New Brunswick College of Pharmacists
Ordre des pharmaciens du Nouveau-Brunswick

Governing the practice of pharmacy for a healthier New Brunswick
Régir l'exercice de la pharmacie pour un Nouveau-Brunswick en meilleure santé

Publication of Complaints Committee Decision

Title of Incident	Medication Error: Incorrect instructions and evasion of responsibility
Name and Registration Number	John Boutilier, #1007
Incident Description	A complaint was lodged with the New Brunswick College of Pharmacists (the College) by a member of the public against John Boutilier, Certified Dispenser (*NB Pharmacy Act Section 49(4)*) for dispensing a prescription for colchicine with inappropriate instructions to take 1.2mg immediately followed by 0.6mg every hour (20 tablets supplied). The error was initially made by another member of the pharmacy team at order entry and was not identified by Mr. Boutilier prior to release of the medication to the patient. The error resulted in an overdose of the drug. The patient self-administered 18 tablets of colchicine and was later hospitalized.
Summary of Findings	An investigation of the incident indicated Mr. Boutilier: • Demonstrated a lack of knowledge regarding the effective and safe dosing of the medication • Practiced in an environment (providing and receiving information) where the language was not understood • Did not engage the patient/patient representative in education regarding effective and safe use of colchicine. Documentation did not justify this omission in care • Evasion of responsibility for the error and transferred blame to the colleague initially entering the prescription instructions on the electronic system • Did not meet current Regulations and Standards of Practice pertaining to documentation of checking prescription accuracy
Analysis	In this case, the panel of the Complaints Committee found: • Practitioner-related deficiencies (therapeutic knowledge, language skills, and patient education) were found to be factors in the error ultimately reaching the patient. • The Member displayed deficiencies in knowledge, skills and professional attitude regarding the importance of systems (accuracy checking and documentation) used to ensure safe and effective practice.

- These findings constitute professional misconduct as described in the **Regulations** of the New Brunswick College of Pharmacists. The member failed to comply with:
  1. The profession's Code of Ethics, **Statements I and VI**
  2. Model Standards of Practice for Canadian Pharmacists (NAPRA 2009), Sections: **Expertise in medication and Medication Use, Collaboration, Safety and Quality and Professionalism and Ethics.**
  3. The Regulations of the New Brunswick College of Pharmacists, in particular **Sections 17.16 and 12.21.**

Orders of the Panel

A. **Censure:** The panel of the Complaints Committee considered the actions of Mr. Boutilier to be a clear abdication of responsibility to this patient's wellbeing. The behaviour discovered through the investigation is incompatible with pharmacy practice and action must be taken to ensure discontinuation.

B. **Counsel**: Mr. Boutlier has retired, however, if an attempt is made to reengage in pharmacy practice, Mr. Boutilier is obliged at his own expense and to the satisfaction of the College to:
   - Complete didactic education, learning assignments and interviews to re-establish and measure the knowledge, skills and attitudes necessary for safe and effective practice
   - Submit to the Ontario College of Pharmacists (OCP's) Peer Review Process or similar as approved by the College and successfully pass that assessment
   - Complete six months of supervised experiential education with a preceptor approved by the College

C. **Publication**: An account of this complaint and decision where Mr. Boutilier is named will be published once in the College's regular newsletter and for two years in the public domain. The account will remain on Mr. Boutilier's file for the period of 2 years from commencement of any future practice.

Messages for Pharmacy Professionals

Labeling a prescription with incorrect instructions, a known potential source of error, can generally be analysed using a systems failure approach rather than focusing on the part an individual played in the error. This allows for a fulsome root cause analysis to target systems improvements. In this instance however, (in)actions of the pharmacy professional in question were considered to be major contributors to the error.

For professionals (managers and staff) and practices, this case highlights the importance of:

- Actively identifying and filling therapeutic knowledge gaps

- Evaluating and declaring risks of language ability to patient care. Procedures and policy to manage risk associated with language barriers should be developed, documented and adhered to
- Undertaking specific training in strategies for effectively responding to patients experiencing a medication error
- Empowering managers to address competency of staff members and human resource needs
- Accepting responsibility for errors
- Proactively and collaboratively responding to and learning from errors whether they reach the patient or not
- Accurately documenting the dispensing (including patient education) process so that failures can be identified and rectified
- Openly and honestly communicating with colleagues to facilitate improvements in patient care
- Using every opportunity to review prescriptions for appropriateness and to educate patients on safe and effective use of their medication

Posted March 12, 2018

For Removal March 12, 2020