Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

Medical Safety Information released in 2012

No.76, March 2013

Medical Safety Information No.62-No.73 was issued monthly from January to December 2012. The full list of bulletins is shown below.

No.	Title
No.62	★ Insufficient Confirmation Concerning Medical Devices Implanted into the Patient's Body
No.63	★ Inadequate Checks Concerning Diagnostic Imaging Reports
No.64	Medical Safety Information released in 2011
No.65	Wrong Pick-up of Drug Set Out on the Emergency Cart
No.66	Misconception of insulin content (1st Follow-up Report)
No.67	Medical Safety Information released from 2006 to 2010
No.68	Drug mix-up (1st Follow-up Report)
No.69	★ Provision of Food to Which the Patient was Allergic
No.70	Burns Caused by the Tip of a Light Source Cable during Surgery
No.71	Forgetting to Check the Pathologic Diagnosis Report
No.72	★ Misconnection of Drugs for Continuous Infusion into the Epidural Space
No.73	Patient Mix-up during Radiological Examinations

For titles with ★, similar cases had been reported after the release of each issue until December 31, 2012.

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◆ The following similar cases occurred.

No.62 Insufficient Confirmation Concerning Medical Devices Implanted into the Patient's Body

The physician failed to ask for sufficient information about the patient and issued an order for an MRI examination of the patient, who had undergone pacemaker implantation. The radiological technologist had not received the MRI medical history form, so s/he verbally asked the patient whether s/he had any metal items implanted in his/her body and the patient answered "I don't think so", so the technologist carried out the MRI examination. The physician subsequently looked at the patient's medical history and noticed that a pacemaker had been implanted. The pacemaker was checked at a later date and it was found to have no abnormalities.

No.63 Inadequate Checks Concerning Diagnostic Imaging Reports

A patient receiving outpatient follow-up for malignant lymphoma was seen at another medical institution for abdominal pain; following a CT examination, a tumor lesion (measuring 50mm) in the liver was pointed out. When the diagnostic imaging reports for the patient's previous CT examinations were reviewed in response to a request for the provision of medical information, it was discovered that a tumor lesion (measuring 35mm) in the liver had been pointed out in a report dated nine months earlier. The physician failed to check the diagnostic imaging report adequately.

No.69 Provision of Food to Which the Patient was Allergic

The patient's meal information card stated that s/he had allergies to hens' eggs and milk, but the cook only noticed the allergy to eggs and overlooked the other information. In addition, when the cook preparing the snacks and the staff member serving them carried out a double-check, they did not check the order sheet that detailed the patient's allergy information. The snacks were served on the ward and the patient was given a sorbet containing dairy products. When the patient ingested the sorbet, his/her face became red and s/he suffered anaphylactic shock, presenting as asthmatic response, hypotension, increased heart rate, and respiratory distress.

◆ Other similar cases are included in the Annual Report 2012.

* 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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