Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.134, January 2018

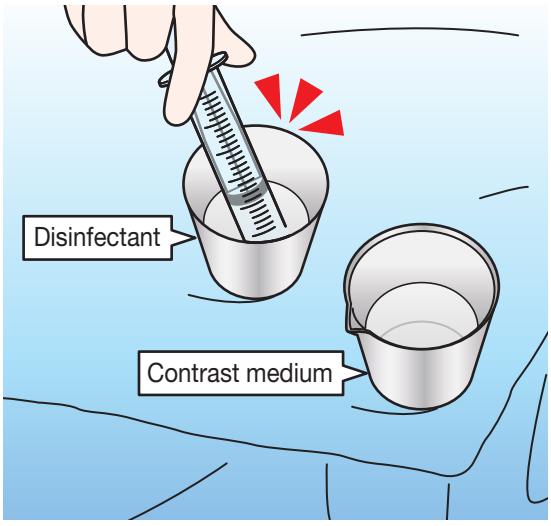
Erroneous Administration of Disinfectant in the Sterilized Area

Four cases have been reported in which disinfectant was drawn up into a syringe and administered in error while multiple containers of drugs were placed in the sterilized area at the time of surgery or treatment (information collection period: from January 1, 2014 to November 30, 2017). This information was compiled on the basis of the content featured in the Analysis Theme “Events Related to Erroneous Use of a Drug in a Container in the Sterilized Area” (49th Quarterly Report).

Cases have been reported in which disinfectant was administered in error while the disinfectant container remained in the sterilized area even after use.

Usage	Drug Meant To Be Administered	Disinfectant Administered in Error
Coronary artery injection	Contrast medium	Hypo Ethanol Solution 2%
Intravenous injection	Contrast medium	Popiyodon Solution 10%
Subcutaneous injection	Xylocaine Injection Polyamp 1%	Germitol Water
Rectus sheath block	0.3% preparation of Anapeine	0.05% Hexizac Water R

Image of case 1



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Case 1

When performing coronary angiography, the disinfectant (Hypo Ethanol Solution 2%) and the contrast medium were prepared in containers of similar size and shape. Neither container was labeled with the name of the drug inside. Physician A ordered Physician B to draw up the contrast medium into a syringe. Physician B assumed that the disinfectant was the contrast medium and drew it up into a syringe, which they handed to Physician A. Physician A injected the disinfectant in the syringe into the coronary artery.

Case 2

For an operation, disinfectant (Germitol Water) and swabs were prepared in a plastic container, while Xylocaine was prepared in a beaker labeled as local anesthetic. After all the swabs were used to disinfect the operative field, the container holding the disinfectant and the beaker holding the Xylocaine were left on the instrument tray. Both were transparent drug solutions. When administering local anesthesia, the assistant physician drew up the disinfectant into a syringe, having mistaken the liquid for Xylocaine, and passed the syringe to the surgeon. The surgeon administered a subcutaneous injection of the disinfectant in the syringe.

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

- **Containers of disinfectant will not be placed in the sterilized area after disinfection.**
- **Containers used in the sterilized area will be labeled with the drug name.**

* 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 the Project website for details.
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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