

Medical Device/Equipment ALERT

Ref. MDEA(NI)2005/70

Issued: 12 October 2005

For:

IMMEDIATE ACTION	✓
ACTION	
UPDATE	
INFORMATION	



**NORTHERN
IRELAND
ADVERSE
INCIDENT
CENTRE**

	Section
Medical Device/Equipment: Operating Theatre patient transfer systems.	▶ ①
Problem: Possible risk of entrapment of Patient Breathing Circuits during patient transfer into or out of the Operating Theatre.	▶ ②
Action by: Anaesthetists, Theatre Managers and Operating Theatre staff.	▶ ③
Action: Trusts should review operational policies and procedures to minimise the risk to patients from the accidental entrapment of Patient Breathing Circuits during patient transfer into or out of the Operating Theatre.	▶ ④
Distributed by NIAIC to: Chief Executive of each HSS Board Chief Executive of each HSS Trust Chief Executive of each Agency NIAIC Liaison Officers	▶ ⑤
Contacts Details of NIAIC contacts.	▶ ⑥
Feedback Requirements to NIAIC None required	▶ ⑦

This Alert is on our web site: <http://www.dhsspsni.gov.uk/niaic>

1. DEVICE/EQUIPMENT:

Operating Theatre patient transfer systems comprising of operating tables, transporters, trolleys or beds.

2. PROBLEM:

NIAIC has been made aware of two incidents that reported the possible entrapment of Patient Breathing Circuits during transfer of the patient out of the operating theatre, one incident involving a fatality. In both cases it was reported that the patient breathing circuit became entrapped between the table top and a wheeled patient transporter while it was being engaged at the end of the operation. During investigation by NIAIC it was noted that a coaxial patient breathing circuit could become entrapped causing an occlusion which could result in patient hypoxia.

While both reported incidents involved a similar operating table and transfer system it is conceivable that the entrapment of a Patient Breathing Circuits could occur with any system used to transfer patients into or out of the operating theatre environment.

3. ACTION BY:

Anaesthetists, Theatre Managers and Operating Theatre staff.

4. ACTION:

- All theatre staff should be aware of the risk that the Patient Breathing Circuit can become entrapped during the transfer of patients into or out of the operating theatre environment and should be vigilant when a moving any equipment close to the operating table.
- Trusts should review operational policies and procedures to minimise the risk to patients from the accidental entrapment of Patient Breathing Circuits during patient transfer into or out of the Operating Theatre. The review of policies and procedures should take into consideration the theatre transport system manufactures instructions on the safe use of their equipment.
- Trusts should ensure that the all appropriate staff are aware of and trained in the operation of these policies and procedures, including locum or agency staff.
- In the event of a patient suffering hypoxia due to a blocked Patient Breathing Circuit, the Anaesthetists should follow an effective recovery strategy as given by The Association of Anaesthetists of Great Britain & Ireland or The Royal College of Anaesthetists
- The Association of Anaesthetists guidelines 'Checking Anaesthetic Equipment-3 2004' recommend that "It is essential that an alternative oxygen supply and means of ventilation (e.g. self-inflating bag, circuit and oxygen cylinder, which must be checked as functioning correctly) are always readily available." Anaesthetists should consider using such a self-inflating bag as a first-line check of any possible breathing circuit problem.

5. ONWARD DISTRIBUTION TO:

Please bring this notice to the attention of all who need to know or be aware of it. This will include distribution to:

- Liaison Officers
- Risk Managers
- Health & Safety Officers/Advisors
- Clinical Governance Leads
- Directors of Anaesthetic Services
- Medical Directors
- Clinical Directors
- Nursing Directors
- Independent Health and Social Care Providers – Private Clinics through HSSRIA
- Operating Theatre Staff
- Resuscitation Officers
- Anaesthetists
- Theatre Managers

6. CONTACTS:

Enquires to NIAIC should quote reference number MDEA(NI)2005/70 and be addressed to:

Northern Ireland Adverse Incident Centre (NIAIC)
Health Estates
Estate Policy Directorate
Stoney Road
Dundonald
Belfast BT16 1US

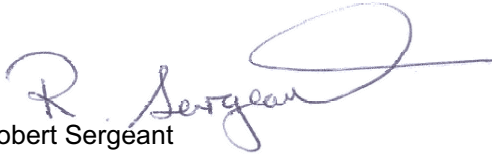
Tel: 028 9052 3868

Fax: 028 9052 3900

Email: NIAIC@dhsspsni.gov.uk

7. FEEDBACK:

None required.



Robert Sergeant
NIAIC Operational Manager

HOW TO REPORT ADVERSE INCIDENTS

Adverse Incidents relating to medical devices, non-medical equipment, plant and buildings should be reported to NIAIC as soon as possible. Advice on how to report is given in MDEA(NI)2005/01. If you are in doubt about how to report incidents, please speak to your liaison officer or contact NIAIC using the telephone number provided. Adverse Incident reporting forms and an on-line reporting facility are available on the NIAIC website at www.dhsspsni.gov.uk/niaic

Heath Estates is an Executive Agency of the Department of Health, Social Services and Public Safety