Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.199, June 2023

Medical Safety Information Highlighted in Quarterly Reports in 2022

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 68th–71st Quarterly Reports, which were published in 2022. 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.29	**Administration of 10 times proper dosage to pediatric patients**	70th
◆ Administration of acelio Bag Intravenous Injection 80 mL (800 mg) instead of 80 mg The pediatric patient was 1 year old and was admitted due to febrile convulsions. When entering the order for when the patient was febrile, the physician intended to order acelio Bag Intravenous Injection 80 mg, but mixed up the units mg and mL, and entered acelio Bag Intravenous Injection 80 mL instead. The nurse did not notice the error and administered the drug in accordance with the physician's order.		
No.78	**Wrong Quantity Prescribed When Switching from Medicines Brought in at Hospitalization to Internal Prescriptions**	70th
◆ Wrong insulin unit entered when preparing the Current Medications Report The patient had been admitted as an emergency and the pharmacist went to their hospital room to check their current medications. The pharmacist was told that the patient was using Lantus S.C. Injection 30 units–0 units –0 units–0 units and NovoRapid Injection 10 units–10 units–10 units–0 units. Based on what they had been told and a copy of the patient's medication notebook, the pharmacist prepared the Current Medications Report using the Current Medications Report screen on the electronic medical record. When doing so, the pharmacist mixed up the number of units of NovoRapid Injection with the number of units of Lantus S.C. Injection and incorrectly entered the number of units of NovoRapid Injection as 30 units–30 units–30 units–0 units. The physician prescribed the drugs based on the Current Medications Report. The nurse administered the insulin preparations in accordance with the physician's prescription. The following day, the patient became hypoglycemic and their level of consciousness declined.		

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No.	Title	Quarterly Report No.
No.86	**Administration of Contraindicated Drug**	69th

◆ Administration of Methotrexate tablets to a patient with renal dysfunction

Following left total nephroureterectomy, the patient had been prescribed Methotrexate (MTX) tablets 8 mg/day (once a week) by the orthopedic department for rheumatoid arthritis. On this occasion, the patient was admitted for postrenal failure due to right renal and ureteral calculi. Although Ccr on admission was 8.3 mL/min, the urologist continued administration of the MTX that had been prescribed prior to admission, as they did not know that MTX is contraindicated for patients with renal dysfunction. The patient was released from hospital after discharging the calculi, but was subsequently admitted as an emergency with pancytopenia. Administration of MTX was halted and administration of Leucovorin started.

No.130	**Air Embolism Due to a Central Venous Line Left Open**	71st

◆ Removal of closed-system connector along with infusion line from central venous catheter, resulting in the central venous catheter being left open to the air

In order to take off the round neck shirt the patient was wearing before giving them a bed-bath, the nurse disconnected the infusion line from the central venous catheter. When the patient stood up to take off their shirt, they developed dyspnea. When another nurse came to the room to assist, they noticed that the closed-system connector had been removed from the central venous catheter along with the infusion line, resulting in the central venous catheter being left open to the air.

No.133	**Chest Drain Left Open to Air**	69th

◆ Pneumothorax due to forgetting the water seal for the chest drainage bag

On the fifth day after surgery for esophageal cancer, the drainage chamber of the patient's chest drainage bag was full, so the nurse decided to change the chest drainage bag singlehandedly. The nurse connected a new bag to the chest drain tube, but when they released the clamp, the patient complained of respiratory discomfort and their SpO_2 fell to around 90%. When the physician checked, they found that there was no water in the water seal chamber of the chest drainage bag, so they injected sterile distilled water into it. The patient's SpO_2 then rose into the mid-90% range. Portable X-ray and CT examinations were carried out and the patient was found to have a pneumothorax.

* 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.

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