

NIAIC MEDICAL DEVICES ONE LINERS

ALL medical devices can fail but an increasing number of incidents which result in significant morbidity or mortality arise out of user/device interface problems or because of poor practices. The aim of this news sheet is to detail briefly some of the problems in an attempt to make users more aware of what can go wrong.....it is all too easy to take equipment for granted.

THE BELLS, THE BELLS!

NIAIC continues to receive reports of failures of alarms on monitoring equipment as a result of inappropriate human action or incorrect use.

Policies, procedures and training issues relating to alarms on clinical monitors are set out in document "Report of the Expert Working Group on Alarms and Clinical Monitors in response to Recommendation 11 of the Clothier Report: The Allitt Enquiry, 1995".

WATT A SHOCKER!

NIAIC continues to receive reports of users receiving electric shocks while carrying out pre-use checks on defibrillators.

Users should always ensure they follow the manufacturers instructions on how to correctly hold the paddles while activating the discharge switches and that the paddles are fully seated in the paddle well.

SHARP PRACTICE!

Users of "the broken needle technique" to obtain blood from small infants should be aware that such needles can pose additional risks if not disposed of safely. Serious injuries resulting from penetration have been reported and exploration needed to

In the circumstances always use devices intended for blood sampling from small infants (see SN(NI)2001/29)

BOARD STAPH?

NIAIC has received a report on contamination of the internal components (circuit boards, air filters) of intensive care ventilators by Methicillin Resistant Staph aureus (MRSA).

Ensure that a schedule for the maintenance of ventilators, monitors and other medical equipment as set out in the manufacturers instructions for use is in place (DB 9904 (NI) section 8; Maintenance and Repair)

SYRINGE DRIVERS!

NIAIC continues to receive reports of user confusion concerning models of syringe driver with different infusion rates.

Users should always ensure that they are clearly aware of the difference in infusion rates being set with different syringe drivers. Some drivers are calibrated in mm/hour or mm/day. Failure to set the correct rate can lead to serious overinfusion with potential fatal consequences (see Hazard Notice HC10/94).

SECOND RATE!

NIAIC has heard of over-infusion of drugs such as potassium when dual rate infusion pumps have been used and the secondary rate accidentally engaged resulting in death.

For pumps and secondary infusion functions, double check that the volume to be infused and the rate of delivery are correctly set for both primary and secondary infusions, particularly when employing drugs where an overdose could lead to serious consequences. If the secondary infusion is not required, check that it is not enabled.

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