

**BEFORE THE BOARD OF PHARMACY EXAMINERS
OF THE STATE OF IOWA**

Re:

Pharmacy License of	)	COMPLAINT
IOWA METHODIST	)	AND STATEMENT
MEDICAL CENTER	)	OF CHARGES
License No. 233	)	AND
Charles M. Falbo,	)	NOTICE
Pharmacist in charge,	)	OF HEARING
Respondent)	

COMES NOW, Lloyd K. Jessen, Executive Secretary/Director of the Iowa Board of Pharmacy Examiners, on the 13th day of December, 1994, and files this Complaint and Statement of Charges and Notice of Hearing against Iowa Methodist Medical Center Pharmacy, a pharmacy licensed pursuant to Iowa Code chapter 155A, and alleges that:

1. Marian L. Roberts, Chairperson; Phyllis A. Olson, Vice Chairperson; Jay J. Cayner; Phyllis A. Miller; Mary Pat Mitchell; Matthew C. Osterhaus; and Arlan D. Van Norman are duly appointed, qualified members of the Iowa Board of Pharmacy Examiners.

2. Respondent is licensed to operate a hospital pharmacy at 1200 Pleasant Street, Des Moines, Iowa 50309, and holds license number 233.

3. Hospital pharmacy license number 233, issued in the name of Iowa Methodist Medical Center Pharmacy with Charles M. Falbo as pharmacist in charge, was renewed on December 6, 1994, and is current until December 31, 1995.

4. Iowa Health System Hospital Corporation is the owner of the Iowa Methodist Medical Center Pharmacy, 1200 Pleasant Street, Des Moines, Iowa 50309.

5. The Board has received investigative information which alleges the following:

a. Between July 19, 1993, and November 1, 1994, James Barton Brown, Jr., Pharm. D., was employed part-time by Respondent as the sole clinical pharmacist in Respondent's psychiatric department. Dr. Brown's duties included evaluating patients, providing pharmaceutical care to patients, providing inservices to Respondent's nursing staff, and other clinical pharmacist activities.

b. James Barton Brown, Jr., engaged in the practice of pharmacy in Respondent's psychiatric department without an Iowa pharmacist license.

c. Respondent knowingly allowed James Barton Brown, Jr., to engage in the practice of pharmacy and to provide clinical pharmacy services to patients between July 19, 1993, and November 1, 1994, without a license to do so.

d. 1993 Iowa Code section 155A.7 provides the following:

1. A person shall not engage in the practice of pharmacy in this state without a license. The license shall be identified as a pharmacist license.

e. 1993 Iowa Code section 155A.3 provides, in part, the following:

26. "Practice of pharmacy" is a dynamic patient-oriented health service profession that applies a scientific body of knowledge to improve and promote patient health by means of appropriate drug use and related drug therapy.

6. Respondent is guilty of violations of 1993 Iowa Code sections 155A.15(2)(c) and 155A.15(2)(e) by virtue of the allegations contained in paragraph 5.

1993 Iowa Code section 155A.15 provides, in part, the following:

2. ...The board may refuse to issue or renew a license or may impose a fine, issue a reprimand, or revoke, restrict, cancel, or suspend a license, and may place a licensee on

probation, if the board finds that the applicant or licensee has done any of the following:...

c. Violated any provision of this chapter or any rule adopted under this chapter or that any owner or employee of the pharmacy has violated any provision of this chapter or any rule adopted under this chapter.

...

e. Allowed an employee who is not a licensed pharmacist to practice pharmacy.

7. Respondent is guilty of violations of 657 Iowa Administrative Code sections 9.1(4)(j), 9.1(4)(u), and 9.1(4)(v) by virtue of the allegations contained in paragraph 5.

657 Iowa Administrative Code section 9.1(4) provides, in part, the following:

The board may impose any of the disciplinary sanctions set out in subrule 9.1(2), including civil penalties in an amount not to exceed \$25,000, when the board determines that the licensee or registrant is guilty of the following acts or offenses:...

j. Violating a statute or law of this state, another state, or the United States, without regard to its designation as either a felony or misdemeanor, which statute or law relates to the practice of pharmacy.

