Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

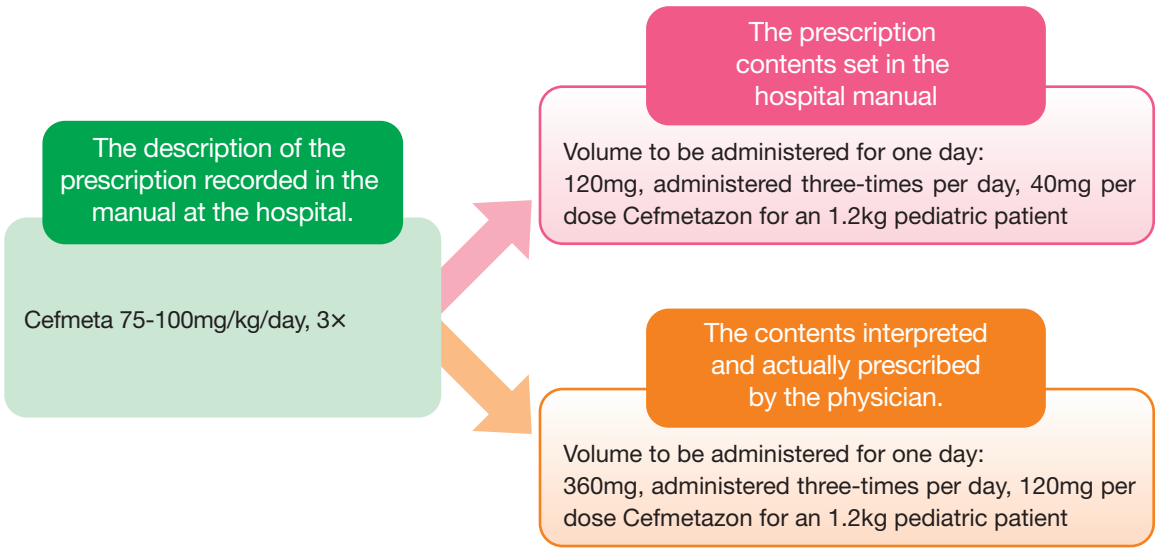
Medical Safety Information

No.41, April 2010

# Drug administered at a wrong dose level due to discrepancy in interpretation of prescription (1st follow-up Report)

Information regarding administration of drug at a wrong dose level due to discrepancy in interpretation of prescription was released as Medical Safety Information No.18 (May 2008). After that, one similar case was reported, so the information is provided here again. (information collection period: from April 1, 2008 to February 28, 2010)

## Misunderstanding between administered drug dosage due to prescription such as "3×" or "3 parts" being interpreted to mean "3 times," have been reported again.



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## Case

When administering an antibiotic to a pediatric patient weighing approximately 1.2kg, the senior physician and the physician read "Cefmeta 75-100mg/kg/day, 3×" in the in-house manual together, and calculated the administration dose. The senior physician said "Cefmeta 120, right?" to the physician, intending to confirm the dose for a day which they calculated together, and requested the physician to input the order. The physician interpreted what the senior physician said as "Cefmetazon 120mg per dose, three-times per day," and prescribed and administered it to the patient.

### Preventive measures taken at the medical institution in which the event occurred.

**Amend the dose described in the manual for clearer dose interpretation, showing whether the dose is for one day or for one time.**

### Complementary comment by the Comprehensive Evaluation Panel

**For prescription description, please refer to "Report on the conference concerning oral medication prescription notation methods."**

- The report has been included in the website of the Ministry of Health, Labour and Welfare http://www.mhlw.go.jp/shingi/2010/01/s0129-4.html
- "Announcement from the Ministry of Health, Labour and Welfare" regarding the report described above is included in the 2009 Annual Report (p.359)

* 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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