Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.39, February 2010

Insufficient confirmation of medicines brought in at hospitalization

Nine cases of insufficient confirmation of medicines brought when a patient was admitted to a hospital, which affected treatment of the patient, have been reported (information collection period: from January 1, 2006 to December 31, 2009; the information is partly included in "Individual Theme Review" (p.60) in the 10th Quarterly Report).

Cases of insufficient confirmation of medicines brought in at hospitalization, which affected treatment of the patient, have been reported.

Details of the insufficient confirmation	Number of case
Did not confirm if medicines was brought in or not.	2
Confirmed that the patient had medicines brought in at hospitalization, but the drug name was not confirmed.	2
Confirmed the name of the medicines brought in at hospitalization, but the dosage and administration was not confirmed.	5

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Case 1

The physician intravenously administered Meropen for four days to a pediatric patient who was emergently admitted to the hospital to treat pneumonia. On the next day after discharge, severe restlessness occurred and the patient was brought to another hospital. The parent received the explanation, "Meropen was administered while taking valproate sodium which might have reduced the blood concentration of valproic acid, and caused restlessness." In the referral form provided at the time of hospitalization and in the present illness on the chart, it was described that the patient was taking anti-epileptic drug brought into the hospital. However, the physician in charge did not take the name of the drug into consideration.

Case 2

The patient brought a referral form from the former physician in charge and a prescription issued on the final visit when admitted to the hospital. Multiple drugs were prescribed during the last six weeks, including Alkeran and Predonine for four days, planned to start from the eighth day from the prescribed date. The patient was admitted to the hospital on the following day after the administration of Alkeran and Predonine for four days. Reading the referral form and the prescription, the physician in charge continued to prescribe and administer Alkeran and Predonine for seven days. After that, when additional administration was ordered, the pharmacist inquired about the prescription. Upon confirmation, the drugs in question were to be taken orally for only four days in MP chemotherapy, resulting in a seven-day overdose.

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

- **Patient's medicines brought in at hospitalization shall be confirmed.**

* 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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