...

u. Violating any of the grounds for revocation or suspension of a license listed in Iowa Code sections 147.55, 155A.12 and 155A.15.

v. Practicing pharmacy without an active and current license.

The Iowa Board of Pharmacy Examiners finds that paragraphs 6 and 7 constitute grounds for which Respondent's license to operate a pharmacy in Iowa can be disciplined.

WHEREFORE, the undersigned charges that Respondent has violated 1993 Iowa Code sections 155A.15(2)(c) and 155A.15(2)(e) and 657 Iowa Administrative Code sections 9.1(4)(j), 9.1(4)(u), and 9.1(4)(v).

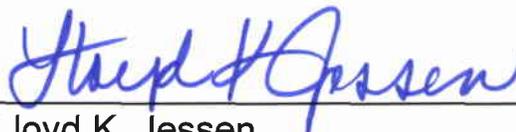
IT IS HEREBY ORDERED, pursuant to Iowa Code section 17A.12 and 657 Iowa Administrative Code section 1.2, that Charles M. Falbo appear on behalf of Iowa Methodist Medical Center Pharmacy before the Iowa Board of Pharmacy Examiners on Wednesday, February 8, 1995, at 10:00 a.m., in the second floor conference room, 1209 East Court Avenue, Executive Hills West, Capitol Complex, Des Moines, Iowa.

The undersigned further asks that upon final hearing the Board enter its findings of fact and decision to discipline the license to operate a pharmacy issued to Iowa Methodist Medical Center Pharmacy on December 6, 1994, and take whatever additional action that they deem necessary and appropriate.

Respondent may bring counsel to the hearing, may cross-examine any witnesses, and may call witnesses of its own. If Respondent fails to appear and defend, Iowa Code section 17A.12(3) provides that the hearing may proceed and that a decision may be rendered. The failure of Respondent to appear could result in disciplinary action, including the permanent suspension or revocation of its license.

The hearing will be presided over by the Board which will be assisted by an administrative law judge from the Iowa Department of Inspections and Appeals. The office of the Attorney General is responsible for representing the public interest in these proceedings. Information regarding the hearing may be obtained from Linny C. Emrich, Assistant Attorney General, Hoover Building, Capitol Complex, Des Moines, Iowa 50319 (telephone 515/281-3658). Copies of all filings with the Board should also be served on counsel.

IOWA BOARD OF PHARMACY EXAMINERS



Lloyd K. Jessen
Executive Secretary/Director

**BEFORE THE BOARD OF PHARMACY EXAMINERS
OF THE STATE OF IOWA**

Re: Pharmacy License of IOWA METHODIST MEDICAL CENTER License No. 233 Charles M. Falbo, Pharmacist in charge, Respondent	} } } } } } }	STIPULATION AND CONSENT ORDER
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On this 20th day of February, 1995, the Iowa Board of Pharmacy Examiners and Iowa Methodist Medical Center of Des Moines, Iowa, each hereby agree with the other and stipulate as follows:

The licensee disciplinary hearing pending before the Iowa Board of Pharmacy Examiners, on the allegations specified in the Complaint and Statement of Charges and Notice of Hearing filed against Respondent on December 13, 1994, shall be resolved without proceeding to hearing, as the parties have agreed to the following Stipulation and Consent Order:

1. That Respondent was issued a license to operate a pharmacy in Iowa on the 6th day of December, 1994, as evidenced by Pharmacy License Number 233, which is recorded in the permanent records of the Iowa Board of Pharmacy Examiners.
2. That Iowa Pharmacist License Number 233 issued to Respondent is current until December 31, 1995.
3. That the Iowa Board of Pharmacy Examiners has jurisdiction over the parties and the subject matter herein.

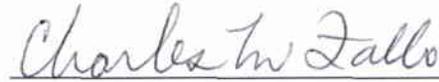
4. A Complaint and Statement of Charges and Notice of Hearing was filed against Respondent on December 13, 1994.

