Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/
Adverse Event Information

Medical Safety Information

No.163, June 2020

Medical Safety Information Highlighted in Quarterly Reports in 2019

The following provides an introduction to the titles of Medical Safety Information and major events highlighted in the Analysis of Recurrent and Similar Events section of the Project to Collect Medical Near-miss/Adverse Event Information's 56th–59th Quarterly Reports, which were published in 2019. 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.54	**Accidental removal of the endotracheal/tracheostomy tube when changing positions**	57th
◆ Removal of the tracheostomy tube when changing positions Two nurses were changing the patient's diaper and clothes. When the nurses turned the patient into the right lateral decubitus position without holding the tracheostomy tube and ventilator circuit connector, the tracheostomy tube came out. The nurses ventilated the patient using a bag valve mask and a physician re-inserted the tracheostomy tube.		
No.68	**Drug mix-up (1st Follow-up Report)** Initial report: Medical Safety Information No.4	57th
◆ Drug mix-up during prescription due to similar names The physician decided to add Zalutia Tablets to the prescription for a patient with benign prostatic hyperplasia. The names Zytiga and Zalutia look and sound similar in Japanese and both drugs were used in the urology department. Consequently, the physician selected Zytiga tablets in error on the electronic record and issued an external prescription. The pharmacist at the dispensing pharmacy dispensed the tablets without making an inquiry about the prescription. The patient continued to take the tablets for about two weeks. When a check of the medical receipts was carried out at the hospital, a medical administration clerk noticed that Zytiga tablets had been prescribed for a patient whose disease name was listed as benign prostatic hyperplasia. When the clerk checked the medical record, they discovered the prescription mix-up.		
No.78	**Wrong Quantity Prescribed When Switching from Medicines Brought in at Hospitalization to Internal Prescriptions**	56th
◆ Wrong quantity prescribed when changing specification The patient had been prescribed Quetiapine Tablets 25 mg, 1 tablet to be taken 3 times/day at another medical institution. The current hospital did not have Quetiapine Tablets 25 mg in its formulary, but did have Seroquel 100 mg Tablets, which contained the same ingredient in a different specification. When switching the patient from the current medications to the internal prescription on the day of admission, the physician prescribed Seroquel 100 mg Tablets, 1 tablet to be taken 3 times/day. The patient took the tablets twice and became drowsy. The nurse subsequently realized that the patient had been prescribed four times the intended dose.		

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No.	Title	Quarterly Report No.
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	59th
◆ Ignition of disinfectant containing alcohol when using an electrosurgical pencil After fixing the patient's tibia, the orthopedic surgeon decided to proceed with surgery on the patient's fibular fracture. When doing so, the orthopedic surgeon disinfected the skin again with a disinfectant containing alcohol (Stericlon W ethanol solution 0.5%). The disinfectant soaked into the stockinette and drapes around the disinfected site and, when the orthopedic surgeon began using the electrosurgical pencil without waiting for the fabric to dry, the stockinette ignited, causing a burn measuring 5 × 10 cm on the patient's lateral lower leg.		
No.110	**Blood Transfusion to Wrong Patient (1st Follow-up Report)** Initial report: Medical Safety Information No.11	59th
◆ Failure to check the patient against the platelets immediately before administering a blood transfusion The physician ordered platelets to be administered to Patient X (type AB: adult). The platelets ordered for Patient X had not arrived, but the nurse assumed that the platelets for Patient Y (type O: pediatric patient), which were in ICU, were the platelets for Patient X. Patient Y's platelets had been unsealed and barcode authentication had already taken place, and the nurse began administering the platelets to Patient X without carrying out barcode authentication again. When disposing of the platelet bag after administration had been completed, the nurse noticed that the platelets were for Patient Y.		
No.113	**Air Embolism after Removal of a Central Venous Catheter**	58th
◆ Air embolism after removal of a dialysis catheter The patient was receiving noninvasive positive pressure ventilation (NPPV). The physician removed the central venous catheter (for blood access) for dialysis that had been indwelling in the right internal jugular vein while the patient's upper body was elevated at an angle of about 20°. The physician applied pressure for a few minutes and then, without applying a dressing, applied gauze and fixed it in place with tape. The patient gradually became bradycardic and suffered a cardiac arrest. In a CT image, air was observed in the right ventricle through to the pulmonary artery, which was thought to be an air embolism that had occurred after removal of the central venous catheter.		

* 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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