

Forgetting to Register the Wireless Transmitter Number on the Central Monitor

Cases have been reported in which a wireless transmitter was fitted to a patient, but the patient's biological information was not displayed on the central monitor because the transmitter number was not registered on the central monitor.

Seven such cases were reported between January 1, 2020 and December 31, 2024. This information was compiled on the basis of the content featured in the Recurrence of Events and Occurrence of Similar Events section of the 77th Quarterly Report.

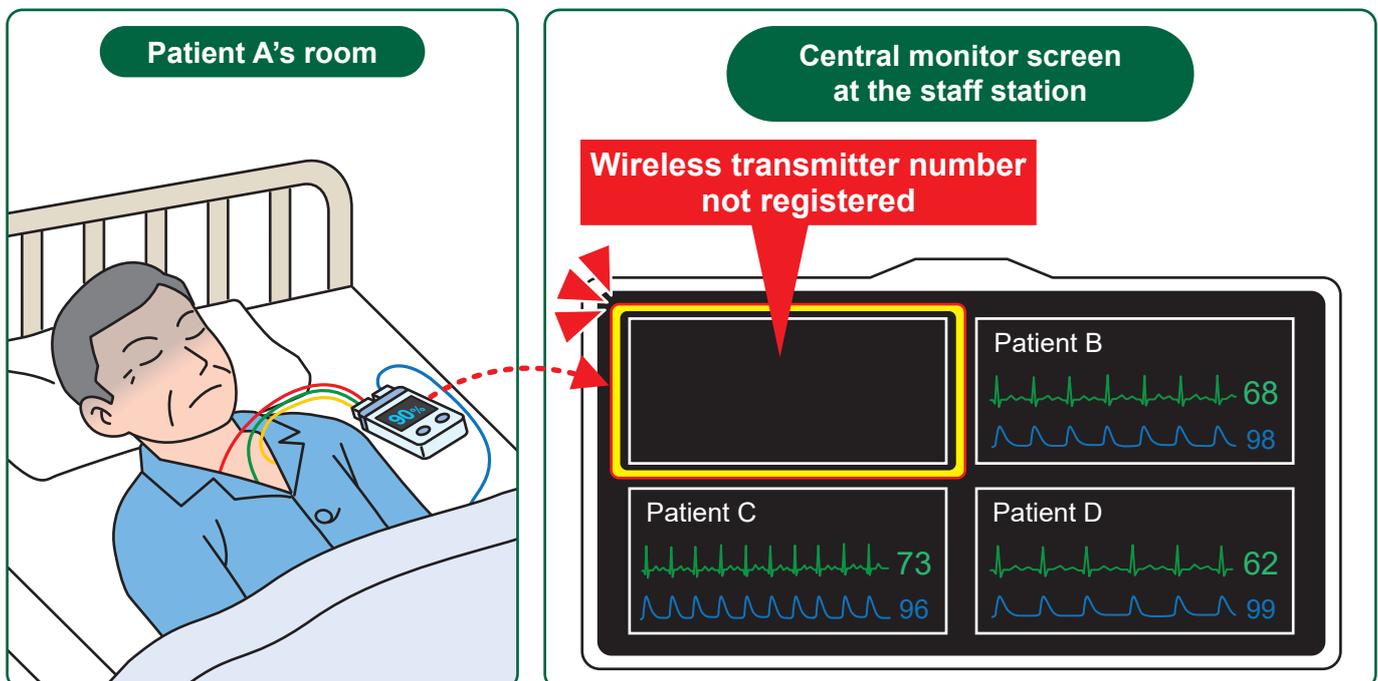
Main Background Factors of Reported Events

-The primary nurse assumed that the lead nurse who prepared the wireless transmitter had registered the transmitter number on the central monitor.

*Multiple cases have been reported.

-The nurse was busy and carried out another task after fitting the wireless transmitter to the patient, so they forgot to register the transmitter number on the central monitor.

Image of case



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Case 1

The lead nurse on the day shift made ready a wireless transmitter in the room of a patient being admitted as an emergency. After the patient's admission, the primary nurse fitted the wireless transmitter to the patient. Assuming that the lead nurse had already registered the wireless transmitter's number on the central monitor, the primary nurse did not look at the central monitor. The night nurse did not notice that the patient's electrocardiogram waveform and SpO₂ were not displayed on the central monitor. When the day shift nurse visited the patient's room the following day, they noticed that the wireless transmitter screen showed that SpO₂ had fallen to 90%. As the nurse call was meant to be connected to the central monitor, but had not sounded, the nurse checked and discovered that the patient's wireless transmitter had not been registered.

Case 2

The physician ordered electrocardiogram monitoring of the patient, who had been admitted as an emergency during the night. The nurse fitted the wireless transmitter to the patient. The nurse then needed to register the wireless transmitter number on the central monitor, but they forgot about it while carrying out other tasks. The nurse visited the patient's room periodically to observe the patient, but did not look at the central monitor. When the nurse visited the patient's room early in the morning, they noticed that the patient was in cardiopulmonary arrest.

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

- Nurses will register numbers on the central monitor before fitting wireless transmitters to patients.
- Immediately after fitting wireless transmitters to patients, nurses will check that the patient's electrocardiogram waveform and SpO₂ level are displayed on the central monitor.
- Lead nurses will check the list of patients for whom monitoring has been ordered and confirm that those patients' names are displayed on the central monitor.

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.

