

# Safety Notice 019/21



# Flow Sensors used in selected GE Healthcare / Datex-Ohmeda Anaesthesia Machines

# 30 August 2021

#### Distributed to:

- Chief Executives
- Directors of Clinical Governance
- Director, Regulation and Compliance Unit

## Action required by:

- Chief Executives
- Directors of Clinical Governance

# We recommend you also inform:

- Directors of Medical Services
- Directors of Nursing and Midwifery
- Directors of Surgery
- Managers of Operating Suites
- Anaesthetists
- Anaesthetic Nurses
- Biomedical Engineers

## **Expert Reference Group**

Content reviewed by:

- Agency of Clinical Innovation
- HealthShare NSW
- Anaesthetic Staff
- Biomedical Staff

## Clinical Excellence Commission

Tel: 02 9269 5500

Email:

CEC-

Recalls@health.nsw.gov.au

Internet Website:

http://health.nsw.gov.au/sab

S

Intranet Website:

http://internal.health.nsw.gov .au/quality/sabs

> Review date August 2022

# **Situation**

The Therapeutic Goods Administration (TGA) has issued a Product Defect Correction for Flow Sensors used in selected GE Healthcare's (GE) / Datex-Ohmeda anaesthesia machines, which are widely used across NSW. The manufacturer has identified the potential for a small number of flow sensors, manufactured before June 2021, to have damaged tubes with small punctures or cuts. These punctures or cuts may not always be evident to the naked eye.

The anaesthetic machine continuing to function in all modes (manual/bag, volume, pressure, and support modes), but the tidal volumes may be inaccurate, resulting in:

- under-delivery of tidal volume leading consulicient ventilation
- over and excessive delivered tidal v lume may lead to hyperventilation or barotrauma.

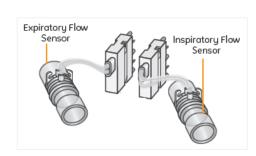
To date, no injuries have been sorted as a result of this defect.

# **Background**

The affected GE Flow pensor is a replaceable part which can be reprocessed and re-used. They cannot be inter-changed with another manufacturer's transfer with two flow sensors are used in each of the following GEHC and establishments:

- 1 Aisys S2
- 2. Avance C.S
- 3. Aisys
- 4. ance
- 5. Amingo
- 6. Aespire View
- 7. Aespire 7900
- 8. Aespire 7100/100
- 9. Protiva 7100
- 10. Aestiva MRI
- 11. Aestiva 7900
- 12. Aestiva 7100, 9100C NXT
- 13. Aelite NXT.





Ref: GE Healthcare Aespire View 6.X Participant Guide, Version A.

Other GE anaesthetic machines and flow sensors are not affected by this issue.



# Safety Notice 019/21



# Flow Sensors used in selected GE Healthcare / Datex-Ohmeda Anaesthesia Machines

### **Assessment**

- The risk to patient safety is LOW if the ANZCA PS31 Guideline on checking anaesthesia delivery systems on checking anaesthesia delivery systems is followed
- These checks should detect issues with the integrity of flow sensors prior to patient use
- Any significant leak during use will cause the machine to alarm
- In paediatric use a small circuit leak may have the potential to have a clinical effect. Anaesthetists should consider the mode of ventilation to minimise any risk where an affected flow sensor is in use
- HealthShare NSW is working with GE to obtain replacement of existing affected stock. However, GE has stated that they may not be able to replace all flow sensors in the market until May 2022.

## **Clinical Recommendations**

- Inspect all inventory of flow sensors, including those installed in anesthesia machines, in spare inventory, in reprocessing locations and other locations not in use
  - Look for the date of manufacture on the flow sensor bed
  - o If the date of manufacture is "2021-06" or later, your use your flow sensor; it is not affected
  - o If the date of manufacture is prior to "2021-06" this "our sensor is affected



Date of Manufacture

- Ideally, the affected product should not be used Howeler, if no unaffected sensors are available, affected sensors manuely be the flow sensor has passed the preoperative checks
- Do not use any flow sensor that has an d the required pre-operative checks
- Where possible, Biomedical Engineers should be consulted in reference to performance of Level 1 checks of all affected GF anaes ether a nines
- Anaesthetic staff to con nue to perform checks as per the ANZCA PS31 Guideline
- For paediatric patients: Agesthete staff consider the use of pressure limit ventilation instead of volume target ventilation
- During use, noting that affected flow sensors may pass the pre-use checkout yet still have issues during use, Anaesthetic staff should have a heightened awareness of the potential for flow sensor defect if a circuit leak is detected (refer to the Customer Letter for specific alarm instructions).
- Ensure spare flow sensors available in relevant clinical areas
- Affected flow sensors that fail checks should be returned to Biomedical Engineering for evaluation.

