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 2011

No.79, June 2013

Cases similar to those published in Medical Safety Information bulletins in 2006-2011 were reported again in 2012.

No.[1)]	Title -Description-	Number of cases reported in 2012
	[Case]	
No.3	**Rectal perforation associated with glycerin enema** – Cases of suffering rectal perforation, etc., associated with glycerin enema –	2
	When administering an enema, the nurse told the patient to lie in the left lateral decubitus position, but the patient's preference was for the right lateral decubitus position, so the enema was administered in the latter position. No fecal matter emerged in response, but bloody discharge (fresh blood) measuring about 10cm in diameter was found in the bottom of the portable toilet, along with some discharged enema liquid. During a rectal examination, the attending physician confirmed that there was no mass in the rectum, but that there was a soft internal hemorrhoid in the anus at the 12 o'clock position, so s/he decided to keep the patient under observation. Five days later, when an abdominal CT examination was carried out prior to discharge, intraluminal air was observed on the right-hand side of the rectum, which revealed that the patient had a rectal perforation. (There was another similar case)	
No.4	**Drug mix-up** – Cases of mix-up due to similarity in drug names –	2
	When starting the patient on 2 tablets of the antihypertensive Almarl 2 times/day, 2 tablets of Amaryl 2 times/day were erroneously prescribed. The error was noticed during a consultation about a month later. The patient had noticed occasional feelings of hunger and there was found to be a slight decline in HbA1c and FBS, so it was presumed that the patient's blood glucose level had declined. The hospital's ordering system had previously been updated to display the term "anti-diabetic drug" after the drug name Amaryl, as a precaution against drug mix-up, but the explanatory note was no longer displayed after the system was changed. (There was another similar case)	
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 –	9
	An infusion pump was used to administer Physio35 at a rate of 50mL/h to a pediatric patient via a peripheral route in the dorsum of the left foot. When the nurse who received the handover from the night shift looked at the insertion site of the indwelling needle in the peripheral vein, s/he noticed swelling, induration, and at least 12 blisters of varying sizes over the whole of the dorsum of the left foot, as well as discoloration of the toes; these symptoms were thought to have been due to extravasation of the infusion. There was no obvious difference between left and right in terms of external appearance from the left knee to ankle, but slight induration of the left leg was observed upon palpation. An orthopedic specialist examined the patient and determined that a relaxing incision was necessary. (There were eight other similar cases)	

Project to Collect Medical Near-Miss/ Adverse Event Information
Medical Safety Information

No.79, June 2013

Medical Safety Information released from 2006 to 2011

No.[1)]	Title -Description-	Number of cases reported in 2012
	[Case]	
No.8	**Wrong site surgery (right/left)** – Cases of wrong site surgery between right and left –	2
The patient was due for radical surgery to repair a left inguinal hernia. Usually, the physician marked the site in the patient's hospital room on the morning of the operation, but in this case, the patient's name and operative site were confirmed verbally after the patient was brought into the operating theater, and the physician marked the right-hand side. According to the findings, the mix-up was not noticed because the patient had hernias on both the left and right sides, so radical surgery was carried out on the right inguinal hernia. The left-right mix-up was noticed during the post-operative rounds, when the patient pointed out that the wrong site had been operated on. (There was another similar case: Medical Safety Information No.50 (January 2011: 1st Follow-up Report))		
No.9	**Confusion between total product amount and content of the active ingredient** – Cases of confusing of the total product amount and the content of active ingredient –	1
The patient, who had a history of epilepsy and was being treated with oral medication prescribed at another medical institution, was admitted to the surgical ward in order to undergo surgery. Based on the medication notebook brought in at the time of admission, which listed the patient's current medication as "Selenica-R Granules 40% 0.333g per dose and Carbamazepine Fine Granules (Tegretol Fine Granules 50%) [Amel] 0.4g per dose, 3 times/day", the physician prescribed six days' supply of anticonvulsants, specifying the daily dose as Selenica-R Granules 40% 1,000mg and Tegretol Fine Granules 50% 1,200mg 3 times/day, to be taken after breakfast, lunch, and dinner. Although the medication notebook listed the total product amount, orders at the hospital were displayed as the active ingredient dosage, so the total product amount was confused with the active ingredient dosage. As a result, 2.5 times the required dose of Selenica-R Granules and double the required dose of Tegretol Fine Granules were prescribed and given to the patient, who took them. After discharge, the patient continued to experience lightheadedness, so a family member asked a dispensing pharmacy to check the prescription medication, resulting in the discovery of the overdose.		
No.10	**Magnetic material (e.g. metal products) taken in the MRI room** – Cases of bringing magnetic material (e.g. metal products) into the MRI room –	4
Cleaning had been outsourced and while one of the cleaning company's employees was carrying out regular cleaning, some of the cleaning equipment became stuck to the MRI scanner. It was the first time that the cleaning company employee had carried out cleaning at a hospital. (There were three other similar cases)		
No.13	**Failure to check of infusion pump flow** – Cases of forgetting to check the flow rate when using an infusion pump, etc. –	1
A patient on a ventilator was being administered a continuous infusion of Propofol Injection at a rate of 6mL/h. The infusion pump for the Propofol was changed when sorting out the drugs for the Swan-Ganz catheter and the infusion route, but it was started without changing the previous settings. Subsequently, the anesthesiologist noticed that the flow rate for the continuous infusion of Propofol was 42mL/h. 28mL had been administered over the course of 40 minutes.		

