Pharmacy

Pharmacist, Mr A

A Report by the

Mental Health Commissioner

(Case 18HDC00795)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. In 2018, Ms B was prescribed a daily dose of methadone.

2. On 23 April 2018, Ms B went to the pharmacy to consume her prescribed dose. The pharmacist was Mr A. Mr A called another consumer's name (with a similar sound to Ms B's first name). Ms B thought her name had been called and went into the consultation room. Mr A was not familiar with the identity of the other consumer or Ms B, and thought that the correct patient went into the consultation room with him.

3. Mr A said that once in the consultation room, he repeated the first name and surname of the other consumer, but Ms B did not say anything. However, Ms B said that Mr A did not say the other consumer's name. Mr A did not undertake an identification check or any further enquiry to confirm the identification of Ms B.

4. As a result, Ms B consumed the other consumer's prescribed dose of methadone and received the other consumer's methadone takeaway package.

5. After both Mr A and Ms B left the consultation room, another staff member informed Mr A that he had just served the incorrect consumer. Mr A immediately followed Ms B and asked her to return to the pharmacy to be administered the correct dose of methadone, and to return the other consumer's methadone takeaway package.

6. After discussing the situation with her staff, the manager of the pharmacy, Ms C, terminated the pharmacy's methadone service to Ms B and informed Ms B's Alcohol and Drug caseworker. However, Ms C did not discuss the issue with Ms B prior to deciding to terminate the methadone service to her.

Findings

7. In light of the conflicting accounts of events and the absence of other evidence, the Mental Health Commissioner was unable to make a finding as to whether the correct patient's name was called by Mr A in the consultation room.

8. Nevertheless, the Mental Health Commissioner found that Mr A should have done more to check the identification of the consumer, according to the Opioid Substitution Treatment Guidelines and the pharmacy's SOP. Accordingly, it was found that Mr A failed to provide Ms B with services in accordance with professional standards, and so breached Right 4(2) of the Code.

9. The Mental Health Commissioner was also critical about the training the pharmacy gave Mr A about its SOPs.

Recommendations

10. The Mental Health Commissioner recommended that Mr A provide a written apology to Ms B. The Mental Health Commissioner also recommended that the pharmacy arrange refresher training for its staff on dispensing and administering methadone, update its

induction programme, and conduct an audit on errors and near misses in relation to dispensing of methadone and staff compliance with its SOPs.

11. The Mental Health Commissioner also recommended that the Ministry of Health review its New Zealand Practice Guidelines for Opioid Substitution Treatment (2014), in light of the findings in this report, to ensure that the Pharmacy Council's Code of Ethics and the Code of Health and Disability Services Consumers' Rights (the Code) are able to be applied appropriately when a pharmacy terminates services for a patient who is receiving opioid substitution treatment.

Complaint and investigation

12. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided by Mr A, a pharmacist. The following issues were identified for investigation:

- *Whether the pharmacy provided Ms B with an appropriate standard of care in April 2018.*
- *Whether Mr A provided an appropriate standard of care to Ms B in April 2018.*

13. This report is the opinion of Kevin Allan, Mental Health Commissioner, and is made in accordance with the power delegated to him by the Commissioner.

14. The parties directly involved in the investigation were:

Mr A	Pharmacist
Ms B	Complainant/consumer
Pharmacy	Provider

15. Further information was received from:

Ms C	Pharmacy Manager
Ms D	Another consumer
Pharmacy Council of New Zealand	

Information gathered during investigation

Background

16. In 2018, Ms B was prescribed a daily dose of methadone. The Controlled Drug Prescription form read as follows:

"R: METHADONE MIXTURE

Daily dose of 60 milligrams per day 5mg/ml …

Biodone Forte 12ml dose

Daily doses of methadone are to be consumed on the pharmacy premises. Takeaway doses are only to be dispensed for days when the pharmacy is closed and when otherwise authorised.

Takeaway doses are authorised for the following days:

COP[1] Mon, Tues, Thur, Fri

[Takeaway] Wed & [weekend]

Prescription to be dispensed at [the pharmacy]."

