Mr C

Ms D

Ms E

A Pharmacy

A Report by the

Health and Disability Commissioner

(Case 02HDC07385)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer (deceased)
Mrs B	Complainant, Consumer's daughter
Mr C	Provider / Pharmacist
Ms D	Provider / Pharmacist
Ms E	Provider / Pharmacist
Ms F	Provider / Pharmacist
Dr G	General Practitioner

Complaint

On 31 May 2002 the Commissioner received a complaint from Mrs B about pharmacy services provided to her father, Mr A. Following some preliminary enquiries, an investigation was commenced on 12 September 2002. The following parties were notified of the complaint:

The pharmacy
The pharmacy did not provide services to Mr A with reasonable care and skill in that on a number of occasions since 21 December 2001 staff at the pharmacy misdispensed insulin to Mr A and/or his representative.

Ms D
On 22 March 2002, Ms D did not provide services to Mr A with reasonable care and skill in that she incorrectly dispensed Humulin N to Mr A, instead of the prescribed Humulin 70/30, in a box labelled Humulin 70/30.

Ms E
On 9 April 2002, Ms E did not provide services to Mr A with reasonable care and skill in that she incorrectly dispensed Humulin N to Mr A, instead of the prescribed Humulin 70/30, in a box labelled Humulin 70/30.

Mr C
On 21 January and 3 February 2002, Mr C did not provide services to Mr A with reasonable care and skill in that he incorrectly dispensed Humulin N to Mr A, instead of the prescribed Humulin 70/30.

Information reviewed

- Letter of complaint, dated 29 May 2002

- Responses from the pharmacy, dated:
  - 30 September 2002 (from the pharmacy's lawyer)
  - 1 October 2002, including Pharmacy records and Standard Operating Procedures for dispensing
  - 25 November 2002
  - 3 April 2003

- Response from Ms E, dated 7 April 2003

- Response from Ms D, dated 31 March 2003

- Mr A's hospital records from a second Public Hospital, dated 23 August 2002

- Information provided by Dr G, including Mr A's notes and a sample prescription form, dated 20 January 2003.

Independent expert advice was obtained from Mr Murray Guy and Ms Eleanor Hawthorn, pharmacists.

Information gathered during investigation

The facts of this case are not disputed and are set out below.

Mr A suffered from Type 2 diabetes mellitus. He first saw Dr G, general practitioner, in October 2001. At that time Mr A was on a regime of isophane insulin (under the brand-name Protophane) and Actrapid. However, Mr A's diabetes was not well controlled.

Dr G commenced Mr A on a four-hourly glucose testing regime. The results of this test were used to establish Mr A's daily insulin needs and, in November 2001, Dr G changed Mr A's medication to Humulin 70/30. Humulin 70/30 is a mixture of isophane insulin (under the brand-name Humulin N), 70%, and Humulin R (which is similar to Actrapid), 30%.

As Humulin 70/30 is a relatively uncommon medication, Dr G talked to Mr A's pharmacy about this change to ensure a smooth transition.

The prescription form for Mr A's Humulin 70/30 describes it as: "Humulin 70/30 Inj Human With Neutral Insulin 100 U Per Ml, 3 Ml".

This description was used on both the prescription forms from Dr G and the pharmacy-generated labels that went onto the boxes.

Mr A's pharmacy dispensed Humulin 70/30 to Mr A on a regular basis until December 2001, when Mr A changed pharmacies to a second pharmacy.

The first prescription was presented to the second pharmacy on 21 December 2001. This prescription included two repeats. The medication was checked by Ms F, pharmacist. However, the medication dispensed was not Humulin 70/30, but Humulin N.

On 21 January and 13 February 2002, the repeat prescriptions were presented to the second pharmacy. These were checked by Mr C, pharmacist. Again, the medication dispensed was Humulin N. These repeats were dispensed off the original prescription, not a Certified Repeat Copy.

