Double error dispensing insulin
(14HDC00551, 19 June 2015)

Pharmacy ~ Pharmacist ~ Diabetes medication ~ Dispensing error ~ Incident reporting ~ Rights 4(1), 4(2)

A woman visited a pharmacy on two occasions to have a prescription filled for her son who is diabetic. On both occasions, the woman was given the wrong insulin - Humulin NPH (a medium-acting insulin) instead of Humulin 30/70 (a mixture of short- and medium-acting insulin).

On the first occasion, the first pharmacist selected, labelled and checked the medication dispensed for the son. Because of the difference in packaging, the woman realised that there was an error and, within three days, she contacted the pharmacy to tell it about the error. The correct medication was then delivered to the son.

On the second occasion, which was two months after the first occasion, the second pharmacist checked the medication dispensed for the son, but it was not clear who completed the other steps of the dispensing process on that occasion.

Twelve weeks after the first incident, an incident reporting form for the first incident was completed by the first pharmacist. Approximately a week later, an incident reporting form was completed for the second incident by the charge pharmacist, after receipt of the complaint to HDC.

It was held that by failing to select the correct medication and then check the medication being dispensed to the woman on the first occasion, the first pharmacist failed to provide services in accordance with professional standards and, as such, breached Right 4(2).

By failing to appropriately check the medication being dispensed on the second occasion, the second pharmacist failed to provide services in accordance with professional standards and, as such, breached Right 4(2).

Adverse comment was made about the first and second pharmacists' failures to promptly fill in incident reporting forms in relation to the incidents.

Overall, the pharmacy did not have appropriate processes in place to support safe dispensing practices, thereby breaching Right 4(1).