Project to Collect Medical Near-Miss/ Adverse Event Information
Medical Safety Information

No.79, June 2013

Medical Safety Information released from 2006 to 2011

No.[1)]	Title -Description-	Number of cases reported in 2012
	[Case]	
No.14	**Tubing (catheter/drain) misconnections** – Cases of tubing (catheter/drain) misconnection for infusion in patients into whom multiple catheters or drains were inserted –	4

The intention was to administer Takepron via an intravenous route, but it was connected to the T-shaped stopcock on the abscess irrigation drain. This was noticed before administration of the drug began and it was administered via the intravenous route. (There were three other similar cases)

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 –	2

5mg (0.5mL) of water-soluble Predonine was prepared in a syringe for Pediatric Patient A, with two nurses carrying out checks, and the syringe was placed on a single tray, along with 13mg (1.3mL) of water-soluble Predonine for Pediatric Patient B. The primary nurse visited Pediatric Patient A's room and verified the bar codes on the injection form, the patient's wristband, and the label on the syringe. Immediately before administering the drug, the alarm on the syringe pump used for Pediatric Patient A sounded, so the nurse put the syringe that s/he had been holding back in the tray and dealt with the alarm, then picked up the syringe from the tray again and injected the drug solution. When s/he returned the syringe to the tray after use, s/he noticed that the syringe containing the drug for Pediatric Patient A was still there and that s/he had mistakenly picked up and injected the injection drug meant for Pediatric Patient B. (There was another similar case)

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

The patient had been brought to the hospital with fever and dyspnea, and although s/he was experiencing involuntary movement of the lower limbs, s/he did not exhibit any dangerous behavior. His/her limbs began to feel cold during the evening, so the patient was kept warm with a quilt, but his/her lower limbs continued to feel cold. Accordingly, the nurse put some warm water (about 60°C) in hot water bottle and placed it near the patient's feet without a cover, keeping it at least 10cm away, to ensure that it did not come into direct contact with the patient. During the rounds two hours later, the nurse found that the hot water bottle was still warm to the touch and checked to ensure that it was not touching the patient. An hour after that, when giving the patient a full bed-bath, the nurse noticed damage to the skin on the right lower leg and the left great toe, and the patient was subsequently diagnosed with a third degree low-temperature burn injury.

No.18	**Drug administered at a wrong dose level due to discrepancy in interpretation of the prescription** – Cases of administration of a drug at a wrong dose level due to discrepancy in interpretation of the prescription 3× and 3 times/day –	1

When Depakene Syrup was being prepared for the patient, Primary Nurse A confirmed that the prescription stated "Depakene Syrup 5% 15mL 3 times/day (after meals)". However, 15mL of Depakene Syrup had been prepared and when s/he checked the handwritten patient list, which detailed the oral medication and doses, it stated "Depakene Syrup 15mL per time". Nurse B, who had written up the patient list, had mistaken the daily dose listed on the prescription for the dose to be given each time and had written this on the patient list. Nurse C, who had prepared the Depakene Syrup, had referred to the patient record when preparing the drug. The mistake was noticed before administering the drug to the patient. (Detailed in Medical Safety Information No.41 (April 2010: 1st Follow-up Report))

Project to Collect Medical Near-Miss/ Adverse Event Information
Medical Safety Information

