Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Pharmacist breaches Code for failing to adequately check medicine
21HDC00539

The Deputy Health and Disability Commissioner has found a pharmacist breached the Code of Health and Disability Services Consumers' Rights (the Code) for failing to check medication properly before dispensing it to a consumer.

An intern pharmacist processed and dispensed 100 tablets of the incorrect medication. This was checked by the most senior pharmacist on duty with responsibility for supervision and functioning of the pharmacy.

A woman took the incorrect medication for 17 days before the error was discovered, which occurred after she went to hospital complaining of back pain. The pharmacy was advised of the error by the hospital.

Deborah James found the pharmacist breached Right 4(2) of the Code for failing to provide services in accordance with professional standards and the pharmacy's own standard operating procedures (SOP).
Ms James said, "I am critical that the pharmacist did not complete the final steps of the dispensing process adequately and failed to identify the error."

The pharmacist also failed to record the error on the woman's file in a timely manner and failed to provide a written apology to her upon becoming aware of the error, both of which evidenced a further failure to comply with the pharmacy's SOP.

The woman's daughter, who complained on behalf of her mother, told HDC she was disappointed with the pharmacy's attitude on hearing of her mother's death. The pharmacy provided a formal written apology five months after the event.

Ms James made adverse comment about the care provided to the woman by the two pharmacy owners in following up the error, and management of the apology.

Adverse comment was also made about the intern pharmacist who had selected the incorrect medication. The Deputy Commissioner noted that the intern pharmacist was only one month away from sitting his final exams.

Ms James recommended the pharmacy combine the SOPs relating to dispensing errors and customer complaints, conduct staff training on the dispensing and checking SOPs and undertake a random audit of the dispensing and checking of medications. The pharmacy is to report its findings back to the HDC with an action plan to address any findings.

Finally, Ms James recommended an anonymised copy of this report be used by all pharmacies in the company for education. Evidence of this must be provided within six months of this report.

17 July 2023

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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