Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.127, June 2017

Medical Safety Information released from 2013 to 2015

Recurrent and similar events to those published in Medical Safety Information bulletins in 2013-2015 were reported again in 2016.

◆ The following lists the titles and number of recurrent and similar events reported in 2016 that were associated with events included in Medical Safety Information issued between 2013 and 2015 (No.74-109). Where five or more events were reported, one of the events in question is described.

No.	Title	Number of cases reported in 2016
No.77	**Vasculitis due to administration of gabexate mesilate (1st Follow-up Report)** Initial report: Medical Safety Information No.33	1
No.78	**Wrong Quantity Prescribed When Switching from Medicines Brought in at Hospitalization to Internal Prescriptions**	2
No.80	**Urethral Damage Caused by an Indwelling Bladder Catheter**	7
	When the nurse inserted an indwelling bladder catheter, no urine was discharged into the catheter. Thinking that this was just because there was no urine in the patient's bladder, due to the nil by mouth order, the nurse injected distilled water into the balloon, whereupon blood flowed into the catheter, so the nurse withdrew it. A urologist subsequently diagnosed urethral damage and performed a cystostomy.	
No.82	**Accidental ingestion of PTP sheets (1st Follow-up Report)** Initial report: Medical Safety Information No.57	8
	Having separated a PTP sheet of Brotizolam Tablets into individual tablets, the evening nurse placed a Brotizolam Tablet into a medicine cup along with drugs removed from a bag in which they had been packaged together, and then handed the cup to the patient. The late night nurse received a handover stating that the PTP sheet for the Brotizolam Tablet could not be found. The next morning, when the nurse checked with the patient whether they had the PTP sheet, the patient said, "My throat is stinging." X-ray and CT imaging subsequently showed what appeared to be a foreign object in the patient's esophagus, so an endoscopy was performed and the PTP sheet was removed.	
No.85	**Accidental Removal of a Drain/Tube during Transfer**	8
	When transferring the patient from the operating table to the stretcher after surgery, the nurse placed the urine collection bag on the patient's abdomen, but failed to check the position of the tube into the urine collection bag. When the patient was moved, the tube caught on the side rail of the operating table, causing the indwelling bladder catheter to come out.	
No.87	**Burns during a Foot Bath or Shower**	1
No.89	**Syringe Pump Mix-up**	1

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No.	Title	Number of cases reported in 2016
No.90	Catheter or Tube Erroneously Cut with Scissors	1
No.92	Forgetting to Connect Ventilator Hoses	2
No.93	Wrongly Registered Antineoplastic Drug Regimen	2
No.94	Magnetic Material (e.g. Metal Products) Taken in the MRI Room (1st Follow-up Report) Initial report: Medical Safety Information No.10	3
No.99	Left-Right Mix-Up When Inserting a Thoracostomy Tube	2
No.101	Wrong Drug Administration Route	5
	The physician intended to administer Oncovin intravenously and Methotrexate and Cylocide intraspinally. After the patient's anti-cancer drugs were prepared in the pharmaceutical department, a tray containing the drug for intravenous administration and a tray containing the drugs for intraspinal administration were delivered to the ward. When the intraspinal administration was taking place, the nurse assumed that there was only one tray for the patient and prepared the Oncovin, which was in a syringe on the tray. The physician drew up the drug proffered by the nurse into a clean syringe and administered the Oncovin intraspinally.	
No.102	Misinterpretation of a Verbal Order	1
No.104	Wrong Weight When Prescribing an Antineoplastic Agent	1
No.105	Forgetting to Open/Close a T-shaped Stopcock	3
No.106	Wrongly Prepared Drug for a Pediatric Patient	3
No.108	Incorrect Concentration of Adrenaline	1
No.109	Wrong Specimen Container When Taking Blood Samples	1

◆ 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.

Department of Adverse Event Prevention
Japan Council for Quality Health Care
1-4-17 Kandamisaki-cho, Chiyoda-ku, Tokyo 101-0061 JAPAN
Direct Tel: +81-3-5217-0252 Direct Fax: +81-3-5217-0253
http://www.med-safe.jp/