On 1 March 2002, the second pharmacy merged with a third pharmacy to form another pharmacy ("the pharmacy"). Mr A chose to use the pharmacy for his dispensing needs.

On 22 March, a second prescription was presented to the pharmacy. The medication was checked by Ms D. Once again the medication dispensed was Humulin N. However, on this occasion it was dispensed in a box, pharmacy-labelled as Humulin 70/30.

Once the pharmacy's Toniq computer system recorded Humulin 70/30 as having been dispensed it automatically began to order more stock of the drug, which was duly received at the pharmacy. This was the first time that Humulin 70/30 was stocked at the pharmacy.

On 9 April, a third prescription was presented. Again Humulin N was dispensed in a box labelled 'Humulin 70/30'. This medication was checked by Ms E, pharmacist.

On 20 April, Mr A was admitted to a Public Hospital after he collapsed following recent cataract surgery. He was transferred to a second Public Hospital for rehabilitation on 26 April. While at the second Public Hospital, Mr A required regular prescriptions of Humulin 70/30. His prescriptions were correctly dispensed from the pharmacy on 26, 29 and 30 April 2002.

In the process of dispensing these hospital prescriptions, the pharmacy staff noticed that the drug being dispensed (Humulin 70/30) was a distinctive bright pink compared to the green-coloured Humulin N that had previously been dispensed to Mr A. The staff at the pharmacy carried out an audit of their stocks of Humulin N and Humulin 70/30 and discovered that Humulin N had previously been dispensed instead of Humulin 70/30.

On 2 May, Mr C met with Mr A's daughter, Mrs B, and her husband to discuss the differences between Humulin N and Humulin 70/30, and Mr A's condition during his stay at the second Public Hospital. Mr C apologised for the dispensing errors that had occurred

with Mr A's prescriptions. Later that day, Mr C met with hospital staff and Dr G to discuss the dispensing errors.

Mr A died on 15 June 2002, aged 87 years. There is no suggestion that Mr A's hospitalisation or death was related to the errors in dispensing his insulin.

Independent advice to Commissioner

Mr Murray Guy, pharmacist
The following expert advice was obtained from Mr Murray Guy, pharmacist:

> "I submit my comments on the above case after reading the copious documents for some time.
> In response to your question … Was it reasonable for the Pharmacists to have incorrectly interpreted Dr [G's] scripts?
>
> Humulin 70/30 insulin is one form of premixed insulin, but is little used, and if the Pharmacist on receipt of the prescription typed up HUMULIN on the computer the following would result
>
> HUMULIN
> HUMULIN –N
> HUMULIN –R
>
> It is only when you pull down the HUMULIN that a sub title Humulin 70/30 appears as mentioned by [the pharmacy's lawyer].
>
> It may be in [the city where Mr A lived], as has been stated, that the Pharmacies had not had a call for this form of Insulin before, and it is reasonable to assume that when the prescription is written:
>
> Humulin 70/30 INJ WITH NEUTRAL INSULIN 100U PER ML
>
> the pharmacist has naturally thought of HUMULIN –N (the N standing for neutral) as the one required.
>
> I have tried to look at this in the light of the fact that the Pharmacists had not used 70/30 insulin before. In our Pharmacy we do use it occasionally and we have a poster on the types of insulins available in this range alongside our refrigerator. I enclose a copy of this which shows the different rates of insulin activity. You will note the similarity in the naming of these Insulins … Humulin N, Humulin R, Humulin U etc. The

question could be asked … 'Could the manufacturer give a greater distinction to the naming of these products'?

The chart indicates that Humulin N has an onset time of four hours and continues up to ten hours.

Humulin 70/30 has an onset time of two hours and lasts up to twelve hours which would account for the fluctuating sugar levels.

I would have to say that I can understand the Pharmacists' reason for dispensing Humulin – N.

While prescribers specify which insulin they want, if it is not written exactly as is on the manufacturer's label, there is an increased probability of confusion or error.

