Dispensing error – larger dose of warfarin
(13HDC00819, 23 June 2014)

Pharmacy ~ Locum pharmacist ~ Orientation ~ Dispensing error ~ Warfarin ~ Professional standards ~ Right 4(2)

A 65-year-old man with a history of cardiac problems received a prescription for 60 1mg warfarin tablets (with two repeats) to be taken twice-daily. On the same day, the man filled the prescription at a pharmacy. The prescription was handled by a locum pharmacist.

The pharmacy used standard operating procedure (SOP) templates which are in use throughout New Zealand. The relevant SOP outlined the steps to be taken in handling prescriptions. Although the pharmacist had not been orientated to the pharmacy's processes or made aware of the relevant SOP, he was aware of the pharmacy's expectations as stated in his employment contract, including that he comply with all of the pharmacy's policies and procedures.

Prescriptions are dealt with in a three step process: processing, dispensing and checking. These tasks should be shared between staff members to reduce the possibility of a mistake. In this case, the pharmacist was the only staff member involved in processing, dispensing and checking the man's prescription. The pharmacist should have dispensed 1mg warfarin tablets in accordance with the man's prescription. The pharmacist dispensed 5mg warfarin tablets in error, but the label on the tablet bottle read "Warfarin sod. Tablets 1 mg" in accordance with the prescription.

The man took the warfarin tablets twice daily as he had been prescribed, and as instructed by the pharmacy label on the medication. Approximately six weeks later he was admitted to hospital with severe generalised abdominal pain and constipation. He was coughing up blood and had blood in his urine. His 'international normalised ratio' level (which measures the clotting tendency of blood) was more than 10 (the normal range for someone on warfarin is between 2 and 3). The man spent five days in hospital.

It was held that the pharmacist failed to ensure that he dispensed the correct dose of warfarin to the man. Accordingly, the pharmacist failed to provide services in accordance with professional standards and breached Right 4(2).

Adverse comment was also made about the pharmacy's orientation processes.