Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

Medical Safety Information released from 2006 to 2012

No.91, June 2014

Cases similar to those published in Medical Safety Information bulletins in 2006-2012 were reported again in 2013.

No.[1)]	Title -Description-	Number of cases reported in 2013
[Case]		
No.2	**Bone Marrow Suppression Due to Antirheumatic (Methotrexate) Overdose** – Cases resulting in bone marrow suppression due to antirheumatic (Methotrexate) overdose –	2

The patient was admitted to the psychiatric department for treatment of psychiatric symptoms. Another hospital had prescribed the patient Methotrexate 2.5mg for chronic rheumatoid arthritis. The pharmacist carried out a check of current medications when the patient was admitted, but did not interview the patient. Moreover, the pharmacist contacted the physician at the other medical institution because the patient did not bring in a treatment information form or medication notebook, but the physician only worked there once a week, so there was a delay in preparing the treatment information form. When the resident checked the usage of Methotrexate with the patient, s/he replied "I take 1 tablet in the morning," so the resident ordered the patient's current medications to be continued after admission, with Methotrexate 2.5mg being administered on consecutive days. The treatment information form was later faxed to the hospital, but the resident did not check the prescription history. On the 13th day after admission, when the nurse queried the lack of a drug holiday with the doctor, it was discovered that the patient had been administered Methotrexate 2.5mg on 12 consecutive days. (There was another similar case: Medical Safety Information No.45 (August 2010: 1st Follow-up Report))

No.3	**Rectal Perforation Associated with Glycerin Enema** – Cases of suffering rectal perforation, etc., associated with glycerin enema –	1

The patient had not had a bowel movement and had developed lower abdominal pain, so the nurse administered a 60mL glycerin enema on the orders of the duty physician. After defecation, the abdominal pain improved, but the patient became febrile and a blood test showed elevated CRP. An infection of the lower gastrointestinal tract was suspected, as the site of the pain was the lower abdomen, so treatment by fasting, infusion management, and the administration of antibiotics was started. The following day, the patient continued to be febrile, so a contrast CT scan was carried out, but free air was not noticed at that stage. The fever was suspected to be due to an exacerbation of a pancreatic cyst infection, so an ENPD tube was inserted. Subsequently, the presence of free air was identified in the interpretation of the image by the radiologist, so emergency surgery was carried out and a rectal perforation was discovered.

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No.[1)]	Title -Description-	Number of cases reported in 2013
	[Case]	
No.7	**Extravascular Leakage in Pediatric Patients** – Cases of requiring subsequent treatment because of extravascular leakage when infusion was administered to the pediatric patients, regardless of whether or not the risk of transfusion leakage is described in the package insert –	4

A pediatric patient less than a year old was receiving a continuous infusion of Meylon via a syringe pump. The insertion site could not be observed properly because it was nighttime and therefore dark. In the morning, the peripheral venous route via which the Meylon was being administered was found to be leaking and medical staff discovered that blisters had formed over an extensive area near where the tape was fixing the route in place. The patient was examined by the dermatology department and erosion was discovered when the tape fixing the route was peeled off, so Propeto was applied and the patient was kept under observation. (There were three other similar cases)

No.8	**Wrong Site Surgery (Right/Left)** – Cases of wrong site surgery between right and left –	2

When undergoing surgery for arteriosclerosis obliterans of the right leg, the patient was in the prone position; having mixed up the patient's left and right as a result, the physician made an incision in the left leg and began the operation. Surgery continued without the error being noticed, and the physician was about to make an incision in the left popliteal artery after administering Heparin. Just then, the anesthesiologist pointed out that "the application form states that it is the right leg, but we are operating on the left leg" and the physician realized that there had been an error. (There was another similar case: Medical Safety Information No.50 (January 2011: 1st Follow-up Report))

No.9	**Confusion between Total Product Amount and Content of Active Ingredient** – Cases of confusing of the total product amount and the content of active ingredient –	4

