Potential mislabelling of dialysate concentrate

There has been a potential problem reported by a dialysis unit with a dialysate concentrate which has occurred in the last 24 hours. During dialysis with a concentrate there have been multiple simultaneous conductivity alarms in 8 machines in one unit when using the particular batch. One patient had a brief adverse reaction and was admitted overnight to hospital for observation.

Provisional in-house testing may suggest that the electrolyte content is not as described on the manufacturer's label. It is suspected that a 1:33 dilution is incorrectly labelled as 1:44, though this cannot be confirmed for certain at the present time. Further testing showed the conductivity alarm picked this up, but the error was not consistent in the batch number as some dialyses progressed without difficulty but some resulted in conductivity alarms.

The unit has withdrawn this batch of concentrates from their dialysis units.

Action

- Any dialysis unit should be aware of potential mislabelling if multiple conductivity alarms occur.
- The company has been notified by the unit affected.
- This issue has been reported to the MHRA.
- Further information will be circulated when available.

Please submit comments, solutions, and personal experience to:

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