Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

Medical Safety Information released in 2008

No.28, March 2009

Medical Safety Information No.14 – No.25 was issued monthly from January to December 2008. Your reconfirmation is greatly appreciated.

No.	Title
No.14	★Tubing (catheter/drain) misconnections
No.15	★Wrong pick-up of syringe containing drug
No.16	Medical Safety Information released in 2007
No.17	★Burn due to use of a hot water bottle
No.18	Drug administered at a wrong dose level due to discrepancy in interpretation of the prescription
No.20	★Use of unsterile medical supplies
No.20	★Failure to transmit an alteration of instructions
No.21	Caution to ensure proper usage of blood glucose testing devices
No.22	★Wrong prescription in chemotherapy protocol
No.23	Wrong input of units on computerized prescription order entry system
No.24	Tubing misconnection of ventilator circuit
No.25	Patient mix-up during medical examination

For title with ★, similar cases were reported from the issuance of the information to December 31, 2008.

Project to Collect Medical Near-Miss/ Adverse Event Information
Medical Safety Information

No.28, March 2009

Medical Safety Information released in 2008

Major similar cases reported after issuance of the Medical Safety Information

No.14 Tubing (catheter/drain) misconnections

Peripheral intravenous line, line for dialysis, and drain for peritoneal lavage were indwelled on the right side of the patient's body. When administering platelet products, the nurse did not check the sites of insertion and connection of the peripheral intravenous line, and erroneously connected the platelet products to the drain for peritoneal lavage. As an infusion set and an extension tube with needle-less injection port were used for the drain for peritoneal lavage, it remained connectable with the peripheral intravenous line.

No.20 Failure to transmit an alteration of instructions

The physician in charge prescribed instructed oral agent of Gatiflo as the discharge prescription, but noticed that it was the drug contraindicated for the patient, therefore, ordered to cancel it around 16:00 p.m. on the following day. The nurse did not notice that the discharge prescription was cancelled, and handed it to the patient. After discharge, the patient intook Gatiflo followed by skin rash which appeared in the genital area.

No.22 Wrong prescription in chemotherapy protocol

In the protocol, after administration of "Cisplatin (only on Day 1) + 5FU (Day 1-5)," three weeks of drug holiday was planned. However, the physician in charge confused it with the regimen of another chemotherapy, and administered Cisplatin and 5FU to the patient even in the second week which is a period of drug holiday.

◆ Other similar cases are to be included in the Annual Report 2008

* 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 "Comprehensive Evaluation Panel" to prevent 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. http://www.med-safe.jp/
* Accuracy of information was ensured at the time of preparation but can not be guaranteed in the future.
* This information is neither for limiting the discretion of healthcare providers nor for imposing certain obligations or responsibilities on them.

Division of Adverse Event Prevention
Japan Council for Quality Health Care
1-4-17 Misakicho, Chiyoda-ku, Tokyo 101-0061 JAPAN
Direct Tel:+81-3-5217-0252 Direct Fax:+81-3-5217-0253
http://www.jcqhc.or.jp/html/index.htm