Insulin dispensing error
(07HDC21772, 27 June 2008)

Pharmacist ~ Pharmacy ~ Dispensing error ~ Out-of-date medication ~ Professional standards ~ Standard operating procedures ~ Incident reports ~ Rights 4(1), 4(2)

A 21-year-old man with type one diabetes complained that a pharmacist not only dispensed him the wrong insulin, but that the insulin he received was out of date.

The man went to collect his usual three-month supply of insulin from the pharmacy. He was prescribed Humalog, a fast-acting, short duration insulin, and Humulin NPH, an intermediate-acting insulin. He received the correct dosage of Humalog but the sole charge pharmacist dispensed Humulin R, a short-acting insulin, in place of Humulin NPH. The consumer questioned the type of Humulin he had received and was told by the pharmacist that the pharmaceutical company had discontinued Humulin NPH and replaced this with Humulin R. The pharmacist instructed the consumer to use Humulin R in the same way as he would have used Humulin NPH.

Ten days later, when the consumer was about to start on his new batch of insulin, he telephoned the pharmacist and again questioned whether he had been given the correct insulin. The pharmacist again told him that Humulin NPH had been discontinued and to take Humulin R in the same way he had previously used Humulin NPH. The consumer did as instructed and within two days suffered serious adverse effects. He was seen by a specialist diabetes nurse, who said that he had been given the wrong insulin and that Humulin NPH had not been discontinued. The consumer also noted that the Humulin R he received had expired by 18 months.

It was held that the pharmacist breached Right 4(1) in not providing an appropriate standard of care, and Right 4(2) for not following the Pharmacy Council's Code of Ethics. The pharmacist relied on his memory concerning changes made to this product and, despite being questioned twice by the consumer, did not take appropriate steps to confirm that he was dispensing the correct medication. When an error is identified, it should be investigated, and dispensing procedures reviewed to minimise ongoing harm and to prevent a recurrence of the error. It was also held that the pharmacy breached Right 4(1) in not having an up-to-date dispensing procedure appropriate for a business mainly reliant on a sole pharmacist, and was severely deficient in documenting and responding to errors.