ACT CIVIL & ADMINISTRATIVE TRIBUNAL

PHARMACY BOARD OF AUSTRALIA v WANG
(Occupational Discipline) [2015] ACAT 70

OR 15/23

Catchwords: OCCUPATIONAL DISCIPLINE – health practitioner regulation – pharmacist – unprofessional conduct due to dispensing of incorrect medication – consent orders reached - significant delay between conduct and hearing

Legislation: *ACT Civil and Administrative Tribunal Act 2008* (ACT) s 55
Health Practitioner Regulation National Law (ACT) s 3, 191, 193, 196

Cases Cited: *Pharmacy Board of Australia v Fitzpatrick* [2012] QCAT 552
Pharmacy Board of Australia v Jattan [2015] QCAT 294
R v Robertson (2007) 177 A Crim R 121
Health Care Complaints Commission (NSW) v Black [2014] NSWCATOD 35
Bar-Mordecai v Medical Council (NSW) [2014] NSWCATOD 142
XG v Medical Board of Australia [2011] VSC 638

Tribunal: Ms M Brennan – Senior Member

Date of Orders: 22 September 2015
Date of Reasons for Decision: 19 October 2015

ACT CIVIL & ADMINISTRATIVE TRIBUNAL **OR 15/23**

BETWEEN:

PHARMACY BOARD OF AUSTRALIA
Applicant

AND:

MANDY WANG
Respondent

TRIBUNAL: Ms M Brennan- Senior Member

DATE: 22 September 2015

ORDER

The Tribunal Orders that:

1. The agreed draft Orders proposed by the parties on 22 September 2015 are made pursuant to section 55 of the *ACT Civil Administrative Tribunal Act 2008* (the ACAT Act).

2. The terms of agreement are:

    a) Pursuant to section 196(1) of the *Health Practitioner Regulation National Law (ACT)* (the National Law) the respondent has behaved in a way that constitutes unprofessional conduct; and

    b) Pursuant to section 196(2) of the National Law the respondent is reprimanded; and

    c) Pursuant to section 196(2) of the National Law the following conditions are imposed on the respondent's registration as a pharmacist:

        i. The practitioner undertakes the *Ethics and Dispensing in Pharmacy Practice* course offered by the Pharmaceutical Society of Australia. Completion of the course is to be funded by the practitioner.

        ii. The practitioner is to provide evidence of enrolment in the *Ethics and Dispensing in Pharmacy* course within 28 days of the imposition of the conditions.

iii. The practitioner is to complete the *Ethics and Dispensing in Pharmacy Practice* course within 9 months of the imposition of these conditions. Evidence of successful completion of the course is to be provided to the Board no more than 28 days after the course is completed.

3. The names of the notifier and consumer of the wrongly dispensed medication in this matter are to be suppressed. The latter will be referred to as customer A.

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Ms M. Brennan – Senior Member

REASONS FOR DECISION

1. In making orders pursuant to section 55 of the *ACT Civil and Administrative Tribunal Act 2008*, the Tribunal must be satisfied that the orders proposed are within the Tribunal's powers and appropriate for the Tribunal to make.

2. Sub-section 196(1)(b)(ii) of the National Law empowers the Tribunal to decide that a practitioner has behaved in a way that constitutes unprofessional conduct.

3. Sub-section 196(2) details the Tribunal's powers after it makes a finding under sub-section 196(1)(b). These include reprimanding the practitioner and imposing a range of conditions on the practitioner's registration, such as, requiring the practitioner complete further training. On the basis of the powers detailed in the National Law, the Tribunal is satisfied that it has the power to make the orders sought by the parties.

4. After hearing the parties, the Tribunal is also satisfied that the orders are appropriate, noting that a key object to be considered is the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.

5. In view of the evidence filed by the parties, which includes statements from the practitioner and a dispensing assistant involved in dispensing and providing the incorrect medication to customer A's agent, the Tribunal is satisfied that the practitioner engaged in unprofessional conduct.

