

Project to Collect Medical Near-Miss/ Adverse Event Information

## Medical Safety Information

No.169, December 2020

# Omission from Prescription/Order When Continuing Prescription for Current Medicines Brought in at Hospitalization

Nine cases have been reported in which inadequate information on or checks of the Current Medicines Identification Sheet resulted in the omission of an item or items from a prescription/order to continue the prescription for current medicines brought in at hospitalization (information collection period: from January 1, 2017 to October 31, 2020). This information was compiled on the basis of the content featured in the Analysis Themes section of the 61st Quarterly Report.

Cases have been reported in which the omission of an item or items from a prescription/order to continue the prescription for current medicines brought in at hospitalization affected a patient.

Factor	Name of Drug Omitted*	Main Background Factors
Inadequate information on the Current Medicines Identification Sheet	Lixiana Tablets	<ul> <li>The pharmacist prepared a Current Medicines Identification Sheet solely for the drugs brought in on admission, but did not realize that the patient had not brought all their drugs with them on admission</li> <li>As the drug not brought in by the patient could not be recorded on the Current Medicines Identification Sheet, the pharmacist noted it on the record, but the physician checked only the Current Medicines Identification Sheet</li> </ul>
	Thyradin S Tablets Atorvastatin Tablets Trichlormethiazide Tablets	
Inadequate checks of the Current Medicines Identification Sheet	Furosemide Tablets  Takelda Combination	The physician prescribed the tablets before the Current Medicines Identification Sheet was prepared
	Tablets Efient Tablets	• The physician did not check the Current Medicines Identification Sheet because it was late reaching the ward
	Cortril Tablets	<ul> <li>The physician overlooked information given on the Current Medicines Identification Sheet</li> </ul>

<sup>\*</sup>Specifications and trade names have been omitted.

<sup>◆</sup> Depending on the medical institution, the Current Medicines Identification Sheet may be known by a different name, such as the Current Medicines Confirmation Sheet or the Current Medicines Report.



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#### Case 1

The patient was taking Lixiana Tablets for atrial fibrillation. At the time of admission, the pharmacist recorded the drugs the patient had brought in on the Current Medicines Identification Sheet, but did not realize that Lixiana Tablets should also be included, because the patient had not brought those tablets with them. The physician issued a prescription after checking the Current Medicines Identification Sheet. Seven days later, the patient was found to have arterial thrombosis in the leg and the omission of the prescription for Lixiana Tablets was discovered.

#### Case 2

The patient was taking Furosemide Tablets for chronic heart failure. At the time of admission, the physician prescribed drugs for the patient without waiting for the report on the Current Medicines Identification Sheet, but omitted to prescribe Furosemide Tablets. The Current Medicines Identification Sheet was later prepared after the pharmaceutical department had finished identifying the medicines brought in at hospitalization. When the prescribed drugs arrived at the ward, nobody checked whether any had been omitted. The patient's heart failure deteriorated as a result of not having taken the Furosemide Tablets.

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

- Check the patient's current medicines from multiple sources of information about their drug history, rather than basing it only on the drugs brought in by the patient at the time of admission.
- Physicians will check the Current Medicines Identification Sheet before issuing prescriptions/orders.
- Establish mechanisms for multidisciplinary checks of whether the patient's current medicines brought in at hospitalization are to be continued or halted.

The measures above are examples. Please consider initiatives suitable for your own facility.

- \* 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. https://www.med-safe.jp/
- \* Accuracy of information was ensured at the time of preparation but cannot be guaranteed in the future.
- st This information is intended neither to limit the discretion of healthcare providers nor to impose certain obligations or responsibilities on them.



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