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

Description: For a routine CABG case, after aortic and venous cannulation with EOPA and 2 Stage Venous cannula the pump was started and patient was put on bypass. Within a minute or two of the bypass run air was seen in the venous line. The venous pressure was raised but [with] no luck and within no time whole venous line drained with a large air lock. Pump was stopped and patient was ventilated again. Venous line was disconnected & the cap on the connector between venous line and venous cannula was loose and was tightened. The venous line was refilled and bypass continued safely.

Contributing factors: Loose cap on venous cannula connector

Corrective action: The cap on the port of the connector situated between venous line and venous cannula was tightened.

Preventative action plan: Routinely ensure the surgeon has checked the cap of the connector before going on bypass.

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