Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Pharmacist breaches Code for failing to check correct medication dispensed
21HDC01574

The Deputy Health and Disability Commissioner has found a pharmacist breached the Code of Health and Disability Services Consumers' Rights for failing to check the correct medication was dispensed to a consumer.

Rose Wall found the pharmacist had breached Right 4(2) of the Code – tautikanga; the right to services of an appropriate standard of care that met all legal, professional, and ethical standards.

The Deputy Commissioner was also critical that the pharmacist failed to provide the consumer with a clear explanation about the adverse side effects of taking the incorrect medication after the dispensing error was discovered. "In my view, a reasonable pharmacist should conduct a thorough and comprehensive review about an incorrectly dispensed medication and inform the affected patient immediately about potential adverse side effects. It is clear that at the time of discovering her error, Ms B checked for information about the dispensed medication, but did not appreciate that there were serious side effects. Accordingly, I am critical that Ms A did not receive a clear explanation about the adverse side effects of the medication she had taken."

The pharmacist accepted full responsibility for her error. Ms Wall recommended she formally apologise to the woman. She also asked her to report back on the learnings she had taken from this case.

Ms Wall also made adverse comment on the pharmacy, saying she was critical of its dispensing and checking standard operating procedures. In her decision, Ms Wall highlighted the importance of pharmacies having thorough operating procedures that contained step-by-step processes for dispensing and checking medications in accordance with the Pharmacy Council Standards. This is particularly important for medications that look alike she said, adding that such medications should be highlighted on dispensary shelves to alert dispensers to the potential error of dispensing an incorrect medication.

The mistake occurred when the woman was prescribed isotretinoin for acne - a medication which is not recommended for use by people planning to become pregnant. The pharmacist told HDC that she advised the woman of the dangers of becoming pregnant while using isotretinoin.

However, the pharmacist incorrectly put acitretin (a medication used to treat skin disorders like psoriasis) in the box marked isotretinoin. Patients using acitretin are required to avoid pregnancy for three years. The woman took the incorrect

medication for 22 days. The pharmacist discovered the error when the woman returned to pick up her repeat medication.

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Health and disability service users can now access an online animation to help them understand their health and disability service rights under the Code.

Editor's notes

The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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