Incident on Monday 23 April 2018

Prior to entering consultation room

17. On Monday 23 April 2018, Ms B went to the pharmacy to consume her prescribed dose of methadone. Mr A[2] was the pharmacist responsible for administering the methadone on that day. Mr A stated that he called out the first name of Ms D, who was also scheduled to receive her methadone dose that morning. Ms D's name ends in an "-ie" (as does Ms B's first name).

18. Ms B said that on that day she did not see anyone else at the pharmacy who was on the methadone programme and waiting to be served. Ms B stated:

"When I came in that morning, I saw no-one else that I know to be on the programme, waiting to be served. When the pharmacist called the name, I thought he said [my name] as I caught the 'ie' at the end, & he was looking directly at me."

19. Ms B told HDC that she stood up and entered the consultation room because she thought that her name had been called.

20. In contrast, Mr A told HDC:

"On 23 April, a staff member … handed me [Ms D's] package and told me that [Ms D] … was in the store. At this stage, I was not yet familiar with [Ms D] or [Ms B] and relied on other staff telling me when they came in. I took [Ms D's] dose and called out '[Ms D's first name]' in a loud voice … CCTV footage was viewed a few days later and it showed both [Ms D] and [Ms B] standing up, in response to me calling out."

21. Ms D told HDC that she was at the pharmacy on 23 April 2018 to receive her dose of methadone. She said that two other women were present in the waiting area, and her

[1] Consume on premises.

[2] Mr A commenced work at the pharmacy in 2018. He began his duties of supervising and administering the methadone consumption at the pharmacy seven weeks later. Mr A has been a registered pharmacist since 2013.

name was called by Mr A. Ms D stated that "as she was about to stand up, the other tall lady stood up quite quickly and barged into the consultation room", so she "did not go into the consultation room and remained seated".

22. Ms B entered the consultation room instead of Ms D.

Dispensing of methadone in consultation room

23. Mr A informed HDC that once in the consultation room, he said "[Ms D's first name and surname]. 5ml" to Ms B before giving her the methadone to consume. Mr A said that Ms B "didn't say anything or do anything indicative of something being wrong. Her facial expression and body language suggested she was all good and ready to take her dose …"

24. Contrary to Mr A's version, Ms B stated that Mr A did not say "[Ms D's first name and surname]. 5ml" in the consultation room, and that there was no further identification check by Mr A. In Ms B's complaint to HDC, she wrote: "[H]ad the pharmacist repeated the name in [the] back room … I would definitely have said no and waited my turn. He did not ask if I was [Ms D] or [my first name] for that matter …"

25. Ms B then consumed Ms D's prescribed dose of methadone. Ms B was also dispensed the methadone takeaway for Ms D.[3] Mr A informed Ms B that the takeaway dose was covered until ANZAC day (Wednesday 25 April 2018). Mr A told HDC:

> "[Ms D's] package wrongly given to [Ms B] would have contained 5 takeaways … On the other hand, [Ms B] took methadone only once a day, so to last up to the end of ANZAC Day, she would have needed only 2 bottles … The package, with 5 bottles inside, would have been clearly bigger and bulkier than one that contained only 2 bottles …"

26. Ms C, the Pharmacy Manager, noted:

> "There were no takeaways for [Ms B] on the day, Monday the 23rd of April 2018. [Ms B's] prescription clearly states she is to have a 60mg (12ml) COP dose for Mon, Tues, Thurs, and Fri, with takeaways on Wed and the weekend. [Ms B] accepted [Ms D's] takeaways in the consulting room …"

27. Ms B told HDC:

> "I [usually] get takeaway on Tue for wed but had queried this when [the] script changed as I believed [the doctor] had said I w[ou]ld be going on to Mon wed Fri consume and receive takeaways for remaining days so I assumed when he handed package to me that my script had b[ee]n amended."

28. Mr A stated that at the time of the incident, Ms B said to him that she assumed that the doctor had changed her takeaway schedule.