I cannot understand how HUMULIN–N was dispensed in boxes and then labelled HUMULIN 70/30. I thought that this might have raised a question of the person checking the prescription.

Mr [C] has been very frank and I believe that it is perfectly reasonable for him **not** to have known of the existence of HUMULIN 70/30.

I understand from information supplied to me that Mr [C] became aware of HUMULIN 70/30 when Mr [A] was admitted to the [second Public] Hospital on 26/4/2002 and at the same time he became aware of the dispensing errors.

Mr [C] expressed his extreme sorrow for the dispensing errors to Mr & Mrs [B] and on the evening of the same day, 2nd May 2002, he informed Dr […] of the [second Public] Hospital and Dr [G] of the problem. I consider that was a responsible attitude. His comments to Mr & Mrs [B] that he intended looking into the procedure within the Pharmacy and submit a report to the Pharmacy Defence Association is reasonable.

The series of dispensing errors are regrettable but in the light of the information supplied are understandable and I feel that further exploration by the investigation officer would be of no useful purpose.

I have no doubt that this experience has stimulated all concerned into being more vigilant and I would hope that this type of mistake might never happen again in the affected Pharmacies.

You ask me to comment on the mitigating factors identified by the Pharmacists. Dr […] [the pharmacy's lawyer] comments in his letter under heading 7 that Miss [F] made the original error. Many pharmacists will say that they rely very heavily on the first dispensing when dispensing repeats and this is certainly so in Insulin prescriptions. I

believe that this is often the case, however it should not happen if stringent checking procedures are in place."

Ms Eleanor Hawthorn, pharmacist
The following additional expert advice was obtained from Ms Eleanor Hawthorn, pharmacist:

"I have reviewed all the material forwarded to me on 27 May 2003.

Although your background report states that Mr [A], an elderly gentleman, had been prescribed Humulin N insulin prior to 21 December 2001, I can find no evidence of this in the documents provided. According to the letter from Dr [G], the first contact he had with Mr [A] was when Mr [A] consulted him on 24 October 2001 with regard to an eye infection. At that stage Dr [G] noted that Mr [A] was a Type 2 diabetic (that he was dependent on therapy with insulin) and that HbA1c level was 9.2. This is an indication that Mr [A's] diabetes was not well controlled and Dr [G] comments that there was evidence of target organ damage, namely diabetic nephropathy (disease of the kidneys) and diabetic neuropathy (which denotes functional disturbances and/or pathological changes in the peripheral nervous system). Dr [G] notes that at that stage he was on an insulin regime of Protaphane (an intermediate acting insulin) and Actrapid (a fast acting insulin). Tests were done over 48 hours and in November Dr [G] decided to prescribe Humulin 70/30, a combined insulin, which gives a similar effect to the Protaphane (Isophane Insulin) and Actrapid that Mr [A] had been using. Humulin 70/30 is a mixture of Isophane Human Insulin (Humulin N) 70%, which has an intermediate action and Soluble Human Insulin (Humulin R) 30%, which has a fast action. The combination gives a faster onset of action than Isophane Insulin (Protaphane or Humulin N) does on its own. Humulin R is similar to Actrapid.

Dr [G] rang [Mr A's pharmacy] on 23 November 2001 to ascertain that they could provide Mr [A] with the Humulin 70/30 insulin that he wished to prescribe. Unfortunately there is no evidence in the material provided to ensure that this was the insulin dispensed. Dr [G's] records clearly state that Humulin 70/30 was prescribed, but there are no pharmacy records to confirm what was dispensed on that date. I assume Mr [A] was dispensed the correct insulin.

