Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.151, June 2019

Medical Safety Information Highlighted in Quarterly Reports in 2018

The following provides an introduction to the titles of Medical Safety Information and major events highlighted in the Analysis of Recurrent and Similar Events in the Project to Collect Medical Near-miss/Adverse Event Information's 52nd–55th Quarterly Reports, which were published in 2018. Detailed analyses of recurrent and similar events can be found on the project's website.
http://www.med-safe.jp/contents/report/similar.html

No.	Title	Quarterly Report No.
No.19	**Use of unsterile medical supplies**	52nd
The intraocular lens (preloaded into the injector) was packaged in plastic, which was inside aluminum packaging, which was itself contained in an outer box. When an intraocular lens implantation was to be performed, Circulating Nurse A opened the box and took out the aluminum packaging. Thinking that the contents of the aluminum packaging had been sterilized, Circulating Nurse A opened it and placed the plastic packaging on the instrument tray. Scrub Nurse B opened the plastic packaging. The surgeon received the injector and inserted the intraocular lens into the patient. It was subsequently discovered that the plastic packaging was unsterilized and only the injector had been sterilized. (*The title in the 52nd Quarterly Report was "Use of Unsterilized Medical Devices.")		
No.71	**Forgetting to Check the Pathologic Diagnosis Report**	55th
The physician performed an upper gastrointestinal endoscopy on a patient who had been examined in the department of gastrointestinal medicine due to melena, and took a biopsy after spotting a lesion in the esophagus. At the time of the follow-up examination, the physician confirmed from the blood tests that there was no progression in the patient's anemia, but did not check the pathologic diagnosis report. The patient's progress was subsequently monitored as an outpatient. Four years later, when the patient underwent an upper gastrointestinal endoscopy due to feeling as though there was a blockage when swallowing, the physician took a biopsy after noticing findings strongly suggestive of cancer in the esophagus. At that point, the physician noticed that the pathologic diagnosis report from four years earlier had not been read and that it mentioned squamous cell carcinoma.		

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No.	Title	Quarterly Report No.
No.85	**Accidental Removal of a Drain/Tube during Transfer**	53rd
When four physicians and two nurses moved the patient from a prone to a supine position and transferred them to a transfer bed after the operation ended, they checked the positions of the endotracheal tube, peripheral venous line, arterial pressure line, indwelling bladder catheter, and subcutaneous drain in the posterior region of the neck. Although they changed the patient's position slowly, the subcutaneous drain caught on the corner of the transfer bed and was dislodged.		
No.102	**Misinterpretation of a Verbal Order**	55th
The patient was positive for irregular antibodies, so a T&S order could not be issued and RBC had been dispensed. As a transfusion was not required after surgery, the gynecologist said to the anesthesiologist, "Give it back," meaning that the RBC should be returned to the blood transfusion department. The anesthesiologist interpreted "Give it back" to mean that the patient should be given a blood transfusion and gave the patient an unnecessary blood transfusion.		
No.104	**Wrong Weight When Prescribing an Antineoplastic Agent**	54th
The patient's weight had remained around 50 kg since admission. When the patient was weighed for chemotherapy (Day 1), the nurse erroneously entered 70.1 kg on the electronic medical record. When ordering the chemotherapy, the physician did not notice that the weight was wrong. The ward pharmacist who had been checking the order for chemotherapy (Day 8) noticed the error and realized that the patient had received an overdose.		
No.111	**Delays in Urgent Contact Regarding Panic Values**	53rd
The blood test showed a blood glucose level of 38 mg/dL (panic value), so the clinical laboratory technologist told the outpatient clerk, "This is an emergency contact value report. Glucose is low at 38. Please report it to the physician." The clerk printed out the patient's blood test results and wrote a note saying, "Contact from clinical laboratory department. Glucose 38. Please check." The clerk placed it on the medical records shelf, but did not mention it to anyone. 15 minutes later, the nurse noticed the paper on the medical records shelf and telephoned the physician, but the line was busy. The nurse went to find the patient and discovered that the patient had noticed their own hypoglycemia and was eating a sweet.		

* 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 the Project website for details.
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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