Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Pharmacists make dispensing error in providing excess medication to woman with mental health difficulties.
21HDC00955

A registered pharmacist and a pharmacy manager breached the Code of Health and Disability Services Consumers' Rights (the Code) by giving a woman the incorrect strength of medication.

The woman, who has a history of mental health difficulties, was prescribed venlafaxine by her GP on the advice of her mental health team. The woman had asked not to be given a large amount of venlafaxine and her doctor had prescribed a specific quantity and strength of her medication to be dispensed at a time.

The woman collected her medication from the pharmacy and noticed when she got home that she had received 21 tablets at 150mg strength instead of the correct strength of 37.5mg that she was prescribed.

Deborah James, Deputy Health and Disability Commissioner, found a registered pharmacist and the pharmacy manager (also a pharmacist) breached Right 4(2) of the Code which gives every consumer the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

On the day in question, which followed a long weekend, the pharmacy was understaffed and had a backlog of scripts to fill. Ms James acknowledged this but noted "it is a fundamental patient safety and quality assurance step in the dispensing process to adequately check the medication being dispensed against the prescription for accuracy. This involves checking that the correct medicine, dose, form, strength, and quantity is being dispensed, and checking for any interactions."

The registered pharmacist told HDC the pharmacy's standard dispensing procedure is to process and generate labels for a prescription. Another staff member will then dispense the prescription, and another pharmacist will carry out the final check to minimise dispensing errors.

The registered pharmacist said on that day he shared tasks with another staff member, instead of each one starting and finishing each step of the dispensing process, as they usually do.

Ms James said, as the pharmacist dispensing the medication, it was the registered pharmacist's responsibility to perform these checks.

The pharmacy manager said he checked for the correct medicine name, strength and instructions on the label, but did not check the contents of the box to ensure the

dispensing pharmacist had selected the correct strength of medicine, as he normally would have.

Ms James said the pharmacy manager also had a duty to provide adequate care and was responsible for providing services of an appropriate standard.

The pharmacy now adds a sundry label to print after each time venlafaxine is processed through the dispensary computer to alert dispensers and checkers to ensure the correct strength is dispensed. The different strengths of venlafaxine are now also physically separated on the dispensary shelves.

Ms James commended the pharmacy for extending the pharmacy premises and recruiting more staff following this event, and for recognising staffing levels were inadequate, the premises were too small for the volume of work, and the workflow was putting huge stress on the staff.

She recommended the registered pharmacist and the pharmacy manager each provide written apologies to the woman and complete the Improving Accuracy and Self-Checking Workbook provided by the Pharmaceutical Society of New Zealand.

She also recommended the pharmacy undertake a random audit of the medication dispensing and checking, provide yearly refresher training for staff in relation to dispensing and checking medications and dispensing errors and ensure there is a process for registering and managing pharmacy complaints and incidents.

27 November 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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