Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No. 14. January 2008

Tubing (catheter/drain) misconnections

Four cases of incorrect connections of infusion tubes to catheters or drains placed for different purposes were reported (information collection period, from October 1, 2004 to November 30, 2007; the information is partly included in "Medical Adverse Event Information to Be Shared" in the 10th Quarterly Report).

Cases of infusion tubing misconnection have been reported, in patients to whom multiple catheters or drains were inserted.

Items connected	A catheter or drain inserted to the patient Wrong connection to ★: The background reason for misconnection
Infusion tube	Central venous catheter ★PTCD drainage tube: A 3-way stopcock was used.
Infusion tube	Central venous catheter ★Chest tube: A central venous catheter was used as a substitute for it.
Infusion tube	Central venous catheter ★Peritoneal drainage tube: A 3-way stopcock was used.
PTCD waste bottle	PTCD drainage tube Peritoneal drainage tube ★Chest tube: A central venous catheter was used as a substitute for it.

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Case 1

A central venous catheter and PTCD drain were inserted to the patient and each was wrapped with a gauze and fixed in the middle of the abdomen. The nurse A connected a sedative to mix with an infusion, however, because the patient was sleeping before the mixed infusion began to drip, the nurse A did not start the drip. The connection was left as it was. At this time, the nurse A had actually connected the infusion to the PTCD drain. An hour later, the patient was awake and complained of not being able to sleep and nurse B began the drip infusion without verifying the area of insertion. Later, when nurse B was assisting the patient with the toilet, the nurse B realized that the infusion that was believed to be connected to the central venous catheter had been mistakenly connected to the PTCD drainage tube. A 3-way stopcock was connected to the PTCD drain for washing it with a syringe.

Case 2

A central venous catheter and a chest tube were inserted to the patient through the right side of the patient's trunk. The nurse began the infusion without verifying the site of insertion when connecting the infusion. At this time, the nurse had actually connected the infusion to the chest tube. Later, the physician realized that the infusion was connected to the chest tube. The patient was highly emaciated, therefore, in order to reduce the damage on the patient's skin, a flexible central venous catheter made of soft material with a thin diameter was used as a substitute for a chest tube.

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

On occasions where a catheter or a drain is connected to another catheter or drain, the site of insertion and the connection shall be verified by tracing the line between them.

* 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 "Comprehensive Evaluation Panel" to prevent 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 can not be guaranteed in the future.
* This information is neither for limiting the discretion of healthcare providers nor for imposing certain obligations or responsibilities on them.

Division of Adverse Event Prevention
Japan Council for Quality Health Care
1-4-17 Misakicho, Chiyoda-ku, Tokyo 101-0061 JAPAN
Direct Tel:+81-3-5217-0252 Direct Fax:+81-3-5217-0253
http://www.jcqhc.or.jp/html/index.htm