

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.

YOUR NICKED!

Alarms in some high street thief detection security systems may be activated by some metallic heart valves. Whilst there is no patient safety issue, patients may be subject to embarrassment, concern, confusion and honesty charges. The problem arises through the metal component of the heart valve “mimicking” the way in which security tags on goods function.

Patients should be made aware of this issue and encouraged to co-operate with store security staff.

TAIL END ?

Several incidents of the distal portion of epidural catheters remaining in patients following discontinuation of pain relief have been reported. Such patients have often had to undergo surgical retrieval procedures which are not always successful. Such incidents have occurred mainly due to inadvertent withdrawal through the needle during the insertion procedure.

Please ensure that epidural catheters are not withdrawn against the needle during insertion.

EYE RISK!

NIAIC has become aware of the use of inappropriate filters for lasers used in ophthalmic surgery. This can lead to permanent eye damage for the operator.

When connecting a laser to a protective system with filters, ensure that the wavelengths of laser radiation for which the filters offer protection match the output wavelength of the laser. If a fault is suspected with the filters, the procedure should be discontinued and the filters examined by a trained engineer.

EXPIRE OR EXPIRE!

NIAIC has become aware that the use of some patient breathing system devices in combination with a cuffed endotracheal or tracheostomy tube may put patients at risk from excessive gas pressure.

Staff with responsibility for prescribing, assembling and maintaining breathing systems to be used in association with endotracheal or tracheostomy tubes should ensure that appropriate procedures are followed to minimise the risk of the patient's airway being occluded or obstructed (SN(NI) 2002/25)

OXY-MORON !

NIAIC has been informed by the Medical Devices Agency that they are aware of patients receiving severe burns where defibrillators are used in the presence of an oxygen rich atmosphere. This results from lack of disconnection of a ventilation system with gas mixtures involving high oxygen concentrations or where disconnected oxygen tubes, still connected to the oxygen supply , are lying near the patient.

Always ensure that when a patient undergoes defibrillation, the oxygen line is disconnected and the source switched off.

OPPOSITES ATTRACT!

Staff should be aware that confusion can occur concerning the meaning of “compatible” when applied to MRI Scanners and Monitoring Devices.

Monitoring devices used with MRI scanners can be categorised as “MRI Compatible”. This usually means that the monitoring devices are compatible in terms of interference suppression. It does not always mean that they are compatible in terms of non-attraction to the Magnetic Field of the MRI Scanner. Staff should ensure that all monitoring devices are located in relation to the MRI scanner in accordance with the instructions provided by the device manufacturer.