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Pharmacy Liability for Dispensing Errors



PHARMACY LIABILITY FOR
DISPENSING ERRORS

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This monograph discusses the legal responsibility of pharmacists for errors in their product distribution role. The liability exposure of pharmacists for order processing error is examined. The legal case study method is used to demonstrate how pharmacists may be held liable for dispensing errors and how pharmacists may successfully defend themselves in cases alleging liability for dispensing errors.

Learning Objectives

Pharmacist

- 1 List the types of dispensing errors that can lead to pharmacist liability.
- 2 Evaluate the allegations by a patient that the products and services provided by the patient's pharmacist fell below the standard of care.
- 3 Recognize elements of an effective plan to implement techniques that will reduce pharmacy exposure to malpractice liability based on dispensing errors.

Pharmacy Technician

- 1 List the types of dispensing errors that can lead to pharmacist liability.
- 2 Evaluate the allegations by a patient that the products and services provided by the patient's pharmacist fell below the standard of care.
- 3 Recognize elements of an effective plan to implement techniques that will reduce pharmacy exposure to malpractice liability based on dispensing errors.

Nurse

- 1 List the types of dispensing errors that can lead to pharmacist liability.
- 2 Evaluate the allegations by a patient that the products and services provided by the patient's pharmacist fell below the standard of care.
- 3 Recognize elements of an effective plan to implement techniques that will reduce pharmacy exposure to malpractice liability based on dispensing errors.

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Pharmacists, Pharmacy Technicians, Nurses

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Introduction

Professional people accept responsibility for the consequences of both the things they do and the things that they do not do, if their commissions or omissions cause harm to someone who is the recipient of their professional products or services. It is an extension of the responsibility children are taught at an early age. If you break someone's property, or if you hurt another person, you apologize and compensate the person for the loss in the best way you can. It is the respectful thing to do. It is the responsible thing to do.

To be responsible connotes a duty to respond to a recognized risk. The failure to be responsive may lead to accountability. An explanation by way of accounting may be accepted as justification for non-response, or an insufficient accounting may be rejected as a failure to meet a recognized responsibility. Assigning culpability is the next step following responsibility and accountability. If the failure to respond to a risk had not been adequately accounted for, then the professional person may be found culpable if there is a direct causal connection between the failed response and harm to the recipient of products or services. The final step in this process is liability. A professional person who is responsible, and whose accounting is inadequate, and who is blameworthy (culpable), can be held legally liable for the consequences. This progression from responsibility, to accountability, to culpability, and finally to liability can result in an award of money damages to be paid by the professional person to the client or patient who suffered the consequences of professional malpractice.

A No-Errors Profession

Pharmacists are held to a standard of care that requires absolute accuracy in order processing. The fact of error speaks so loudly that, when a patient had received the wrong drug, or the right drug in the wrong strength, or the right drug with the wrong directions, a presumption of negligence arises, and the pharmacist is virtually powerless to rebut the presumption. The pharmacist may have been careful and attentive when the prescription was being filled, but what matters is that an error occurred, not how careful the pharmacist may have been in processing the prescription. This reality of pharmacist malpractice law places pharmacists in a dilemma. Since: (1) all humans make mistakes, (2) all pharmacists are human, and (3) any mistake in pharmacy leads to a legal determination of negligence, all pharmacists are occasionally negligent.

In most professions, an "honest error in judgment" rule protects from liability those who have tried their hardest, and have intended the best result possible, but who have inevitably on rare occasion erred due to the frailty of the human condition. The rule

recognizes that human judgment cannot be guaranteed, and that it is unfair to penalize humans for their imperfections when they are doing the best they can under the circumstances. However, in the order processing function, courts have difficulty seeing that any professional judgment is used. It just seems so easy to select the right medication, generate an accurate label, and deliver the medication to the right patient. Courts over-simplify the processing of prescriptions by pharmacists. The system interferences with professional activity, in what appears to be such an uncomplicated transaction, are often missed by the courts. In traditional dispensing activity, errors are not seen as the inevitable result of human frailty. Errors are deemed fully preventable and blameworthy. The “honest error in judgment” rule does not apply in pharmacy order processing error cases.