6. In examining the practitioner's conduct the Tribunal took account of its seriousness and the significant medical complications suffered by customer A due to the incorrect medication being dispensed on 12 May 2012. The Tribunal also notes the practitioner's inexperience, being only granted full registration as a pharmacist on 5 April 2012. The poor and highly risky practices at the respondent's place of employment were also considered, which resulted it seems, in the medication being dispensed and given to customer A's agent without it being checked by the practitioner.

7. The Tribunal also noted the practitioner's insight, demonstrated by the voluntary and practical steps she took to enter into mentoring relationships with other more experienced pharmacists to assist her in her practice. Her remorse is also evident from the contact she made with customer A as soon as she became aware of the dispensing error. On balance, the Tribunal considers the risk of the practitioner repeating the conduct is very small.

8. The applicant referred the Tribunal to the decision of *Pharmacy Board of Australia v Fitzpatrick* [2012] QCAT 552 which involved a dispensing error resulting in serious injury to a customer. In that case the tribunal found the practitioner had also engaged in unsatisfactory professional conduct. The Tribunal agrees with the applicant's submissions that the respondent's case differs to Mr Fitzpatrick's as she made several attempts to contact the customer to apologise and offer assistance. She also alerted her employer to the system failures which led to the incorrect dispensing and attempted to address the issues promptly. The two cases also differ in the experience level of the practitioners; Mr Fitzgerald was a very experienced pharmacist unlike the respondent.

9. The applicant's submissions also refer to the Queensland decision of *Pharmacy Board of Australia v Jattan* [2015] QCAT 294 where a finding of unsatisfactory professional conduct was made and a formal reprimand recorded. In that decision the Tribunal noted the practitioner's admissions, level of insight and co-operation with the Board's investigation in the determination of the respondent's conduct.

10. The respondent's counsel submitted that the 'extraordinary delay' between the relevant misconduct and the date of the hearing should be considered by the Tribunal in considering the appropriate sanction. In this case the practitioner's conduct, forming the subject of the application before this Tribunal, occurred on 14 May 2012. A notification was lodged on 8 June 2012 and the practitioner was advised about its lodgment six days later. She provided a response to the notification, as requested, within a week.

11. On 10 October 2012 the practitioner was advised the matter had been referred to a performance and professional standards panel. The panel's hearing did not occur until 30 July 2014, 21 months after the respondent was notified of the referral. Due to forming a reasonable belief that the practitioner may have engaged in professional misconduct, the panel referred the matter to this Tribunal pursuant to section 193(1)(b) of the National Law. The application for disciplinary action was filed with the Tribunal on 11 June 2015, 10 months after the panel's referral.

12. The respondent's counsel cited a number of criminal decisions, including *R v Robertson* (2007) 177 A Crim R 121 where Rothman J noted at [24]:

> *A delay in investigation and prosecution of an offence may, when lengthy, lead to a degree of leniency being extended… Delay is, a factor to the extent that it affects fairness because, for example, of changed circumstances, additional suspense or anxiety, significant periods of conditional liberty, inexplicable delay by the prosecuting authority, and the like.*

13. This impact of delay in progressing a case by an applicant has been examined in numerous tribunal and court decisions covering health practitioners. See for example *Health Care Complaints Commission (NSW) v Black* [2014] NSWCATOD 35 and *Bar-Mordecai v Medical Council (NSW*) [2014] NSWCATOD 142. The decision of *XG v Medical Board of Australia* [2011] VSC 638 involved an application for an order permanently staying the proposed health panel hearing established by the former Medical Practitioners Board of Victoria. The practitioner raised the delay in bringing the complaints against him.

14. In examining the factors that should be considered in making such an order, Kyrou J noted at [10] that they include: the importance of protecting the public from incompetence and professional misconduct on the part of medical practitioners; the requirements of fairness to the medical practitioner; and the length of any delay in the making of a complaint against the medical practitioner or in its investigation and the reasons for the delay.

