



Project to Collect Medical Near-Miss/
Adverse Event Information

Medical Safety Information

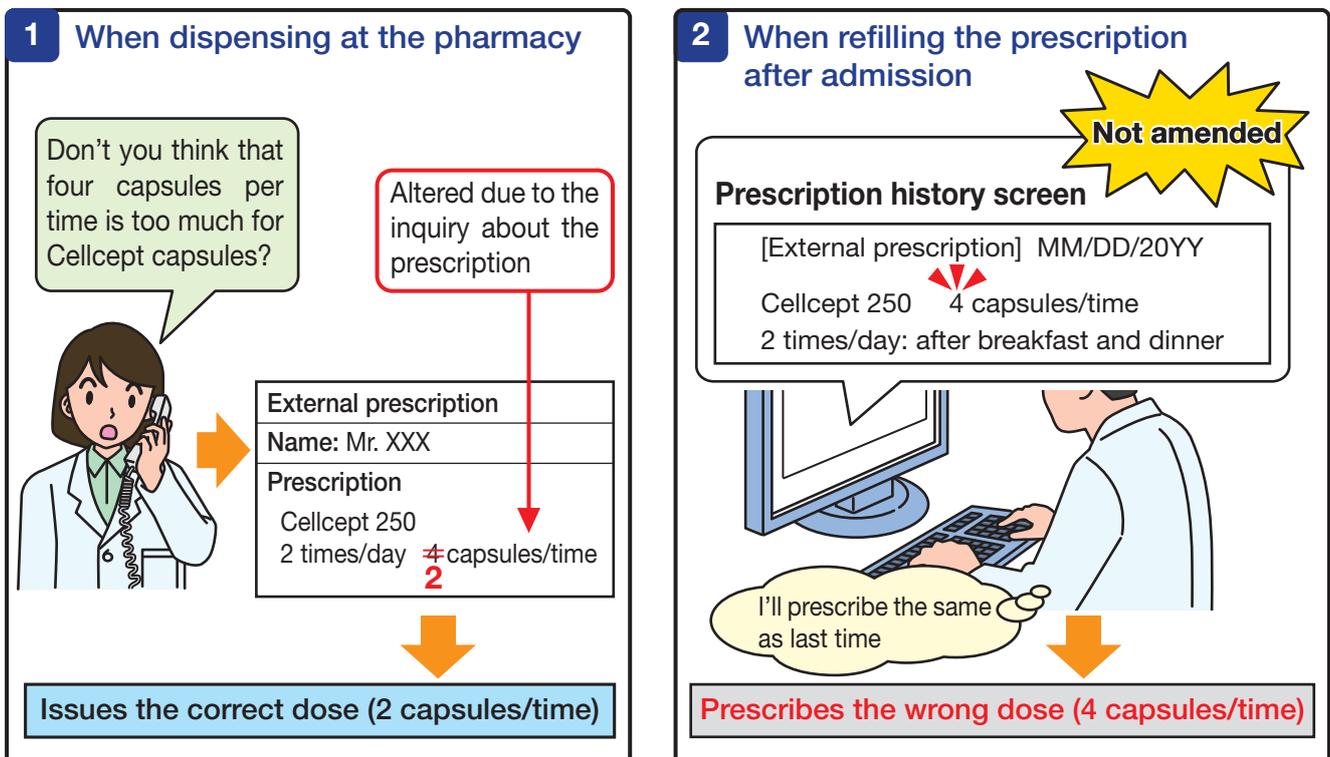
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Error When Refilling a Prescription Due to Failure to Revise Prescription Details

Two cases have been reported in which a pharmacist's inquiry about a prescription resulted in a change to the medication quantity, etc., but the details of the prescription on the electronic medical record were not amended, so when the prescription was refilled, the drugs prescribed were based on the prescription history prior to the change (information collection period: from January 1, 2017 to August 31, 2018). This information was compiled on the basis of the content featured in the Analysis Themes section of the 50th Quarterly Report.

Cases have been reported in which an inquiry about a prescription resulted in a change to the prescription, but the prescription was subsequently refilled based on the prescription history prior to the change, as the record had not been amended.

Image of case 1



Error When Refilling a Prescription Due to Failure to Revise Prescription Details

Case 1

When entering an external prescription for Cellcept 250 2 capsules/time, 2 times/day (4 capsules/day), the physician entered 4 capsules/time, 2 times/day (8 capsules/day) in error. The physician received an inquiry about the prescription from the pharmacist at the pharmacy and changed the dosage, and the pharmacist dispensed the prescription accordingly. However, the physician did not amend the prescription details on the electronic medical record. The patient was subsequently admitted as an emergency on a holiday and was prescribed Cellcept 250 4 capsules/time, 2 times/day based on the prescription history. The overdose was discovered when the patient's blood concentration was measured after admission and found to be high.

Case 2

Outpatient Physician A prescribed Bisoprolol Fumarate Tablets 12.5 mg. When the hospital pharmacist made an inquiry about the prescription, asking whether the quantity prescribed was not too much, it was altered to 1.25 mg. Physician A did not amend the prescription details on the electronic medical record at that time. When the patient was subsequently admitted after being examined at the emergency room overnight, Physician B prescribed Bisoprolol Fumarate Tablets 12.5 mg based on the dosage in the prescription history. Neither the pharmacist nor the nurse noticed and the patient took the drug.

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

- Physicians will amend the prescription details on the record without fail if the drug quantity, etc. is changed as a result of an inquiry about a prescription.

* 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 the Project website for details.

<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.

