**Permission to print:** Yes  
**Near Miss or Accident** Near Miss  
**Type of incident:** Management  
**Category** Air in circuit  
**Knowledge Error** No  
**Protocol issue** No  
**Rule Error** Yes  
**Skill Error** No  
**Team Issue**  
**Violation**  
**Chance Chance event:** No  

**Description:** ECMO circuit was de-aired kept recirculating while cannula's were being inserted into the patient. An air pocket was noted on the arterial side of the oxygenator [Medos] just above the arterial line exit from oxygenator. Pump was stopped all the taps were tightened, circuit was de-aired and left recirculating. After 20 minutes waiting to go on ECMO a pocket of air was again seen at the same spot. Circuit was stopped and de-aired again with literally opening and closing all the taps. Still waiting to go on ECMO air pocket was again seen at the same spot. All taps were checked for cracks and tightened again. Additionally temperature probe port was tightened. After that no air was seen in the oxygenator.

**Contributing factors:** Possible temperature probe was not tight enough on the oxygenator.

**Corrective action:** De-aired the circuit.

**Preventative action plan:** Check temperature probe is tightened addition to other ports.

**Manufacturer advised:** No  
**Discussed with team:** Yes  
**Ext Authority Advised** No  
**Patient outcome variance f** Nil