Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.179, October 2021

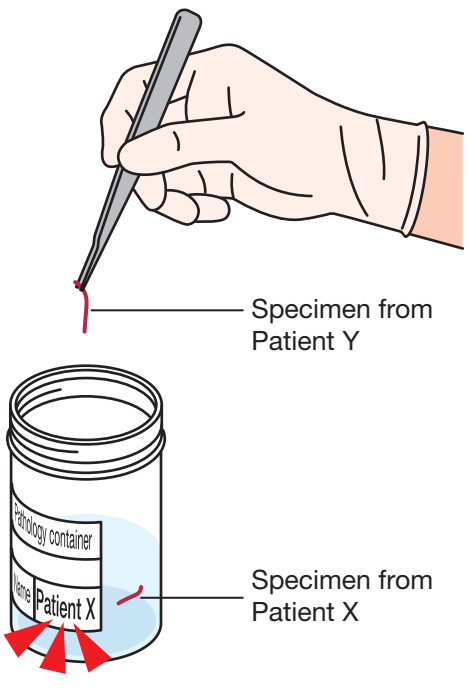
Contamination with Another Patient's Pathology Test Specimen

Four cases have been reported in which a pathology test specimen was placed in a container holding another patient's specimen (information collection period: from January 1, 2015 to August 31, 2021). This information was compiled on the basis of the content featured in the Recurrence of Events and Occurrence of Similar Events section of the 65th Quarterly Report.

Cases have been reported in which a pathology test specimen was placed in a container holding another patient's specimen.

Type of Examination	Number of Cases	Main Background Factors
Liver biopsy	2	• The unused container had been put in the same place as a container holding a specimen
Lung biopsy	1	• Failure to check the label attached to the container
Cervical cytology	1	• Failure to check whether there was already a specimen in the container

Image of case



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Case 1

When Patient Y's liver biopsy was performed after Patient X's liver biopsy, the nurse handed the container holding Patient X's pathology test specimen to the physician without checking the label bearing the patient name. The physician placed the specimen inside the container handed to them without checking the label. When submitting the specimen, the nurse noticed that Patient X's container held specimens from two people.

Case 2

When preparing for Patient Y's lung biopsy after Patient X's lung biopsy, Physician A erroneously placed the container holding Patient X's pathology test specimen on the treatment bench. Attached to the container was a label on which Patient X's name had been printed. After collecting Patient Y's specimen, Physician B placed it inside the container on the treatment bench without checking the label, assuming that the container was unused. Physician B realized immediately afterwards that they had placed Patient Y's specimen inside the container holding Patient X's specimen.

Preventive measures taken at the medical institutions in which the events occurred

- **Put unused containers in a place where they can be distinguished from containers holding specimens.**
- **If there is a label attached to the container, check the patient name on the label during the time out.**
- **Check that the container is unused before placing the pathology test specimen inside.**

The measures above are examples. Please consider initiatives suitable for your own facility.

* 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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