Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/
Adverse Event Information

Medical Safety Information

No.187, June 2022

Medical Safety Information Highlighted in Quarterly Reports in 2021

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 64th–67th Quarterly Reports, which were published in 2021. 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.9	**Confusion between total product amount and content of active ingredient**	66th

◆ Administration of 10 times the intended dose of Aleviatin Powders

At this hospital, prescriptions for powdered medication were meant to be ordered on the basis of active ingredient dosage. The physician did not know that powdered medication has both a product volume and an active ingredient dosage. Accordingly, when switching from the patient's current medications to an internal prescription, the physician ordered "Aleviatin Powders 2,000 mg/day 2 times/day: after breakfast and dinner" after seeing "Aleviatin Powders 2 g/day 2 times/day: after breakfast and dinner" on the patient referral document. When the pharmacist made an inquiry about the prescription, the physician checked the patient referral document and, thinking that 2,000 mg should be fine because the document stated 2 g, told the pharmacist to dispense the prescription as ordered. The pharmacist prepared and dispensed an active ingredient dosage of 2,000 mg/day (product volume of 20 g/day). The nurse administered the drug to the patient, without questioning the fact that the sachets contained a large quantity of powder. The ward pharmacist noticed the overdose two days later.

No.15	**Wrong pick-up of syringe containing drug**	65th

◆ Administration of Protamine Sulfate for I.V. Inj. in error when starting a cardiopulmonary bypass

In the operating theater, the circulating nurse looked at the Cardiopulmonary Bypass Order Sheet and prepared a 20 mL syringe of Heparin Sodium Injection for administration before starting the cardiopulmonary bypass and another 20 mL syringe of Protamine Sulfate for I.V. Inj. for administration when taking the patient off the cardiopulmonary bypass. When doing so, the circulating nurse affixed labels stating the drug name and dosage to the syringes and placed both the syringes in the same tray. Before starting the cardiopulmonary bypass, the nurse received an order from the anesthesiologist for Heparin Sodium Injection and the nurse handed over the syringe containing Protamine Sulfate for I.V. Inj., without first checking the drug name on the label affixed to the syringe. The anesthesiologist also failed to check the drug name on the label and administered the drug to the patient.

No.69	**Provision of Food to Which the Patient was Allergic**	67th

◆ Provision of baby food containing wheat and dairy products, to which the patient was allergic

The pediatric patient was allergic to wheat and dairy products. While the baby food on the menu that day did not contain any foods unsuitable for individuals with a wheat or dairy allergy, the cook misread the menu and prepared and served the food on the following day's menu, which did contain wheat and dairy products. The pediatric patient developed symptoms of anaphylaxis after eating the baby food.

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No.	Title	Quarterly Report No.
No.82	**Accidental ingestion of PTP sheets (1st Follow-up Report)** Initial report: Medical Safety Information No.57	64th
◆ Accidental ingestion of PTP sheet separated into individual tablet sheets Thinking the patient would remove the drugs from the PTP sheet before taking them, the nurse handed over the patient's drugs separated into individual tablet sheets. The patient subsequently complained of discomfort in their pharynx and said that they had swallowed the sheets along with the drugs. A CT examination showed the PTP sheets lodged in the esophagus and they was extracted by means of an upper gastrointestinal endoscopy.		
No.94	**Magnetic Material (e.g. Metal Products) Taken in the MRI Room (1st Follow-up Report)** Initial report: Medical Safety Information No.10	66th
◆ Patient's hearing aids taken in The patient used hearing aids on both ears. Before the MRI examination, the radiological technologist asked the patient if they had any metal items on their person, but the patient did not reply. The technologist allowed the patient to enter the MRI examination room without checking that the hearing aids had been removed. After entering the room, the radiological technologist discovered that the patient was wearing hearing aids on both ears and removed them. After the examination had been completed, the patient complained that something was wrong with their hearing aids, which were then discovered to have failed.		
No.99	**Left-Right Mix-Up When Inserting a Thoracostomy Tube**	66th
◆ Left-right mix-up during thoracentesis of a patient with bilateral pleural effusion A new left pleural effusion was found on a chest X-ray image of a patient already found to have a right pleural effusion, so a left thoracentesis was planned. The patient sat upright with the right-hand side of their chest toward the physician. The physician confirmed the right pleural effusion by means of an ultrasound examination and proceeded to carry out a right thoracentesis. The physician noticed the left-right mix-up when writing up the record after the procedure and carried out the planned left thoracentesis.		

* 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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