Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/Adverse Event Information

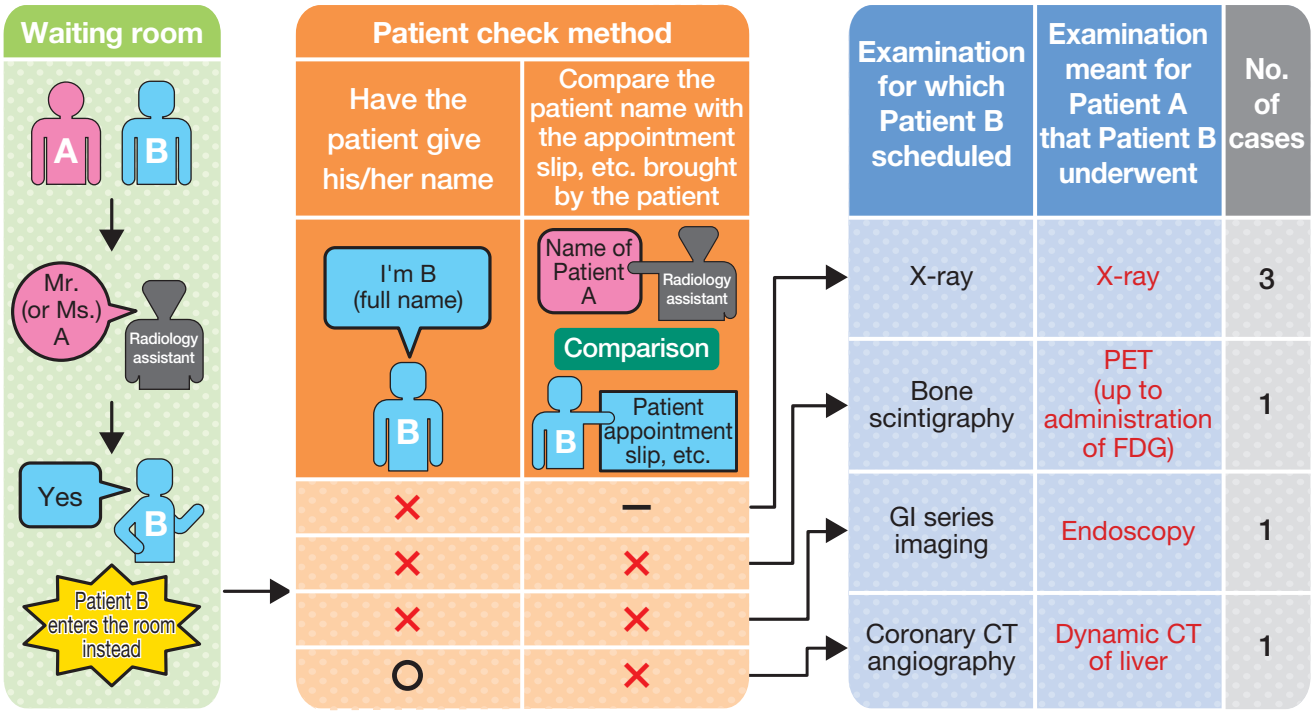
Medical Safety Information

No.73, December 2012

Patient Mix-up during Radiological Examinations

Six cases have been reported involving radiological examinations being carried out on the wrong patient as a result of patient misidentification due to inadequate checks of patient names (information collection period: from January 1, 2008 to October 31, 2012; the information is partly included in “Individual Theme Review” (p.131) in the 19th Quarterly Report).

Cases of inadequate checks of patient names resulting in radiological examinations being carried out despite the wrong patient having entered the room have been reported.



*○ : Procedure was in place and was followed
× : Procedure was in place, but was not followed
— : No procedure in place

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Case 1

X-ray imaging was to be carried out, so the radiological technologist called out only the patient's family name. At that point, the patient him/herself was supposed to give his/her name, but the technologist did not check this. Accordingly, Patient B was misidentified as Patient A and underwent a chest X-ray.

Case 2

When the resident called out Patient A's name in order to administer the FDG for a PET examination, Patient B, who was waiting in the corridor after bone scintigraphy, entered the injection room. When calling the patient into the injection room, the resident was supposed to check the appointment slip and the medical history form brought by the patient, and then have the patient give his/her name, but the resident did not follow this procedure and when s/he called Patient A's name, Patient B nodded, so s/he began to prepare to give the injection. The supervising physician administered the FDG to Patient B, thinking that the resident had followed the agreed procedure to check that it was Patient A. When s/he asked to see Patient B's medical history form after administering the FDG, s/he realized that it was the wrong patient.

◆ FDG: Fludeoxyglucose (^{18}F) Injection.

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

- **The patient him/herself will be asked to give his/her name, without fail.**
- **There will be thorough adherence to the hospital's prescribed patient check methods when carrying out radiological examinations.**

(e.g.) · **The appointment slip or medical history form brought by the patient will be checked.**

· **Color-coded cards for each type of examination will be created and given to patients.**

* 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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