Dispensing error
(14HDC01653, 29 October 2015)

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

A woman was taking a regular medication called fluoxetine (a selective serotonin reuptake inhibitor) to manage depression. She was travelling in New Zealand and needed further fluoxetine, so she saw a general practitioner (GP) to obtain a repeat prescription.

She had the prescription filled at a pharmacy. The pharmacist on duty that day dispensed Duride 60mg in place of fluoxetine 20mg. Duride is cardiac medication used to prevent angina. The pharmacy's medication label, printed and affixed on the medication box, stated that the contents were fluoxetine; however, the box and pill packets were marked "Duride". The woman did not question the name "Duride" on the box or pill packets.

The woman then started taking the Duride dispensed by the pharmacist. During the time she was not taking fluoxetine, she experienced an exacerbation in depression. She started seeing a counsellor again and struggled to find a job owing to feelings of inadequacy. Her relationship broke down and she suffered severe migraines, felt nauseous, experienced random heart palpitations, and was always fatigued.

The woman went to another GP for a further prescription. The GP immediately told her that the pills she had been taking for depression were not anti-depressants. The GP contacted the pharmacy on the woman's behalf and alerted it to the error.

The pharmacy had relevant Standard Operating Procedures in place at the time, but the pharmacist failed to ensure that he dispensed the correct medication and the correct dose. 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 found not to have breached the Code or to be vicariously liable for the pharmacist's breach.