5. For the limited purposes of entering into this Stipulation and Consent Order, Respondent agrees not to contest the allegations set forth in the complaint. The Respondent understands that there is no admission on its part of the truth of the allegations, but merely an agreement that the Respondent does not contest the allegations, solely for the purpose of reaching the informal settlement represented by this Stipulation and Consent Order.

6. Respondent agrees to accept a citation and warning for the alleged violations set forth in the complaint. Respondent also agrees to submit a written report to the Board within thirty (30) days of acceptance of this Stipulation and Consent Order which outlines the action taken by Respondent to ensure that all pharmacists employed by Respondent, including all clinical pharmacists, obtain and maintain an active and current Iowa pharmacist license. In addition, within sixty (60) days of the date that this Stipulation and Consent Order is accepted by the Board, the Respondent shall pay a civil penalty of \$5,000.00 by delivering a check made payable to the Treasurer of the State of Iowa to the Executive Secretary/Director of the Board. The check shall be deposited into the general fund.

7. This proposed Stipulation and Consent Order is subject to approval of a majority of the full Board. If the Board approves this Stipulation and Consent Order, it becomes the final disposition of this matter. If the Board fails to approve this Stipulation and Consent Order, it shall be of no force or effect to either party.

8. This Stipulation and Consent Order is accepted by Respondent on the 13th day of February, 1995.



CHARLES M. FALBO, R.Ph.
Pharmacist in charge
IOWA METHODIST MEDICAL CENTER
Respondent

Subscribed and Sworn to before me on this 13th day of February, 1995.



NOTARY PUBLIC IN AND FOR THE
STATE OF IOWA

9. This Stipulation and Consent Order is accepted by the Iowa Board of Pharmacy Examiners on the 20 day of February, 1995.



PHYLLIS A. OLSON, Vice Chairperson
Iowa Board of Pharmacy Examiners
Executive Hills West
1209 East Court Avenue
Des Moines, Iowa 50319

BEFORE THE IOWA BOARD OF PHARMACY

Re:) Pharmacy License of) IOWA METHODIST MEDICAL) CENTER PHARMACY) License No. 233,) Respondent.)	Case No. 2010-131 STATEMENT OF CHARGES
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COMES NOW, the Complainant, Lloyd K. Jessen, and states:

1. He is the Executive Director for the Iowa Board of Pharmacy and files this Statement of Charges solely in his official capacity.
2. The Board has jurisdiction in this matter pursuant to Iowa Code Chapters 155A and 272C (2011).
3. On November 30, 2010, the Board renewed general pharmacy license number 233 for Iowa Methodist Medical Center Pharmacy (hereinafter, "Respondent"), allowing Respondent to engage in the operation of a pharmacy, subject to the laws of the State of Iowa and the rules of the Board.
4. At all times material to this statement of charges, Respondent was operating a general pharmacy at 1200 Pleasant Street, Des Moines, Iowa 50309 with Brian Benson as the pharmacist in charge.

A. CHARGE

COUNT I – LACK OF PROFESSIONAL COMPETENCY

Respondent is charged under Iowa Code § 155A.15(2)(c) (2011) and 657 Iowa Administrative Code § 36.1(4)(b) with a lack of professional competency as demonstrated by Respondent's (a) substantial deviation from the standards of learning and skill ordinarily possessed and applied by other Iowa pharmacies, (b) failure to exercise in a substantial respect that degree of care which is ordinarily exercised by an Iowa pharmacy and (c) willful and repeated departures from, and a failure to conform to, the minimal standard and acceptable and prevailing practice of pharmacy in the state of Iowa.

