Provision of methadone treatment to wrong patient
18HDC00795, 19 June 2019

Pharmacist ~ Pharmacy ~ Methadone ~ Identification ~
Opioid Substitution Treatment Guidelines ~ Training ~ Right 4(2)

A woman who had been prescribed a daily dose of methadone went to a pharmacy to consume her medication. The pharmacist called another person's name (with a similar sound to the woman's first name). The woman thought her name had been called, and went into the consultation room. The pharmacist was not familiar with the identity of either of the patients, and thought that the correct patient went into the consultation room with him.

The pharmacist said that once in the consultation room, he repeated the first name and surname of the other person, but the woman did not say anything. However, the woman said that the pharmacist did not say the other person's name. The pharmacist did not undertake an identification check or any further enquiry to confirm the woman's identification.

As a result, the woman consumed the other person's prescribed dose of methadone, and received the other person's methadone takeaway package.

After both the pharmacist and the woman left the consultation room, another staff member informed the pharmacist that he had just served the incorrect person. The pharmacist immediately followed the woman and asked her to return to the pharmacy to be administered the correct dose of methadone, and to return the other person's methadone takeaway package.

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

Findings

In light of the conflicting accounts of events and the absence of other evidence, it was not possible to make a finding as to whether the correct patient's name was called by the pharmacist in the consultation room.

Nevertheless, it was held that the pharmacist should have done more to check the identification of the woman, according to the Opioid Substitution Treatment Guidelines and the pharmacy's SOP. Accordingly, it was found that the pharmacist failed to provide the woman with services in accordance with professional standards, and so breached Right 4(2).

Criticism was made about the training the pharmacy had given the pharmacist about its SOPs.

Recommendations

It was recommended that the pharmacist provide a written apology to the woman. It was 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.

It was also recommended that the Ministry of Health review its New Zealand Practice Guidelines for Opioid Substitution Treatment (2014), in light of the findings in the 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.