Medical Safety Information

Pharmaceuticals and Medical Devices Agency

Pmda **No. 46   Revised December 2015**

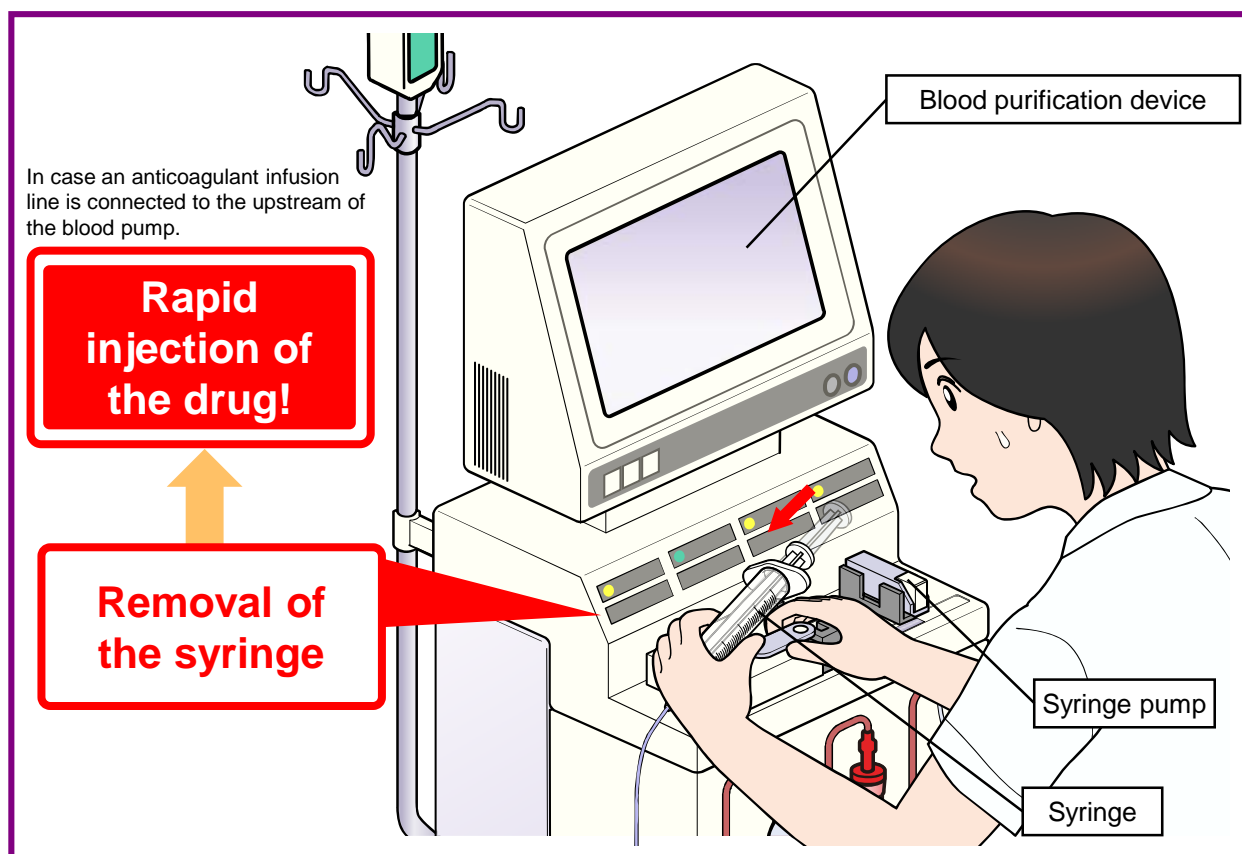# Precautions When Handling the Blood Purification Device