15. No satisfactory explanation was given by the applicant for the delay in this matter between when the Board referred the matter to a panel and the hearing it

eventually conducted. The applicant submitted at the hearing that this delay had been to the practitioner's benefit as she was able to show there were no further notifications during the intervening period and she had also been able to establish mentoring relationships with other pharmacists. The Tribunal found this to be a poor submission. Clearly, the public was not being adequately protected during this time as the respondent's conduct had not been reviewed by a panel as section 181 of the National Law intended. Practically, it meant that the respondent was practising without any conditions on her registration, such as those on which the parties have now agreed. The uncertainty and anxiety suffered by the practitioner due to this delay is also unfair.

16. The guiding principles of the national registration and accreditation scheme include, in section 3(3)(a) of the National Law, that the scheme is to operate in a transparent, accountable, efficient, effective and fair way. It appears to the Tribunal that the delay in this case demonstrates a lack of efficiency, effectiveness and fairness.

17. Finally, it is in the interests of the parties and the wider community that this matter could be resolved without requiring a hearing. In making a consent order of this kind the Tribunal had the opportunity to review and comment upon the consent orders proposed. There was also the opportunity to review the agreed statement of facts with the registered health practitioner in order to confirm her understanding of the importance of the matter and what steps she had taken to ensure the future risks of dispensing errors were minimised.

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Ms M Brennan - Senior Member

STATEMENT OF AGREED FACTS

A. BACKGROUND

1. The respondent is a registered pharmacist, having been first registered provisionally to practice pharmacy on 18 January 2011. Her current general registration will expire on 30 November 2015 (**Document 1**). The respondent has no conditions on her registration.

2. The respondent completed her undergraduate qualification at Charles Sturt University, Wagga NSW, and she holds a Bachelor of Pharmacy degree.

3. The respondent has been employed as a pharmacist:

   (a) from 13 December 2010 at The Chemist Warehouse, Phillip;
   (b) from 18 October 2013 at The Chemist Warehouse, Queanbeyan; and
   (c) from 4 November 2014 at The Chemist Warehouse, Majura Park.

B. RESPONDENT'S REGISTRATION HISTORY

4. The respondent was first registered on a provisional basis (supervised practice) on 18 January 2011.

5. The respondent became eligible to apply for general registration on 22 February 2012 after passing the Pharmacy Board of Australia (**the Board**) oral examination.

6. The respondent was granted full registration as a pharmacist on 5 April 2012.

C. CUSTOMER A NOTIFICATION

7. On 8 June 2012, the Australian Health Practitioner Regulation Agency (**AHPRA**) received a notification from Customer A's agent regarding the respondent's practice of pharmacy (**Customer A Notification**) (**Document 2**). Customer A agent's notification contained the following allegations:

   (a) that she had submitted a prescription at The Chemist Warehouse in Phillip, ACT on 14 May 2012 where the respondent was the pharmacist on duty;

   (b) that she had submitted the prescription on behalf of her husband, Customer A;

(c) the prescription was issued to Customer A by his renal specialist, Dr Krishna Karpe on 13 May 2012, and was for the diuretic Lasix at a dosage of 250mg twice daily;

(d) Customer A had suffered from chronic kidney failure from the age of three weeks, and had undergone a kidney transplant in 2002;

(e) the medication dispensed in accordance with Dr Karpe's prescription was Digoxin. The label on the medication from The Chemist Warehouse instructed Customer A to take 250mcg of Digoxin twice daily;

(f) Digoxin is a medication used to slow a person's heart rate. Customer A's agent stated that she has since been advised by a doctor that Digoxin is not commonly prescribed, particularly in the dose it was dispensed to Customer A, because Digoxin is "toxic";

(g) Customer A began to take the Digoxin provided from The Chemist Warehouse in Phillip as directed on the medication label;

(h) On 20 May 2012, Customer A began to experience vomiting and diarrhoea;

(i) By 25 May 2012, Customer A had no improvement in his symptoms so Customer A's agent took him to the Emergency Department at The Canberra Hospital (**TCH**);

