Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

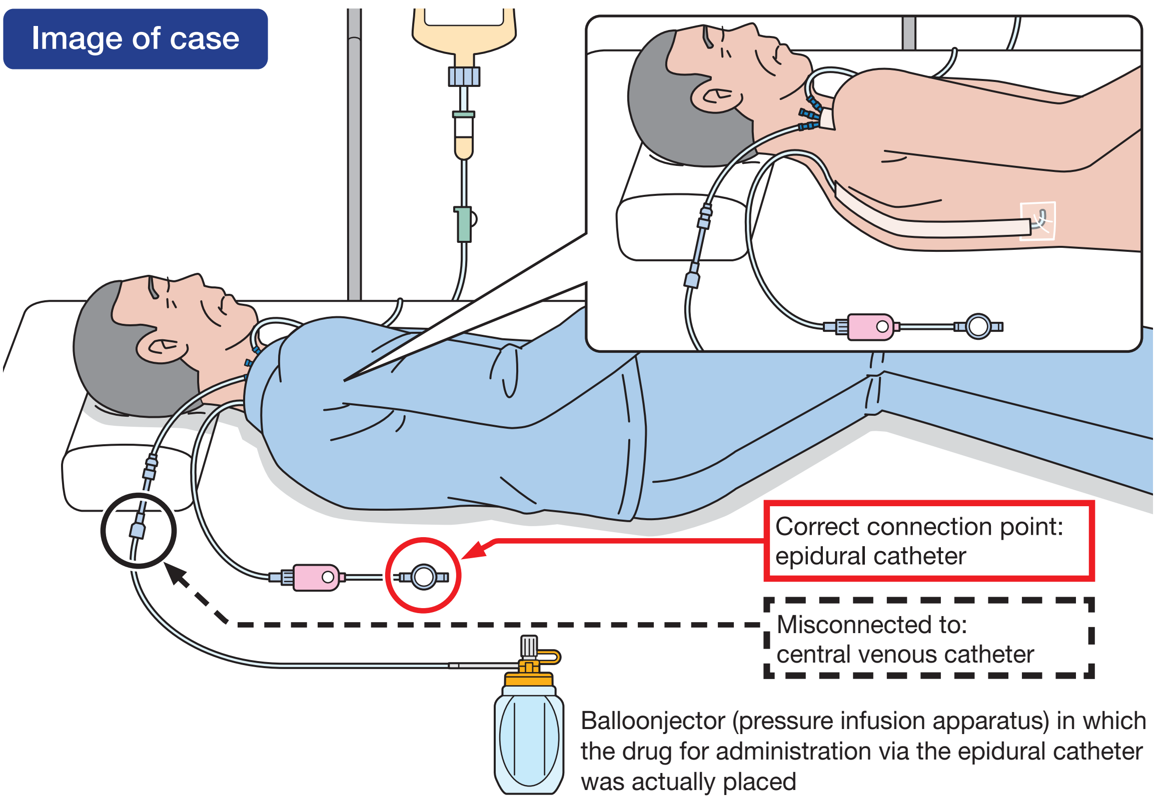
No.72, November 2012

Misconnection of Drugs for Continuous Infusion into the Epidural Space

Two cases have been reported involving drugs meant for continuous infusion into the epidural space being misconnected to and administered via an intravenous catheter (information collection period: from January 1, 2008 to September 30, 2012; the information is partly included in "Individual Theme Review" (p.139) in the 28th Quarterly Report).

Cases of drugs meant for continuous infusion into the epidural space being misconnected to and administered via an intravenous catheter have been reported.

Image of case



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Case

Droleptan, Popscaine and morphine hydrochloride were infused continuously via an epidural catheter using a Balloonjector (pressure infusion apparatus), in order to control pain following surgery for esophageal cancer. On the third day after surgery, redness and swelling were observed when the epidural catheter insertion site was being cleaned, and when the nurse looked at the catheter, s/he saw that the connector had become dislodged. When s/he traced back the line from the Balloonjector to which the epidural catheter should have been connected, s/he discovered that the Balloonjector was actually connected to the Sureplug extension line connected to the central venous catheter.

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

- **Routes will be checked by tracing them back from the connection site to a point at which the insertion site can be identified.**
- **In the event that they cannot be checked at a point at which the insertion location can be identified, markers will be placed close to the route connection point, indicating "for epidural administration" and "for intravenous administration" (or similar), so that the insertion site can be identified.**
- **Different pressure infusion apparatus will be used for epidural administration and intravenous administration, in order to distinguish 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 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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