Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.135, February 2018

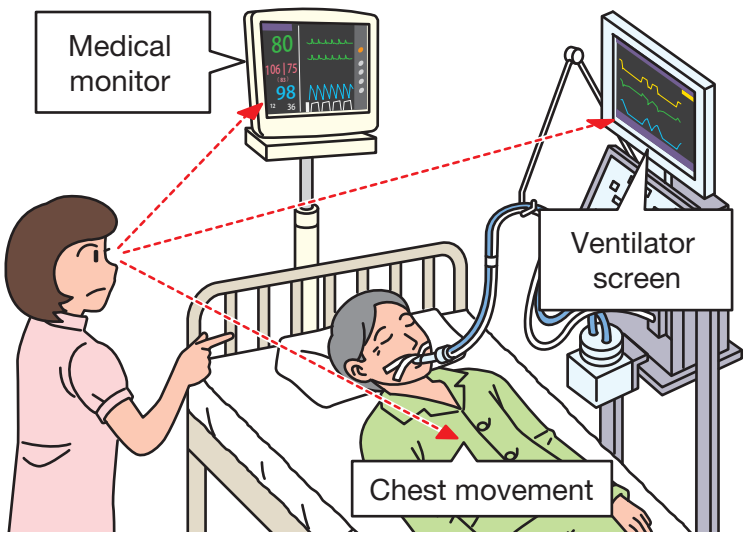
Failure to Release Standby Mode When Resuming Ventilation (1st Follow-up Report)

Information about the failure to release "standby" mode when resuming ventilation was provided in Medical Safety Information No.37 (December 2009). As 7 similar events have been reported since then, information about this issue is provided here again (information collection period: from November 1, 2009 to December 31, 2017). The information is compiled based on “Recurrence of Events and Occurrence of Similar Events” in the 50th Quarterly Report.

Cases of ventilation not beginning after the ventilator was fitted to the patient while in "standby" mode have been reported again.

Circumstances of Use of Standby Mode	Number of Cases
Patient transfer	3
Tracheal suction	3
Unknown	1

Example of a check after fitting a ventilator



◆ Ventilation does not take place when in standby mode.

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Case 1

When switching the patient from a ventilator to a Jackson Rees for a CT examination, the physician placed the ventilator in standby mode. After the patient returned to their room, another physician and a nurse fitted the ventilator to the patient, but did not notice that it was in standby mode. The patient went into cardiopulmonary arrest about 4 minutes later.

Case 2

The physician and the nurse placed the ventilator in standby mode, carried out tracheal suction, and then fitted the ventilator to the patient. When doing so, both the physician and the nurse thought that the other had released standby mode and failed to check that the ventilator was functioning. The patient experienced bradycardia and hypotension about 10 minutes later. The physician and the nurse noticed that the ventilator was in standby mode when administering a vasopressor.

Preventive measures taken at the medical institutions in which the events occurred

- **After fitting a ventilator, staff will observe the movement of the chest and look at the ventilator screen to check that ventilation is taking place.**
- **Staff will not place the ventilator in standby mode when carrying out tracheal suction.**

Pharmaceutical Notice No.248 “Measures Against Medical Adverse Events Related to Ventilators Used as Life-support Systems” issued by the MHLW in March 2001 mentions their use in combination with medical monitors (pulse oximeters and capnometers).

http://www.pmda.go.jp/files/000144806.pdf

* 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 the Project website for details.
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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