Dispensing error — antihypertensive (01HDC10717, 31 May 2002)

Pharmacist ~ Pharmacy ~ Dispensing error ~ Standard Operating Procedures ~Right 4(1)

A man presented to his GP with inadequately controlled blood pressure. Instead of Accupril 10mg tablets, as prescribed, the pharmacist dispensed Accupril 5mg tablets with a label stating that they were 10mg tablets. The man also complained that on an earlier occasion the pharmacist dispensed an incorrect dose of the beta-blocker atenolol on a repeat prescription.

The importance of the checking process when dispensing prescription medicines cannot be overstated. The Pharmaceutical Society of New Zealand's Quality Standards for Pharmacy emphasise the responsibility of dispensing pharmacists to maintain a disciplined procedure in order to ensure that the appropriate product is selected and dispensed correctly and efficiently.

The pharmacist acknowledged his errors, apologised and reimbursed the man. He also revised the pharmacy's Standard Operating Procedures.

The Commissioner held that the pharmacist breached Right 4(1) in that he failed to take reasonable care and skill when checking and dispensing the prescriptions. As the pharmacy had taken reasonable steps to prevent the error that occurred, it was not vicariously liable for the breach of the Code. The matter was referred to the Director of Proceedings, who decided not to issue proceedings.