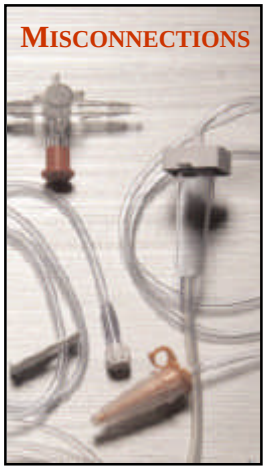
FRONT



American Nurses Training Association

ANTA.TRAININGFORNURSES@GMAIL.COM

BACK

TUBING MISCONNECTIONS:

A persistent and potentially deadly occurrence

The above *Tubing Misconnections* Sentinel Event Alert was issued by the Joint Commission on Accreditation of Healthcare Organizations in April 2006.

In a tertiary healthcare setting medical devices are connected to patients for the purposes of delivering medications, gases & enternal feedings.

These devices frequently have similar & often identical connectors. The multitude of similar connectors in a clinical environment may lead a patient care provider to connect two devices which have different intended purpose, thus leading to a "misconnection."

– ❖ –

INSIDE

DON'T BE A MISFIT; CHECK BEFORE YOU CONNECT!

Nursing Interventions To Prevent Misconnections:

1. Always trace a tube or catheter from the patient to the point of origin before connecting any new device or infusion.

2. Line reconciliation: Recheck connection & trace all patient tubes & catheters to their sources upon the patient's arrival to a new setting or service as part of the hand-off process.

3. Label epidural, intratheral and arterial catheters.

– ❖ –

4. Inform non-clinical staff, patient and their families that they must get help from clinical staff whenever there is a real or perceived need to connect or disconnect devices or infusions.

5. Whenever possible, route tubes & catheters having different purposes in different standardized directions.

- **a.** IV lines routed toward the head
- **b.** Enteric lines toward the feet

6. Use oral medication syringes to deliver medication; do not use a standard luer syringe for oral medications or enteric feedings.

– ❖ –