[3] Ms D's prescription of methadone is 5mg/ml and a 5ml dose per day, and she was authorised for takeaway doses on Tuesday, Wednesday, Friday, and the weekend.

Subsequent event following interaction in consultation room

29. Shortly afterwards, both Ms B and Mr A left the consultation room. Mr A was then informed by another staff member that the person he had just served was Ms B, and not Ms D. Mr A immediately followed Ms B to the car park, and apologised and explained to her the error that had occurred. He told her that she needed to return to the pharmacy and be administered a further 7ml of methadone to match her prescription. Mr A took the incorrect takeaway package from Ms B.

30. On the same day, Ms C made a decision that the pharmacy would cease to provide methadone services to Ms B.

Termination of methadone services

31. On the same day, Ms C communicated the decision to terminate the pharmacy's methadone service to Ms B to Ms B's Alcohol and Drug caseworker (A&D caseworker). Ms C said that this is the process that she has "used for the last eight and a half years". Ms C told HDC that, in her opinion, Ms B "had two opportunities to say she was not [Ms D] and two opportunities to question the volume of 5ml instead of 12ml, and the takeaways she was handed when she wasn't expecting them". Ms C said that, accordingly, she felt that it was no longer appropriate for the pharmacy to continue to dispense methadone to Ms B.

32. Ms B's A&D caseworker told Ms B of the pharmacy's decision to terminate its methadone services to her. Ms B explained her perspective of the events, and the A&D caseworker then rang Ms C and informed her of Ms B's explanation. Ms C told HDC: "[The A&D caseworker was] rude and unhelpful. I was not being listened to … and my reasoning was not considered by this person." She said that she informed the A&D caseworker: "[I]t doesn't matter, I'm not changing my mind." Ms C told HDC that "methadone is a medicine with a high risk of harm and if taken incorrectly or inappropriately, and [the pharmacy] has zero tolerance for any individual who is dishonest with us with this service".

33. Ms C also told HDC that she had a discussion with the prescribing doctor for Ms B's methadone programme. Ms C said that she explained her concerns, and why she had terminated the pharmacy's methadone service to Ms B. The prescribing doctor said that he would discuss this with A&D caseworker.

34. On 27 April 2018, Ms B dropped off a letter to the pharmacy addressing her concerns about the pharmacy terminating its methadone service to her. On 30 April 2018, Ms C sent a letter to Ms B stating: "I have investigated this incident and spoken to those members of staff involved. As a result of this, the decision to terminate services to you still stands."

Mr A's experience and training provided by the pharmacy

35. In relation to his experience, Mr A stated:

> "I have been dispensing controlled drugs and Methadone since shortly after I registered in 2013. I was doing Methadone administering under supervision up until about September 2013. I did the OST[4] training on Blink.co.nz in August 2013 and was

[4] Opioid Substitution Treatment.

> then able to do OST administering without supervision … I have dealt with Methadone patients on a fairly regular basis for most of my pharmacy career since September 2013. From 2014 to about 2016, I did small scale OST preparation and administering at a pharmacy with only 4 OST patients. From 2017 to early 2018, I did OST preparation and administering on a larger scale at a pharmacy with about 15 OST patients, but only worked there 2 days weekly …"

36. In relation to any training he received from the pharmacy regarding administration of methadone, Mr A stated:

> "I was not given any orientation of the [Standard Operating Procedures (SOPs)], I was made aware of where all the SOPs were kept if I needed to refer to them. I was shown how the OST was prepared and arranged and what records were kept. My employer felt that as I have been doing OST administering for a few years now that I should know well enough how to administer methadone to patients without having to read the SOPs."

37. When asked about the scope of the training provided to Mr A, Ms C stated:

> "[Mr A] worked at the pharmacy for seven weeks to become familiar with the pharmacy's process before I commenced him on methadone COP supervision. He commenced methadone duties in earnest on the 16th April 2018 … [Mr A] was shown where the safe was and how to open it and where in the safe we stored the methadone doses. He was shown where the consulting room was and was informed of our processes when dealing with methadone clients. He was able to observe other pharmacists undertaking these tasks before he commenced them himself. [Mr A] has been registered for five years and has dispensed methadone in other pharmacies before commencing at the pharmacy."