The records start to match at Mr [A's] next visit to Dr [G] on 21 December. On this date, Dr [G] increased the dose of Mr [A's] Humulin 70/30 as he was still needing to use the Actrapid insulin during the day for control. Another prescription was written for Humulin 70/30 and this time the prescription was dispensed at [the second pharmacy]. On that date the prescription was incorrectly processed into the computer as Humulin N and presumably Humulin N was dispensed. On that occasion the prescription was checked by Ms [F]. Repeats of this prescription were dispensed on 21 January and 13 February 2002, and apparently, on each occasion checked by Mr [C]. It is unclear whether the pharmacy at that time, as a matter of policy, dispensed repeats off the

original prescription or whether repeats were dispensed from the Certified Repeat Copy. The Certified Repeat Copy is a copy of what has been processed into the computer when the prescription was originally dispensed. Prior to 2001, Health Benefits Ltd, as part of their audit procedure, required the original prescription to be submitted to them when the first claim was made for payment. During this period of time, many pharmacies relied upon the accuracy of the computer record to dispense repeats, while others kept photocopies of the original prescription to ensure that the pharmacist checking the correctness of the dispensing, was left in no doubt as to what had been written by the prescriber. If dispensing from the Certified Repeat Copy was the policy of this pharmacy, then once the prescription had been incorrectly recorded at the first dispensing, inevitably, the repeats would also be incorrect.

At the beginning of March of that year [the second pharmacy] merged with [a third pharmacy] and the new pharmacy is known as [the pharmacy].

On 22 March 2002 Dr G wrote another prescription for Humulin 70/30. It is unclear from the records of the [health centre], how long this prescription was intended to last Mr [A]. It is written as 1 injection and 2 repeats. At the pharmacy, it was interpreted as 1 month and 2 repeats and the correct insulin was processed into the computer. 9 cartridges, sufficient for 1 month's supply were dispensed, although it appears that Humulin N was again dispensed. On this occasion, the prescription was checked by [Ms D]. The pharmacy clearly relies upon the computer for stock control and as the consequence of this correct processing of the information on this prescription, 2 boxes of 5 cartridges of Humulin 70/30 were supplied by CDC Pharmaceuticals on 25 March 2002. The computer assumes that if the item has been used it needs to be replaced.

Six days later on 28 March, Dr [G] wrote another prescription for Humulin 70/30 although it does not appear that this prescription was dispensed. This was probably due to the fact that Mr [A] clearly had sufficient insulin for his needs. Nevertheless, another prescription was written on 9 April, for an increased dose, and 10 cartridges of insulin were dispensed. The prescription was correctly processed into the computer, but again, Humulin N was dispensed. This time the prescription was checked by [Ms E]. The correct processing is confirmed, not only by the fact that CDC Pharmaceuticals replenished the stock of Humulin 70/30, but also by the appearance of the sticker that identifies the unique number on the prescription form. Note that when Humulin N was processed into the computer the little square sticker on the prescription says 'HUMU,3' and when Humulin 70/30 was processed, the sticker says 'HUMU,7'. As I use the same dispensing system as [the pharmacy] I have attached to this report two labels generated from my own system to demonstrate to you how I can tell what has been processed into the computer.

It wasn't until Mr [A] was admitted to hospital later in April, and Humulin 70/30 was charted for him while he was there, that the errors were recognised.

When Mr [A] was discharged from hospital on 2 May 2002, his daughter, Mrs [B], contacted the pharmacy to inquire about the different insulins that had been dispensed. There is no record of Mr [A's] Blood Sugar Levels other than those in the [second Public] Hospital report. Even while in hospital and on the correct insulin, the monitoring report indicates that the readings varied quite considerably. This could be expected as the patient was under stress, related to his surgery, his eating times may have been different, and the food he was eating may not have been his normal diet.

I have reviewed the Standard Operating Procedures for [the pharmacy] and they are very comprehensive and well written. These documents were generally written before the dispensing errors were recognised or have been updated since. Clearly, the fact that this dispensing occurred on 5 occasions, demonstrates that a number of steps in the dispensing process were not observed.