In attempting to rebut a presumption of negligence following the commission of an error, a pharmacist may introduce testimony from colleagues and other witnesses who would testify that the pharmacist is careful, conscientious, and highly committed to accuracy. This type of professional character testimony has routinely been disallowed. The fact that a pharmacist may have exercised extremely high care on many other occasions, with many other prescriptions, for many other patients, is not relevant to a specific incident of error, of which the professional character witnesses have no specific or direct knowledge.

Competent Practitioners

Courts have recognized that pharmacies have a responsibility to hire personnel who are competent to perform the functions to which they will be assigned. At the most basic level, this requires that personnel understand the risks of medications they dispense, and the consequences to patients if dispensing errors are made. Pharmacy personnel must have their duties within the pharmacy specifically defined for them, so that they do not overstep the boundaries of their employment assignments.

Pharmacists must exercise both skill and care in the performance of their duties to avoid causing untoward effects from dispensing medications to patients. Courts have separated skill and care as two separate measures of professional competence. Skill refers to the ability to produce good results, and care refers to the effort one expends in producing good results. A pharmacist who is skillful but careless will not produce good results. A pharmacist who is careful but lacking in skills will also not produce good results. Both attributes are important, and an employer of pharmacists is responsible for assuring that pharmacists possess each of them.

Litigation against pharmacies has accused management of not being aggressive enough in the termination of the employment of a pharmacist who has committed an error. The fact of a previous error is sometimes overemphasized in lawsuits, leading plaintiff's lawyers to rhetorically ask of the pharmacy "How could you possibly continue to employ a pharmacist who had made an error with a prescription?" However, judges have generally supported pharmacies in the adoption of a more compassionate and productive response to error by a pharmacist. Courts generally have not seen as reasonable an argument that every erring pharmacist should be fired. Rather, the expectation is that a pharmacist who has erred must take the incident seriously and the employer must provide a mechanism to promote improvement and reduce the risk of future errors. Most courts have ruled that evidence of prior unrelated errors is irrelevant and inadmissible in a claim for malpractice against a pharmacist. On the other hand, if the evidence shows that a pharmacist has repeatedly made the exact same error, without adopting remedial measures, then a court may be more willing to allow a jury to consider the significance of a pattern of malpractice as documented in the past incident reports.

Accessibility and Distractions

There is general recognition that pharmacists are the most accessible health professionals. No appointment is necessary to talk with a pharmacist. Evenings and weekends are no problem. Unfortunately, with accessibility comes distractions. Patients sometimes feel entitled to talk with a pharmacist, even when other issues command the pharmacist's attention. Prescribers may become impatient if they have to wait to talk with a pharmacist regarding a patient and the patient's medication.

Malpractice cases against pharmacists have alleged that the work environment in a pharmacy led to an error that harmed a patient. Courts have recognized that pharmacy is a stressful profession, practiced in public view, with numerous distractions that interrupt a pharmacist's efforts to focus on each individual prescription for the time it takes to perform all necessary professional actions. All professions are busy and stressful, yet the community pharmacy environment is significantly different from the controlled setting of the operating room in a hospital or the examination room in a clinic.

Courts have also acknowledged the significance of unusual challenges such as natural disasters or health epidemics. When pharmacists are required to serve substantially more patients, with fewer support resources, legal expectations can be reduced to reflect the circumstances.

Even the routine chaos experienced during busy times at a pharmacy may be relevant to a pharmacist's exposure to malpractice liability. In one case, a court considered allegations that a pharmacist had switched two drugs, placing Drug A in the vial labeled for Drug B, and vice versa. The patient was hospitalized, and his lawsuit against the pharmacist and pharmacy resulted in a verdict for the defense.

