Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

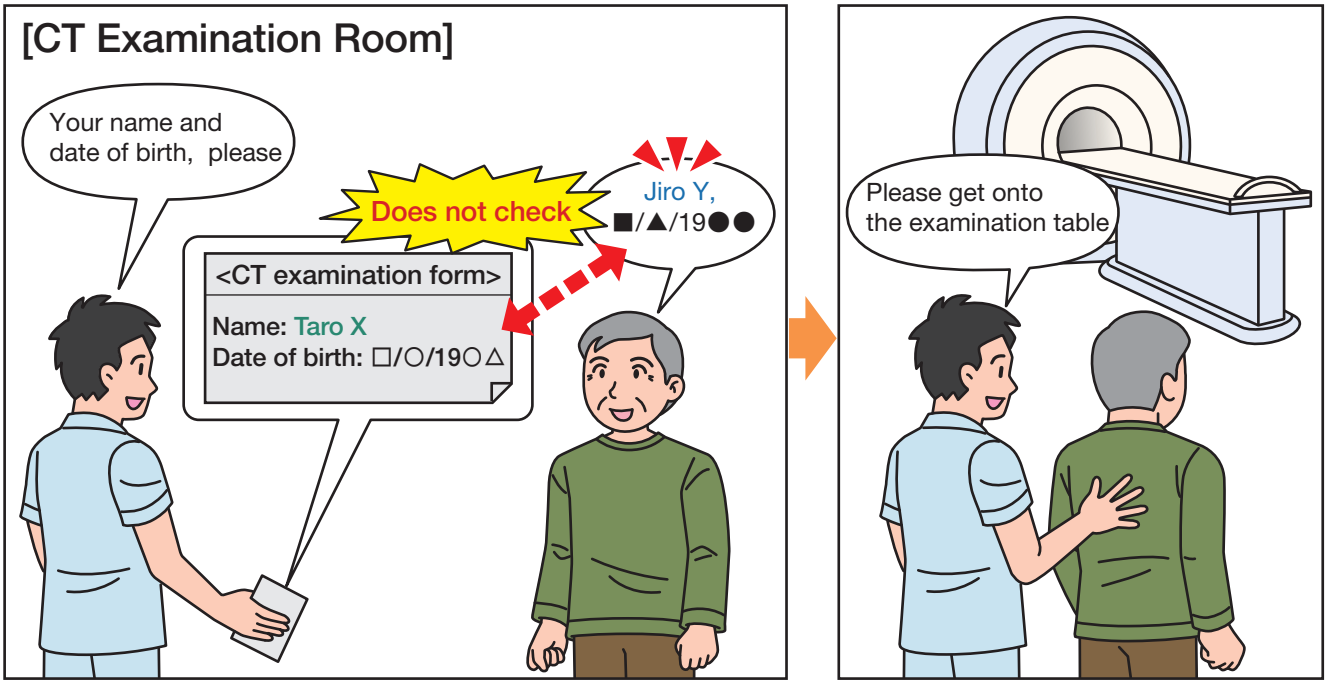
No.195, February 2023

Examination/Procedure Conducted on Wrong Patient Due to Failure to Carry out Checks

Medical Safety Information No.25 highlighted cases of patient mix-up during medical examination, while Medical Safety Information No.73 focused on patient mix-up during radiological examinations. Both these Medical Safety Information bulletins warned medical personnel that they should have patients give their own names. Since then, five cases have been reported in which an examination, treatment, or procedure was conducted on the wrong patient even though the patient gave their name and other details when called, because the medical staff member did not check these details against the information at hand (information collection period: from January 1, 2019 to December 31, 2022). This information was compiled on the basis of the content featured in the Analysis Themes section of the 68th Quarterly Report.

Cases have been reported in which an examination, treatment, or procedure was conducted on the wrong patient even though the patient gave their name and other details when called, because the medical staff member did not check these details against the information at hand.

Image of case 1



Project to Collect Medical Near-Miss/ Adverse Event Information

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

No.195, February 2023

Examination/Procedure Conducted on Wrong Patient Due to Failure to Carry out Checks

Case 1

Patient X and Patient Y were in the waiting room of the CT examination room, waiting for their examinations. When Radiological Technologist A looked at the CT examination form and called Patient X by their full name, Patient Y answered. Patient Y entered the room and Technologist A had them give their name and date of birth, but did not check the information against the CT examination form for Patient X and went ahead with the examination. When Radiological Technologist B went to check on the situation after Patient X asked how much longer they would have to wait for their examination, they realized that Patient X's examination had been carried out on Patient Y.

Case 2

Patient X was due to have a bone scintigraphy starting at 09:00, while Patient Y was scheduled for a cholescintigraphy starting at 10:00. As Patient Y had arrived at the hospital at 09:00, the radiological technologist assumed they were Patient X, who was due for a bone scintigraphy, and ushered Patient Y into the examination room. The hospital had a rule that when a patient entered the room, their details were to be checked against the information at hand, in the form of the examination schedule. Although the technologist had Patient Y give their name and date of birth, they did not check this information against the examination schedule. The physician also failed to check whether the patient was Patient X and administered the radiopharmaceutical used for bone scintigraphy to Patient Y. When subsequently explaining details such as the time that imaging would take, they realized that the patient had a different name and discovered that they had administered the radiopharmaceutical for Patient X to Patient Y.

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

- **Have the patient give two identifiers, such as their name and date of birth, and then check them against information held by medical personnel (such as the electronic medical record screen).**

The measure above is an example. 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.
https://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/