I believe that there are several possible contributing factors to these errors:

1. I expect that when Mr [A] was first dispensed his insulin from [the pharmacy], Dr [G] had not long been writing prescriptions on his computer. It is only recently that doctors have written computer generated prescriptions to any extent. When doctors hand-wrote prescriptions, they generally limited the description of what they wanted to prescribe to the least amount of writing e.g. 'Humulin N' 'Humulin 70/30' and this is what pharmacists were used to seeing. The new doctor's computer systems are often very explicit in how they describe the product e.g. 'Humulin 70/30 Human with Neutral Insulin 100u' (much more than is selected as the product description on the pharmacy label, which is limited by size – see attached examples). I expect that whoever processed the prescription into the computer focussed on the Humulin and the N for Neutral as this was the insulin that staff in the pharmacy were familiar with. The error was not picked up in checking.
2. If the repeats of R. 749688/1, dispensed on 21 January and 13 February 2002, were dispensed from the Certified Repeat Copies, inevitably they would have been incorrect, as the Certified Repeat Copies would have reflected what had originally been processed into the computer. This does not make any excuse for the original prescription being dispensed incorrectly, nor would there be any excuse if the repeats were dispensed from the original prescription (or a photocopy of it).
3. If this were an insulin that staff at [the pharmacy] were unfamiliar with, and had not used before, it would be 'hidden' in the computer system. If the word Humulin was keyed into the computer, and Humulin N was the only product in that range which had previously been dispensed at the pharmacy, then probably Humulin N would be the only variation of Humulin that appeared on the screen. To look for other variations the 'Unhide Meds' option would have needed to have been selected. This would have then displayed all the options that were available in the Humulin range. I have attached a chart from the manufacturer and the Medsafe Data Sheet which clearly demonstrate that there are a number of variations.

I have read the letter from [the pharmacy's lawyer] in support of the staff at [the pharmacy] and I generally agree with his letter to you. I do not agree though that 'the confusing way that prescriptions are now written' is in any way related to it 'becoming a major problem particularly with the advent of locum and foreign doctors from overseas'. Nor do I agree that 'the prescription would not necessarily alert the pharmacist to the specific variety of the brand of insulin required'. The prescription clearly says Humulin 70/30 -----. [The pharmacy's lawyer] comments that in the letter from Mrs [B] it was noted that the insulin inside the packet was not what was on the label, that Humulin N is bright green whereas Humulin 70/30 was bright lolly pink. This is correct, at least as far as the boxes which contain the insulin are concerned. It is less obvious on the cartridges within the box. Mr [A] was used to seeing a green pack – he had had the wrong insulin dispensed for 3 months in a row. In my experience patients often do not even read the label (which in March and April was correct, even though the incorrect insulin was dispensed). Mr [A] was an elderly gentleman and was receiving what he was used to receiving. There would be no reason for him to look at the detail. It wasn't until it was realised that the error had occurred, that someone looked closely at that detail.

I agree with other points that [the pharmacy's lawyer] has made. I believe that once the error was detected, every effort was made to ameliorate the situation as far as was possible. It is a very chastening experience for a pharmacist to find that they have been involved in a dispensing error, particularly one that has been perpetuated to the extent that this one was. I believe that the response of the pharmacists, subsequent to learning of the dispensing error, has been absolutely appropriate in terms of their apology to Mr [A's] family, their concern in assisting the family to understand their rights under the legislation, their review of all the protocols that apply to the dispensing procedure in the pharmacy and their concern that stringent controls be put in place to avoid this situation ever happening again.

I have reservations about [the pharmacy's lawyer's] suggestion that all medications should be able to be prescribed by the Pharmacode. The Pharmacode is a number which is used throughout the pharmaceutical industry in New Zealand, and is specific for each product, strength and pack size of that product. The prescriber is never going to know which pack size is going to be used by the pharmacist as this will vary from pharmacy to pharmacy, depending on their usage of any particular item. My other reservation is that generally speaking, doctors have no understanding of what is currently on the Pharmaceutical Schedule and what will be funded, so leave it to the pharmacist to decide which brand of product to dispense.

