Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 23HDC01508)

Introduction

1. This report is the opinion of Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. The report discusses the care provided to a baby by a pharmacy. In particular, the complaint concerns a pharmacist's failure to check a medication before it was dispensed. The dispensed medication dose on the box should have read 0.9ml but instead read 4.5mls, which was five times the prescribed dose. The report highlights the importance of pharmacists undertaking adequate checks, following process and guidelines on the dispensing of medication, and of managing dispensing errors and complaints. It also highlights the importance of pharmacies providing adequate training to staff to ensure that processes are followed.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

3. The following issues were identified for investigation:

- *Whether the pharmacy provided Baby A with an appropriate standard of care on 12 May 2023.*
- *Whether Ms B provided Baby A with an appropriate standard of care on 12 May 2023.*

4. The parties directly involved in the investigation were:

Baby A	Consumer
Mr and Mrs A	Parents of consumer
Provider/pharmacy	
Ms B	Individual provider/pharmacist
Ms C	Trainee pharmacy technician
Pharmacy managing partner	

5. Further information was received from:

The Pharmacy Council	Regulatory body
A public hospital	

Information gathered during investigation

Background

6. On 11 May 2023, Mrs A took Baby A (four weeks old at the time of events) to their general practitioner (GP) as Baby A had been unwell with a croup-like seal-barking cough and Mr and Mrs A considered it important she be checked given her age, and the acute nature of croup. Baby A was diagnosed with croup[1] and prescribed 'Redipred[2] 5mg/1mL Liq 30ml'. The GP advised Mrs A to give Baby A the medication if she heard her cough again. On the prescription form it specified next to the 'Sig'[3] part that the dose of medication should be '4.5mg po[4] daily' taken over two days. Mrs A told HDC she did not fill the prescription that afternoon as Baby A appeared settled later that afternoon and evening.

7. On 12 May 2023 at around 9.15am, Mrs A took Baby A with her to collect the prescription from the pharmacy. The label on the box containing the medication stated: 'Give 4.5mls with food ONCE daily in the morning for a TWO-day course as directed.' Mrs A confirmed that she received no counselling about the prescription when it was handed to her by the pharmacist nor was she asked about Baby A's weight. Mrs A stated that she was unaware of any error with the label on the prescribed medication at that time.

8. Mrs A told HDC that on the same day, once she was home, Baby A started to cough at around 1.10pm and so she administered the medication as per the label instructions from the

[1] A viral illness in young children that causes narrowing of the upper airways.
[2] An oral steroid drug used to treat asthma attacks and control symptoms such as wheezing by improving swelling inside the airways and reducing the amount of mucus in the airways.
[3] The part of the prescription that contains the prescriber's directions to the patient.
[4] The medication is to be taken by mouth, or orally.

pharmacy, namely 4.5ml of Redipred via a 5ml syringe very slowly into the corner of Baby A's mouth. Mrs A described how Baby A aspirated what she estimated to be about the last 0.5ml of the full 4.5ml dose and stopped breathing. Mrs A said Baby A then turned blue and floppy. Mrs A carried out CPR and Baby A started breathing again after about 10 seconds.

9. Mrs A took Baby A to the Emergency Department at the public hospital, and she was assessed by a triage nurse at 2.11pm. The provisional diagnosis at the hospital from the CED Assessment Note was stated as 'Likely viral LRTI',[5] 'BRUE',[6] and 'inappropriate steroids use and dose'.

10. Baby A was prescribed emergency medication[7] and admitted to the General Paediatrics Department for overnight observation and monitoring. On examination she was noted to be well except for 'ejection systolic heart murmur[8] 2/6 loudest at left upper sternal edge, radiating to lung fields'.

Discovery and management of dispensing error

11. Mrs A told HDC that upon arrival at the hospital, she informed the triage nurse that she had administered 4.5ml of Redipred as per the label instructions from the pharmacy. Initially staff at the hospital inferred that Mrs A had misread the dose on the label of the medication and, as a result, Mrs A questioned herself believing she had made a mistake and had caused Baby A to stop breathing from an overdose of the medication.

12. It was only later in the afternoon of 12 May 2023, following a conversation with the paediatrician, that Mrs A rang the pharmacy from the hospital. Mrs A said that she called to obtain a copy of the prescription to check it, as initially she had thought that their GP had been responsible for stating the wrong dosage on the prescription form, and she was intending to follow up with their GP on the Monday (15 May 2023).

13. Mrs A stated that she spoke to the locum pharmacist on duty that day, Ms B,[9] who admitted that there had been a dispensing error in that she had not checked the label on the Redipred box against the prescription from the GP. Mrs A told HDC that Ms B was very apologetic and accepted full responsibility for her error and made a comment along the lines of, 'I thought I should check it because it was a 4-week old but I thought it would be fine.' Mrs A told HDC that Ms B seemed 'mortified' that she had not carried out the necessary checks.

14. Whilst Ms B told HDC that she acknowledged the error in the telephone conversation, for which she apologised and accepted responsibility, she does not recall saying, 'I thought I should check it because it was a [four-week-old] but I thought it would be fine.' In their response to the provisional opinion, Mr and Mrs A stated that 'the comment made by [Ms

[5] Lower respiratory tract infection.
[6] Brief resolved unexplained event.
[7] Ibruprofen, paracetamol, fentanyl, lidocaine + tetracaine + adrenaline (Topicaine®), tetracaine (Ametop®) and salbutamol.
[8] An unusual heart sound like a 'swish' or 'whoosh' after the first heart sound that occurs when the heart muscle contracts.
[9] Ms B had been contracted by the pharmacy to work as a locum pharmacist to cover leave on 12 May 2023.

B] was the entire basis of complaint to the Pharmacy Council'. Ms B recognised that this initial call with [Mrs A] was 'not ideal'. Ms B told HDC that 'the music in the Pharmacy was also loud and [she] was struggling to process the information from [Mrs A] during the call'. A copy of the prescription form later provided to Mrs A had a box that provided for signatory entries to be completed when the medication was entered, dispensed, and checked. All these boxes were signed by Ms B on the prescription form, including the checked box.

15. Later in the conversation, when questioned further by Mrs A, Ms B informed her that a pharmacy technician (now known to be Ms C) had typed the label against the prescription, but Ms B still acknowledged that it was '100%' her responsibility to check the label against the prescription. Mrs A stated that she thanked Ms B for her apology at that time.

16. On the afternoon of 13 May 2023, Baby A was discharged from the hospital. The advice on the Clinical Summary form to the family GP was for the GP or a private paediatrician to 'auscultate for murmurs and refer to cardiology if this is persistent'. Advice was also given to Mr and Mrs A on discharge, including for them to check with their GP/paediatrician regarding the heart murmur, and if Baby A's situation deteriorated, to return to the hospital.

17. On 13 May 2023 the hospital also made a referral to the Paediatric Community Nurse to check in with Baby A and Mrs A following discharge.

