NSW GOVERNMENT Health

Safety Alert 002/17

Insufflator Gas Connectors

12 January 2017

Distributed to:

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

Action required by:

- Directors of Clinical Governance
- Directors of Anaesthetics

We recommend you also inform:

- Directors of Surgery
- Department Head – Biomedical Engineering
- Directors of Intensive/Critical Care
- Operating Theatre Staff
- LHD/SHN Directors of Nursing and Midwifery
- Directors of Medical Services
- Directors of Clinical Services
- Theatre Managers
- Theatre Orderlies / Wardsperson

Deadline for completion of action

3 February 2017

Expert Reference Group

Content reviewed by:

- Electromedical Engineering Unit, Healthshare

Clinical Excellence Commission

Tel. 02 9269 5500
Fax. 02 9269 5599

Email: CEC-PatientSafety@health.nsw.gov.au

Internet Website: http://www.health.nsw.gov.au/quality/sabs

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

Review date

January 2019

Background

The potential for serious harm to both patients and staff has been identified in relation to missing pins in insufflator connectors.

Gas connectors are widely used throughout NSW Hospitals. These connectors are fitted with pins to prevent connection of the wrong gas. Pin design and placement for each type of gas cylinder is different.

It is critical to ensure pins are in place on an insufflator connector in order to prevent an oxygen cylinder being used instead of a carbon dioxide cylinder.

Insufflator gas connectors should resemble the images below

Obsolete

Hospitals must check and tag all relevant insufflator gas connectors and ensure the pins are present prior to connecting to a new gas cylinder.

Actions required by Local Health Districts/Networks

1. Distribute this Safety Alert to all relevant clinical staff
2. Check and tag all relevant insufflator gas connectors and ensure the pins are present
3. Check each bottle for correct gas prior to connection to the insufflator
4. Check the insufflator gas connector has the pins prior to connection of carbon dioxide
5. Review storage of all oxygen and carbon dioxide cylinders, and ensure co-location does not occur
6. Ensure relevant staff undergo cylinder identification training as a priority
7. Ensure any incidents relating to this equipment are notified in the Incident Information Management System (IIMS)
8. Provide acknowledgement of this Safety Alert within two (2) days of receipt to: CEC-PatientSafety@health.nsw.gov.au
9. Provide LHD/N response to the actions identified in this Safety Alert by cob Friday 3 February 2017.

Made Obsolete September 2022

Note: Actions to be completed by 3 February 2017