Trandate dispensed instead of prescribed tramadol (04HDC11276, 24 May 2005)

Pharmacist ~ Pharmacy ~ Dispensing error ~ Handwriting ~ Checking ~ Professional standards ~ Vicarious liability ~ Right 4(2)

Following a hip replacement, a 41-year-old man was discharged from hospital with a prescription for the pain-relief medication tramadol. The man's wife filled the prescription on the way home from hospital. The prescription was handwritten and the pharmacist found the small handwriting difficult to read. He misread "tramadol" as "Trandate", a medication used to treat hypertension. He did not enquire as to why the medication had been prescribed, but commented that the dose prescribed (50mg) had not been available for some time. When the pharmacist said that he would check the prescription with the prescribing doctor before dispensing the medication, the man's wife said that the doctor would have left the hospital. As the pharmacy was busy and the woman was in a hurry to get back to her husband, who was in pain, the pharmacist agreed to fill the prescription unquestioned.

The pharmacist then asked another local pharmacy if it had 50mg tablets of Trandate that he could borrow; when it did not, he offered to cut 100mg tablets in half in order to fill the prescription. This was done and an information sheet about Trandate was enclosed with the medication.

When the man went to take the medication that evening, he noticed that the tablets were a different colour from the tramadol dispensed at the hospital, and presumed this was because it was a different dosage. He did not read the enclosed information sheet, and took two half-pills that evening. The following morning, he complained of severe headache, dizziness and hallucinations. His wife consulted the information sheet, realised that a dispensing error had been made, and consulted an urgent pharmacy, where the mistake was verified. She then contacted the dispensing pharmacy, which admitted to the mistake, apologised, refunded the dispensing fee and gave the couple petrol vouchers.

It was held that the mistake was one of human error rather than a failure to follow procedures, and the pharmacist was found in breach of Right 4(2). In reviewing his practice, the pharmacist undertook not to dispense any prescription over which there is any doubt until clarification is sought from the prescriber. The systems in place in the pharmacy were adequate, and the pharmacy was not held vicariously liable.