18. Ms B told HDC that on Tuesday, 16 May 2023 she contacted Baby A's GP to notify him of the error.

19. On Friday, 19 May 2023, Mrs A received an apology letter from Ms B. In the apology, Ms B acknowledged the error with the prescription stating that the prescription had been misread when processing through the pharmacy's computer software, which had resulted in the label stating the incorrect dose of 4.5ml (as opposed to 4.5mg as stated on the prescription). There was also an acknowledgment that this had not been identified by Ms B when she undertook the final check.

Post-error communication

Mrs A's concerns

20. Mrs A told HDC that she was concerned about the following conversations Ms B had with her after the error was discovered:

a) On 12 May 2023, Ms B offered to compensate Mrs A for her baby's admission to the hospital, which Mrs A declined.

b) Mrs A told HDC that after the initial call, Ms B called her and asked if she could speak to her on her mobile phone rather than the pharmacy phone. Mrs A said that she asked Ms B politely not to contact her again but said she understood that Ms B wanted to check that Baby A was okay and so reassured her that she would call her the following week with an update on Baby A's condition. Mrs A explained to HDC that if she had had the information, she would have provided it to Ms B.

c) Mrs A advised that on the same evening (12 May 2023) and the following morning (13 May 2023), Ms B called her four times from multiple numbers and also called Mr A on

one occasion. Mrs A said that she had felt harassed and did not feel it was her responsibility to 'provide reassurance and effectively, professional supervision to the pharmacist who had made a grave error'.

d) On 13 May 2023, Ms B offered to sit with Baby A whilst Mrs A had a break and tended to her other children. This offer was also declined by Mrs A, who said that she explained to Ms B that she did not have the capacity to speak to her because she needed to focus on her baby. Mrs A told HDC that during this call Ms B told her that on 12 May 2023 she had been busy, and the pharmacy had been short on staff, as an explanation for not checking the prescription. However, Mrs A told HDC that there had been only one other patient waiting for a prescription at the time, although she acknowledged that Ms B may have had other prescriptions to dispense.

21. Mrs A described feeling 'alarmed' and 'deeply uncomfortable' during these conversations and said she also felt that they were 'unprofessional and inappropriate'.

Ms B's response

22. Ms B told HDC that she spoke to Mrs A twice on 12 May 2023, first when Mrs A called her and Ms B admitted that there had been a dispensing error, and secondly, following discussions with the Professional Services Department and Pharmacy Defence Association. Ms B explained that she made this second call as she realised that she needed to gather more information about how Baby A was doing and her condition and because Mrs A 'had asked [her] to call her back to tell her about the process which would be followed for the incident'. Ms B confirmed that she had been unable to contact Mrs A, so she called Mr A, who assured her that Baby A was okay and advised her to speak to Mrs A directly.

23. In response to the provisional opinion, Mr and Mrs A stated:

> '[Ms B], had no reason for, or entitlement to any information regarding [Baby A's] condition and to "gather more information". Her motivation for this was, by her own admission, self-motivated, following advice from the Professional Services Department and the Pharmacy Defence Association (PDA).'

24. In response to the provisional opinion, Mr and Mrs A also said that they felt that Ms B's comments in relation to her discussion with Mr A were misleading. Mr A advised that he did not reassure Ms B of anything, nor did he advise her to contact Mrs A directly.

25. Ms B said that she then called Mrs A from a private consultation room at the pharmacy and was advised during that second call to Mrs A that Baby A had been admitted to the hospital and was awaiting further review by the consultant. Ms B said that Mrs A told her that she was 'thankful that she had given [Baby A] a small volume instead of a full dose'. Ms B stated that during this phone call, she explained to Mrs A that as she was a locum pharmacist, she might not be available at the pharmacy, and this is why she provided Mrs A with her mobile number to contact her if necessary.

26. In response to the provisional opinion, Mr and Mrs A said they felt that Ms B's response was misleading in relation to this call. Mrs A told HDC that she never said she was 'thankful that

she had given [Baby A] a small volume instead of a full dose'. Mrs A said that she has always stated that she administered the full dose, explaining that it was only on the last 0.5ml of the full dose when Baby A aspirated. Mrs A stated that this is clarified in information provided to the hospital Emergency Department upon triage, on admission of Baby A, and when 'every doctor and nurse … obtained a history from [Mrs A]'.

27. Ms B confirmed to HDC that she did call Mrs A again on 13 May 2023 as she was 'genuinely concerned for Baby A and wanted to ensure she was providing continuity of care'. Ms B said that she asked whether Baby A was still in the hospital and if there was anything else she could do to help.

28. In response to the provisional opinion, Mrs A wanted it noted that she 'only answered this phone call because [she] thought this may have been the Cardiology Department contacting [her] for an Echocardiogram of Baby A's heart after she developed a grade III systolic murmur as a result of the Redipred overdose'. Mrs A also stated that she was unsure what 'continuity of care' Ms B anticipated could be provided, knowing that Baby A was in the hospital, and she felt that this was 'harassment'.

29. However, in contrast, Ms B stated that Mrs A asked her whether the error was due to a busy work environment, or if the pharmacy was short staffed. Ms B said that she responded that these were not contributing factors and that as the checking pharmacist, she was responsible for the error. In Ms B's response to HDC, she stated that she 'did not intend to blame the Pharmacy workflow or staff level and [she] is sorry if this was the impression [Mrs A] took from the conversation'.

30. In response to the provisional opinion, Mrs A stated:

> 'I did not "take" anything from the conversation other than what [Ms B] said — that she was busy and short-staffed which is why [Ms B] did not check the prescription. This formed part of [her] complaint to the Pharmacy Council to highlight a potentially unsafe work environment.'

31. Ms B told HDC that she considered that 'the level of staffing during the morning was reasonable for the volume of work', and she did not believe the error was caused by a lack of staff or a busy dispensary.

32. Ms B said that in the same call on 13 May 2023, when Mrs A asked her how the error had happened and who was involved in the incident, she explained that she had not picked up on the unit error when undertaking the final check of the prescription. Ms B also said that she explained that the prescription had been processed and dispensed by a trainee pharmacy technician, although the error was '100%' her fault and that 'she should have double checked the dose against the prescription'.

33. In relation to Mrs A's complaint that Ms B 'blamed' the pharmacy's computer software for not identifying the 'ml' and 'mg' error in the dose, Ms B clarified in her response:

> '[T]he trainee pharmacy technician who was processing [Baby A's] prescription misread the unit when entering the information into the dispensary software. The software does not detect or automatically convert units. [I accept] it was [my] responsibility to check the units as the checking pharmacist. [I do] not apportion blame to the dispensary software or the pharmacy technician.'

34. In response to the provisional opinion, Ms B's lawyer stated:

> '[Ms B] never offered to sit with [Baby A] while [Mrs A] had a break. This clearly would not have been appropriate. She made a general offer of help. This was intended to be an offer of help in her role as a pharmacist. For example, to provide any further information which [Baby A's] treatment team might need from the Pharmacy.'

