Insulin dispensing error
(02HDC07385, 13 January 2004)

Pharmacists ~ Pharmacy ~ Professional standards ~ Dispensing error ~ Right 4(2)

Following a four-hourly glucose testing regimen, commenced to investigate poorly controlled Type 2 diabetes mellitus, an 87-year-old man was prescribed Humulin 70/30 by his GP. Humulin 70/30 is a mixture of isophane insulin (brand-name Humulin N), 70%, and Humulin R (which is similar to Actrapid), 30%. As it is a relatively uncommon medication, the GP talked to the patient's pharmacy about the change to ensure a smooth transition.

The patient was dispensed the medication correctly until he changed pharmacy a month later. On the next three visits the patient was dispensed Humulin N, not Humulin 70/30. The next month the patient was again dispensed Humulin N, but this time in a box labelled as Humulin 70/30. The pharmacy's computer system began to automatically restock Humulin 70/30, but this was the first time it had been stocked at the pharmacy. The following month the patient was again dispensed Humulin N in a box marked "Humulin 70/30".

Later that month the patient was admitted to hospital after he collapsed following recent cataract surgery. During his admission the pharmacy correctly dispensed his Humulin 70/30, but noticed that it was a different colour from the Humulin N previously dispensed. Staff at the pharmacy carried out an audit of their stocks and discovered that they had been dispensing Humulin N instead of Humulin 70/30. One of the pharmacists involved later met with the patient's family, GP and hospital staff to discuss the errors and apologise.

The three pharmacists who dispensed the insulin were unaware of the product Humulin 70/30. When confronted with a prescription for "Humulin 70/30 Inj with Neutral Insulin", they assumed that the "Neutral" referred to Humulin N, with which they were familiar. All three pharmacists were found in breach of Right 4(2) of the Code in not following the Standard Operating Procedures for the pharmacy or the Pharmaceutical Society's Code of Ethics. They failed to scrutinise all the relevant information, in particular the figure "70/30", and should not have assumed that the prescription was for Humulin N.