Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/
Adverse Event Information

Medical Safety Information

No.175, June 2021

Medical Safety Information Highlighted in Quarterly Reports in 2020

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 60th–63rd Quarterly Reports, which were published in 2020. Detailed analyses of recurrent and similar events can be found on the project's website.
https://www.med-safe.jp/contents/report/similar.html

No.	Title	Quarterly Report No.
No.5	**Burn during assisted bathing**	60th
◆ Burn while Bathing a Newborn Infant When bathing a neonatal patient (17 days old), the new nurse filled the baby bath with hot water, but failed to notice that the temperature adjustment lever on the tap was set to about 60°C. There was no thermometer installed, so the nurse did not check the temperature of the water. Failing to notice how hot the water was, due to wearing two layers of gloves, the nurse bathed the infant, who suffered burns extending from the lower back to the legs.		
No.14	**Tubing (catheter/drain) misconnections**	63rd
◆ Intra-arterial Injection of a Drug Meant for Intravenous Administration The physician inserted the IABP catheter via the arterial sheath in the left inguinal region of a patient with myocardial infarction, and then administered cardiovascular agents via the venous sheath in the patient's right inguinal region. When administering an infusion containing a potassium chloride preparation using an infusion pump, the nurse connected it in error to the T-shaped stopcock attached to the arterial sheath in the left inguinal region. Although a number of nurses were involved in the patient's care thereafter, none noticed the error. It was discovered in the afternoon of the following day, when the physician pointed out that the infusion was being administered via the arterial sheath.		
No.45	**Bone marrow suppression due to antirheumatic (Methotrexate) overdose (1st Follow-up Report)** Initial report: Medical Safety Information No.2	61st
◆ Administration of a Methotrexate Preparation on Consecutive Days When increasing the dosage of Rheumatrex Capsules from 6 mg/week to 8 mg/week, the physician wrote "Take once a week (on Mondays)" in the comments field of the prescription, but erroneously issued it as an external prescription for 28 days' supply along with other drugs. The pharmacist at the patient's regular pharmacy did not make an inquiry about the prescription in respect of the number of days' supply. Moreover, the pharmacist did not note the day on which the drug was to be taken on the drug bag, nor did they explain it, as they concluded that the patient understood on which day they were to take their medication. While the patient thought it odd, they took the drug on consecutive days. When the patient attended their regular consultation 28 days later, they were admitted to hospital, as they were suspected to be suffering side-effects from the Rheumatrex Capsules. When the ward pharmacist checked with the patient, they discovered that the patient had been taking the Rheumatrex Capsules on consecutive days.		

Project to Collect Medical Near-Miss/ Adverse Event Information

Project to Collect Medical Near-Miss/ Adverse Event Information
Medical Safety Information

No.175, June 2021

Medical Safety Information Highlighted in Quarterly Reports in 2020

No.	Title	Quarterly Report No.
No.60	**Vaccination with an Immunization Vaccine Past its Expiry Date**	62nd
◆ Vaccination with an Influenza Vaccine Past its Expiry Date The pharmaceutical department received orders for the influenza vaccine for four patients and the pharmacist dispensed 2V of Influenza HA Vaccine "Biken" to the pediatric ward, without checking the expiry date. The nurse vaccinated the patients without checking the expiry date. A month later, during an inventory in the pharmaceutical department, one of the pharmacists found influenza vaccines from the previous year that had passed their expiry date. This resulted in the discovery that the vaccines dispensed to the ward a month earlier also had passed their expiry date.		
No.90	**Catheter or Tube Erroneously Cut with Scissors**	60th
◆ Cuff Inflation Tube of Endotracheal Tube Cut in Error The nurse intended to use scissors to cut a pad to the right size to protect the skin on the cheek of a patient with tracheal intubation. Failing to notice that the cuff inflation tube was nearby, the nurse cut the pad near the right-hand side of the patient's mouth and heard the sound of air escaping. As sounds began to emerge from the patient's mouth and the tidal volume fell, the nurse realized that they had also cut the cuff inflation tube.		
No.125	**Insufficient Understanding of Drugs to be Halted Pre-operatively —Oral Contraceptives—**	62nd
◆ Forgetting a Drug Holiday for Anti-dysmenorrhea Drugs Containing the Same Ingredients as Oral Contraceptives The female patient in her 20s underwent examination in the neurosurgery department. At the time of the patient's first consultation, Physician A noted on the record that she was taking Frewell Combination Tablets LD. When the date of surgery was subsequently decided, Physician B looked at the record and saw that the patient was taking medication to treat dysmenorrhea, but was unaware that it necessitated a drug holiday and therefore failed to order a drug holiday. On the day of admission, the ward pharmacist checked the patient's current medications and noticed that she had not taken a drug holiday from Frewell Combination Tablets LD, so her surgery had to be postponed.		

* 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.

Department of Adverse Event Prevention
Japan Council for Quality Health Care
1-4-17 Kandamisaki-cho, Chiyoda-ku, Tokyo 101-0061 JAPAN
Direct Tel: +81-3-5217-0252 Direct Fax: +81-3-5217-0253
https://www.med-safe.jp/