Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

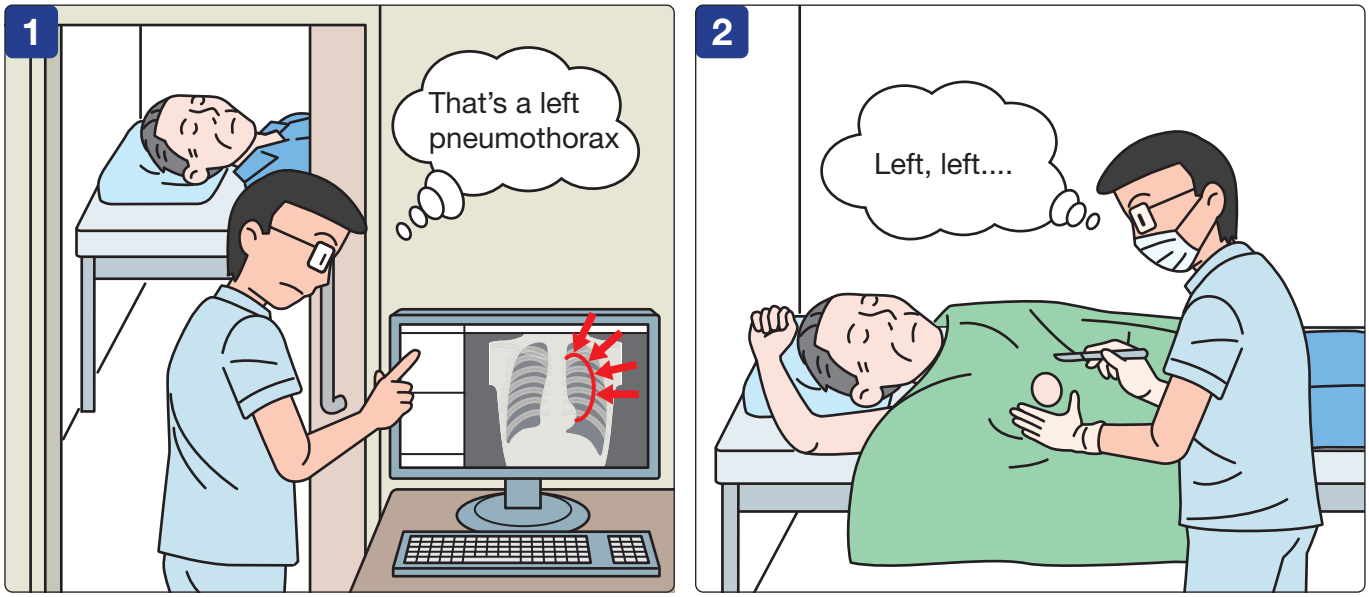
No.99, February 2015

# Left-Right Mix-Up When Inserting a Thoracostomy Tube

Eight cases have been reported involving left-right mix-up due to an error in the patient's position or orientation when inserting a thoracostomy tube or performing a thoracentesis (information collection period: from January 1, 2011 to December 31, 2014). The information is compiled based on "Individual Theme Analysis" (p.174) in the 34th Quarterly Report.

**Cases of left-right mix-up when inserting a thoracostomy tube or performing a thoracentesis have been reported. In all of these cases, the medical staff failed to check the site immediately before the procedure.**

## Image of case 1




◆ Of the eight cases reported, seven involved the insertion of a thoracostomy tube and one involved a thoracentesis.

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## Case 1

A patient with left pneumothorax was to have a thoracostomy tube inserted. Usually, the patient waits in a sitting position and is placed in the position required immediately before the procedure. However, in this case, when the physician entered the examination room, the patient was already lying on the bed in a supine position, oriented in the direction required for performing the procedure from the right-hand side. Assuming that this was the correct orientation, the physician marked the right thoracic area and inserted a drain. The physician subsequently noticed that there was no air leaking from the tube and realized that s/he had erroneously inserted it into the right-hand side.

## Case 2

Outpatient Department Physician A and Ward Physician B checked the planned site of tube insertion on an image taken from a patient admitted with a diagnosis of left pneumothorax. Two hours later, they decided to carry out the procedure in the patient's room, because the treatment room was unavailable. To make it easier to carry out the procedure, the positions of the patient's head and feet were reversed. In doing so, the physicians got their left and right the wrong way around and placed the patient in the left lateral decubitus position before marking the 2nd right intercostal space, into which they inserted the tube. When a chest X-ray was taken to check the site of the tip of the tube, they discovered that they had erroneously inserted it into the right-hand side.

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

- **The physician and assisting nurse will use images and/or the consent form, etc. to check the patient's name, the puncture site, and the position required when carrying out the procedures.**
- **The physician will look at the image immediately before the procedure and compare it with the planned insertion site.**

* 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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