When prescribing "Furosemide fine granules 4% 0.25g once a day after breakfast," the attending physician converted 0.25g as 250mg and prescribed "Furosemide fine granules 4% 250mg once a day after breakfast." At this hospital, the unit “mg” was used in prescriptions to indicate a titer (active ingredient dosage), while g was used to indicate the amount dispensed (total amount of the preparation), but the physician was unaware of this rule. Thinking that 250mg seemed a large amount, the pharmacist checked the order on the chart, but this stated "start Furosemide fine granules 250mg," so s/he handed over the drug without directly checking with the physician. Subsequently, the pharmaceutical department inquired about another patient's prescription for Furosemide fine granules 4% and the attending physician noticed that there had been an error in this patient's prescription. (There were three other similar cases)

No.10	**Magnetic Material (e.g. Metal Products) Taken in the MRI Room** – Cases of bringing magnetic material (e.g. metal products) into the MRI room –	4

A drainage tube was left indwelling in the wound of a post-operative patient undergoing an MRI examination of the head, and this was connected to a suction reservoir providing continuous suction. When transferring the patient onto the MRI examination table, the radiological technologist noticed the drain, but did not know that the suction reservoir was not compatible with MRI equipment, so s/he placed it at the patient's feet, where it would not interfere with the examination. When the bed was moved inside the gantry to start the examination, the suction reservoir stuck to the gantry. The point at which it stuck to the gantry was close to the wound, so the drainage tube was not stretched or dislodged from its original position. (There were three other similar cases)

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No.[1)]	Title -Description-	Number of cases reported in 2013
	[Case]	
No.11	**Blood Transfusion to Wrong Patient** – Cases where the blood product to be given to the patient was not finally checked when connecting the blood products for a transfusion –	3

Patient A had a strong bleeding tendency, so red cell concentrate was being administered. When taking out Patient A's red cell concentrate from the blood cabinet, the nurse actually took out and administered red cell concentrate meant for Patient B, who had the same blood type. When the nurse carried out barcode authentication 10 minutes later, s/he noticed the patient mix-up. Before administering the red cell concentrate, the nurse checked the patient name on the computer order screen, but omitted to check the patient's name on the transfusion docket. Moreover, the nurse did not authenticate the barcode before administering the red cell concentrate, so s/he did not notice the patient mix-up. (There were two other similar cases)

No.14	**Tubing (Catheter/Drain) Misconnections** – Cases of tubing (catheter/drain) misconnection for infusion in patients into whom multiple catheters or drains were inserted –	1

The patient had abdominal pain and ascites, so an emergency laparotomy was performed, as peritonitis was suspected. The cause of the peritonitis was deemed to be an enterostomy tube, so the stoma was changed to a button device. In addition, a peritoneal drain (pleat drain) was left indwelling in the right side of the abdomen. After surgery, the patient was admitted to ICU, returning to the ward the following day. When the charge nurse on the day shift was receiving the handover from ICU, s/he knew that the enterostomy tube had been switched to a button device, but the night nurse was unaware of the change in the stoma and the fact that a peritoneal drain had been left indwelling. The button device meant that there was no stoma tube outside the body. Accordingly, when administering an immunosuppressant, the night nurse connected a T-shaped stopcock for tube feeding to the drain and injected the drug into it, assuming that the pleat drain was the enterostomy tube. When the attending physician heard from the patient's family that the patient had complained of increased abdominal pain due to the administration of the immunosuppressant, s/he realized that it had been injected wrongly.

No.15	**Wrong Pick-up of Syringe Containing Drug** – Cases of multiple syringes being prepared for operation or treatment with labels displaying the drug name, but despite this, wrong pick-up of syringe containing drug occurred because these labels were not checked –	5

When introducing anesthesia, the anesthesiologist meant to administer the muscle relaxant Rocuronium, but actually administered the vasopressor Ephedrine 32mg intravenously. Intubation of the patient was subsequently attempted, but the intubation tube would not go in, so the procedure was halted. The patient had a slight cough reflex and his/her systolic pressure rose to 241mmHg immediately afterward, so 1mg of Nicardipine was administered and the patient's blood pressure decreased. The anesthesiologist erroneously administered 8mg of Ephedrine, again assuming it to be a muscle relaxant, but there was no marked rise in the patient's blood pressure after that, so the patient was intubated. When the anesthesiologist checked the drug administered because s/he had observed a slight cough reflex once more, s/he realized that it was not a muscle relaxant. (There were four other similar cases)

