2025 New Equipment - Gas Hoses

Date	27/11/2025
Permission to print:	Yes
Category	Gas Supply
Category 2	
Severity	Good Catch No Harm Incident
Description:	Our institution recently procured a new heart-lung machine. In addition to the machine, we purchased new air/oxygen hoses for connection to the electronic blender. Approximately 2-3 weeks after installation, brown staining was observed at multiple locations on both the air and oxygen hoses while the machine was being configured and tested under wet-lab conditions in the perfusion room. The affected hoses were replaced with a new, visibly unaffected batch. However, within 1-2 weeks the replacement hoses developed the same staining pattern. This issue was reported to the company. It is noted that these hoses are a different brand and design from those historically used on previous heart-lung machines. The older-style hoses currently in service have not shown any discolouration. The company has advised that they are unfamiliar with this issue and have arranged to remove the affected hoses for analysis. They intend to supply an alternative hose type. We have tested the disinfectants used for heater cooler cleaning on the external surface of the hoses for potential chemical reactions. Discolouration has yet to appear. In parallel with reporting to the company, we contacted other nearby hospitals that have recently installed new equipment. Two hospitals provided photographs demonstrating similar staining, consistent with our observations, although the issue had not yet been detected at those sites. At this stage, it is unknown whether gas quality or patient safety is affected. As a precaution we have elected not to use any affected hoses until an alternative product has been provided and evaluated.
GOOD CATCH - what went well	Early detection of the colour change on the new air/oxygen hoses was a key step in preventing potential risk. The affected hosing was promptly removed, and the issue was reported to the supplier. Notification was sent to other units to request feedback and determine whether the issue was isolated or more widespread. This allowed rapid confirmation of similar findings at other sites and supported timely escalation to the manufacturer for investigation and corrective action.
What could we do better	Nil
Preventive actions	None yet
Type of incident:	Equipment
Manufacturer advised	Yes
Timing of incident:	Not Entered
Procedure acuity:	Not Entered
Discussed with team	Yes
Hospital incident file	Not Entered
Ext Authority Advised	Not Entered
Patient outcome variance	Nil