Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.20, July 2008

Failure to transmit an alteration of instruction

Two cases of the original instructions being implemented although they were altered, due to failure to transmit an alteration of instruction to the related department have been reported. (information collection period, from January 1, 2006 to April 30, 2008; the information is partly included in "Medical Adverse Event Information to Be Shared" in the 10th Report)

Cases of original instructions being implemented although they were altered, due to failure to transmit an alteration of instruction to the related department have been reported.

Original instructions	Alterations	Altered documents	Actions implemented / Not implemented
Administration of anti-tumor agent	Cancellation of administration	Injection instructions (Input on-screen)	Altered (Transmitted to an administration office)
		Medical chart	Unaltered
		Injection sheet	Unaltered
Right eye surgery	Changed the side to the left eye	Preoperative administration of eye drop in a ward	Altered
		Surgery application form	Unaltered
		Medical chart	Unaltered

Not transmitted to an outpatient chemotherapy ward

Not transmitted to an operation room

Project to Collect Medical Near-Miss/
Adverse Event Information

Project to Collect Medical Near-Miss/
Adverse Event Information
Medical Safety Information

No.20, July 2008

Failure to transmit an alteration of instructions

Case

The instructions for outpatient chemotherapy are recorded by the physician beforehand on medical record and on injection sheet. This was also entered onto the computer screen for ordering. On the day of examination, the injection sheet is checked after the medical examination is completed.
On the day of the treatment, white blood cell count of the patient was low, therefore, the physician decided to cancel the administration of antitumor drug (IV) for that day. The physician canceled the instruction on a computer screen, but forgot to write down instruction to cancel it on a medical chart. The physician also forgot to cancel it on the injection sheet. When the nurse from the outpatient chemotherapy ward verified the medical chart and injection sheet before beginning treatment, the cancellation of the administration of antitumor drug was not recorded there and the nurse began administering the drugs.

Preventive measures taken at the medical institution in which the event occurred.

Measures shall be developed within the hospital to effectively transmit alterations of instructions.

* 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 "Comprehensive Evaluation Panel" to prevent 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 can not be guaranteed in the future.
* This information is neither for limiting the discretion of healthcare providers nor for imposing certain obligations or responsibilities on them.

Division of Adverse Event Prevention
Japan Council for Quality Health Care
1-4-17 Misakicho, Chiyoda-ku, Tokyo 101-0061 JAPAN
Direct Tel:+81-3-5217-0252 Direct Fax:+81-3-5217-0253
http://www.jcqhc.or.jp/html/index.htm