Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

Medical Safety Information released in 2007

No.16, March 2008

Medical Safety Information No.1-No.13 was issued every month from December 2006 to December 2007. After that until December 31, 2007, similar cases Note1) occurred. Your reconfirmation is appreciated.

No.	Information provided	Cases reported before issuance of the information Note2)	Cases were reported after issuance of the information
No.1	Misconception of insulin content	1	4
No.2	Bone marrow suppression due to antirheumatic (methotrexate) overdose	3	0
No.3	Rectal perforation associated with glycerin enema	7	2
No.4	Drug mix-up	7	4
No.5	Burn during assisted bathing	2	3
No.6	Misconception of insulin unit	2	4
No.7	Extravascular leakage in pediatric patients	9	2
No.8	Wrong site surgery (right/left)	9	5
No.9	Confusion of total product amount and content of active ingredient	4	0
No.10	Magnetic material (e.g. metal products) taken in the MRI room	2	1
No.11	Blood transfusion to wrong patient	6	0
No.12	Contact during patient transfer	2	0
No.13	Failure to check of infusion pump flow	2	0

Note 1) If the reported case related to multiple descriptions, it is multiple calculated.
Note 2) "Cases reported before issuance of the information" are cases occurring during the information collection period.

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Major similar cases reported after issuance of the Medical Safety Information

No.1 Misconception of insulin content / No.6 Misconception of insulin unit

A nurse received an instruction for "Novolin R Injection 50 units + normal saline 50 mL." Looking at the label that indicated "Novolin R 100 Injection" on the vial (contains 10 mL = 1000 units), the nurse thought one vial contained 100 units, prepared an IV drip mixed with 500 units instead of 50 units of Novolin R and administered it to the patient.

No.5 Burn during assisted bathing

Two nurses lowered a patient on the stretcher into the bathtub without checking the water temperature, both thinking the other had already checked it. The stretcher was raised immediately after the water was found to be too hot, however, the patient had burn in areas such as the back, the buttocks, the back of both forearms, and both heels.

No.8 Wrong site surgery (right/left)

A patient was scheduled for extirpation of a mass in the right side of the back. The surgical site was observed by the surgeon and the nurse in a ward on the day of surgery but was not marked. The left side was determined as the surgical site based on the MRI image and ultrasonography. The left-right mix-up was identified by the patient himself after the operation.

◆ Other similar cases are included in the Annual Report 2007

* 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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