

Project to Collect Medical Near-Miss/  
Adverse Event Information

# Medical Safety Information

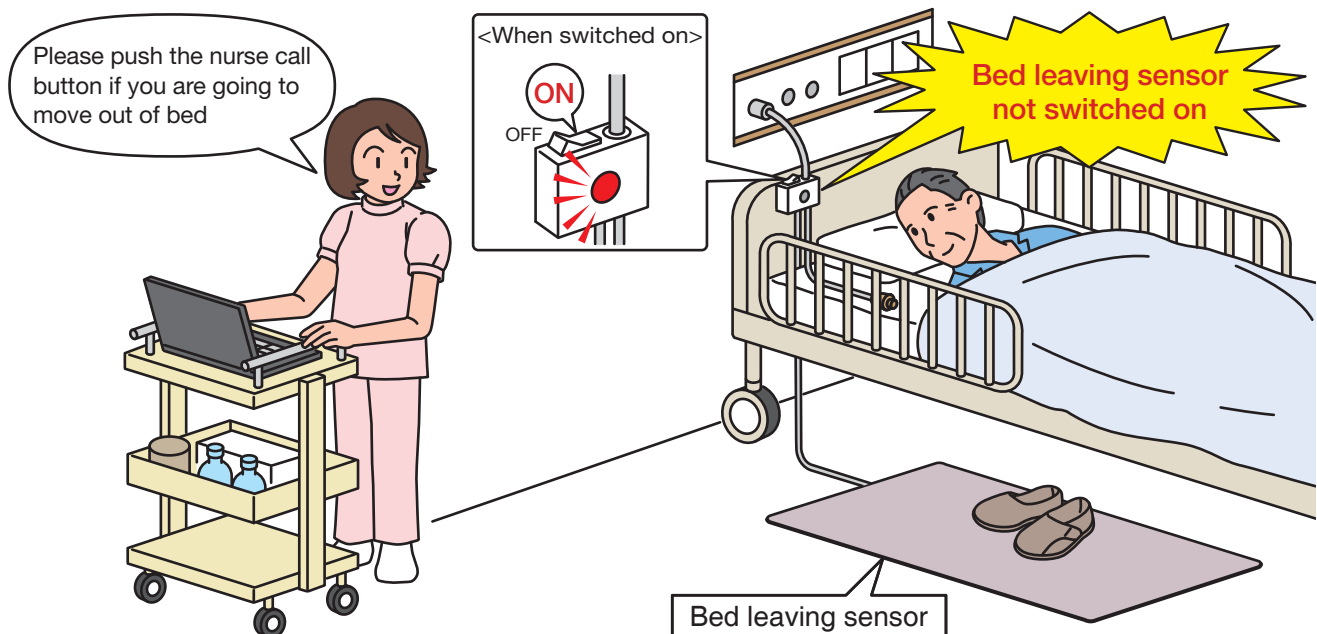
No.197, April 2023

## Forgetting to Switch on the Bed Leaving Sensor

Twenty-six cases have been reported in which it was not possible to detect that a patient had left their bed because medical personnel forgot to switch on a bed leaving sensor installed on or near the patient's bed after carrying out a procedure or nursing care (information collection period: from January 1, 2020 to February 28, 2023). This information was compiled on the basis of the content featured in the Analysis Themes section of the 71st Quarterly Report.

**Cases have been reported in which it was not possible to detect that a patient had left their bed because medical personnel forgot to switch on the installed bed leaving sensor, and the patient subsequently suffered a fall.**

### Image of case



## Forgetting to Switch on the Bed Leaving Sensor

### Case 1

The nurse installed a floor mat sensor to the right of the patient's bed. When first installing it, the nurse was supposed to stand on the mat to check that it was working, but another patient pushed their nurse call button, so the nurse left the first patient's bedside without checking whether the sensor was working. Half an hour later, the nurse went to the patient's room after hearing a loud noise and found the patient collapsed face upward. The floor mat sensor was not switched on. A CT examination was subsequently performed and the patient was diagnosed with a compression fracture of the first lumbar vertebra.

### Case 2

The occupational therapist switched off the bed sensor when they took the patient to the rehabilitation room in a wheelchair. The occupational therapist told the lead nurse that they had switched it off, but the charge nurse was not informed. When the patient returned to their bed after the rehabilitation session, the charge nurse checked that the patient was recumbent, but did not check whether the bed sensor was switched on. Upon going to the room later on, the nurse found the patient collapsed by their bedside. The bed sensor was not switched on. An X-ray examination was carried out and the patient was diagnosed with a rib fracture.

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

- After installing a bed leaving sensor, check that it is working.
- Check that the bed leaving sensor is switched on during each visit to the room.

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.

<https://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.

