Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.162, May 2020

Falls When Transferring to a Bed

Nine cases have been reported in which a patient fell because the bed moved when they were being transferred to a bed using a slider or other transfer assistive device (information collection period: from January 1, 2016 to March 31, 2020). This information was compiled on the basis of the content featured in the Recurrence of Events and Occurrence of Similar Events section of the 56th Quarterly Report.

Cases have been reported in which patients fell during transfer from one bed to another.

Bed That Moved	Lock Status of Brakes on Bed That Moved	
	Not Locked	Not Fully Locked
Bed Transferred From	2	1
Bed Transferred To	4	2
Number of Cases	6	3

◆ Includes cases in which a stretcher was used.

Image of case 1

Project to Collect Medical Near-Miss/ Adverse Event Information

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

No.162, May 2020

Falls When Transferring to a Bed

Case 1

When transferring the patient from a bathing stretcher to the bed, the nurse stood on the same side as the bed, while the nursing assistant stood on the same side as the stretcher. They had not locked the brakes on the bed and when the nursing assistant pushed the slider (transfer assistive device) on which the patient was lying, the bed moved and the patient fell. A head CT was carried out and the patient was diagnosed with a subcutaneous hemorrhage in the occipital region.

Case 2

The nurse was rushing, because the patient was due for treatment imminently, and tried to move the patient from the bed to a stretcher singlehandedly, using a slider (transfer assistive device). The nurse had not fully locked the brakes on the stretcher and when the nurse pushed the patient in an attempt to slide them onto the stretcher, supporting the patient's left shoulder and hip, the stretcher moved and the patient fell. A CT examination of the patient's legs was carried out and the patient was diagnosed with a right tibial malleolar fracture.

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

- **Lock the brakes on beds and stretchers before transfer and check that they have been fully locked, without fail.**
- **Ensure that medical staff are in appropriate positions when transferring the patient.**
- **Ensure that all medical staff are fully aware of how to use sliders and other transfer assistive devices.**

The measures above are examples. Please consider initiatives suitable for your own facility.

* 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.

Department of Adverse Event Prevention
Japan Council for Quality Health Care
1-4-17 Kandamisaki-cho, Chiyoda-ku, Tokyo 101-0061 JAPAN
Direct Tel: +81-3-5217-0252 Direct Fax: +81-3-5217-0253
http://www.med-safe.jp/