Changes made since incident

38. The pharmacy advised that no change has been made to its current methadone administration procedure since the incident. The pharmacy stated that it has "adequate checks in place to ensure we are administering the methadone to the correct patient". It also told HDC that any new pharmacists will be shown SOPs relevant to their job, including the methadone SOP, and clarification will be given to new pharmacists that the patient's name will be spoken in the waiting area to welcome the patient to the consultation, then the patient will be asked for his or her full name while inside the room to confirm that the correct patient is present.

39. Mr A told HDC that as a result of this incident he has made changes to his practice, including:

> "[A]sking a staff member familiar with the patients to identify a patient if I was not sure.

> … [G]etting a patient to confirm their name and dose rather than me saying it … if I were ever to encounter new OST patients, I would get them to confirm name and dose, and show ID
>
> … [M]entioning the patient's name when greeting them rather than just saying 'hello' by itself
>
> Whenever I am about to hand to patients their takeaway packages, I now show them the name of the label on the package, point to their name on it and state their name. Once they affirm, I point to the days on the label which the takeaways cover and state it. This allows them to see clearly it's their items."

Methadone Dispensing SOP

40. The pharmacy's Methadone Dispensing SOP states:

> "Guidelines
>
> - All regulations regarding Controlled Drugs are to be complied with.
> - All requirements of the National Methadone Protocol are to be met.
> - All requirements of the New Zealand Practice Guidelines for Opioid Substitution treatment in New Zealand 2014 are met.
> - All requirements of the Guidelines and Contract used by [the] Alcohol & Drug Unit that pertain to Pharmacy will be followed and enforced.
> - All requirements of Appendix 5B to [the Contract] will be followed and enforced.
> - Patient confidentiality is to be preserved.
> - Methadone dispensing is to be kept to a level acceptable to other pharmacy clients.
>
> …
>
> Dispensing/consuming
>
> - All doses to be 'Consumed on Premises' will be consumed under the supervision of a pharmacist.
> - Client taken to designated area — currently the consulting room — and their identification checked.
> - Prepared dose poured into the cup and also consumed.
> - Water poured into the cup and also consumed.
> - Client to dispose of the cup in the lined bin provided in the consulting room.
> - Any spillage of the dose or water to be cleared up immediately using disposable paper towels and spray meth's.
> - Check patient has swallowed dose by having a conversation with client. This is also a way of ascertaining the well-being of the client.

- Once client has consumed their dose, the pharmacist supervising consumption must sign on the 'Record of Pharmacist Supervising COP of Methadone or Suboxone' sheet, which is on the wall in the wet area. At the end of the month, these sheets must be placed with the 'Methadone Dispensing Record' and retained in the pharmacy for four years."

41. Ms C advised in a letter dated 12 September 2018 that the Alcohol and Drug Unit has rescinded any contract between the Alcohol and Drug Unit, the client, and the pharmacy, and that the pharmacy now uses the New Zealand Practice Guidelines for Opioid Substitution Treatment in New Zealand 2014. Ms C also told HDC that the Alcohol and Drug Unit did not notify the pharmacy regarding this change and, as a result, the SOP was not updated.

Responses to provisional opinion

Ms B

42. Ms B was provided with an opportunity to comment on the "information gathered" section of the provisional report.

Mr A

43. Mr A was provided with an opportunity to comment on the provisional opinion, and responded that he had no further comment to make.

The pharmacy

44. The pharmacy was provided with an opportunity to comment on the provisional opinion. Where relevant, changes have been made to the report to reflect its comments.

