

Permission to print:	Yes
Category	Pump Servoregulation
Near Miss or Accident	Accident
Type of incident:	Equipment
Knowledge Error	No
Rule Error	No
Skill Error	No
Violation	No

**Description:** Prior to priming an adult CPB circuit on a Sorin S5 HLM, a crack in the touch screen of the 150 roller pump used for 4:1 cardioplegia delivery was observed. Priming of the cardioplegia circuit with the pump was uneventful, however concern of a possible fault developing during CPB prompted formulation of an action plan to relocate the cardioplegia delivery set to another (S580) pump in the event of a problem. 2 x 1/4" connectors were made available to lengthen the 1/4" blood delivery line (that would have been too short to reach the alternate pump) with a piece of excess 1/4" prime line to be inserted. At cross clamping the aorta the cardioplegia pump would not run.

**Contributing factors:** A cracked touchscreen affected the microprocessors.

**Corrective action:** The aortic cross clamp was removed on the request of the perfusionist and the affected pump settings checked and were correct. The pump would not run (red stop light on touch screen active) so the 4:1 tubing was placed in the alternate pump as planned and the cardioplegia control module was reassigned to that pump. Thereon cardioplegia delivery was uneventful.

**Preventative action plan:** The affected pump was rechecked following the case and it was found to be the stop link function that prevented the pump from running even when the linked pump was running. This was the same when the affected pump was stop linked to any other pump. The affected pump was swapped with another 150 pump on the console and placed in a position (pump sucker) that did not require stop linking and was functional in that mode. The manufacturer was advised and arrangements made for repair of the affected pump.

Manufacturer advised:	Yes
Discussed with team:	No
Ext Authority Advised	No
Hospital incident filed:	No
Patient outcome variance	Nil