Permission to print:	Yes
Catagory	Circuit disruption
Near Miss or Accident	Accident
Type of incident:	Management
Knowledge Error	No
Rule Error	Yes
Skill Error	No
Team Issue	Yes
Violation	Yes
Description:	The patientt was on fem/fem bypass. Near to weaning and discontinuing bypass the surgeon unsutured arterial cannula in preparation for de-cannulation. At half flow, it was determined that full bypass should be resumed at full flows (4 lpm). Some 10 minutes later, increasing line pressures were noted, bleeding at the site was also noted by the scrub nurse. On examination, the arterial cannula then came out of the femoral artery, with bypass discontinued immediately. Another aortic cannula was inserted into the femoral artery and bypass was resumed within 80 seconds.
Contributing factors:	Surgeon unsecuring cannula before coming off bypass
Corrective action:	Arterial line and venous line were immediately clamped, and once bypass was resumed, and an arterial blood gas was taken.
Preventative action plan:	Cannula was secured in for the rest of bypass
Manufacturer advised:	No
Discussed with team:	Yes
Ext Authority Advised	No
Hospital incident filed:	No
Patient outcome variance f	unknown
Commentary	