## Required actions for the Local Health Districts/Networks

- 1. Distribute this Safety Notice to all relevant NSW Health stakeholders
- 2. Ensure all affected GE anaesthetic machines and flow sensors are inspected
- 3. Conduct a risk assessment of existing stock to determine if continued use of the affected flow sensors is required
- 4. Escalate any concerns to CEC-Recalls@health.nsw.gov.au
- 5. Report any incidents associated with the affected devices into ims+ and TGA For ims+ notifications, please ensure "GE Flow Sensor" is included in the Equipment tab "Item/Equipment Type" field, to assist in collation of incidents related to this issue.

Reference: ANZCA PS31 Guideline on checking anaesthesia delivery systems [Online]. Available: https://www.anzca.edu.au/getattachment/ae5886cc-d498-496c-a981-c2699c1b937a/PS31-Guideline-on-checking-anaesthesia-delivery-systems [Accessed 27 August 2021].



# URGENT PRODUCT DEFECT CORRECTION

GE Healthcare 32 Philip Street Parramatta, NSW 2150

27 August 2021

GEHC Ref# 34120 TGA # RC-2021-RN-01623-1

To: Chief of Anesthesia

Director of Biomedical / Clinical Engineering Health Care Administrator / Risk Manager

RE: Flow Sensors with Potentially Damaged Tubes in GE Healthcare / Datex-Ohmeda Anesthesia

Machines (ARTG 93955)

This document contains important information for your product. Please ensure all potential Users in your facility are made aware of this safety notification and the recommended actions.

Please retain this document for your records.

## Safety Issue

GE Healthcare (GEHC) has internally identified that a small durber of flow sensors built prior to June 2021 could have damaged to a with small punctures or cuts.

The device will continue to function in all moles (chapual pag, volume, pressure, and support modes), but the tidal volumes in vote in occurate. This issue could cause leaks resulting in incorrect anestheria has been expected to under-delivery or over-delivery or volume to the patient. There may be alarms in these scenarios to indicate a publicial, as outlined below.

Please note, this issue is distinct from the GEHC Ref# 34109 / RC-2020-RN-00944-1. Ensure that you follow the Sust mer/User actions described below on all affected flow sensors, if cluding those you may have received as part of GEHC Ref# 34109 / RC-2020-RN-0944.

To date, there have been injuries reported as a result of this issue.

#### **Health Risk**

There is the potential to sunder-delivery of tidal volume may lead to insufficient ventilation, while our and excessive delivered tidal volume may lead to hyperventilation or arotrauma.

Actions to be taken by Customer / User

Always complete a pre-operative Checkout, including Circuit Leak test or Breathing system tests, on your anesthesia machine prior to use. Follow instructions in the anesthesia machine User's Reference Manual sections for "Preoperative Checkout" and "Preoperative Tests". Take care while handling Flow Sensors during removal, insertion, reprocessing, storing, or other types of handling, as damage could occur to the tubing and create cuts or punctures that affect flow sensor performance.

- Inspect ALL inventory of flow sensors, including those installed in anesthesia machines, in spare inventory, in reprocessing locations, and other locations not in use.
  - a. Look for the date of manufacture on the flow sensor body (see Figure 1 below). The date is listed as YYYY-MM (year then month), e.g., 2021-04 = April 2021.

**Important:** Use the date etched on the flow sensor body (not on the outside packaging, as it could vary from the date etched on the flow sensor body). Flow sensors should be taken out of their packaging for inspection.

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- b. If the date of manufacture is "2021-06" or later, you can continue to use your flow sensor; it is not affected.
- If the date of manufacture is prior to "2021-06", this flow sensor is affected.
  - i. GEHC will replace all affected flow sensors.
  - ii. Ideally, the affected product should not be used. However, if it is necessary to use an anesthesia machine with an affected flow sensor (due to shortage of devices and clinical demand) then this should be done as safely as possible.
  - iii. If you **only** have affected flow sensors in stock at this time, you can continue to use them by following all safety precautions, such as:, completing the pre-operative checkout, including a Circuit Leak test or Breathing System tests, on the anesthesia machine and ensuring heightened awareness of the potential for tidal volume inaccuracies. If the pre-operative Checkout fails, do not use your flow sensor.
  - iv. It is possible that an affected flow sense will pass a pre-operative checkout but still have issues duting the case. If any of the following alarms appear, consider that all of the flow sensor may be the cause. These alarms can also scur for other reasons during a case:
    - "Volume sensors sagre"
    - "Reverse exp flow. Ceck

