Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

Medical Safety Information released in 2018

No.148, March 2019

Medical Safety Information No.134–No.145 was issued from January to December 2018. The full list of bulletins is shown below.

No.	Title
No.134	★ Erroneous Administration of Disinfectant in the Sterilized Area
No.135	★ Failure to Release Standby Mode When Resuming Ventilation (1st Follow-up Report)
No.136	Medical Safety Information released in 2017
No.137	★ Burns When Using a Heat Pack
No.138	★ Inadequate Checks Concerning Diagnostic Imaging Reports (1st Follow-up Report)
No.139	Medical Safety Information released from 2014 to 2016
No.140	Administration of an Antineoplastic Agent in Excess of the Total Dosage Limit
No.141	Falls from an Examination Table
No.142	★ Urethral Damage Caused by an Indwelling Bladder Catheter (1st Follow-up Report)
No.143	Error When Refilling a Prescription Due to Failure to Revise Prescription Details
No.144	★ Failure to Submit a Pathology Specimen
No.145	Administration of the Usual Dosage of Drugs for Patients with Impaired Renal Function

For titles with ★, recurrent and similar events had been reported after the release of each issue until December 31, 2018.

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No.148, March 2019

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◆ These are recurrent and similar events reported in 2018.

No.135 Failure to Release Standby Mode When Resuming Ventilation (1st Follow-up Report)

After a tracheal intubation, Physician A used a Jackson-Rees circuit for manual ventilation, while the nurse carried out tracheal suction. The ventilator alarm continued to sound, so the nurse placed the ventilator in standby mode, but failed to tell anyone. Physician A subsequently fitted the ventilator, but did not check whether it was ventilating. About six minutes later, Physician B noticed that the ventilator was in standby mode.

No.137 Burns When Using a Heat Pack

The occupational therapist placed heat packs on the patient's back in the shoulder area before rehabilitation. When the occupational therapist removed the heat packs 40 minutes later, they checked whether the patient had felt too hot. The patient said, "It was fine," so the occupational therapist did not look at the condition of the skin. The following day, the areas with which the heat packs had been in contact had blistered and burned.

No.138 Inadequate Checks Concerning Diagnostic Imaging Reports (1st Follow-up Report)

A thoracoabdominal CT examination was carried out on the day of the outpatient consultation as a follow-up after surgery for an aortic aneurysm. At the time of the consultation, the physician looked at the image and checked the site of the aortic anastomosis, but did not notice a lesion in the liver. A diagnostic imaging report was prepared after the consultation, but the physician forgot to check it. A neurologist who was following up a cerebral infarction subsequently noticed that the diagnostic imaging report mentioned hepatocellular carcinoma.

No.142 Urethral Damage Caused by an Indwelling Bladder Catheter (1st Follow-up Report)

The nurse inserted an indwelling bladder catheter into a patient. Although the nurse was unable to confirm the discharge of urine, it was able to be inserted without any resistance, so the nurse injected sterile distilled water into the balloon. When withdrawing the catheter because no urine was discharged, the nurse noticed bleeding. A urologist examined the patient and diagnosed urethral damage.

* 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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