ONE LINERS

ON THE RIGHT TRACH 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 newssheet 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. This edition focuses on a number of user issues that have been reported to MHRA, which involve tracheostomy tubes.

Be Narrow-Minded!

MHRA has received reports of blockages and difficulties in suction when small bore (paediatric/neonatal) tracheostomy tubes are cut to length.

In these circumstances, ensure that the connector is not crushed on insertion.

The Hole Truth!

Problems have been reported with percutaneous tracheostomy tube insertion if fenestrated tubes are being used as the first tube. Displacement of the fenestration into the tissues of the neck can lead to life-threatening surgical emphysema.

Under these circumstances, always follow the manufacturers' instructions for use and follow the procedures set out.

Window Pain!

MHRA is aware of a number of circumstances where it is not known whether the patient has a fenestrated or non-fenestrated outer tube fitted, leading to the incorrect inner tube being used. This may make it impossible to ventilate the patient in an emergency

Always keep adequate records including date and time of insertion/change and ensure that your staff can recognise the type of tracheostomy tube that has been inserted.

Slide Rule!

MHRA is aware of incidents when there has been slippage of tubes which rely on friction fixation, into the trachea due to lubricant having been left in situ after suctioning.

Always check that tubes have been cleaned in accordance with the manufacturers' instructions for use. Note that correct cleaning also includes proper drying.

When the Balloon Goes Up?!

We have received a number of reports of failure of the cuff to inflate after insertion, leading to the need for a repeat procedure.

Always check that the cuff inflates properly before inserting the tracheostomy tube into a patient.

Time Out?

MHRA has received several reports of tracheostomy tubes becoming degraded with time, leading to blockage and respiratory difficulty.

A tracheostomy tube should never be left in situ longer than the time recommended by the manufacturers in their instructions for use.

Size Matters?

MHRA has received reports of inappropriate sized tracheostomy tubes being used, e.g. a size 6 is inadequate for the average male.

Always use a tracheostomy size appropriate for the patient.

MHRA
Medicines and Healthcare products Regulatory Agency

If you would like to discuss or report an adverse incident, including 'near misses' involving a device, either contact your Trust Medical Devices Liaison Officer, or contact us directly on: 020 7084 3123 (medical), 3128 (nursing) or e-mail: devices@mhra.gsi.gov.uk

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