

Medical Device Alert

Device

Anaesthetic machine: Auxiliary Common Gas Outlet (ACGO).

All Aestiva, Aisys, Aespire and Avance anaesthetic machines.

Manufactured by GE Healthcare.

Problem	Action
The accidental, incorrect setting of the ACGO switch will result in no fresh gas flow to the patient. Furthermore, if the circle breathing circuit is incorrectly attached to the ACGO, this may result in patient barotrauma. Action by Anaesthetic and theatre staff involved in the set-up and use of these devices.	 the position of the ACGO lever and breathing circuit connections are checked before the start of every case, as recommended by the manufacturers and in the Association of Anaesthetists of Great Britain and Ireland (AAGBI) pre-use checklist. Care is especially recommended for paediatric lists where breathing circuits are changed routinely between patients. relevant members of staff have been fully trained in the use of these anaesthetic machines and are aware of the manufacturer's training guidance produced in collaboration with the Safety Committee of AAGBI – see appendix.
CAS deadlines	Contact
Action underway: 09 December 2011 Action complete: 16 December 2011	Manufacturer Paul Mardle, UK Regulatory Affairs David Walker, UK Product Manager GE Healthcare Tel: 01707 263 570 Email: paul.mardle@med.ge.com david.walker@med.ge.com

Distribution

This MDA has been sent to:

- NHS trusts in England (Chief Executives)
- Care Quality Commission (CQC) (Headquarters) for information
- HSC trusts in Northern Ireland (Chief Executives)
- NHS boards in Scotland (Equipment Co-ordinators)
- Local authorities in Scotland (Equipment Co-ordinators)
- NHS boards and trusts in Wales (Chief Executives)
- General practitioners (for information)

Onward distribution

Please bring this notice to the attention of relevant employees in your establishment. Below is a suggested list of recipients.

Trusts

CAS and SABS (NI) liaison officers for onward distribution to all relevant staff including:

- · A&E departments
- · Anaesthesia, directors of
- · Anaesthetic nursing staff
- Anaesthetists
- Day surgery units
- Maternity units
- · Operating department practitioners
- · Recovery wards
- Risk managers
- Theatres

Independent distribution

Establishments registered with the Care Quality Commission (CQC) (England only)

This alert should be read by:

- · Hospitals in the independent sector
- · Independent treatment centres

Please note: CQC and OFSTED do not distribute these alerts. Independent healthcare providers and social care providers can sign up to receive MDAs directly from the Department of Health's Central Alerting System (CAS) by sending an email to: safetyalerts@dh.gsi.gov.uk and requesting this facility.

Contacts

Manufacturer

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Email: paul.mardle@med.ge.com david.walker@med.ge.com

England

If you are in England, please send enquiries about this notice to the MHRA, quoting reference number MDA/2011/108 or 2011/006/027/401/017

Technical aspects

Douglas McIvor or Emma Rooke Medicines & Healthcare products Regulatory Agency Floor 4 151 Buckingham Palace Road London SW1W 9SZ

Tel: 020 3080 7193 / 6609

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Email: douglas.mcivor@mhra.gsi.gov.uk emma.rooke@mhra.gsi.gov.uk

Clinical aspects

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Email: tom.clutton-brock@mhra.gsi.gov.uk

How to report adverse incidents

Please report via our website http://www.mhra.gov.uk

Further information about CAS can be found at https://www.cas.dh.gov.uk/Home.aspx

Northern Ireland

Alerts in Northern Ireland will continue to be distributed via the NI SABS system.

Enquiries and adverse incident reports in Northern Ireland should be addressed to:

Northern Ireland Adverse Incident Centre

Health Estates Investment Group

Room 17 Annex 6

Annex 6
Castle Buildings
Stormont Estate
Dundonald BT4 3SQ

Tel: 02890 523 704 Fax: 02890 523 900

Email: NIAIC@dhsspsni.gov.uk

http://www.dhsspsni.gov.uk/index/hea/niaic.htm

How to report adverse incidents in Northern Ireland

Please report directly to NIAIC, further information can be found on our website http://www.dhsspsni.gov.uk/niaic Further information about **SABS** can be found at http://sabs.dhsspsni.gov.uk/

Scotland

Enquiries and adverse incident reports in Scotland should be addressed to:

Incident Reporting and Investigation Centre Health Facilities Scotland NHS National Services Scotland Gyle Square 1 South Gyle Crescent Edinburgh EH12 9EB

Tel: 0131 275 7575
Fax: 0131 314 0722
Email: nss.iric@nhs.net

http://www.hfs.scot.nhs.uk/online-services/incident-reporting-and-investigation-centre-iric/

Wales

Enquiries in Wales should be addressed to:

Dr Sara Hayes Senior Medical Officer Medical Device Alerts Welsh Assembly Government Cathays Park Cardiff CF10 3NQ

Tel: 029 2082 3922

Email: Haz-Aic@wales.gsi.gov.uk

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Addressees may take copies for distribution within their own organisations

Appendix



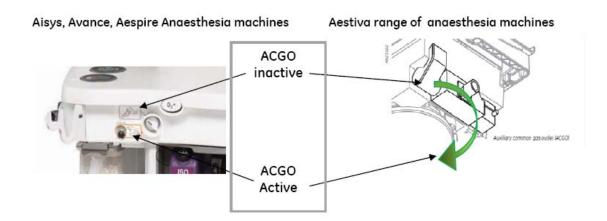
Training Guidance Aestiva, Aisys, Aespire and Avance Machines

Ref: ACGO (Auxiliary Common Gas Outlet)

Following reports of User mis-connections regarding the ACGO, we feel it would be helpful to issue the following reminder on the use of the auxiliary common gas outlet on anaesthesia machines.

Users are also reminded to follow the Manufacturers, regulatory and training guidelines accordingly for Anaesthetic machines and the testing of breathing circuits.

- 1. Please ensure all relevant machine and circuit checks are carried out at the start of the list.
- 2. If the circuit is changed you must ensure it is configured correctly as per the user manual guidelines.
- 3. Check that the ACGO switch is set appropriately for the required circuit in use.



 Complete Manufacturers circuit test procedure as directed in the relevant Anaesthesia machine manual before use. In conjunction with the AAGBI guidelines on the anaesthesia pre-use check out procedure.

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