Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

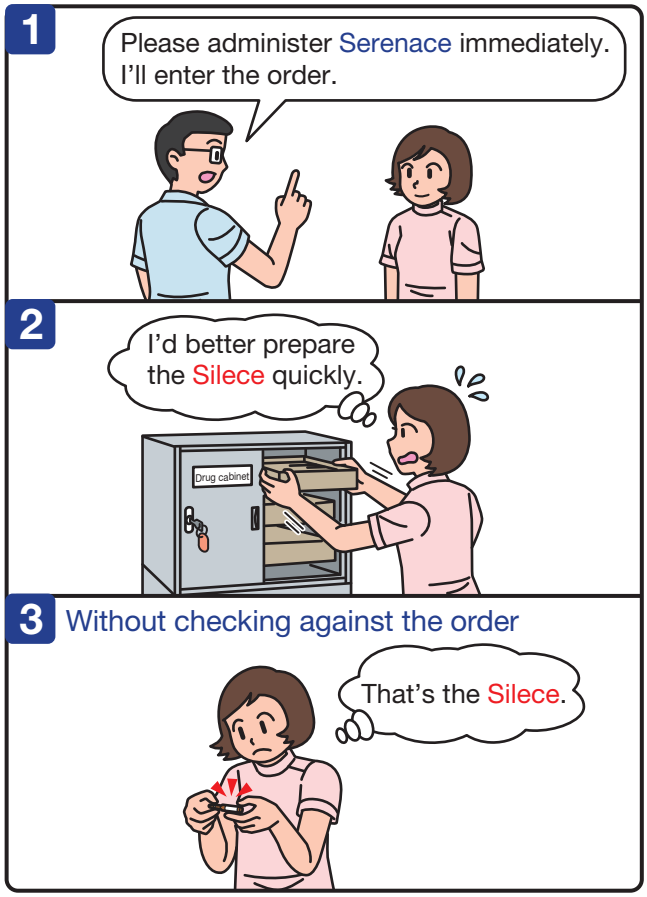
No.182, January 2022

Drug Mix-up between Serenace Injection and Silece

Six cases have been reported in which, when preparing Serenace Injection from stock drugs, Silece was taken from the drug cabinet in error and administered (information collection period: from January 1, 2016 to November 30, 2021). This information was compiled on the basis of the content featured in the Analysis Themes section of the 65th Quarterly Report.

Cases have been reported in which Silece was administered instead of Serenace Injection after being prepared from stock drugs in error.

Image of case

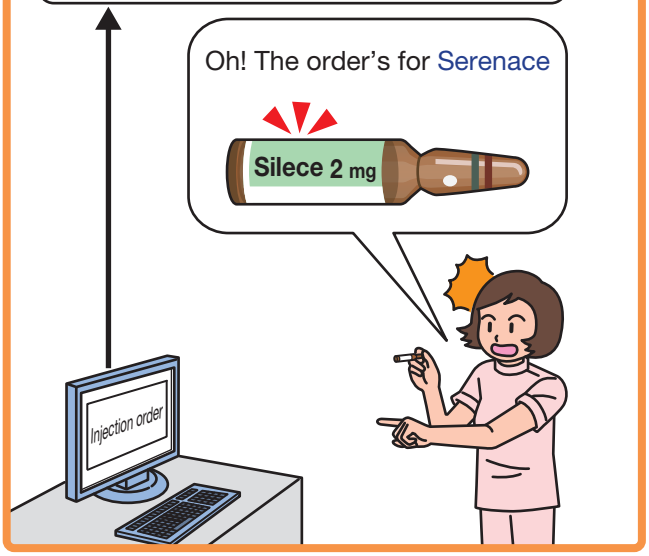


Check the drug against the order

Make sure you check the name of injection drugs against the order

[Injection order]

5 mL of Serenace Injection 1 A
+ normal saline 9 mL IV



◆ In the reported events, either an order for as-needed use had been noted on the record or the order had been entered on the record after the verbal order had been issued.

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Case 1

The ICU duty physician gave the nurse a verbal order to administer Serenace Injection to the patient. Assuming that the physician had ordered Silece rather than Serenace Injection, the nurse took Silece out of the locked drug cabinet. The ICU duty physician entered “5 mL of Serenace Injection 1 A + normal saline 9 mL IV” on an injection order on the electronic medical record, but the nurse did not view it. The nurse prepared Silece 1 A + normal saline 9 mL and injected it intravenously. The patient’s SpO_2 subsequently fell to 74%, so they were fitted with a BiPAP mask. When checking the drugs in the drug cabinet after the shift change, the lead nurse noticed that there were fewer Silece ampoules and realized that Silece had been administered in error.

Case 2

Nurse A checked the as-needed order for Serenace Injection on the electronic medical record. When Nurse A asked Nurse B where Serenace Injection could be found, Nurse B confused it with Silece and replied that it was in the locked drug cabinet. Nurse A also assumed that Serenace Injection was Silece and took it out of the drug cabinet. Nurse A prepared Silece 1 A + normal saline 100 mL and administered it to the patient, marking the infusion bottle with the patient’s name and Silece 1 A. Upon visiting the patient’s room when the alarm warning of a fall in the patient’s SpO_2 subsequently sounded, the nurse found the patient to be cyanotic, with a pale face, and reported the situation to the duty physician. When looking at the infusion bottle, the duty physician noticed that it was marked Silece.

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

- **Check the drug name on both the order and the ampoule label without fail when preparing drugs from stock drugs.**
- **Consider removing Silece from the stock drugs.**

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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