

Medical Safety Information

Pharmaceuticals and Medical Devices Agency



No. 47

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Handling of Lines for Drug Solution Administration

POINT

Key points for safe use

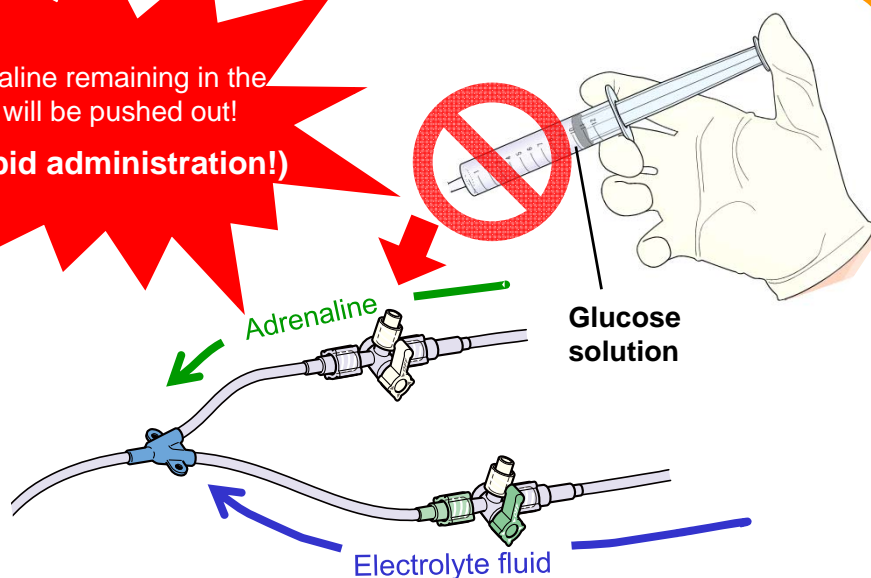
(Case 1) When administering glucose solution through a double-lumen central venous (CV) catheter, glucose solution was accidentally injected into the line for adrenaline, causing bolus administration of adrenaline, which resulted in ventricular fibrillation in the patient.

1 Precautions when administering drug solution through Y-site injection port

- Before the administration of drug solution via the Y-site injection port, make sure to check what kind of drug solution is present in the tubing.

Adrenaline remaining in the line will be pushed out!

(Rapid administration!)



Note: A double lumen catheter possesses two lumens.