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No.[1)]	Title -Description-	Number of cases reported in 2013
	[Case]	
No.17	**Burn during Use of a Hot Water Bottle** – Cases of burn during use of hot water bottles –	4
	The patient had right hemiplegia and was using 2 hot water bottles as a hot compress because his/her limbs felt cold. The patient was able to use his/her left hand to move the hot water bottles and sometimes placed his/her feet on the hot water bottles to alleviate the feeling of cold in the side that was paralyzed. When the nurse gave the patient a bed-bath and changed the patient's clothes, s/he discovered that two 4cm blisters had formed on the patient's right ankle. (There were three other similar cases)	
No.19	**Use of Unsterile Medical Supplies** – Cases involving preparation of unsterile medical supplies and incorrect use of them –	3
	When Nurse A received external fixator pins from the distributor, the instrument check sheet for the pins carried a request for them to be sterilized, but Nurse A assumed that the items had already been sterilized. On the day of surgery, 3 unsterilized external fixator pins were inserted into a patient undergoing external fixation of a fracture; the operation was then completed. When tidying up after surgery, Circulating Nurse B noticed that the external fixator pins that had been inserted were unsterilized. (There were two other similar cases)	
No.20	**Failure to Transmit an Alteration of Instruction** – Case of original instructions being implemented although they were altered, due to the alteration not being transmitted to the related department –	1
	The physician informed the radiological technologist verbally that radiotherapy was to be cancelled. The technologist thought that s/he had conveyed the message to the physician in the radiotherapy department, but had not actually done so. Accordingly, radiotherapy was carried out 3 times after it was supposed to have been cancelled. The physician only gave the technologist a verbal order and did not issue a written order to cancel radiotherapy.	
No.22	**Wrong Prescription Related to Chemotherapy Protocol** – Cases of incorrect prescription related to chemotherapy protocol –	1
	The drug Fludara is administered for 5 consecutive days, followed by a 23-day drug holiday, so when administering Fludara, the physician prescribed 5 days' supply of Fludara and 7 days' supply of the other drugs, intending to have the patient come to the hospital a week later. However, the patient told the physician that s/he could not come to the hospital a week later, so the physician changed the prescription to a 2-week supply and handed the prescription to the patient. When the patient returned 2 weeks later, the physician realized that s/he had prescribed 10 days' supply of Fludara, because the prescription stated 5 days' supply of Fludara × 2 (weeks).	
No.23	**Wrong Input of Units on Computerized Prescription Order Entry System** – Cases of overdose due to wrong input of units on computerized prescription order entry system –	6
	When prescribing Risperdal, the resident needed to change the unit from “g” to “mg”, but did not do so. Accordingly, s/he prescribed 1.5g of Risperdal instead of 1.5mg. The pharmaceutical department handed the drug to the patient without making an inquiry about the prescription. The patient did not wake up the following morning, so the supervising physician checked the prescription and noticed the error. (There were five other similar cases)	

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No.[1)]	Title -Description-	Number of cases reported in 2013
	[Case]	
No.29	**Administration of 10 Times Proper Dosage to Pediatric Patients** – Cases of overdose due to administration of 10 times proper dosage to pediatric patients –	11

When ordering Vancomycin, the physician erroneously wrote "dissolve 1V of Vancomycin in 4mL of normal saline and use 2mL of this" as a comment on the order "administer Vancomycin 25mg." The nurse dissolved 1V (0.5g) of Vancomycin in 4mL of normal saline and administered 2mL of it, in accordance with the order. As a result, whereas the physician had intended the patient to receive 25mg of Vancomycin, 250mg – 10 times the proper dosage – was administered. (There were 10 other similar cases)

No.30	**Administration of Allergic Drug to Patient with Previous Known Allergy History** – Cases of administration of contraindicated drug occurred due to drug allergy information not described in the predetermined site on the medical chart –	1

The patient had a history of allergy to the use of contrast medium, with symptoms including discomfort and hypotension. Oypalomin (an iodinated contrast media) had been entered on the ICU computer system as a contraindicated drug, but no allergy information had been entered on the clinical decision support system. When a CT was subsequently carried out using a contrast medium, the patient suffered anaphylactic shock.