35. Ms B told HDC that she does not recall Mrs A saying that she did not want to be contacted further. Ms B agreed that Mrs A said that she would contact her the following week to update her on Baby A's condition. Ms B advised that she respected this and did not call Mrs A again.

36. In response to the provisional opinion, Mrs A said that she finds it 'alarming and concerning' that Ms B does not recall her saying that she did not want to be contacted further. In contrast, in response to the provisional opinion, Ms B reiterated that Mrs A never asked not to be contacted by her again.

Pharmacy process

37. The pharmacy stated that section 42 of the Medicines Regulations 1984[10] permits pharmacy technicians to process prescriptions under the supervision of a pharmacist, which the pharmacy advised is standard practice. However, it confirmed that the 'final check of the prescription (both accuracy and clinical) must be performed by a pharmacist at the last stage of the dispensing process'.

38. At the time of the incident, the Standard Operating Procedure[11] (SOP) stated that when dispensing a medication, it should be checked against the original prescription, including the patient, medication, strength, quantity, dosage form, and directions on the label to confirm

[10] '**42 Dispensing of prescription medicines**

(1) Except as provided in subclause (2), no person other than an authorised prescriber, veterinarian, pharmacist, pharmacy graduate, a pharmacy technician, a student, or dispensary technician may dispense a prescription medicine.

(1A) The following persons may not dispense prescription medicines unless under the direct personal supervision of a pharmacist:
(a) dispensary technicians:
(b) pharmacy graduates:
(c) pharmacy technicians:
(d) students.'

[11] See relevant paragraphs from the Standard Operating Procedure at Appendix A that was applicable at the time of the incident. These are documents that describe standard procedures and actions to be taken by staff when performing their duties.

that the details are correct. The SOP also requires the pharmacist to confirm that these details, amongst others, are correct, in terms of checking the dispensed medication.

39. The SOPs also state that the pharmacist will ensure that the medication dispensed is therapeutically appropriate in terms of the correct dose, correct dosage form, and medication for the indication, and that when handing out the dispensed medication to patients, they will be counselled appropriately by the pharmacist on the use of their medication.

40. In terms of customer complaints and managing the dispensing error, the SOPs state that the customer should be referred immediately to the 'Pharmacist in charge (for dispensary error and/or complaints) or the Retail Manager for shop complaints', and the responsible person(s) for dealing with the complaint will be the Retail or Pharmacy Manager.

41. Some of the SOPs have since been updated following the incident[12] (see the 'Changes made' section of this report below).

42. Ms B told HDC that her usual process for checking a prescription is to 'circle the patient's age, the dose, and for paediatric prescriptions, to note the patient's weight'. She said that if she has any concerns about the medication, she will look up the New Zealand Formulary to check the clinical appropriateness of the prescription.

43. Whilst Ms B advised that she does not specifically remember checking Baby A's prescription, she acknowledged in her response that the prescription is signed as having been checked by her. However, she recognised that she did not follow her usual process of circling the age and dose, obtaining and recording Baby A's weight, or looking up Redipred in the New Zealand Formulary at the time of checking the prescription.

44. Ms B also told HDC that her usual practice when a patient collects medication is to 'verify the patient's identity, check the medicine indication and any previous history of use, and counsel the patient on how to use the medication'.

45. Ms B acknowledged that whilst she checked the address and Baby A's identity, she did not discuss the medication any further with Mrs A.

46. Ms B confirmed that once aware of the error, she completed a PDA[13] Incident Notification Form that same day (12 May 2023), which was uploaded to Baby A's file at the pharmacy and updated over the next few days as more information was collected. The description of the dispensing error/incident on the PDA Incident Notification Form completed by Ms B outlined that an incorrect dose of prednisolone (Redipred) had been dispensed.

47. Ms B also notified the Professional Services Department and contacted the Pharmacy Defence Association to seek advice.

[12] See updates from the new Standard Operating Procedures dated 10 July 2023 also at Appendix A.
[13] Pharmacy Defence Association: https://www.pda.org.nz/Category?Action=View&Category_id=182

Medication error

48. In her response to HDC, Ms B stated that she was covering for the usual Charge Pharmacist on 12 May 2023 and was the sole Charge Pharmacist at the pharmacy for that morning, supported by two intern pharmacists and a trainee technician. The pharmacy confirmed to HDC that trainee pharmacy technician Ms C was qualified to type and dispense medication under the supervision of a pharmacist.

49. Ms B told HDC that Ms C incorrectly typed the dose of Redipred as 4.5ml (not 4.5mg, which equates to 0.9ml, as prescribed) when processing the prescription through the pharmacy's dispensary software. This resulted in the information on the label of the Redipred medication dispensed for Baby A and given to Mrs A being incorrect.

50. In a statement provided to HDC dated 19 September 2023, Ms C confirmed that she was working as a trainee pharmacy technician on 12 May 2023 at the pharmacy whilst doing her work placement. Ms C told HDC that she remembered typing the prescription very quickly into the system and printing the label to pass to the pharmacist (Ms B) for checking.

51. Whilst Ms C stated that she cannot remember exactly what happened and the details, she suggested reasons for the error as:

> 'I may have been disturbed by a customer, or was dealing with multiple tasks, and some customers may be waiting at the script-in counter. I might have tried to serve the customer first, after I came back to type the label, I misread 4.5mg to 4.5ml, and when the prescription error happened we haven't realized we have given 4.5ml of prednisone to the patient.'

52. In response to the provisional opinion, Mrs A stated: 'There was no other customer at the counter, save for the person waiting in front of me to collect their prescription.'

Relevant guidelines

53. The Pharmacy Council guidelines 'Competence Standards for the Pharmacy Profession (2015)'[14] state:

> '***Competency — Make effective decisions***
>
> …
>
> M1.6.1. Demonstrates the ability to make accurate, evidence based and timely decisions'
>
> '***Competency — Consult with the patient***
>
> …
>
> 01.1.2. Uses appropriate sources to obtain or clarify additional relevant clinical information'

[14] https://pharmacycouncil.org.nz/wp-content/uploads/2021/04/CompStds2015Web.pdf

'***Competency — Review and Manage Patient's Medicine Therapy***

…

01.3.5 Educates patient and confirms understanding of the medical condition, required monitoring and/or medication treatment'

'***Competency — Deliver Quality and Safe Services***

…

01.4.1 Advocates for, and ensures patients access and receive quality services and care commensurate with their health needs

…

01.4.7 Supports and provides continuity of care with accurate and timely documentation of clinical and professional interventions, using agreed handover protocols'

'***Competency — Assess Prescriptions***

…

03.1.1 Validates prescriptions ensuring they are authentic, meet all legal and professional requirements and are correctly interpreted

…

03.1.3 Applies knowledge in undertaking a clinical assessment of the prescription to ensure pharmaceutical and therapeutic appropriateness of the treatment and to determine whether any changes in prescribed medicines are warranted'

