Project to Collect Medical Near-Miss/Adverse Event Information

Medical Safety Information

January 2024

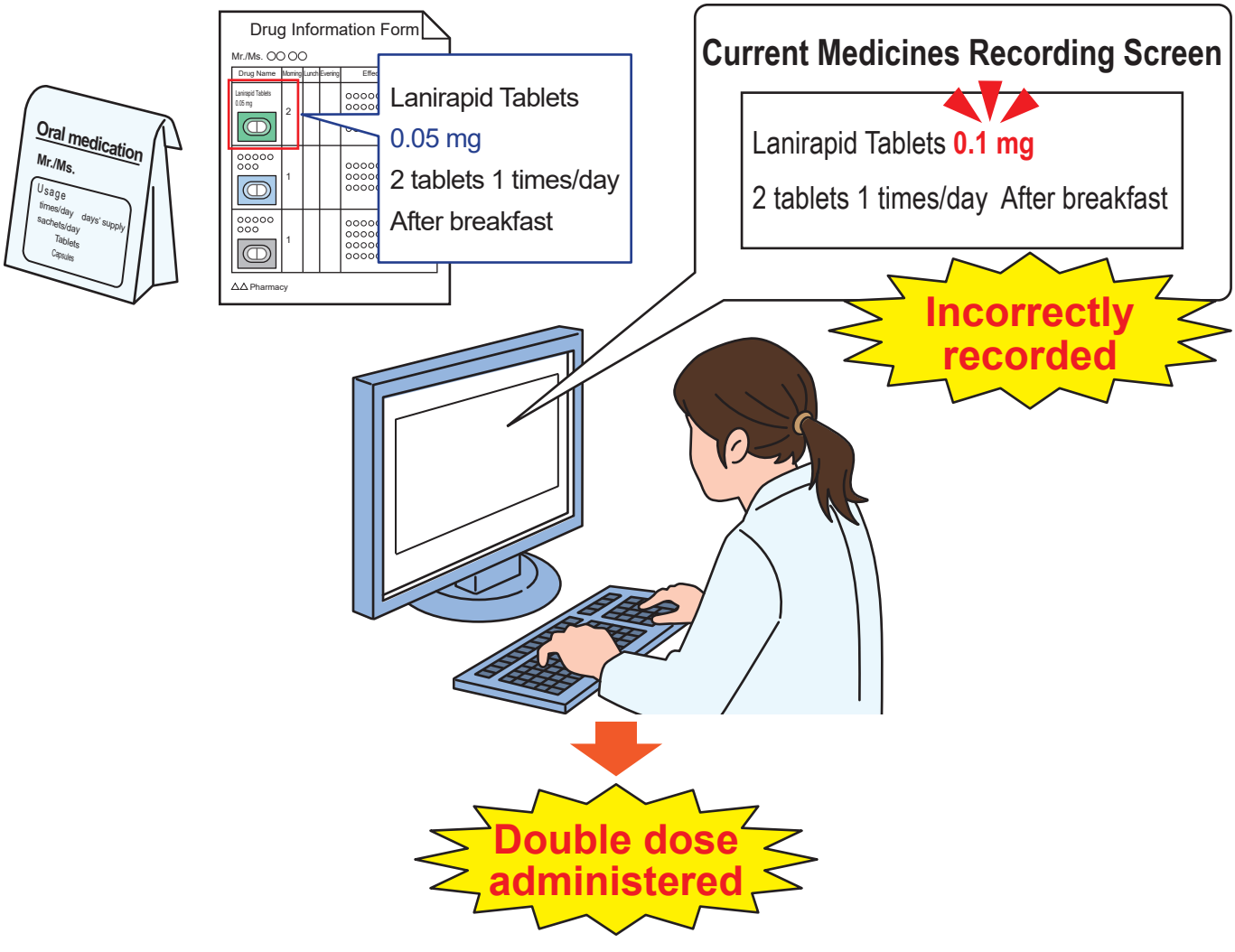
No.206

Wrong Quantity Prescribed When Switching from Medicines Brought in at Hospitalization to Internal Prescriptions (1st Follow-up Report)

Cases have been reported in which the pharmacist incorrectly recorded the quantity of medicines brought in at hospitalization and that quantity was administered without being rectified.

Information was originally provided in Medical Safety Information No.78 “Wrong Quantity Prescribed When Switching from Medicines Brought in at Hospitalization to Internal Prescriptions” (May 2013). Subsequently, seven events of this nature were reported between January 1, 2019 and November 30, 2023. This information was compiled on the basis of the content featured in the Recurrence of Events and Occurrence of Similar Events section of the 70th Quarterly Report.

Image of case 1



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Medical Safety Information No.206 Jan. 2024

Wrong Quantity Prescribed When Switching from Medicines Brought in at Hospitalization to Internal Prescriptions (1st Follow-up Report)

Case 1

The patient was taking “Lanirapid Tablets **0.05 mg**, 2 tablets 1 times/day: after breakfast,” along with two other medicines. When preparing the Current Medicines Identification Sheet based on the medicines brought in at hospitalization and the Drug Information Form, the ward pharmacist incorrectly recorded the Lanirapid Tablets as “**0.1 mg**, 2 tablets 1 times/day: after breakfast” The following day, the physician prescribed the tablets as stated on the Current Medicines Identification Sheet. Subsequently, after being told by the patient that the drug quantity differed from what they had been taking until now, the nurse informed the ward pharmacist. When the ward pharmacist checked, they discovered that the correct quantity was “Lanirapid Tablets 0.05 mg.”

Case 2

The patient had been prescribed “Rivotril Fine Granules 0.1% 0.5 g (product volume) 2 times/day: after breakfast and dinner” at another medical institution. At the time of admission, the pharmacist prepared the Current Medicines Identification Sheet based on the medicines brought in at hospitalization and the patient’s medication notebook. At the medical institution in question, the standard practice was to report medications based on the active ingredient dosage. Whereas the pharmacist should have recorded it as **0.5 mg**/day, they calculated the active ingredient dosage incorrectly and recorded it as “**5 mg**/day.” The physician prescribed 5 mg/day of Rivotril Fine Granules 0.1%, as stated on the Current Medicines Identification Sheet. The patient subsequently became drowsy.

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

-Pharmacists will record on the electronic medical record the information from the patient’s medication notebook, the Drug Information Form, and other information referred to when identifying medicines brought in at hospitalization, so that it can be checked.

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

Key Preventive Measures

○ **Ensure pharmacists are aware that it is difficult to correct information about medicines brought in at hospitalization once it has been recorded incorrectly, and that recording incorrect information can lead to prescription errors.**

(Comprehensive Evaluation Panel)

* 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.
* 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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