Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

Medical Safety Information released in 2011

No.64, March 2012

Medical Safety Information No.50-No.61 was issued monthly from January to December 2011. The full list of bulletins is shown below.

No.	Title
No.50	★ Wrong site surgery (right/left) (1st Follow-up Report)
No.51	★ Insufficient knowledge of the administration status for warfarin potassium and blood coagulability
No.52	Medical Safety Information released in 2010
No.53	Specimen mix-up at pathological diagnosis
No.54	★ Accidental removal of the endotracheal/tracheostomy tube when changing positions
No.55	Medical Safety Information released from 2006 to 2009
No.56	Burns caused by a high-frequency electric current loop during MRI examination
No.57	★ Accidental ingestion of PTP sheets
No.58	★ Rupture of the subcutaneous port and catheter
No.59	★ Burns due to incorrect handling of an electrosurgical pencil
No.60	Vaccination with an immunization vaccine past its expiry date
No.61	Contraindicated combined administration of drugs

For titles with ★, similar cases had been reported after the release of each issue until December 31, 2011.

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◆ The following similar cases occurred.

No.50 Wrong site surgery (right/left) (1st Follow-up Report)

As a result of a CT scan following a cerebral contusion, the patient was diagnosed with brain herniation due to an acute right frontal subdural hematoma and emergency surgery was carried out. After the surgeon marked the left frontal area unassisted, s/he began to disinfect the area and commenced the surgery without taking a time out. After the surgery, when checking the patient's anisocoria, it was found that the right pupil was bigger and the mix-up between left and right during surgery was discovered.

No.54 Accidental removal of the endotracheal/tracheostomy tube when changing positions

The patient, who was fitted with a ventilator, was to be moved into the left lateral decubitus position. The ventilator was on the patient's right side. Nurse A, who was on the patient's left, held the breathing tube and the patient's head, while Nurse B held the patient's shoulders and waist. In addition, Nurse C, who was on the patient's right side, pushed the patient's back to turn him/her into the left lateral decubitus position. In doing so, Nurse A's hold on the tracheostomy tube was not firm enough, so the tracheostomy tube was pulled off.

No.57 Accidental ingestion of PTP sheets

The nurse separated each tablet of the oral medication, which was still in its PTP sheet, and placed it in a cup which s/he then put on the overbed table before leaving the room. Subsequently, the patient complained "I took the medicine without removing it from the PTP sheet. Now my throat is stinging." When the empty bag was checked, there was no empty PTP sheet for the single Loxonin tablet, and it could not be found in the patient's oral cavity, pharynx or larynx. After examining the patient, the duty physician carried out an emergency endoscopy and found and removed from the esophageal orifice the PTP sheet containing the Loxonin.

◆ Other similar cases are included in the Annual Report 2011.

* 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 the "Comprehensive Evaluation Panel" to prevent the 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 cannot be guaranteed in the future.
* This information is intended neither to limit the discretion of healthcare providers nor to impose certain obligations or responsibilities on them.

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