(j) When Customer A was seen by the doctors at TCH, it became apparent that Digoxin had been dispensed to Customer A in error;

(k) Customer A was diagnosed with Digoxin Toxicity and was administered five vials of Digibind (an antidote to Digoxin);

(l) The dosage directions on the Digoxin given to Customer A was four times the recommended dose for a patient with renal impairment;

(m) Customer A had some kidney functioning tests on 25 May 2012 at TCH which suggested that the Digoxin had had a detrimental impact on Customer A's kidney functioning and brought forward the need to begin dialysis;

(n) Customer A was subsequently admitted to the Critical Care Unit within the Cardiology Ward at TCH;

(o) Customer A was discharged from TCH on the afternoon of 26 May 2012 and advised to return to the TCH Emergency Department if his condition deteriorated;

(p) Customer A attended his GP on 28 May 2012 and further blood tests were ordered to check the Digoxin levels in Customer A's body;

(q) Customer A had further blood tests on 30 May 2012 which showed his Digoxin levels were still in the "high" range;

(r) Due to his ingestion of Digoxin, Customer A required two weeks away from work on sick leave. He returned to work part-time on 4 June 2012;

(s) On 4 June 2012, Customer A's blood tests showed that his Digoxin levels had decreased to an almost "normal" level;

(t) Customer A began dialysis on 6 June 2012; and

(u) If Customer A had continued taking Digoxin as directed on the medication label and without medical intervention, his symptoms would have become much more acute and could have been fatal.

8. The respondent was provided with a copy of Customer A's agent's notification by AHPRA by letter dated 14 June 2012 (**Document 3**). The respondent was invited to provide any response by 21 June 2012.

9. The respondent provided a written response to the Notification on 19 June 2012 (**Document 4**). That response can be summarised as follows:

(a) A prescription for Customer A was presented to The Chemist Warehouse, Phillip between 10.30am and 11.00am on 14 May 2012 for Lasix 250mg tablets. The dose prescribed was "one tablet, twice per day", and the words "high dose" were also written on the prescription;

(b) The prescription was handwritten in "a reasonably legible manner";

(c) Customer A is a regular customer of the pharmacy, but the respondent has never met him. She understands that his carer submits and collects all his prescriptions;

(d) On 14 May 2012, Customer A's prescription was received by a dispensary assistant at the "Scripts In" counter;

(e) The medication dispensed in response to the prescription was Sigmaxin (Digoxin) 250mcg tablets. The dosing instruction provided to Customer A on the mediation packaging was one tablet, twice per day as directed by the doctor;

(f) The respondent concedes that "the Sigmaxin was dispensed for Customer A in error";

(g) The respondent then outlines her recollection of the arrangements at The Chemist Warehouse on 14 May 2012:

(i) There were four dispensary assistants and two pharmacists on duty;

(ii) The pharmacy was experiencing a very high workload at the time Customer A's prescription was dropped off. The respondent's role during this period was to consult non-prescription customers and check scripts placed in her "designated script checking area";

(iii) Due to an "overwhelming" number of scripts, the respondent was called back to dispensing duties;

(iv) Customer A's prescription was dispensed by a dispensary assistant, Ms Shelby Clark;

(v) Since the incident, the respondent had learned that Customer A's regular prescription was for Lasix 40 mg tablets, and that 250mg was a new dosage for him. She was not informed of the change in dosage by Ms Clark or anyone else;

(h) The respondent says she has no recollection of what specifically happened regarding Customer A's prescription, but states she believes the following events occurred:

(i) Ms Clark placed the script next to her dispensing computer with the intention of putting it in the respondent's designated "script checking area";

(ii) the script was not placed in her designated “script checking area”;

(iii) She recalls Ms Clark telling her there was a script to be checked when she was free;

(iv) At the time the script required checking, the respondent was attending to another customer;

(v) No other pharmacy staff recall seeing the respondent check Customer A’s script;

(vi) “It is possible that, in a busy pharmacy environment, the incorrect medication was handed out without a confirmation from a pharmacist”;

(vii) The respondent was not involved in giving out the prescription, nor was she alerted to the fact the script had been dispensed; and

(viii) The respondent had no recollection of checking the incorrectly dispensed prescription.

