Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.38, January 2010

Wrong pick-up of syringe containing drug in sterilized area

Five cases of wrong pick-up caused by identification error of prepared syringes in sterilized area of surgery or examination, etc., have been reported (information collection period: from January 1, 2006 to November 30, 2009; the information is partly included in "Medical Adverse Event Information to Be Shared" (p.141) in the 10th Quarterly Report).

The cases of wrong pick-up caused by identification error of prepared syringes in sterilized area have been reported.

Drug which should have been administered	Wrong pick-up
Isovist	Xylocaine
Heparin in normal saline	Omnicain
Omnipaque	Xylocaine
Xylocaine	Oxydol
Xylocaine	0.05 $^{w}/_{v}$ % Maskin water

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Case 1

Xylocaine injection and 0.05 w/v % Maskin water were prepared in syringes for a skin biopsy in the outpatient treatment room, but no information was provided to identify the drug name on the two syringes. Customarily, the syringes with 0.05 w/v % Maskin water were placed standing in a beaker in the outpatient treatment room, but in the operation room, syringes with Xylocaine injection were placed standing in a beaker. The physician thought that the syringe prepared standing in a beaker would be Xylocain injection, and mistakenly injected 0.05 w/v % Maskin water.

Case 2

Omnicain and Heparin in normal saline for flash were prepared in syringes and placed in a sterilized area during a catheter examination. The physician mistakenly administered Omnicain instead of Heparin in normal saline, and the patient showed tendency of bradycardia. Originally, the physician identified the drug by attaching a 22G needle on the syringes with Omnicaine. However, the needle was removed from the syringe after the local anesthesia was applied and the syringe was placed in the sterilized area. As a result, the physician took the syringe with Omnicain for the syringe with the Heparin in normal saline.

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

- **Clearly identify the drugs prepared in syringes when placing them in the sterilized area by the methods below.**
  - ○ **Attach a label indicating the drug name on a syringe.**
  - ○ **Use different colored syringes and needles, etc., to identify specific syringes.**
- **Unify and comply the rules to identify drugs prepared in syringes throughout the hospital.**

Complementary comment by the Comprehensive Evaluation Panel

- **Make it a principle to prepare drugs in syringes by the user him/herself just before use.**
- **When preparing drugs in a syringe beforehand is unavoidable, make it easy to identify.**
- **Do not prepare antiseptics and other drugs in similar containers.**

* 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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