No.79, June 2013

Medical Safety Information released from 2006 to 2011

No.[1)]	Title -Description-	Number of cases reported in 2012
	[Case]	
No.19	**Use of unsterile medical supplies** – Cases involving preparation of unsterile medical supplies and incorrect use of them –	4

On the day of the surgery, which was a holiday, Theater Nurse A was warming up the autoclave in the sterilization room, because the contractor had delivered the instruments. Nurse A and Nurse B went to the sterilization room and pushed the start button after receiving the instruments. An hour later, they took the instruments out and delivered them to the operating theater. When Nurses A-D checked the items in the operating theater, they noticed that there were more water droplets than usual on the outer cloth. When they checked with someone working in the sterilization room, the staff member there thought that the instruments had already been sterilized, so s/he told them "If you are using it straight away, the moisture won't have penetrated inside"; accordingly, surgery proceeded as normal. The following morning, when the staff member from the sterilization room arrived at work and carried out the start-up inspection of the autoclave, s/he noticed that the machine records showed that it had gone through the warming up process but not the sterilization process, and s/he realized that the instruments used had not been sterilized. (There were three other similar cases)

No.20	**Failure to transmit an alteration of instruction** – Case of original instructions being implemented although they were altered, due to the alteration not being transmitted to the related department –	3

Pontal Syrup had been prescribed using the standard pre-operative order, but aspirin was contraindicated for the patient, so an order was given to halt Pontal Syrup. However, Nurse A, who received the order, did not make the necessary arrangements to return the drug. Nurse B removed from the refrigerator the Pontal Syrup that had been prescribed for the patient and administered it to the patient without checking the prescription, having looked only at the name on the bottle of drug solution. An hour later, when Charge Nurse C went to the hospital room, the patient was wheezing and complaining of dyspnea, and his/her oxygen saturation was found to be in the 80% range. The patient reported that s/he "drank the white medicine". (There were two other similar cases)

No.22	**Wrong prescription related to chemotherapy protocol** – Cases of incorrect prescription related to chemotherapy protocol –	1

The physician thought that the anticancer drug administration schedule was five days, as per the standard protocol, but a six-day regimen had been registered on the electronic medical record. The physician noticed the error when administration began on the sixth day.

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 –	4

When starting the patient on parenteral nutrition, an order to administer 80mL of 10% sodium chloride was given, because "4A (ampoules)" was erroneously entered, instead of "4mL". The physician who gave the order noticed the error and corrected it, but this was not communicated to the nurse and s/he carried out the infusion in accordance with the original order. (There were three other similar cases)

No.24	**Tubing misconnection of ventilator circuit** – Cases of the tubing misconnection of ventilator circuit –	3

The patient was on a ventilator and receiving NO therapy (nitric oxide inhalation therapy). Having gone to the bedside to assist Charge Nurse A, Nurse B noticed that the NO supply circuit was connected to the patient's mouth and changed the circuit connection, thinking that connecting it to the inspiratory side would provide a more stable flow. The following day, the clinical engineer came to the ward to observe another patient and was asked to check the circuit, whereupon s/he discovered that the NO had been connected to the expiratory side instead of the inspiratory side. (There were two other similar cases)

Project to Collect Medical Near-Miss/ Adverse Event Information
Medical Safety Information

