Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

Medical Safety Information released from 2006 to 2007

No.31, June 2009

Cases similar to those published in Medical Safety Information bulletins in 2006-2007 were reported again in 2008.

No.※1)	Title	Number of case reported in 2008
	[Case]	
No.1	**Misconception of insulin content** – Cases due to misconception of the vial label "100 units/mL" –	2

Nurse A prepared "Normal saline 39mL + Humulin R 100 units" according to the physician's instruction. Nurse A saw "100 units /mL" on the insulin vial, and believed that 1 vial contained 100 units. Instead of adding 100 units (1mL), the nurse added 1000 units (10mL 1 vial) of Humulin R to 39mL of normal saline and administered it to the patient. The nurse A and B did not confirm the unit during the double-check. (There was another similar case.)

No.4	**Drug mix-up** – Cases of mix-up due to similarity in drug names –	3

On duty physician A input "Sa-ku-shi (in Japanese)" in a search box in order to input "Saxizon" in the electronic chart, but erroneously inputted "Succin" displayed as the search result and "Succin 200mg 2A + Normal saline 100mL" was ordered. Nurse B and nurse C confirmed the drug, and nurse C administered it to the patient. When nurse D visited the patient room two hours later, the patient suffered respiratory arrest. The physician A on duty confirmed the administered drug and noticed the erroneous input. The purchase of "Saxizon" was discontinued at the hospital, but "Succin" was used only for surgery. (There were two other similar cases.)

Notification regarding drug mix-up due to similarity in drug names have been issued by the Ministry of Health, Labour and Welfare.
Issued by the Health Policy Bureau, No.1204001, December 4, 2008
Issued by the Pharmaceutical and Food Safety Bureau, No.1204001, December 4, 2008
http://www.info.pmda.go.jp/iryoujiko/file/20081204.pdf

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No.※1)	Title	Number of case reported in 2008
	[Case]	
No.5	**Burn during assisted bathing** – Cases of burn due to not checking the hot water temperature just before assisted bathing –	1

Two nurses were assisting a patient to take a bath. When preparing the hot water in the bathtub, the nurse pressed the 57 ˚C water supply button instead of the 42 ˚C button, and filled the bathtub. The nurse then assisted the patient into the bathtub without confirming water temperature either with a thermometer or by her hand. As a result, the patient suffered burn.

No.7	**Extravascular leakage in pediatric patients** – Cases of requiring subsequent treatment because of extravascular leakage when infusion was administered to the pediatric patients, regardless of whether or not the risk of transfusion leakage is described in the package insert –	4

A Jelco needle was indwelled into the medial malleolus of the right foot, and continuous infusion was performed by using infusion pump. Later, swelling and bulla were observed from below the knee through down to toe due to extravascular leakage. A splint was fixed with an elastic bandage in order to avoid extravascular leakage, but observation of the insertion site was thereby difficult as a result. (There were three other similar cases.)

No.8	**Wrong site surgery (right/left)** – Cases of wrong site surgery between right and left –	3

The physician A confirmed the name of the patient and the surgical site (left eye) in the operation room, and marked near the left temple with a felt tip pen. The physician B sterilized around the eye to be operated (left eye), and after the sterilization, the cover cloth was placed on the patient with the right eye exposed. The physician C noticed that eyelashes were still on the exposed right eye, thought that this was an oversight, and removed them. Next, the physician D entered the operation room, thought operation was to be on the right eye, and began surgery. The following day, the wrong site surgery between the right and left eye was pointed out by the family of the patient. (There were two other similar cases.)

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No.※1)	Title	Number of case reported in 2008
	[Case]	
No.10	**Magnetic material (e.g. metal products) taken in the MRI room** – Cases of bringing a magnetic material (e.g. metal products) in the MRI room –	1
	After emergency MRI examination, the physician brought a stretcher with an oxygen tank into the MRI room, so that the patient would leave the room. The oxygen tank flew off and attached to the gantry under the examination table. The oxygen tank was originally set parallel to the floor under the stretcher, so flew out to the gantry under the examination table and did not harm the patient on it.	
No.11	**Blood transfusion to the wrong patient** – Cases where the blood product to be used on the patient was not finally checked when connecting the blood products for a transfusion –	1
	Blood products for patient A and patient B were placed in a constant-temperature bath. The nurse C erroneously took the product for patient B from the constant-temperature bath to administer the product for patient A, and hung it on IV stand. At that time, the nurse failed to verify blood ordering sheet with the product and to check the compatibility between the patient and the product. The nurse D did not confirm the product hung on IV stand and administered it to patient A. The nurse C noticed the mismatched blood transfusion after administering about 70mL.	

※1) "No." indicates the provision number of the Medical Safety Information.

◆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.

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