

2026 Cardioplegia table line fault

Permission to print:	Yes
Category	Disposable Failure
Category 2	Cardioplegia
Severity	Good Catch Near Miss
Description:	<p>During an elective CABG, cardioplegia was given down the root as normal with no issues. Once cardioplegia was finished the aortic root vent was turned back on under the instruction of the surgeon. After 10 minutes of cardioplegia time, the bubble detector alarmed and it was noticed by the primary perfusionist and the n+1 perfusionist that blood was being drawn up the table. The assisting perfusionist clamped the line before the air reached the surgical field and the primary perfusionist stopped the vent. The line previously was clamped before the connector. The bubble detector was put right after the luer lock connector. The surgeon was informed and the vent was turned on again after the cardioplegia line was clamped towards the table. The table line was replaced and no further issues were noticed throughout the case in regard to cardioplegia delivery. The patient was stable and the rest of the bypass was uneventful. The patient came off bypass with no issues. The patient was extubated the day after without any post-operative complications.</p>

GOOD CATCH - what went well

The perfusion team inspected the cardioplegia line and found that the connector was securely attached and showed no obvious signs of damage at the time of inspection. However, an evident leak was present, and it was suspected that a small fracture within the table line had allowed to open the system to air, resulting in gradual venting when the aortic root vent flow was increased. The line was clamped prior to the connector, and the bubble detector was put past the connector. Therefore, the alarm did notify the team at the start of the event, and the team took action to resolve the issue. The line was retained following completion of the procedure and subsequently disinfected for further examination. On closer inspection, two small cracks were identified on the luer lock connector. The incident has been reported to the manufacturer, and all required safety reporting processes and hospital incident reporting procedures have been completed. This was a good catch/near miss incident. The perfusion, surgical, and anaesthetic team communicated efficiently and in a calm and pragmatic approach the issue was resolved immediately with no harm done to the patient or any delays in the surgery.



Type of incident: Equipment

Manufacturer advised: Yes

Discussed with team: Yes

Hospital incident filed: Yes

Ext Authority Advised Yes

Patient outcome variance from incident NIL