



Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/
Adverse Event Information

Medical Safety Information

No.15, February 2008

Wrong pick-up of syringe containing drug

Five cases of multiple syringes being prepared with labels displaying the drug name, but despite this, wrong pick-up of syringe containing drug occurred because the labels were not checked. (information collection period, from October 1, 2004 to December 31, 2007; the information is partly included in "Medical Adverse Event Information to Be Shared" in the 10th Quarterly Report)

Cases of multiple syringes being prepared with labels displaying the drug name, but despite this, wrong pick-up of syringe containing drug occurred because these labels were not checked.

Drugs which should have been administered	Drugs mixed-up
Atropine sulfate	Musculax intravenous
Xylocaine injection	Dehydrated Ethanol
Local anesthetics (Drug name unknown)	Dehydrated Ethanol
Normal saline	Detoxol injection
Perdipine injection	Bosmin injection

Wrong pick-up of syringe containing drug

Case 1

The physician in the operating room planned to administer a mix of Atropine sulfate and Vagostigmin intravenously. At this time, the physician mixed up Vagostigmin and Musculax before surgery and administered the mixed drugs intravenously. The drug names were displayed on the syringe, but the physician did not check it.

Case 2

Dehydrated ethanol and Xylocaine liquid for injection were both prepared in separate syringes on the preparation table in the treatment room in order to perform an outpatient ingrown toenail surgery. The physician intended to inject the patient with Xylocaine, but injected the patient with Dehydrated ethanol instead. The drug name had written on the syringe, but was not checked.

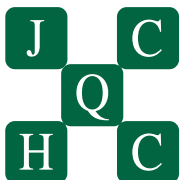
Preventive measures taken at the medical institutions in which the events occurred.

**When using a drug prepared in a syringe,
make sure to check the drug name displayed.**

* 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 "Comprehensive Evaluation Panel" to prevent 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 can not be guaranteed in the future.

* This information is neither for limiting the discretion of healthcare providers nor for imposing certain obligations or responsibilities on them.



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