Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

Medical Safety Information released in 2015

No.112, March 2016

Medical Safety Information No.98-No.109 was issued monthly from January to December 2015. The full list of bulletins is shown below.

No.	Title
No.98	Wrong Method of Administering a Potassium Preparation
No.99	★ Left-Right Mix-Up When Inserting a Thoracostomy Tube
No.100	Medical Safety Information released in 2014
No.101	★ Wrong Drug Administration Route
No.102	Misinterpretation of a Verbal Order
No.103	Medical Safety Information released from 2011 to 2013
No.104	★ Wrong Weight When Prescribing an Antineoplastic Agent
No.105	Forgetting to Open/Close a T-shaped Stopcock
No.106	★ Wrongly Prepared Drug for a Pediatric Patient
No.107	Surgical Fire Due to Ignition of a Flammable Drug by an Electrosurgical Pencil (1st Follow-up Report)
No.108	Incorrect Concentration of Adrenaline
No.109	Wrong Specimen Container When Taking Blood Samples

For titles with ★, similar cases had been reported after the release of each issue until December 31, 2015.

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◆ The following similar cases occurred.

No.99 Left-Right Mix-Up When Inserting a Thoracostomy Tube

The physician planned to perform a left thoracentesis, but confirmed a pleural effusion in the right thoracic cavity on an ultrasound examination, assuming it to be the right-hand side. The nurse assisted, unaware of whether the thoracentesis was to be performed on the left or right. After local anesthesia was administered, the physician performed a right thoracentesis, but was unable to remove as much of the pleural effusion as s/he had expected. When the physician checked the X-ray again, s/he noticed that the large amount of pleural effusion had built up in the left thoracic cavity and realized that s/he had mixed up left and right.

No.104 Wrong Weight When Prescribing an Antineoplastic Agent

When entering Patient A's weight (42kg) on the temperature chart, the nurse erroneously entered Patient B's weight (60.9kg). The dosage on the regimen ordering screen is calculated on the basis of the weight entered on the temperature chart. When prescribing anticancer drugs for Patient A, the physician ordered a dosage calculated on the basis of Patient B's weight, so an overdose was administered.

No.106 Wrongly Prepared Drug for a Pediatric Patient

The physician issued an order for the administration of UNASYN-S for Intravenous Use (1.5g/V) 30mg dissolved in 1mL of glucose solution. Nurse A misunderstood UNASYN-S 1V to be 150mg, so s/he calculated that 30mg of the drug solution would be 1mL when dissolved in 5mL glucose solution and prepared the drug accordingly. Assuming, just as Nurse A had, that UNASYN-S 1V was 150mg, Nurse B, who had been asked to check the calculation, did not notice the error. Nurse A administered the 300mg of UNASYN-S that had been erroneously prepared.

◆ Other similar cases are included in the Annual Report 2015.

* 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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