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

Description: Approximately 45 mins into case clear fluid was observed under the membrane of the Avant oxygenator. Closer inspection revealed a slow leak of blood from the outlet pores at the bottom of the oxygenator at the gas outlet area. There was no effect on the performance of the oxygenator and 2 blood gas samples prior to discovering leak had been acceptable and the gas settings had been set at the usual rates.

Contributing factors: none

Corrective action: Surgeon informed, and as Aortic Valve surgery had commenced and there was no decline in the function of membrane, it was decided to continue with implant and observe the leak. Patient cooled further from 32 to 28 to achieve safer circulatory arrest period if change out required. A second oxygenator was primed and brought into theatre ready for change out. There was no change in rate of leak detected. After further discussion about integrity of oxygenator rewarming was commenced and patient was successfully separated from bypass with no incident.

Preventative action plan:	n/a
Manufacturer advised:	Yes
Discussed with team:	Yes
Ext Authority Advised	No
Hospital incident filed:	No
Patient outcome variance	Nil