Gas Supply - 2017

Permission to print:	Yes
Incident type	No Harm Incident
Type of incident:	Management
Catagory	Gas Supply
Description:	CPB for a 71kg male for CABG was initiated (naso temp 35.4) and the colour of the blood leaving the oxygenator was immediately recognised as being dark without change. The M4 on line gas analyser confirmed a decreasing SaO2 with a gas flow of 2.3LPM and FiO2 of 56%. The decision was made by the perfusionist to immediately wean back off CPB and find the source of the problem. The 0.2micron gas filter (obscured from direct view) was found to be disconnected from the fixed silicone gas line on the heart lung machine. I was assumed that following the gas flow test at this point the filter has not been fully reconnected and on handing up the AV lines to the table, tension on the gas line caused the disconnection. The exit from bypass was 1.5 minutes from initiation and the time off bypass (fully ventilated) was <2 minutes. CPB resumed with normal gases.
Preventive actions	The silicone gas tubing to which the filter is attached for each case has a tendency to stretch over time and a monthly check to trim the end of the gas line has been instituted
GOOD CATCH - what went	Close observation of the colour of the arterial line arterial line blood and immediate confirmation of the on line SaO2 resulted in an immediate fix
Protocol issue	No
Rule issue	Yes
Skill issue	No
Team Issue	No
Violation	No
Manufacturer advised:	No
Discussed with team:	Yes
Hospital incident filed:	No
Ext Authority Advised	No
Procedure acuity:	Elective
Commentary	