

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.

Contra Indicator?

MHRA has received reports from Trusts describing incorrect results with blood glucose meters. In some cases, investigation has revealed that the patients were suffering from shock, dehydration or DKA. These conditions are contra-indicated in the instructions for use.

Ensure you are familiar with the instructions for use and limitations of the device.

Length-wise?

MHRA received a report of an incident where a gravely ill male patient had a female urinary catheter inserted. Inflating the balloon resulted in severe urethral/bladder trauma and haemorrhage, leading to serious consequences.

Always ensure that the urinary catheter is appropriate for the patient by checking the labelling.

Aqueous Humour?

MHRA has received reports of over-infusion by small ambulatory pumps typically used to administer opiates, due to fluid ingress into the pump.

Ensure that infusion pumps do not become wet. If there is any question that fluid may have entered the case of the pump, stop its use and return to your maintenance department immediately.

Wall-op?

MHRA has received reports of monitors and pump docking stations falling from walls or stands because their mounting brackets have been incorrectly installed initially, or reinstalled incorrectly following maintenance or redecoration.

Installers should ensure that all the components of bracket mounting kits are used and assembled in line with the manufacturers' recommendations during the initial and any subsequent installation.

Double Negative!

MHRA has received a report of the use of a dual channel pump being used to deliver infusions to two patients simultaneously. This may result in confusion relating to both the drug administered and dosage given.

Users should only use multi-channelled pumps to deliver infusions to a single patient at any one time.

P-waves?!

Incidents have been reported to the MHRA of interference from dialysis machines when used in conjunction with ECG systems. In some instances, the misunderstanding of the resulting ECG wave forms has led to near medical intervention.

Users should be aware that a superimposed pattern on the ECG, that correlates to the rotation of the dialysis blood pump, is likely to be due to interference.