'***Competency — Dispense Medicines***

…

03.2.1 Maintains a logical, safe and disciplined dispensing procedure'

Follow-up actions by Ms B and the pharmacy

54. The pharmacy confirmed that as well as Ms B completing the PDA Incident Notification form (referred to in paragraph 46 above), the following was carried out:

a) On 17 May 2023, Ms B 'asked one of the regular pharmacists to inform the full dispensary team to ensure everyone was aware of this incident', and a warning note was added to Baby A's profile in the dispensary software as a reminder to the team at the pharmacy to be 'extra careful' when dispensing her medicines. Ms B also amended Baby A's record at the pharmacy so that the error was not repeated.

b) On the same day (17 May 2023), a staff meeting led by Ms B was held specifically to discuss the incident. Ms B said that the discussion included strategies to minimise dispensing errors, especially for paediatric prescriptions.

c) A further staff meeting was held at the pharmacy on 6 July 2023 to provide additional training. The incident was discussed again with all dispensary staff, and the importance of checking units on prescriptions and the clinical appropriateness of the dose was highlighted.

Further information

Mrs A

55. Mrs A told HDC that this was an incredibly traumatic experience for her and her family. She stated that if she had not known how to do CPR for Baby A on the day she gave her the medication, the outcome would have been disastrous, and Baby A could have died. Mrs A said that she is still unable to process what happened.

56. Mrs A advised that Baby A has recovered following intensive follow-up with a private paediatrician in the community team at the hospital and, whilst the medium-term outlook for her is good, there are still uncertainties about the longer-term effects.

57. Mrs A stated that Ms B's sole contractual, ethical, and professional role was to check the prescription. However, having admitted to not checking it, signing it as checked and then stating it was checked but not identifying the error was 'reckless and unreasonable'. Mrs A told HDC: 'This should never have happened, and it must never happen again.'

Pharmacy

58. In its response to HDC, the pharmacy acknowledged the error in dispensing Baby A's prescription on 12 May 2023 and stated:

> 'We are sorry that this happened and for the distress caused to [Baby A's] family … [W]e regret the fact of this error and its impact on [Baby A] and her family. We remain committed to providing a high standard of services and welcome any further suggestions from the HDC.'

59. The pharmacy told HDC that on 12 May 2023, a total of 412 prescriptions were processed, which is 'slightly busier than usual', and in contrast to the month of May 2023, when 333 prescriptions were processed per day. The pharmacy confirmed that around the time of Mrs A's visit to drop off Baby A's prescription, between 9am and 9.30am a total of 20 prescriptions were dispensed, and it became much busier around lunchtime.

60. The pharmacy confirmed that on 5 July 2023 an unannounced audit was carried out at the pharmacy by the Ministry of Health's Medicines Control.[15] The audit came about because of the referral from HDC to Medicines Control[16] on 27 June 2023 regarding this complaint. In its assessment, Medsafe noted the seriousness of the situation, and that Baby A had been hospitalised following the incident.

61. A subsequent Investigation Report completed by Medsafe dated 12 September 2023 (the Medsafe Report) was provided to the pharmacy. The Medsafe Report focused on

[15] https://www.health.govt.nz/our-work/regulation-health-and-disability-system/medicines-control
[16] Medicines Control was previously situated within Medsafe at Manatū Hauora|Ministry of Health.

investigating 'the alleged dispensing error made by the Pharmacy' and 'To obtain assurance that the pharmacy practice activities relating to dispensing conducted at [the pharmacy] are appropriate and do not present an ongoing risk to public safety'.

62. Out of three criteria relevant to the incident, Medsafe's findings showed:

a) One partially attained criteria of moderate risk — 'Prescriptions are not consistently assessed for clinical appropriateness as part of the dispensing process.'

b) One partially attained criteria of low risk — 'The SOPs reviewed aligned with current good practice and service delivery, reflecting the processes in the pharmacy, however, the SOPs for the Pharmacy's dispensing process and managing customer complaints was not followed for the incident.'

c) One fully attained criteria — 'Dispensing incidents (near-miss events & dispensing errors) are consistently & appropriately documented.'

63. Medicines Control required quality improvement activities to be implemented in the two areas of risk. This included a demonstration of assessment for the clinical appropriateness of medicine prescribed for each prescription, and on the process for managing complaints. The pharmacist in charge was required to manage any complaints received and staff to be trained in these areas. Medicines Control highlighted that on review of documentation seen at the audit, Ms B had failed to document properly in the PDA incident form or staff meeting notes about the clinical appropriateness aspect of the dispensing error.

64. The pharmacy has confirmed that these improvements have now been completed.

65. The Medsafe Report confirmed that a 'full Pharmacy Quality Audit will be conducted by Medsafe at the Pharmacy, within the next 6 to 12 months, to provide ongoing assurance of the standard of pharmacy practice activities at the Pharmacy'. Ms B was also referred to the Pharmacy Council pursuant to section 34 of the Health Practitioners Competence Assurance Act 2003 due to concerns over her competence.

Ms B

66. Ms B told HDC that she has been registered as a pharmacist since 2013 and had worked as a locum for the pharmacy since 2023. She stated that during her almost 10 years working as a pharmacist/charge pharmacist and locum pharmacist, this is the first complaint she has received.

67. Ms B again acknowledged that she failed to identify the discrepancy in the dose when undertaking the final check and is 'very sorry for her error and the distress which it has caused to [Baby A] and her family'.

68. Ms B said that she identified that it could be possible that she did not give the script the attention it required because of the slow pace of the pharmacy that day and the straightforward nature of the script (see 'Changes made' below). Ms B said that she was used to busier pharmacies.

69. Ms B also apologised for not being clear in her communication with Mrs A regarding whether the error was due to a lack of staff or a busy dispensary.

70. Ms B stated that she had wanted to ensure that Mrs A had the information she required, and to provide continuity of care and any support the family required. However, she stated that she was aware that it was a balancing act between gathering information in a timely manner and allowing the family space and time to process what happened, and she apologised for any distress caused to Mrs A by her calls, as this had not been her intention.

Responses to provisional opinion

Mr and Mrs A

71. Mr and Mrs A were given an opportunity to respond to the 'Information gathered during investigation' and 'Changes made since events' sections of the provisional opinion. Where appropriate, their comments have been incorporated above. They said they consider that 'this is not a case of "failure to check a medication adequately", but an admitted failure to check a prescription against the label in its entirety, and then signing the prescription as entered, dispensed and checked'.

72. Mr and Mrs A stated that they were 'shocked and distressed to read [Ms B's] account of events' as they considered 'it was dishonest and misleading and implied that [they] were not truthful'. They told HDC that they also felt that Ms B's apology letter was 'misleading' where she stated that she 'misread' the prescription, and they consider that this is inconsistent with what happened in that she actually did not undertake the final check of the prescription label. Mr and Mrs A highlighted that in Ms B's response she 'does not remember checking [Baby A's] prescription' and 'recognises she did not follow her usual process of circling the age and dose, obtaining and recording [Baby A's] weight, or looking up Redipred in New Zealand Formulary at the time of checking the prescription'.

