

	INODAYA Hospitals - Kakinada		Documentation code: INH/HIC.Doc.NO:21
	POLICY ON MEASURES TO AVOID CATHETER AND TUBING MISCONNECTIONS		Issue date: 11/11/2025
	Reference NABH standard (5th edition): MOM 07h		Issue no: 01
	Prepared date: 11/11/2025	Review date: 10/11/2026	Revision Number: 00

MOM 7h: POLICY FOR MEASURES TO AVOID CATHETER AND TUBING MISCONNECTIONS

1.0 POLICY:

Inodaya Hospitals will follow safe standards related to medical tubes.

2.0 PURPOSE:

To provide for the safety of the patients requiring various types of medical tubing related to their care.

3.0 DEFINITION:

Tubing misconnections are tubes, cables or other hospital equipment connected to the wrong port which may result in patient injury or death.

1.1 Tubing misconnections are tubes, *catheters*, cables or *medical / surgical* equipment's connected to the wrong port which may result in patient injury or death.

Tubing or catheter types may include but are not limited to:

- Intravenous (IV) tubing peripheral or central *venous catheters*
- Chest tubes
- Epidural *catheters*
- Feeding tubes
- Endotracheal / Tracheostomy tubes
- Bladder (Foley) catheters

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- Percutaneous nephrostomy tubes
- Ventriculostomy drainage devices used for head trauma
- Arterial lines
- Naso gastric tubes
- Intrathecal lines
- *Haemodialysis /Peritoneal dialysis catheters*
- Ventilator tubing's

Oxygen devices

1. Near miss: A misconnection that is recognized immediately and disconnected. This results in no harm to the patient.
2. Trace: Track or follow a tube or catheter from the patient to the point of origin.
3. Luer Lock: A connective device or syringe that can accept and allow many connections. Due to the ease of the connection, there may be no indication that the connection may be wrong.

4. 4.0 SCOPE:

All Patient Care areas

4.0 RESPONSIBILITY:

Doctors, Nursing staff, technicians

4.1 DISTRIBUTION:

All patient care areas

PROCESS DETAILS:

2. PROCEDURE

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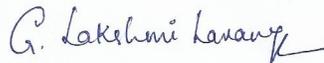
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- 2.1 Trace all lines back to their origin before making connections.
- 2.2 Trace and re-check all patient tubes and catheters to their source upon a patient's admission to a new department or unit or returning to the room after undergoing a procedure or diagnostic imaging as part of the hand-off process.
- 2.3 Do not force connections.
- 2.4 If a connection is difficult to make, it may be because the connection is incorrect. Do not tape, force or otherwise make the connection. Stop and ask for assistance.
- 2.5 Do not use adaptors unless they are clearly required for the application.
- 2.6 Using an adaptor might permit the connection of two inappropriate components such as two luer connectors or two different sized parts.
- 2.7 Inform all non-clinical staff, patients and their families that they must get help from nursing whenever there is a real or perceived need to connect or disconnect devices.
- 2.8 *Aseptic* caps must be attached to all unused vascular access needleless connectors.
- 2.9 Turn on a light in a darkened room before connecting or re-connecting tubes or devices.
- 2.10 High risk catheters to be labelled (e.g: arterial, epidural, Intrathecal etc)
- 2.11 Report *and raise incident for* all near-miss misconconnections and discovered tubing misconconnections.
- 2.12 Never use tubes, catheters or connectors for unintended purposes.
- 2.13 Non-clinical staff, Patients and family members are educated that devices should never be connected or disconnected by them. Help should always be asked from Nursing or Medical staff.
- 2.14 Oxygen flow meters are color coded White and vacuum lines are yellow. Always trace connections to the wall outlet / gas cylinder for positive source gas identification.

