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