


# 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...

## Eau Dear!


A recent case of Legionnaire's Disease has been associated with the use of nebulisers containing residual moisture after being cleaned in water contaminated with legionella bacteria.



Users of reusable nebulisers are reminded of the importance of thorough drying after cleaning, in line with the manufacturers' instructions for use.

## Thin Air?


We have become aware that users frequently overestimate the time that oxygen can be supplied from commonly used portable oxygen cylinders. On high flows, a cylinder will only last 20-30 minutes.



Healthcare professionals involved in transport of patients using oxygen should be aware of these time limits and ensure that a back-up supply is available, particularly when transferring from one hospital to another.

## Burn Out!

Electrocautery devices are incorrectly considered to be self-sterilizing by some practitioners. The heating effect of the electrocautery will, however, leave charred residues, which could be antigenic or may still contain viable infective agents.




Electrocautery devices should be used either with disposable tips or tips that the manufacturer states can be reprocessed using a validated decontamination process, which includes cleaning prior to sterilization by autoclaving.

## Acid Test!


The MHRA is aware of cases of positioning of naso-gastric tubes in the lungs, the position having been checked by testing aspirate with litmus paper.

Litmus paper is not sufficiently sensitive to distinguish between gastric and bronchial secretions for confirming naso-gastric (feeding) tube placement. pH paper should be used.



## End-O-Leak?

The MHRA has received reports of deaths associated with the use of long dilators during percutaneous central venous insertions. These fatalities occurred as a result of cardiac tamponade or haemothorax following puncturing of the atrial vessel walls by the dilator tip.



Users should ensure that the dilator is inserted only far enough to create a pathway through the subcutaneous tissues to facilitate entry into the vein. The vein lumen does not require dilatation and the dilator should NOT be fully inserted into the subclavian or jugular veins.

## On the Pull?

We are aware of a number of incidents where external defibrillators have malfunctioned because of physical damage to the cable, often caused by excessive pulling on the plug's stress boot.

Regular checks should be carried out on defibrillator patient cables to ensure no damage or signs of stress or deformity are apparent to the cables, connectors and strain relief boots. These cables should be stored carefully so as not to cause unnecessary stress and damage. Always follow the manufacturers' instructions for care, storage and replacement criteria of these accessories.