



Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/
Adverse Event Information

Medical Safety Information

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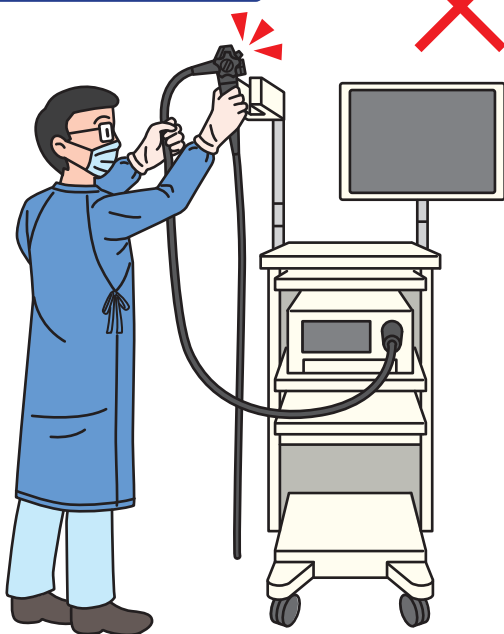
Use of a Used Endoscope on Another Patient

Nine cases have been reported in which a used endoscope was used on another patient without being washed or disinfected (information collection period: from January 1, 2016 to February 28, 2022). This information was compiled on the basis of the content featured in “Individual Theme Review” in the 39th Quarterly Report.

Cases have been reported in which a used endoscope was used on another patient without being washed or disinfected because the endoscope had not been put in the designated place after use.

End of examination

Image of case



Example of how endoscopes
should be handled after use



Use of a Used Endoscope on Another Patient

Case 1

Examinations of three patients in the fluoroscopy room were planned, using two bronchoscopes. After completing the examination of the first patient, Patient X, Physician A asked for the bronchoscope to be washed in the endoscopy room so that it could be used on the third patient, Patient Z. After completion of the examination of the second patient, Patient Y, the bronchoscope should have been put in the designated place for used endoscopes, but Physician A left it hung up beside the monitor. When conducting the examination of Patient Z, Physician B was supposed to go and get the washed bronchoscope from the endoscopy room, but because there was a bronchoscope hung up beside the monitor, Physician B used it, believing it to be unused. After the examination had been completed, the fact that the bronchoscope used on Patient Y was also used on Patient Z was discovered when the endoscopy room team contacted the fluoroscopy room team to say that nobody had been to collect the bronchoscope.

Case 2

Two consecutive emergency colonoscopies were carried out in the same examination room overnight. After performing the examination on the first patient, Patient X, Physician A replaced the endoscope in the bag from which it had originally been removed and put it in the clean zone of the space where cameras were to be placed in the examination room, not knowing the rules about putting used endoscopes in the place specifically designated for them. When examining the second patient, Patient Y, Physician B found that the bag containing the endoscope in the clean zone of the space where cameras were to be placed was already open, but used it anyway, thinking that someone had prepared it for use. The next morning, the gastroenterological endoscopy technician noticed that although two examinations had been performed the day before, only one endoscope had been used. The technician checked with Physician B and discovered that the physician had used the endoscope previously used for Patient X on Patient Y.

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

- Decide on the places where endoscopes should be put before and after use, and inform all staff involved in performing endoscopies.
- Put up signs to indicate the place where used endoscopes should be put.
- After completing an examination, put the used endoscope in the designated place.

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.