Relevant standards

45. The Ministry of Health's New Zealand Practice Guidelines for Opioid Substitution Treatment (2014) (Opioid Substitution Treatment Guidelines) states:

> "6.4 Managing challenging behaviour
>
> Some clients have significant behavioural and impulse control problems Realistic expectations, a non-judgemental attitude and patience are essential in the management of such clients. Assisting clients to identify and label emotions and encouraging reductions in impulsiveness may improve clients' functioning and have a positive impact on their therapeutic outcomes …
>
> Key workers should discuss treatment policies and procedures ('the rules') with clients and their support people, and provide rationales for them upfront. Where a client does not follow a certain policy, the service should review his or her case as soon as possible; a support person should participate in this review wherever possible, to collaborate on minimising adverse consequences and avoiding recurrence. This approach is in keeping with the Code of Health and Disability Services [Consumers']

Rights 1996 … Specialist services must acknowledge the imbalance of power between clients and professionals. This imbalance can cause problems, particularly with clients who are very vulnerable or who have difficulty with authority figures.

…

9.1.1 Providing a confidential service free from discrimination

Pharmacist should ensure that all pharmacy staff are aware of their obligation with respect to maintaining confidentiality and the protection of the health and information of OST clients.

Most OST clients have experienced stigma to some extent. Such experiences can lead to feelings of anger, fear, distrust or helplessness, or a sense of being excluded from society. As clients attend pharmacies frequently, this setting has the potential to be a significant source of stigmatising experiences. Pharmacy staff can minimise the risk of such experiences by being aware of the potential for discrimination, taking a non-judgemental, empathic approach to clients and providing sensitive service; for example, by making available a discreet area for supervised consumption.

…

9.2.1 Dispensing

Safe dispensing of OST medication involves ensuring the legality of prescriptions; positively identifying clients (if necessary checking recent photographs provided by the specialist service or prescriber and/or checking photo identification provided by clients); and following correct labelling, record-keeping and filing procedures …

Opioid substitution medication — in particular, methadone — can cause death from overdose if the incorrect dose is dispensed …

…

9.2.3 Administering observed consumed doses

Clients receiving OST medication must consume the full prescribed dose under observation at the time of each administration. The procedure should involve the pharmacist:

- First checking the client for symptoms of intoxication or withdrawal from opioids or other illicit substances
- Accurately measuring the prescribed dose
- Giving the methadone dose to the client in a disposable cup (disposable cups must not be recycled, and must be disposed of safely) or giving the (crumbled) sublingual buprenorphine tablets to the client in a medication pottle
- Observing the client taking the dose
- If diversion is strongly suspected or observed, notifying the prescriber or specialist service."

…

9.3.2 Managing challenging behaviour in the pharmacy

Difficult behaviour and difficult situations involving OST clients are a significant cause of concern among some pharmacists. Pharmacists can reduce the likelihood of such situations arising by taking a consistent approach to OST dispensing that maintains firm, professional boundaries and a confidential and non-judgemental service. When a pharmacist is confronted with challenging behaviour, de-escalation may be sufficient to manage the situation. Pharmacy staff should remain calm, listen to the individual's concerns in an empathic, non-confronting manner, emphasise a desire to help and try to make the individual more comfortable.

Pharmacists should not condone threatening and abusive behaviour by any client. In such a situation, pharmacy staff should follow the pharmacy's internal procedures, and contact police if necessary. Pharmacy staff should report all incidents of difficult or unlawful behaviour to the prescriber or specialist service."

46. The Pharmacy Council's Code of Ethics 2018 states:

"Principle 2 articulates that pharmacists must display respect for patients and respect diversity by avoiding discrimination on any grounds. They must also enable and involve the patient in making choices …

C. Encourages patients to participate in shared decision-making through respectful conversations, and assists by providing information and advice relevant to the patient's clinical needs in culturally appropriate language, detail and format."