The plaintiff appealed, arguing that the work environment at the pharmacy should have supported a verdict for the plaintiff. The court took note of that environment in this way:

"In 1990, three full-time pharmacists were employed at [the defendant pharmacy], with [another pharmacist] filling in part-time. The pharmacy filled about 800 prescriptions per day. Based on the average eight-hour day, counsel for the plaintiff figured, and [the defendant pharmacist] agreed, that the average number of prescriptions filled per hour was 28.5, or one prescription every 2.1 minutes. This took a great deal of concentration, and if interrupted during the process, he would have to start over again. He was often interrupted to answer questions or to answer the telephone."

Keeping in mind that these numbers reflect a very high volume for a pharmacy three decades ago, it does not seem unreasonable that the court actually used the work environment argument as a justification for the defense verdict, rather than as support for the plaintiff's position. The court noted that it was inconclusive whether the medication switch had occurred in the pharmacy or in the patient's home. And the court acknowledged the pharmacist's testimony that in 30 years of practice he had never made a dispensing error. (Pharmacists might tend to be more skeptical of this claim than the court apparently was). The court affirmed the defense verdict for the pharmacy and pharmacist, viewing the work environment faced by pharmacists as a mitigating factor rather than as an aggravating factor.

The System Sets Up Pharmacists for Success or Failure

Courts have willingly accepted the concept of system failure in pharmacy, and the correlative recognition that errors in pharmacy may be due to both individual missteps and to system interferences. This does not mean that pharmacist can consistently blame "the system" for their own mistakes. Rather, a more in-depth analysis of each error will incorporate both individual and systems factors in an assessment of liability.

It would be an understatement to say that the traditional pharmacy dispensing system presents many challenges to pharmacists. One could probably not design a worse system if one were asked to do so. In fact, using the word "system" gives to the existing

“non-system” a certain level of deference that it probably does not deserve. The traditional medication use system begins with a physician prescribing medication for a patient who is told little about the diagnosis or treatment. Prescribers are allowed to use non-standard abbreviations if they wish. The prescription is written using Latin terms, to obscure the information it contains. Handwritten prescriptions are often illegible. Physicians are difficult to contact if a pharmacist has a question, and patients are usually clueless. The medications have been given names that look alike and sound alike, with labeling and packaging that identify and distinguish the manufacturer rather than the drug. The public layout of a traditional pharmacy deters meaningful conversation between pharmacist and patient, where an error might be detected and corrected.

As a solution to this traditional system, electronic prescribing and order transmission has been developed. But most studies support the conclusion that e-prescribing does not reduce errors; it just changes the nature of them. Many e-prescriptions rely on the use of drop-down menus in devices that are so small they are hard to read and hard to manipulate. Prescribers often select the wrong drug, the wrong patient, or the wrong directions when issuing e-prescriptions. Courts initially were forgiving of pharmacists who dispensed medication incorrectly because the e-prescription had been issued incorrectly. That perspective has changed so that courts have begun to expect that pharmacists will screen e-prescriptions for errors by the prescriber and consult with the prescriber any time an e-prescription “just does not seem right.”

Most lawsuits against pharmacies are based on what the law calls “vicarious liability.” This is an old Anglo-American legal principle, under which the “master” is liable for errors of a “servant.” However, pharmacies may also be held liable themselves for failing to develop a system that provides employees with the support and resources necessary to avoid errors.

One of the first cases to apply the principles of primary liability to a pharmacy was based on allegations that the defendant pharmacy should be held liable for an error by its pharmacist in dispensing the wrong drug pursuant to a very unclear written prescription. The facts showed that the pharmacy had been recording errors made over time, but that no process of improvement had been implemented as a result of what had been learned from these recorded errors. The court focused less on the error itself than on the absence of a systematic process by the pharmacy to learn from the past and improve in the future. The court ruled that the pharmacy “failed to initiate sufficient institutional controls over the manner in which prescriptions were filled.” The pharmacy was held liable for punitive damages as well as compensatory damages.

Categories of Malpractice Cases

Technical accuracy in order processing is no longer a guarantee that pharmacist responsibilities have been met. Expanded pharmacist responsibilities open up new avenues of liability. Yet order processing error continues to be the overwhelming source of malpractice litigation for pharmacists. Understanding how these cases develop and evolve is an important first step in the creation of malpractice reduction systems for pharmacists.

