Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/Adverse Event Information

Medical Safety Information

Medical Safety Information Released in 2021

No.184, March 2022

Medical Safety Information No.170–No.181 was issued from January to December 2021. The full list of bulletins is shown below.

No.	Title
No.170	Provision of Unsuitable Food to a Patient with Impaired Chewing/Swallowing Function
No.171	★ Reactivation of Hepatitis B Due to Immunosuppression/Chemotherapy
No.172	Medical Safety Information Released in 2020
No.173	★ Tenfold Error in Flow Rate of Infusion Pump, etc.
No.174	Failure to Inject Enteral Nutrient after Administering Insulin
No.175	Medical Safety Information Highlighted in Quarterly Reports in 2020
No.176	★ Disconnection of Ventilator Circuit Tubing
No.177	★ Accidental Ingestion of PTP Sheets (2nd Follow-up Report)
No.178	Burn while Bathing a Newborn or Infant
No.179	Contamination with Another Patient's Pathology Test Specimen
No.180	Incorrect Prescription of Meylon Injection 250 mL Preparation
No.181	Retention of Resected Organ/Tissue When Performing Laparoscopic Surgery

For titles with ★, recurrent and similar events had been reported after the release of each issue until December 31, 2021.

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Medical Safety Information
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◆ These are recurrent and similar events reported in 2021.

No.171 Reactivation of Hepatitis B Due to Immunosuppression/Chemotherapy

The patient had begun taking steroids after being diagnosed with an allergic pulmonary disease six years earlier. At the time, the patient was HBs antigen negative and HBc and HBs antibody positive. An HBV DNA quantitative test was carried out during the two months after starting steroids and came up negative, but HBV DNA quantitative test monitoring was not conducted thereafter. When an HBV DNA quantitative test was carried out as a check prior to stepping up treatment following an exacerbation of the patient's condition a month earlier, the patient was found to be positive.

No.173 Tenfold Error in Flow Rate of Infusion Pump, etc.

The physician issued an order for "Fentanyl preparation 0.2 mL/h continuous subcutaneous injection" for a patient with cancer pain. Setting flow rates as decimal fractions is a rare occurrence, as flow rates for continuous intravenous infusions are normally set as whole numbers. The nurse set the flow rate by turning the syringe pump dial with some force, as usual, and began administering the drug. When the nurse checked four hours later after the alarm signaling a low quantity remaining sounded, they noticed that the flow rate had been set at 2.0 mL/h in error.

No.176 Disconnection of Ventilator Circuit Tubing

When changing the ventilator circuit, the nurse checked by touch that the connection between the flex tube and the ventilator circuit was not loose. After changing the patient's position and carrying out suction, the nurse carried out only a visual check that the ventilator circuit was connected before leaving the room. Because the medical monitor alarm sounded, the nurse subsequently noticed that the patient's heart rate was 130 bpm and their SpO_2 was 87%. The nurse went to the patient's bedside and found that the flex tube and the ventilator circuit were disconnected.

* 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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