

latest PIRS report

Permission to print:	Yes
Catagory	Coagulation
Near Miss or Accident	Accident
Type of incident:	Management
Knowledge Error	No
Rule Error	No
Skill Error	No
Team Issue	No
Violation	No
Description:	<p>[An elective] MVR + CABG patient had an anaphylactic type reaction following anaesthetic induction. The patient's MAPS dropped and CPR was commenced and Heparin was given (35000iu). There was 15000iu in the prime. The patient was put on bypass in an emergency situation. Anaesthesia requested the cardiotomy sucker to be started with ACT still at 227 and climbing. An additional 10,000 iu heparin was added to the cardiotomy reservoir. Some blood was sucked back in to venous reservoir before ACT reached target level. The arterial line and venous lines were connected and patient was put on bypass. After 50 min on bypass while taking down the Left Internal mammary artery it was observed that filter inside the venous reservoir appeared to be clotting with resemblance to coagulated blood. There was no obvious restriction to blood flow. Surgeon was informed and two colleagues were consulted for an opinion. After doing a thorough check it was decided to change the venous reservoir. Change out procedure was followed and venous reservoir changed by coming off bypass; with patient maps in high 60mmHg as the heart was still ejecting. It took 2.5 mins to do the complete change out and resume cardiopulmonary bypass. Subsequent inspection of the drained reservoir showed the appearance of fibrin on the reservoir filter.</p>
Contributing factors:	Possible [that the] heparin was not fully circulated due to CPR and emergency.
Corrective action:	Changed out the Venous Reservoir
Preventative action plan:	nil
Manufacturer advised:	No
Discussed with team:	Yes
Ext Authority Advised	No
Hospital incident filed:	No
Patient outcome variance f	unknown