Warfarin dispensing error
(03HDC13660, 17 February 2004)

Pharmacist ~ Pharmacy ~ Professional standards ~ Dispensing error ~ Right 4(2)

On discharge from hospital, an 81-year-old gentleman was given a prescription for his multiple medical problems. The patient and his daughter collected the medication from the pharmacy on their way home. The medication was dispensed in blister packs, where all medication to be taken at a particular time is dispensed into individual compartments.

The next day the man advised his daughter that his medication appeared to have changed. Instead of one (3mg) warfarin tablet he now had three tablets. He had never previously been given more than 5mg. His daughter decided not to telephone the hospital because she was never able to get hold of the doctor who prescribed the medication. She advised her father that the doctor must know what he is doing and to take the medication.

Six days later the patient's daughter noticed that her father was bleeding from scratches on his feet, and she telephoned their general practitioner. The general practitioner saw the patient that day and determined that on discharge he had been prescribed only 3mg warfarin. The patient's INR (a blood test to determine clotting time) was greater than 10 (therapeutic range 2.0-3.0). The patient was admitted to hospital for administration of vitamin K to reverse the anti-clotting effects. This was successful but the patient's previous medical problems resurfaced and he died several weeks later.

The patient's daughter raised the matter with the pharmacist, who accepted the error and was upset and apologetic. He had incorrectly entered the figure 3 into the computer to denote how many 3mg tablets were required each day. The pharmacist also failed to check the print-out against the prescription, and had made up the blister packs against the print-out rather than the prescription, contrary to the pharmacy's dispensing policy. He was held to have breached Right 4(2).