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 2008

No.43, June 2010

Cases similar to those published in Medical Safety Information bulletins in 2006-2008 were reported again in 2009.

No.※1)	Title	Number of case reported in 2009
[Case]		
No.3	**Rectal perforation associated with glycerin enema** – Cases of suffering rectal perforation, etc. associated with glycerin enema –	2
A patient was assisted in a wheelchair to the toilet by a nurse for an enema scheduled just before examination. The nurse performed a glycerin enema on the patient in the standing position (bending forward position). After 30 minutes, the patient complained of abdominal pain. The CT scan showed rectal perforation, and emergent surgery was carried out. (There was another similar case.)		
No.4	**Drug mix-up** – Cases of mix-up due to similarity in drug names –	3
When a regular prescription was dispensed, 120mg of Phenytoin was weighed instead of Phenobarbital powder. The error was not noticed during packaging and auditing, and the prescription was sent to the ward and administered to the patient. At a blood examination a month later, the phenobarbital concentration in the blood was low and the mix-up in the preparation was found on confirmation. The drugs with similar product names and the same efficacy were placed in line on the storage shelf. (There were two other similar cases.)		
No.6	**Misconception of insulin unit** – Cases resulting in hypoglycemia due to insulin overdose –	4
Instructions to mix 4units of Humulin R to Soldem 3A 500mL and administer at a constant infusion of 60mL/hr, was issued. The nurse mixed 4mL of Humulin R (400units) into Soldem 3A 500mL, and administered it to the patient. Two and a half hours later, symptoms of hypoglycemia were observed in the patient. (There were three other similar cases.).		
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 –	7
An infusion was administered via a central venous line to a 14-year-old patient, but due to a defective drip, the peripheral line was secured on the right thumb. After indwelling, Proternol and Dormicum were administered. The following day, nurse A noticed swelling and pale color of the skin around the insertion site of the peripheral line. Nurse B notified the physician, removed the infusion, and protected the insertion site with gauze. The following day, the peripheral of the the first joint of the thumb became necrotic. (There were six other similar cases).		

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No.※1)	Title	Number of case reported in 2009
	[Case]	
No.8	**Wrong site surgery (right/left)** – Cases of wrong site surgery between right and left –	4
	A physician scheduled a surgery of left inguinal hernia for a patient, but protrusion of the inguinal hernia was observed on the right side by palpation, when the surgical site was marked before the surgery. Then the right side was marked, and the surgery. During surgery, the anesthesiologist noticed the surgical side was scheduled to be the left, and noticed the mix-up between the right and the left. The physician did not mark the surgical site beforehand. He/she looked at the chart upon entering the room, and confirmed the surgical side verbally. However, he/she did not confirm it after marking. (There were three other similar cases).	
No.9	**Confusion between total product amount and content of active ingredient** – Cases of confusing of the total product amount and content of active ingredient –	1
	The patient was administered Spironolactone 25mg orally, but the physician decided to prescribe 12.5mg, a half dosage of the original prescription. Spironolactone 25mg was in tablet form, so in order to prescribe an amount less than that, the physician entered the prescription "125mg" intended to the total drug amount of Aldactone-A Fine Granules 10% (active ingredient: Spironolactone). The pharmacist thought that when drug is prescribed as "mg," this meant the active constituent. In addition, Aldactone-A (active ingredient: Spironolactone) "125mg" was not an excessive amount to administer to a normal adult, so the pharmacist prepared the entered prescription "125mg" as an active ingredient. After administration by the patient for 12 straight days, the department of pharmacy noticed the error.	
No.10	**Magnetic material (e.g. metal products) taken in MRI room** – Cases of bringing a magnetic material (e.g. metal products) in the MRI room –	5
	As preparation for an MRI scan, the resident physician the patient to administer a contrast agent. At that time, a barrette (metallic object) from her hair flew into the magnet. After making sure that there was no harm to the patient by visual confirmation and interview, and then the barrette was collected. The resident forgot to remove the barrette prior to MRI scan and entered into the scan room. At the moment that the resident noticed that the barrette was attracted to the magnet, the barrette already flew into the magnet. (There were four other similar cases).	
No.11	**Blood transfusion to 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 –	2
	The physician described the blood transfusion order of patient A (blood type A) on the ICU chart as "RCC 2units at 60/hr (with parallel infusion at 40/hr during the RCC transfusion)," and asked nurse B on the late night shift, "Do you have RCC?" There were two bags of blood products for the patient C (blood type O) in the ICU's blood storage and the nurse B thought this was for the patient A. The nurse B brought back one bag, verbally confirmed the blood type and lot number with nurse D, and connected the blood product for the patient C (blood type O) to the patient A (blood type A). (There was another similar case)	

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No.※1)	Title	Number of case reported in 2009
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No.14	**Tubing (catheter/drain) misconnections** – Cases of tubing (catheter/drain) misconnection for infusion in patients to whom multiple catheters or drains were inserted –	2