B. CIRCUMSTANCES

An investigation was commenced on October 25, 2010, which revealed the following:

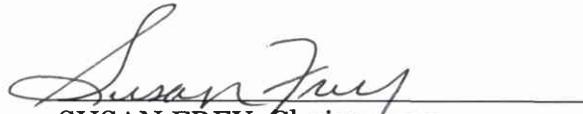
1. Respondent operates a general pharmacy at 1200 Pleasant Street, Des Moines, Iowa with Brian Benson as the pharmacist in charge.
2. An order for 62.5 units of heparin, in a 250ml bag of dextrose 12.5%, was incorrectly entered in the Respondent's computer software program as 62.5 units of heparin *per milliliter*.
3. Thus, Respondent compounded a 250ml bag of dextrose 12.5% with 15,625 units of heparin added. The compound contained 250 times the heparin dosage ordered.
4. The amount of heparin needed to prepare the compound caused Respondent's Automix compounding machine to require re-filling (with heparin) an inordinate number of times. Although Respondent's employees thought the number of re-fills was unusual, they proceeded with preparation and dispensing of the compound.

Wherefore, the Complainant prays that a hearing be held in this matter and that the Board take such action as it may deem to be appropriate under the law.



LLOYD K. JESSEN
Executive Director

On this 10th day of November 2011, the Iowa Board of Pharmacy found probable cause to file this Statement of Charges and to order a hearing in this case.



SUSAN FREY, Chairperson
Iowa Board of Pharmacy
400 SW Eighth Street, Suite E
Des Moines, Iowa 50309-4688

cc: Scott M. Galenbeck
Assistant Attorney General
Hoover State Office Building
Des Moines, Iowa

BEFORE THE IOWA BOARD OF PHARMACY

IN THE MATTER OF:	)	CASE NO: 2010-131
	)	DIA NOS. 11PHB043,046
Pharmacist License of)	
TRI TRAN)	
License No. 20585)	
	)	FINDINGS OF FACT,
Pharmacy Technician Registration of	)	CONCLUSIONS OF LAW,
DAVID GRAHAM	)	DECISION AND ORDER
Registration No. 10562)	
)	
Pharmacy License of)	
IOWA METHODIST MEDICAL)	
CENTER PHARMACY)	
License No. 233)	
)	
RESPONDENTS)	

On November 10, 2011, the Iowa Board of Pharmacy (Board) found probable cause to file Statements of Charges against Respondents Tri Tran, David Graham, and Iowa Methodist Medical Center Pharmacy. All three Statements of Charges alleged Lack of Professional Competency, in violation of Iowa Code section 155A.15(2)(c)(2011) and 657 IAC 36.1(4)"b." The consolidated hearing was held on March 6, 2012 at 1:00 p.m. in the Board Conference Room, 400 SW 8th Street, Des Moines, Iowa. The following members of the Board served as presiding officers for the hearing: Susan Frey, Chairperson; Edward Maier; Mark Anliker; James Miller; LaDonna Gratias; and Margaret Whitworth. Assistant Attorney General Scott Galenbeck represented the state. Respondents appeared and were represented by attorney Connie Diekema. The hearing was closed to the public at Respondents' request, in accordance with Iowa Code section 272C.6(1) and 657 IAC 35.19(10). Administrative Law Judge Margaret LaMarche assisted the Board in conducting the hearing and was later instructed to prepare the Board's written Decision and Order for their review, in conformance with their deliberations.

THE RECORD

The record includes the testimony of Tri Tran and Brian Benson; State Exhibits 1-4 (See Exhibit Index for description) and Respondents' Exhibits A and B.

FINDINGS OF FACT

1. On July 6, 2007, the Board issued license number 20585 to Tri Tran, thereby authorizing him to engage in the practice of pharmacy in the state of Iowa, subject to the laws of the state and the rules of the Board. At all times material to the Statements of Charges, Tri Tran was employed as a pharmacist by Iowa Methodist Medical Center (IMMC) Pharmacy, which has been issued pharmacy license number 233. Brian Benson was the pharmacist-in-charge of the IMMC pharmacy at the time relevant to the Statements of Charges. (State Exhibits 1-4; Testimony of Tri Tran; Brian Benson)

