Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

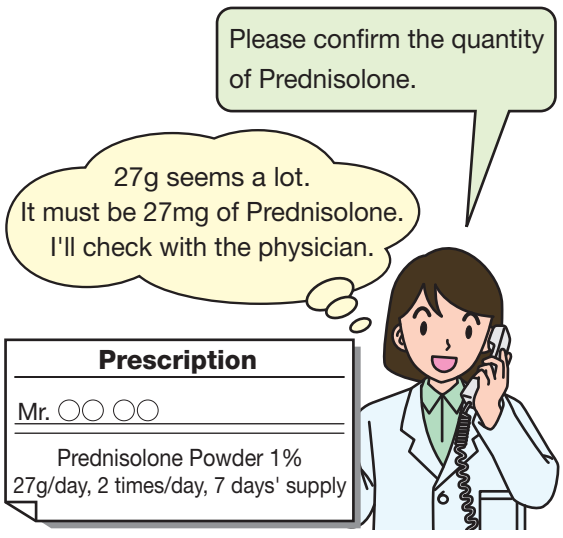
No.84, November 2013

Insufficient Confirmation of Incorrect Prescription

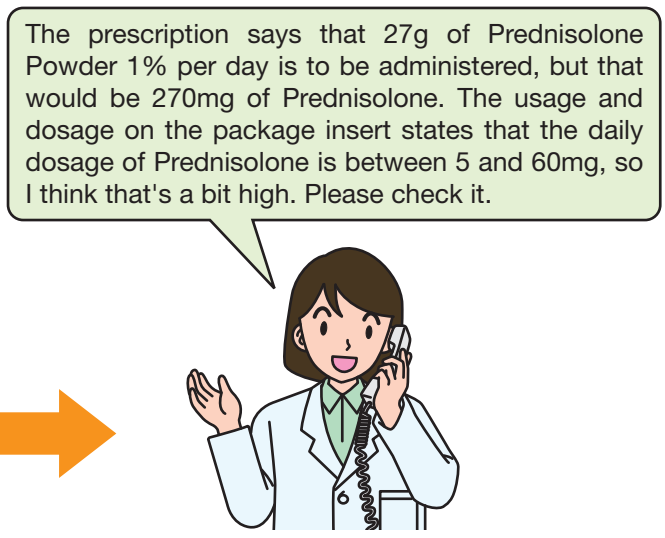
Three cases have been reported involving an overdose that occurred because, although the pharmacist had a query about the prescription, the nature of the query was not communicated properly when making the inquiry about the prescription, with the result that the prescription was not revised (information collection period: from January 1, 2010 to September 30, 2013; the information is partly included in “Individual Theme Review” (p.64) in the 11th Quarterly Report).

Cases have been reported in which an overdose occurred because, although the pharmacist had a query about the prescription, the nature of the query was not communicated properly when making the inquiry about the prescription, with the result that the prescription was not revised.

Image of case



Example of an inquiry about a prescription that is clear about the point at issue



Project to Collect Medical Near-Miss/ Adverse Event Information

Project to Collect Medical Near-Miss/ Adverse Event Information
Medical Safety Information

No.84, November 2013

Insufficient Confirmation of Incorrect Prescription

Case 1

When prescribing 27mg/day of Prednisolone for a patient, the physician erroneously prescribed Prednisolone Powder 1% 27g/day (270mg of the active ingredient) 2 times/day for 7 days. When the pharmacist from the dispensing pharmacy made an inquiry about the prescription, s/he said, "Please confirm the quantity of Prednisolone." The hospital staff member who took the call thought that the pharmacist meant that the faxed prescription was hard to read, so s/he read out the content of the prescription from the electronic medical record. Although the pharmacist's query was not resolved, s/he went ahead and dispensed the amount on the prescription and handed it over to the patient. The physician noticed the overdose after the patient queried the quantity of the drug on the grounds that it seemed a large amount.

Case 2

The cardiologist gave a verbal order for an "intravenous injection of 2,000 units of Heparin once daily," for the purpose of anticoagulant therapy. Assuming that 2,000 units was 20,000 units, the attending physician in the department of rheumatology prescribed an intravenous injection of Novo-Heparin for Injection 5,000 units/5mL 4V once a day. When the hospital pharmacist made an inquiry about the prescription, s/he asked, "The quantity of Novo-Heparin prescribed is 20,000 units – is that correct?" The pharmacist did not fully communicate the purpose of the query, so the attending physician did not revise the prescription. The overdose was noticed after the intravenous injection was administered, because the patient's APTT became prolonged.

Complementary comment by the Comprehensive Evaluation Panel

- **When making an inquiry about a prescription, pharmacists should specify the nature of their question, to clarify the point at issue.**
- **When receiving an inquiry about a prescription, physicians should ensure that they understand the specific point(s) that the pharmacist wishes to clarify, and then check the prescription before replying.**

* 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.

Department of Adverse Event Prevention
Japan Council for Quality Health Care
1-4-17 Misakicho, Chiyoda-ku, Tokyo 101-0061 JAPAN
Direct Tel: +81-3-5217-0252 Direct Fax: +81-3-5217-0253
http://www.jcqhc.or.jp/