Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

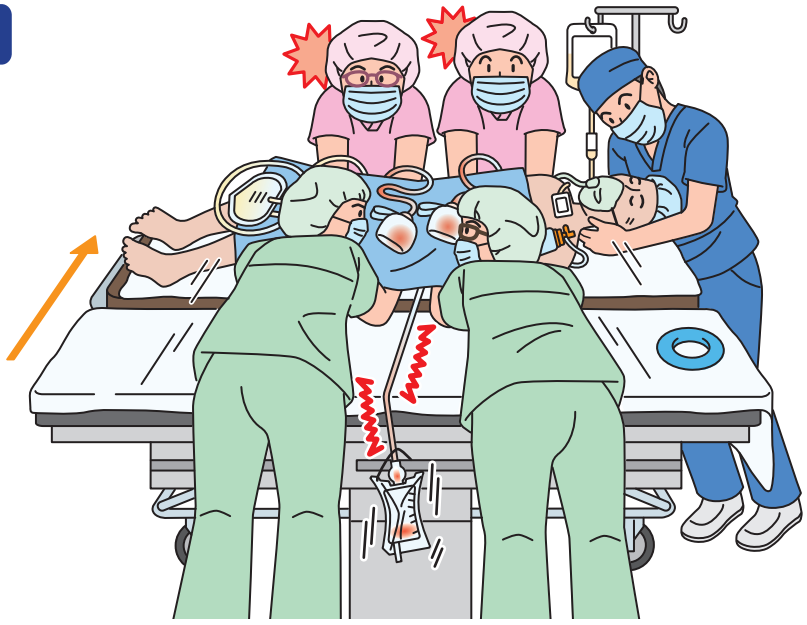
No.85, December 2013

Accidental Removal of a Drain/Tube during Transfer

Eleven cases have been reported involving the accidental removal of a drain/tube inserted into a patient during transfer of the patient from one bed to another (information collection period: from January 1, 2010 to October 31, 2013; the information is partly included in “Medical Adverse Event Information to be Shared” (p.142) in the 13th Quarterly Report and “Recurrence of Events and the Occurrence of Similar Events” (p.201) in the 34th Quarterly Report).

Cases have been reported in which a drain/tube inserted into a patient came out during transfer of the patient, due to inadequate checking of the position of the drain/tube.

Image of case



◆ As well as cases involving transfer for the purpose of surgery, the 11 cases reported include some involving transfer for the purpose of a bath or an examination.

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Case

The medical team attempted to transfer the patient from the operating table to the stretcher, with the anesthesiologist standing at the patient's head, the nurses at the patient's right-hand side, and the surgeons at the patient's left. Three drains had been inserted into the patient one in the midline of the abdomen, and one each on the left and right sides of the abdomen.
The nurse carried out a visual check to confirm that the drains in the midline and right side of the abdomen were in a position that enabled the patient to be moved safely, but thought that the physician standing on the patient's left had checked the drain on the left side of the abdomen. When the all members of the medical team moved the patient without checking or calling out to confirm that the drains/tubes were in a position that enabled the patient to be moved safely, the drain on the left side of the abdomen came out.

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

- **The staff member serving as leader will take the initiative and have all medical team members check that drains/tubes are in a position that ensures that they will not come out.**

* 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 quarterly reports and annual reports posted on the Japan Council for Quality Health Care website for details of the Project.
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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