Wrong Drug Errors. There is simply no question that pharmacists have a legal responsibility to dispense the correct drug, with correctness being defined as the drug that the prescriber ordered. It would be difficult to find a pharmacist who disclaims this clear responsibility. Malpractice cases tend to focus on the process through which a wrong drug error occurred, rather than any debate about responsibility. Analysis of the process may serve to ameliorate the blame attached to an obvious error. This is a difficult analysis, because memories of the event are generally poor. If a pharmacist is asked to recall what happened when a wrong drug error occurred, the pharmacist is usually stumped. One tends not to remember things of which one is unaware, and had the pharmacist been aware of the error when it occurred, then it would have been corrected and no harm would have resulted.

Communication breakdowns are one source of wrong drug error. When this occurs, there is no question that there will be liability to the patient, but there is a question of who will be held liable. Sloppy prescriber handwriting is a common cause of communication error, as are unclear verbal messages left on recording devices by prescriber office personnel who are unfamiliar with the pronunciation of unusual drug names. Electronic devices may prompt a prescriber to select an unintended drug. Courts have made it clear, under all circumstances of ambiguous communication, that pharmacists have a responsibility to confirm uncertain orders. A pharmacist who attempts to explain why the wrong drug was dispensed by saying “well, I assumed that.....” will not be in a comfortable position. Courts expect pharmacists to confirm ambiguities, not make assumptions.

Another step at which wrong drug errors can be made is computer data entry. When a prescription is entered into a pharmacy’s computer, there may be “suggestions” of what the pharmacist or technician intends to select as the correct drug. Making the wrong choice at this early step may result in the wrong drug ultimately being dispensed, because final checking is not a foolproof method of preventing errors. Courts have generally held that pharmacists are responsible for this type of wrong drug error.

Product retrieval is another opportunity for wrong drug error. Subtle differences between products, for example immediate release and extended release dosage forms, may lead to the dispensing of one when the other is intended. Likewise, prescription assembly is a point where errors can occur by the placement of medication in a vial intended for a different medication. While technologies have been developed to provide support in assuring that these types of wrong drug errors are minimized, there is no way to completely eliminate them. Pharmacists will be held liable for these errors.

Wrong Strength or Dose. The strength and dose of a drug are related, but they are not the same. Most patients are prescribed a particular strength of drug with directions for use that will result in the desired daily dose. Some courts seem to have difficulty with this concept, and they consistently refer to a pharmacist having provided the wrong dose of a medication, when the reality is that the pharmacist is alleged to have provided the wrong strength. Although this distinction may seem subtle, the resolution of a pharmacist malpractice case often rests on a clear understanding of facts, so clarifying strength and dose is an important point to make.

Many wrong strength errors are off by a factor of ten. This may be due to a decimal being misplaced or going unnoticed. A discussion of this type of error must include reference to "naked decimals" and "trailing zeros." A naked decimal can be unnoticed, for example, when one-half milligram is written as ".5 mg" rather than as "0.5 mg." When the decimal is not covered by a leading zero, it is considered naked and it can "disappear," resulting in a strength of 5mg. Similarly, the use of a trailing zero, as in "5.0 mg" can be misinterpreted as fifty if the decimal "vanishes." So, the standard method of ordering five mg is "5 mg." Faintly written decimals are not always the pharmacist's fault. Prescribers will normally share some of the liability when this happens.

While prescribers usually specify a strength in a prescription order, this is not always the case. Some prescribers, particularly oncologists, may prescribe a total daily dose to be divided over the day. For example, an order of "600mg in three divided doses daily." This is a type of order that can easily be misinterpreted as 600mg three times daily. For this reason, some health institutions and practices have forbidden the use of daily dosing orders. A prescriber who nevertheless opts to use a forbidden order technique may bear the full legal responsibility for a pharmacist's dispensing of an erroneous strength. Pharmacists should decline filling of orders that have been issued contrary to institution rules.