2. This contested case concerns an error that occurred on October 9, 2010 in the IMMC pharmacy's sterile compounding room. The error caused a neonatal patient to be given intravenous (IV) fluids containing 250 times the dosage of heparin that was ordered by the physician. Heparin is an injectable medication used to prevent blood from clotting. The IV was removed approximately ten hours after it was started when the patient began bleeding from his umbilical catheter. Sutures were placed to stop the bleeding, and the patient was given plasma. The patient was discharged on October 12, 2010 with normal blood coagulation values. (Exhibit 1, p. 1; Exhibit 1F, p. 1)

The record reveals the following chain of events prior to the error:

a) On October 9, 2010, a physician ordered IV fluids for a neonatal patient at IMMC's Blank Children's Hospital. The order clearly indicates that it is for a pediatric patient in the intensive care nursery. The order was for 12.5% dextrose in water with 0.25 units per milliliter of preservative-free heparin. Based on this order, the neonatal patient was to have received a 250ml IV bag of 12.5% dextrose containing 62.5 units of heparin. (State Exhibit 1, 1A; 1F, p. 1; Testimony of Tri Tran)

b) The physician's order was correctly entered into the pharmacy's computer system (CareCast) by one of the pharmacists working in the hospital. The CareCast program then produced a label with the correct quantity and

concentration of heparin. The CareCast label shows, in part, that the IV fluids were to contain 62.5 units of heparin at a concentration of 0.25 units/ml. (State Exhibit 1, 1B; Testimony of Tri Tran)

c) After the CareCast label was generated, the physician's order and the CareCast label were forwarded to the pharmacy's sterile compounding area, where Pharmacist Tri Tran was working. Mr. Tran reviewed the CareCast label for accuracy by comparing it to the physician's order and then added his initials to the CareCast label. (Testimony of Tri Tran; State Exhibit 1, 1A and 1B)

3. The IMMC pharmacy uses a computerized compounding machine called an "Automix." The Automix interfaces with a Baxa compounder software program known as "Abacus." The information from the physician's order (and from the CareCast label) must be entered into the Baxa Abacus program in order to begin the compounding process. This can be done by the pharmacist or by a pharmacist technician, with pharmacist review. After the information is entered, the Baxa Abacus compounder program automatically generates a label with a bar code. The Baxa compounder label is then held up to the bar-code reader on the Automix machine. After scanning the label, the Automix machine starts pumping and automatically adds the necessary ingredients to the empty IV bag. (State Exhibit 1; Testimony of Tri Tran; Brian Benson)

a) Pharmacist Tri Tran was responsible for entering the information from the CareCast label into the Baxa Abacus program on October 9, 2010. The compounding program has built-in template orders, and Mr. Tran selected a template pediatric order for heparin. According to Mr. Tran, the template order for heparin required him to enter the total volume needed (250 ml) for the IV bag, the percentage of dextrose needed (12.5%), and the total amount (value) of heparin needed (62.5). Once those values were entered the computer calculated the diluent required to dilute the 70% dextrose to the desired concentration of 12.5% dextrose with 0.25 heparin units/ml. (Testimony of Tri Tran)

b) On October 9, 2010, the Abacus program allowed the person entering the heparin order to select the appropriate numerator/denominator for the substance from a drop down menu. In this case, when Tri Tran entered 62.5 for the heparin value, the numerator/denominator on the drop down menu should have read "units." Mr. Tran testified that he never previously had to select or change the numerator/denominator. In his experience the correct numerator/denominator "units" was supplied by the template order. This time,

however, the numerator/denominator for the heparin came up as "units/ml" rather than "units" after Mr. Tran entered 62.5. This had never happened before that Mr. Tran could recall, and he did not notice that this occurred. (Testimony of Tri Tran; See, e.g., State Exhibit 1C¹)

c) After Tri Tran entered the values for the volume, dextrose, and heparin, the Baxa Abacus compounder program generated a label for the patient's order. The compounder program included a built-in warning system (red screen) that should stop a label from being automatically generated if the dosage appeared to be too high. The pharmacist then has to over-ride the red screen in order to generate a label if the information is in fact correct. No such warning appeared in this case, and the machine generated the label without a red screen.

