Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.22, September 2008

Wrong prescription related to chemotherapy protocol

Twenty five cases of wrong prescription related to chemotherapy protocol have been reported. Among these, five cases of administration of anti-tumor agent on a drug holiday due to wrong prescription, have been reported (information collection period, from January 1, 2006 to July 31, 2008; the infomation is partly included in "Medical Adverse Event Information to Be Shared" in the 11th Quarterly Report).

Cases of administration of anti-tumor agent on a drug holiday due to wrong prescription have been reported.

Scheduled protocol	Implemented administration Administration date of ■ was incorrect
Randa Inj. Only Day 1 5-FU Injection Day 1-5	Randa Inj. Day 1-3 5-FU Injection Day 1-5
Nidran For Injection Only Day 1 (concurrent administered medicine: unknown)	Nidran For Injection Day 1-3 (concurrent administered medicine: unknown)
Carboplatin Only Day 1 Topotecin Intravenous Drip Infusion Day 1, 8, 15	Carboplatin Day 1, 8 Topotecin Intravenous Drip Infusion Day 1, 8, 15
Carboplatin Only Day 1 Paclitaxel Inj. (administration day: unknown)	Carboplatin Day 1, 8, 15 Paclitaxel Inj. (administration day: unknown)
Adriacin Injection Only Day 1 Briplatin Injection Day 1-7	Adriacin Injection Day 1, 8 Briplatin Injection Day 1-8

◆ In addition to these, drug mix-ups and wrong doses have also been reported as wrong administration related to chemotherapy protocol.

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Case 1

In the protocol, "Randa (Day 1 only)+ 5-FU (Day 1-5)" were planned to be administered. However, the physician erroneously prescribed Randa for both Day 2 and Day 3, and administered it to the patient.

Case 2

In the protocol, "Carboplatin (Day 1 only)+Topotecin (Day 1, 8, 15)" were planned to be administered. However, the physician erroneously input "Carboplatin Day 8" in the computer, and administered it to the patient.

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

- **Share the protocol with patient, physicians, pharmacists, and nurses, etc.**
- **Carry out the prescription and the prescription verification based on the protocol.**

* 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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