

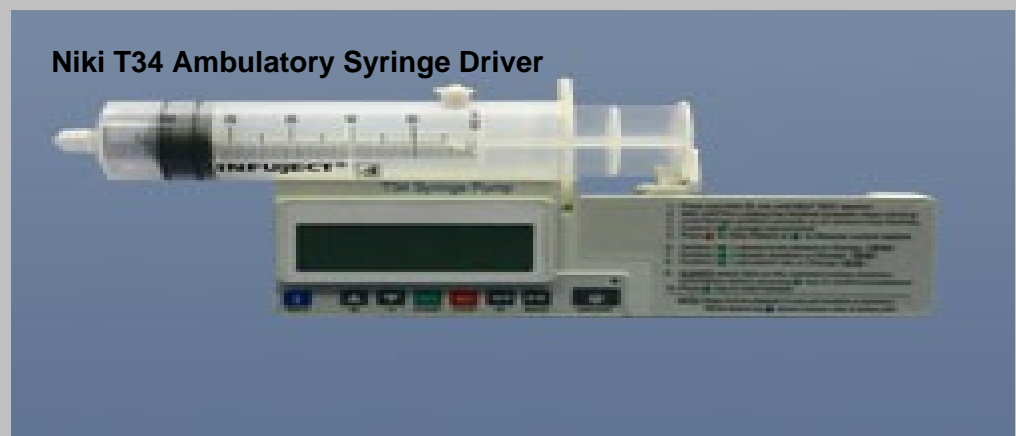


patient safety

ALERT

Alert 3, March 20 2009

Subject



Issued by

Queensland Health Patient Safety Centre

Issue date

20th March, 2009

Authority

Queensland Health Patient Safety Executive Committee

Issue

1. *Potential syringe incompatibility - when 10ml BD-Plastipak syringes are used with this device there has been a demonstrated possibility of incorrect infusion rate.*
2. *Syringe alignment - If the syringe is dislodged or not loaded precisely into this device, unexpected changes in the delivery period may occur.*

Specific incidents

When using a 10ml BD-Plastipak syringe, the displayed volume infused by the Niki T34 syringe driver did not correlate with amount delivered. In this case, there was a difference of greater than 1 ml.

Action

The District CEO must ensure that:

1. *the Niki T34 ambulatory syringe driver is to be immediately removed from clinical use until further notice*
2. *alternative devices are available*
3. *adverse events associated with this device are logged in PRIME Clinical Incidents*

	<p>4. the Patient Safety Centre is notified of:</p> <ul style="list-style-type: none"> • The number of devices currently in-service in your District • The number of devices removed from clinical care. <p>If unable to source alternative devices please contact the Patient Safety Centre on 36369714.</p> <p>Queensland Health will ensure that:</p> <ol style="list-style-type: none"> 1. extensive tests on the Niki T34 syringe driver and the use of various syringes including the BD-Plastipak are conducted by Biomedical Technology Services 2. Biomedical Technology Service liaise with the manufacturer and TGA with regards to possible software and calibration problems 3. Patient Safety Centre will notify District CEO's of outcomes of above actions.
Distribution List	<p>Director General, Chief Health Officer, CEO Centre for Healthcare Improvement, District Chief Executive Officers, District Directors of Nursing, District Executive Directors of Medical Services, Material Supply Managers, Patient Safety Officers, Director of Clinical and Statewide Services, Senior Director Biomedical Technology Services</p>
Contact	<p>Rowena Richardson, Patient Safety Centre 36369717 or rowena_richardson@health.qld.gov.au</p>
Alert	<p>“An Alert communicates a serious patient safety risk that requires specific action by an identified person, with feedback process to confirm that the action has been taken.”</p>