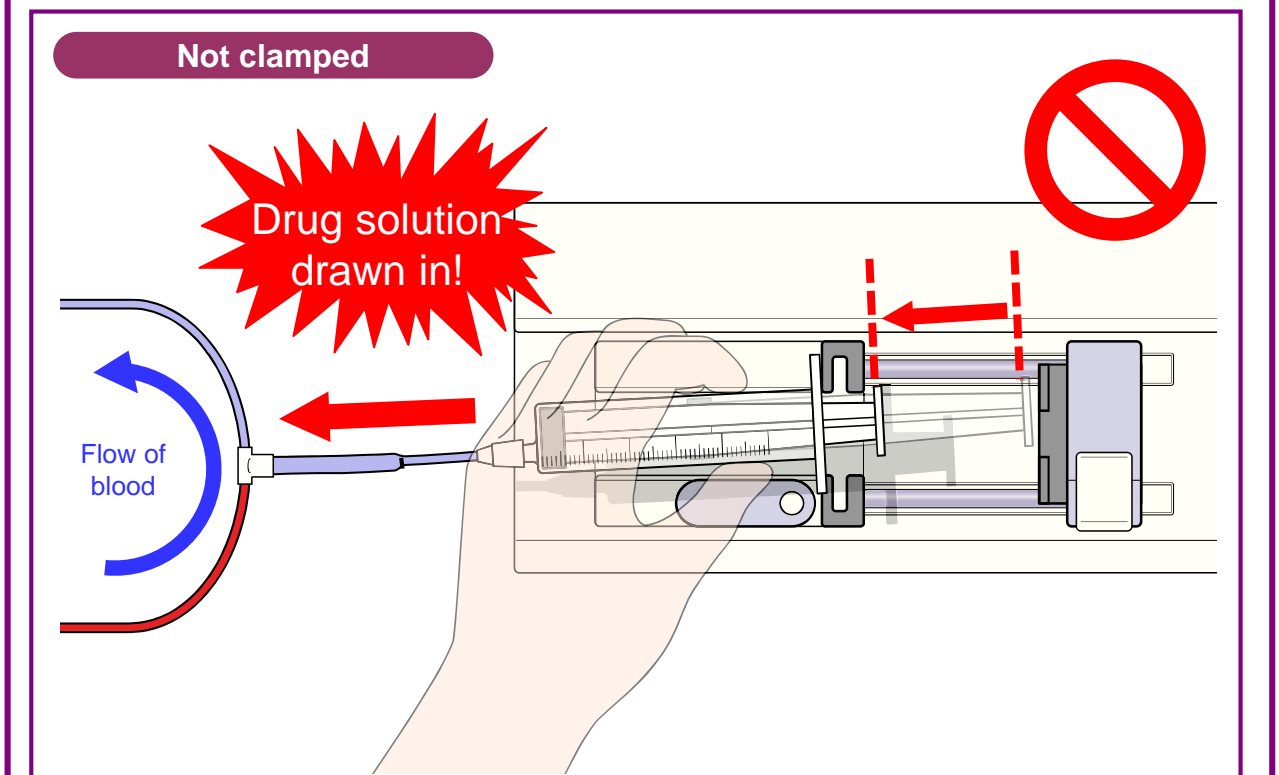