(i) The Chemist Warehouse dispensary policy as at 14 May 2012 was that all scripts to be checked by a pharmacist be placed in one designated area.

(j) The first the respondent knew of the dispensing error to Customer A was on 25 May 2012 when the pharmacy received a phone call from TCH;

(k) The respondent made numerous attempts to contact Customer A and/or his agent. She apologised to Customer A’s agent when she was able to speak with her by phone and sent flowers to their home address;

(l) The respondent believes she should have placed herself at the “script out” counter as she would have had “more experience on the counselling of this medication than a dispensary assistant.” The respondent believes that it is very likely that she would have picked up the error had she been at the “script out” counter;

(m) She expresses her deepest regrets at the error and any adverse effect on Customer A’s health. She believes the

mistake could have been prevented had “more rigorous dispensing procedures” been implemented at the pharmacy;

(n) Since the error in dispensing Customer A’s medication, the Chemist Warehouse, Phillip has altered its procedures in the following ways:

(i) All medication given to customers must have the personally imprinted initials of a registered pharmacist which indicates it has been fully checked by that pharmacist;

(ii) Medication cannot be handed to a customer unless it has the personal imprinted initials of a pharmacist;

(iii) All staff must place completed scripts in one designated script checking area. Medications may not be left sitting next to a dispensing computer;

(iv) A copy of the Pharmaceutical Defence Ltd “Guide to Good Dispensing” chart has been placed in a visible position at each dispensing station; and

(o) A staff meeting was held at the Chemist Warehouse, Phillip following the incident where staff were warned to follow the new procedures. Failure to comply would be met with a reprimand.

10. On 21 June 2012, the respondent also provided the Board with a written statement by Ms Shelby Clark, the named dispensary assistant present at the time the prescription was dispensed to Customer A’s agent. Customer A’s written statement can be summarised as follows:

(a) She was working with the respondent on 14 May 2012;

(b) She was “dispensing under [Ms Clark’s] name and [the respondent’s] name that day”;

(c) She was “the one who dispensed the medication”;

(d) The script from the doctor requested Lasix 250mg and the medication she dispensed was Sigmaxin 250mcg;

(e) She had dispensed the medication and left it on the counter while she dispensed the next basket of scripts;

(f) She had asked the respondent to check the script, and the respondent advised she was helping another customer. The script was left “on the spot”;

(g) She did not see the respondent check the prescription, nor did she hear the respondent say she had checked the prescription “so someone might have taken the script and handed it out without checking if it was checked or not”; and

(h) Ms Clark concludes that “they must not have double checked with the Pharmacist and that is where I think the problem is”.

11. On 10 July 2012, the Board considered the Notification and the material in response from the respondent. The Board determined it was appropriate to establish a Performance and Professional Standards Panel (**PPSP**) to consider the matter. The Board came to this view as the Board believed the respondent’s conduct may be unsatisfactory; the Board noted particularly that the respondent failed to use a barcode scanner which was in contravention of the Board’s approved dispensing guidelines (**Document 5**).

12. At joint consideration with the Health Services Commissioner on 11 September 2012, it was agreed the Notification should proceed to a PPSP.

13. The respondent was notified in writing of the establishment of a PPSP on 10 October 2012 (**Document 6**).

14. Due to resourcing constraints within AHPRA, it was not possible to convene an appropriately qualified PPSP for some time.

15. On 4 June 2014, the respondent was advised in writing that the PPSP hearing would be conducted on 30 July 2014 (**Document 7**).

16. On 5 June 2014, the Board appointed the following members to the PPSP to investigate the Notification (**Document 8**):

(a) Mr Anthony Pannuzzo;
(b) Mr John Alati; and
(c) Mr Anthony Tassone.

