Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

Medical Safety Information Released in 2020

No.172, March 2021

Medical Safety Information No.158–No.169 was issued from January to December 2020. The full list of bulletins is shown below.

No.	Title
No.158	★ Administration of a Sustained-Release Preparation in Ground-Up Form
No.159	★ Misconnection Causing Obstructed Exhalation in Patients with an Endotracheal/Tracheostomy Tube
No.160	Medical Safety Information released in 2019
No.161	★ Burns Caused by a Pulse Oximeter Probe
No.162	Falls When Transferring to a Bed
No.163	Medical Safety Information Highlighted in Quarterly Reports in 2019
No.164	Central Venous Catheter Guide Wire Left Behind
No.165	★ Alert Failure Resulting in Administration of a Drug to a Patient Allergic to It
No.166	Surgical Procedure Other Than Patient-Consented Procedure Carried Out
No.167	Bone Marrow Suppression Due to Antirheumatic (Methotrexate) Overdose (2nd Follow-up Report)
No.168	★ Failure to Check Oxygen Tank Valve Was Open
No.169	Omission from Prescription/Order When Continuing Prescription for Current Medicines Brought in at Hospitalization

For titles with ★, recurrent and similar events had been reported after the release of each issue until December 31, 2020.

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◆ These are recurrent and similar events reported in 2020.

No.158 Administration of a Sustained-Release Preparation in Ground-Up Form

The patient was taking Onetram Tablets. The nurse knew that sustained-release preparations must not be ground up, but was unaware that Onetram Tablets were a sustained-release preparation. The patient developed problems with oral ingestion, so the nurse ground up the Onetram Tablets to assist the patient in taking them orally. The patient subsequently became completely unable to ingest anything orally, so the nurse asked the pharmaceutical department to grind up the Onetram Tablets. The nurse learned at this point that the tablets were a sustained-release preparation, which must not be ground up.

No.159 Misconnection Causing Obstructed Exhalation in Patients with an Endotracheal/Tracheostomy Tube

Oxygen was being administered to a patient with a tracheostomy tube via a tracheal mask connected to the corrugated tube. When the patient was about to take a shower, the lead nurse told the primary nurse to administer oxygen by attaching a connector to the oxygen line and connecting it to the tracheal mask. However, the primary nurse connected the connector attached to the oxygen line directly to the tracheostomy tube, instead of to the tracheal mask. The patient was unable to exhale, their level of consciousness declined, and they suffered a pneumothorax.

No.161 Burns Caused by a Pulse Oximeter Probe

The SpO_2 of a neonatal patient (3 days old) was being monitored. The site where the pulse oximeter probe was attached was being changed once per shift (three times per day) on the ward. When bathing the patient, the nurse removed the probe from the infant's foot, to which it had been attached, and noticed a burn measuring about 3 mm in the middle of the sole of the foot. The pulse oximeter probe's package insert stated, "Check the state of the skin at the site of attachment at least once every eight hours and change the site if necessary" and "Neonates and low birth weight infants are at greater risk of skin disorders, depending on the patient's condition and the state of the site of attachment."

* 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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