Permission to print: Yes
Category: Circuit error
Incident type: Good Catch Near Miss
Duration of incident: seconds
Description: A pump that had been set up the day before and primed by another colleague was used for this case. Prior to the initiation of CPB when the cardiotomy pump sucker was turned on at the appropriate ACT target it blew and did not suck. It was immediately noted that both the cardiotomy pump sucker and the vent sucker pump boots were loaded the wrong way in the pump raceway. The pump sucker and vent pump boots were immediately repositioned correctly. This was a very recently redesigned tubing circuit where the cardiotomy suction line and the pump boot is preconnected whereas it was previously separate. (The vent line contains a non return valve). This reconfiguration has resulted in a preference to load the pump from the opposite side of the HLM that could explain the reversed loading.

GOOD CATCH - what went well
Immediate recognition of the problem before CPB initiated with the use of an intracardiac vent.

What could we do better
A more thorough check of the set up and I missed the water test check of the cardiotomy suckers at the beginning of the procedure after handing up the lines to the table.

Preventive actions
Discussed at the team meeting and a change to the pre CPB portion of the checklist to be more specific to the pack change has been instituted. Colour coding also added to the pump inlets. The importance of the water test reiterated.

Type of incident: Management
Hospital incident filed: No
Ext Authority Advised: No
Discussed with team: Yes
Rule issue: Yes
Skill issue: Yes
Patient outcome variance: Nil
Commentary: PIRS2 continues to receive occasional reports of reversed cardiotomy return pump boots. While non return valves (used in this report) are mandated in standards and guidelines, despite pre CPB checks, the "water test" of vents and pump suckers pre use is an essential check for the team - both perfusionist and surgeon. PIRS2 Ed.