Dispensing errors
(04HDC10718, 28 June 2005)

Pharmacist ~ Pharmacy ~ Multiple medications ~ Multiple prescriptions ~ Stacker trays ~ Standard operating procedures ~ Professional standards ~ Right 4(2)

A 78-year-old woman who was on multiple long-term prescription medications was discharged from hospital with a prescription for additional medications. The woman and her caregivers were concerned that she might not be able to manage taking 12 different medications at different times of the day.

A neighbour, who was a nurse, asked the local pharmacy if the medications could be dispensed in blister packs. While the pharmacy was unable to do this, the pharmacist offered to dispense the medication in stacker-trays. Stacker-trays are plastic containers which each have eight trays: seven are marked with the days of the week, the eighth being an unmarked spare tray. Each tray is further divided into four compartments labelled morning, noon, evening and night. The labelling and compartments help patients to identify the medications they are required to take at a particular time of the day.

The pharmacist offered to sort the woman's existing medicines, and those to be dispensed that day, into the trays. The neighbour dropped off the medicines and the new prescriptions. When she collected them, however, she noticed that the pharmacist had omitted one medicine from the evening intake and had doubled another. The medicine to be taken that evening had been placed in a paper bag, which was incorrectly marked as the morning dose.

As the errors were discovered before the stacker-trays were delivered to the woman, she was not adversely affected. The pharmacist corrected the error, notified the woman's GP of the error, apologised to the woman and her doctor, and reviewed the pharmacy's dispensing and checking systems.

It was held that the pharmacist's failure to follow his usual practice and the pharmacy's standard operating procedures was a breach of Right 4(2).