Medical Device Alert

Ref: MDA/2013/073 Issued: 10 October 2013 at 11:30

Device

Pressure relieving air mattresses and overlays.

All models and manufacturers.

Problem

Risk of fatality from house fire.

The MHRA is aware of fatal domestic house fires starting from lit cigarettes being dropped onto non-fire-retardant bedding covering air mattresses and air overlays.

This resulted in a breach of the mattress or overlay material, and leakage of the pumped air aided combustion and the spreading of the fire.

Note
The MHRA does not possess a list of manufacturers or suppliers of these devices.

CAS deadlines

Action underway: 24 October 2013

Action complete: 10 December 2013

Note: These deadlines are for systems to be in place to review and update risk assessments and local policies.

Action

- Identify affected devices used in a home environment.
- Review and if necessary update the risk assessments and local procedures to ensure that the possibility of fire due to patients smoking in bed is included.
- For patients at risk, consider using alternative pressure area care equipment and fire retardant bedding.
- Ensure patients are aware of the dangers of smoking in bed.

Action by
All those responsible for the provision of pressure relieving air mattresses and overlays used in a home environment.

Distribution

This MDA has been sent to:

- Care Quality Commission (CQC) (headquarters) for information
- Clinical commissioning groups (CCGs)
- HSC trusts in Northern Ireland (chief executives)
- Local authorities in Scotland (equipment co-ordinators)
- NHS boards and trusts in Wales (chief executives)
- NHS boards in Scotland (equipment co-ordinators)
- NHS England area teams for information
- NHS trusts in England (chief executives)
- Social services in England (directors)

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:

- Community nurses
- District nurses
- Health visitors
- Hospital at home units
- Occupational health departments
- Occupational therapists
- Risk managers
- Safety officers
- Tissue viability nurses

Social services

Liaison officers for onward distribution to all relevant staff including:

- Care at home staff
- Care management team managers
- Community care staff
- Equipment supplies managers
- In-house domiciliary care providers (personal care services in the home)
- In-house residential care homes
- Occupational therapists

Independent distribution

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

This alert should be read by:

- Adult placement
- Care homes providing nursing care (adults)
- Care homes providing personal care (adults)
- Domiciliary care providers
- Hospices

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/2013/073** or **2013/001/030/401/005**

Technical aspects

Andy Marsden or Ian Sealey
Medicines & Healthcare Products Regulatory Agency
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Clinical aspects
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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