Incorrect connection of epidural infusion in a high dependency unit

S

The patient was admitted after emergency abdominal surgery to the HDU in the early hours of the morning. A lumbar epidural was sited by the theatre anaesthetist. A test dose was given and there were no concerns about position. The epidural infusion was not connected; instructions were left for epidural to be connected in HDU.

B

On the consultant ward round the following morning the epidural low dose infusion was noted to be connected to peripheral venous line.

A

The infusion was stopped, the patient was monitored; no harm was identified.

The incident was reported as a never event and near-miss. Investigation as a serious incident is on-going but early learning has focused on distraction error, workload of HDU nurses and training.

This has been disseminated in briefings within critical care including safety huddles, handovers and governance meetings.

R

Ideally epidural infusions to be connected by the person inserting catheter.

Where this not possible then a two-person check should be performed to ensure correct connection.

Lobby manufacturers to produce agreed dedicated epidural connectors incompatible with venous or arterial systems.

Welcome to our safety learning bulletins, which aim to disseminate learning that has been shared from adverse incidents

We invite you to submit anonymous summaries of incidents that have occurred in your local units that have important lessons that we can all learn from to improve patient safety.

If you have an incident and learning that you would like to share please submit using the SBAR format.

We welcome any feedback regarding our shared learning process