Improper Labeling. Patient compliance or adherence is a much sought-after result of diagnosis, prescription, and dispensing. Patients who do not use their medication as

they have been instructed risk therapeutic failures or toxic effects. Pharmacists label medication vials with their interpretation of the instructions provided by prescribers in the prescription. The accurate translation of this information from prescriber to patient is the pharmacist's responsibility. Most of the time, patients use medications in the way they have been instructed on the label. It is vital that this information be correct.

The most common labeling error in pharmacy malpractice litigation is an instruction to patients that the drug be used more frequently than the prescription indicated it should be used. For example, a drug that should be used once daily is labeled with directions to use it twice, three times, or even four times daily. And there have been several lawsuits resulting in the liability of pharmacists for labeling methotrexate to be taken once or twice daily for rheumatoid arthritis, when the prescription instructed that the drug be taken once or twice weekly. One might expect there to have been lawsuits based on erroneous labeling with instructions to take too little medication (once daily when the prescription called for twice daily) but there appear to have been no such lawsuits.

The pervasiveness of computer alerts and real-time claims adjudication might lead one to believe that the generation of a label with instructions to use more of a drug than is usually used would generate computer alerts that caution the pharmacist to recheck the prescription. While this undoubtedly does occur under many circumstances, it is apparently not a universal occurrence. This lapse has not gone unnoticed by plaintiff lawyers, who have sued both computer software vendors and third-party payers, alleging that they had a legal responsibility to alert a pharmacist to the possibly erroneous instructions on the label of their patient's medication vial. These lawsuits have been generally unsuccessful. It is the legal responsibility of the pharmacist, and not of the software vendor or third-party payer to assure that labeling accurately states the instructions for medication use.

Undoubtedly the most significant malpractice risk for pharmacists is the prescription issued by a physician with an "as directed" or "ut dict." sig. This is an invitation to a lawsuit. The stories of how this single challenge has led to pharmacist malpractice lawsuits are many and varied. Physicians always claim that they thoroughly instructed the patient on appropriate medication use at the physician's office, although pharmacists know that this instruction generally does not happen or is rarely remembered by the patient. The large number of lawsuits based on pharmacist labeling with "Take as directed" instructions suggest that pharmacists should just never do this. A prescription without directions cannot be honored. Contact the physician, or have the

patient return to the physician with the prescription and insist that explicit directions for use be provided prior to dispensing the medication.

Wrong Route of Administration. There have been many cases in which a prescription specified ophthalmic drops but a pharmacist dispensed otic drops in error. Hardly ever does it happen the other way, because ophthalmic drops are not painful when administered in the ear. The extremes to which pharmacy managers will go in their efforts to prevent this error were illustrated in a lawsuit against a pharmacy where the error had occurred multiple times previously. The manager had tried educating technicians about the difference between otic and ophthalmic, but the errors continued. The two different products were placed in very different shelving areas, to no avail. Finally, the manager put the otic products in a sealed plastic kitchen container in a bottom drawer at the rear of the pharmacy area, and on the lid he put a picture of an ear and the words "For The Ear Only." Despite these efforts, a technician made the error again, selecting the otic preparation rather than the ophthalmic preparation, and a lawsuit resulted. The pharmacy was held liable, but only for minimal damages. The mitigation efforts, despite their lack of success, were a factor in the low award of damages.

Changes in route of administration, or in dosage form, should be checked with the prescriber and confirmed with all involved. A pharmacist was sued after he received an order for IM injection of a drug for which the standard route of administration was IV. The pharmacist changed the order and dispensed the correct IV dosage form, without contacting the home health nurse who administered the drug through IM injection. In another case, the pharmacist switched an oral antibiotic tablet prescription to oral liquid, because the patient said she could not swallow a tablet. But the patient did not care for the bubble gum flavor of the oral liquid, so she did not use the medication at all. Both of these cases resulted in a verdict in favor of the pharmacist. Yet they both teach that communication is an important step in litigation avoidance.