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3. Various types of misconnections posing dangers:

Enteral feeding tube	connected to	IV
Limb cuff inflation device	connected to	IV (For example, a 71-year-old woman died post- operatively after a blood pressure cuff was accidentally connected to her IV line, causing an air embolism.)
Epidural solution (intended for epidural administration)	connected to	Peripheral or central IV catheter
Epidural line	connected to	IV infusion
Bladder irrigation solution using primary IV tubing (connected as secondary infusion)	connected to	Peripheral or central IV catheter
IV infusion (intended for IV	connected to	Indwelling bladder (foley) catheter
IV infusion (intended for IV	connected to	Nasogastric (NG) tube
Primary IV tube	connected to	Blood product (intended for transfusion)
Enteral feeding (gastric or nasal)	connected to	Tracheostomy tube

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IV solution	administered via	Blood administration set
Primary IV solution	administered via	Various functionally dissimilar catheters (such as external dialysis catheter,

Event	Potential To harm	Safety Tip
Feeding tube erroneously connected to trach tube	High	Always trace a tube or catheter from the patient to the point of origin before connecting any new device or infusion
Epidural tubing erroneously connected to IV tubing	High	For certain high-risk catheters (e.g., epidural, intrathecal, arterial), label the catheter and do not use catheters that have injection ports.
IV tubing erroneously connected to trach cuff	High	Emphasize the risk of tubing misconnections in orientation and training curriculum.
IV tubing erroneously connected to nebulizer	High	Do not purchase non-intravenous equipment that is equipped with connectors that can physically

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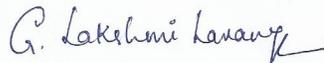
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		mate with a female luer IV line connector
Oxygen tubing erroneously connected to a needless IV port	High	Identify and manage conditions and practices that may contribute to healthcare worker fatigue, and take appropriate action.
Blood pressure tubing erroneously connected to IV catheter	High	Inform non-clinical staff, patients 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.
IV tubing erroneously connected to nasal cannula	High	Recheck connections and trace all patient tubes and catheters to their sources upon the patient's arrival in a new setting or service as part of the handoff process. Standardize this "line reconciliation" process.
IV tubing erroneously connected to enteral feeding tube	Moderate	Inform non-clinical staff, patients 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
Syringe erroneously connected to trach cuff	High	Always trace a tube or catheter from the patient to the point of origin before connecting any new device or infusion
Foley catheter	Low	Inform non-clinical staff, patients and their

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erroneously connected to NG tube		families that they must get help from clinical staff whenever there is a real or perceived need to connect or disconnect devices or infusions.
Enteral feeding tube erroneously connected to ventilator in-line suction catheter	High	Emphasize the risk of tubing misconconnections in orientation and training curriculum.

Precautions to be taken:

- When changing body positions
- While moving patients between beds
- Patient's behavior
- Caught by a bed rail
- Caught by a wheel chair
- Labelling has to done for identification of tubbings

Labelling Identifications:

- Central Line : Red Colour tag (CL1,CL2,CL3)
- NG tube : Green Colour tag
- Foleys Catheters : Orange Colour tag
- Arterial : Blue Colour tag
- All Drains : Yellow Colour tag (D1,D2.....)
- Epidurals Catheter : white Colour tag

Causes of connection related injuries:

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- The luer connector, a type of connector that makes connecting unrelated tubing too easy.
- Workarounds (rigging) – using adapters, tubes or catheters in a manner for which they were no intended.
- Providers making connection errors after going into “automatic” mode due to stress, fatigue or distractions.
- Poor lighting and other environmental factors.
- Positioning functionally dissimilar tubing in close proximity to one another – often called the “spaghetti syndrome.
- Not rechecking or tracing tubing connections after a patient is moved as part of the handoff process, or during other key transitions.
- Less-than-optimal reporting of adverse events and near misses as part of efforts to educate and raise awareness – there is still a fear of repercussions and legal action.

References :

- 6.1 NABH 5th Edition Standard April 2020, MOM 7h
- 6.2 WHO Patient safety solution 7 - Avoiding Catheter and Tubing Misconnections
- 6.3 Sentinel Alert Event: A complimentary publication of the Joint Commission Issue 53, August 20, 2014

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