Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

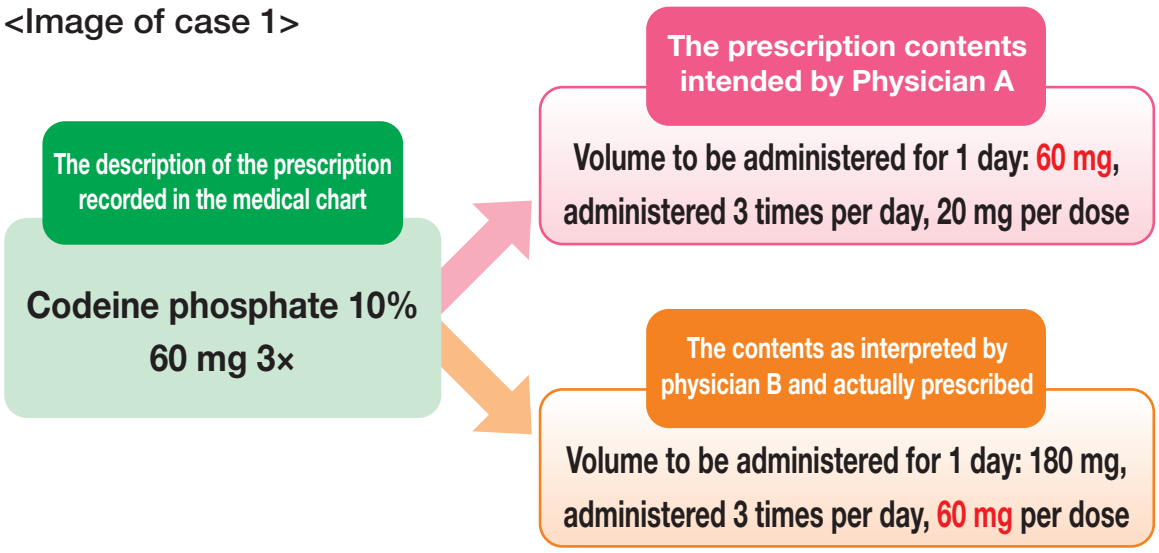
No.18, May 2008

Drug administered at a wrong dose level due to discrepancy in interpretation of the prescription

Three cases have been reported of misunderstanding in drug dosages due to different interpretations in writing prescriptions. (information collection period, from January 1, 2006 to March 31, 2008; the information is partly included in "Medical Adverse Event Information to Be Shared" in the 11th Report)

Cases have been reported of misunderstanding between administered drug dosage due to prescription such as “3×” or “3 parts” being interpreted to mean “3 times”.

<Image of case 1>



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Case 1

Pulmonologist A examined an in-patient in the hospital upon request by primary physician B of Dermatology. Physician A wrote, "Codeine phosphate 10% 60 mg per day, 3×," intending to administer for 1 day: 60 mg per day, administered 3 times per day, and 20 mg per dose. Primary physician B looked at "3×" written in the medical chart and interpreted this as an instruction to administer a daily dose of 180 mg per day divided into three doses at 60 mg per dose. Physician B prescribed "Codeine phosphate 180 mg, 3 parts" and administered according to it to the patient.

Case 2

The patient was taking Aleviatin 250 mg (dose/day) orally that had been prescribed by another clinical department. The patient had difficulties taking the medicines orally, therefore, the primary physician altered the prescription to an intravenous drip of Aleviatin. When the oral prescription was changed from "Aleviatin 250 mg 3 parts" to an IV prescription of Aleviatin, the physician misinterpreted this to mean "250 mg per dose, administered 3 times per day," submitted instructions and administered this to the patient.

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

When issuing prescriptions, amount shall be clearly described as whether the amount for a single day or for a simple dose.

* 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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