Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

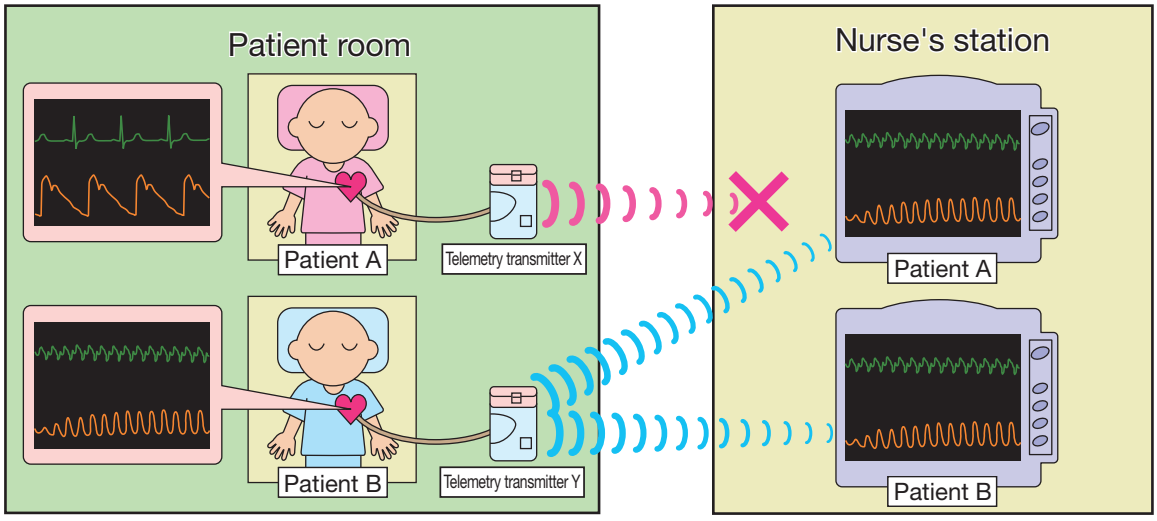
No.42, May 2010

Reception error of patient's ECG waveform in central monitoring system

Five cases of conducting treatment and procedures to patients according to the electrocardiogram (ECG) monitor displayed by another patient's data as one telemetry transmitter sent ECG waveform to multiple locations, have been reported (information collection period: from January 1, 2006 to March 31, 2010; the information is partly included in "Medical Adverse Event Information to Be Shared" (p.135) in the 16th Quarterly Report).

Cases of conducting treatment and procedures to patients according to the electrocardiogram (ECG) monitor displayed by another patient as one telemetry transmitter sent ECG waveform to multiple locations, have been reported.

Image of the case



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Case

At the ward in question, the electrocardiograms of the patients in the ward were monitored using multiple monitors in central monitoring system. The nurse input the incorrect channel number of telemetry transmitter when setting up the central monitor to display the electrocardiogram of patient A. The input number was that for patient B, so the electrocardiogram of patient B was displayed instead of that of patient A. The electrocardiogram displayed as patient A (although actually that of patient B) showed ventricular arrhythmia, and the patient was errorneously treated.

Preventive measures taken at the medical institution in which the event occurred.

- **Confirm if the electrocardiogram channel number being received matches the channel number of telemetry transmitter attached to the patients.**
- **Establish the setting rule of central monitors.**

Complementary comment by the Comprehensive Evaluation Panel

When using a wireless medical devices, clearly identify the management system, such as determining the manager on the channels setting, etc., within the hospital.

* 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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