Medical Safety Information, Project to Collect Medical Near-Miss/Adverse Event Information; No.54, May 2011

Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/
Adverse Event Information

Medical Safety Information

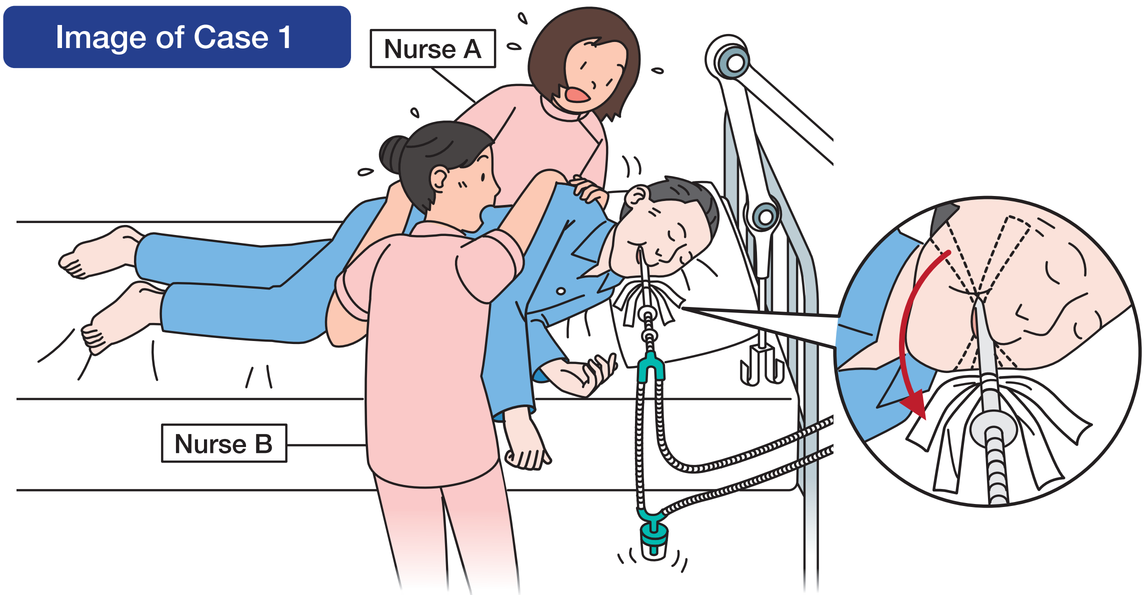
No.54, May 2011

Accidental removal of the endotracheal/tracheostomy tube when changing positions

Twenty-three cases of removal of the endotracheal tube or tracheostomy tube when changing position of a patient on a ventilator have been reported (information collection period: from January 1, 2007 to March 31, 2011; the information is partly included in "Individual Theme Review" in the 15th, 17th, and 19th Quarterly Report).

Cases of removal of the endotracheal tube or tracheostomy tube when changing position of a patient on a ventilator have been reported.

Image of Case 1



- Among twenty-three reported cases, ten cases were removal of the endotracheal tube, and thirteen were removal of the tracheostomy tube.

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Case 1

The ventilator was on the left side of the patient. Nurse A was standing on the right side, and nurse B was standing on the left side. In order to change position of the patient, the corrugated tube was disconnected from the ventilator support arm. Nurse A was pushing the back of the patient so the patient would be in the left lateral decubitus position, and was not holding the tube. When the patient was in the left lateral decubitus position, the weight of the tube pulled off the tape attached to the face of the patient and the endotracheal tube came out 5cm. The physician removed the tube and reintubated a new endotracheal tube.

Case 2

A tracheostomy tube was inserted in the patient. After a bed-bath by two nurses, the patient was re-positioned for body weight measurement, and the hypoventilation alarm of the ventilator sounded. Upon confirmation of the tracheostomy tube, an air leak sound was heard, and was immediately reported to the physician. When the tracheostomy tube attachment was removed, the tube came out, so the physician reintubated a new tracheostomy tube.

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

- **Confirm the endotracheal/tracheostomy tube fixation before changing positions.**
- **When changing position, carry out by two persons and more, decide roles and talk with each other when working.**
- **Hold the ventilator circuit, and avoid excessive tension.**

Complementary comment by the Comprehensive Evaluation Panel

- **Even after changing the position of the patient, confirm breathing conditions, the endotracheal/tracheostomy tube fixation and the operation condition of ventilator.**

* 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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