The physician A intravenously injected air into a pediatric patient's vein instead of the patient's stomach. The physician B administered anesthetics, and the physician A was in charge of intubation. The physician C inserted a gastric tube, connected a 3-way stopcock designed for intravenous line to the gastric tube, and connected the tube to a stomach fluid bag. In order to inject air into the stomach during the surgery, the physician C, E and F instructed the physician A to inject 100mL of air from the 3-way stopcock connected to the gastric tube. The physician A thought that a 3-way stopcock was not usually connected to a gastric tube and that a yellow-colored exclusive syringe should be used for the connection to the gastric tube. However, because he/she heard the others saying "injection through 3-way stopcock " at that time, he/she prepared a regular syringe. The physician A could not find the 3-way stopcock in the begining, and he/she touched a 3-way stopcock under a covering sheet by tracing the line from the end at the gastric bag and believed it was the stopcock connected to the gastric tube a although it actually was that connected to the intravenous line leading to the air injection in to the vein. (There was another similar case)

No.15	**Wrong pick-up of syringe containing drug** – Cases of multiple syringes being prepared for operation or treatment with labels displaying the drug name, but despite this, wrong pick-up of syringe containing drug occurred because these labels were not checked –	3

During surgery, the nurse was to inject Dormicum 1.5mg intravenously by the instruction of the anesthesiologist, but administered Eslax instead. The patient induced tachycardia and dyspnea. Upon confirmation, the syringe which the label of Eslax, not Dormicum, had been attached was connected to the 3-way stopcock, and it was found that Eslax was administered. (There were two other similar cases).

No.17	**Burn during use of a hot water bottle** – Cases of burn during use of hot water bottles –	1

The nurse A prepared two hot water bottles for a patient after surgery, placed one 10cm away from the feet, and placed another between the lower thighs. The nurse B on the following work shift thought that the patient only had the one hot water bottle near the feet. Afterwards, the patient complained of pain on the left thigh. Upon confirmation, the skin of inside of the left thigh was rashed, and burning sensation and blisters formation in three locations were observed.

No.18	**Drug administered at a wrong dose level due to discrepancy in interpretation of the prescription** – Cases of administration of drug at a wrong dose level due to discrepancy in interpretation of the prescription –	1

When administering an antibiotic to a pediatric patient weighing approximately 1.2kg, the senior physician and the physician read "Cefmeta 75-100mg/kg/day, 3×" on the in-house manual together, and calculated the administration dose. The senior physician said "Cefmeta 120, right?" to the physician, intending to confirm the dose for a day which they calculated together, and requested the physician to input the order. The physician interpreted as "Cefmetazon 120mg per time, three-time a day," prescribed and administered it to the patient.

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No.※1)	Title	Number of case reported in 2009
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No.20	**Failure to transmit an alteration of instructions** – Case of original instructions being implemented although they were altered, due to the additional instructions not being transmitted to the related department –	3
	Administration of Prednisolone 15mg orally for a patient with renal dysfunction was initiated. Afterwards, the patient was admitted to the hospital for treatment, and steroid pulse treatment was performed for two days. During the pulse treatment, administration of oral Prednisolone tablet was discontinued. After completing the pulse treatment, re-administration of Prednisolone was ordered, however, it was not resumed because of poor cooperation between the physicians, nurses, and pharmacists. Two days after the pulse treatment, renal function continued to deteriorate and the patient developed a complication of pneumonia. Afterwards, hemodialysis was performed three times a week, and an antibiotic treatment for pneumonia was started. However, inflammatory reaction continued regardless of improvement in the respiratory condition and a finding of chest X-ray. Upon review of the drug ten days after the pulse treatment, it was noticed that Prednisolone was not administered. (There were two other similar cases.)	
No.22	**Wrong prescription related to chemotherapy protocol** – Cases of the administration of anti-tumor agent on a drug holiday due to wrong prescription –	2
	The patient brought a referral form from the former physician in charge and a latest prescription issued on the final visit when admitted to the hospital. Multiple drugs were prescribed during the last six weeks, including Alkeran and Predonine for four days, planned to start from the 8th day from the prescribed date. The patient was admitted to the hospital on the following day after the administration of Alkeran and Predonine for four days. Reading the referral form and the prescription, the physician in charge continued to administer Alkeran and Predonine for seven days. After that, when additional administration was ordered, the pharmacist inquired about the prescription. Upon confirmation, the drugs in question were to be taken orally for only four days in MP chemotherapy, resulting in a seven-day overdose. (There was another similar case)	
No.23	**Wrong input of units on computerized prescription order entry system** – Cases of overdose due to wrong input of units on computerized prescription order entry system –	3
	A 45-day-old extremely low birth weight infant was to be administered Pontal syrup. Though the attending physician should have administered a titer of 1.5mg, a prescription was ordered for 1.5mL (48.75mg) of syrup, and because the nurse administered the drug as prescribed, the pediatric patient was administered about 30 times the planned amount. The overdose was discovered upon examination of the medical chart by the senior physician. The attending physician had no prior experience with prescribing Pontal syrup and was not sufficiently knowledgable. (There were two other similar cases.)	

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

◆Other similar cases are to be included in the Annual Report 2009.

* 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/