The first fatal incident of wrong-route administration of vinca alkaloids occurred in 1968. Initial recommendations for practice change occurred in 2005" Corbitt et al (2017).

Abstract:

The first fatal incident of wrong-route administration of vinca alkaloids occurred in 1968. Initial recommendations for practice change occurred in 2005. In 2012, 54% of oncology treatment sites had changed their practice. The authors' institution has developed a safe, adaptable, and consistent process to prepare, deliver, and administer vinca alkaloids by means of a minibag delivery. A multidisciplinary team, including representatives from the nursing and pharmacy departments, reviewed the literature and developed all processes, including staff education. Minibag administration began in August 2015, and more than 2063 doses have been administered without any extravasations. To date, the simulation strategy for education is effective, and the delivery system is safe.

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Reference:

Corbitt, N., Malick, L., Nishioka, J., Rigdon, A., Szoch, S. and Torr, P. (2017) Instituting

Vincristine Minibag Administration: An Innovative Strategy Using Simulation to Enhance Chemotherapy Safety. Journal of Infusion Nursing. 40(6), p.346-352.

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