Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.65, April 2012

Wrong Pick-up of Drug Set Out on the Emergency Cart

Three cases have been reported involving the wrong drug being picked up when picking up a drug set out on the emergency cart (information collection period: from January 1, 2008 to February 29, 2012; the information is partly included in “Individual Theme Review” (p.101) in the 22th Quarterly Report).

Cases of the wrong drug being picked up when picking up a drug set out on the emergency cart, despite the name of each drug being displayed on labels have been reported.

Drug which should have been administered	Wrong pick-up	Circumstances of the error
Bosmin	Atropine sulfate	Positioned next to each other with the label between them
Atropine sulfate	Vasolan	
Cercine	Digosin	Looked at the labels and assumed that Digosin was Cercine

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Case 1

When carrying out a bronchoscopy, the nurse picked up Bosmin from the emergency cart, in order to prepare Bosmin in normal saline for the purpose of hemostasis. In doing so, the nurse saw the sticker on the partition between the drugs on the emergency cart, which said Bosmin, but because s/he was rushing, s/he did not check the name of the drug on the ampoule.
After the examination, when checking the emergency cart, s/he noticed that the numbers of Bosmin and atropine sulfate ampoules did not correspond and realized that s/he had used the atropine sulfate, which was positioned next to the Bosmin with the label between them.

Case 2

The patient was suffering convulsions, so the physician gave the verbal order "Cercine" to the nurse. Looking at the labels on the emergency cart, the nurse assumed that Digosin was Cercine and prepared it. The physician injected the prepared medication without checking the name of drug.

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

- **The medical institution will devise ways to make it easy to distinguish the drug names on the emergency cart and will standardize this method within the hospital.**
- **The drug name will be checked when picking up drugs from the emergency cart or preparing syringes.**

* 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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