

Medical Device/Equipment ALERT

Ref. MDEA(NI)2005/80

Update of MDEA(NI)2005/70

Issued: 8 November 2005

For:

IMMEDIATE ACTION	✓
ACTION	
UPDATE	✓
INFORMATION	



**NORTHERN
IRELAND
ADVERSE
INCIDENT
CENTRE**

	Section
Medical Device/Equipment: All Anaesthetic Breathing Systems.	▶ ①
Problem: Entrapment of anaesthetic breathing systems between the operating table and patient transfer trolley	▶ ②
Action by: Anaesthetists, Operating Department Practitioners and Anaesthetic Nursing Staff.	▶ ③
Action: <ul style="list-style-type: none"> Staff should ensure breathing circuits do not become trapped between the operating table and patient transfer trolley. Ensure an alternative oxygen supply and means of ventilation are always available, e.g. a self-inflating bag and oxygen cylinder as recommended by the Association of Anaesthetists of Great Britain and Ireland in 'Checking Anaesthetic Equipment, 3, 2004'. Anaesthetists should consider using a self-inflating bag connected directly to the endotracheal tube or mask as a first-line check in any situation in which it becomes difficult or impossible to ventilate a patient. <p>This action is endorsed by the Royal College of Anaesthetists, the Association of Anaesthetists of Great Britain and Ireland, the Association of Operating Department Practitioners and the Association for Perioperative Practice.</p>	▶ ④
Distributed by NIAIC to: <p>Chief Executive of each HSS Board Chief Executive of each HSS Trust</p> <p>Chief Executive of each Agency NIAIC Liaison Officers</p>	▶ 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:

Entrapment of anaesthetic breathing systems between the operating table and patient transfer trolley.

2. PROBLEM:

The Medicines and Healthcare products Regulatory Agency (MHRA) has confirmed that they have been informed of three separate incidents of anaesthetic breathing systems becoming trapped between the operating table and patient transfer trolley. NIAIC Medical Device/Equipment Alert, MDEA(NI)2005/70, issued on 12 October 2005, alerted HPSS staff to the possibility of such entrapment relating to two of these incidents that occurred in Northern Ireland. While both reported incidents to NIAIC involved a similar operating table and transfer system it is conceivable that the entrapment of a breathing system could occur with any system used to transfer patients into or out of the operating theatre environment. The entrapment of the breathing system restricts the flow of gases which can be mistaken for respiratory difficulties such as bronchospasm or laryngospasm. This Alert has therefore been issued to update users on the action agreed and endorsed by the Royal College of Anaesthetists, the Association of Anaesthetists of Great Britain and Ireland, the Association of Operating Department Practitioners and the Association for Perioperative Practice.

3. ACTION BY:

Anaesthetists, Operating Department Practitioners and Anaesthetic Nursing Staff.

4. ACTION:

- Staff should ensure breathing circuits do not become trapped between the operating table and patient transfer trolley.
- Ensure an alternative oxygen supply and means of ventilation are always available, e.g. a self-inflating bag and oxygen cylinder as recommended by the Association of Anaesthetists of Great Britain and Ireland in 'Checking Anaesthetic Equipment, 3, 2004'.
- Anaesthetists should consider using a self-inflating bag connected directly to the endotracheal tube or mask as a first-line check in any situation in which it becomes difficult or impossible to ventilate a patient.

The following action points highlighted in MDEA(NI)2005/70 still apply:

- 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 manufacturers 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.

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)2005/80 and be addressed to:

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

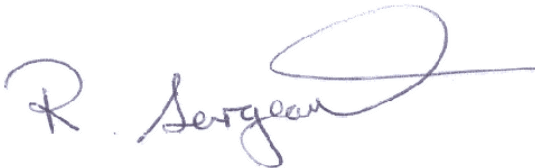
Tel: 028 9052 3868

Fax: 028 9052 3900

Email: NIAIC@dhsspsni.gov.uk

7. FEEDBACK:

None required.

A handwritten signature in blue ink, appearing to read 'R. Sergeant', with a large, stylized flourish extending from the end of the name.

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