

# ONE LINERS



**ALL** medical devices can fail but an increasing number of incidents that 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...

## Colonic Drain

MHRA has received a report of an incident where a high vacuum wound drain was placed in direct contact with the bowel, following abdominal surgery. The patient developed peritonitis from perforated necrotic spots, almost certainly caused by the bowel being sucked into the drain holes.

Users are reminded that they must familiarise themselves with the safety information supplied by the manufacturer before using any device on a patient. In this case, the precautions listed in the information clearly indicated direct contact between the drain and bowel should be avoided.

## Gloves Off

A report has been received of breathing system tubing becoming blocked by a piece of disposable glove in a hospital where the practice was to cover the open end of breathing systems with part of a glove to ensure that the circuit remained clean and dust free between assembly and use.

Breathing systems should remain in their packaging until use or, if this is not possible, then only covers or caps provided by the manufacturer should be used. Breathing systems must always be visually inspected for blockages and checked for adequate gas flow before use.

## LaMentAble

Foreign objects have been discovered in laryngeal mask airways. This is thought to happen whilst they are on their way to the central sterilising department or during processing.

Ensure that such airways are visually inspected for patency and functionality before use, following the manufacturer's recommendations.

## The Hole Truth

MHRA is aware of patient injury after a fenestration was inappropriately cut into a paediatric tracheostomy tube.



Tracheostomy tubes should not be cut or modified unless stated in the manufacturer's instructions. Paediatric fenestrated tubes are available from a number of suppliers, as are custom-made tubes on request.

## No Charge

We are aware of an intra-aortic balloon pump failure during transportation of a patient in an ambulance. The device battery had not been maintained according to the manufacturer's instructions and a spare battery was not available.

Ensure that all devices with rechargeable batteries are maintained and serviced to manufacturer's instructions. This may require regular charging and discharging of the battery. When transporting critically ill patients, ensure that a spare, fully charged battery pack is available during long journeys.

## Stark Contrast

Several incidents have occurred where multi-lumen central venous catheters have ruptured during injection of contrast medium for CT scanning. This has resulted in a number of complications, including blood loss and the interruption of inotropic support.

Wherever possible, peripheral IV access should be used. If no alternative IV access is available then the use of a central line can be considered but maximum pressures that the catheter can withstand should be clarified by contacting the manufacturer (see MDA/2004/010).