

2023 HCU/CP air

Permission to print:	Yes
Category	Heater Cooler unit
Incident type	Good Catch Near Miss
Duration of incident:	minutes
Description:	<p>Equipment: Soren S5, Soren Vanguard CPG HE, Getinge HCU40 model. After initiation, while priming the cardioplegia (to the table but not connected to the patient) for cold Del Nido I identified that the HCU cardioplegia temperature was 34 degrees despite pressing the set temp 3 degrees button, There was water flow but despite pressing the 3C set temp. button on the HCU40 control panel, it had somehow been changed in the settings to bring the temperature to 34C instead. So, when I needed to adjust the temperature, I had to use the temperature control dial on the control panel instead. I manually wound down and confirmed the temperature at 3 degrees, and I communicated to the surgeon that the cardioplegia line was warm and required further time to cool appropriately for another flush/prime. The surgeon requested a new Del Nido bag, and when reattaching the bag and commencing a new flush/prime (before attaching to the patient), the clamp was left on leading to the formation of bubbles in the line [cavitation]. I notified the surgeon and asked for one of the other perfusionists to help as I proceeded to de-bubble the CPG circuit by unclamping the bag line and opening the circuit to the recirc bag watching for air. The prime to the surgeon was recommenced without issue and no further bubble was identified. CPG was delivered at appropriate temperature without issue.</p>
GOOD CATCH - what went well	Self-identified the problem, prior to patient connection. Communicated early with surgeon and throughout process. Problem-solved and troubleshooted thoroughly.
What could we do better	Better visual and tactile checks for temperature earlier, slowing down and performing a more thorough check of the circuit after the changes were made.
Preventive actions	Manually winding down the temperature on HCU. Touching the CPG water lines from the HCU more frequently for temperature check. Performing a visual and tactile 'follow-through' check along circuits or lines that have had adjustments or changes made, frequent clamp counts to help ensure correct numbers are on and off circuit.
Type of incident:	
Hospital incident filed:	No
Ext Authority Advised	No
Discussed with team:	Yes
Knowledge issue	No
Protocol issue	No
Skill issue	No
Team Issue	No
Patient outcome variance f	Nil