47. The Pharmacy Council's Competence Standards for the Pharmacy Profession (January 2015) states:

"M1.6 Make Effective Decisions …

M.1.6.4 Listens to others when decisions are questioned and is open to further evidence

M1.6.5 Communicates decisions comprehensively including the rationale behind the decision"

Opinion: Mr A — breach

Failure to follow Opioid Substitution Treatment Guidelines

48. I accept that there are several inconsistencies between the statements given by Ms B and Mr A about their interactions on 23 April 2018. Mr A stated that he called another patient's name on two separate occasions (the first when he called the other patient's name outside the consultation room and the second when he repeated the other patient's

name inside the consultation room). However, Ms B stated that she simply thought that her name was called (both names end in "-ie"), and so she entered the consultation room. She said that Mr A did not check her identification or repeat the other patient's name in the consultation room.

49. Mr A's description of the first occasion outside the consultation room is supported by Ms D, who stated that she heard Mr A call her own name.

50. Based on the evidence, I accept that Mr A called another patient's name outside the consultation room. I also accept that Ms B thought that her name had been called, as her name sounds similar to that of Ms D. However, determining what happened inside the consultation room is more difficult, as Mr A and Ms B give conflicting accounts of events. In the absence of other evidence, I am unable to make a finding as to whether or not Mr A repeated the other patient's name inside the consultation room.

51. The pharmacy's methadone dispensing SOP states that Mr A was required to "check the patient's identification". The Opioid Substitution Treatment Guidelines also require that pharmacists positively identify clients, "if necessary checking recent photographs provided by the specialist service and/or checking photo identification provided by clients".

52. Mr A accepts that he was not familiar with the identity of either Ms B or the other patient. As noted above, I am unable to make a finding as to whether Mr A repeated the other patient's first name in the consultation room. However, even if he did, I do not consider this to have been sufficient. Mr A did not ask Ms B to identify herself or confirm her identity by asking for her photo identification. In failing to do so, he did not comply with the pharmacy's SOP or the Opioid Substitution Treatment Guidelines. Methadone is a Class B controlled drug, and can cause death if the incorrect dose is dispensed. In my view, Mr A should have been more cautious given his lack of familiarity with the patients, particularly in light of the high risk of adverse effects.

53. In respect of the takeaway package, Mr A told HDC that Ms B received methadone takeaways when she was not supposed to, and would have been aware of this because she was not scheduled to receive takeaways on that day, and the takeaway package had the other patient's name on it. In contrast, Ms B stated that she thought that her takeaway dose had been changed according to a discussion she had had with her prescribing doctor. It is not necessary for me to make a finding about whether or not Ms B realised that the takeaway package was not hers. The key point is that Ms B was dispensed the other client's takeaway package as a result of Mr A's failure to check Ms B's identity adequately before dispensing the package to her.

54. Mr A accepts that he mistakenly dispensed and administered another patient's methadone dose to Ms B. As a registered pharmacist, Mr A is responsible for complying with professional standards. By failing to identify Ms B clearly, as required by the Opioid

Substitution Treatment Guidelines, I consider that Mr A failed to provide Ms B with services in accordance with professional standards, and so breached Right 4(2).[5]

Opinion: The pharmacy

Training provided to Mr A — adverse comment

55. As a healthcare provider, the pharmacy is responsible for providing services in accordance with the Code. The pharmacy has an obligation to ensure that it has adequate policies in place to facilitate safe and disciplined dispensing. It also has a responsibility to ensure that all pharmacists working in the pharmacy are appropriately trained and experienced, and aware of the pharmacy's expectations, including the SOPs.[6]

56. The Pharmacy's SOP states that the patient's identification must be checked. This requirement is similar to the Opioid Substitution Treatment Guidelines, which also form part of the pharmacy's SOPs, and require patients to be positively identified, if necessary checking photo identification.

57. Mr A had been a registered pharmacist since 2013, and had dispensed methadone previously in other pharmacies before being employed by the pharmacy. The pharmacy has stated that Mr A was informed of the pharmacy's processes when dealing with methadone clients, and was shown where the written SOPs were kept. Mr A told HDC that given his prior experience, the pharmacy understood that he was experienced with administering methadone to patients without needing to read the SOPs.

