Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.78, May 2013

Wrong Quantity Prescribed When Switching from Medicines Brought in at Hospitalization to Internal Prescriptions

Four cases have been reported involving the wrong quantity being prescribed when switching from medicines brought in at hospitalization to internal prescriptions (information collection period: from January 1, 2009 to March 31, 2013; the information is partly included in "Individual Theme Review" (p.74) in the 9th Quarterly Report).

Cases of the wrong quantity being prescribed when switching from medicines brought in at hospitalization to internal prescriptions have been reported.

Drug Brought in	Drug Prescribed in Hospital	Scale of Overdose	Background to Prescription of Wrong Quantity
Halcion tablets 0.125mg 1 tablet	Halcion tablets 0.25mg 1 tablet	2 times	Identical standard unavailable
Aspenon capsules 10mg 4 capsules	Aspenon capsules 20mg 4 capsules	2 times	
Hydantol combination tablets* 6 tablets	Hydantol tablets 100mg* 6 tablets	4 times	
Asverin tablets 10mg 6 tablets	Asverin powder 100mg/g 6g	10 times	Identical dosage form unavailable

* Active ingredient dosage in Hydantol combination tablets and Hydantol tablets 100mg:
12 Hydantol combination tablets contain 300mg of Phenytoin and 100mg of Phenobarbital.
1 Hydantol tablet contains 100mg of Phenytoin.

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Case 1

After admission, the patient was taking the medicines brought in at hospitalization, but they ran out, so the physician switched to an internal prescription. In doing so, the physician ascertained that the referral letter stated "Aspenon capsules 10 4C 2 times/day, after breakfast and dinner". When s/he then entered "Aspenon" in the computer, only Aspenon capsules 20mg were displayed, as the 10mg standard was not used in the hospital. In the case of Aspenon capsules 20mg, the prescription should have been 2 capsules 2 times/day, but the physician did not notice that the dosage was different, so s/he prescribed 4 capsules 2 times/day. The patient suffered convulsions one morning, five days after discharge, and was taken to another medical institution as an emergency.

Case 2

At the time of admission, the patient was taking 6 Hydantol combination tablets 2 times/day, which had been prescribed by another medical institution. When switching to an internal prescription, the physician prescribed four days' supply of 6 Hydantol tablets 100mg 2 times/day, which was the internal prescription, as s/he was unaware that the quantity of Phenytoin and the active ingredient content in Hydantol combination tablets differed from those in Hydantol tablets. The pharmacist did not notice the mistake and dispensed the drug in accordance with the prescription. The physician noticed his/her mistake because the pharmacist submitted an inquiry about the prescription when dispensing the next prescription, querying the fact that the quantity of Phenytoin was above the upper daily limit.

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

- **When switching from medicines brought in at hospitalization to an internal prescription, attention will be paid to the standard, dosage form, and active ingredient dosage when entering prescriptions.**
- **The pharmacist will be involved as much as possible when switching a patient from medicines brought in at hospitalization to an internal prescription.**

* 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 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 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.

Division of Adverse Event Prevention
Japan Council for Quality Health Care
1-4-17 Misakicho, Chiyoda-ku, Tokyo 101-0061 JAPAN
Direct Tel: +81-3-5217-0252 Direct Fax: +81-3-5217-0253
http://www.jcqhc.or.jp/