

# 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 these problems in an attempt to make users more aware of what can go wrong – it is all too easy to take equipment for granted...

## Soft Metal Jacket

MHRA has received reports of damage to the new style oxygen cylinders from screw fitting on the cylinder cradles.

Be aware that the new high pressure cylinders are made of aluminium with kevlar wrapping rather than steel and are more easily damaged by sharp objects.

## Date-Line?

MHRA is aware that some needle-free connectors are being used beyond the maximum period recommended by the manufacturer, with the potential for an increased risk of infection or failure of the device.

Always read the instructions for use to obtain information on the maximum period of use or maximum recommended number of accesses. If the manufacturer provides a recommendation for both of these, the device should be replaced whenever the first is reached. If this information is not given in the instructions, contact the manufacturer.

## Torquing Heads

MHRA has received a report of an adjustable torque screwdriver being incorrectly set during the insertion of skull screws for a Halo Jacket. This led to inadvertent perforation of the skull.

Check that the torque settings are appropriate for the clinical procedure being undertaken.

## Oh Yes They Do!

The urban myth, promulgated by recent articles in the literature and general press, is that modern mobile phones do not interfere with medical devices. MHRA has demonstrated that, under certain circumstances, this is not the case and is now receiving adverse events where devices, e.g. infusion pumps, have malfunctioned or performed unexpectedly, due to the proximity of a mobile phone.

Read MHRA advice (DB 1999(02)) and, based on the risk approach suggested, limit the use of mobile phones in critical care areas.

## Sound Advice

MHRA has received a report of a patient going into ventricular fibrillation, where the central station alarm volume was set to the minimum level and was therefore inaudible to the user. Additionally, because of the low setting, the user did not recognise the 'weak battery' and 'replace battery' signals.

Ensure that all alarms are set appropriately for the clinical environment and regularly check the upper and lower limits of the alarm settings.

## Trap-Water

A report has been received from a neonatal intensive care unit of an infant CPAP flow driver accumulating excessive water in the patient's circuits. This could backtrack to the infant, resulting in a potential drowning.

Be aware that self-sealing water traps should be used to avoid this problem.