Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

Medical Safety Information released in 2009

No.40, March 2010

Medical Safety Information No.26 – No.37 was issued monthly from January to December 2009. Please confirm them again.

No.	Title
No.26	Wrong application of reagent strips not designated for a specific blood glucose testing devices
No.27	★Wrong dosage of drug due to incomplete verbal instruction
No.28	Medical Safety Information released in 2008
No.29	★Administration of 10 times proper dosage to pediatric patients
No.30	★Administration of allergy drug to patient with previous known allergy history
No.31	Medical Safety Information Follow-up on issues 2006 and 2007
No.32	Insufficient closure of water trap cup
No.33	★Extravascular leakage of gabexate mesilate
No.34	Surgical fire due to the flammables by electrocautery
No.35	Respiratory depression due to Remifentanil (Ultiva) remained in intravenous infusion line
No.36	Insufficient confirmation of relevant information at a time of tooth extraction
No.37	Failure to resume ventilation without releasing "standby" mode

For titles with ★, similar cases had been reported after the release of each issue until December 31, 2009.

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No.27 Wrong dosage of drug due to incomplete verbal instruction

The physician A intended to administer 3mg (0.3mL) /hr continuous IV of Ketalar to the patient, and verbally ordered the physician B to "administer 3milli per hour." The physician B administered 3mL (30mg) /hr to the patient. The physician A abbreviated the unit of the drug, and verbally gave the instruction. The physician B did not confirm the physician A by repeating the instruction.

No.29 Administration of 10 times proper dosage to pediatric patients

The physician intended to administer "0.45mL" of KCL to a one-month-old pediatric patient, but miscalculated and administered "4.5mL." Later, bradycardia and wide QRS on the ECG was observed, and the reading of SpO_2 varied unstable. Upon confirmation, it was realized that the administration was 10 times the planned dose.

No.30 Administration of allergy drug to a patient with previous known allergy history

Regarding the patient who was emergently admitted to the hospital, "Voltaren" was described on the allergy history of the nursing profile during a previous hospitalization. At the hospital, if patients had any allergy, it should be described on the patient's individual worksheet, but the nurse forgot to do so. The following morning, the patient developed a 38.2°C fever, so another nurse reported the condition to the physician on duty, received verbal instruction to administer Voltaren suppo 50mg, and administered it to the patient. Afterwards, the patient suffered prurigo and dyspnea.

◆ Other similar cases are included in the Annual Report 2009

* 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/