17. On 9 July 2014, the respondent was issued with a Notice of Hearing for the PPSP to be held on 30 July 2014 (**Document 9**). That notice requested that any written statement or any further material for consideration by the Panel be provided by the respondent 23 July 2014.

18. The Notice of Hearing for the PPSP contained a list of the matters the Panel was required to consider, namely:

(a) Whether the respondent had acted in a way which constituted unsatisfactory professional performance in practising her profession based on the Notification; and

(b) The allegations that:

(i) the respondent dispensed to Customer A medication being Sigmaxin (Digoxin) 250mcg rather than T Lasix 250mg as prescribed;

(ii) the respondent selected the incorrect medication from the shelf in response to the prescription;

(iii) in the process of labelling and checking the medication against the script, the respondent failed to detect that an error had been made;

(iv) The respondent breached section 10 of the Pharmacy Board of Australia Guidelines for the Dispensing of Medicines by failing to use a barcode scanner in the checking process; and

(v) The respondent failed to follow up the incident in accordance with the required standard.

19. On 29 July 2014, the respondent provided a further written response to the Panel to assist its consideration of the matters outlined in the Notice of Hearing (**Document 10**). That written response can be summarised as follows:

(a) The respondent believed that the error occurred because there were inadequate protocols in place at The Chemist Warehouse, Phillip, to minimise or detect dispensing errors;

(b) The dispensary environment at The Chemist Warehouse, Phillip, was at times “chaotic” due to the work volume;

(c) The respondent believes that she did not check the prescription as she believes she would have remembered the unusual dose;

(d) The respondent believes the medication was placed in a “waiting area” by the dispensary technician and was given to Customer A’s agent before it could be checked by the pharmacist on duty;

(e) The prescription was initially dispensed by a dispensary technician and the respondent was not involved in selecting the medication from the shelf;

(f) The respondent states that the “normal procedure” is for medication to be taken from the shelf and processed through the “dispensing program”, which enforces the scanning of all medication;

(g) The respondent believes she was not involved in the labelling of the medication for Customer A;

(h) The script was handed out by a dispensary technician who failed to detect that the medication had not been checked;

(i) After the incident involving Customer A, there was a major restructure of the workstations at the pharmacy. The “last work station” is now for handing out medications and is to be staffed by pharmacists or interns only;

(j) The pharmacy has also since implemented a procedure whereby all prescriptions being handed out must have a pharmacist’s initials. This is intended to pick up dispensing errors;

(k) The dispensary technician who processed the script has been trained to use the barcode scanner, and in the respondent’s experience, that technician adhered to that requirement;

(l) The dispensary technician who processed the script selected the wrong medication from the shelf, but still used the barcode scanner for dispensing;

(m) After hearing of Customer A’s admission to hospital, the respondent contacted his agent immediately to offer assistance and provided her personal contact details;

(n) The respondent also contacted the practitioner who had prescribed Lasix originally to advise of what had occurred and that Customer A was in hospital;

(o) The respondent attempted to follow up with the hospital regarding Customer A’s condition but was unable to obtain many details due to privacy issues;

(p) An emergency meeting was held at the pharmacy with the proprietor and all staff. Each staff member was given a copy of the Pharmaceutical Defence guideline to good dispensing. Procedures

were discussed, such as: using the barcode scanner, consulting a pharmacist for “first time supply prescriptions”, pharmacists to initial medication once checked, and use of the “last work station” for pharmacists and interns. Dispensary technicians were advised they were no longer permitted to hand out medication;

(q) The pharmacy has also introduced a “new medication cue card” which is placed in a basket with a script if the customer advises the prescription is new for them. The pharmacist then knows to provide additional education or counselling; and

(r) The respondent expresses deep regret over the incident and now enforces very rigid protocols at her workplace.

D. PPSP HEARING

20. The PPSP hearing was held as scheduled on 30 July 2014 before Panel members Mr John Alati (Community Member and Chairperson), Mr Anthony Pannuzzo (Health Practitioner Member) and Mr Anthony Tassone (Health Practitioner Member). The respondent was in attendance with Mr Donald Grant, a support person. Ms Meredith Boroky of AHPRA was counsel assisting the Panel.