No.33	**Extravascular Leakage of Gabexate Mesilate*** – Cases of using concentrations which exceeded the recommended dosage as listed on the “precautions regarding use and dose” in the package insert, during administration of gabaxate mesilate, leading to extravascular leakage –	1

Using a route into a peripheral vein in the patient's left forearm, 500mL of Bfluid was being administered via the main line, while 6V of gabexate mesilate 100mg + 500mL of 5% glucose solution were being administered via a side route. When the nurse went to the patient's room in the evening to check the insertion site, there seemed to be slight redness in the area. Reversed flow of blood to the line was unable to be confirmed, so the nurse stopped the infusion and reported the situation to the duty physician. The physician subsequently administered a subcutaneous injection of 1% Xylocaine and Dexart into the site of redness, then applied Dermovate Cream, covered the area with a gauze dressing to protect it, and proceeded to cool the area. (Medical Safety Information No.77 (April 2013: 1st Follow-up Report))
* In the 1st Follow-up Report (No.77), the title was changed to "Vasculitis due to administration of gabexate mesilate," to cover not only extravascular leakage, but also vasculitis associated with this. The report also covered cases in which the drug was used in concentrations in excess of that specified in the Precautions for Use Concerning Usage and Dosage on the package insert.

No.34	**Surgical Fire Due to Ignition of a Flammable Drug by an Electrosurgical Pencil** – Cases of patients sustaining burns due to the use of an electrosurgical pencil causing a drug to ignite –	2

When operating on a subdural hygroma, after using a disinfectant containing ethanol to disinfect the skin, the physician covered the patient with a sterile sheet, sealed the wound site with a film containing Isodine, and made an incision about 4cm long on the left side of the scalp. Subsequently, when using an electrosurgical pencil to stop the skin bleeding, flames suddenly appeared near the occipital region, so the physician immediately removed the drape, whereupon both the paper diaper placed under the occipital region and the patient's hair ignited. The surgeon and the two physicians assisting with the surgery used their hands to beat out the flames and extinguished the fire using normal saline. It was determined that the disinfectant containing a high concentration of ethanol had vaporized the paper diaper and the patient's hair and accumulated in the sterile sheet, with the result that it ignited when the electrosurgical pencil was used. (There was another similar case)

