Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/Adverse Event Information

Medical Safety Information

No.139, June 2018

Medical Safety Information released from 2014 to 2016

Recurrent and similar events to those published in Medical Safety Information bulletins in 2014–2016 were reported again in 2017.

◆ The following lists the titles and number of recurrent and similar events reported in 2017 that were associated with events included in Medical Safety Information issued between 2014 and 2016 (No.86–121). Where three or more events were reported, one of the events in question is described.

No.	Title	Number of cases reported in 2017
No.89	**Syringe Pump Mix-up**	1
No.90	**Catheter or Tube Erroneously Cut with Scissors**	2
No.93	**Wrongly Registered Antineoplastic Drug Regimen**	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	3
No.95	**Dead Battery in a Central Monitor Transmitter**	1
No.99	**Left-Right Mix-Up When Inserting a Thoracostomy Tube**	3
No.101	**Wrong Drug Administration Route**	3
	The patient had a CV port implanted in the right precordium and a peripheral intravenous route inserted into the left forearm. When preparing Fulcaliq 3 for administration via the CV port, Nurse A and Nurse B checked the details and quantities of the drugs to be co-injected, but did not check the administration route. Nurse B connected the Fulcaliq 3 to the peripheral intravenous route without checking the administration route order on the injection order sheet. Eight hours later, the patient complained of pain in the left forearm and the area was found to be red, swollen, and hot.	
No.102	**Misinterpretation of a Verbal Order**	3
No.104	**Wrong Weight When Prescribing an Antineoplastic Agent**	1
No.106	**Wrongly Prepared Drug for a Pediatric Patient**	1
No.107	**Surgical Fire Due to Ignition of a Flammable Drug by an Electrosurgical Pencil (1st Follow-up Report)** Initial report: Medical Safety Information No.34	2

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No.	Title	Number of cases reported in 2017
No.109	**Wrong Specimen Container When Taking Blood Samples**	1
No.110	**Blood Transfusion to Wrong Patient (1st Follow-up Report)** Initial report: Medical Safety Information No.11	3
	The physician was due to explain about platelet transfusion to Patient X (type B) and to administer a platelet transfusion to Patient Y (type AB). The physician went to Patient X's room, taking both Patient X's transfusion consent form and Patient Y's platelet concentrate. After explaining the transfusion to Patient X, the physician had the patient sign the consent form and then, assuming that the platelet concentrate for Patient Y that they had brought with them was actually for Patient X, began to administer the platelet concentrate to Patient X without checking the patient's name or blood type. When the physician used the authentication system to record the administration of the transfusion after it began, an error was displayed. As a result, the physician noticed that the wrong blood type was being administered and halted the transfusion.	
No.113	**Air Embolism after Removal of a Central Venous Catheter**	3
	The physician removed the central venous catheter (triple lumen) that had been indwelling in the left internal jugular vein while the head of the patient's bed was elevated at an angle of about 30°. After applying pressure to the removal site for five minutes, the physician attached a breathable dressing and fixed a folded piece of gauze in place with tape to apply pressure to the area. The patient subsequently complained of shortness of breath and their SpO_2 and level of consciousness gradually declined. When an echocardiogram was carried out, air was found to have entered.	
No.116	**Patient Mix-up in Drug Administration**	6
	Nurse A was asked by Nurse B to administer Patient X's enteral nutrient and anticonvulsant. Failing to check the patient's name using the wristband or name on the bed, Nurse A assumed that Patient Y was Patient X and administered the enteral nutrient and anticonvulsant to Patient Y. When Nurse B went to Patient Y's room, they noticed that a bottle of enteral nutrients bearing Patient X's name was connected to Patient Y.	
No.117	**Inadequate Checks of Meal Type Information from Other Facilities**	2
No.118	**Drug Mix-up Due to Similar Appearance**	1
No.120	**Administration of the Wrong Drug from a Syringe Not Labeled with the Drug Name**	1
No.121	**Wrongly Inserted Nasogastric Feeding Tube**	2

◆ Other recurrent and similar events are included in the Annual Report 2017.

* 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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