21. The respondent relied upon her written submissions to the Panel of 29 July 2014 and also made verbal submissions to the Panel at the hearing.

22. During the course of the PPSP hearing, the respondent made oral statements to the following effect:

(a) She did not deny that the error in dispensing Digoxin to Customer A had occurred;

(b) She believed the error had occurred as there were inadequate protocols in place at The Chemist Warehouse, Phillip, to minimise or detect dispensing errors;

(c) She had been dispensing alone in a very busy environment and often did so while another pharmacist attended to administrative matters such as payroll;

(d) On the day in question, she had been supervising four dispensary technicians;

(e) It was not unusual for The Chemist Warehouse, Phillip to dispense between 500-600 prescriptions per day;

(f) On 14 May 2012 when Customer A prescription was incorrectly filled, she estimated that approximately 60% of prescriptions dispensed were completed without the patient's medical history being checked by a pharmacist;

(g) On 14 May 2012 when Customer A's prescription was incorrectly filled, she observed it was regular practice for Schedule 3 medications (pharmacist only medications) to be provided to customers on request by pharmacy staff (other than pharmacists) and without a pharmacist being consulted;

(h) On the day of the error in Customer A's prescription, only one pharmacist was on duty to supervise four dispensary technicians. That one pharmacist was on dispensing duty for more than six hours during the day;

(i) The respondent believed she did not check Customer A's prescription as she would have remembered such an unusual dose. She believed that, instead, the medication was placed in a "waiting area" by the dispensary technician and handed out before it could be checked;

(j) When questioned by the Panel, the respondent stated that at the time of the incident involving Custoemr A, she had held general registration as a pharmacist for approximately one or two months and had been an intern for the 12 months prior to that;

(k) The respondent admitted that, at the time of the incident, she was inexperienced and did not realise that the dispensing systems and procedures at The Chemist Warehouse, Phillip, were not logical or systematic;

(l) The respondent stated she did not believe she was involved in selecting the medication from the shelf or labelling the medication;

(m) The respondent submitted that the dispensary technician who selected the incorrect medication had used the barcode scanner as required;

(n) After hearing about Customer A's admission to hospital, the respondent contacted Customer A's partner to offer assistance and provided her personal contact details. She also contacted the original prescriber of the medication and followed up with hospital staff treating Customer A. She assisted in coordinating an

emergency meeting within The Chemist Warehouse, Phillip to alert staff to the error and implement new management strategies; and

(o) The respondent outlined the changes made at The Chemist Warehouse, Phillip since the incident involving Customer A: a change in the structure of the workstations, the introduction of a "new medication" cue card, and improved supervision by pharmacists.

23. From the written and oral submissions provided by the respondent, the PPSP was able to make the following findings regarding the allegations set out in the Notice of Hearing:

(a) The incorrect medication had been dispensed to Customer A;

(b) It was more likely than not that a dispensary assistant had selected the incorrect medication from the shelf in response to the prescription;

(c) It was more likely than not that a dispensary technician had incorrectly labelled the medication, had failed to check it against the prescription, and had failed to detect that an error had been made;

(d) It was established that the respondent had failed to detect that an error had been made;

(e) A barcode scanner had been used appropriately;

(f) The respondent had "followed-up" adequately after the error was discovered.

E. EVENTS SINCE THE NOTIFICATION

24. Since the Notification on 8 June 2012:

(a) There have been no further notifications or complaints to the Board regarding the respondent's professional conduct or competence;

(b) The respondent had engaged in a mentoring relationship with Ms Angela Cheng, a registered pharmacist and approved AHPRA examiner for the Board's oral examinations;

(c) The respondent no longer works at The Chemist Warehouse, Phillip;

(d) The respondent has agreed that her conduct in relation to the Notification can be characterised as "unprofessional conduct" as

defined in section 5 of the *Health Practitioner Regulation National Law (ACT)*.