SAFETY-ALERT

ON WRONG-TUBE CONNECTIONS TO THE RESPIRATOR with potentially fatal outcome

WHAT HAPPENED?

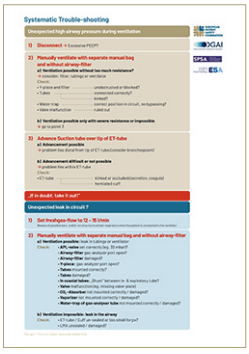
Several case were reported in Germany and France of severe complications with even fatal outcomes after induction of general anaesthesia, caused by wrongly connected tubes to the respirator. [1, 2] In addition to that, **cases of blocked tubes with fatal outcome have been reported in the UK** and the corresponding recommendations published. [3, 4]

REPORTED ERRORS

- An **accidental shortcut of respirator tubes on the level of the water-traps.**
- The **wrong connection of the manual ventilating-bag on the exspiratory connector of the ventilator.**
- **Blocking of the tubings** (angle-piece etc.) due to e.g. i.v.-caps.

GENERAL RECOMMENDATIONS ARE

1. Proceed with technical check of every ventilator according to the manufacturer's guidelines before it is connected to a patient.
2. Every anaesthesiologist must confirm that the ventilator is duly functioning.
3. Every ventilator must be equipped with a separate manual ventilating bag.
4. **„Self-check"** of some of the ventilators does NOT always guarantee the proper connection of tubes, water-traps etc.
5. Perform a short-check of the functionality of the ventilator before each induction of general anaesthesia following the **"Ventilator checklist."**
6. In case of problem, follow the **"Sysytematic troubleshooting"** checklist.



References

1 Prient T et al, Anästh Intensivmed 2019; 60:75–83
2 Theissen A et al, Anaesthesia Critical Care & Pain Medicine 2019; 38:143-145
3 Carter JA, Anaesthesia, 2004; 59:105–107
4 Checking Anaesthetic Equipment-3. 2003. Association of Anaesthetists of Great Britain and Ireland, 21 Portland Place London.