Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

Medical Safety Information released from 2012 to 2014

No.115, June 2016

Recurrent and similar events to those published in Medical Safety Information bulletins in 2012-2014 were reported again in 2015.

- This table shows the number of recurrent and similar events to those highlighted in Medical Safety Information bulletins (No.62-97).
- Where five or more recurrent and similar events were reported, a case relevant to that Medical Safety Information bulletin is also described.

No.[1)]	Title	Number of cases reported in 2015
No.62	**Insufficient Confirmation Concerning Medical Devices Implanted into the Patient's Body**	2
No.63	**Inadequate Checks Concerning Diagnostic Imaging Reports**	11
An endovascular stent graft repair was performed five years earlier, due to an abdominal aortic aneurysm, and CT examinations were subsequently carried out for evaluation by the cardiovascular surgery department. The physician in the cardiovascular surgery department looked at the CT images before receiving the diagnostic imaging reports and explained the results to the patient, but did not check the diagnostic imaging reports after the consultations. The patient was later found by the department of respiratory medicine to have lung cancer, so the diagnostic imaging reports from the previous CT examinations were checked and it was discovered that a tumor shadow in the tracheal carina, near the esophagus, had been pointed out three years earlier. (There were 10 other similar cases)		
No.65	**Wrong Pick-up of Drug Set Out on the Emergency Cart**	3
No.66	**Misconception of insulin content (1st Follow-up Report)** Initial report: Medical Safety Information No.1	3
No.68	**Drug mix-up (1st Follow-up Report)** Initial report: Medical Safety Information No.4	4
No.69	**Provision of Food to Which the Patient was Allergic**	1
No.71	**Forgetting to Check the Pathologic Diagnosis Report**	5
When the physician conducted a regular examination of the patient, s/he noticed that early gastric cancer had been pointed out in the pathologic findings from an endoscopic examination carried out a year earlier. The most recent endoscopic examination showed that the gastric cancer had grown in size, necessitating that the patient be treated without delay. (There were four other similar cases)		
No.72	**Misconnection of Drugs for Continuous Infusion into the Epidural Space**	1
No.73	**Patient Mix-up during Radiological Examinations**	2
No.75	**Total Dose Wrongly Entered as Flow Rate in Infusion Pump, etc.**	1
No.77	**Vasculitis due to administration of gabexate mesilate (1st Follow-up Report)** Initial report: Medical Safety Information No.33	2

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No.[1)]	Title	Number of cases reported in 2015
No.78	**Wrong Quantity Prescribed When Switching from Medicines Brought in at Hospitalization to Internal Prescriptions**	4
No.80	**Urethral Damage Caused by an Indwelling Bladder Catheter**	10
The nurse was able to insert an indwelling bladder catheter without resistance, but no urine was discharged. The nurse thought that there was no urine in the bladder because the patient had gone to the toilet to urinate immediately before the procedure, so s/he injected 10mL of distilled water into the balloon. The patient complained of pain, so the nurse removed the indwelling bladder catheter. Subsequently, the patient suffered bleeding from the urethra during urination, so the urologist examined the patient and diagnosed hemorrhage due to urethral damage. (There were nine other similar cases)		
No.81	**Body Part Trapped in Gaps in Side Rails, etc. When Operating Beds**	2
No.82	**Accidental ingestion of PTP sheets (1st Follow-up Report)** Initial report: Medical Safety Information No.57	11
The nurse used scissors to cut PTP sheets into individual tablets before distributing medication to the patient. Subsequently, the patient said that s/he ingested one tablet's PTP sheet along with the tablet and complained of having difficulty swallowing. When the nurse checked the waste bin, s/he discovered that all of the PTP sheets for the drugs to be taken after dinner were there, except for the PTP sheet for Loxoprofen. (There were 10 other similar cases)		
No.83	**Failure to Reopen All Clamps on a Cerebrospinal Fluid Drainage Circuit**	1
No.85	**Accidental Removal of a Drain/Tube during Transfer**	7
When the patient was transferred from the operating table to the bed after surgery, a central venous catheter that had been placed in the right internal jugular vein caught on the slide board and was pulled out from the insertion depth of 13cm, at which it had been secured, to a depth of 6cm. Dobupum was being administered via the central venous catheter and the patient's blood pressure temporarily dropped into the 60mmHg range. (There were six other similar cases)		
No.86	**Administration of Contraindicated Drug**	1
No.92	**Forgetting to Connect Ventilator Hoses**	1
No.94	**Magnetic Material (e.g. Metal Products) Taken in the MRI Room (1st Follow-up Report)** Initial report: Medical Safety Information No.10	4
No.95	**Dead Battery in a Central Monitor Transmitter**	2
No.97	**Wrong Choice of Pneumococcal Vaccine Preparation**	1

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

◆ Recurrent and similar events to those published in Medical Safety Information bulletins No.1-97 are to be 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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