Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/
Adverse Event Information

Medical Safety Information

No.120, November 2016

Administration of the Wrong Drug from a Syringe Not Labeled with the Drug Name

Three cases have been reported in which a drug other than that intended was administered in error because the syringe prepared for the patient was not labeled with the drug name (information collection period: from January 1, 2013 to September 30, 2016). The information is compiled based on “Individual Theme Review” (p.69) in the 17th Quarterly Report.

Cases have been reported in which a drug in a syringe not labeled with the drug name was administered to a patient, but was not the drug intended.

Syringe Size	Intended Drug	Drug Administered in Error
5mL	ProHance (MRI contrast medium)	Citosol Injection (general anesthetic)
20mL	Normal saline	Heparin (10,000 units) +normal saline
20mL	Gaster Injection 1A +normal saline	Fentanyl Injection 0.1mg 5A +normal saline

Image of case 1

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Case 1

On the ward, the physician dissolved Citosol Injection 0.5g for a pediatric patient's MRI examination. The physician then dispensed some into a 5mL syringe and took the syringe to the examination room. When carrying this out, the physician was supposed to indicate the name of the drug and the name of the patient on the syringe, but did not do so. The physician placed their white coat and the syringe of Citosol on a table in the examination room. The contrast medium had not been prepared, but the radiological technologist assumed that the syringe on the table contained contrast medium prepared by another radiological technologist and passed it to the physician. The physician thought that there was a bit too much in the syringe to be contrast medium, but administered it to the patient without checking, while observing the patient's condition. The error was noticed when the patient's breathing slowed immediately after administration.

Case 2

The nurse took a tray to the patient's room to inject a Bisolvon bolus and refill the continuous intravenous infusion of heparin. There were three syringes on the tray: a syringe containing Bisolvon, which was labeled with the drug name; a 20mL syringe of normal saline to be injected before and after administering the Bisolvon, which was also labeled; and an unlabeled syringe containing 10,000 units of heparin + normal saline (20mL in total). Assuming that the unlabeled syringe contained normal saline, the nurse administered the whole of the syringe's contents before and after administering the Bisolvon. Subsequently, another nurse discovered the normal saline left over on the tray and realized that the heparin preparation had been administered in error.

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

- **Syringes will be labeled with the drug name, without fail, and this will be checked immediately before administration.**

* 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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