HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Pharmacy breaches Code for failing to correctly dispense insulin pen

21HDC03101

The Deputy Health and Disability Commissioner has found a pharmacy breached the Code of Health and Disability Services Consumers' Rights (the Code) for failing to dispense an insulin pen correctly. Dr Vanessa Caldwell found the pharmacy breached a woman's right to services of an appropriate standard.

The breach concerns the dispensing error of the fast-release insulin pen NovoMix 30, rather than the woman's usual slow-release pen Lantus Solostar. The pharmacy had supplied the woman with a seven-day dosage of what she thought was her usual medication. During that time she experienced sweating, shaking, dizziness, blurred vision and fainting. She also believed she may have blacked out while driving.

A week later, when the woman checked her medication, she realised the discrepancy and rang her GP who confirmed the woman had become hypoglycaemic (low blood sugar) and prescribed the correct Lantus Solostar pen. The woman returned to the pharmacy to pick up her new pen and advised pharmacy staff of the error.

An incident notification form was provided to the Pharmacy Defence Association by the working pharmacist which outlined the events but did not analyse how or why the error occurred. It was also not able to determine which pharmacist completed the final check of the prescription or which individuals were involved in the incident.

Dr Caldwell acknowledged the pharmacy owner's willingness to accept responsibility for the error. However, notwithstanding this, she stated, "A serious incident occurred that resulted in significant adverse side effects… Ultimately, the pharmacy has an organisational responsibility to provide a reasonable standard of care to its consumers."

She added, "…although it is not clear how the dispensing error occurred, or whether the medication was checked before being dispensed, I consider it more likely than not that staff practice did not match the required SOPs [standard operating procedures] at the time this event took place and failed to pick up that the incorrect medication was being dispensed."

The pharmacy has since made a range of improvements, including increasing staff levels, changes to its SOPs and dispensing area.

Dr Caldwell acknowledged the thorough apology and offers of compensation the pharmacy has since made to the woman, and the significant changes to its SOPs.

“I am satisfied the changes made are an appropriate response and will mitigate such an event occurring again,” she said.

However, she recommended the pharmacy undertake an audit of a random sample of 20 dispensed insulin pens to check whether they were dispensed in line with the new SOPs. The results, and any corrective actions, are to be supplied to HDC within three months of the date of her decision.

10 June 2024

Editor’s notes

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC’s website - see HDC's 'Latest Decisions'.

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 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

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