

## Oral Medication Interrupted Due to Omission from Prescription at Discharge

Cases have been reported in which a patient's oral medication was interrupted because the drug the patient was supposed to take after discharge was omitted from their discharge prescription.

Six such cases were reported between January 1, 2020 and May 31, 2025. This information was compiled on the basis of the content featured in the Analysis Themes section of the 76th Quarterly Report.

### Main Background Factors of Reported Events

Prescribed separately from regular prescription	<ul style="list-style-type: none"> <li>-While adjusting the dosage of Predonine due to the patient's condition, the physician prescribed the drug separately from the patient's regular prescription, but only prescribed the drugs on the regular prescription at the time of discharge.</li> <li>-The physician intended to add Predonine to the discharge prescription after checking the dosage with a senior physician, but forgot to do so.</li> <li>-The physician resumed Samsca granules after a drug holiday, but omitted the Samsca granules from the discharge prescription because the timing differed from the prescription date of the other drugs.</li> </ul>
Prescribed by other clinical department jointly providing treatment	<ul style="list-style-type: none"> <li>-The physician in the department of gastrointestinal medicine had been prescribing Takecab Tablets to a patient admitted to the urology department, but did not check which clinical department would prescribe the drug at the time of discharge.</li> </ul>

### Image of case 1

While hospitalized

Regular Prescription
XX Tablets
YY Tablets

Temporary Prescription
Predonine Tablets



At discharge

Discharge Prescription
XX Tablets
YY Tablets



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### Case 1

The patient had been admitted for treatment of dermatomyositis and steroid induced diabetes. The physician prescribed Predonine separately from the patient's regular prescription, because they were adjusting the dosage of the drug. Planning to reduce the dosage of Predonine from the time of discharge, the physician intended to add it to the discharge prescription after checking the dosage with a senior physician, but forgot to do so. The nurse did not notice that Predonine Tablets did not appear on the discharge prescription. After discharge, the patient experienced disturbance of consciousness and was brought in as an emergency.

### Case 2

The patient had been admitted to the urology department for treatment of bladder cancer. As the patient was found to have a hemorrhagic duodenal ulcer, the gastroenterologist performed endoscopic hemostasis and began administration of Takepron Intravenous. After the patient resumed meals, the gastroenterologist switched to oral administration of Takecab Tablets. The Takecab Tablets were not prescribed at the time of discharge, because neither the gastroenterologist nor the urologist had checked which clinical department would prescribe them. After discharge, the patient again suffered a hemorrhage from their duodenal ulcer and was hospitalized.

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

**-Physicians will check that drugs deemed necessary on the basis of the patient's medical history and progress of treatment have been prescribed.**

**-Pharmacists and nurses will check that drugs that the patient should take orally after discharge have not been omitted from the discharge prescription.**

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

### Key Preventive Measures

- Remember that the following drugs have a higher tendency to be omitted from discharge prescriptions:
  - Drugs that were prescribed separately from regular prescriptions
  - Drugs that were prescribed by another clinical department jointly providing treatment
  - Drugs that have been switched from injection drugs to oral medication
  - Drugs that have been subject to a temporary drug holiday

(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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