73. Mr and Mrs A also stated:

> 'Dispensing errors such as this must never happen again. [Baby A] stopped breathing, and it was entirely preventable.
>
> The consequence of these events is that [Baby A], but for my administration of CPR successfully, would likely have died. We do not know what her long-term outcome is medically.'

74. Mr and Mrs A provided evidence of the telephone call records made by Ms B referred to in paragraph 20 above. They reiterated the further distress caused by the phone calls in what was an already stressful situation for them.

Pharmacy

75. The pharmacy was given an opportunity to respond to the provisional opinion.

76. The pharmacy told HDC that once Ms B reported the incident the same day, their Professional Services (PSD) Team 'took immediate action to offer assistance to [Ms B] in responding to the complaint'. The pharmacy stated:

> '[Ms B] was advised to notify the regular dispensary team as well as the Pharmacist in Charge (Pharmacy Manager). She was advised by PSD to draft a formal apology letter. She was also advised to reflect on the incident and consider practice improvements to avoid a reocurrence, both at an individual level and pharmacy level. This approach by [the pharmacy's] PSD is consistent with the Pharmacy Defence Association's advice to [Ms B].'

77. The pharmacy told HDC that it considers that 'there was significant support and guidance available to [Ms B]' from the pharmacy, as well as SOPs available to manage complaints appropriately, at the time of the incident. The pharmacy also said that if Ms B required further guidance and support, this was available to her.

Ms B

78. Ms B's lawyer responded to the relevant parts of the provisional opinion and confirmed that she accepts the finding that she breached Right 4(2) of the Code by failing to identify the dosage error on the dispensed medication. Where appropriate, her comments have been incorporated into the report above. Ms B stated that she 'regrets that this error occurred and is sorry for the impacts on [Baby A] and her family'.

79. Ms B's lawyer also told HDC:

> 'This was the first (and only) significant error in [Ms B's] 10 years as a pharmacist. She is committed to ensuring that there is no repeat of the error. She has undertaken further training and reflection with the assistance of a mentor over the last few months. This has had a particular focus on her paediatric knowledge. She has returned to a permanent position and ceased working as a locum to ensure that she can focus on strong systems for checking prescriptions and applying clinical reasoning.'

80. Ms B considers that being the most senior pharmacist available at the time, with several years' experience as a Charge Pharmacist, it was appropriate for her to manage the initial response to the error. She noted that the Charge Pharmacist was on leave and not available, and the Area Manager was a Retail Manager not a pharmacist. She also advised that the pharmacy PSD never raised any concerns about her management of the complaint.

81. Ms B stated that Mrs A did not raise concerns about communication with her at the time of the events, and she became aware of these only upon receipt of Mrs A's written complaint to HDC. Ms B therefore considers that she was correct in following the 'Managing Dispensing Errors' SOP rather than the 'Customer Complaints' SOP.

82. Ms B reiterated that she is sorry for any distress caused to Mrs A. Ms B stated:

> 'This was not my intention. At the time, it appeared to me that [Mrs A] was seeking information about what had occurred and what the next steps were. She had a lot of

> questions for me. I was trying to provide continuity of care and respond to [Mrs A's] questions with the correct and fulsome information.'

83. Ms B acknowledged that there is a balance between providing information and giving the family space and stated: 'Pharmacists and other health practitioners are often criticised for not providing enough information and patient contact following an error.' Ms B said that her contact with Mrs A was 'well intentioned and in accordance with her understanding of what [Mrs A] wanted'.

84. Ms B confirmed that she accepted the recommendations in the provisional opinion and that she is willing to provide a further apology to Mr and Mrs A and to provide HDC with evidence of the work she has already completed and her reflections on this event.

Opinion

Introduction

85. The dispensing error resulted in Mrs A having to resuscitate Baby A, and Baby A was admitted to hospital for treatment and monitoring. This would have been an extremely traumatic and distressing experience for Mr and Mrs A. Mrs A has commented that she has still been unable to process what happened. I hope that the longer-term outlook for Baby A is a positive one and that this report can bring some resolution to Mrs A and her family. I commend them for bringing this complaint to my attention.

Ms B — breach

Failure to comply with standards and SOPs

86. As a registered and experienced pharmacist of almost 10 years, and as a locum pharmacist for the pharmacy at the time, Ms B had a duty to provide services of an appropriate standard. Ms B was also required to comply with the professional standards set by the Pharmacy Council.

87. The Pharmacy Council of New Zealand's Competence Standards for the Pharmacy Profession (2015) provide that a pharmacist 'uses appropriate sources to obtain or clarify additional relevant clinical information', 'educates [the] patient and confirms understanding of the medical condition, required monitoring and/or medication treatment' and 'maintains a logical, safe and disciplined dispensing procedure'.

88. In similar cases that involved medication dispensing errors, this Office stated:[17]

> 'It is a fundamental patient safety and quality assurance step in the dispensing process to adequately check the medication being dispensed against the prescription for accuracy. This involves checking that the correct medicine, dose form, strength and quantity is being dispensed, and checking for any interactions.'

[17] Cases 20HDC00383, 20HDC02229, and 21HDC00955.

89. In addition, the pharmacy's SOP required checks to be carried out against the original prescription in terms of strength, quantity, dosage form, and directions on the label, both during the dispensing process (paragraph 31 of the SOP) and when checked by the pharmacist prior to dispensing the medication (paragraph 34 of the SOP). The SOPs also state that the pharmacist will 'ensure' that the medication dispensed is therapeutically appropriate in terms of the 'dose' and 'correct medication for the indication' (paragraph 36 of the SOP).

90. Mrs A was given medication labelled with the incorrect dose for Baby A, which resulted in an extremely serious situation in which Baby A required resuscitation and was hospitalised. The trainee pharmacy technician, Ms C, has admitted to the error, where she 'misread' 4.5mg as 4.5ml and typed the prescription quickly into the system and printed the label for the pharmacist for checking. It is also not disputed that in line with paragraphs 34 and 36 of the SOP and the professional standards in place, it was Ms B's responsibility, as the pharmacist, to complete the final check of the medication against the prescription.

91. Ms B has acknowledged that she failed to identify the error in the stated dosage of the dispensed Redipred medication for Baby A when undertaking the final check. Whilst I cannot determine what exactly was discussed during the initial conversation between Mrs A and Ms B around her reasoning of how this happened, it is clear that at the time of the prescription being dispensed, Ms B was aware that it was for a four-week-old baby. In my view, it was imperative for necessary checks to be carried out. While this is essential for any medication, it was especially important in this case given that the patient was a four-week-old infant who would be particularly vulnerable to even the most minor adjustments to medication doses.

92. Ms B also acknowledged that she failed to look up Redipred in the New Zealand Formulary at the time of checking the prescription, and Medsafe's Report recognised this as a moderate risk.

