Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.190, September 2022

World Patient Safety Day 17 September

To mark the WHO World Patient Safety Day (September 17), we have selected orange as this month's theme color.

Ministry of Health, Labour and Welfare page on WPSD

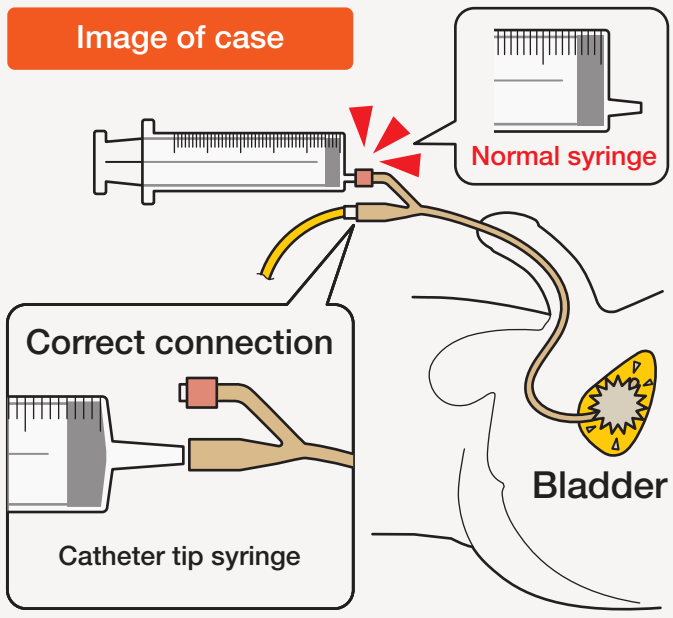
Selection of Wrong Connection for Indwelling Bladder Catheter

Four cases have been reported in which, during a procedure to inject normal saline into the bladder, a large volume of normal saline was erroneously injected into the inlet of the balloon used to keep an indwelling bladder catheter in place (information collection period: from January 1, 2019 to July 31, 2022). This information was compiled on the basis of the content featured in the Analysis Themes section of the 61st Quarterly Report.

Cases have been reported in which, during a procedure to inject normal saline into the bladder, a large volume of normal saline was erroneously injected into the inlet of the balloon used to keep an indwelling bladder catheter in place, due to a lack of understanding of the catheter structure, causing the balloon to rupture and necessitating the removal of the foreign body from the bladder.

Purpose of Injection into the Bladder	Volume Injected into Balloon
Bladder irrigation	50 mL
Check for bladder damage during surgery	50 mL
Fill the bladder before an abdominal ultrasound examination	80 mL
Measure intravesical pressure	25 mL, several times

Image of case



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Case 1

The physician ordered that bladder irrigation be performed. As second-year Nurse A had no experience of bladder irrigation, they checked the procedure verbally with their more senior colleague Nurse B and decided to carry out the procedure alone. Nurse A prepared the normal saline in a normal syringe instead of a catheter tip syringe. When Nurse A had injected 50 mL, there was a bursting sound like a pop and the patient simultaneously exclaimed, “Ouch!” Just at that time, Nurse C visited the room and noticed that Nurse A was injecting the normal saline into the balloon inlet. The situation was reported to the physician and when the indwelling bladder catheter was removed, the balloon was found to have ruptured. The balloon fragments were subsequently recovered with a cystoscope.

Case 2

When performing an abdominal ultrasound examination on the patient, the physician decided to inject normal saline via the indwelling bladder catheter in order to fill the patient’s bladder. The physician prepared the normal saline in a normal syringe instead of a catheter tip syringe. The physician then injected a total of 80 mL of normal saline via the balloon inlet of the indwelling bladder catheter and performed the examination. A nurse subsequently noticed that the patient’s indwelling bladder catheter had come out. As the balloon was not inflated and part of it was missing, a cystoscope was used to recover the balloon fragments.

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

- **Ensure that medical staff understand the structure of an indwelling bladder catheter and the significance of the procedure being performed.**
- **Ensure that medical staff check the supplies required and correct procedure for any procedures they are performing for the first time or that they do not fully understand, and then are observed by their supervisor while carrying out the procedure.**

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.

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