Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

Medical Safety Information released in 2010

No.52, March 2011

Medical Safety Information No.38-No.49 was issued monthly from January to December 2010. Please confirm them again.

No.	Title
No.38	★Wrong pick-up of syringe containing drug in sterilized area
No.39	★Insufficient confirmation of medicines brought in at hospitalization
No.40	Medical Safety Information released in 2009
No.41	Drug administered at a wrong dose level due to discrepancy in interpretation of prescription (1st Follow-up Report)
No.42	Reception error of patient's ECG waveform in central monitoring system
No.43	Medical Safety Information released from 2006 to 2008
No.44	Connection of medical and electrical devices exceeding the electrical capacity of the outlet (rated current)
No.45	★Bone marrow suppression due to antirheumatic (Methotrexate) overdose (1st Follow-up Report)
No.46	Burn caused by a bed-bath towel
No.47	Mix-up of the tooth extraction site
No.48	Failure to check oxygen remaining
No.49	Failure to implement measures to prevent mother-to-child transmission of Hepatitis B

For titles with ★, similar cases had been reported after the release of each issue until December 31, 2010.

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◆ The following similar cases occurred.

No.38 Wrong pick-up of syringe containing drug in sterilized area

Two beakers containing heparin in normal saline and Hypoalcohol were taken to the sterilized area during cardiac catheter examination without information for identification. When the physician flushed the sheath placed on the left radial artery, he/she thought the beaker placed in sterilized area containing Hypoalcohol was holding heparin in normal saline for flushed, and filled the syringe and injected the solution into the patient. Immediately after, the patient complained of pain, and redness and swelling on left forearm was observed.

No.39 Insufficient confirmation of medicines brought in at hospitalization

On the day of admission to the hospital, the primary physician and the nurse only confirmed the medicines brought in by the patient because there was no documentation describing the medication that the patient was currently taking, such as the referral form from the other hospital and drug history handbook. The primary physician was informed that the patient stopped taking Bayaspirin (antiplatelet agent) due to drug rash, but did not know that Plavix (antiplatelet agent) and Cerocral were prescribed by the other hospital. Plavix and Cerocral were not included in the medicines brought in by the patient. Plavix and Cerocral were not administered for a several days as they were not included in the order for continuous administration of medicines.

No.45 Bone marrow suppression due to antirheumatic (Methotrexate) overdose (1st Follow-up Report)

In the follow-up of an increased steroid dose, the physician decided to prescribe the drug for one week and explained it to the patient. When the physician prescribe medicine in addition to the steroids, Rheumatrex capsules 2mg to be administered for seven days, instead of the intended two days, was entered. The patient received the prescribed drug at the external pharmacy, and visited the hospital after seven days of administration. The physician was told that the patient administered it for seven days, and realized the administrative mistake. And that, the physician carried out a blood examination. No abnormality was found in the data, but Leucovorin was prescribed for prophylaxis.

Note) Directions for the use of antirheumatic (Methotrexate): Oral administration three times at 12 hours interval from the initial day to second day, followed by drug holiday of the rest five days. Repeat this in every other week.

◆ Other similar cases are included in the Annual Report 2010.

* 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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