Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

Medical Safety Information Released in 2019

No.160, March 2020

Medical Safety Information No.146–No.157 was issued from January to December 2019. The full list of bulletins is shown below.

No.	Title
No.146	★ Inadequate checks of Oxygen Remaining (1st Follow-up Report)
No.147	★ Injury from a Wheelchair Footrest
No.148	Medical Safety Information released in 2018
No.149	★ Operation/Examination Postponed Due to Delays in Stopping Drugs
No.150	★ Forgetting to Check the Pathologic Diagnosis Report —Upper Gastrointestinal Endoscopy—
No.151	Medical Safety Information Highlighted in Quarterly Reports in 2018
No.152	★ Gauze Remaining After Surgery (1)—Gauze Count—
No.153	★ Gauze Remaining After Surgery (2)—Checking the X-ray Image—
No.154	Patient Mix-up When Using Electronic Medical Records
No.155	★ Falls from a Pediatric Bed
No.156	Incorrect Administration of Injection Drug Used for Sedation
No.157	Rectal Injury Due to Glycerin Enema Administered in a Standing Position

For titles with ★, recurrent and similar events had been reported after the release of each issue until December 31, 2019.

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◆ These are recurrent and similar events reported in 2019.

No.147 Injury from a Wheelchair Footrest

The patient had pronounced edema in the limbs. When transferring the patient from a wheelchair to the bed, Nurse A held the patient's trunk from the front, while Nurse B held the patient's gown and underwear at the hips from behind to get the patient into a standing position and then turned the patient around. In doing so, the nurses did not check to ensure that the patient's legs did not come into contact with the footrest. After being transferred to the bed, the patient complained of pain, so the nurses looked at the patient's legs and found that they were bleeding from a V-shaped laceration on the lateral right lower leg. The patient was examined by a physician and received 20 sutures.

No.149 Operation/Examination Postponed Due to Delays in Stopping Drugs

At a perioperative outpatient consultation, the pharmacist explained to the patient that they would require a 14-day drug holiday from Plavix Tablets. The patient was then seen as an outpatient in the department of breast surgery, where the physician explained to the patient that they would require a 4-day drug holiday from Plavix Tablets. As the explanations from the pharmacist and the physician differed, the patient queried this with the outpatient nurse. The outpatient nurse checked with the physician and replied that the patient should take a 4-day drug holiday, but the patient should actually have taken a 14-day drug holiday. After admission, the medical team discovered that the patient's drug holiday had been too short, so surgery was postponed.

No.152 Gauze Remaining After Surgery (1)—Gauze Count—
No.153 Gauze Remaining After Surgery (2)—Checking the X-ray Image—

During laparoscopic surgery, the number of Trox gauze sponges (a gauze sponge used for endoscopic surgery) in the gauze count before closing was one fewer than it should have been, so the surgical team searched the abdominal cavity several times, but failed to find the missing gauze. After taking X-ray images, including lateral views, physicians, nurses, and the radiological technologist checked the images on the screen of the portable X-ray machine and determined that no gauze remained inside the patient. When a CT examination was performed the following morning to check for the gauze sponge, it was found to have been left inside the patient, so emergency surgery was performed and the gauze removed.

* 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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