CANADIAN ANESTHESIOLOGISTS' SOCIETY

PATIENT SAFETY BULLETIN

Reports of Coring Issues with BD Blunt Needles

December 2024

Background

We have received reports from anesthesiologists in Ontario regarding coring issues when using BD Blunt needles to draw medications. Coring involves a small piece of the rubber stopper detaching during needle insertion, which may lead to contamination or injection of rubber fragments into patients.

Key Observations

- Coring has been noted with multiple medications but consistently involves the BD Blunt needle.
- Changes in rubber stopper composition or needle design may be contributing factors, but this remains unclear.
- Traditional technique recommends inserting needles at a 90-degree angle to prevent needlestick injuries; however, some practitioners are now suggesting a 45-degree angle to reduce coring risks.

Immediate Recommendations

Local Reporting: Encourage all practitioners to report coring incidents to their local Pharmacy and Quality Improvement teams for investigation and monitoring of the issue.
Engage Pharmacy Teams: Collaborate with pharmacy to assess the local incidence of coring events and identify any patterns related to specific drugs, stoppers, or needles.
Additional Recommendations: Anesthesiologists should focus on local vigilance, and speak up about any problems encountered in the ABSENCE of BD-blunt needle.
Technique Adjustment: Consider trialing a 45-degree insertion angle for drawing medications, while maintaining vigilance for safety and adherence to institutional protocols. Consider using a filter needle.

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Next Steps

We will engage local stakeholders to investigate potential causes and solutions. Further updates with specific recommendations will follow as more information becomes available.

For questions or to report an incident, please contact your local Patient Safety Officer or Pharmacy Team.

Prepared by the CAS Quality and Patient Safety Committee.

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