Double-lumen CV catheter

Line for electrolyte fluid

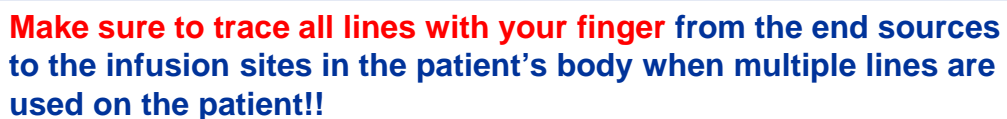
Line for adrenaline

Adrenaline

Electrolyte fluid

2 Precautions in connecting lines: 1

Right

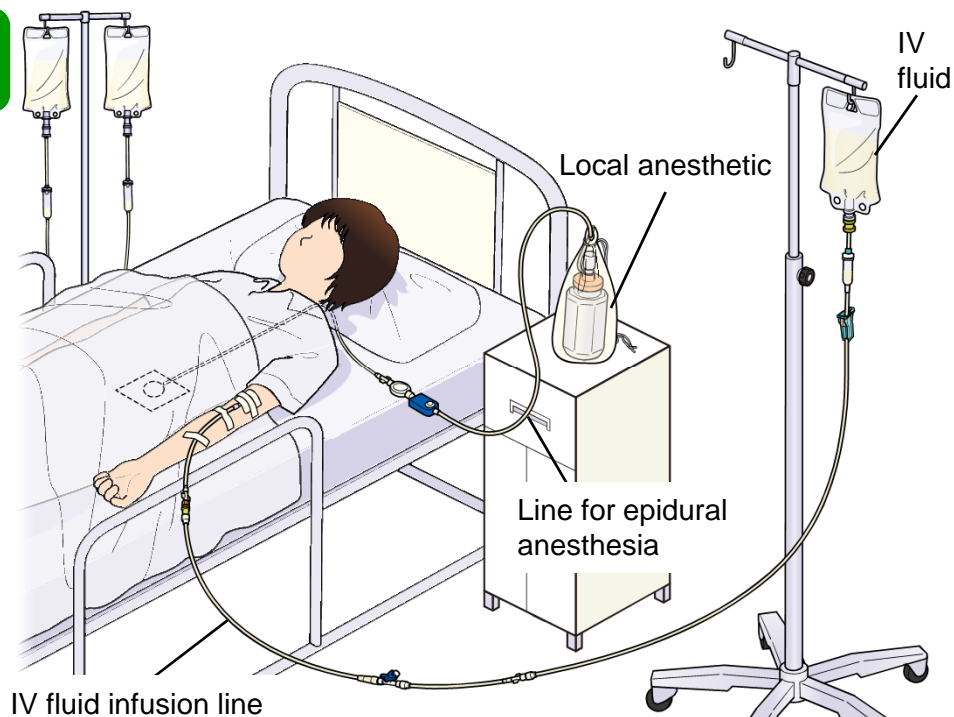


(Case 3) After the line for epidural anesthesia was disconnected, it was accidentally reconnected to the IV fluid infusion line.

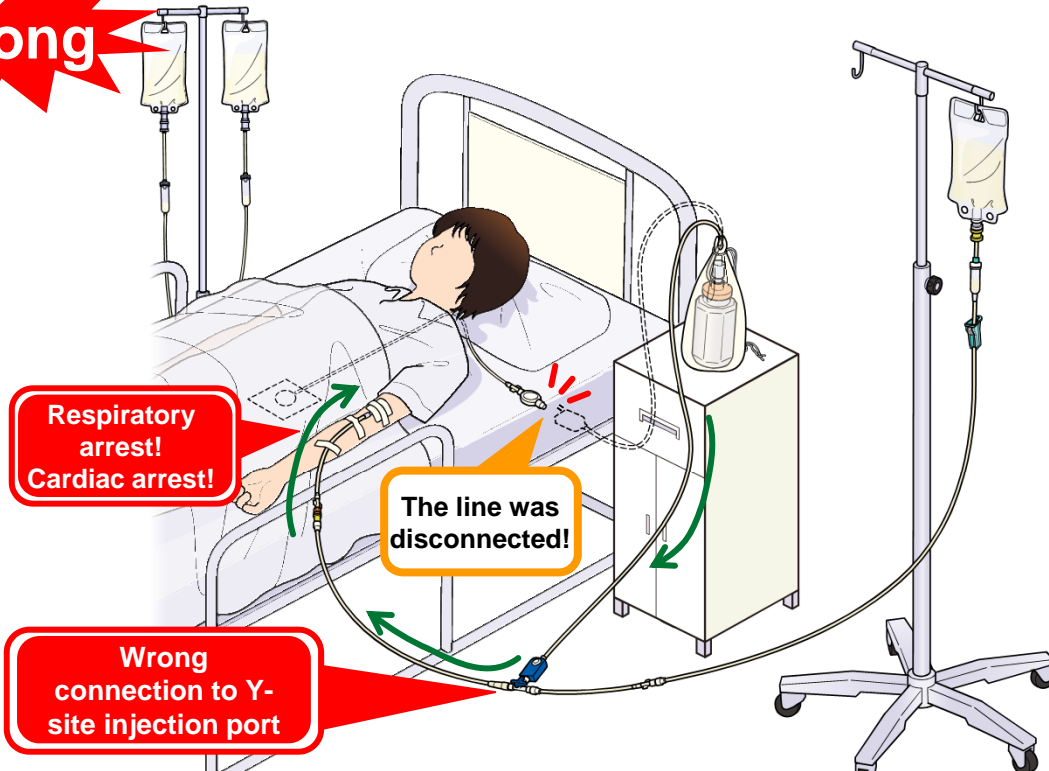
3 Precautions in connecting lines: 2

Incorrect connection of the epidural anesthesia line to the IV fluid infusion line