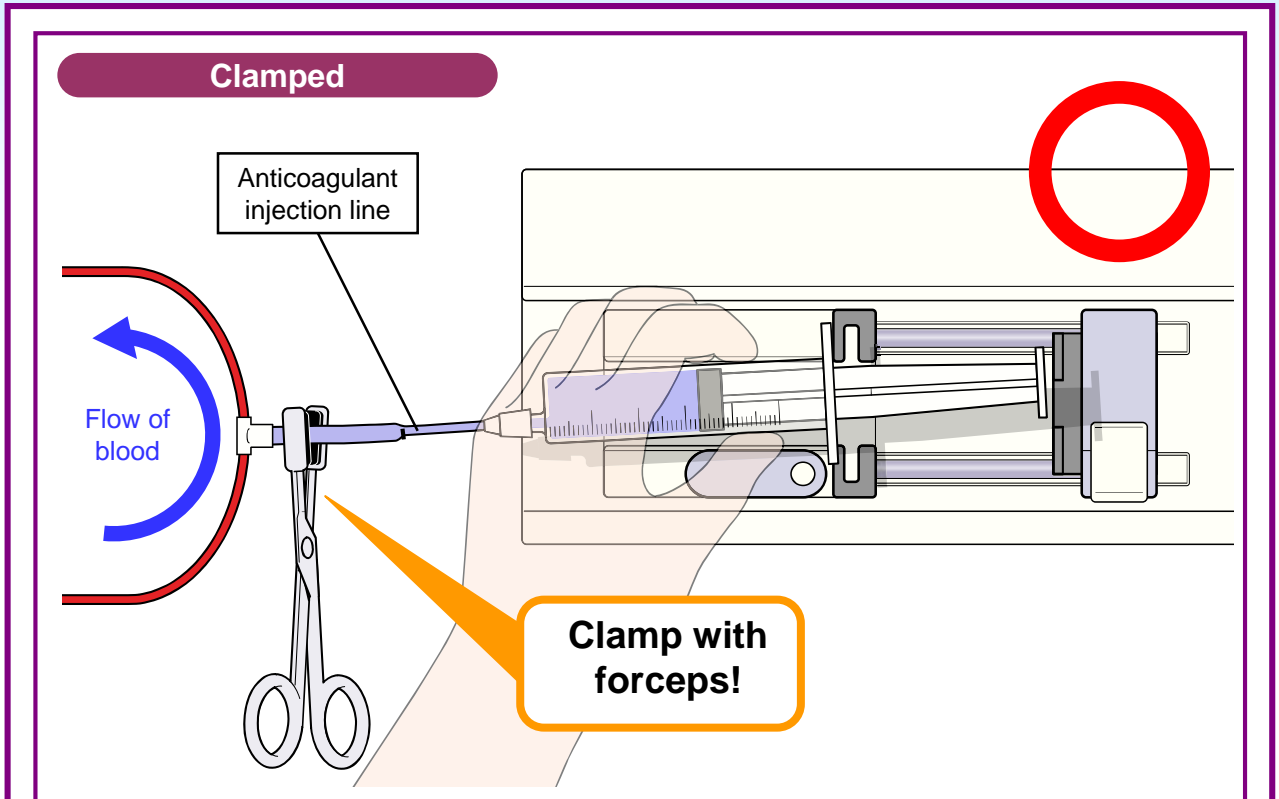## POINT Key points for safe use