93. Whilst Ms B signed the prescription stating that she had 'checked' the label against the prescription, I consider that had this been done properly following the process in the SOPs, she would have identified the error in the dosage prior to dispensing the medication to Mrs A. Ms B also failed to check for clinical appropriateness of the dose of the medication. For this reason, I do not accept that a proper 'check' was carried out by Ms B in line with the pharmacy's SOPs and the Pharmacy Council of New Zealand's Competence Standards, and I am critical of this.

94. In a previous HDC case,[18] the independent advisor stated that failure to notice incorrect stock being dispensed constituted a departure from accepted practice. Whilst that case related to the incorrect medication being dispensed, I consider Ms B's error of dispensing an incorrect dosage of medication for a four-week-old infant to be just as serious.

95. Ms B also acknowledged that although she checked Baby A's address and identity, she did not discuss the medication or provide any counselling to Mrs A around how to use the

[18] Case 20HDC00383.

dispensed medication for Baby A. This, along with the failure to check Baby A's weight, was another missed opportunity to identify the dosage error. I am critical of this. By not counselling Mrs A on how to use the medication, Ms B failed to adhere to 01.3.5 of the Pharmacy Standards and Section 43 of the pharmacy's SOP (see Appendix A).

96. I note that Ms B has undertaken a fishbone analysis to reflect on the cause behind the error. She considered that one of the factors was the slow pace of the pharmacy, and that because the script was straightforward, she may not have given it the attention it required. My understanding of this comment is that Ms B did not take as much care with the script as usual because the pharmacy was quiet. In my view, if the pharmacy was not busy, this would allow more time for attention to be given to a script, and I consider this not to be a relevant factor in the error.

97. Although Ms B was a locum at the pharmacy, she had almost 10 years' experience as a pharmacist. By not properly checking the dispensed medication against the prescription or identifying the error on the prescription dosage, thus allowing an incorrect dosage of medication to be dispensed, Ms B failed to adhere to the professional standards set by the Pharmacy Council of New Zealand and the pharmacy's SOPs. As stated above, Ms B also failed to adhere to the pharmacy's SOPs by not providing counselling to Mrs A on how to administer the medication dispensed. Accordingly, I find that Ms B breached Right 4(2)[19] of the Code of Health and Disability Services Consumers' Rights (the Code).

Post-error communication — adverse comment

98. I note that the Medsafe Report recognised that the SOPs were not followed in relation to the management of customer complaints by Ms B for this incident. Medsafe's findings of a low risk was due to information around the clinical appropriateness aspect of the dispensing error not being recorded in the PDA incident form. Medsafe noted that this should have been completed by the Pharmacist in Charge or management level, to comply with the SOPs.

99. The Medsafe Report also highlighted that the responsible person who should have dealt with the complaint was the Retail Manager or Pharmacy Manager. I acknowledge Ms B's response that she was the most senior pharmacist available at the time and it was appropriate for her to manage the initial response to the error in this circumstance. Ms B submitted that as it was not at that time a complaint, it was appropriate for her to manage the initial response under the 'Managing Dispensing Errors' SOP rather than the 'Customer Complaints' SOP. I accept this reasoning and that it was appropriate for Ms B to manage the response initially.

100. That said, I have some concerns about the communications between Ms B and Mrs A following the events. Whilst it is understandable that Ms B wanted to check on Baby A's condition, clearly it was a stressful time for Mrs A and her family. I consider that they should have been given time to focus on Baby A's care and recovery at the hospital without having Ms B contact them for updates or offers of assistance. In Ms B's initial response to HDC she

[19] Right 4(2) states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards.'

said that she did not recall Mrs A's request not to contact her further, and in her response to the provisional opinion she stated that this request never happened. I am inclined to place more weight on the first response Ms B made, which was provided closer to the time of the events. I accept that Ms B's actions came from a place of concern, but she should have respected Mrs A's request not to contact her further and should have maintained appropriate professional boundaries. I am critical that this did not happen, and that Ms B continued to contact Mrs A.

Ms C — educational comment

101. I acknowledge that Ms C, as a trainee pharmacy technician, was still in the process of learning, although she was qualified to type and dispense Baby A's medication under the supervision of a pharmacist.

102. In my view, the serious error in this case occurred in part because Ms C incorrectly typed the prescription of '4.5ml' instead of '4.5mg' into the computer system. Ms C told HDC that she remembered typing the prescription into the system very quickly.

103. I remind Ms C of the importance of slowing down and being meticulous when inputting information from prescriptions into the computer system, because of the potential for errors to be made at this step of the process.

104. I consider that Ms C should reflect and learn from what happened, and I have made recommendations around this below.

Pharmacy — educational comment

105. The pharmacy had a duty to ensure that it provided services to Baby A with reasonable care and skill. This included ensuring that its staff, or any locum staff, provided safe, accurate, and efficient dispensing services.

106. As I have found above, Ms B and Ms C made errors in the process of inputting medication data into the pharmacy system and dispensing the medication. No evidence has been provided to me that indicates a lack of training or guidance for staff in the pharmacy's processes in the SOP. In my view, the errors were individual failings, which have been acknowledged by the staff members involved.

107. I note that the Medsafe Report identified a moderate risk that prescriptions were not consistently assessed for clinical appropriateness as part of the dispensing process. In order to avoid a serious incident like this happening again, I have made a recommendation for the pharmacy (see paragraph 125 below).

108. The Medsafe Report also highlighted that the pharmacy's SOP was not followed in relation to complaints management. The report states that the responsible person who should have dealt with the complaint was the Retail Manager or Pharmacy Manager, rather than Ms B. I acknowledge that the pharmacy's PSD team provided an appropriate level of support and guidance to Ms B once they were notified of the complaint. As the Pharmacist in Charge was

on leave, I would have expected Ms B to be advised that it was not appropriate for her to continue to manage the incident and for this to be dealt with by the pharmacist director at that time, which eventually happened. This may have prevented the concerns raised about being contacted multiple times by Ms B. However, I note the eventual corrective actions taken by the pharmacy following Medsafe's involvement, and that the pharmacist director then took on the responsibility of managing the incident.

109. I acknowledge that since the incident and visit from Medicines Control, the pharmacy has put in place several measures and improvements to ensure that such an incident does not happen again. The measures include having reviewed and updated its SOP, provided staff training on these changes, provided staff with other training and reminders, and arranged regular staff meetings for better practices and shared learning with other pharmacy branches. However, I note that some of these changes occurred only after the Medicines Control surprise audit and investigation report findings. I acknowledge the prompt action taken by Medicines Control following my referral of this complaint.

110. I remind the pharmacy of the importance of maintaining and complying with up-to-date SOPs to ensure that they reflect best practice and any changes in the pharmacy guidelines and environment, and also to ensure that staff are trained regularly in these and that appropriate checks on compliance are undertaken. I have made further recommendations in relation to this below.