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No.[1)]	Title -Description-	Number of cases reported in 2013
	[Case]	
No.39	**Insufficient Confirmation of Medicines Brought in at Hospitalization** – Cases of patient treatment being affected because of insufficient confirmation of medicines brought in at hospitalization –	2
	The patient had a history of Kawasaki disease with coronary artery aneurysm, and had continued to take Bayaspirin before admission. When admitted for a PCI, the patient did not bring in the Bayaspirin that s/he had been prescribed as an outpatient, but the physician assumed that the patient had brought in the Bayaspirin at hospitalization and was continuing to take it. The PCI was carried out without any problems the day after admission. On the 6th day after the procedure, exercise stress myocardial perfusion scintigraphy was carried out and the myocardial ischemia observed prior to the PCI was found to have improved. When the patient returned to his/her room after the scintigraphy ended, s/he felt chest pain, so s/he underwent an examination. An acute myocardial infarction was diagnosed and an emergency PCI carried out. At that stage, it was discovered that the patient had not been taking aspirin since his/her admission. (There was another similar case)	
No.46	**Burn Caused by a Bed-bath Towel** – Cases of burn due to a hot towel prepared in a plastic bag coming in contact with patient's body during bed-bath –	1
	When giving the patient a bed-bath and changing his/her gown, because the original one had become soiled, the nurse placed the bed-bath towels, which were inside plastic bags, on top of the bed cover at the foot of the patient's bed. The nurse changed the patient's gown and changed his/her position, but when s/he then looked at the patient's feet, s/he saw a bed-bath towel on the patient's left foot and noticed that the skin had become red and was peeling.	
No.47	**Mix-up of the Tooth Extraction Site** – Cases of the mix-up of the tooth extraction site in the dental department –	7
	The patient was undergoing orthodontic treatment at an orthodontic clinic and had undergone an examination at the hospital after being referred there for extraction of impacted mandibular wisdom teeth on both sides, as these were an obstacle to the correction of the patient's teeth. The right lower no.8 wisdom tooth was extracted and the patient experienced no abnormalities thereafter. 20 days later, when an X-ray was taken to check the wound, it was discovered that the right lower no.7 tooth had been extracted, instead of the right lower no.8. The patient's right lower no.8 wisdom tooth was completely impacted, while part of the crown of the right lower no.7 was exposed in the oral cavity, so the right lower no.7 had been misidentified as the right lower no.8 wisdom tooth. (There were six other similar cases)	
No.53	**Specimen Mix-up at Pathological Diagnosis** – Cases of the mix-up of specimens from different patients during pathologic diagnosis –	4
	After being sliced into thin sections, biopsy specimens from Patient A and Patient B were floated in one section of a water tank. Accordingly, when attaching the sections to microscope slides, the person involved attached the specimens from Patient A to the slides for Patient B, and vice versa. The diagnostic pathologist noticed the error because what s/he had been told by the physician did not match up with the examination results. (There were three other similar cases)	

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No.[1)]	Title -Description-	Number of cases reported in 2013
	[Case]	
No.54	**Accidental Removal of the Endotracheal/Tracheostomy Tube When Changing Positions** – Cases of the removal of the endotracheal tube or tracheostomy tube when changing the position of a patient on a ventilator –	7

After replacing the tape fixing the endotracheal tube in place, the 3 nurses (no division of roles had been determined; Nurse A stood near the right side of the patient's head, Nurse B at the right side of the patient's feet, and Nurse C in the middle on the left) tried to move the patient into the right lateral decubitus position in order to change his/her diaper and deal with a dressing on the sacral area. The endotracheal tube was connected to a ventilator circuit, but none of the nurses held the circuit after it was detached from the arm. After placing the patient in the right lateral decubitus position, the patient was briefly placed in the supine position because the Hydrosite dressing on the sacral area had become soiled. After Nurse A turned away from the patient to pick up the dressing, Nurse B said, "Be careful!" When Nurse A turned back, 10cm of the endotracheal tube had come out. (There were six other similar cases)

No.57	**Accidental Ingestion of PTP Sheets** – Cases of taking medicine without removing the PTP sheets –	12

When administering oral medication, to prevent accidental ingestion of PTP sheets, nurses were supposed to remove tablets from their PTP sheets and distribute them in a drug case for oral medication. When distributing drugs to the patients in a 4-person room, the nurse distributed the drugs to be taken before sleeping to 3 of the 4 patients after removing the tablets from their PTP sheets, but left the 3 tablets for the final patient in their PTP sheets when putting them into the drug case. The patient took all 3 tablets as they were in one swallow, but subsequently complained of throat discomfort. This was reported to the attending physician and the 3 tablets that had become stuck in the patient's esophagus were later removed endoscopically. There was found to be slight damage to the esophageal mucosa. (There were 11 other similar cases: Medical Safety Information No.82 (September 2013: 1st Follow-up Report))

No.58	**Rupture of the Subcutaneous Port and Catheter** – Cases of catheter rupture in patients with subcutaneous ports –	13

The patient was due to undergo his/her 12th round of chemotherapy. When the premedication was being administered via a drip after a needle puncture into the port was carried out, the patient complained of discomfort and swelling of the precordium from the top of the port to near the clavicle, along with swelling and pain in the arm, so administration was halted. A chest X-ray was carried out, which revealed that the central venous catheter had ruptured and had migrated into the heart. (There were 12 other similar cases)

