Venous reservoir 2017

Permission to print:	Yes
Incident type	Near Miss
Type of incident:	Equipment
Catagory	Venous Reservoir
Description:	Standard valve case, patient was heparinised, and the surgeon asked to go on bypass. I reached over to remove the clamp from the venous line, and as I did so I spotted some blood (~5ml) on the floor under my oxygenator (inspire 6). Before this I had not seen the blood as my view of it was obstructed by the oxygenator. I informed the surgeon that I was not going on bypass as I wanted to identify the source of the blood on the floor. I found that it had leaked from the seal at the cardiotomy turret where the suckers attach (we had been using the pump sucker) , and had dripped down the back of the reservoir onto the floor. I called a colleague in for a 2nd brain, and we decided to the change out the reservoir before going on bypass.
Preventive actions	Discussed with manufacturer and advsed this was a known problem related to the gasket lubricant and reservoir molding that was undergoing a 2 stage fix (stage 1 new lubricant , stage 2 revised moulding - still in process. If recurrent then consider using a dual reservoir that has not had the same problem until the new moulding fix is in place.
GOOD CATCH - what went	Early recogntion of the problem (pre CPB) and team support in the decision and actioning reservior change out
Protocol issue	No
Rule issue	No
Skill issue	No
Team Issue	No
Violation	No
Manufacturer advised:	Yes
Discussed with team:	Yes
Hospital incident filed:	No
Ext Authority Advised	No
Procedure acuity:	Elective
Commentary	

Permission to print:	Yes
Incident type	No Harm Incident
Type of incident:	Equipment
Catagory	Venous Reservoir
Description:	After approx. 10 mins on bypass (AVR + MVR + myectomy) I noticed that I had blood leaking from around the cardiotomy turret (Inspire 6 - LivaNova). I called the co-ordinating perfusionist who happened to be one of the most experienced perfusionists in the universe. After a brief discussion of options (adding a second reservoir and rerouting the suckers) He suggested applying bone wax around the join. This worked really well, and there was no further leaking during the case.
Preventive actions	Discussed with manufacturer and advised this was a known problem related to the gasket lubricant and reservoir moulding that was undergoing a 2 stage fix (stage 1 new lubricant , stage 2 revised moulding - still in process. If recurrent then consider using a dual reservoir that has not had the same problem until the new moulding fix is in place. Of interest was the fact that as users of the product we were unaware of this same fault having occurred elsewhere.
GOOD CATCH - what went	Team collaboration to find an effective minimalist solution of applying bone wax to a minor leak and avoiding any interruption to the procedure
Protocol issue	No
Rule issue	No
Skill issue	No
Team Issue	No
Violation	No
Manufacturer advised:	Yes
Discussed with team:	Yes
Hospital incident filed:	No
Ext Authority Advised	No
Procedure acuity:	Elective
Commentary	This is the second report of this problem in quick succession to PIRS. While this was a relatively minor incident, a particular point of interest is the fact that the user was not aware of a previous rash of reports of the same issue with the same device in the same region. The explanation for not sharing this knowledge was that it was thought to be isolated to one centre. There had been no previous reports to PIRS of this gasket leak - neither from the centre where it occurred nor from the supplier. Under reporting is well known however this raises the opportunity for a closer partnership with the industry in voluntary reporting of near miss and other product related issues. PIRS is looking to initiate a dialogue with the corporate sector on how this might be usefully progressed - PIRS Ed