

ONE LINERS

Vapour Trail

MHRA is aware of an incident where an overfilled anaesthetic vaporiser resulted in the administration of an overdose of the anaesthetic agent with resulting patient bradycardia and hypotension. Investigation revealed that the vaporiser was tilted whilst being filled, thus overcoming internal safety features, allowing it to be overfilled.

When filling all types of anaesthetic vaporisers, follow the manufacturer's instructions precisely. Never tilt the vaporiser to increase the flow of anaesthetic agent as this can flood the internal chambers. Always follow the Association of Anaesthetists of Great Britain and Ireland's pre-use checks and other actions outlined in the MHRA Medical Device Alert 2003/039.

Jaws!

MHRA is aware of incidents where there have been slippages of liga clips following abdominal surgery leading to serious outcomes. These were due to the fact that the jaws of the applicator had become overstressed resulting from the use of larger sized clips than intended.

Always ensure that the applicator is adequately maintained and only use clips specified in the instructions for use.

Rate Limiting?

MHRA continues to receive reports of pre-filled glass syringes that cannot be connected to some types of needle-free IV connectors. This has the potential for delay in administering treatment. Although adapters are available, MHRA has also received one report in which the adapter was left connected, resulting in an open-ended line posing a risk of infection.

Ensure that pre-filled syringes are compatible with the needle-free connector in question. Details of the size limits to ensure compatibility are provided in the instructions for use. If using an adapter to connect the syringe, ensure that this is removed from the connector after use.

Fracture Line

MHRA has received a report of damage to the tip of a multi-parameter neonatal sensor during removal, which may have been caused by cross-clamping the sensor on the removal from the umbilical artery catheter. This resulted in a fragment of the sensor remaining in situ.

During removal of the sensor, follow the manufacturer's instructions and ensure that the sensor has been fully retracted before crimping or clamping the artery catheter. Do not use forceps or surgical clamps. Wherever possible remove the catheter and sensor together.

Footsore?

The MHRA has been made aware that wheelchair users who have diabetes are vulnerable to injuries or pressure ulcers of the feet, in addition to the more obvious load bearing areas such as ischial tuberosities.

Risk to the feet should always be checked, especially if the patient cannot wear normal footwear. The NHS trust supplying the wheelchair should be contacted for appropriate foot support or padding.

Pole Dancing

MHRA has received reports of monitor pole stands being used when the pole had become loose on its base. The pole stands became live because the monitor's mains cable became trapped between the pole and the base of the stand.

Users should always check the security of the pole and base of monitor or drip set stands to ensure mains cables (from monitors or pumps) cannot be trapped.

Spark Gap

A defibrillator failed to charge in use because, although the paddle cable was connected, there had been failure to tighten the connector's locking ring.

Users of defibrillators should ensure the paddles are attached to the defibrillator in accordance with the instructions for use.