

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



**NORTHERN
IRELAND
ADVERSE
INCIDENT
CENTRE**

TITLE:

**POSSIBILITY OF OVER INFUSIONS WITH
IVAC 591, 597, 598 AND 599 INFUSION PUMPS**

MANUFACTURER/SUPPLIER

ALARIS Medical Systems

PROBLEM

The Medical Devices Agency (MDA) and ALARIS have received an increase in the number of reports of over infusions with these pumps at the start of infusion.

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/Advisors
- Device Managers
- Medical Directors
- Nurse Directors
- Medical, Nursing and Care Staff
- Neonatal and Paediatric Units
- Intensive Care Units
- Delivery Units
- All ward areas
- Operating Theatre Staff
- Accident & Emergency Departments
- General Medical Practitioners
- Practice Nurses
- District Nursing Teams
- Community Care Staff
- Residential and Nursing Homes
- Hospices
- Private Clinics

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

To avoid undetected over infusions, the following actions must always be undertaken BEFORE starting an infusion.

Check that:

- No fluid is flowing in the drip chamber
- No drops are falling in the drip chamber

If fluid flow is observed before starting an infusion, close the roller clamp and ensure the set is correctly loaded. If the problem persists, withdraw the pump from use and contact your Electromedical Engineering Department/Estates Department or your ALARIS representative.

Users are reminded of the importance of following the set loading instructions and for ensuring that the pumps are maintained in accordance with the manufacturer's instructions.

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HEALTH ESTATES
ESTATE POLICY

**NORTHERN
IRELAND
ADVERSE
INCIDENT
CENTRE**

**HAZARD
NOTICE**

BACKGROUND

The MDA and ALARIS have received an increase in the number of reports of over infusions at the start of infusions with these pumps.

Investigations are being carried out by ALARIS to identify the cause of the over infusions.

ALARIS has issued the advice above in their Important Customer Information letter as an interim measure. Further copies may be obtained from ALARIS at the address below.

ENQUIRIES

Enquiries to the manufacturer should be addressed to:

Pierre Rebours
Director of Quality and Regulatory Affairs
ALARIS Medical Systems
The Crescent, Jays Close
Basingstoke. Hants.

Tel: 0800 917 8776

Fax: 01256 330 860

Enquires to the NIAIC should quote the reference number HN(NI) 2002/12 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) 2002/01. 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
Áisíneacht Feidhmeannach don Roinn Sláinte, Serbhísí Sóisialta agus Sábháilteacht Phoiblí*