Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/Adverse Event Information

Medical Safety Information

Medical Safety Information Released in 2022

No.196, March 2023

Medical Safety Information No.182–No.193 was issued from January to December 2022. The full list of bulletins is shown below.

No.	Title
No.182	Drug Mix-up between Serenace Injection and Silece
No.183	★ Confusion between Product Volume and Active Ingredient Dosage (1st Follow-up Report)
No.184	Medical Safety Information Released in 2021
No.185	Use of a Used Endoscope on Another Patient
No.186	★ Failure to Check Blood Test Results before Administering Anticancer Drugs
No.187	Medical Safety Information Highlighted in Quarterly Reports in 2021
No.188	Fitting of Elastic Stockings to Patients with Arteriosclerosis Obliterans of the Lower Limbs
No.189	★ Burn Caused by a Hot Towel
No.190	Selection of Wrong Connection for Indwelling Bladder Catheter
No.191	Local Injection of High-Concentration Adrenaline Due to Container Mix-Up
No.192	★ Pressure Ulcers Caused by Medical Devices
No.193	Wrong Drug Administration Route (1st Follow-up Report)

A ★ next to a title indicates that recurrent and similar events were reported during the period to December 31, 2022.

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◆ These are recurrent and similar events reported in 2022.

No.186 Failure to Check Blood Test Results before Administering Anticancer Drugs

The patient was receiving combination therapy of nivolumab and ipilimumab as an outpatient. The physician was conducting blood tests to check for side-effects. Two months after chemotherapy began, the patient was found to have a side-effect in the form of reduced thyroid function, so the physician started oral administration of Thyradin-S Tablets. That same day, the physician ordered an assay of the patient's blood cortisol and ACTH levels from an external provider, to check the patient's adrenal function. When examining the patient a month later, the physician forgot to check the results of the outsourced examination from the previous month and continued administration of the anticancer drug, without realizing that the patient had developed an abnormal decline in adrenal function. A month after that, the patient went into shock due to adrenal insufficiency and was admitted to hospital as an emergency.

No.189 Burn Caused by a Hot Towel

A patient on bed rest requested a hot compress for numbness. Nurse A placed a hot towel inside a plastic bag without checking that it was an appropriate temperature and applied the bag directly to the patient's lumbar region. When Nurse B subsequently visited the room to give the patient a bed-bath, they noticed that the hot towel had been applied directly to the lumbar region. Nurse B observed the skin and noticed redness, which was diagnosed as a first-degree burn.

No.192 Pressure Ulcers Caused by Medical Devices

The patient had a nasogastric tube inserted. The nurse changed the tape fixing the gastric tube in place every day, but was unaware of the risk of medical device-related pressure ulcers (MDRPU) and consequently had fixed the tape in a way that applied tension to the wing of the nose. The physician replaced the gastric tube twice, but always inserted it via the left nasal cavity. The nurse discovered redness at the left nasal cavity and fixed the tape in such a way as to ensure that the gastric tube did not touch the area of redness. When a certified nurse in wound, ostomy and continence nursing observed the patient the following day, they noticed skin damage with necrosis at the patient's left nasal cavity.

* 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. 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.

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