Incorrect dose dispensed by pharmacist breaches the Code

23HDC01508

A pharmacist breached the Code of Health and Disability Services Consumers' Rights (the Code) for failing to provide services of an appropriate standard to a four-week old baby.

In a report released today, Deputy Health and Disability Commissioner Dr Caldwell found the pharmacist failed to comply with the professional standards set by the Pharmacy Council and the pharmacy's standard operating procedures (SOP).

The female baby, aged four weeks, was prescribed the oral steroid drug Redipred by her GP to treat croup symptoms. The medication dispensed by the pharmacy was incorrectly labelled to give a 4.5ml dose instead of the 4.5mg, around -0.9ml, which was prescribed.

After the baby received close to the full dose as written on the medication , the baby stopped breathing. She was given CPR by her mother and then admitted to hospital.

The medication label had been typed by a trainee pharmacy technician and then checked by an experienced pharmacist who was a locum at the pharmacy. In addition to not properly checking the dispensed medication against the prescription, or not identifying the error on the prescription dosage, the pharmacist also failed to provide advice to the mother on how to administer the medication.

These failings meant the pharmacist did not adhere to the professional standards set by the Pharmacy Council of New Zealand or the pharmacy's own SOP, and accordingly breached the Code, which gives consumers the right to appropriate standards.

Dr Caldwell made an adverse comment about the post error communication by the pharmacist who contacted the parents several times following the event. She said the pharmacist, "should have respected the mother's request not to contact her further and should have maintained appropriate boundaries."

Dr Caldwell also made educational recommendations in relation to the trainee pharmacy technician and the pharmacy.

She reminded the trainee pharmacy technician of the importance of slowing down and being meticulous when inputting information from prescriptions into the computer. She reminded the pharmacy of the importance of maintaining and complying with up-to-date SOPs to ensure they reflect best practice and any changes

in the pharmacy guidelines and environment and to also ensure staff are trained regularly on these.

Dr Caldwell acknowledged the changes made by the pharmacist and pharmacy since the events and made several further recommendations for all parties, which are outlined in the report.

9 September 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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