As [the pharmacy's lawyer] says, pharmacists intervene many times a day to ensure that the patient gets what the doctor intended them to have – not necessarily what was written.

You have asked for my decision on the following points:

Should a reasonably skilled pharmacist have known about Humulin 70/30, prior to being shown a prescription for it?

In my own experience, the Humulin insulins are less commonly used than the competitor's range of insulins. From the chart that I have attached, I can say that my own pharmacy has not dispensed either Humulin L or Humulin U in the 5 years for which I have immediate recall in my computer system. Nor have I dispensed Humulin R for 3 years. I have one patient on Humulin 70/30. The most commonly prescribed insulin in this range is Humulin N. My pharmacy is in [a city] and we have a large number of diabetic patients. I believe that it is reasonable to expect that the pharmacists at [the pharmacy] were unaware of the existence of Humulin 70/30.

Should a pharmacist using reasonable care and skill, and in the circumstances of this case, have correctly identified a script for Humulin 70/30 with Neutral Insulin 100 u per ml, 3ml, as being for Humulin 70/30?

I believe that insufficient attention was paid to the figure 70/30 and that all that was recognised was the N, which in this case indicated Neutral, not Humulin N as was dispensed. I believe that in this situation, the pharmacists concerned did not demonstrate an appropriate level of care and skill.

Did the errors of Ms [D] and Ms [E] in dispensing Humulin N in boxes labelled Humulin 70/30 constitute a failure to use reasonable care and skill?

These errors relate to only 2 of the 5 errors reported in this claim. Ms [D] and Ms [E's] failure to recognise an error was no different to the errors made when the prescription was first processed and dispensed in December 2001, and subsequently repeated in January and February 2002. In the earlier case the error was that the dispensed prescription was neither labelled nor dispensed in accordance with what was prescribed. In the latter case the error was that Humulin N was dispensed in a box labeled Humulin 70/30. The label that is generated by the Toniq computer system clearly says Humulin 70/30. There should have been no confusion with Humulin N when the prescriptions were checked. To what extent familiarity with Mr [A's] (incorrectly dispensed) Humulin N played a part is unknown. His computer history would certainly have shown that Humulin N was what he had had in the past, and that may have been a contributing factor in the error. A dispensing error must inevitably constitute a failure to use reasonable care and skill.

If the pharmacists in this case should reasonably have identified the prescription for Humulin 70/30, what role, if any, did their use of the Toniq computer programme play in their error?

I believe that the fact that the Humulin 70/30 would have been 'hidden' in the computer system did play a role in the error. The staff at the pharmacy were not familiar with this particular product and it would not have been displayed on the screen when the

prescription was processed as it was not a product that had formerly been dispensed at that pharmacy. There is a very valid reason for this to be the situation, as all products generally available on the Pharmaceutical Schedule, both now and in the past, are in the file. Products no longer available need to be retained in the file because from an audit perspective, they refer to prescriptions that have been dispensed previously. Brands of items that are no longer funded need to be kept on file for the same reason. This means that the drug files are very large and if all options were readily available, pharmacists would have to scan through many 'pages' of products to find the correct item, thereby exposing themselves to an even greater risk of error. All pharmacies would keep the products they regularly use on immediate recall and would 'hide' those that they did not use regularly, or the products would be hidden automatically if they had never been used.

Were [the pharmacy's] dispensing procedures, including for the use of the Toniq Programme, of an appropriate standard?

I believe that dispensing procedures were appropriate if the examples I have been supplied with were current at the time. It is unfortunate that the checking procedures were not observed.

Did [the pharmacy] staff use reasonable care and skill in using the Toniq Programme?

