

# 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...

## Concentration Conflagration

MHRA has received several reports where patients have caused serious fires because they have been smoking cigarettes whilst using an oxygen concentrator in their homes.

Those issuing oxygen concentrators to domiciliary patients should ensure that patients are fully aware about the dangers of smoking whilst on oxygen therapy.

## Boxing Clever

MHRA has received reports from two centres of incorrect components of a joint replacement having been implanted because the size labels were misread, resulting in size 26 components being mistaken for size 28. An investigation has revealed that some implant boxes have two labels (one at each end), only one of which has a font size sufficient for size identification under theatre conditions.

Be aware that there may be two labels and present the label with the larger font to the surgical team.

## Clamp Down

MHRA has received reports of the incorrect application of umbilical cord clamps resulting in blood loss from newborn babies.

Users should ensure that they are familiar with the operation of cord clamps and that the clamps are fitted correctly before use to avoid this potential complication.

## Myo-Sin

MHRA has received a report concerning an ambulatory blood pressure monitor which failed to obtain a reading as a patient moved their arms during driving. The monitor increased the cuff pressure by 50 mm of Hg and repeated. This continued until 300 mm Hg was reached. The patient suffered ischemic damage to the forearm muscles.

Patients should be informed to keep their arms still throughout the measurement phase and how to stop inflation when this occurs at an inconvenient time or when the cuff pressure is too high and causes distress.

## Drinks-Break

We are aware of a failure of an anaesthetic machine during a surgical procedure after a cup of coffee was spilled over the work surface. This tracked down into the electronics of the machine, causing a short circuit electrical burn and eventual failure of the machine.

Although anaesthetic machines are designed to withstand accidental spillages, they will not tolerate larger volumes of liquid.

## Dys-Solution?

Implantable infusion pumps are susceptible to damage from the use of inappropriate medicines or formulations. MHRA has had a report of a pump failure caused by using medicine that was not approved for the pump in question.

Only use medicines, and in the correct concentration, that are approved by the implantable pump manufacturer.