HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Man's rights breached under the Code for prescription error
22HDC00897

Note: events outlined in this report took place in 2021-2022

A man's rights under the Code of Health and Disability Services Consumers' Rights (the Code) were breached by a supervising pharmacist, according to a report published today by Deputy Health and Disability Commissioner Deborah James.

The man's prescription was faxed by his GP to his pharmacist and was printed by the pharmacy as four double sided pages. The final page contained a prescription for Sinemet, a medication for Parkinson's Disease, which was intended for another patient at the same practice.

The intern pharmacist who processed the prescription noted that Sinemet was new for the man but did not identify that it was not prescribed for him. The supervising pharmacist checked the prescription and also did not identify that the medication was prescribed for another patient.

The man returned for two more repeat prescriptions of the medication over three months until he complained to his GP of dizziness and imbalance and the GP discovered that the Sinemet had been incorrectly dispensed to the man. The GP contacted the pharmacy and an internal investigation confirmed the error.

Ms James found the supervising pharmacist breached the Code for failing to provide services of an appropriate standard | tautikanga. The breach covered several failings.

First, the supervising pharmacist did not verify the patient details on each page of the prescription during the checking process.

Second, the pharmacist did not follow the Standard Operating Procedures (SOPs) for processing, dispensing and checking prescriptions. These procedures are designed to prevent this kind of error occurring and ensure patient safety.

Finally, there was no documentation of the required counselling conversation with the man about the new medication. Proper documentation is crucial to maintain a record of the care provided.

Ms James made an adverse comment about the intern pharmacist for not verifying patient details under pressure. She also made an adverse comment about the pharmacy for missed opportunities to identify the error and inadequate documentation of patient counselling.

Since these events, the pharmacy has made several changes to prevent future errors, including retraining staff, updating SOPs, and switching to ePrescriptions. In addition to these changes, Ms James made further recommendations, outlined in the report.

2 December 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 group 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%.

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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