



# Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/  
Adverse Event Information

## Medical Safety Information

No.102, May 2015

### Misinterpretation of a Verbal Order

Four cases have been reported involving the misinterpretation of a verbal order or request because the intended meaning of the order/request was not conveyed (information collection period: from January 1, 2011 to March 31, 2015). The information is compiled based on “Individual Theme Analysis” (p.162) in the 40th Quarterly Report.

**Cases of misinterpretation of a verbal order or request because the intended meaning was not conveyed have been reported.**

Intended Meaning		Misinterpretation	
Surgeon	Please remove it (the gastric tube)	Anesthesiologist	Please remove it (air in the stomach)
Physician	I haven't done the examination (of the upper gastrointestinal tract, although I inserted the endoscope as far as the throat)	Nurse Nursing assistant	I haven't done the examination (so I didn't use the endoscope)
Physician	Please give the patient the drug (aspirin) on the day of the examination	Nurse	Please give the patient the drug (premedication) on the day of the examination
Nurse	Please put in 10% Sodium Chloride Injection (into the terminal)	Resident	Please put in 10% Sodium Chloride Injection (into the patient)

- ◆ This Medical Safety Information focuses on cases other than those covered in Medical Safety Information No.27 “Wrong dosage of drug due to incomplete verbal instruction,” which highlighted cases in which the unit, quantity, or dilution of a drug was not conveyed clearly in a verbal order, and Medical Safety Information No.84 “Insufficient Confirmation of Incorrect Prescription,” which highlighted cases in which details were not conveyed in the course of inquiries about prescriptions.

## Misinterpretation of a Verbal Order

### Case 1

When the physician began an upper gastrointestinal endoscopy of the patient, the patient demonstrated a strong vomiting reflex, so the examination was halted when the endoscope had reached as far as the throat. The physician said to the nurse who entered the endoscopy room, "I haven't done the examination" and placed the endoscope on the examination table. The nurse interpreted the physician's words to mean, "I haven't used the endoscope." Having heard the conversation between the physician and the nurse, the nursing assistant responsible for washing the endoscope also interpreted the physician's words to mean that the endoscope had not been used, so the endoscope was used on another patient without having been washed or disinfected.

### Case 2

With the intention of requesting that the previous day's 20mL of 10% Sodium Chloride Injection be entered on the system as having been carried out, the nurse said to the resident, "Please put it in." Interpreting this to mean that an intravenous injection should be administered (as "utsu" – the Japanese verb used – can mean both "to type" and "to give an intravenous injection"), the resident administered an intravenous injection of 10% Sodium Chloride Injection to the patient.

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

- When giving verbal orders or making verbal requests, staff members will use words that clearly convey their intended meaning.

#### Complementary comment by the Comprehensive Evaluation Panel

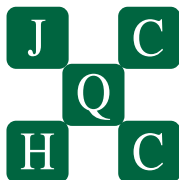
- When receiving a verbal order or request, check it by repeating the order/request back to the person who gave it.

\* 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.



Department 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/>