Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.111, February 2016

Delays in Urgent Contact Regarding Panic Values

Three cases have been reported involving delays in urgent contact with physicians in situations where laboratory data were indicative of the medical institution's predetermined panic values (information collection period: from January 1, 2012 to December 31, 2015). The information is compiled based on "Individual Theme Review" (p.152) in the 42nd Quarterly Report.

Cases of patient treatment being delayed due to the failure to make urgent contact with physicians regarding panic values have been reported.

Laboratory Data		Background
Glucose	800mg/dL	• Few people were on duty during the lunch break, so the clinical laboratory technologist had no time to spare and forgot to report the result.
Glucose	892mg/dL	• The clinical laboratory technologist telephoned the outpatient section of the department of internal medicine, but nobody picked up and the electronic medical record showed that the patient had already paid the bill, so the technologist did not report the result.
Potassium	6.4mEq/L	• The clinical laboratory technologist informed the outpatient nurse, but was told to telephone the ward because the patient had already been admitted, so the technologist informed the ward nurse. • The ward nurse did not know how to contact the physician when the physician was not present.

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Case 1

A blood test carried out before the consultation revealed lowered hemoglobin levels, so an iron preparation was prescribed and the patient went home. At the time of the consultation, the patient's blood glucose level was displayed as "under examination," but in fact, it was being re-tested, due to an abnormal value. The patient's blood glucose level was 800mg/dL, so the clinical laboratory department should have reported this to the physician as a panic value, but few people were on duty during the lunch break, so the clinical laboratory technologist had no time to spare and forgot to contact the physician. The patient telephoned 10 days later, complaining of feelings of fatigue, so the physician checked the previous test results and discovered that the patient's blood glucose level had been 800mg/dL, so the patient was admitted to the hospital.

Case 2

After having a blood sample taken as an outpatient, the patient was admitted. The patient was experiencing general malaise and the ward nurse confirmed that the patient's blood pressure was 80/50mmHg. In addition, the patient was experiencing respiratory distress, with SpO_2 of 89%. The patient's serum potassium level indicated a panic value (6.4mEq/L), so the clinical laboratory technologist re-tested it and then reported it to the outpatient nurse. The outpatient nurse asked the clinical laboratory technologist to contact the ward directly, so the technologist reported the serum potassium level to the ward nurse. The ward nurse did not know how to contact the physician when the physician was not present, so the panic value was not communicated to the physician.

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

- **All staff will be made aware of the reporting procedure in the event that laboratory data are indicative of a panic value.**
- **When making contact about panic values, the clinical laboratory department will leave a record showing the test result, the person who contacted the physician, and the name of the physician whom s/he contacted.**
- **The institution will establish a contact/response system for situations in which the physician is not present and will ensure that all staff are aware of it.**

* 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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