2018 Electric / electronic 2

Permission to print:	Yes
Incident type	Good Catch Near Miss
Type of incident:	equipment
Category	Electrical / electronic
Description:	Routine CABG, perfusionist did not notice that MAP was not being transferred from anaesthetic monitoring (Datex) to perfusion monitoring (Connect). This would routinely be noticed during setup and check lists. Nothing was able to be done as bypass was about to occur and decision made not to risk resetting anaesthetic machine. The cause of the problem was not able to be identified till after the case and it was found that a label had been inadvertently changed on the anaesthetic machine
GOOD CATCH - what went well	Problem was identified pre bypass and perfusionist made strategy to document manually MAP during case. .
Preventive actions	Plan to have a list of correct anaesthetic labels and how to change them available for all perfusion staff.
Manufacturer advised:	No
Discussed with team:	No
Ext Authority Advised	No
Hospital incident filed:	No
Knowledge issue	No
Rule issue	No
Skill issue	No