Medical Device Alert

Ref: MDA/2013/077 Issued: 31 October 2013 at 11:30

Device

Receptal suction canisters and liners.
Manufactured by Hospira (formerly manufactured by Abbott).
All Abbott and Hospira list numbers are affected.
All lot numbers and sizes are affected.

Problem

Potential for failure or loss of suction if a canister and liner of different sizes are used in combination.

Due to a number of customer complaints, Hospira has issued a Field Safety Notice (dated 06 September 2013) to advise customers of appropriate use and combination of liners and canisters.

The MHRA is not confident that Hospira has been able to reach all affected customers.

Action by

All staff who use these devices.

Action

- Identify affected devices.
- Ensure that the correctly sized liner is used with the canister.
- Obtain a copy of the revised instructions for use from Hospira when this is made available.

Use only Receptal liners with Receptal canisters in the following combinations:

- 1.5 litre liner with a 1.5 litre canister
- 2 litre liner with a 2 litre canister
- 3 litre liner with a 3 litre canister

Please note that all 1 litre liners and canisters have been recalled. See MDA/2013/048 for further information.

CAS deadlines

Action underway: 21 November 2013

Action complete: 12 December 2013

Note: These deadlines are for systems to be in place to ensure staff are aware of the revised instruction.

Contact

Manufacturer
Wilson Kennedy
Hospira UK Limited
Tel: 0192 682 0820
Email: devicesfieldactions@hospira.com

Device

This is a closed, disposable system that is used to isolate suction waste. It is used with adult, paediatric and neonatal patients.

Hospira has only been able to provide the Abbott list numbers for the 1 litre liners and canisters.

Distribution

This MDA has been sent to:

- HSC trusts in Northern Ireland (chief executives)
- NHS boards and trusts in Wales (chief executives)
- NHS boards in Scotland (equipment co-ordinators)
- NHS England area teams
- NHS 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:

• All clinical departments
• All staff
• All wards
• Ambulance staff
• Clinical governance leads
• Community hospitals
• Directors of nursing
• Medical directors
• NHS walk-in centres
• Outpatient clinics
• Resuscitation officers and trainers
• Risk managers
• Theatres
• Walk-in centres

NHS England area teams

CAS liaison officers for onward distribution to all relevant staff including:
• General dental practitioners
• General practitioners
• Palliative care teams

Independent distribution

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

This alert should be read by:
• Care homes providing nursing care (adults)
• Care homes providing personal care (adults)
• Clinics
• Hospices
• Hospitals in the independent sector
• Independent treatment centres

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.

Contacts

Manufacturer
Hospira UK Limited, Queensway, Royal Leamington Spa, Warwickshire, CV31 3RW
Tel: 0192 682 0820 Fax: 0192 683 5250
Email: devicesfieldactions@hospira.com

England

If you are in England, please send enquiries about this notice to the MHRA, quoting reference number **MDA/2013/077** or **2013/009/009/081/009**

Technical aspects
Emma Rooke or Louise Mulroy
Medicines & Healthcare Products Regulatory Agency
Floor 4, 151 Buckingham Palace Road, London SW1W 9SZ
Tel: 020 3080 6609 / 7344
Fax: 020 8754 3965
Email: emma.rooke@mhra.gsi.gov.uk or louise.mulroy@mhra.gsi.gov.uk

Clinical aspects
Mark Grumbridge
Medicines & Healthcare Products Regulatory Agency
Floor 4, 151 Buckingham Palace Road, London SW1W 9SZ
Tel: 020 3080 7128
Fax: 020 8754 3965
Email: mark.grumbridge@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/

Scotland

All requests regarding return, replacement or modification of the devices mentioned in this alert should be directed to the relevant supplier or manufacturer.

Other enquiries and adverse incident reports in Scotland should be addressed to:

Incident Reporting and Investigation Centre
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