Permission to print:	Yes
Category	Circuit disruption
Near Miss or Accident	Accident
Type of incident:	Management
Knowledge Error	No
Rule Error	No
Skill Error	Yes
Violation	No

Description: During the transportation of an ECMO patient from ICU to CT the centrifugal pump head came out of the pump drive. A Medtronic 560 pump with an external drive was used with an adaptor to allow for the use of a Jostra pump head. The ECMO unit was connected to the patient's bed via the use of two hook attachments. The patient had already been transferred from the CT scanner onto the bed, it occurred whilst other equipment was being moved.

Contributing factors: Tension of the inflow tubing to the pump head may have caused it to have become dislodged from the adaptor. The flow probe potentially became stretched upon the movement of the bed away from the CT table.

Corrective action: The outlet of the centrifugal pump outlet was clamped, the pump was turned off and the pump head placed back into the pump drive. The pump was turned back on, the revolutions increased and the clamp removed, resuming flow. The incident was resolved within seconds. The patient was on VV ECMO, blood pressure was unaffected. The saturations decreased to

Preventative action plan: Extra vigilance required upon ECMO transfer, particularly with the use of pump head adaptors.

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