No.59	**Burns Due to Incorrect Handling of an Electrosurgical Pencil** – Cases of burns due to an electrosurgical pencil not properly being stored in the holder during use –	2

During a pancreatic tumor resection, the assistant's hand came into contact with the hand switch of the electrosurgical pencil, which had been placed on the patient's body. The tip of the electrosurgical pencil, through which current was flowing, was touching the patient's right lower abdomen, so it caused a 5 × 2mm burn. The burn was sutured closed. (There was another similar case)

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No.[1)]	Title -Description-	Number of cases reported in 2013
	[Case]	
No.61	**Contraindicated Combined Administration of Drugs** – Cases of the combined administration of a drug listed on the package insert of a prescription drug as being contraindicated for combined administration (i.e. it should not be administered in combination with the other drug) –	1

The physician prescribed the immunosuppressant Imuran Tablets 50mg 2 tablets/day to a patient attending the hospital regularly for treatment of systemic lupus erythematosus. At a regular examination, the patient's uric acid levels were found to be high, so the physician prescribed Feburic Tablets via the ordering system to treat the problem. The patient obtained the drug at a dispensing pharmacy and began to take it. At the patient's regular consultation the following month, the blood test showed no problems, so the physician continued to prescribe Feburic Tablets. The patient subsequently developed symptoms including dizziness, lightheadedness, and shortness of breath on exertion. As a result of an outpatient blood test, the patient was found to be anemic, so s/he was admitted as an emergency for treatment. After admission, it was discovered that the anemia was due to bone marrow suppression caused by combined use of Feburic Tablets while taking Imuran.

No.62	**Insufficient Confirmation Concerning Medical Devices Implanted into the Patient's Body** – Cases of MRI examination conducted without adequate checks of medical devices implanted into the patient's body –	1

The patient had undergone surgery to implant a permanent pacemaker 20 years earlier, due to a complete atrioventricular block. The physician ordered the patient to undergo an MRI, but no check for the presence of metal items was carried out at the time of the order. The nurse knew that patients who had pacemakers inserted should not undergo MRI examinations, but did not realize that this patient fell into that category. In the morning, after being contacted by the radiology department, the primary nurse transported the patient to the MRI room. The radiological technologist asked whether or not the patient had any metal items and the primary nurse answered that s/he did not. After the examination ended, the team leader nurse realized that the patient had a pacemaker inserted.

No.63	**Inadequate Checks Concerning Diagnostic Imaging Reports** – Cases of the physician failing to check the content of the diagnostic imaging report after conducting imaging tests and therefore failing to notice a diagnosis that s/he had not anticipated, with the result that treatment might have been delayed –	4

Physician A in the vascular surgery department requested a CT of a patient who had been admitted, having been diagnosed with deep venous thrombosis 2 years earlier. The radiology department's interpretation of the image stated, "Recommend dynamic CT due to possibility of RCC (renal cell carcinoma)," but nobody checked the findings while the patient was hospitalized. The patient was subsequently discharged and began attending regularly as an outpatient, under the care of Physician B. 18 months later, Physician B was transferred, so Physician C took over as the patient's outpatient physician. "RCC" appeared again in the radiology department's interpretation of the image from the CT requested by Physician C, but Physician D, who was serving as the outpatient locum, only checked the blood vessels that were the focus of the CT and did not properly check the results of the interpretation of the image. 5 months after that, Physician E in the department of geriatric medicine noticed the results of the interpretation of the CT image and contacted the urology department. (There were three other similar cases)

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No.[1)]	Title -Description-	Number of cases reported in 2013
	[Case]	
No.69	**Provision of Food to Which the Patient was Allergic** – Cases of the nutrition department erroneously providing food to which the patient was allergic, even though information about the patient's food allergies had been conveyed to the department –	5

