Pharmacist

Report on Opinion - Case 97HDC9419

Complaint

The Commissioner received a complaint from the consumer about the services he received from the pharmacist in early August 1997 at a pharmacy in a city.

The complaint is that:

- *In early August 1997, the pharmacist dispensed the wrong insulin medication to the consumer.*
- *The insulin level the consumer was dispensed was equivalent to a double dose and made his blood sugar levels unstable.*
- *The pharmacist's method of record keeping needs to be upgraded.*

Investigation

The complaint was received by the Commissioner on 24 October 1997 and an investigation was undertaken. Information was obtained from:

The Consumer
The Pharmacist
The Consultant Physician

As part of the investigation, a copy of the prescription of mid-July 1997 (dispensed in early August 1997) was obtained as was a copy of the label from the "*Penmix Injection 20*" packet.

Information Gathered During Investigation

In April 1996, the consumer was diagnosed with diabetes. He was treated by the consultant physician. After a trial on oral medications, the consumer started insulin injections. Several insulin regimes were tried and a combination of *actrapid* and *ultratard* was the regime being used by the consumer at the time of the complaint.

In mid-July 1997 the consultant physician prescribed 3ml cartridges of *actrapid* and three vials of *ultratard* insulin for the consumer. The consultant physician's nurse presented the script to the pharmacy.

In early August 1997 the consumer went to the pharmacy, which is owned and operated by the pharmacist, to pick up the last repeat of insulin prescribed on the consultant physician's script of mid-July 1997.

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Information Gathered During Investigation, *continued*

The consumer was dispensed *penmix 20* by the pharmacist. Although the consumer was not familiar with the names of various insulins, he knew that the insulin he was being dispensed was different from that which he was currently using. The consumer raised this matter with the pharmacist who was adamant that *penmix 20* was the insulin the consumer was taking. After some discussion the consumer accepted the pharmacist's assertion.

The pharmacist's account of this discussion differs as he recalled that the insulin was, *"only dispensed after discussion and assurance from him* [the consumer] *that it was the correct one".* The pharmacist advised the Commissioner that, *"all our insulin customers know the type they are on",* and his pharmacy policy is to, *"always to check with our customer the insulin they are currently using".* The pharmacist was asked to supply a copy of this policy. However, to date, this has not been received by the Commissioner.

The label on the dispensed container states:

"PENMIX INJECTION 20 3ML
TAKE AS DIRECTED
No Repeats Left
[The consumer]
958002/3 14 Aug97 SM RME [The consumer's address]*"*

The consumer believed that the dispensing error occurred because the pharmacist acted on an old prescription and he attributed the error to the pharmacist's method of record keeping.

The consumer confirmed to the Commissioner that he had been prescribed *penmix* insulin before June 1997 but had been prescribed *ultratard* during June and July 1997. The prescription uplifted in early August 1997 was intended as part of the latter prescription.

In mid-October 1997 the consumer discovered that he, *"had been effectively double dosing"* himself with the insulin he was dispensed. The consumer stated to the Commissioner that as a result his blood sugar levels became unstable.

Pharmacist

Report on Opinion - Case 97HDC9419, continued

Code of Health and Disability Services Consumers' Rights

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.

...

3) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

...

Relevant Standards

Pharmaceutical Society of New Zealand Code of Ethics, December 1996

Rule 2.1
"A pharmacist must safeguard the interest of the public in the supply of health and medical products".

Rule 2.11
"A pharmacist must be responsible for maintaining and supervising a disciplined dispensing procedure that ensures a high standard is achieved ...".

Rule 2.12
"A pharmacist must dispense the specific medicine prescribed and must not substitute any other medicine unless authority has been given in advance by the prescriber...".

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Relevant Standards, *continued*

Pharmaceutical Society of New Zealand, Pharmacy Practice Handbook, January 1998

Part 3 Legislation and Regulatory

3.2 Medicines Act 1981

3.2.4 Records

(Regulation 57 Medicines Regulations 1984)

A record must be kept of every Prescription Medicine and Pharmacist Only Medicine dispensed pursuant to a prescription. The following information must be kept in the record:

- *the date of each transaction;*
- *the name of the patient…*
- *the address of the patient…*
- *the name of the medicine supplied;*
- *the quantity of the medicine supplied;*
- *the name of the prescriber;*
- *in the case of a prescription medicine the unique identifying number or code of the prescription.*

This record should be kept in a secure place for ten years after the date of the last entry in the register or other approved record form…

Pharmacist

Report on Opinion - Case 97HDC9419, continued

Opinion: Breach

In my opinion the pharmacist breached Rights 4(2) and 4(4) of the Code of Health and Disability Services Consumers' Rights.

Right 4(2)

In early August 1997 the consumer was dispensed the wrong insulin by the pharmacist. Instead of dispensing *ultratard* (a long acting insulin), the pharmacist dispensed *penmix 20* (a rapid and sustained action insulin). Combined with the *actrapid* (a rapid acting insulin) which the consumer was also taking, the dispensing error resulted in the consumer taking extra doses of rapid acting insulin.

The Pharmaceutical Society views the dispensing of the correct medicine as a basic professional standard. The pharmacist breached Rules 2.1, 2.11 and 2.12 of the Code of Ethics of the Pharmaceutical Society of New Zealand (December 1996).

In my opinion the pharmacist did not provide services of an appropriate standard. He did not ensure that the correct medication was dispensed nor did he use a dispensing procedure that would have alerted him to this fact.

Right 4(4)

The pharmacist's dispensing system meant that he did not provide services that minimised potential harm to the consumer. The pharmacist stated that all his insulin customers knew the type of insulin they were on, and yet when the consumer tried to correct the pharmacist and raised his concerns that an error had occurred, the pharmacist continued to insist the pharmacist was correct. The pharmacist made no attempt to check his prescription records and has given me no evidence that he has procedures for ensuring medication has been dispensed correctly, as required by the Medicines Regulations 1984. Information received from the consultant physician indicates that although the consumer's life was not put in danger as a result of the pharmacist's dispensing error, the consumer's health and wellbeing were compromised.

Pharmacist

Report on Opinion - Case 97HDC9419, continued

Actions

I recommend that the pharmacist take the following actions:

- Provide a written apology to the consumer for his breach of the Code of Rights. This is to be sent to my office and I will forward it to the consumer.
- Familiarise himself with the Pharmaceutical Society's requirements for dispensing medications and provide evidence that systems are in place that comply with the professional dispensing standards expected of a competent pharmacist.
- Review his record keeping and provide evidence that his pharmacy procedures meet with the minimum requirements specified in clause 3.2.4 of the Pharmacy Practice Handbook.

Other Actions

A copy of this opinion will be sent to the consumer and the Pharmaceutical Society of New Zealand for its consideration.

The Pharmaceutical Society of New Zealand is to review the pharmacist's system for dispensing and record-keeping as set out in my recommendations above and confirm they are satisfied the system meets professional standards.

I have decided to refer this matter to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any action should be taken.