Background
The potential for serious harm to both patients and staff has been identified in relation to missing pins in insufflator connectors.

Gas connectors are widely used throughout NSW Hospitals. These connectors are fitted with pins to prevent connection of the wrong gas. Pin design and placement for each type of gas cylinder is different.

It is critical to ensure pins are in place on an insufflator connector in order to prevent an oxygen cylinder being used instead of a carbon dioxide cylinder.

Insufflator gas connectors should resemble the images below

Hospitals must check and tag all relevant insufflator gas connectors and ensure the pins are present prior to connecting to a new gas cylinder.

Actions required by Local Health Districts/Networks
1. Distribute this Safety Alert to all relevant clinical staff
2. Check and tag all relevant insufflator gas connectors and ensure the pins are present
3. Check each bottle for correct gas prior to connection to the insufflator
4. Check the insufflator gas connector has the pins prior to connection of carbon dioxide
5. Review storage of all oxygen and carbon dioxide cylinders, and ensure co-location does not occur
6. Ensure relevant staff undergo cylinder identification training as a priority
7. Ensure any incidents relating to this equipment are notified in the Incident Information Management System (IIMS)
8. Provide acknowledgement of this Safety Alert within two (2) days of receipt to: CEC-PatientSafety@health.nsw.gov.au