Medication dispensing error
(13HDC01618, 13 January 2015)

Pharmacist ~ Dispensing error ~ Medication selection ~ IVF treatment ~ Incident management ~ Right 4(2)

A woman who was undergoing a frozen embryo transfer as part of her in vitro fertilisation (IVF) treatment was prescribed "Oestradiol Valerate" as part of her treatment. The prescription was faxed to the pharmacy and the woman went to the pharmacy to pick it up.

The pharmacist who processed the prescription entered the first four letters of the medication — "oest" — into the pharmacy computer software in order to generate the label. The medication that came up on the screen was oestriol (brand name Ovestin), which the pharmacist selected. The oestriol was then packaged and dispensed to the woman. The woman took the oestriol in accordance with the prescription instructions.

A few weeks later, on day 14 of the woman's menstrual cycle, she started spotting. The woman went to see her doctor and at that time the woman questioned the medication she had been taking and it was discovered that she had been dispensed an incorrect form of oestrogen (oestriol rather than the correct oestradiol valerate). As a result of taking the wrong medication, the woman's embryo transfer cycle had to be abandoned.

The woman later returned to the pharmacy to take back the oestriol and pick up the oestradiol valerate. At that time, the woman spoke to another pharmacist. The woman recalls the pharmacist said that she was sorry for the error, and that it was a computer error.

It was held that by failing to check the medication he was dispensing against the original prescription, the pharmacist failed to provide the woman with services in accordance with professional standards. Accordingly, the pharmacist breached Right 4(2).

It was accepted that the standard operating procedures (SOPs) for dispensing medications in place at the pharmacy at the time of this incident were appropriate, and that the pharmacist was aware of the dispensing requirements. Furthermore, there is no evidence that the pharmacy was particularly busy at the time of the incident. It was concluded that the pharmacy was not responsible for the pharmacist's breach of the Code.

Adverse comment was made about the pharmacy's incident management in this case.