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: A patient on ECMO needed to be transferred from CVICU to the CT room to be scanned. To facilitate transfer of the patient, metal arms can be linked from the patient bed to the ECMO cart. In order for the metal arms to link to the bed, manipulation of the ECMO pump head unit and oxygenator was needed. As the pump head unit was manipulated, the catch to hold to the pump head was depressed and the pumphead popped out of its holder. This caused the system to alarm as forward flow was stopped. The outlet line was clamped to stop retrograde flow. I tried to place the pump head back in the holder, and of course the revolutions were still running therefore the pump wouldn't couple properly. A nurse came over to turn down the revolutions and then the pump head was properly seated and then flow was re established.

Contributing factors: No factors

Corrective action: The outlet line was clamped to stop retrograde flow. I tried to place the pump head back in the holder, and of course the revolutions were still running therefore the pump wouldn't couple properly. A nurse came over to turn down the revolutions and then the pump head was properly seated and then flow was re-established.

Preventative action plan:	ECMO Course and Simulation training
Manufacturer advised:	No
Discussed with team:	Yes
Ext Authority Advised	No
Hospital incident filed:	Yes
Patient outcome variance	Nil