Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Pharmacy breached Code for dispensing error
21HDC03090

The Health and Disability Commissioner has found a pharmacy breached the Code of Health and Disabililty Services Consumers' Rights (the Code) for a dispensing error which saw a four-year-old boy admitted to hospital.

The boy had been prescribed liquid loratadine for hay fever by his GP and the medication was administered twice by the boy's parents. Shortly after the second administration, the boy experienced an apparent severe allergic reaction and was admitted to hospital. A toxicology screening of the liquid medication identified the presence of an antipsychotic medication, haloperidol.

The dispensing pharmacy was made aware of the error and they reviewed the incident including interviewing the staff members involved, and outlining the actions taken as a result. MedSafe also conducted a comprehensive investigation into this matter.

Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, with the agreement of the Pharmacy, adopted the findings of the Medsafe report. She considered it more likely than not that the inadvertent addition of haloperidol to the loratadine dispensing bottle was a result of a dispensing error at the pharmacy.

Dr Caldwell found the pharmacy in breach of Right 4(1) of the Code for failing to dispense liquid loratadine correctly.

"The pharmacy has an organisational responsibility to provide a reasonable standard of care to its consumers. In my opinion, the error represents a failure by the pharmacy to provide services with reasonable care and skill."

Following the investigation conducted by Medsafe, the pharmacy made a number of changes, including acquiring a tablet counting machine and a blister packaging machine to ensure more accurate dispensing and reduce error rates. Both machines free up technicians and pharmacists to focus on other tasks, such as dispensing and checking. The pharmacy also increased staffing levels and implemented new processes to ensure staff members are aware of any brand changes and changes to medication positioning.

Dr Caldwell commended the pharmacy on the actions taken once it became aware of the incident, including openly disclosing to the boy's parents that the incident had occurred and that the pharmacy was investigating it, extending an apology, and undertaking an incident notification.

Further to the changes already made, Dr Caldwell recommended the pharmacy undertake an audit of a random sample of 20 dispensed liquid medications that required reconstitution/compounding or transfer to a dispensing bottle, to determine whether these were checked by two people, and that they report back to HDC with an audit summary and any corrective actions.

26 February 2024

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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