



Project to Collect Medical Near-Miss/
Adverse Event Information

Medical Safety
Information

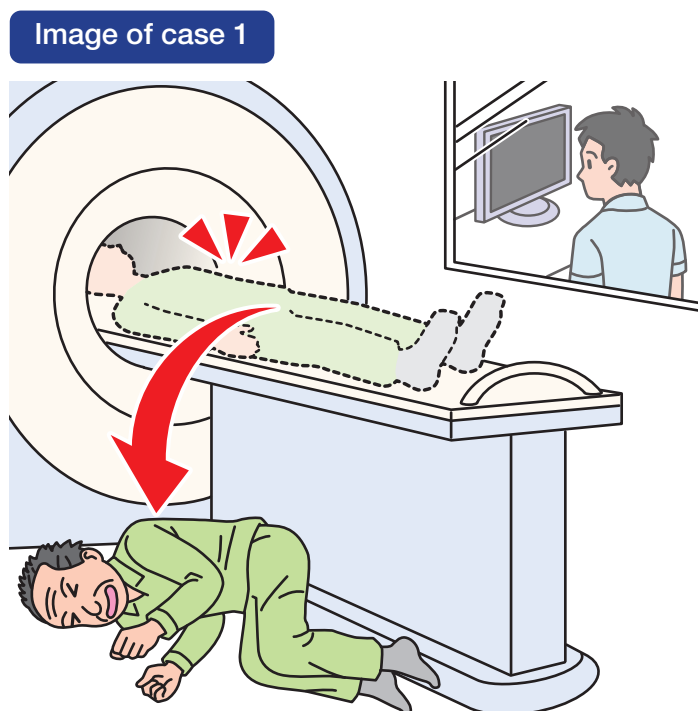
No.141, August 2018

Falls from an Examination Table

Nine cases have been reported in which the patient fell from an examination table during an examination, treatment, or procedure (information collection period: from January 1, 2014 to June 30, 2018). This information was compiled on the basis of the content featured in the Analysis Themes section of the 50th Quarterly Report.

Cases have been reported in which patients were affected by falling from an examination table during an examination, treatment, or procedure.

Examination, Treatment, or Procedure	Number of Cases
Head MRI	2
Endoscopy	2
Fluoroscopically guided procedure	2
Cardiac catheterization	1
Cerebral angiography / interventional radiology	1
Chest X-ray	1



Falls from an Examination Table

Case 1

The nurse and the radiological technologist moved the patient onto the examination table for an MRI examination of the head. When doing so, the nurse failed to tell the radiological technologist that the patient had dementia. The radiological technologist secured the patient's head, but did not secure the patient's body, because they thought that the communication had been adequate. 10 minutes after starting the imaging process, they noticed that the patient was not on the examination table. When they entered the examination room, they found the patient curled up on the floor to the right of the examination table. X-ray imaging was subsequently carried out and the patient was found to have a right intertrochanteric fracture of the neck of the femur.

Case 2

During cardiac catheterization, the patient was sedated. The nurse went to get something while the examination was underway and when they returned to the examination room, the patient had fallen with their right foot out of alignment. The physician had turned their back on the patient and was working at the sterile table, the clinical engineer was operating the instruments, and the radiological technologist was checking the images, so nobody was watching the patient. A head CT was subsequently carried out and the patient was found to have a traumatic subarachnoid hemorrhage.

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

- Medical personnel will ascertain the patient's clinical condition and share patient information with each other.
- Medical personnel will be aware of the risk of patients falling off examination tables and will ask each other not to take their eyes off the patient.

Complementary comment by the Comprehensive Evaluation Panel

- To ensure safety during examinations with a risk of falls, explain the situation to the patient and secure their body to the examination table.

* 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.