Wrong Patient. Sometimes great care is taken in the accurate processing of a prescription order, consultation with the prescriber regarding potential problems with a prescription, and negotiation with a third-party payer to assure coverage of a prescription, only to have the prescription then given to the wrong person at will call. Patients will use the medication they have been given by their pharmacist, even if it has the wrong name on it. This perhaps is a negative factor of pharmacists consistently being named among the most trusted professionals in the country. Sometimes patients may take their trust of pharmacists too far.

Lawsuits against pharmacists have established that confirmation of patient identity by verifying a factor such as phone number or street address during medication pickup is a standard of care. Persons who are picking up controlled substance medications either for themselves or for another person must be required to show ID before they receive the medication.

There are many legal cases that shed additional light on the complicated subject of pharmacist liability for order processing errors. What follows in this monograph is an overview of two cases in which patients have alleged harm due to a pharmacy error. The allegations of the patients and the contrary arguments asserted by the defendant pharmacies are reviewed.

Look Alike and Sound Like Drug Names

A patient was diagnosed with pancreatic cancer. She underwent a surgical procedure to remove a substantial portion of her stomach, small intestine, and pancreas. After the surgery, she was given a prescription for Pepcid 20mg "to protect her stomach from stomach acid and to decrease her nausea and increase her appetite."

The pharmacy erroneously placed 20mg Paxil in the vial labeled as 20mg Pepcid. The patient took this incorrect medication twice daily as the Pepcid had been prescribed for her. During this time, she exhibited increased irritability, weakness, confusion, and inattention to hygiene. Her physician, unaware of the pharmacy dispensing error, prescribed Zoloft for her "to control her behavior." The physician discontinued the Zoloft several days later due to the patient's very low blood pressure. On the following day, the patient became dizzy, she fell, and she fractured her left leg and foot. Medical testimony established that the fall and fractures were the result of a loss of equilibrium caused by Paxil.

The patient was then admitted to a nursing home. A nurse at the nursing home discovered the pharmacy dispensing error, and the physician discontinued the Paxil. The patient's daughter notified the pharmacy of the error, and she was told that an incident report would have to be filed. The court said, "At no time did [the pharmacy] discuss the side effects of Paxil with the family or warn of potential withdrawal problems associated with the abrupt discontinuation of the drug." Several days later, while at the nursing home, the patient fell again and suffered injuries to her head, back, and pelvis. Medical testimony attributed this fall to "symptoms of a withdrawal syndrome associated with the abrupt discontinuation of Paxil."

The patient sued the pharmacy for compensatory damages and punitive damages. A jury returned a verdict for \$100,000 in compensatory damages and \$150,000 in punitive damages. The pharmacy paid the compensatory damages award but appealed the punitive damages award. The pharmacy contended that there had been insufficient evidence of willful and wanton disregard of the rights of the patient to support punitive damages. At worst, the pharmacy contended, "the evidence supported nothing more than a simple mistake." Punitive damages are generally not awarded in cases of simple inadvertent error.

The appellate court disagreed with the pharmacy, saying "the evidence in this case was not limited to one innocent misfill." The pharmacist on duty when the "prescription was misfilled during the busy noon hour admitted the need for extra technicians to help staff during the noon rush at the pharmacy." The appellate court also observed that "there were thirty-four incident reports in evidence. These reports indicated dispensing errors nearly identical to the dispensing error in this case: The incorrect medication begins with the same alphabetic character as the correct medication prescribed. The errors all occurred within a three-year period before the incident in question." The court concluded that the jury could reasonably infer that the pharmacy "had a serious problem in this regard, knew it had the problem, but did not take adequate steps to prevent it."

The court noted that what made the pharmacy's conduct "particularly egregious" was the pharmacy's "failure to warn [the patient] or her doctors of the serious adverse effects associated with Paxil or the abrupt discontinuance of the drug." The pharmacy had learned of its dispensing error twelve days before the patient's second fall, yet contrary to pharmacy standards and its own policy and procedures manual, the pharmacy "neglected to warn [the patient] or her family of such adverse effects." The court concluded that there was sufficient evidence to support punitive damages. The pharmacy's appeal was denied.

