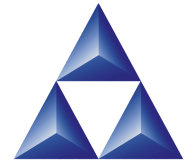


SN (NI) 2001/18

DATE: 3 May 2001

For Attention and Action by:
Chief Executive of each HSS Trust
General Manager/Chief Executive of each HSS Board
Chief Executive of each Agency



HEALTH ESTATES
ESTATE POLICY

**NORTHERN
IRELAND
ADVERSE
INCIDENT
CENTRE**

TITLE:

**Cavendish Anaesthetic Machines:
Oxygen Leakage from Flush Valve**

MANUFACTURER/SUPPLIER

MIE

PROBLEM

Incorrect oxygen flush valves have been supplied by MIE and may have been inadvertently fitted to the Cavendish Anaesthetic machine allowing the leakage of oxygen. This problem potentially affects all Cavendish 250, 500, 750, 460, 680, 460M and 680M machines in service.

DISTRIBUTION

This notice should be brought to the attention of all who need to know or be aware of it, including those listed below, in accordance with local procedures. This will include:

- Liaison Officers
- Risk Managers
- Health & Safety Officers/Advisors
- Device Managers
- Medical Directors
- Nursing Directors
- Anaesthetic Directors
- Medical, Nursing and Technical Staff
- EME/EBME & Medical Physics
- Operating Theatre Managers
- Accident & Emergency Departments
- General Dental Practitioners
- Maternity Wards

Boards/Trusts should ensure that if appropriate, this information is passed to all persons having the responsibility for the premises registered under "THE REGISTERED HOMES (NI) ORDER 1992.

ACTION

Trusts must be aware of the attached technical note issued by Anmedic (See Appendix 1). This will enable Trusts to verify whether the correct valve has been fitted to their machines.

BACKGROUND

The Department received a report that oxygen was leaking into the common gas outlet from the oxygen flush valve. It was found that the leakage contributed an extra 5 litres per minute of oxygen to the total gas output of the machine with a consequent reduction in the concentration of the volatile anaesthetic agent delivered to the patient.

Investigation found the oxygen flush valve (part no. 8698-016) did not fit the housing in the correct manner. Repair of this failure revealed that two different lengths of valve had

SAFETY

NOTICE

been supplied by MIE. The longer (20mm) valve could be inadvertently loosened causing the leak. The shorter (16mm) valve when correctly fitted cannot be loosened.

Anmedic do not have complete records of MIE or the present location of all affected machines, therefore we are alerting all users to this problem. As MIE are no longer trading the responsibility for this corrective action has fallen to Trusts and their servicing agents.

ENQUIRIES

Enquiries to the manufacturer should be addressed to:

Mr Bill Quick
Engineering Manager
Anmedic
Unit 2, The Business Centre
Molly Millars Lane
Workingham
Berkshire RG41 2RZ
Tel: 0118 9786929
Fax: 0118 9789934

Enquires to NIAIC should quote the reference number SN(NI) 2001/18 and be addressed to:

Northern Ireland Adverse Incident Centre (NIAIC)
Health Estates
Estate Policy
Stoney Road
Dundonald
Belfast BT16 1US

Marked for the attention of Mr Brian Godfrey

Tel: 02890 523714
Fax: 02890 523900
Email: brian.godfrey@dhsspsni.gov.uk

Brian Godfrey
NIAIC Manager



HEALTH ESTATES
ESTATE POLICY

**NORTHERN
IRELAND
ADVERSE
INCIDENT
CENTRE**

SAFETY

NOTICE

HOW TO REPORT ADVERSE INCIDENTS

Adverse Incidents relating to medical devices, non-medical equipment, plant and buildings should be reported to NIAIC as soon as possible. Advice on how to report is given in Safety Notice SN (NI) 2001/01. If you are in doubt about how to report incidents, please speak to your liaison officer or contact NIAIC using the telephone number provided.

*Heath Estates is an Executive Agency of the Department of Health, Social Services and Public Safety
Áisíneacht Feidhmeannach don Roinn Sláinte. Serbhíst Sóisialta agus Sábháilteacht Phoiblí*