(Case) Incorrect attachment of an anticoagulant syringe was found after starting blood purification. When the syringe was removed from the syringe pump, the drug solution was rapidly injected.

1 Rapid injection of an anticoagulant

- **Attach the anticoagulant syringe to the syringe pump correctly.**

- **Clamp the anticoagulant line with forceps when removing the syringe from the syringe pump while the blood pump is activated.**

In case an anticoagulant infusion line is connected to the upstream of the blood pump.

Rapid injection of the drug!

Removal of the syringe

Blood purification device

Syringe pump

Syringe

Precautions when removing the syringe

Clamped

Anticoagulant injection line

Flow of blood

Clamp with forceps!
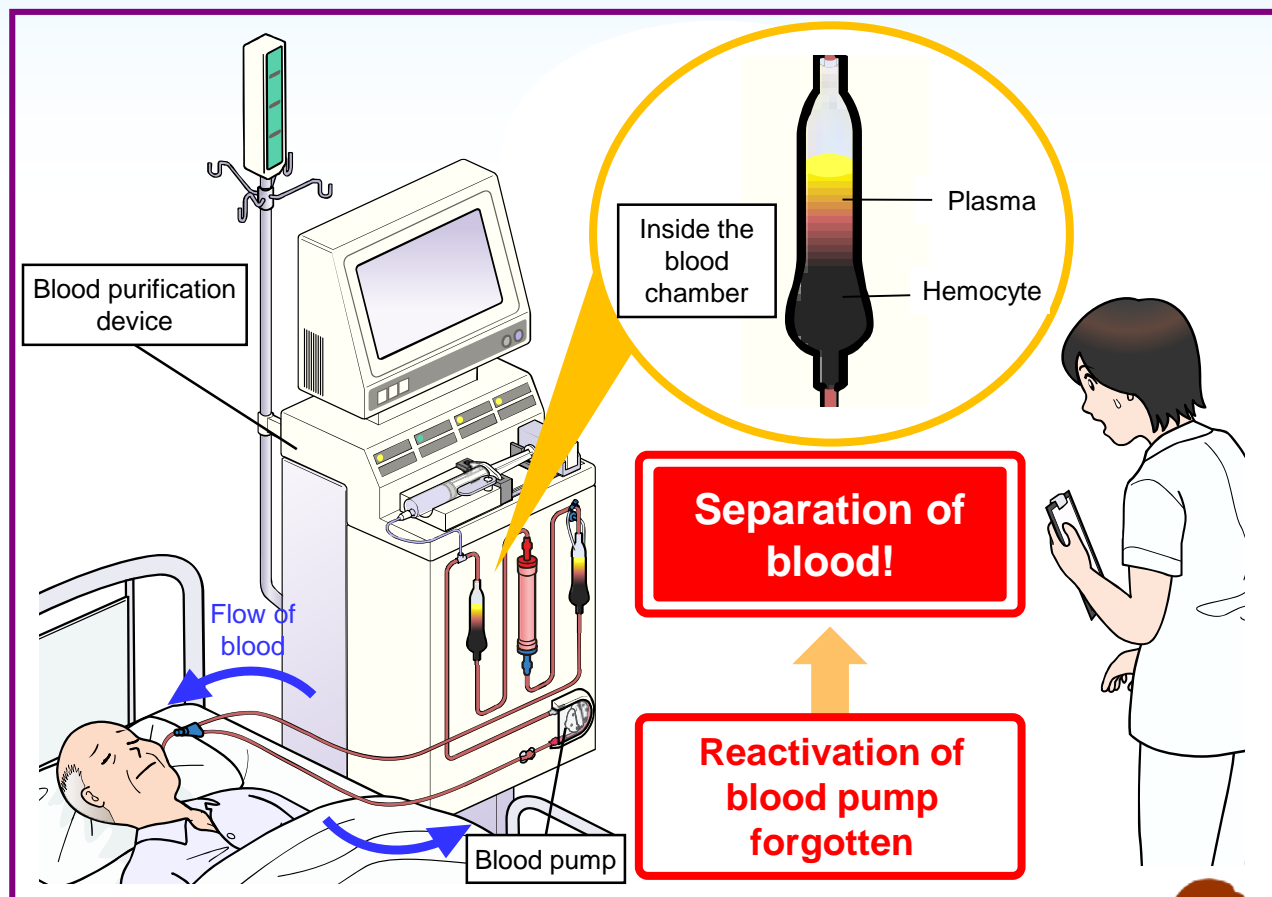
Not clamped

Drug solution drawn in!

Flow of blood

⚠ **In a blood circuit with an anticoagulant injection line located upstream of the blood pump, the drug solution will be rapidly drawn in when the syringe is removed from the syringe pump.**
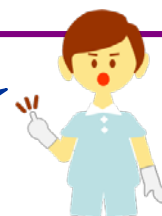
(Case 2) An alarm went off to warn of an increase in venous pressure during continuous hemodiafiltration (CHDF). The treatment was resumed after taking a corrective action. Later, the blood pump was found to be inactivated and the blood in the circuit was separated.

2 Forgotten reactivation of a blood pump after an alarm is triggered

● **Make sure the blood pump is activated after resuming treatment.**

Blood purification device

Inside the blood chamber

Plasma

Hemocyte

Separation of blood!

Flow of blood

Reactivation of blood pump forgotten

Blood pump

After the alarm is turned off, correct the cause of treatment interruption and make sure the blood pump is reactivated when the treatment is resumed.

About this information

* PMDA Medical Safety Information is issued by the Pharmaceuticals and Medical Devices Agency for the purpose of providing healthcare providers with clearer information from the perspective of promoting the safe use of pharmaceuticals and medical devices. The information presented here has been compiled, with the assistance of expert advice, from cases collected as Medical Accident Information Reports by the Japan Council for Quality Health Care, and collected as Adverse Drug Reaction and Malfunction Reports in accordance with the Pharmaceutical Affairs Law.

* We have tried to ensure the accuracy of this information at the time of its compilation but do not guarantee its accuracy in the future.

* This information is not intended to impose constraints on the discretion of healthcare professionals or to impose obligations and responsibility on them, but is provided as a support to promote the safe use of pharmaceuticals and medical devices by healthcare professionals.

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