No.79, June 2013

Medical Safety Information released from 2006 to 2011

No.[1)]	Title -Description-	Number of cases reported in 2012
	[Case]	
No.25	**Patient mix-up during medical examination** – Cases of patient mix-up due to inadequate verbal confirmation of the patient's name at the time of outpatient examination –	1
	The patient mistakenly presented her daughter's patient registration card at the reception desk. The patient entered the examination room when the clerk called the full name of her daughter, as shown on the patient registration card. The physician neglected to check the patient once she was in the examination room and looked only at the daughter's name and patient number before ordering a CT examination. When the radiological technologist had the patient give her full name and date of birth before carrying out the CT, s/he noticed that the patient's name differed from the name on the request form.	
No.27	**Wrong dosage of drug due to incomplete verbal instruction** – Cases of Incorrect dosage orders occurring due to not clearly transmitting the units, dose or dilution conditions when verbal instructions were given –	4
	Linton was used for a patient in an agitated state, but no improvement was seen. At the nurse's request, the duty physician from the oral surgery department contacted the supervising physician by telephone and received an order for "2 milli (=2mg) of Cercine". The duty physician understood "2 milli" to mean 2mL (=10mg) and gave the intravenous injection accordingly. (There were three other similar cases)	
No.29	**Administration of 10 times proper dosage to pediatric patients** – Cases of overdose due to administration of 10 times proper dosage to pediatric patients –	3
	A neonate born by emergency cesarean section was placed in the NICU. The patient was managed on a ventilator and antibiotic preparations were used to treat a neonatal infectious disease, but this was changed to Meropen + Vancomycin due to elevated CRP and thrombocytopenia. When changing the order, the attending physician miscalculated the dosage of Vancomycin and ordered 0.27g to be administered each time (10 times the proper dose) instead of 0.027g. The attending physician noticed the overdose after the first dose was administered. (There were two other similar cases)	
No.30	**Administration of allergic drug to patient with previous known allergy history** – Cases of administration of contraindicated drug occurred due to drug allergy information not described in the predetermined site on the medical chart –	6
	When the patient gave birth to her first child by cesarean section, Atonin was used as a uterotonic. At that time, she suffered tachycardia and ST segment depression, but this was not recorded in the allergy information on the electronic medical record. Two years later, the patient suffered atonic bleeding during an elective cesarean section for the birth of her second child, so Atonin was used, whereupon the patient suffered symptoms including chest pain, ST segment depression, and reduced blood pressure. A vasodilator was used intraoperatively and the symptoms improved. (There were five other similar cases)	

Project to Collect Medical Near-Miss/ Adverse Event Information
Medical Safety Information

No.79, June 2013

Medical Safety Information released from 2006 to 2011

No.[1)]	Title -Description-	Number of cases reported in 2012
	[Case]	
No.33	**Extravascular leakage of gabexate mesilate** – Cases of using concentrations which exceeded the recommended dosage as listed on the “precautions regarding use and dose” in the package insert, during administration of gabaxate mesilate, leading to extravascular leakage –	2
	The patient was transferred to the hospital with a double lumen CV catheter inserted, so the medical team commenced administration of parenteral nutrition via lumen (1) of the CV catheter and Reminaron 1,500mg / normal saline 48mL via lumen (2). Subsequently, an order was received for a blood transfusion, but although a peripheral route was secured, it was 22G, which was too narrow, so it was decided to administer the blood transfusion via the side duct of lumen (2) of the CV catheter. Two nurses discussed the situation and decided to switch to administering Reminaron via the peripheral route in the dorsum of the right hand. Subsequently, the Reminaron being administered via the dorsum of the right hand leaked and the area became red and more swollen. The patient was examined in the dermatology department and a local injection of Rinderon was administered, among other treatment, but the ulceration and necrosis spread, so debridement was carried out. (There was another similar case)	
No.34	**Surgical fire due to ignition of a flammable drug by an electrosurgical pencil** – Cases of patients sustaining burns due to the use of an electrosurgical pencil causing a drug to ignite –	1
	When inserting a pleat drain from the left abdomen following a total gastrectomy, the insertion site in the abdominal wall was disinfected before making the incision. Normally, Isodine Solution, which is alcohol-free, was used, but the medical staff neglected to check the ingredients in the disinfectant solution and used 0.5% Hexizac Alcohol Solution. When making the incision under the dermis with the electrocautery, the alcohol in the disinfectant solution ignited, causing the patient to suffer burns.	
No.37	**Failure to release "standby" mode when resuming ventilation** – Cases of ventilation not taking place because the ventilator was fitted to the patient while in "standby" mode –	1
	The physician and the nurse checked that the ventilator was functioning. Ten minutes later, the nurse again confirmed that the ventilator was functioning when s/he looked at the patient's infusion. 30 minutes later, when the physician and the nurse went to aspirate the patient, the physician discovered that the ventilator was in standby mode and had stopped.	
No.38	**Wrong pick-up of syringe containing drug in sterilized area** – Cases of wrong pick-up caused by identification error of prepared syringes in sterilized area of surgery or examination, etc. –	3
	After using calipers to measure age-related macular degeneration, an operation taking about a minute was carried out, in which Lucentis was injected into the vitreous humor and then Panimycin was injected under the conjunctiva. On this occasion, the patient's eyeball moved, causing the field of view in the operative field to deteriorate, because a spring-action eyelid retractor was being used, and it took time to adjust it again, with the calipers and the Lucentis being used repeatedly. The Panimycin was in the same type of syringe as the Lucentis and the nurse handed the Panamycin over to the surgeon, saying "Panamycin". The surgeon assumed that s/he had said "Lucentis" and injected it into the vitreous humor, without noticing the quantity of drug solution or the size of the needle. (There were two other similar cases)	

