Incorrect dispensing of insulin
(16HDC01665, 9 June 2017)

Pharmacy ~ Pharmacy technician ~ Pharmacist ~ Dispensing error ~ Checking ~ Professional Standards ~ Rights 4(1), 4(2)

A woman was prescribed, among other medications, 15 units (three months' supply) of NovoRapid FlexPen (NovoRapid) for type 1 diabetes mellitus. She visited a pharmacy to have her prescription dispensed. A pharmacy technician selected NovoMix FlexPen (NovoMix) instead of NovoRapid. A pharmacist checked the pharmacy technician's dispensing but did not read the medication name carefully. As a result, the woman was dispensed NovoMix instead of NovoRapid.

On another occasion, the woman presented to the pharmacy again with a repeat prescription of NovoRapid. The same pharmacy technician dispensed the repeat prescription, but again erroneously selected NovoMix. Another pharmacist checked the dispensing but did not read the medication name carefully. As a result, the woman was dispensed NovoMix instead of NovoRapid for a second time.

By failing to check the medication she was dispensing carefully against the prescription in accordance with the pharmacy's SOP, and dispensing the incorrect medication on two occasions, the pharmacy technician failed to provide services to the consumer with reasonable care and skill, and breached Right 4(1).

The first pharmacist failed to check the medication dispensed to the consumer adequately, in accordance with the professional standards set by the Pharmacy Council of New Zealand, and with the pharmacy's SOPs and, therefore, failed to provide the consumer with services in accordance with professional and other relevant standards, in breach of Right 4(2).

The second pharmacist also failed to check the medication dispensed to the consumer adequately. She also failed to report the error and complete an incident report form in a timely manner. By doing so, the pharmacist failed to provide the consumer with services in accordance with professional and other relevant standards, in breach of Right 4(2).

Criticism was made about the pharmacy not having adequate systems in place to communicate warnings and previous errors to appropriate staff. However, the pharmacy had adequate SOPs in place to ensure safe dispensing, checking, and incident reporting for those who followed them. The errors made by the pharmacy technician and the pharmacists were theirs alone, and not a result of poor or inadequate processes in place at the pharmacy. Therefore, the pharmacy did not breach the Code and is not vicariously liable for its staff's breaches of the Code.

It was recommended that the pharmacy randomly audit, over a period of three months, its staff compliance with the pharmacy's SOPs for dispensing and checking medication, and confirm that training with the local Diabetes Association has taken place on the different types of insulins for all pharmacy technicians and pharmacists. It was also recommended that all parties provide a written apology to the woman.