The take-home message of this case is that having learned of a dispensing error, pharmacies have a responsibility to mitigate damages to the patient. At a minimum this responsibility requires contacting the prescriber and consulting with the patient's current physician regarding anticipated adverse effects. Referring the patient and the patient's physician to a local poison center could be an effective response as well. Failing to follow up on the error has the appearance of a cover-up, and it increases the risk of liability for punitive damages. It is not possible to go back in time and undo an error that has occurred. But it is possible to look forward in time and act to prevent foreseeable harm from the error.

Look Alike and Sound Alike Patient Names

Note: The policy in freeCE monographs is to not include patient names, even though patient names are made public in legal proceedings. The name of the patients was central to this case, so names have been used in the synopsis, but the names have been changed to fictional names.

The plaintiff was the estate of a patient named "Aaron Franklin" who arrived at the defendant pharmacy to pick up a supply of prednisone that had been prescribed for him. Instead of prednisone, the patient was given ramipril, which was intended for "Albert Franklin." A pharmacy technician gave the medication to the patient at will-call. The court explained that "part of her job was to ring up customers who came to pick up their prescriptions, and this involved identifying the customers, providing them with the medications they ordered, getting them to sign for the medication, and accepting payment."

The court said that pharmacy "policy at the time was to match customers to their prescriptions by having pharmacy technicians ask for two pieces of identifying information: the customer's name and the customer's address." The plaintiff alleged that this did not happen with the patient, and that it obviously could not have happened because he received the wrong patient's medication. The technician could not remember specifics of the incident, but she explained that she "knew Aaron Franklin by sight and would recognize him if he came to the window, and she would not even need to ask him his name."

The patient took the ramipril that had been mistakenly given to him, along with his regular antihypertensive medication. This combination resulted in his dialysis being terminated because his blood pressure was too low. The patient required surgery and he died. The plaintiff's lawsuit alleged that the defendant pharmacy had breached the standard of care. The plaintiff filed a motion asking the court to rule as a matter of law that the pharmacy standard of care had been breached by the defendant, leaving only causation and damages as issues for trial. The defendant pharmacy opposed the motion, contending that the issues of duty and breach had not been sufficiently addressed to warrant a judicial ruling on them.

The court examined a declaration by an expert witness pharmacist who testified that: "It is a deviation from the acceptable standard of care applicable to a pharmacy for that pharmacy, through its employees, to give medication intended for one patient, and labeled with that patient's name, to a different patient. A pharmacy, through its employees, is required by the standard of care to verify that the correct medication is

given to a patient. This can be done in a number of ways, such as by comparing unique identifying information such as the patient's name coupled with his or her birthdate, address, or other unique identifying data."

The expert continued: "When a pharmacy, through its employees, fails to use unique identifying data to make sure that the medication it is providing to a patient is, in fact, the medication intended for that patient, and instead provides that patient with medication intended for and labeled with the name of a different patient, that pharmacy deviates from the standard of care and breaches its duty to the patient to whom it provides the incorrect medication."

The defendant pharmacy argued that it was "not undisputed that it breached the applicable standard of care," therefore a jury should be allowed to decide the issue of breach of duty, rather than having the court make this decision. The court then undertook to determine whether obtaining firm patient identification at medication pickup is simply an optional good practice or instead is an uncontested requirement to meet the standard of care. Having examined the evidence, the court concluded, "No reasonable jury could return a verdict that the defendant did not breach the applicable standard of care." The court granted the plaintiff's motion for summary judgment on the issue of breach of the standard of care.

The take-home message of this case is that patient identification at the pharmacy will-call area is mandatory. It is not simply an optional good idea. How patient identification is accomplished is left to each individual pharmacy to determine. Even if pharmacists and pharmacy technicians may feel embarrassment at asking for the name of a patient whose name they should already know, the policy of firm patient identification should override any such feelings.

Conclusion

Pharmacists have a core responsibility of accuracy in pharmaceutical product distribution. When a patient receives a medication with any pharmacy error, or when a patient fails to receive a medication due to a pharmacy error, the pharmacy can be held liable for any harm resulting from an error in order processing.

