Project to Collect Medical Near-Miss/Adverse Event Information

Medical Safety Information

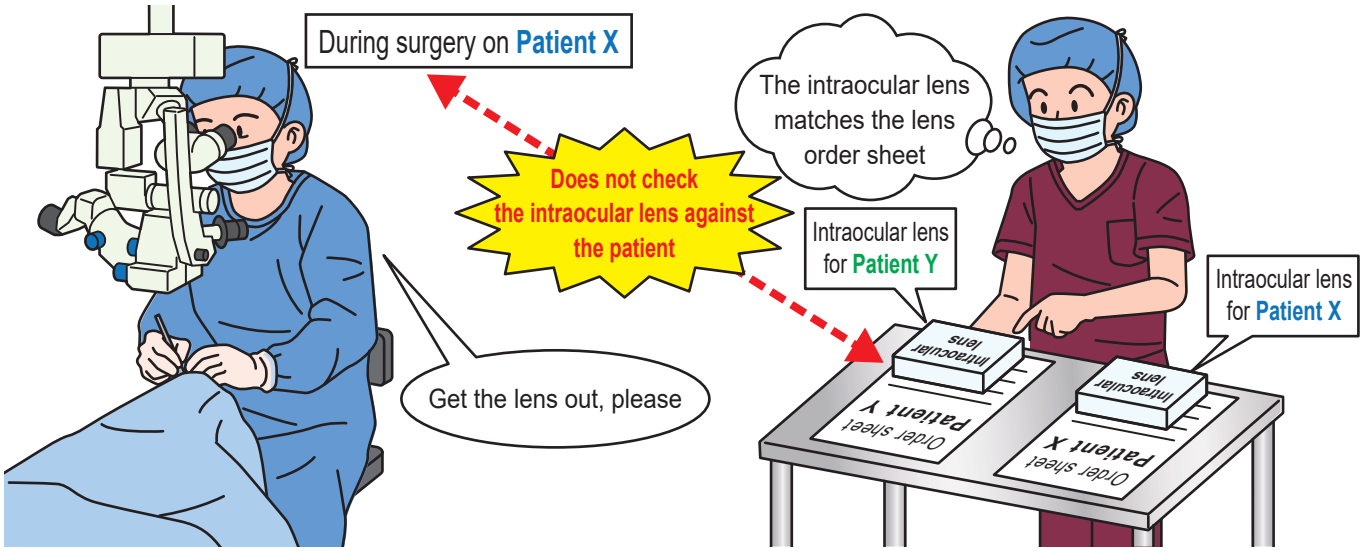
December 2023 No.205

Implantation of Another Patient's Intraocular Lens

Cases have been reported in which another patient's intraocular lens was erroneously implanted in a patient during cataract surgery.

Fourteen such cases were reported between January 1, 2020 and October 31, 2023. This information was compiled on the basis of the content featured in the Recurrence of Events and Occurrence of Similar Events section of the 61st Quarterly Report.

Image of case 1



Main Background Factors of Reported Events

- During surgery on Patient X, the nurse assumed surgery was being performed on Patient Y and checked Patient Y's intraocular lens against the order sheet before placing it in the sterilized area.
- During surgery on Patient X, the nurse took out an 18.5 D intraocular lens (Patient Y's) and checked it against the information on the ophthalmic surgery list, but did not check the patient's name.
- The nurse only checked the intraocular lens against the data on the electronic medical record and did not check the intraocular lens against the patient.
- The nurse looked at the label with the patient's name and took out Patient X's intraocular lens from among several intraocular lenses on the trolley, but was then ordered to place the local anesthetic in the sterilized area and therefore placed the intraocular lens back on the trolley temporarily. The nurse subsequently placed Patient Y's intraocular lens in the sterilized area without looking at the label with the patient's name.

Implantation of Another Patient's Intraocular Lens

Case 1

The supply processing and distribution (SPD) coordinator prepared a set consisting of an intraocular lens and a lens order sheet for each of two patients. During surgery on Patient X, when the physician ordered the nurse to take out the intraocular lens, the nurse assumed surgery was being performed on Patient Y and checked Patient Y's intraocular lens against the lens order sheet. The nurse read out Patient Y's name and lens power as stated on the lens order sheet, and then placed the intraocular lens in the sterilized area. The physician did not notice the difference in the names and implanted Patient Y's intraocular lens in Patient X. After Patient X's operation had been completed, the SPD coordinator noticed that Patient X's intraocular lens was left over.

Case 2

Intraocular lenses for two patients had been placed in the operating theater inside a bag. After Patient X's operation had begun, the physician ordered the nurse to take out the intraocular lens. Nurse A took out an 18.5 D intraocular lens (Patient Y's) and checked it against the information on the ophthalmic surgery list, but did not check the patient's name. Nurse A read out only the type and specifications of the intraocular lens and, as the physician replied "Okay," placed the intraocular lens in the sterilized area. After Patient X's operation had been completed, Nurse B looked at the used intraocular lens label and the list, and realized that Patient Y's intraocular lens had been implanted in Patient X.

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

Before commencing surgery, carry out steps (1)-(3) below.

(1) Check the name of the patient undergoing surgery against the name on the lens order sheet.

(2) Check the intraocular lens specifications and type against those on the lens order sheet.

(3) Decide on the place where checked intraocular lenses will be put to distinguish them from the other lenses.

The measures above are examples. 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.

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