Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.101, April 2015

Wrong Drug Administration Route

Four cases have been reported involving the administration of a drug via a different route from that specified in the usage directions on the package insert (information collection period: from January 1, 2010 to February 28, 2015). The information is compiled based on “Individual Theme Analysis” (p.67) in the 14th Quarterly Report.

Cases of the administration of drugs via the wrong administration route, despite the right route being specified in the order, have been reported.

Preparation Name	Usage Specified on Package Inserte	Administration Method Used	Background
Risperdal Oral Solution	Oral administration	Subcutaneous injection	Prepared in a syringe
Kaytwo Syrup	Oral administration	Intravenous injection	Prepared in a syringe
Meptin inhalation solution	Inhalation	Eye drops	Mistaken for eye drops because of the shape of the container
Liquid Thrombin Softbottle	Topical spray, irrigation, application or oral administration	Intravenous injection	Interpreted the warning “Injection prohibited” on the bottle to mean that drawing it up into a syringe was prohibited

◆ This Medical Safety Information focuses on cases other than those covered in Medical Safety Information No.14 “Tubing (catheter/drain) misconnections” and Medical Safety Information No.72 “Misconnection of Drugs for Continuous Infusion into the Epidural Space,” which highlighted cases in which infusions, etc. were connected to the wrong place.

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Case 1

Risperdal Oral Solution 0.5mL had been drawn up into a syringe used for subcutaneous injections and placed into a medicine cup for oral medication with the needle still attached to the syringe. Nurse A administered a subcutaneous injection of Risperdal Oral Solution without checking the order. When Nurse B administered Risperdal Oral Solution to the patient orally the following day, the patient said, “Yesterday, Nurse A gave it to me as an injection.” When Nurse B checked with Nurse A, Nurse B discovered that Nurse A had administered Risperdal Oral Solution as a subcutaneous injection.

Case 2

An order was given to administer 5,000 units of Liquid Thrombin Softbottle orally 3 times/day to a patient who had undergone an endoscopic procedure. The nurse took the Liquid Thrombin Softbottle, which had been stored in a cool place, out of a drug bag used for oral medication. However, unaware that Liquid Thrombin Softbottle is an oral medication, the nurse saw the warning “Injection prohibited” on the bottle and interpreted it to mean that drawing up the Liquid Thrombin into a syringe to inject it intravenously was prohibited. Subsequently, the nurse connected the bottle to the infusion route and administered it intravenously, without checking the order, etc.

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

- **Staff members will use a catheter tip syringe when preparing liquid oral medication.**
- **Staff members will check the 6Rs* when preparing the drug and immediately before administering it.**

*** Right patient, Right drug, Right purpose, Right dose, Right route, and Right time.**

* 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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