



# Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/  
Adverse Event Information

## Medical Safety Information

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# Wrong Weight When Prescribing an Antineoplastic Agent

Four cases have been reported involving an overdose of an antineoplastic agent due to the patient's weight being entered incorrectly at the time of prescription (information collection period: from January 1, 2011 to May 31, 2015). The information is compiled based on "Individual Theme Analysis" (p.71) in the 19th Quarterly Report.

**Cases of overdose due to the use of the wrong weight when prescribing an antineoplastic agent have been reported.**

Drug Administered	Correct Weight	Wrong Weight	Background
Oncovin for Inj. 1mg	Weight of Patient A (1 year old)*	Weight of Patient B (3 years old)*	The physician prescribed the quantity of medication based on a calculation using Patient B's weight and height
ELPLAT I.V.INFUSION SOLUTION	43.1kg	99kg	The physician prescribed the drug based on a provisional figure for the weight because s/he did not know the patient's weight
Randa Inj. 50mg/100mL	Patient A's weight 45.0kg	Patient B's weight 78.5kg	The nurse erroneously entered the weight of Patient B, who had the same family name, and the physician prescribed the drug based on the recorded weight
Unknown	51.5kg	61.5kg	The nurse made a typing error when entering the figures and the physician prescribed the drug based on the recorded weight

\*In this case, the height entered was also that of Patient B.

## Wrong Weight When Prescribing an Antineoplastic Agent

### Case 1

Before using the ordering screen to prescribe Oncovin for Inj. for Patient A (aged 1), the physician referred to the electronic medical record for Patient B (aged 3), who was being treated for the same disease with the same protocol. Subsequently, on the basis of the body surface area in the record, which had been calculated using Patient B's height and weight, the physician prescribed exactly the same quantity of the drug to Patient A as had been prescribed to Patient B. As it was an out-of-hours prescription, the drug was delivered to the ward without the patient's weight being checked by the pharmaceutical department. The nurse prepared the drug in accordance with the order and the physician injected it intravenously. When the pharmaceutical department subsequently carried out a check, the pharmacist noticed that the actual dosage was greater than the dosage calculated on the basis of Patient A's height and weight, so they queried it with the physician, but administration had already been completed.

### Case 2

When prescribing an antineoplastic agent, the quantity of the drug to be administered is meant to be calculated on the basis of the patient's body surface area, which is calculated when the patient's height and weight are entered. The physician had not weighed the patient at the time of the outpatient, so s/he entered a provisional weight of 99kg, with the intention of amending it later, and prescribed ELPLAT I.V.INFUSION SOLUTION. On the day of administration, the physician amended the weight on the prescription to 43.1kg. However, the pharmaceutical department had already finished preparing the drug and it was administered to the patient without taking into account the revised weight. The pharmacist subsequently recalculated the dosage and realized that the dosage calculated on the basis of the patient's weight differed from the dosage actually administered.

#### Preventive measures taken at the medical institutions in which the events occurred.

- Staff members will weigh the patient at the time the regimen is ordered and the physician will prescribe on the basis of the correct figure.

\* As part of the Project to Collect Medical Near-Miss/Adverse Event Information (a Ministry of Health, Labour and Welfare grant project), this medical safety information was prepared based on the cases collected in the Project as well as on opinions of the "Comprehensive Evaluation Panel" to prevent the occurrence and recurrence of medical adverse events. See quarterly reports and annual reports posted on the Japan Council for Quality Health Care website for details of the Project.

<http://www.med-safe.jp/>

\* Accuracy of information was ensured at the time of preparation but cannot be guaranteed in the future.

\* This information is intended neither to limit the discretion of healthcare providers nor to impose certain obligations or responsibilities on them.

