HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Pharmacist breaches Code for dispensing incorrect medicine

22HDC01295

The Deputy Health and Disability Commissioner, Dr Vanessa Caldwell, has found a pharmacist breached the Code of Health and Disability Services Consumers' Rights (the Code) for dispensing incorrect medicine to a woman.

The woman had been prescribed Provera and clomiphene by a fertility clinic which she sought to have dispensed at a pharmacy. When she returned home from the pharmacy she noticed she had been given clomipramine (an antidepressant) instead of clomiphene (used to treat infertility by stimulating ovulation). She called the fertility clinic, who confirmed that she had received the wrong medication. The medicine was processed by a pharmacist and dispensed by a pharmacy technician. The woman returned to the pharmacy the next day and raised the error with another pharmacist at the pharmacy who acknowledged and apologised for the error.

In her report, Dr Caldwell found the pharmacist's lack of thorough checking meant he did not identify the dispensing error at several stages of the dispensing process, despite the various checkpoints set out in the pharmacy's standard operating procedures (SOPs). Ultimately this led to the wrong medication being dispensed to the woman.

Dr Caldwell acknowledged the pharmacist had been practising full-time for less than a year when the error occurred, but said he still had an obligation to meet and be measured against the standards required of all registered pharmacists.

"The assessment and checking steps are basic competencies required of a registered pharmacist, as set out by the Pharmacy Council. I find that by not providing services that complied with professional standards, [the pharmacist] breached Right 4(2) of the Code (the right to have services provided that comply with legal, professional, ethical, and other relevant standards)."

Dr Caldwell commended the pharmacist for taking full responsibility for his mistake, and for taking proactive steps to learn from this event and make appropriate changes to his practice. She recommended he provide a formal written apology to the woman and complete the Pharmaceutical Society of New Zealand's 'Improving Accuracy in Your Dispensary' course.

Dr Caldwell also made an adverse comment about the pharmacy technician for not following the SOPs, as she selected the medication from the shelf against the label, not against the prescription itself. She recommended the technician provide evidence of recent self-review of the SOPs, particularly those relating to dispensing processes.

She also made an adverse comment about the pharmacy for not having up to date SOPs and for their staffing arrangements. She recommended the pharmacy consider whether the SOPs should include guidance on how new/junior staff will be supported.

5 July 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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