

# Rapid Response Report

NPSA/2011/RRR003

From reporting to learning

28 November 2011

## Minimising Risks of Mismatching Spinal, Epidural and Regional Devices with Incompatible Connectors

### Issue

Spinal, epidural and regional devices, with non-luer compatible neuraxial connectors, that will not connect with intravenous equipment, are being placed on the market by industry in response to the NPSA Patient Safety Alert issued in 2009.\* Although the use of these devices will reduce the risks of wrong route errors, it is essential that effective controls are in place to minimise the risk of mis-selection and supply of devices with incompatible connectors that could cause delay in clinical procedures and harm patients. The NPSA has recently received details of a patient safety incident, where a spinal needle with a neuraxial connector was supplied and used in error when a device with a Luer connector was required. The labelling and packaging of the two devices with Luer and neuraxial connectors, from the same manufacturer, looked very similar in their appearance. This RRR provides additional guidance to the Alert.

### Incident summary

*"Patient undergoing elective caesarean section. After spinal needle inserted, discovered that the needle fitted with a neuraxial connector. Only Luer syringes were available for use. These would not connect to the spinal needle used. The spinal needle was removed. Procedure delayed until (a second) spinal needle with Luer connector was obtained. (A second) procedure went ahead, no further incident. No permanent harm to the patient. Investigation discovered that a routine order for spinal needles (with Luer connectors) was placed with the usual medical device distributor. A box of spinal needles with neuraxial connectors, from the same manufacturer, was supplied in error by the distributor. A hand written label with the code for spinal needles fitted with Luer connectors had been applied to the box of spinal needles with neuraxial connectors, and supplied to the hospital."* **Fortunately the delay in treatment reported in this incident did not cause permanent harm, however, if this had been an emergency caesarean section, the risk of serious harm to the mother and particularly the baby would have increased.**

### Design for patient safety

The National Patient Safety Agency (NPSA) has alerted devices manufacturers of this risk and will promote the need for safer design. This will include the use of colour, wording and symbols, on neuraxial devices, labelling, packaging and shipping cartons, to clearly indicate the type of connector used in these devices.

**For IMMEDIATE ACTION by all organisations in the NHS and independent sector who use spinal, epidural and regional devices. Deadline for ACTION COMPLETE: 31 March 2012.**

1. Alert healthcare staff who order, receive, transport, restock and clinically use spinal, epidural and regional devices of the risk of mis-matching connectors.
2. Check current stocks of spinal, epidural and regional devices to ensure these devices are compatible.
3. Amend written distribution and clinical procedures to confirm the identity of the connectors used in devices. Checks should not solely rely on catalogue code numbers. The term 'Luer' and where neuraxial connectors are fitted, the device trademark should be used to identify different connector designs. Currently Correctinject®, Hall Lock®, Neurax®, Surety®, UniVia® are trademarks being used. Only devices with the same connector descriptors are compatible. In addition, other design elements such as colour, text and symbols should assist users to identify the type of connector used in the device.
4. Use procedure packs where feasible and appropriate to ensure that all the devices required for a specified procedure are compatible and readily available.
5. Recommend clinical staff check all devices required for a procedure are fitted with the same connector design before commencing the procedure.



### Further information

Information on the Patient Safety Alert<sup>1</sup> and Neuraxial Update Newsletter are available at [www.npsa.nhs.uk/rrr](http://www.npsa.nhs.uk/rrr). Further queries email [rrr@npsa.nhs.uk](mailto:rrr@npsa.nhs.uk) or telephone 020 7927 9500. NPSA has informed NHS organisations, the independent sector, commissioners, regulators and relevant professional bodies in England and Wales.

\* Safer spinal (intrathecal), epidural and regional devices: NPSA/2011/PSA001 31 January 2011, NPSA/2009/PSA004B 24 November 2009, <http://www.nrls.npsa.nhs.uk/resources/?EntryId45=94529>