

ONE LINERS

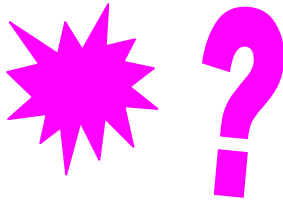


ALL medical devices can fail but an increasing number of incidents that result in significant morbidity or mortality arise out of user/device interface problems or because of poor practices. The aim of this news sheet is to detail briefly some of the problems in an attempt to make users more aware of what can go wrong – it is all too easy to take equipment for granted...

Caput!

The MHRA is aware that some IV devices such as stopcocks are provided with vented caps to allow for the entry and exit of ethylene oxide gas during sterilization. There is a potential for leakage and loss of sterility if these are left secured to IV devices whilst in use.

Ensure that IV devices with vented caps are replaced with non-vented caps when in use.



Wind of change

Peak expiratory flow meters manufactured to the new European standard EN13826 are being introduced and may read differently from the traditional Wright scale models that are being phased out, with potential to cause confusion.

Peak flow meters manufactured to the new standard have been available since 1 September 2004. Be aware of the differences in readings between the old and the new meters. Before prescribing or issuing a new peak flow meter, check that a patient's personal best and treatment levels have been reassessed on the new scale (see MDA/2004/025)

Playing with fire?

We have received a report of a fire involving the oxygen supply hose attached to a transport ventilator. The rupture and subsequent ignition was due to the hose being used beyond its recommended lifetime.

Always ensure a system is in place for the regular inspection and replacement of hoses in line with manufacturer's instructions (see MDA/2003/007 'Medical gas hoses for oxygen')

End of the line

We are aware that some needle-free IV access connectors are being used beyond the maximum period recommended with the potential for an increased risk of infection.

Always read the instructions for use to obtain information on the maximum period of use or maximum number of accesses for such a device. If no information is given in the instructions, contact the manufacturer.

Eye of the needle holder?

The MHRA has received reports of the tip of fine surgical instruments used in ophthalmic and phaco-emulsification procedures breaking off into the eye during use. Investigation has concluded this to be the result of damage sustained through mishandling during reprocessing.

Fine ophthalmic surgical instruments are delicate and must be handled with care at all times. Tips should be inspected carefully after reprocessing before further use.



Don't DIY

Misuse/off-label use of medical devices, user modifications of devices other than directed by the manufacturer or use of non-medical products for medical purposes (e.g. paperclips in wound closure) carry many potential dangers.

Be aware that consequences of such misuse exposes users and patients to unknown and unacceptable risks. There may also be legal and ethical implications (see MDA/2004/006)