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STATE OF WISCONSIN
BEFORE THE PHARMACY EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
TIMOTHY MELIN, R.Ph., RESPONDENT.	:	LS0612063PHM

[Division of Enforcement Case # 05 PHM 020]

The parties to this action for the purposes of Wis. Stat. § 227.53 are:

Timothy Melin, R.Ph.
717 Ash Court
Verona, WI 53593

Division of Enforcement
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Wisconsin Pharmacy Examining Board
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Pharmacy Examining Board. The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Timothy Melin, R.Ph., ("Respondent"), date of birth March 24, 1963, is licensed by the Wisconsin Pharmacy Examining Board as a pharmacist in the state of Wisconsin pursuant to license number 11085, which was first granted March 16, 1988.

2. Respondent's address of record with the Department of Regulation and Licensing is 717 Ash Court, Verona, WI 53593.

3. On all relevant dates, Respondent was employed by Walgreen Company as the pharmacy manager at Walgreens Pharmacy #05087 ("the pharmacy") in Fitchburg, Wisconsin.

4. On March 24, 2005 and on March 28, 2005, the pharmacy used an automated medication dispensing device known as the Baker Cell. The Baker Cell eliminated the need to hand-count a prescribed number of tablets or capsules. The device was comprised of a series of cells, each individually assigned for a specific tablet or capsule. The operator would indicate the quantity of tablets needed and would then press the individual cell's activating switch. The tablets would be automatically delivered into a chute until the pharmacist released the tablets into a prescription vial.

5. On March 24, 2005, Patient PM presented a prescription for 40 mg tablets of Citalopram. Citalopram is used

to treat depression and is among a class of antidepressants known as selective serotonin reuptake inhibitors. Patient PM's prescription was filled using the Baker Cell.

6. Between March 24, 2005 and March 29, 2005, Patient PM felt "miserable," and experienced lightheadedness and fainting episodes.

7. On March 28, 2005, Respondent was verifying another patient's prescription when he discovered that within the dispensing device, 4 mg tablets of Doxazosin had been mixed in with the Citalopram.

8. Doxazosin is an antihypertensive medication, generally used to treat high blood pressure. Doxazosin and Citalopram are manufactured by the same pharmaceutical company and are the same shape, size and color. The medications are visibly distinguishable only by numerical markings imprinted on their surfaces.

9. Some patients experience withdrawal symptoms upon cessation of Citalopram. Symptoms of withdrawal include dizziness, tingling sensations, tiredness, vivid dreams, and/or irritability.

10. Upon discovering the potential dispensing error, pharmacy staff removed the Citalopram and Doxazosin from the distribution cell. They further called patients who had filled prescriptions for Citalopram and who may have been subject to the error.

11. Patient PM was among those alerted to the potential error, and her medication was found to include Doxazosin. On March 29, 2005, the pharmacy replaced Patient PM's medication. Pharmacy staff again used the Baker Cell device to fill Patient PM's prescription for Citalopram.

12. On March 29, 2005, Patient PM discovered that her replacement medication again included both Citalopram and at least one tablet of Doxazosin.

13. On March 29, 2005, Patient PM saw a physician who reported the additional error to the pharmacy. A pharmacist told the physician that, "almost all pills are accounted for."

14. On May 25, 2005, Respondent admitted that the dispensing errors had occurred and explained that a pharmacist had initially filled the dispensing cell incorrectly. Through his investigation, Respondent was unable to attribute the error to one pharmacist. Respondent believes that the second dispensing error occurred because at least one tablet of Doxazosin was improperly left in the dispensing device's counting cell and the dispensing device was used for the replacement fill.

15. Because the Citalopram and Doxazosin are similar in appearance, Respondent contacted the manufacturer and alerted other Walgreen stores to possible error. Respondent personally talked to the staff to educate them. In response to the second dispensing error, Respondent removed Citalopram from the group of drugs to be dispensed through the Baker Cell.

16. Respondent explained that he received no formal training in the operation of the Baker Cell, but that Walgreens itself demonstrates the machines to staff. He stated that the machines were put in so long ago he is not sure of what formal training he had. Respondent stated he was not previously aware that medication could remain in a counting cell, but in retrospect, he believes it does make sense that a tablet might remain in the counting cell.

17. Respondent, as managing pharmacist of a community pharmacy, is responsible for assuring that an automated dispensing system is stocked accurately.

18. Respondent, by failing to verify that Patient PM's replacement prescription contained only Citalopram created an unreasonable risk of danger to the health, welfare and safety of Patient PM.

19. Respondent, by failing to immediately remove Citalopram from those drugs dispensed through the automated device created an unreasonable risk of danger to the health, welfare and safety of the public.

CONCLUSIONS OF LAW

1. The Wisconsin Pharmacy Examining Board has jurisdiction over this matter pursuant to Wis. Stat. § 450.10 and has authority to enter into this stipulated resolution of this matter pursuant to Wis. Stat. § 227.44(5).

2. The conduct described in paragraphs 18 and 19 constitutes a violation of Wis. Admin. Code § Phar 10.03(2) and subjects Respondent to discipline pursuant to Wis. Stat. § 450.10(1).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED:

1. Respondent, Timothy Melin, R.Ph., is REPRIMANDED for the conduct set out above.

2. Respondent shall, within 60 days from the date of this Order, pay to the Department of Regulation and Licensing a forfeiture in the amount of $250.00, pursuant to Wis. Stat. § 450.09(8).

3. Respondent shall, within 60 days from the date of this Order, pay to the Department of Regulation and Licensing costs of this proceeding in the amount of $447.86, pursuant to Wis. Stat. § 440.22(2).

4. All payments required by this Order shall be mailed or delivered to:

Department Monitor
Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Ave.
P.O. Box 8935
Madison, WI 53708-8935
Fax: (608) 266-2264
Telephone: (608) 267-3817

5. In the event Respondent fails to timely submit any payment of the forfeiture as set forth above or fails to pay costs as ordered, Respondent's license SHALL BE SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order.

6. This Order is effective on the date of its signing.

Wisconsin Pharmacy Examining Board

By: Michael Bettiga 12-06-2006
A Member of the Board Date