

Pharmaceuticals and Medical Devices Agency

Pmda No. 44 May 2014

Medication Errors in Prescription Orders

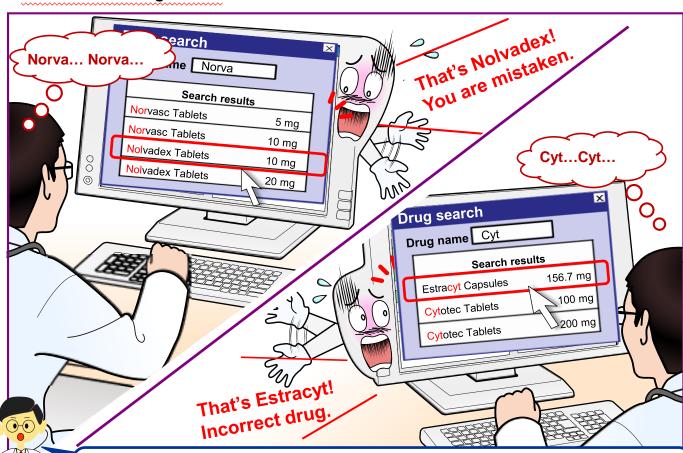
# **POINT** Key points for safe use

(Case 1) Nolvadex\* Tablets were mistakenly prescribed instead of Norvasc Tablets.

\* A number of prescribing or selecting error cases involving name confusion between "Norvasc" and "Nolvadex" may occur because this name pair share the same first three Japanese letters string, 'ノルパ'.

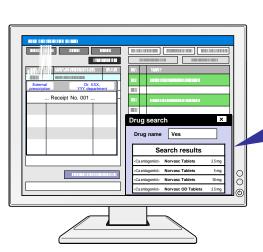
(Case 2) Estracyt Capsules were mistakenly prescribed instead of Cytotec Tablets.

- 1 Selection errors of medicine names in prescription ordering system (Part 1)
  - The prescription ordering system should be designed to reduce risks of selection error due to similar drug names.



Other than those above cases, any number of selection errors involving name confusion between "Myslee Tablets" and "Mystan Tablets" name pair and "Seroquel Tablets" and "Cerocral Tablets" name pair have been reported!

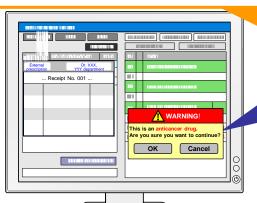
## Suggestion for the correct prescription order 1



Display therapeutic category before the product name, as shown on the diagram.



"WARNING" displayed for high-risk medications such as anticancer drugs.

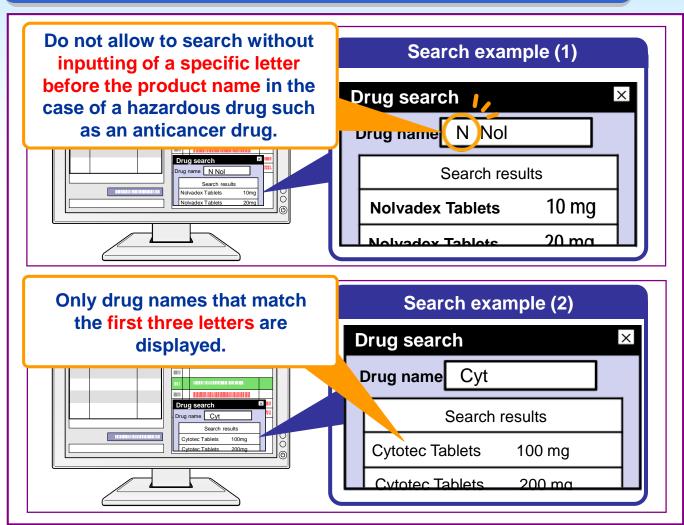






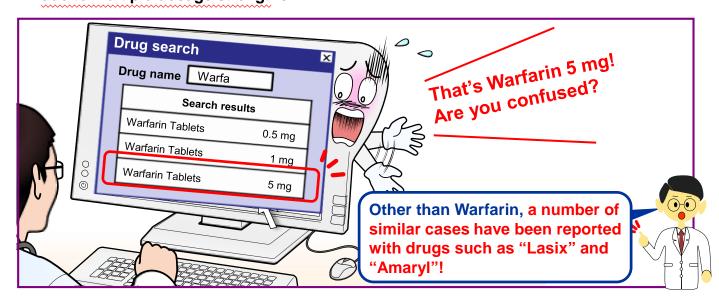
Alerts such as "therapeutic category" or "warning" on the screen can be designed for prescribing orders to prevent selection errors.

### Suggestion for the correct prescription order 2

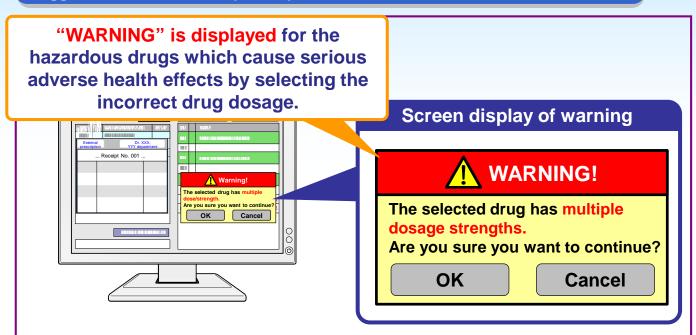


(Case 3) Warfarin Tablets 5 mg were mistakenly prescribed instead of Warfarin Tablets 0.5 mg.

- 2 Selection errors of medicine names in prescription ordering system (Part 2)
  - The prescription ordering system should be designed to reduce risks of selection error due to multiple dosage strengths.



#### Suggestion for the correct prescription order 3





Check the prescription ordering system in the hospital and modify the ordering display and search method as necessary to prevent drug selection errors. Design systems as shown above to prevent drug selection errors when installing the new system.

\*Related information is available at the following manual (only available in Japanese language)
Medical Safety Manual for Healthcare Professionals. Japan Medical Association; Table 73, page 141

http://www.med.or.jp/anzen/manual/menu.html

#### About this information

- \* PMDA Medical Safety Information is issued by the Pharmaceuticals and Medical Devices Agency for the purpose of providing healthcare providers with clearer information from the perspective of promoting the safe use of pharmaceuticals and medical devices. The information presented here has been compiled, with the assistance of expert advice, from cases collected as Medical Accident Information Reports by the Japan Council for Quality Health Care, and collected as Adverse Drug Reaction and Malfunction Reports in accordance with the Pharmaceutical Affairs Law.
- \* We have tried to ensure the accuracy of this information at the time of its compilation but do not guarantee its accuracy in the future.
- \* This information is not intended to impose constraints on the discretion of healthcare professionals or to impose obligations and responsibility on them, but is provided as a support to promote the safe use of pharmaceuticals and medical devices by healthcare professionals.