pharmacy dispensed *digoxin* tablets, the label stated that *digoxin* 0.0625mg had been dispensed.

Six days after the prescription was dispensed the consumer stayed with his daughter, the complainant. The complainant, a nurse, observed that the *digoxin* tablets her father had been dispensed were white. From her nursing experience, the complainant thought that *digoxin* 0.0625mg tablets were blue tablets not white.

Four days after her father had come to stay with her the complainant contacted the pharmacy to check the colour of *digoxin* 0.0625mg tablets. The manager confirmed to her that *digoxin* 0.0625mg tablets are blue. The complainant then queried why her father's tablets were white in appearance. The manager was unable to provide an explanation but suggested that the medication had been incorrectly dispensed.

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Pharmacist

Report on Opinion - Case 98HDC15457, continued

Information Gathered During Investigation, *continued*

The manager was also unable to advise the complainant who the dispensing pharmacist was. The original prescription was obtained from Health Benefits Ltd. The form was not signed by the dispensing pharmacist. The manager has accepted responsibility for the matter.

The Code of Health and Disability Services Consumers' Rights

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.
…

Pharmaceutical Society of New Zealand Code of Ethics

Rule 2.12 states
"*A pharmacist must dispense the specific medicine prescribed …*"

Rule 2.13 states
"The pharmacist responsible for a dispensed product must always be readily identifiable … each prescription must be annotated with the initials of the person dispensing the prescription and the initials of the pharmacist responsible for the dispensed product."

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Pharmacist

Report on Opinion - Case 98HDC15457, continued

Opinion
Breach

In my opinion the manager breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights.

I was unable to identify the individual pharmacist who dispensed the consumer's *digoxin* as the prescription form was not signed. The manager advised the Commissioner that there were no written protocols or procedures for dispensing at the pharmacy. As manager of the pharmacy the manager must therefore take responsibility for the actions of the dispensing pharmacist.

Digoxin 0.25mg was dispensed in error and no record kept of who dispensed the tablets. By doing this the manager failed to comply with relevant professional standards as contained in the Pharmaceutical Code of Ethics and therefore breach of Right 4(2) of the Code.

Actions

I recommend that the manager:

- provide a written apology for the breach of the Code of Rights to the consumer's family;
- establish procedures and policies to ensure dispensing is checked independently where possible, and prescription forms are signed for by the dispensing pharmacist;
- confirm to the Commissioner that these procedures and policies on dispensing and checking of medication are in place.

A copy of this opinion will be forwarded to the Pharmaceutical Society of New Zealand.