NHS National Services Scotland

Safety Information Message

Reference: SIM2212 **Issued:** 03 November 2022 **Review Date:** 03 November 2023

Wireless Cardiotocograph (CTG) monitoring.

Summary

A safety issue has been identified with the use of wireless cardiotocograph (CTG) monitoring. A CTG machine being used with a wired transducer went into wireless mode unexpectedly. It started to pick up the signal from a transducer in an adjacent room, where CTG monitoring was also being undertaken wirelessly, and printed out the fetal monitoring trace from that adjacent room. NHS England has issued safety advice in the interim whilst investigations continue.

Action

1. Bring this notice to the attention of all appropriate managers, staff and contractors.

2. Please follow the attached interim safety advice issued by NHS England (dated 07 October 2022).

3. Ensure incidents involving wireless cardiotocograph monitoring are reported locally (Datix or Ullyses) and to IRIC: report an incident

Background

In the identified incident, a CTG machine being used with a wired transducer went into wireless mode unexpectedly, the reason for this is still being investigated with the manufacturer and the MHRA. When it went into wireless mode, it started to pick up the signal from a transducer in an adjacent room, where CTG monitoring was being undertaken wirelessly, and printed out the fetal monitoring trace from the adjacent room. It was not immediately obvious that the CTG trace was not of the baby being monitored in the room. No harm resulted from this specific incident. However, if action is not taken and the issue occurs again, there is the potential for an adverse event.

Preliminary investigation findings have identified that the CTG machines, and associated transducers, in the two rooms were set to different channels but had defaulted to the same frequency. It should be noted that some machines have a range of channels that default to the same frequency.

Suggested onward distribution

Health & Safety
Physiological Monitoring
Maternity
Risk Management
Medical Physics

Enquiries

Enquiries and adverse incident reports should be addressed to:

Incident Reporting & Investigation Centre (IRIC)
NHS National Services Scotland
Tel: 0131 275 7575 Email: nss.iric@nhs.scot

Accessibility: Please contact us using the above details if you are blind or have a sight impairment and would like to request this alert in a more suitable format.

IRIC remit: general information about adverse incidents, safety alerts and IRIC's role can be found in CEL 43 (2009), *Safety of Health, Social Care, Estates and Facilities Equipment: NHS Board and Local Authority Responsibilities,* issued 30 October 2009.

Report an incident: Information on how to report an adverse incident

NHS National Services Scotland is the common name for the Common Services Agency for the Scottish Health Service https://www.nss.nhs.scot/

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Annex:

07 October 2022

Wireless Cardiotocograph (CTG) monitoring

A safety issue has been identified with the use of wireless CTG monitoring. The investigation into the underlying issues is still underway, but it was felt necessary to issue advice in the interim.

In the identified incident, a CTG machine being used with a wired transducer went into wireless mode unexpectedly, the reason for this is still being investigated with the manufacturer and the MHRA. When it went into wireless mode, it started to pick up the signal from a transducer in an adjacent room, where CTG monitoring was being undertaken wirelessly, and printed out the fetal monitoring trace from the adjacent room. It was not immediately obvious that the CTG trace was not of the baby being monitored in the room.

No harm resulted from this specific incident. However if action is not taken and the issue occurs again, there is the potential for an adverse event.

Preliminary investigation findings have identified that the CTG machines, and associated transducers, in the two rooms were set to different channels but had defaulted to the same frequency. It should be noted that some machines have a range of channels that default to the same frequency. We are therefore advising that:

- The Head/Director of Midwifery and the Lead Obstetrician should oversee a process to ensure that **wireless** CTG monitoring is **not** used until EBME/Clinical Engineering department have checked that the devices have been set up as per manufacturer's instructions for use, and that no two machines share the same frequency.

- Midwives should be made aware of this issue and should **check and document** hourly if CTG is recording via wired monitoring or wirelessly, as part of the 'fresh eyes' review – this information would be displayed on the screen and/or a symbol may appear on the tracing.

This issue could potentially occur with any wireless CTG device. Additional information can be obtained from the device manufacturer.

Once the investigation is complete, further learning will be shared via the appropriate channels.

National Patient Safety Team **Office of the Chief Midwifery Officer**