Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.154, September 2019

Patient Mix-up When Using Electronic Medical Records

Six cases have been reported in which, when using an electronic medical record to issue an order for Patient A, the order was issued in error from the screen for Patient B (information collection period: from January 1, 2015 to July 31, 2019). This information was compiled on the basis of the content featured in the Analysis Themes section of the 56th Quarterly Report.

Cases have been reported in which, when issuing an order for Patient A, the order was issued in error from the screen for Patient B due to a failure to check the patient name on the electronic medical record.

Type of Order	Number of Cases	Main Background Factors
Prescription	2	Patient A and Patient B were admitted at night and orders for both patients had to be entered at the same time. The physician intended to order a prescription for Patient A, but entered the order on Patient B's screen
Blood transfusion	2	When ordering red blood cells (RBC) in the operating room for Patient A from the blood transfusion department, the physician did not notice that the screen for Patient B, who had been operated on immediately beforehand, was open
Blood test	2	The electronic medical record near Patient A's bed in ICU had Patient B's screen open, but the physician assumed it was Patient A's screen

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Case 1

At night, Patient A was admitted to the critical care unit due to status epilepticus, while Patient B was admitted to the pediatric ward due to fever. The physician prescribed Fostoin for Injection for Patient A from Patient B's screen without checking the patient name on the electronic medical record. The critical care unit nurse subsequently reported that Patient A's Fostoin for Injection had not been prescribed. The physician prescribed the drug from Patient A's screen, thinking that the details entered had not been recorded in the system. When the pharmacist checked with the physician after becoming concerned that Fostoin for Injection had been prescribed for two patients in succession, they discovered that the drug had been prescribed for Patient B in error.

Case 2

When ordering red blood cells (RBC) in the operating room for Patient A from the blood transfusion department, the electronic medical record was showing the screen for Patient B, who had been operated on immediately beforehand. The physician issued the order without checking the patient name and the blood transfusion department dispensed RBC for Patient B.

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

- **Check the patient name on the electronic medical record every time when entering an order.**
- **Set electronic medical records to log off automatically after a certain period of time.**

* 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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