Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

Medical Safety Information released in 2014

No.100, March 2015

Medical Safety Information No.86-No.97 was issued monthly from January to December 2014. The full list of bulletins is shown below.

No.	Title
No.86	★ Administration of Contraindicated Drug
No.87	★ Burns during a Foot Bath or Shower
No.88	Medical Safety Information released in 2013
No.89	Syringe Pump Mix-up
No.90	★ Catheter or Tube Erroneously Cut with Scissors
No.91	Medical Safety Information released from 2006 to 2012
No.92	Forgetting to Connect Ventilator Hoses
No.93	Wrongly Registered Antineoplastic Drug Regimen
No.94	★ Magnetic Material (e.g. Metal Products) Taken in the MRI Room (1st Follow-up Report)
No.95	Dead Battery in a Central Monitor Transmitter
No.96	Insulin Pen Mix-up
No.97	Wrong Choice of Pneumococcal Vaccine Preparation

For titles with ★, similar cases had been reported after the release of each issue until December 31, 2014.

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◆ The following similar cases occurred.

No.86 Administration of Contraindicated Drug

A patient with Parkinson's disease was in an excited state, so the medical professional involved administered an injection of Serenace as a sedative, forgetting that Serenace is contraindicated for patients with Parkinson's disease.

No.87 Burns during a Foot Bath or Shower

The nurse filled a bucket with hot water and transferred it into the handbasin in the patient's room, to bathe the patient's hands and feet. When doing so, the nurse did not use a thermometer and adjusted the temperature of the hot water while wearing gloves. When s/he placed the patient's left hand into the handbasin, the skin turned red, so the nurse immediately removed the patient's hand from the handbasin. When s/he checked the patient's skin, s/he found excoriation. A dermatologist subsequently examined the patient and diagnosed him/her with a second-degree burn.

No.94 Magnetic Material (e.g. Metal Products) Taken in the MRI Room (1st Follow-up Report)

An MRI examination was carried out on a patient into whom a J-VAC® portable low-pressure continuous suction system had been inserted. When the patient sat down on the examination table in the MRI room, the reservoir (standard type) began to be pulled toward the gantry, but the bag was inside a pouch hung around the patient's neck, so the drain was not dislodged. The reservoir bore the warning "Do not use around MRI equipment, etc. Contains metal springs." However, this warning was not visible, because the reservoir was inside a pouch.

◆ Other similar cases are included in the Annual Report 2014.

* 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.

Department 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/