Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

Medical Safety Information released from 2011 to 2013

No.103, June 2015

Cases similar to those published in Medical Safety Information bulletins in 2011-2013 were reported again in 2014.

- This table shows the number of recurrent and similar events to those highlighted in Medical Safety Information bulletins since 2011 (No.50 onwards).
- Where five or more recurrent and similar events were reported, a case relevant to that Medical Safety Information bulletin is also described.

No.[1)]	Title	Number of cases reported in 2014
No.50	**Wrong site surgery (right/left) (1st Follow-up Report)**	8
The physician diagnosed a right chronic subdural hematoma from a CT and wrote the order “Right” on the surgical handover form. However, the physician did not mark the area. After entering the operating theater, while the nurse was measuring the patient’s vital signs and preparing for surgery, the physician shaved the left side of the patient’s head and, murmuring “I will operate on a right chronic subdural hematoma” to him/herself, commenced the operation. While making the incision into the dura mater, the physician noticed that there was no hematoma and realized that s/he had mixed up left and right. (There were seven other similar cases: Medical Safety Information No.8 (July 2007: 1st Follow-up Report was released in January 2011))		
No.54	**Accidental removal of the endotracheal/tracheostomy tube when changing positions**	1
No.56	**Burns caused by a high-frequency electric current loop during MRI examination**	2
No.57	**Accidental ingestion of PTP sheets**	5
When distributing patients’ drugs, the nurse placed the patient’s drugs - still in the PTP sheet - in a medicine cup and handed them to the patient. After taking the drugs, the patient felt discomfort in his/her throat and was coughing, but the nurse thought that the patient had accidentally aspirated some food, so s/he carried out suction and kept the patient under observation. The following morning, the patient reported that s/he had “taken the tablet along with the ‘shell’” and a CT examination confirmed the accidental ingestion of the PTP sheet. (There were four other similar cases: Medical Safety Information No.82 (September 2013: 1st Follow-up Report))		
No.58	**Rupture of the subcutaneous port and catheter**	2
No.59	**Burns Due to Incorrect Handling of an Electrosurgical Pencil**	8
The physician did not notice that the electrosurgical pencil was under a piece of gauze near the operative field and placed his/her hand on it. When the physician did so, s/he inadvertently switched on the electrosurgical pencil and the patient sustained a burn measuring 5.5mm on his/her left heel. (There were seven other similar cases)		
No.61	**Contraindicated Combined Administration of Drugs**	1
No.62	**Insufficient Confirmation Concerning Medical Devices Implanted into the Patient's Body**	2
No.63	**Inadequate Checks Concerning Diagnostic Imaging Reports**	9
When a CT was performed to investigate post-operative fever, the patient was found to have peritonitis, so treatment was carried out. The physician did not look at the radiologist’s comments on the interpretation of the image at that stage. Three years later, when the department of respiratory surgery at another medical institution requested a patient referral document for the patient, the physician noticed a comment concerning “a nodular lesion on the right lung field” on the CT from three years earlier. (There were eight other similar cases)		

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No.[1)]	Title	Number of cases reported in 2014
No.66	Misconception of insulin content (1st Follow-up Report)	1
No.68	Drug mix-up (1st Follow-up Report)	3
No.69	Provision of Food to Which the Patient was Allergic	5
At the time of admission, the patient disclosed allergies to beef and pork, so a meal order stating “No beef/pork” was issued. Dinner on the day in question was meatloaf, so an alternative meal of miso-baked fish was supposed to be provided. However, the cook placed the meatloaf on the patient’s tray, without checking the meal information card, which stated “no beef/pork” in red letters, as well as “alternative meal.” The patient consumed the meatloaf, thinking it to be a fish product, and developed allergic symptoms. (There were four other similar cases)		
No.70	Burns Caused by the Tip of a Light Source Cable during Surgery	4
No.71	Forgetting to Check the Pathologic Diagnosis Report	4
No.73	Patient Mix-up during Radiological Examinations	2
No.77	Vasculitis due to administration of gabexate mesilate (1st Follow-up Report)	2
No.78	Wrong Quantity Prescribed When Switching from Medicines Brought in at Hospitalization to Internal Prescriptions	1
No.80	Urethral Damage Caused by an Indwelling Bladder Catheter	14
The nurse inserted an indwelling bladder catheter into a male patient. Although no urine was discharged, the nurse was able to insert it without any resistance, so s/he injected 10mL of sterile distilled water into the balloon. Bleeding from the urethral opening was subsequently noticed and the patient was diagnosed with urethral damage. (There were 13 other similar cases)		
No.81	Body Part Trapped in Gaps in Side Rails, etc. When Operating Beds	1
No.83	Failure to Reopen All Clamps on a Cerebrospinal Fluid Drainage Circuit	1
No.84	Insufficient Confirmation of Incorrect Prescription	1
No.85	Accidental Removal of a Drain/Tube during Transfer	2

1) “No.” indicates the provision number of the Medical Safety Information.

◆ Other similar cases are to be 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.

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