

HN (NI) 2001/27

DATE: 26 November 2001

**For Attention and Action by:
Chief Executive of each HSS Trust
General Manager/Chief Executive of each HSS Board
Chief Executive of each Agency**



HEALTH ESTATES
ESTATE POLICY

**NORTHERN
IRELAND
ADVERSE
INCIDENT
CENTRE**

TITLE:

**Anaesthetic Breathing System Components: Risk of
Blockages from Intravenous Administration
(Giving) Set Caps**

MANUFACTURER/SUPPLIER

Various

PROBLEM

NIAIC has received reports from the Medical Devices Agency (MDA) of intravenous administration set caps becoming lodged in breathing system components. Blockage can lead to death or serious permanent injury.

Following further investigation this information reiterates and supplements the advice given in HN (NI)2001/12 published in August 2001 and HN (NI) 2001/15 published in September 2001.

DISTRIBUTION

This notice should be brought to the attention of all who need to know or be aware of it, including those listed below, in accordance with local procedures. This will include:

- Liaison Officers
- Risk Managers
- Health & Safety Officers/Advisers
- Device Managers
- Estates Managers
- Medical Directors
- Theatre Managers
- General Dental Practitioners
- Private Clinics
- Clinical Governance Departments
- Clinical Directors
- Nursing Directors
- Directors of Anaesthetics
- Adult & Paediatric Intensive Care Unit
- Maternity Department
- A&E Departments
- Special Care Baby Units
- Ambulance Services
- Operating Department Practitioners

Boards/Trusts should ensure that if appropriate, this information is passed to all persons having the responsibility for the premises registered under "THE REGISTERED HOMES (NI) ORDER 1992.

IMMEDIATE ACTION

- Every component of the breathing system **must** be visually inspected and functionally checked for adequate gas flow through them, immediately before **each** patient is anaesthetized.
- Breathing system components must be stored in such a way to minimize the possible entry of extraneous components and foreign bodies. Where possible single use devices should remain in their original packaging until use. Reusable devices must be carefully stored and individually wrapped between use where appropriate.
- Immediately after removal, the protective caps of intravenous administration sets and other items must be disposed of in an appropriate container if they are not going to be immediately replaced.

**HAZARD
NOTICE**



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BACKGROUND

NIAIC Hazard Notices HN (NI)2001/12 and HN (NI)2001/15: 'Anaesthetic Breathing System Components: Risk of Blockages' were published in August and September 2001. These notices recommended that all breathing system components **must** be visually inspected and functionally checked for patency immediately before **each** patient use. This reinforced the guidance given in the 'Checklist for Anaesthetic Apparatus' produced by the Association for Anaesthetists. These publications were in response to reports of occlusion in breathing systems due to the presence of foreign bodies, one resulting in the death of a patient.

The police have been collating and analyzing data provided by the health service and researched the possibility of foreign objects inadvertently blocking anaesthetic breathing system components, including angle pieces, adapters and catheter mounts. This work has established that the cap protecting the male conical fitting of an intravenous administration set can become accidentally lodged in breathing system components completely occluding them.

There has been no evidence of manufacturing failure at this time. Reusable breathing system components must be stored in a separate area to avoid the inadvertent blockage by administration set caps that have not been properly discarded after use. The police enquiry is ongoing. It is essential that all users continue to exercise vigilance.

Users and their managers should be aware that liability for any adverse incidents that may occur when devices are used outside the manufacturer's instructions would almost certainly lie with their organization.

The **IMMEDIATE ACTION** recommended above is fully endorsed by the Royal College of Anaesthetics and the Association of Anaesthetists of Great Britain and Ireland.

ENQUIRIES

Enquires to the NIAIC should quote the reference number HN (NI) 2001/27 and be addressed to:

Northern Ireland Adverse Incident Centre (NIAIC)
Health Estates
Estate Policy Directorate
Stoney Road
Dundonald
Belfast BT16 1US
Marked for the attention of Mr Brian Godfrey

Tel: 02890 523714
Fax: 02890 523900
Email: brian.godfrey@dhsspsni.gov.uk

Brian Godfrey
NIAIC 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 Safety Notice SN (NI) 2000/NIAIC. If you are in doubt about how to report incidents, please speak to your liaison officer or contact NIAIC using the telephone number provided.

*Heath Estates is an Executive Agency of the Department of Health, Social Services and Public Safety
Áisíneacht Feidhmeannach don Roinn Sláinte. Serbhísí Sóisialta agus Sábháilteacht Phoiblí*