



Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/
Adverse Event Information

Medical Safety Information

No.4, March 2007

Drug mix-up

Seven cases of drug mix-up due to similarity in drug names were reported. (information collection period, from October 1, 2004 to December 31, 2006; the information is partly included in "Medical Adverse Event Information to Be Shared" in the 3rd Quarterly Report)

Drugs which should have been administered	Drugs mixed-up
Almarl	Amaryl
Allelock tablets	Arelix tablets
Cefmetazon for intravenous injection	Sefmazon for injection
Taxol injection	Taxotere
Taxotere	Taxol injection
Funguard for infusion	Fungizone for injection
Lactec D injection	Lactec injection

**Mix-up due to similarity
in drug names have been reported.**

- ◆ In addition to above cases, 2006 Annual Report P148-149 of this project listed other major drugs with similar names which are assumed to be the cause of medical near-miss event.

Drug mix-up

Case 1

At the ward in question, the original template form of instruction sheet for chemotherapy prescriptions was installed in PC. "Taxol 200mg + Paraplatin 400mg" were scheduled to be administered to the patient, however, wrong instruction "Taxotere 200mg + Paraplatin 400mg" made through the unaware output of incorrect instruction sheet on which "Taxotere" and "Paraplatin" were printed was implemented to the patient.

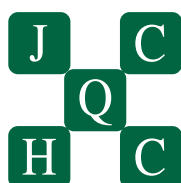
Case 2

The antibiotic "Cefmetazon" was prescribed. The pharmacist erroneously dispensed "Sefmazon" and the auditing pharmacist also did not noticed the error. "Sefmazon" was delivered to the ward. The nurse at the ward confirmed both of the injection instruction sheet and the prescribed drugs, but believed that "Sefmazon" was "Cefmetazon" and dripped wrong infusion for the patient.

* 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.



Division 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.jcqhcc.or.jp/html/index.htm>