58. I acknowledge that Mr A was not immediately given the duty of supervising the administration of methadone to patients. Mr A started his employment with the pharmacy in 2018, and began methadone administration duty seven weeks later. During this seven-week period he was able to observe other pharmacists undertaking these tasks, and to become familiar with the pharmacy's process.

59. However, I am critical that Mr A did not receive training on the written SOPs, and that the pharmacy did not take steps to ensure that a new pharmacist had read and understood its SOPs. A pharmacy should actively engage with staff in respect of its SOPs, and support staff understanding of, and compliance with, its SOPs.

Decision to terminate methadone services to Ms B — other comment

60. The pharmacy terminated its methadone services to Ms B immediately following the incident on 23 April 2018, and Ms C informed Ms B's A&D caseworker of the decision the same day. The pharmacy did not communicate directly with Ms B or Ms B's A&D caseworker prior to making the decision to terminate its methadone services.

[5] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."
[6] Opinion 13HDC00819, 23 June 2014.

61. I acknowledge that in doing so, the pharmacy followed its internal procedures, and that the pharmacy informed the A&D caseworker of its decision to terminate the service to Ms B in accordance with its understanding of the Opioid Substitution Treatment Guidelines (the Guidelines).

62. Under the Guidelines, the A&D caseworker is the point of contact for a service provider to communicate any concerns that the service provider has about a consumer's behaviour. This means that the usual expectation in the Pharmacy Council's Code of Ethics — that of encouraging patients to participate in shared decision-making, which presumably should include involving the consumer and the consumer's representative and, given the opportunity, the case worker and the pharmacist, through respectful conversations — does not apply in this case.

63. Most patients who have received opioid substitution treatment have experienced stigma to some extent, and such experiences can lead to feelings of frustration (rather than anger), and of fear or a sense of being excluded from society.[7] Therefore, I consider it essential that all patients who receive opioid substitution treatment are treated with a reasonable, non-discriminatory, non-judgemental and empathetic approach. In my view, it is important that input from the consumer is sought prior to any decision to terminate a pharmacy's service to that consumer. Unilateral termination of services without any direct engagement with the consumer is likely to be based on incomplete information, and risks being unfair and unreasonable. For this reason, I have invited the Ministry of Health to review the Guidelines to ensure that the Pharmacy Council's Code of Ethics and the Code of Health and Disability Services Consumers' Rights are being applied consistently in that environment.

Recommendations

64. I recommend that Mr A provide a written apology to Ms B for his breach of the Code. The apology should be sent to HDC, for forwarding to Ms B, within three weeks of the date of this report.

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

a) Arrange refresher training for its staff in relation to dispensing and administering methadone, and confirm to HDC that the training has occurred.

b) Update its induction programme to include orientation to, and training on, its SOPs, and report back to HDC with a copy of the updated induction programme.

d) Conduct an audit, for a period of one month, on the following matters:

[7] Section 9.1.1 of the Opioid Substitution Treatment Guidelines.

i. Any errors or near misses in relation to dispensing of methadone, and common themes or patterns found; and

ii. Staff compliance with page 99 of the SOPs regarding "methadone dispensing and consuming".

e) Report back to HDC on the outcome of the audit, including any actions taken by the pharmacy to improve its policies and practices as a result of the audit findings.

66. I also recommend that the Ministry of Health review its New Zealand Practice Guidelines for Opioid Substitution Treatment (2014), in light of the findings in this report, to ensure that the Pharmacy Council's Code of Ethics and the Code of Health and Disability Services Consumers' Rights are able to be applied appropriately when a pharmacy terminates services for a patient who is receiving opioid substitution treatment.

Follow-up actions

67. An anonymised copy of this report, with details identifying the parties removed, will be sent to the Pharmacy Council of New Zealand, and it will be advised of Mr A's name.

68. An anonymised copy of this report, with details identifying the parties removed, will be sent to the New Zealand Pharmacovigilance Centre, the Health Quality & Safety Commission, the Ministry of Health, the Office of the Director of Mental Health and Addiction Services, Te Pou o te Whakaaro Nui, and the Mental Health Foundation of New Zealand, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.