I believe that reasonable care and skill were used when using the Toniq Programme. If Humulin 70/30 was not known by the staff member who processed the original prescription in December 2001 and the 'Neutral' on the prescription was interpreted as Humulin N, then there would have been no reason to go searching for a product that was hidden. When the new prescription was processed in March, obviously the person who processed it did go searching for Humulin 70/30, found it, produced the correct label, but the item was wrongly dispensed.

If [the pharmacy] staff did use reasonable care and skill when using the Toniq Programme, what aspects of service should have been improved?

In a busy dispensary, in the course of any day, errors are made when prescriptions are processed. The errors can be simple spelling errors, choice of incorrect product, incorrect quantity calculated, incorrect number of repeats allocated etc and when these are identified the prescription is sent back to be re-processed. It is up to every member of the dispensing staff to check and recheck, but the ultimate responsibility lies with the pharmacist who does the final check. That pharmacist is expected to sign the prescription off before it is given out and this was done at this pharmacy. Without this signature, or mark, the pharmacists involved in this error would not have been able to be identified. Apart from ensuring the accuracy of this final check, I am not able to identify any other aspects of the service that need to be improved.

Did Mr [C] take reasonable actions once he became aware that Humulin N had been dispensed in error from December 2001 to March 2002?

I believe that the actions taken by Mr [C] were entirely reasonable and appropriate.

If in answering any of the above questions you consider that [the pharmacy] or any of its staff did not meet the required standard of care, please indicate the severity of the error.

I do not believe that there are any aspects of the care provided by [the pharmacy] and/or any of its staff, that warrant further exploration by the Investigation Officer. I believe that all the staff will have learnt a salutary lesson from this experience. I do not take from Mrs [B's] letter that she wishes disciplinary action to be taken but I can understand her concern. As can be seen from the chart I have provided, the difference between the 2 products in question is the quicker onset of the combined one. Although Dr [G] possibly did not understand why Mr [A] still needed Actrapid Insulin, the Actrapid Insulin he was prescribing as recently as 28 March 2002, was actually compensating for the quick acting component of the Humulin 70/30. This is the component that Mr [A] was not getting when he was dispensed Humulin N. Quite coincidentally, Mr [A] was actually receiving both components of the Humulin 70/30, although possibly not in the same proportions and certainly not in the way that either he, his family, or Dr [G] realised. Fortunately Mr [A] suffered no harm from this experience."

Code of Health and Disability Services Consumers' Rights

The following provision in the Code of Health and Disability Services Consumers' Rights is applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

Other Relevant Standards

Principle 2.6 of the Pharmaceutical Society's Code of Ethics (2001) states:

> "The pharmacist who is responsible for the dispensing of a prescription must verify its authenticity, interpret and evaluate the prescription, ensure that it is correct and complete, assess its suitability for the patient within the limitations of available information, and dispense it correctly."

Opinion: Breach – Mr C, Ms D, Ms E

Dispensing errors
It is accepted by the parties that instead of dispensing Humulin 70/30, as prescribed by Dr G, Mr C, Ms D and Ms E each dispensed Humulin N.

I note that all the pharmacists involved were unaware that Humulin 70/30 existed. When confronted with a prescription for "Humulin 70/30 Inj Human with Neutral Insulin", they assumed that the "Neutral" referred to Humulin N, with which they were familiar.

I accept Ms Hawthorn's advice that, despite the pharmacists' lack of knowledge about Humulin 70/30, they should not have assumed that the prescription was for Humulin N. The pharmacists did not pay enough attention to the figure "70/30", and focused exclusively on the "N". In failing to scrutinise all the relevant information available, the pharmacists failed to exercise reasonable care and skill.

The Pharmaceutical Society's Code of Ethics emphasises the responsibility of pharmacists to accurately interpret and dispense prescriptions. I note Ms Hawthorn's advice that the Standard Operating Procedures (SOP) for the pharmacy are very comprehensive and well written and that, had the pharmacists properly followed the SOP, they would not have made the dispensing errors.

