

## **Warning - Auto/Manual Switch Block on Commonly Used Anaesthesia Machines**

The Consultative Council on Anaesthetic Mortality and Morbidity has received a number of reports of critical incidents involving the Auto/ Manual Switch Block on commonly used Anaesthesia machines (incidents will occur with any particular machine that has this switch including the Ulco CO2 absorber units).

The Auto/ Manual Switch Block is a system that allows the user to switch from the manual bag to the ventilator and hence eliminate the need to disconnect the bag hose and connect the ventilator hose prior to switching the ventilator on.

These incidents have involved failure of the anaesthetist to turn the switch to the appropriate setting. This may result in failure of ventilation at the commencement of intermittent positive pressure ventilation when the switch has been on ventilator mode (suggesting poor machine checking). More commonly there is failure to turn the switch to ventilator mode prior to switching the ventilator on. In several instances the ventilator has failed to alarm as the ventilator is able to cycle within the alarm settings. The only evidence of failed ventilation was the end-tidal CO2 trace. If the adjustable pressure limiting (APL) valve is closed this error may also lead to hyperinflation of the lungs with its consequences of barotrauma or reduced cardiac output leading to cardiac arrest.

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