Project to Collect Medical Near-Miss/ Adverse Event Information
Medical Safety Information

No.79, June 2013

Medical Safety Information released from 2006 to 2011

No.[1)]	Title -Description-	Number of cases reported in 2012
	[Case]	
No.39	**Insufficient confirmation of medicines brought in at hospitalization** – Cases of patient treatment being affected because of insufficient confirmation of medicines brought in at hospitalization –	6

The patient was transferred to the hospital for surgery. S/he had previously undergone coronary stenting, so continuous infusion of an anticoagulant (Heparin) was commenced from the time of admission. The discharge summary from the previous physician stated "Bayaspirin and Plavix stopped", but the Plavix had not been removed from the bags in which the medicines brought in at hospitalization were packaged together, while the Bayaspirin had been removed from some, but not from others. The nurse assumed that the only anticoagulant to be stopped was Bayaspirin, so removed only this from the drug bags. The pharmacist checked the Patient's Medication Checklist, but did not notice this fact. Subsequently, when the nurse checked the patient's oral medication, s/he noticed that the Plavix that was supposed to be stopped before surgery was packaged together with the other drugs in the drug bag. The attending physician judged the risk of hemorrhage to be too high, so surgery was postponed for a week. (There were five other similar cases)

No.46	**Burn caused by a bed-bath towel** – Cases of burn due to a hot towel prepared in a plastic bag coming in contact with patient's body during bed-bath –	2

Nurse B placed five steamed bed-bath towels in a plastic bag and brought them to where Nurse A was cleansing the patient's genital area; s/he placed them on the bed (to the left of the patient) and began to give the bed-bath. At that point, Nurse B's cellphone rang and s/he was informed that another patient was leaving the ward for an examination, so s/he left the room. Before leaving, Nurse B did not tell Nurse A that the steamed towels were on the bed. When Nurse C subsequently visited the room to take the patient's temperature, Nurse A was washing the patient alone, so Nurse C helped Nurse A with the task. They placed the patient in the left lateral decubitus position and cleansed his/her buttocks, but when they returned him/her to the supine position, Nurse C noticed that the patient's left thigh was red and realized that the steamed towels in the plastic bag were on the bed. It was thought that the burn had resulted from the patient's leg being placed on the steamed towels when s/he was placed in the left lateral decubitus position. The patient was examined by a dermatologist and was diagnosed with a second-degree burn. (There was another similar case)

No.47	**Mix-up of the tooth extraction site** – Cases of the mix-up of the tooth extraction site in the dental department –	9

The patient was due to undergo removal of a fragment of a fractured tooth from the gum in the right upper no.7 area, but bone resorption in the right upper no.6 was observed on the X-ray image and mistaken for the tooth fragment, so the right upper no.6 was extracted. Someone noticed the error after the extraction and explained the situation to the patient before re-implanting the right upper no.6 and extracting the fragment of fractured tooth from the gum in the right upper no.7 area. (There were eight other similar cases)

No.48	**Failure to check oxygen remaining** – Cases of failure to check oxygen remaining –	3

On the day of discharge, the patient was switched from the oxygen pipe in the hospital room to an oxygen tank for home oxygen therapy. The patient's family brought in a portable oxygen tank that the patient had at home, so the nurse checked the flow rate of the oxygen upon discharge, but neither the physician, nor the nurse, nor the home oxygen contractor, nor the patient checked the amount of oxygen remaining. The patient became aware of dyspnea while in the elevator at the hospital and his/her symptoms abated when s/he was placed recumbent on a stretcher, but discharge was halted. It was subsequently ascertained that the pressure gauge on the portable oxygen tank was at zero. (There were two other similar cases)

Project to Collect Medical Near-Miss/ Adverse Event Information
Medical Safety Information

No.79, June 2013

Medical Safety Information released from 2006 to 2011

No.[1)]	Title -Description-	Number of cases reported in 2012
	[Case]	
No.53	**Specimen mix-up at pathological diagnosis** – Cases of the mix-up of specimens from different patients during pathologic diagnosis –	1

Needle biopsies of mammary glands from three patients were fixed in formalin and placed in three specimen jars, which were sent to the pathology department together. A pathology number should have been written on each of the specimen vials, which should then have been lined up in numerical order, but the specimen vials were lined up first. In doing so, whereas they should have been lined up in the order A→B→C, they were lined up in the order B→C→A and the pathology numbers were then written on them. The mix-up of the specimens was discovered when someone noticed that the name on the pathology form for specimen A (the third specimen) differed from the name on the specimen vial itself.