The Baxa Abacus label showed a value of heparin PF 62.5 units/ml, instead of 62.5 units. Mr. Tran reviewed this label for accuracy by rechecking the drug name (heparin) and the number of units (62.5), but he did not notice that the numerator/denominator appeared on the label as "units/ml" rather than "units." At hearing, Mr. Tran testified that there was another part to the label, which is not part of the record, which caused him to wonder if the amount of heparin might be too high. Mr. Tran could not recall specifically what the label said to raise his concern, but it prompted him to ask two pharmacy technicians if they had ever seen that amount of heparin before, and both indicated that they had. After speaking to the pharmacy technicians, Mr. Tran put aside his concern and assumed that the heparin would be appropriately diluted down when machine compounded the IV bag. (Testimony of Tri Tran; State Exhibit 1D)

d) After the Baxa compounding label was generated, Mr. Tran gave the label and an empty 250ml sterile IV bag to pharmacy technician David Graham, who was working in the clean room. Mr. Graham only had to hold the Baca Abacus label up to the bar-code reader on the Automix machine to start the compounding process. During the compounding of the IV bag, the Automix machine prompted Mr. Graham to add another IV syringe of 100 unit/ml heparin dilution because the first one was empty. Mr. Graham informed Tri Tran that he needed to make another syringe of heparin dilution to attach to the Automix

¹ After this error was discovered, IMMC changed its template order so that the numerator/denominator is locked for particular dosages and cannot be changed through a drop down menu. Exhibit 1C is an example of the current template. (Testimony of Brian Benson; Exhibit 1F, pp. 1-2)

machine. Mr. Tran gave Mr. Graham the heparin vial to make the syringe. During the compounding, Mr. Graham had to make two additional heparin syringes to attach to the Automix machine, and each time he informed Pharmacist Tri Tran. Tri Tran testified that he did not realize that the additional heparin was all for this single IV bag. When the compounding process was completed, the finished IV bag contained 15,625 units of heparin instead of 62.5 units. (State Exhibit 1, pp. 2-3; State Exhibit 1E; Testimony of Tri Tran)

e) After the compounding was complete, Pharmacist Technician David Graham labeled the IV bag and returned it to Tri Tran for a final check. During the final check Mr. Tran reviewed the measured weight of the final product. The measured weight was 0.4% less than the expected weight. This did not raise any red flags for him because anything within 3% (plus or minus) of the expected weight is considered acceptable. (Testimony of Tri Tran; State Exhibit 1, p. 3; 1E)

4. After the error was discovered, the IMMC pharmacy conducted its own investigation and a root cause analysis to determine how the error occurred and to prevent similar errors in the future. IMMC discovered that it could lock its template for NICU dextrose with heparin so that the numerator, denominator, and value fields were all locked in. At the current time the template always brings up the standard heparin dose of 0.25 units per milliliter. In non-standard cases requiring a higher (.5 unit) dose, a second template is selected which triggers a "hard stop" and a red, dose-limit warning screen appears. The pharmacist cannot send the order on to the Automix machine without manually entering an explanation for the more concentrated strength.

IMMC has also reduced the volume of heparin inventory in the IV room and has reviewed the circumstances of this error with its staff in the pharmacy department. In addition, although the CareCast program was not the cause of the error in this case, IMMC has just recently installed a new upgraded system for computerized physician order entry, order processing and order verification. (Testimony of Brian Benson: State Exhibit 1, pp. 3-4; 1E-1H)

CONCLUSIONS OF LAW

The Board is authorized by statute to discipline pharmacists, registered pharmacy technicians, and pharmacies for any violation of Iowa Code chapter

155A or any rule of the Board. Iowa Code §§155A.12(1); 155A.6A(5); 155A.15(2)(c)(2011).