Other comment

111. I have concerns about Ms B's reference to having had a less than ideal initial call with Mrs A because the music in the pharmacy was 'loud', which caused her to struggle to process information from Mrs A during the call.

112. Whilst acknowledging that there are some benefits in relation to ambient music being played, research[20] suggests that where sound levels are increased, the error rate can increase to a point, then decrease. Given the pharmacy environment and importance of discussions with patients and customers, and the need for concentration when dispensing medication, in my view it is not acceptable for 'loud' music to be played.

113. I consider it appropriate that the pharmacy has reviewed the levels of music played in the pharmacy and has considered whether these are appropriate for a dispensing pharmacy.

Changes made since events

Ms B

114. I acknowledge that Ms B immediately acknowledged her responsibility upon learning of this error and took steps to investigate how the error occurred. She has again acknowledged that she made an error in checking Baby A's prescription and again apologised to Baby A and her family for this.

[20] https://pubmed.ncbi.nlm.nih.gov/8976624/

115. Ms B confirmed that the error has been a source of on-going reflection and learning and she is committed to ensuring that there is no repeat of the error.

116. Ms B told HDC that a recommendation following a Pharmacy Council visit in August 2023 was for her to undertake further reflection on the causes of the error.

117. Ms B also told HDC that on a personal level, she has reflected on the error and why she did not follow her usual processes for checking the prescription. Ms B said that initially, she 'identified the cause of the error as inattentional blindness, after reading an article about this on the Pharmacy Defence Association website'.

118. Following the incident and visit from the Pharmacy Council, Ms B implemented the following changes to her practice:

a) She commenced a fishbone analysis for the error to reflect on the cause behind it, and as part of that reflection she identified two possible additional factors for what happened, namely:

   i. That she is used to working in busier pharmacies. The slow pace of the pharmacy in the morning and the straightforward nature of the script (containing only one item) may have resulted in her not giving it the attention it required.

   ii. She was also unaware before the error of the level of the pharmacy technician. If she had known this, she would have either typed up the script herself or supervised this more closely.

b) She now ensures that she slows down and follows the check process, even when the prescription appears to be straightforward.

c) She identified that she would benefit from additional learning regarding clinical checks and handling paediatric prescriptions, which she has added to her continuing professional development. Learning to date has included the Clinical Check Workbook (Pharmaceutical Society of New Zealand); Avoiding Medication Errors in Children (bpac[21]), and reading 'The importance of Professional Boundaries' (Pharmacy Council's 15 June 2023 newsletter).

Pharmacy

119. The pharmacy advised that following an internal investigation and the investigation report by Medicines Control into this incident, the pharmacy undertook the following to prevent a similar error happening in the future:

a) It reviewed and updated its SOPs in relation to the Dispensing Process (P2.7), Managing Dispensing Errors (P2.13), and Customer Complaints (P5.4) and provided training to all staff on these changes in September 2023. The pharmacy confirmed that this training included a discussion on the Pharmaceutical Society of New Zealand Clinical Checking Workbook. The training also emphasised the importance of patient counselling,

[21] Best Practice Advocacy Centre New Zealand (bpac[nz]) advocates for best practice in healthcare treatments and investigations across a wide range of health service delivery areas.

especially if a patient is new, the medicine prescribed is new to the patient's regimen, or there are any changes in treatment and clinical interventions.

b) It reminded all dispensary staff of the importance of checking the units closely, and of annotating on the prescription if these need to be converted.

c) There is now closer supervision and extra care when working with trainee technicians.

d) Two separate staff/pharmacists are involved in the dispensing and checking step, when possible, with the dispenser self-checking before signing off the dispensing step as being complete and correct, and pharmacists must always consider clinical appropriateness, in addition to the accuracy check.

e) It emphasised the importance of allowing the pharmacist to undertake the checking procedure without interruption. If an interruption is unavoidable, the pharmacist is required to begin the checking procedure again.

f) All clinical interventions must be recorded in the pharmacy's system under the patient's note, and important information must be annotated on the prescription.

g) It arranged regular staff meetings that can lead to better practices for all.

h) It shared learning across all the pharmacy's branches in a monthly bulletin in 2023.

120. In response to the suggestion made in the provisional opinion, the pharmacy confirmed that a review has now been carried out in relation to the levels of music played in the pharmacy and advised:

> '[The pharmacy] provide[s] all staff across all stores the opportunity to give feedback to it on whether noise levels in the store, including music, or any other factors impacting their practice. [The pharmacy] has not received any negative feedback from staff or customers on the noise level in stores. Nor had it received any complaints prior to this event. That said, [the pharmacy] welcomes any formal guidance from the Ministry of Health or other agencies on the appropriate noise level for a pharmacy environment and will continue to review stores and invite feedback from staff.'

Recommendations

Ms B

121. I recommend that Ms B provide a formal written apology to Mr and Mrs A for the breach of the Code identified in this report. The apology is to be sent to HDC, for forwarding to Mr and Mrs A, within three weeks of the date of this report.

122. I note that Ms B has already completed the Clinical Check Workbook from the Pharmaceutical Society of New Zealand, 'Avoiding Medication Errors in Children' from bpac^{nz}, and has read the article 'The importance of Professional Boundaries' in the Pharmacy Council's 15 June 2023 newsletter. I recommend that Ms B provide evidence of this and outline any further changes or improvements she has made to her practice as a result of this training, within three months of the date of this report.

123. In the provisional opinion, I recommended that Ms B complete training on handling paediatric prescriptions. Ms B advised that she had reviewed the best practice guide 'Avoiding medication errors in children: a practical guide for healthcare professionals' and completed three months of mentoring with a specific focus on her paediatric knowledge. I recommend that Ms B provide feedback to the pharmacy and HDC on any learning made as a result of this training, within three months of the date of this report.

Ms C

124. I recommend that Ms C:

a) Review her practice in light of this report and report back to HDC on her learning and any changes to her practice, within three months of the date of this report.

b) Complete the Improving Accuracy and Self-Checking Workbook provided by the Pharmaceutical Society of New Zealand and outline any further changes made to her practice as a result of this training, within six months of the date of this report.

Pharmacy

125. I recommend that the pharmacy:

a) Undertake a random audit of the overall processing, dispensing, and checking of medication of 50 prescriptions over a one-month period to assess compliance with the processing, dispensing, clinical appropriateness, and checking of prescriptions. The summary of findings with any corrective actions to be implemented is to be provided to HDC within three months of the date of this report.

b) Arrange yearly refresher training for staff (with the next training due in September 2024) in relation to the SOPs for the dispensing process, managing dispensing errors, and dealing with customer complaints. Evidence of the training and any learning should be provided to HDC within 12 months of the date of this report.

c) Review its induction programme to identify how to effectively train locum or temporary staff on its SOPs where this includes information specific to the pharmacy (noting that fully qualified pharmacists must understand and comply with standard dispensing procedures) and provide HDC with evidence by way of an induction programme schedule, within six months of the date of this report.

d) Use this case as a basis for developing ongoing education/training on the dispensing process, managing dispensing errors, and dealing with customer complaints, for staff across all the pharmacy branches, including any new staff. Evidence confirming the content of the training material, which can include a copy of its regular staff communication, instructions, and recommended advice of 3 July 2023, is to be provided to HDC within six months of the date of this report.

