

Inquest findings

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search was launched, and she was found deceased with a note and four medication containers beside her body.

Toxicology results showed venlafaxine in the blood samples. No olanzapine was found in the samples. It was determined that on the day of her death, she had obtained refills of 90 Effexor® 150 mg XR and 60 Zyprexa® Zydys® from her regular pharmacy, using previously authorized refills on the two prescriptions. The Effexor XR® vial was found beside the body with six capsules in the container.

Coroner recommendations

In the current PharmaNet system, medications that are discontinued by the prescriber are not automatically cancelled on the patient's PharmaNet record. If the prescriber wishes to cancel refills remaining on a prescription, he or she can advise the patient's individual pharmacy of this change, and the refills can be cancelled on the pharmacy's local computer system. This information is not transmitted to PharmaNet.

The pharmacy can also transmit a "discontinued" status to PharmaNet. The prescription status on PharmaNet then changes from "F" (filled) to "D" (discontinued).

The "discontinue" function should only be used to identify drugs that have been removed from the patient's regimen due to an adverse drug reaction, a medication change, or a dosage change. The discontinued status cannot be "undone" once transmitted by some pharmacy systems.

Only the pharmacy that dispensed the prescription can transmit the "discontinue" notification to PharmaNet. If the physician does not know which pharmacy dispensed the prescription, the PharmaNet helpdesk can identify the pharmacy.

The College of Physicians and Surgeons of B.C. has also been asked to advise physicians about the need to request that a "discontinue" notification be sent to PharmaNet when it is not intended that a patient continue to take previously dispensed medication.

what went wrong

Dear College:

I am on the methadone maintenance program. A community pharmacy dispenses my weekly carries. Last month, my purse was stolen and the thief obtained my methadone. As a result, the thief died of an overdose. I discussed this with the police and my doctor. I also called the pharmacy and spoke with the pharmacist on duty.

The following week, when I went to the pharmacy for my weekly pick up, I didn't recognize the pharmacist on duty and told him so. In response, he said, "...Don't you remember talking to me last week about the guy that stole your purse, drank your methadone, and died?"

A number of patients heard the pharmacist! I believe he violated his ethical obligation to keep my personal medical information confidential. It's nobody's business to know that I am on methadone and further, to know that it was stolen and someone died as a result.

In the many years that I've been on methadone maintenance, I've never experienced such disregard for my personal information.

Concerned about Confidentiality

The pharmacist involved acknowledges:

There was a "loud discussion about the previous theft of methadone" while he was in the dispensary and the patient was at the pharmacy counter.

Suggestions:

Here are some suggestions to improve privacy in the dispensary area to ensure patients receive the information they need, while maintaining confidentiality:

1. Always be mindful of how loud you are speaking when discussing confidential information with patients.
2. If the pharmacy has a private or semi-private counselling area, move to that area when discussing confidential information with patients.
3. Politely ask waiting patients to step back a few feet so you can have a private conversation with the patient you are serving.

4. Place stanchions a few feet in front of the dispensary where patients hand in and pick up their prescriptions. You might only need one stanchion to give people the idea that they should stand back. Some stanchions include a "Please wait here" sign.
5. Place a line of brightly coloured tape on the floor a few feet from the dispensary. If it isn't effective on its own, a sign on the dispensary that reads, "Help us respect privacy and confidentiality. Please wait behind the red line until we can assist you" may help.
6. Use a small mat in front of the prescription drop-off/pick-up area to delineate the space.

Situations like the one described above provide an excellent opportunity to reflect on your personal pharmacy practice and to make sure your pharmacy has a system in place to identify, prevent, manage, and report practice errors and omissions.