Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

Medical Safety Information released in 2016

No.124, March 2017

Medical Safety Information No.110–No.121 was issued from January to December 2016. The full list of bulletins is shown below.

No.	Title
No.110	★ Blood Transfusion to Wrong Patient (1st Follow-up Report)
No.111	Delays in Urgent Contact Regarding Panic Values
No.112	Medical Safety Information released in 2015
No.113	★ Air Embolism after Removal of a Central Venous Catheter
No.114	★ Forgetting to Resume Anticoagulants/Antiplatelet Drugs
No.115	Medical Safety Information released from 2012 to 2014
No.116	★ Patient Mix-up in Drug Administration
No.117	★ Inadequate Checks of Meal Type Information from Other Facilities
No.118	★ Drug Mix-up Due to Similar Appearance
No.119	Incorrect Setting of Medication Quantity or Solution Volume on a Syringe Pump
No.120	Administration of the Wrong Drug from a Syringe Not Labeled with the Drug Name
No.121	Wrongly Inserted Nasogastric Feeding Tube

For titles with ★, recurrent and similar events had been reported after the release of each issue until December 31, 2016.

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No.124, March 2017

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◆ The following recurrent and similar events occurred.

No.113 Air Embolism after Removal of a Central Venous Catheter

When removing a central venous catheter (blood access catheter), the physician removed the catheter while the patient was in a sitting position, thinking that this position would be easy for the patient to maintain. In doing so, the physician failed to consider the possibility that removing the catheter while the patient was in a sitting position could cause an air embolism. The patient's level of consciousness subsequently declined and the patient suffered a PEA (pulseless electrical activity). This was thought to be an air embolism caused by the entry of air from the site from which the catheter was removed.

No.116 Patient Mix-up in Drug Administration

When handing out drugs, the nurse mistook Patient A for Patient B, who was in the bed opposite. Without having the patient give their name or checking the patient name on the drug package against that on the name band, the nurse gave Patient A the Ancaron 200mg and Eliquis tablets 5mg intended for Patient B. Subsequently, the nurse realized that Patient A had taken Patient B's medication. Patient A's surgery had to be postponed because they had taken Patient B's medication in error.

No.117 Inadequate Checks of Meal Type Information from Other Facilities

The summary prepared for the patient's transfer specified the meal type required as "100% rice gruel," but the nurse was unaware of this information at the time of admission. Accordingly, bread was provided for the patient's breakfast. The nurse set out the breakfast and checked that the patient was eating the bread. Upon returning to the room eight minutes later, the nurse found the patient cyanotic and collapsed on the bed, with their mouth full of bread.

◆ Other recurrent and similar events are included in the Annual Report 2016.

* 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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