QUIZ – June 2020 • Liability for Dispensing Errors

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LESSON EVALUATION

Please fill out this section as a means of evaluating this lesson. The information will aid us in improving future efforts. Either circle the appropriate evaluation answer, or rate the item from 1 to 7 (1 is the lowest rating; 7 is the highest).

1a. PHARMACISTS, TECHNICIANS AND NURSES ONLY: Does this lesson meet the learning objectives? (Circle choice).

List the types of dispensing errors that can lead to pharmacist liability.

YES NO

Evaluate the allegations by a patient that the products and services provided by the patient's pharmacist fell below the standard of care.

YES NO

Recognize elements of an effective plan to implement techniques that will reduce pharmacy exposure to malpractice liability based on dispensing errors.

YES NO

2. Was the program independent & non-commercial? YES NO

Low Relevance

Very Relevant

3. Relevance of topic 1 2 3 4 5 6 7

4. What did you like MOST about this lesson? _____

5. What did you like LEAST about this lesson? _____

6. How would you improve this lesson? _____

Activity Test

Pharmacy Liability for Dispensing Errors

A passing grade of 70 or higher are required to earn credit.

1. Which of the following is the final step in the process of determining whether an award of money damages must be paid by a professional person to a client or patient?
 - a. Culpability.
 - b. Liability.
 - c. Responsibility.
 - d. Accountability.
2. In what way does the "honest error in judgment" rule protect pharmacists from liability for order processing error?
 - a. It applies to errors regarding dosage.
 - b. It applies to errors regarding directions.
 - c. It applies to errors regarding packaging.
 - d. The "honest error in judgment" rule does not apply in pharmacist order processing error cases.
3. One measure of professional competence that courts have recognized is the ability to produce good results. What is this measure of competence called?
 - a. Knowledge.
 - b. Care.
 - c. Skill.
 - d. Attitude.
4. What health professional is generally recognized as being the most accessible?
 - a. Nurse.
 - b. Pharmacist.
 - c. Physician.
 - d. Dentist.
5. What aspect of the traditional pharmacy system sets up pharmacists to fail?
 - a. Patients are told little about their therapy by prescribers.
 - b. Drug names look and sound alike.
 - c. The public layout of traditional pharmacy deters meaningful conversation between patients and pharmacists.
 - d. All of the above.

6. What is the standard method of designating five milligrams in a prescription, to avoid error and resulting liability?
 - a. Five MG
 - b. mg
 - c. 5.0 mg
 - d. 0.5 mg

7. What is the most common labeling error in pharmacy malpractice litigation?
 - a. Instructing the patient to use a drug more frequently than it has been prescribed.
 - b. Instructing the patient to use a drug less frequently than it has been prescribed.
 - c. Instructing the patient to use a drug through a different route of administration than it has been prescribed.
 - d. Instructing the patient to use a drug with food when that instruction is not necessary.

8. A pharmacist learns that a patient cannot swallow the prescribed tableted form of medication, and the pharmacist decides the patient needs a liquid form of the same medication. Whom should the pharmacist contact prior to making this change in dosage form to avoid potential legal liability?
 - a. The prescriber.
 - b. The board of pharmacy.
 - c. The patient's insurance company.
 - d. None of the above. This change can be made independently by the pharmacist with no concern for legal liability.

9. In the Pepcid/Paxil error case, what conduct by the pharmacy did the court note as being "particularly egregious?"
 - a. The manufacturer's choice of look-alike and sound-alike names.
 - b. The placing of these two drugs next to each other on the pharmacy shelving.
 - c. The failure to warn the patient or her doctor of the serious adverse effects associated with abrupt discontinuance of Paxil.
 - d. The lack of a computer DUR alert that would have prevented the error.

10. In the case where medications for "Albert Franklin" were given to "Aaron Franklin," what information did the pharmacy technician say that she used to verify the patient's identity?
 - a. Telephone number.
 - b. Birth date.
 - c. Street address.
 - d. None. The technician said that she knew "Aaron Franklin" by sight and would not even need to ask him his name.