At the time of admission, the physician entered a meal order, requesting a meal for those with allergies, containing no milk or dairy products. The following morning, bread was served, so the patient's mother checked whether the milk contained in the bread would affect the patient. When the nurse checked with the contract dietician whether it was safe for a pediatric patient with a milk allergy to eat bread, the dietician's response was that it would be fine, because it did not contain milk. The contract dietician subsequently telephoned the hospital dietician to check. 20 minutes later, the contract dietician telephoned the ward to say that although the bread contained no milk, it did contain skimmed milk powder. However, the pediatric patient had already consumed 80% of the bread. The pediatric patient developed hives and dyspnea, so oral medication and inhalation were administered and the symptoms dissipated 15 minutes later. (There were four other similar cases)

No.70	**Burns Caused by the Tip of a Light Source Cable during Surgery** – Cases of burns resulting from having placed the tip of a light source cable on the surgical drape over the patient during surgery while the power supply was still on –	1

When performing endoscopic surgery to remove ureteral calculi, the physician placed the light source on the patient's abdomen while the power supply was still on. When the anesthesiologist checked after discovering a burn on the drape, the patient was found to have a third-degree burn measuring 5mm. The scrub nurse noticed that the physician had removed the light source, but had no time to think about it after that, as s/he was preparing for the next procedure. In addition, the scrub nurse thought that the physician would tell the circulating nurse to place the light source on standby, as per the rules.

No.71	**Forgetting to Check the Pathologic Diagnosis Report** – Cases of delays in treatment due to failure to check the report on the results of a pathologic examination –	7

During an examination by the respiratory department, although the patient's bronchitis was improving, the patient complained that s/he was not putting weight back on, so the physician asked the gastroenterological endoscopy center to carry out an upper gastrointestinal endoscopy. This was performed the same day. The endoscopy found gastric cancer, so a biopsy was performed. At that stage, it was discovered that an endoscopy had been performed 2 and a half years earlier, which had resulted in a pathologic diagnosis of adenocarcinoma. The attending physician who had requested the endoscopy at the time had forgotten to check the results of the pathologic diagnosis. (There were six other similar cases)

No.72	**Misconnection of Drugs for Continuous Infusion into the Epidural Space** – Cases of drugs meant for continuous infusion into the epidural space being misconnected to and administered via an intravenous catheter –	1

The patient called the nurse, saying that the tip of the infusion had come out, so the nurse went to the room. When the nurse checked, s/he found that the tip of the PCA pump route had come out. Near the tip that had come out was a T-shaped stopcock for administering an infusion into a peripheral vein and, as the patient had had a bed-bath, the nurse assumed that the PCA pump had become disconnected from the side line through which the infusion was being administered into the peripheral vein. Accordingly, s/he disinfected it with an alcohol swab and connected it. The following day, the misconnection was discovered when another nurse noticed that the PCA pump for the epidural had been connected to the side route of the infusion route into the peripheral vein, and that the epidural catheter tip was open.

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No.[1)]	Title -Description-	Number of cases reported in 2013
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No.73	**Patient Mix-up during Radiological Examinations** – Cases of inadequate checks of patient names resulting in radiological examinations being carried out despite the wrong patient having entered the room –	1

Patient A was going to the examination room as s/he was due to undergo an MRI examination of the head. Patient B went through the registration procedure at the radiology department and was told to wait in front of the CT room. When calling the patient into the CT room, Radiological Technologist X asked Patient A, who had gone through registration at the same time and was going to the examination room, "Are you Mr./Ms. B?" Patient A answered in the affirmative, so Technologist X misidentified him/her as Patient B and showed Patient A to the place where an infusion route would be secured. Because Technologist X had brought the patient in, the nurse did not subsequently check the patient's identity and simply secured the infusion route. After the infusion route was secured, Technologist Y showed Patient A into the CT room, while Technologist X and Technologist Z sorted out the settings for the examination. At that stage, Technologist Y also assumed that this was Patient B, so did not check the patient's identity again. When sorting out the settings, they called Patient A by Patient B's name several times, but Patient A did not tell them that they had the wrong name at that stage. The patient mix-up was discovered after carrying out the CT examination, when Patient A was told to go to the department of gastrointestinal medicine and s/he told staff that s/he was under the care of the neurosurgery department.

1) "No." indicates the provision number of the Medical Safety Information.

◆ Other similar cases are to be included in the Annual Report 2013.

* 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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