

# **Medical Device Alert**

Ref: MDA/2012/049 Issued: 23 July 2012 at 15:00

# Device

Neonatal and paediatric endotracheal tube clamp/holder.

All product codes.

All lot numbers.

Manufactured by EMS Medical.



Examples of packaging

| Problem   | Action  |
|---|---|
| Risk of airway loss due to slippage of the clamp/holder   | Identify, do not use and dispose of affected devices. |
| or  |   |
| airway obstruction as a result of over-tightening of the clamp/holder.                          |   |
| EMS Medical has gone into administration and therefore cannot be contacted.                     |   |
| The MHRA has issued this Medical Device Alert to ensure that all users are aware of this issue. |   |
| Action by   |   |
| All staff who may use or handle this device, particularly supplies and paediatric departments.  |   |
| CAS deadlines   | Contact   |
| Action underway: 30 July 2012   | No contact available                                  |
| Action complete: 13 August 2012   |   |
| Note: These deadlines are for devices to be identified and disposed of.                         |   |

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# Device

This device assists in securing an endotracheal tube (ETT) in position for neonatal and paediatric patients.

#### **Problem**

The composition of the plastic used to make the clamp/holder was changed to a DEHP-free material. This affected the physical properties of these components, resulting in an increased risk of slippage or tube obstruction.

EMS Medical went into administration before this issue was identified and it is not known how many affected devices have been supplied.

#### Distribution

This MDA has been sent to:

- NHS trusts in England (Chief Executives)
- HSC trusts in Northern Ireland (Chief Executives)
- NHS boards in Scotland (Equipment Co-ordinators)
- Local authorities in Scotland (Equipment Co-ordinators)
- NHS boards and trusts in Wales (Chief Executives)
- Primary care trusts in England (Chief Executives)

#### **Onward distribution**

Please bring this notice to the attention of relevant employees in your establishment. Below is a suggested list of recipients.

#### **Trusts**

CAS and SABS (NI) liaison officers for onward distribution to all relevant staff including:

- A&E departments
- Ambulance staff
- Anaesthetists
- Clinical governance leads
- Day surgery units
- Health and safety managers
- Intensive care medical staff (paediatric)
- Intensive care nursing staff (paediatric)
- Maternity units
- Medical directors
- Midwives
- Neonatal nurse specialists
- Neonatology departments
- Neonatology directors
- Nursing executive directors
- · Paediatric surgery, directors of
- Paediatric intensive care units
- Paediatric wards
- Resuscitation officers and trainers
- Risk managers
- Special care baby units
- Supplies managers
- Theatres

#### **Primary care trusts**

CAS liaison officers for onward distribution to all relevant staff including:

· Resuscitation officers

# Independent distribution Establishments registered with the Care Quality Commission (CQC) (England only)

This alert should be read by:

- · Hospitals in the independent sector
- Independent treatment centres

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Please note: CQC and OFSTED do not distribute these alerts. Independent healthcare providers and social care providers can sign up to receive MDAs directly from the Department of Health's Central Alerting System (CAS) by sending an email to: safetyalerts@dh.gsi.gov.uk and requesting this facility.

### **England**

If you are in England, please send enquiries about this notice to the MHRA, quoting reference number MDA/2012/049 or 2012/007/005/081/015.

#### **Technical aspects**

Louise Mulroy and Emma Rooke
Medicines & Healthcare products Regulatory Agency
Floor 4
151 Buckingham Palace Road
London SW1W 9SZ

Tel: 020 3080 7344 or 6609

Fax: 020 8754 3965

Email: louise.mulroy@mhra.gsi.gov.uk

emma.rooke@mhra.gsi.gov.uk

#### Clinical aspects

Jonathan Plumb
Medicines & Healthcare products Regulatory Agency
Floor 4
151 Buckingham Palace Road
London SW1W 9SZ

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Email: jonathan.plumb@mhra.gsi.gov.uk

#### How to report adverse incidents

Please report via our website http://www.mhra.gov.uk

Further information about CAS can be found at https://www.cas.dh.gov.uk/Home.aspx

### Northern Ireland

Alerts in Northern Ireland will continue to be distributed via the NI SABS system.

Enquiries and adverse incident reports in Northern Ireland should be addressed to:

Northern Ireland Adverse Incident Centre

Health Estates Investment Group

Room 17 Annex 6

Castle Buildings Stormont Estate

Dundonald BT4 3SQ

Tel: 02890 523 704 Fax: 02890 523 900

Email: NIAIC@dhsspsni.gov.uk http://www.dhsspsni.gov.uk/index/hea/niaic.htm

#### How to report adverse incidents in Northern Ireland

Please report directly to NIAIC, further information can be found on our website http://www.dhsspsni.gov.uk/niaic

Further information about SABS can be found at http://sabs.dhsspsni.gov.uk/

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# Scotland

Enquiries and adverse incident reports in Scotland should be addressed to:

Incident Reporting and Investigation Centre Health Facilities Scotland NHS National Services Scotland Gyle Square 1 South Gyle Crescent Edinburgh EH12 9EB

Tel: 0131 275 7575 Fax: 0131 314 0722

Email: nss.iric@nhs.net

http://www.hfs.scot.nhs.uk/online-services/incident-reporting-and-investigation-centre-iric/

## Wales

Enquiries in Wales should be addressed to: Improving Patient Safety Team Medical Directorate Welsh Government Cathays Park Cardiff CF10 3NQ

Tel: 029 2082 3922 Email: Haz-Aic@wales.gsi.gov.uk

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