In this case, each of the pharmacists failed to exercise reasonable care and skill when dispensing and checking Mr A's prescriptions and did not comply with professional and ethical standards. In these circumstances, the pharmacists breached Right 4(2) of the Code.

Opinion: No Breach – The pharmacy and the second pharmacy

Employers are vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code of Health and Disability Services Consumers' Rights. Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from doing or omitting to do the thing that breached the Code.

The pharmacists involved were employees of the pharmacy and/or its predecessor the second pharmacy (the pharmacies). However, the pharmacies had taken such steps as were reasonably practicable to ensure that their staff had sufficient guidance and instruction on dispensing procedures. Accordingly the pharmacies are excused from vicarious liability for the pharmacists' breaches of Right 4(2) of the Code.

Other Comments

Ms F
On the basis of the information available, it appears that Ms F misdispensed Humulin N to Mr A on 21 December 2001. Ms F is apparently now resident in another country and was unable to be contacted during my investigation.

Contributing factors
It appears that two factors contributed to the dispensing errors in this case.

First, the pharmacists may not have been used to seeing such an extensive (and thus potentially confusing) description of the medication, as computer prescriptions, such as the one used by Dr G for the Humulin 70/30, are much more detailed than hand-written ones. In the past, doctors have usually handwritten a prescription using the least amount of information necessary, such as "Humulin N" or "Humulin 70/30". It is essential that pharmacists become familiar with computer prescriptions and meet their obligations to interpret and evaluate such prescriptions and dispense them correctly.

Secondly, the misunderstandings were compounded by the Toniq computer system used in the pharmacies. I have been advised that when a pharmacist enters "Humulin" into the system it provides a short-list of commonly used Humulin medications, which includes Humulin N, but not Humulin 70/30. In order to dispense Humulin 70/30 a pharmacist must identify it from a "hidden" list of medications not commonly prescribed. This "hidden" list is necessary to avoid the pharmacist having to choose from a very large and potentially confusing list of possible medications, many of which are no longer available. I accept my expert advice that the pharmacists used reasonable care and skill when dispensing through the Toniq system. Having incorrectly assumed that the prescription was for Humulin N,

there was no reason for them to search the hidden list to check for other possibilities. And, with Humulin 70/30 being hidden, Humulin N was the obvious option. This explanation highlights the need for particular care in checking carefully what has been prescribed.

Providers' response to errors
I am satisfied that the pharmacy and the pharmacists involved handled this error appropriately once it was discovered. On becoming aware of the errors they:

- acted immediately to discuss the matter with other providers involved in Mr A's care to minimise the risk of harm to Mr A
- accepted responsibility for their errors
- identified and implemented changes to their practice to minimise the risk of similar errors occurring in the future
- met with Mr A's family to discuss the errors
- wrote to Mr A and his family, offering an apology
- co-operated with my investigation, providing substantial amounts of information in a timely manner.

I also note my expert advice that the pharmacy has very comprehensive and well-written Standard Operating Procedures (which include dispensing procedures).

Responsibility for errors
In the course of any day, pharmacists will inevitably make errors when processing prescriptions. Pharmacies have strict checking procedures to ensure that such errors are identified and corrected before the prescription is given out to the consumer. This process requires vigilance by all the pharmacy staff involved in the dispensing process. However, while dispensing is often a "team effort", it is up to the checking pharmacist to check that the medication has been dispensed correctly and sign off the prescription before the medication is given to the consumer. Thus, it is ultimately the checking pharmacist who takes responsibility for any error that has occurred in the process.

I note that for each instance of misdispensing in this case the checking pharmacists have identified themselves and accepted responsibility for their error.

Actions taken

The pharmacists involved have already apologised to Mr A and his family, and have reviewed their practice in light of this incident.

Further actions

- A copy of this report will be sent to the Pharmaceutical Society of New Zealand to draw its attention to the factors that contributed to the dispensing errors in this case.

- A copy of this report, with details identifying the parties removed, will be sent to the Pharmaceutical Society of New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.