Project to Collect Medical Near-Miss/Adverse Event Information

Medical Safety Information

June 2024

No.211

Medical Safety Information Highlighted in Quarterly Reports in 2023

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 72nd–75th Quarterly Reports, which were published in 2023.
Detailed analyses of recurrent and similar events can be found on the project's website.

No.	Title	Quarterly Report No.
No.7 No.203	**Extravascular Leakage in Pediatric Patients** **Extravascular Leakage in Pediatric Patients (1st Follow-up Report)**	73rd

◆ Delays in noticing extravascular leakage

For surgery on a two-year-old pediatric patient, the anesthesiologist secured a peripheral venous line in the dorsum of the left hand. After the patient returned to their room, the area from the left hand to the forearm was fixed with a splint and protected with a dressing, and Veen-D Injection was being administered at a rate of 20 mL/h using an infusion pump. Overnight, the nurse checked that there was no swelling or redness at the insertion site. The following morning, when the nurse went to the patient's room because the infusion pump's obstruction alarm sounded, they found that the patient's left hand was swollen, with the skin engorged and painful to the touch. Blisters and erosion developed, which required continued treatment after the patient's discharge.

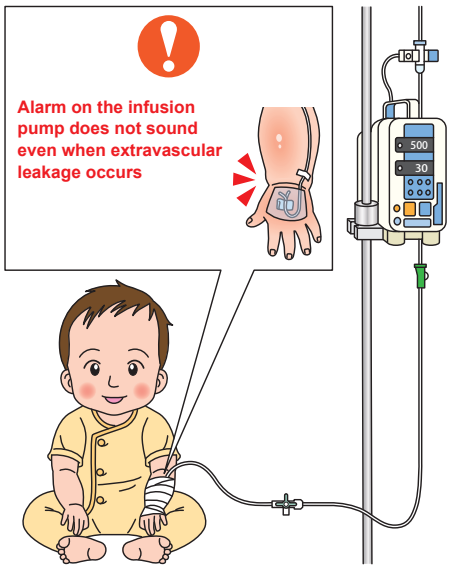

*Illustration published in Medical Safety Information No.203

No.	Title	Quarterly Report No.
No.24	**Tubing misconnection of ventilator circuit**	72nd

◆ Misconnection of inspiratory and expiratory sides of a ventilator circuit

As there was a possibility that a ventilator would be fitted to the patient after surgery, the clinical engineer had prepared a ventilator beforehand. When the ventilator was fitted to the patient after surgery, the humidification alarm sounded. When the nurse checked the ventilator circuit, they noticed that the inspiratory and expiratory sides of the ventilator circuit had been connected the wrong way around.

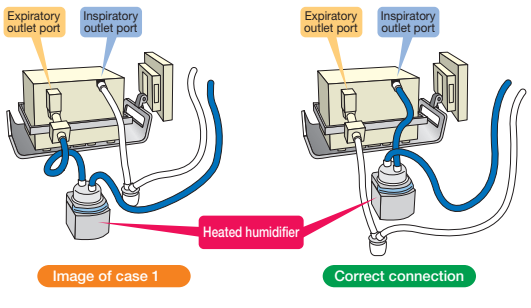

*Illustration published in Medical Safety Information No.24

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No.	Title	Quarterly Report No.
No.48 No.146	**Failure to check the oxygen remaining** **Inadequate Checks of Oxygen Remaining (1st Follow-up Report)**	73rd

◆ Interruption of oxygen administration due to failure to switch the tube over to the central piping system during an examination

A patient who required the administration of high-concentration oxygen at all times was to undergo an echocardiogram as an emergency. The nurse checked that there was enough oxygen left in the tank for the journey from the ward to the examination room and back again. In the examination room, the clinical laboratory technologist carried out the examination without switching the tube to the central piping system, leaving the patient to continue using the oxygen tank. While waiting to be collected by a nurse from the ward after the examination, the patient complained of respiratory discomfort. When the clinical laboratory technologist checked the amount of oxygen remaining in the tank, they found that it was zero.

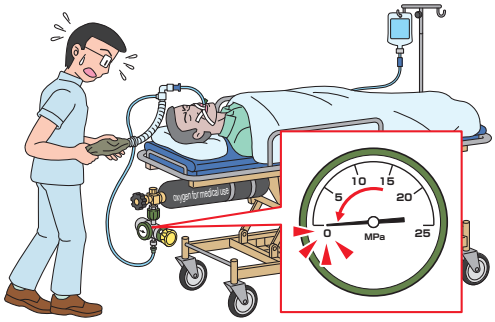

*Illustration published in Medical Safety Information No.48

No.	Title	Quarterly Report No.
No.56	**Burns caused by a high-frequency electric current loop during MRI examination**	74th

◆ Burns caused by the patient's thigh and hand touching during an MRI examination

For an MRI examination of the lumbar vertebra, the patient's arms were placed at the sides of their body. The radiological technologist had intended to place towels between the patient's thighs and hands, but their hands and thighs were in direct contact with each other. After the examination, the patient complained of pain in their left thumb and left thigh; the radiological technologist checked the area and, as they suspected a burn, they contacted a physician. There was a possibility that a high-frequency electric current loop had formed.

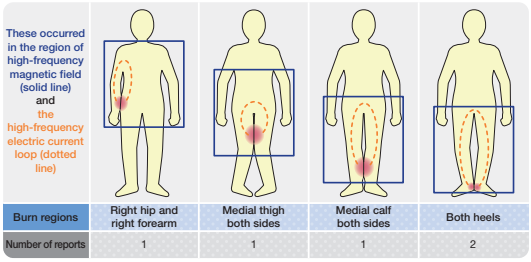

*Figure published in Medical Safety Information No.56

* 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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