No.54	**Accidental removal of the endotracheal/tracheostomy tube when changing positions** – Cases of the removal of the endotracheal tube or tracheostomy tube when changing the position of a patient on a ventilator –	5

When providing oral care to a patient on a ventilator, the primary nurse checked the fixation of the endotracheal tube. 40 minutes later, when two nurses moved the patient into the left lateral decubitus position while changing the patient's diaper, the ventilator circuit was removed from the arm, but they did not hold the circuit, so the endotracheal tube came out. Assisted ventilation was then carried out using a bag valve mask, before re-intubating the patient. There was no change in the patient's oxygen saturation. (There were four other similar cases)

No.56	**Burns caused by a high-frequency electric current loop during MRI examination** – Cases of burns due to a high-frequency electric current loop occurring somewhere on the body, as a result of skin to skin contact of the patient during MRI examination –	1

When entering the MRI room, the radiological technologist carrying out the MRI checked whether or not the patient had any metal objects, dentures, or hearing aids, then had him/her lie on the examination table in the supine position. The technologist placed four folded towels under the patient's lower abdomen and positioned the body coil so that it covered the patient from the umbilical region to a point about a third of the way down the thigh, then carried out the examination. The patient was wearing a robe-type examination gown, so no towels were placed under the patient's groin or thighs. After finishing the simple image, the patient said, "I feel hot in the groin area", so the radiological technologist removed the body coil and checked that there was no metal there, but did not check the patient's inner thighs or the skin on the groin. Four days later, when the patient returned to the hospital, s/he said, "When I had the MRI the other day, my groin felt hot and when I checked after returning home, I found marks like a burn." When the patient was examined, s/he was found to have patches of redness measuring 3cm and brown scars measuring 1cm on the insides of both thighs. It was subsequently ascertained that these were burns from a high-frequency electric current loop during the MRI.

No.57	**Accidental ingestion of PTP sheets** – Cases of taking medicine without removing the PTP sheets –	13

Nurse A placed seven tablets, still in their PTP sheets, in a cup and handed them over to a patient with poor vision. The patient always had his/her drugs removed from the PTP sheets before being placed in the cup, so s/he took them as they were, but experienced pain and spat them out. The patient informed Nurse B of this, but it did not occur to Nurse B that the patient might have accidentally ingested them, so the Nurse B removed from the PTP sheets the drugs that the patient had spat out and administered them without checking how many s/he had given to the patient. The following day, having heard of this from the patient, the possibility of accidental ingestion occurred to Nurse C and s/he reported the event to the attending physician. When an X-ray was taken, something resembling a PTP sheet showed up and the foreign body was removed by means of an endoscopy. It was unclear how many tablets had been accidentally ingested, so the patient was kept under observation. (There were 12 other similar cases)

Project to Collect Medical Near-Miss/ Adverse Event Information
Medical Safety Information

No.79, June 2013

Medical Safety Information released from 2006 to 2011

No.[1)]	Title -Description-	Number of cases reported in 2012
	[Case]	
No.58	**Rupture of the subcutaneous port and catheter** – Cases of catheter rupture in patients with subcutaneous ports –	6
	The catheter in a subcutaneous port (not being used at the time) implanted in the left subclavian vein five years earlier for the administration of anticancer drugs ruptured and the tip of the catheter had migrated into the left pulmonary artery. The patient was experiencing no symptoms, but the rupture was found at the time of a CT examination carried out for follow-up of the cancer. The patient was admitted and the tip extracted from within the blood vessel. (There were five other similar cases)	
No.61	**Contraindicated Combined Administration of Drugs** – Cases of the combined administration of a drug listed on the package insert of a prescription drug as being contraindicated for combined administration (i.e. it should not be administered in combination with the other drug) –	2
	The patient had autism and was taking Orap on an external prescription. When the patient had an outpatient consultation for a cold, the physician prescribed Clarith on an internal prescription. The pharmacist was unaware of the content of the external prescription, so s/he handed over the drug to the patient. When the patient took it at lunchtime, s/he became drowsy, which was unusual. When the patient's family contacted the hospital and checked, it was discovered that Clarith is contraindicated for combined administration with Orap. (There was another similar case)	

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

◆ Other similar cases are to be 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.

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/