Permission to print: Yes
Category Gas Supply
Near Miss or Accident Near Miss
Type of incident: Management
Knowledge Error No
Rule Error Yes
Skill Error Yes
Violation No
Description: It had been noted that Arterial Filters did not appear to be de-airing as well as usual by a number of perfusionists despite using normal CO_2 flushing techniques. [It was subsequently] discovered that 2 out of 4 workstations [in the pump room] had CO_2 lines to the HLM blender were plugged into [medical] air ports therefore flushing with air.

Contributing factors: CO_2 gas lines [with a universal schraeder fitting between the HLM blender and the ceiling mounted CO_2 supply line] fit into ports of the air lines [from the ceiling of the pump room]. HLM CO_2 flush Lines are sometimes moved between workstations when lines are broken / being repaired.

Corrective action: Lines placed in correct CO_2 supply ports.
Preventative action plan: Replace the CO_2 gas supply line from the ceiling with an uninterrupted line terminating in the unique CO_2 connector to the electronic blender.

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