# 2024 Coagulation (Heparinisation)

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| Permission to print: | Yes |
| Category | Coagulation |
| Severity | Good Catch Near Miss |
| Duration of incident: | minutes |
| Description: | Loading dose of 35,000u Heparin given to patient via the proximal lumen of a PA catheter, as standard for this anaesthetist. After 3 minutes, a sample was drawn for an ACT, which finished at 158 seconds with visible clot. A second sample was drawn for a second ACT, which finished at 155 seconds with visible clot. A further 15,000u Heparin was given again via the proximal lumen of the PA catheter. After a further 3 minutes a sample was drawn for an ACT, which finished at 155 seconds with visible clot. (The surgeon, throughout this period was putting pressure on the perfusionist to "just turn on cardiotomy/just go on bypass"). At around this point the anaesthetist remembered that he had pulled back the PA catheter in readiness for a Maze procedure, and in checking under the drapes, could see clear liquid within the PA catheter sheath (most likely all the Heparin) A further 35,000u Heparin was given and flushed through the distal lumen of the PA catheter. A subsequent ACT stopped at 629 seconds. CPB was started and the case proceeded as normal. |
| GOOD CATCH - what went well | Perfusionists refused to turn on cardiotomy suckers or go on CPB until the ACT was above 400 seconds |
| What could we do better | Heparin could have been given earlier to allow more time for ACT testing and subsequent trouble shooting |
| Preventive actions | Surgeon asked to give Heparin earlier in procedure. Incident was discussed with all perfusion staff, all surgeons, and anaesthetic staff, with emphasis on waiting for the pre-bypass ACT EVERY case |
| Type of incident: | Management |
| Hospital incident filed: | Yes |
| Ext Authority Advised | No |
| Discussed with team: | Yes |
| Knowledge issue | No |
| Rule issue | No |
| Protocol issue | No |
| Skill issue | Yes |
| Team Issue | Yes |
| Chance Chance event: | Yes |
| Patient outcome variance f | Nil |
| Commentary | This incident the second incident relating to inadequate heparinisation recently reported to PIRS and illustrative of a problem that due to various factors is not uncommon. The good catch on this occasion is the perfusionist resisting pressure from the surgeon to "just turn on cardiotomy/just go on bypass". The hierarchy of the operating room can be intimidating especially for junior staff when there is pressure to proceed requiring support. PIRS Ed. |