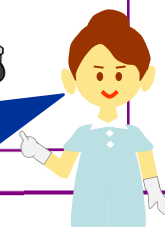
Right



Wrong



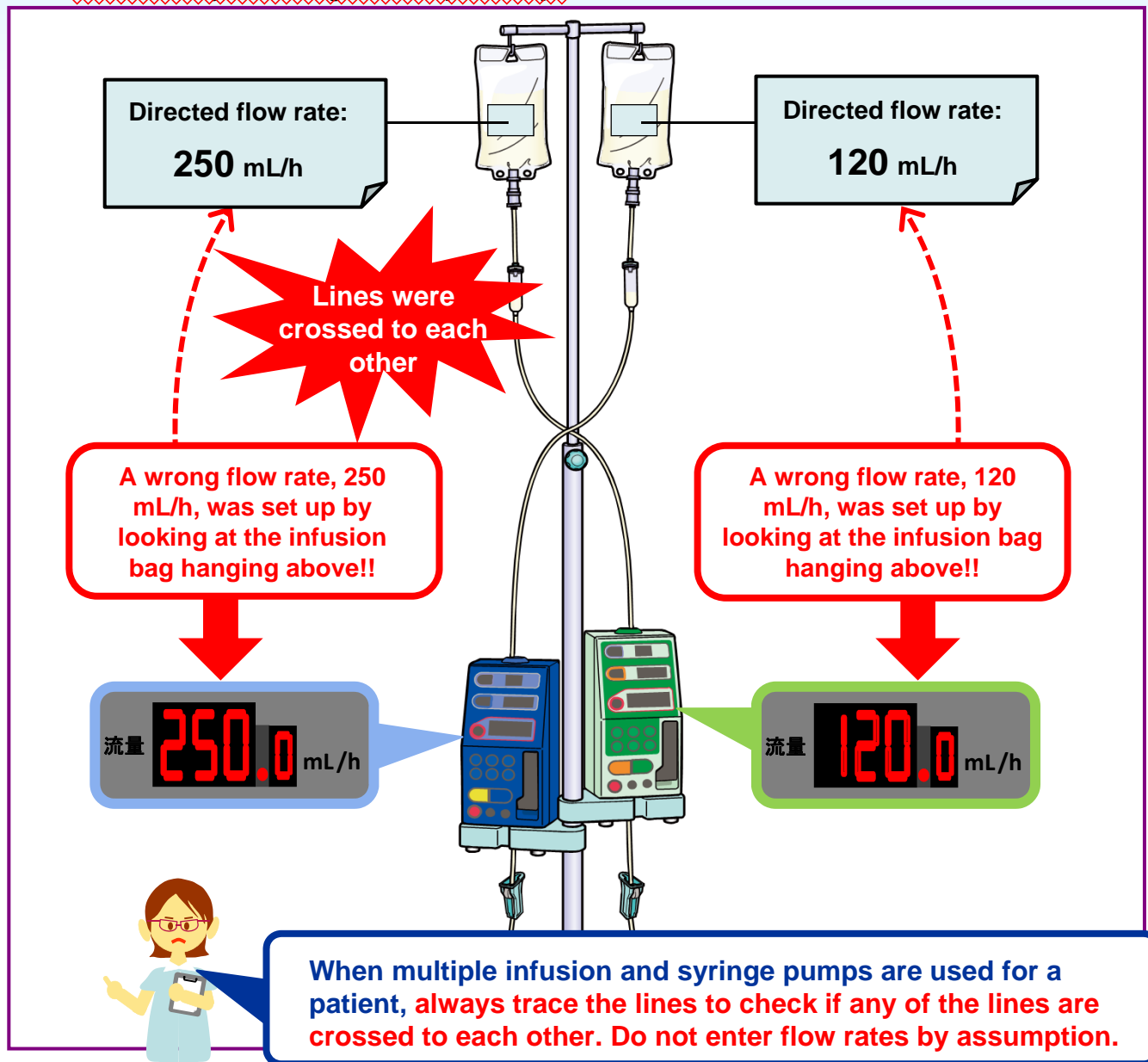
When you find a disconnected line, trace the line calmly!
In particular, use extra caution at night when the room is dark.



(Case 4) Flow rates for the two fluids were entered in reverse by mistake, and administration of drug solutions had started.

4 Mix-up of administration lines

- When entering the flow rate of the infusion pump, make sure to confirm the indicated flow rate by following the line precisely.



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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