Follow-up actions

126. I note that Medsafe has already referred Ms B to the Pharmacy Council in relation to her competence and I am satisfied that this is an appropriate outcome.

127. A 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 Ms B's name.

128. A copy of this report with details identifying the parties removed will be sent to the Pharmaceutical Society of New Zealand (College Education and Training Branch), Medicines Control, and the New Zealand Pharmacovigilance Centre, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Pharmacy's SOPs

The following SOP (last reviewed 23 October 2021) was updated on 6 July 2023 (changes highlighted in yellow).

'**Dispensing Process [P2.7]**

…

Dispensing medication

…

31. Check the dispensed medication against the original prescription.

- Patient;
- Doctor;
- Medication;
- Strength;
- Unit;
- Quantity;
- Dosage form;
- Brand;
- Directions on label; and
- CALs.
- Sign right hand side of the stamp on the prescription to indicate that the dispensed medication has been checked against the prescription

…

Checking the dispensed medication

…

34. The pharmacist will confirm the following details are correct:

- Patient;
- Doctor;
- Medication;
- Strength;
- Unit
- Quantity;
- Dosage form;
- Brand;
- Directions on label; and
- CALs.

…

36. Pharmacist will ensure that the medication dispensed is therapeutically appropriate.

- Correct dose;
- Correct dosage form;

- Correct medication for the indication.

37. Pharmacists should refer to literatures such as New Zealand Formulary (NZF or NZF Children) to help clinically appraise the medication prescribed in addition to accuracy check.

…

Handing out dispensed medication to patients

…

43. The patient will be appropriately counselled on the use of their medication by the pharmacist.
    - If required, the patient will be shown the correct technique on how to use the device associated with their medication.

…

Customer Complaints [P5.4]

…

Responsible person(s)

- Retail Manager
- Pharmacy Manager

Procedure

- When a customer approaches any staff member with a complaint, refer the customer immediately to the Pharmacist in charge (for dispensary error and/or complaints) or the Retail Manager for shop complaints.'

Revised dispensing process

On 10 July 2023 the pharmacy created the following revised dispensing process:

'**DISPENSING PROCESS (FOR DISPENSARIES WITHOUT PACTS) [P2.7]**

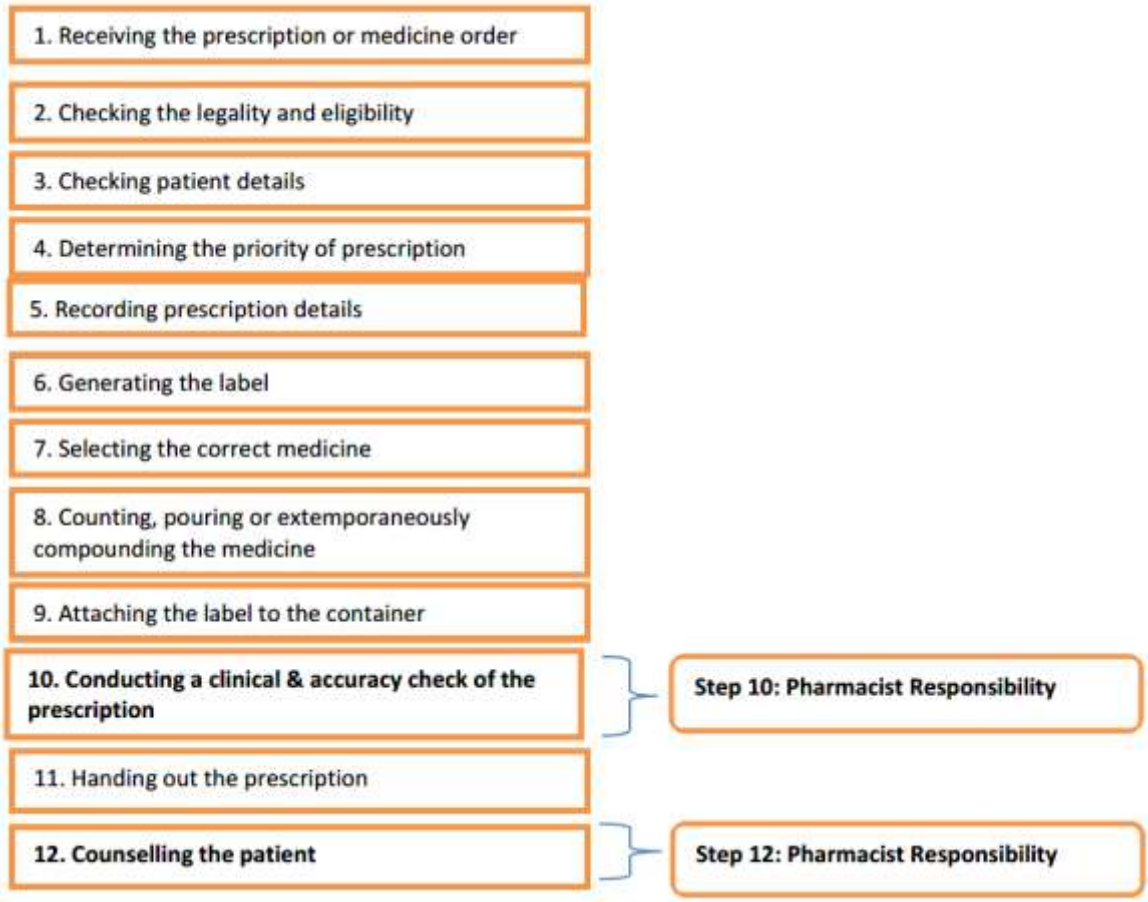
…

Responsible person(s)

- All pharmacists
- Locum pharmacists
- Intern pharmacists
- Pharmacy students
- Dispensary technicians
- Technician students

Procedure

In a pharmacy, the dispensing process starts when a prescription is received to when the prescription is collected. Dispensing process follows the usual steps.



…

Clinical and Accuracy Check of the Dispensed Medication

- Pharmacist will ensure that the medication dispensed is therapeutically appropriate.
  - Correct dose and unit;
  - Correct dosage form and route of administration;
  - Correct medication for the indication.

…

- Pharmacist should cross check literature like [New Zealand Formulary or New Zealand Formulary Children] for any medicine that they haven't come across to learn more about that medicine.

…

- Check label accuracy for name, date, medicine strength and form, instructions, CALs, expiry date if applicable and contents accuracy — correct medicine, dose, form and quantity

…

Handing out dispensed medication to patients

…

- Counselling will be undertaken by a pharmacist who will explain to the patient how to use their medications. If required but not limited to, the patient will also be shown the correct technique on how to use the device associated with their medication.

…'