Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

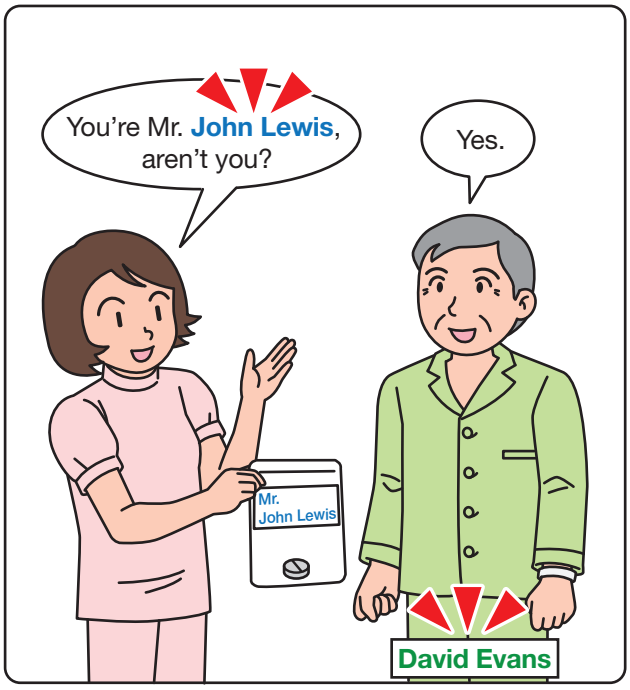
No.116, July 2016

Patient Mix-up in Drug Administration

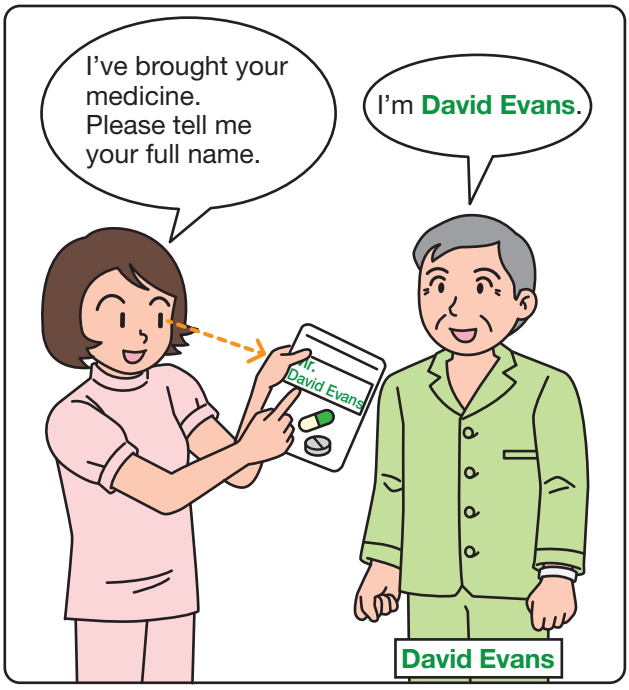
Six cases have been reported involving patient mix-up in drug administration, due to inadequate checks of the patient's name (information collection period: from January 1, 2013 to May 31, 2016). The information is compiled based on "Individual Theme Review" (p.129) in the 42nd Quarterly Report.

Cases of patient mix-up in drug administration due to failure to check the patient's name or use of an inappropriate method of checking it have been reported.

Image of case 1



Example of Patient Identification



◆ The reported cases also included a case in which only the family name was checked and a case in which the name band of a patient unable to give his/her own name was not checked.

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Case 1

A nurse carried a drug with Patient B's name written on it and went to Patient A. The nurse assumed Patient A to be Patient B, and called the patient by his/her full name saying, "Are you Mr./Ms. B?" while showing the patient the drug for Patient B. Patient A answered, "Yes," and took one 40-mg furosemide tablet that had been prescribed for Patient B. Immediately after that, the nurse saw the name on Patient A's wristband and noticed the error.

Case 2

When administering a hypnotic drug to Patient B, a nurse assumed Patient A to be Patient B, and went to the room of Patient A who was of the same sex and similar in age to Patient B. The nurse administered the hypnotic drug that had been prescribed for Patient B to Patient A through a gastric tube without cross-checking the patient's name on the drug package and that on the patient's wristband. Later, when Patient A's airway was obstructed by his/her tongue, the nurse realized that there had been no order to administer a hypnotic drug to Patient A. Looking into Patient A's trash basket, the nurse found an empty drug package with Patient B's name written on it.

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

- **When administering drugs, staff members will check the name on the drug package, etc. against that on the wristband.**
- **When checking a patient's name verbally, staff members will have the patient give his/her name and will check it against the name on the drug package, etc.**

* 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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