Project to Collect Medical Near-Miss/Adverse Event Information

Medical Safety Information

March 2024

No.208

Medical Safety Information Released in 2023

Medical Safety Information No.194–No.205 was issued from January to December 2023. The full list of bulletins is shown below.

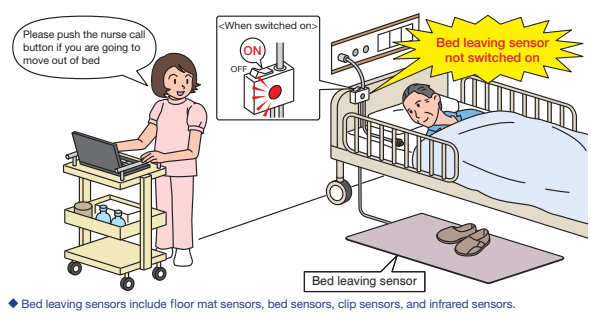
No.	Title
No.194	Forgetting to Reconnect Ventilator Circuit Tubing Due to Use of a Test Lung
No.195	★Examination/Procedure Conducted on Wrong Patient Due to Failure to Carry out Checks
No.196	Medical Safety Information Released in 2022
No.197	★Forgetting to Switch on the Bed Leaving Sensor
No.198	★Magnetic Material (e.g. Metal Products) Taken in the MRI Room (2nd Follow-up Report)
No.199	Medical Safety Information Highlighted in Quarterly Reports in 2022
No.200	★Burn Caused by Hot Water Used to Prevent Laparoscopic Lens Fogging
No.201	Wrong Unit Selected on Syringe Pump
No.202	Failure to Open the Central Seal of a Dual Chamber Infusion Bag
No.203	★Extravascular Leakage in Pediatric Patients (1st Follow-up Report)
No.204	Misconnection of Inspiratory and Expiratory Sides of a Ventilator Circuit
No.205	★Implantation of Another Patient's Intraocular Lens

A ★ next to a title indicates that recurrent and similar events were reported during the period to December 31, 2023.

No.197 Forgetting to Switch on the Bed Leaving Sensor

Cases have been reported in which it was not possible to detect that a patient had left their bed because medical personnel forgot to switch on the installed bed leaving sensor, and the patient subsequently suffered a fall.

Image of case

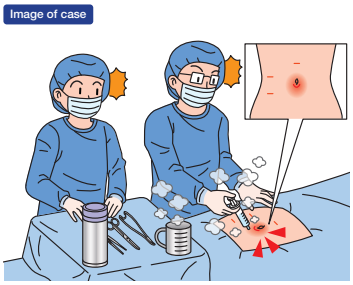


◆ Bed leaving sensors include floor mat sensors, bed sensors, clip sensors, and infrared sensors.

No.200 Burn Caused by Hot Water Used to Prevent Laparoscopic Lens Fogging

Cases have been reported in which a patient suffered burns during laparoscopic surgery, because hot water used to prevent laparoscopic lens fogging was used instead of warm normal saline to irrigate subcutaneous tissue or skin while the incision was being closed.

Image of case



Main Background Factors

- Due to having no experience of subcutaneous irrigation, the scrub nurse was rushing and passed the surgeon the hot water used to prevent fogging, rather than preparing fresh normal saline for irrigation.
- As some time had passed since the hot water used to prevent fogging had been prepared, the scrub nurse thought its temperature would have fallen.
- The scrub nurse placed their hand in the hot water used to prevent fogging, but as they were wearing two pairs of gloves, it did not feel hot.
- The scrub nurse stated that they would prepare warm normal saline for irrigation, but the surgeon did not wait for it to be prepared.

Medical Safety Information Released in 2023

◆These are recurrent and similar events reported in 2023.

No.195 Examination/Procedure Conducted on Wrong Patient Due to Failure to Carry out Checks

When Nurse A called Patient X into the outpatient treatment room, Patient Y came in. Nurse A took Patient Y's patient registration card, had Patient Y give their name and date of birth, and compared them against the details on the patient registration card, but did not check the details against the injection order form and therefore did not realize that the patient was not Patient X. Nurse A injected Patient Y with the rheumatoid arthritis drug intended for Patient X. By the time Nurse B subsequently called Patient Y into the outpatient treatment room, Patient Y had gone home. When Nurse B checked what had happened, they found that Patient X's drug had been administered to Patient Y.

No.197 Forgetting to Switch on the Bed Leaving Sensor

The nurse had installed a bed leaving sensor on the patient's bed, in accordance with the patient's activities of daily living; as the patient's walking had stabilized, the sensor was switched off in the daytime, between the hours of 10:00 and 16:00. On the day in question, the nurse had forgotten to switch on the bed leaving sensor at 16:00. At 16:42, a nurse discovered the patient on the floor in front of their room, following a fall.

No.200 Burn Caused by Hot Water Used to Prevent Laparoscopic Lens Fogging

When performing a laparoscopic appendectomy, the nurse had placed normal saline in an insulated bottle to prevent the laparoscopic lens from fogging. The surgeon decided to irrigate the wound when closing the incision. The surgeon had previously always used normal saline from the pot for this purpose and had never found it to be too hot, so they used the normal saline as usual. While irrigating the wound, the surgeon realized that the normal saline was hotter than usual. The patient sustained a burn that caused excoriation in the umbilical region.

* 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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