    - "Check flow sensors"
    - "Calibrate dry, r remace flow sensors" (after End Case is selected)
    - "TV not achieved"
      - Circu lean
    - System leak?"

are sthesia machine User's Reference Manual and replace your floorson(s).

v. Contact your local GEHC sales or service representative with any questions and/or to expedite replacement flow sensor(s).

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Figure 1: Flow Sensor Body Date of Manufa cure

- 2. Complete and return the attached "Customer to ponsition."
  - a. If you DO NOT have any affected flow a sors, shock box #1 to indicate that you do not have affected Flow Sensors. E-mail the completed form to FMI34120.FLOWSENSOR@CT.CO.4
  - b. If you DO have affected flow sections check box #2 to indicate that you do have affected Flow Sections and provide the relevant information (e.g., quantities). E-mail the concleted orm to FMI34120.FLOWS ANSOR COM.

# Affected Product Details

Flow Sensors are ged in the GEHC anesthesia machines listed below to measure from and com the patient. These anesthesia machines are intended to provide general in alance anesthesia and ventilatory support to a wide range of patient (neonatal, ediatric, adult). Flow Sensors are installed in your anesthesia machine or could be kept as standalone user replaceable spare parts.

• Affected Flow ensor Part Numbers:

2089610-001 FLOW SENSOR, LEGACY VAR ORF BCG (blue, cleanable) 2089610-001-S FLOW SENSOR, LEGACY VAR ORF BCG, SERVICE (blue, cleanable)

2087640-001 FLOW SENSOR, LEGACY VAR ORF AUTOCLAVABLE BCG (gray, autoclavable)

2087640-001-S FLOW SENSOR, LEGACY VAR ORF AUTOCLAVABLE BCG, SERVICE (gray, autoclavable)

2096513-001-S FLOW SENSOR ASSEMBLY

5697309 R-FMI34109-FLOW SENSOR, LEGACY VAR ORF BCG 5697310 R-FMI34109-FLOW SENSOR, LEGACY VAR ORF AUTOCLAVABLE BCG

- Affected Flow Sensors with Date of Manufacture: Prior to 2021-06
- Affected Flow Sensors are used in the following GEHC anesthesia machines: Aisys CS<sup>2</sup> (GTIN: 00840682102322), Avance CS<sup>2</sup> (GTIN: 00840682102292), Aisys, Avance, Amingo, Aespire View, Aespire 7900, Aespire 7100/100, Protiva 7100, Aestiva MRI (GTIN: 0080682102339), Aestiva 7900, Aestiva 7100, 9100C NXT, Aelite NXT

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#### Note:

No other GEHC / Datex-Ohmeda anesthesia machines or flow sensors are affected.

**Product** Correction GE Healthcare will replace all affected products at no cost to you. A GE Healthcare representative will contact you to arrange for the replacement.

Contact Information If you have any questions or concerns regarding this notification, please contact GE Healthcare Service at 1-800-659-465 or your local Service Representative.

Please be assured that maintaining a high level of safety and quality is our highest priority. If you have any questions, please contact us immediately per the contact information above.

Sincerely,

Laila Gurney

Chief Quality & Regulatory Officer

GE Healthcare

Jeff Hersh, PhD MD Chief Medical Officer **GE** Healthcare

QARA Leader ANZ GE Healthcare

Eddy McFadden



GEHC Ref# 34120

# URGENT PRODUCT DEFECT CORRECTION CONFIRMATION -- CUSTOMER RESPONSE REQUIRED

Please complete this form and return it to GE Healthcare (GEHC) promptly upon receipt and no later than 30 days from receipt. This will confirm receipt and understanding of the Product Defect Correction Notice.

Customer/Consignee N	ame:			
Street Address:				
City/State/ZIP/Country:				
Email Address:				
Phone Number:				
Please provide the na	me of the individual v	vith responsibil	ity who complete this	form.
Signature:			XU	
Printed Name:				
Title:				
Please check <b>one</b> of the	d before the replacer e following and come	te the requested	ng process can comment information and send ba	nce. ck via one of the
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