

2019 Gas Supply

Region	ANZ
Description:	<p>For an Acute CABG. All checks were completed in theatre [including gas flow to oxygenator]. Once on bypass all appeared ok. As the X-Clamp went on the SaO2 started to drop to 89%, I thought it was going to be ok, additionally; as a result I changed my FiO2 to 51% from 47%. This did not help immediately and SaO2 continued with a downward drop from 70% to 40%. This downward trend was followed by the SvO2 saturation as well from 81% towards 23%. The time frame of this event was approximate 2 minutes starting from 19:25 hours to 19:27 hours. During the whole process the DO2i kept constant above the 270. After obvious trouble shooting, it was confirmed there was a loss of gas flow to the oxygenator. Before further delay I obtained an oxygen cylinder with flow meter and connected it to the oxygenator directly. Once the patient saturations were corrected, I commenced troubleshooting all the connections thoroughly.</p> <p>After further thought I suspect while connecting the VAMOS CO2 monitoring device, I may have accidentally pushed VAMOS CO2 monitoring device that in turn caused Isoflurane dispenser dislodge from the bracket and stop the gas supply to the oxygenator. I tried to turn the Isoflurane dispenser on and off but that did not make any difference. Then Isoflurane dispenser was completely unhooked from the connections and repositioned by the second perfusionist on- call present in the room. This completely solved the problem and I shifted the gas line from external gas bottle to the main circuit.</p>
GOOD CATCH - what we	<ul style="list-style-type: none">• Connected to direct Oxygen ASAP without delay and it was easy to do.• Having an emergency plan (ie accessing the A size O2 bottle and with flowmeter from the patient bed directly outside OR with a D cylinder available in the pump room if required for prolonged supply• Having a second perfusionist available for all emergencies
What could we do better	little else - there is a an effective plan for loss of gas supply. Possibly reciti
Preventive actions	Make sure you remove the dispenser and then put it back again if leak suspected.
Catagory	Gas Supply
Incident type	Good Catch No Harm Incident
Type of incident:	Management
Manufacturer advised:	No
Hospital incident filed:	Yes
Ext Authority Advised	No
Discussed with team:	Yes
Commentary	There have been a number of reports to PIRS of loss of gas supply due to partial unseating of the vaporiser and this can be subtle and not immediately obvious as in this case. The value of the availability of a second perfusionist (the N+1 principle) is noteworhy. PIRS Ed