Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.29, April 2009

Administration of 10 times proper dosage to pediatric patients

Eight cases of overdose due to administration of 10 times proper dosage to pediatric patients have been reported (information collection period, from January 1, 2006 to December 31, 2008; the information is partly included in "Medical Adverse Event Information to Be Shared" in the 13th Quarterly Report).

Eight cases of overdose due to misdosage of 10 times proper dosage to pediatric patients have been reported.

Overdosed drug and dose

Administered drug	Expected dosage	Administered dosage	Patient Age
Incremin syrup	1.5mL/day	15mL/day	1month
Digosin powder	0.03mg/day	0.3mg/day	3months
Decadron tablets	2mg/day	20mg/day	6years old
Novantron injection	1.2mg/time	12mg/time	9months
Fragmin IV	75units/kg/day	750units/kg/day	8months
Flumarin	25mg/time	250mg/time	2months
Mystan	0.2mg/kg/day	2mg/kg/day	9months
Warfarin	0.6mg/day	6mg/day	8months

- Regarding factors leading to administration of 10 times proper dosage to pediatric patient, physician's misunderstanding, miscalculation, and wrong digit entering, have been reported.

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Case 1

A physician was to prescribe Digosin powder "0.03mg" to a 3-month-old patient, but input "0.3mg" instead of "0.03mg," and did not confirm the input of prescription. Moreover, the pharmacist did not notice that the prescribed volume was excessive during the prescription inspection, and prepared it as it was. Consequently, a dosage which was 10 times of the planned dosage was administered.

Case 2

A physician was to prescribe Flumarin IV "25mg" to a 2-month-old patient, but erroneously input as "250mg," and did not confirm the input of prescription. Moreover, the pharmacist did not notice that the prescribed volume was excessive during inspecting the prescription and prepared it as it was. Consequently, a dosage which was administered 10 times the expected dosage. The ordering system was set to alarm when the prescribed volume exceeds the single dose amount or one-day amount for an adult which were officially described in the drug reference.

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

When inputting or inspecting the prescription, confirm the drug dose based on age and body weight, etc.

* 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 "Comprehensive Evaluation Panel" to prevent 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 can not be guaranteed in the future.
* This information is neither for limiting the discretion of healthcare providers nor for imposing certain obligations or responsibilities on them.

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