NSW HEALTH

Safety Alert 001/08

The actions specified are mandatory in accordance with NSW Health Policy Directive PD2006_102

10 October 2008

Peripherally Inserted Central Catheter (PICC) Lines

Distributed to:

- Chief Executives
- Directors of Clinical Operations
- Director of Clinical Governance
- Clinical Product Managers

Action required by:

- Director of Clinical Governance.

For response by:

- Directors of Clinical Governance.

We recommend you also inform:

- Vascular Access Teams
- Nurses and doctors of paediatric units
- Nurses and doctors of NICU
- Clinical Heads NICU
- Clinical Heads PICU
- Area Directors of Nursing
- Nurses
- Medical staff

Deadline for completion of action

15th October 2008

Quality and Safety Branch
NSW Department of Health
Tel. 02 9391 9200
Fax. 02 9391 9556
Email
quality@doh.health.nsw.gov.au

www.health.nsw.gov.au/quality/sabs/register.html

Background

The Therapeutic Goods Administration (TGA) has received several reports of serious adverse events associated with the use of Peripherally Inserted Cental Catheter (PICC) Lines.

TGA received a medical device adverse event report from a hospital concerning an incident during a procedure to insert an Arrow brand PICC Line in a child.

The report advises that the outer winding of the indwelling wire separated from the inner core and embolised into the pulmonary artery of the patient after the length of line was trimmed to an appropriate length for a small patient. Subsequent scans showed the presence of wire fragment in the pulmonary artery that was successfully removed.

The TGA's Medical Device Incident Report Investigation Scheme (IRIS) reports prior to this latest set were single reports to the TGA in 2004 and 2005.

The TGA investigated similar incidents in 2002 and 2005, and on three previous occasions has issued warning about the risks of cutting catheter guidewires in PICC and central lines. The advice was also published through the "TGA News" information sheet with recommendations that wherever possible shortening of the catheter should be avoided, but if necessary to do so, the manufacturer's instructions should be very carefully followed.

The TGA is investigating these incidents.

Actions required by Area Health Services

1. Wherever possible shortening of the catheter should be avoided, but if necessary to do so, the manufacturer's instructions should be very carefully followed.
2. AHS to respond to SABS email address within 2 working days of receipt of this alert.