657 IAC 36.1(4)"b" provides that the Board may impose any of the disciplinary sanctions set out in subrule 36.1(2) when it determines that a licensee, registrant, or permittee is guilty of professional incompetency. Professional incompetency, as defined by rule, includes but is not limited to:

- (1) A substantial lack of knowledge or ability to discharge professional obligations within the scope of the pharmacist's practice.
- (2) A substantial deviation by a pharmacist from the standards of learning or skill ordinarily possessed and applied by other pharmacists in the state of Iowa acting in the same or similar circumstances.
- (3) A failure by a pharmacist to exercise in a substantial respect that degree of care which is ordinarily exercised by the average pharmacist in the state of Iowa acting under the same or similar circumstances.
- (4) A willful or repeated departure from, or the failure to conform to, the minimal standard or acceptable and prevailing practice of pharmacy in the state of Iowa.

657 IAC 36.1(4)"b"(1)-(4).

Pharmacy Technician David Graham was not responsible for the error in this case. Mr. Graham did not enter any information into the pharmacy's computer software program and was not responsible for reviewing and approving the compounding label. Mr. Graham's role was limited to taking the compounding label that had been reviewed and approved by Pharmacist Tri Tran and scanning it on the Automix bar code reader. Moreover, Mr. Graham alerted the pharmacist each time that the Automix ran out of heparin and needed an additional syringe. The evidence failed to establish that Respondent David Graham is professionally incompetent, as that term is defined in 657 IAC 36.1(4)"b."

Pharmacist Tri Tran was the person responsible for the compounding error on October 9, 2010. Mr. Tran was responsible for entering the information from the physician's order/CareCast label into the compounding software program. He

was also responsible for reviewing the label generated by the Baxa Abacus compounding program. Finally, Mr. Tran was responsible for the final check of the IV bag after compounding was complete. As the pharmacist who entered the data from the physician's order into the pharmacy's computer system, Mr. Tran should have recognized that the numerator/denominator came up as "units/ml" instead of the "units" on the Baxa label. Mr. Tran had several additional opportunities to recognize and correct this error but failed to do so. Moreover, the fact that this was a pediatric order for a neonatal patient should have prompted extra care in reviewing the label and the compounded IV bag, particularly when three additional syringes of heparin had to be added to the compounding machine.

There is no evidence that Tri Tran has committed any other similar errors or that there have been any other problems with his professional practice. In his testimony at hearing, Mr. Tran appeared to be very knowledgeable and conscientious. He showed appropriate remorse for his error and concern for the patient. Based on his testimony and on the training records provided by his employer, it appears that Mr. Tran does possess the learning and skill ordinarily possessed by competent pharmacists in this state. Mr. Tran clearly made an error that could have caused serious harm to the patient. The Board was not persuaded, however, that this isolated error can fairly be characterized as professional incompetency, as defined in 657 IAC 36.1(4)"b."

The preponderance of the evidence also failed to establish that the Iowa Methodist Medical Center (IMMC) Pharmacy was guilty of professional incompetency. The IMMC Pharmacy had appropriate policies and procedures in place to prevent this type of error from occurring but there was an obvious breakdown in procedures on this particular day. After the error was discovered, IMMC took appropriate steps to investigate the cause of the error, to conduct a root cause analysis, and to cooperate with the Board's investigation. Since that time the IMMC Pharmacy has instituted important additional safeguards to avoid similar errors in the future, including staff training, development of new templates, locking the fields on templates where possible and appropriate, reducing the inventory of heparin maintained in the IV compounding room, and implementing a new electronic system for entering and verifying physician's orders.

DECISION AND ORDER

IT IS THEREFORE ORDERED that the Statement of Charges filed against Pharmacy Technician David Graham on November 10, 2011 is hereby DISMISSED.

IT IS FURTHER ORDERED that the Statement of Charges filed against Pharmacist Tri Tran on November 10, 2011 is hereby DISMISSED.

IT IS FURTHER ORDERED that the Statement of Charges filed against the Iowa Methodist Medical Center Pharmacy on November 10, 2011 is hereby DISMISSED.

Dated this 27th day of April, 2012.



Susan Frey, Chairperson
Iowa Board of Pharmacy

cc: Scott Galenbeck, Assistant Attorney General
Connie Diekema, Respondents' Attorney

Any aggrieved or adversely affected party may seek judicial review of this decision and order of the board, pursuant to Iowa Code section 17A.19.