

## Cardiac Ischaemia (Awake)

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3 C DE			Stage				
C DE	Own (drov	vsy if sedation used)					
DE Rx		97% (on choice of oxyge	n). Patient start	s feeling shortnes	s of breath, grow	ing into inability to	
DE Rx	HR 110, BP chest pain		nplaining of che	est discomfort, initially ache growing into cardiac			
Rχ.	Draped for specifically	CG morphology changes praped for surgery, surgery has just begun. Surgeon unaware of anaesthetic/patient concerns until pecifically told so. Surgeon can ask anaesthetist to 'stop patient moving' atient starts developing dizziness/nausea and vomiting					
	Recognise Assess pati Call for he Treat as pe 12 lead EC	developing critical incide ent, develop differential o p (as appropriate for leve r loca protocol/QRH han G, consider cardiac arres	ent, communico diagnosis, consi el) dbook st trolley	ate this with tear ider cardiac isch	aemia		
	Ensure oxygenation, analgesia, treat haemodynamic instability, Consider GTN Stage 2						
4	Own						
		92% (unless O2 given), pc	tiont COB and	unable to lie flat			
		· ÷ · ·			noio if the start of the		
	Cardiac cl If ECHO pe	85/32. ECG ST elevation ( nest pain, radiating to left erformed – new regional w	arm.		mia ir untreated		
	Drowsy, diz						
		p (if not already) atre team are aware of c completion of surgery	ritical incident				

up to full blown shortness of breath, chest pain) Blood pressure cuff (on left) is quite tight, can it be released?				
Concerns Am I going to die?		/ /		
Guidance for ODP role		C		
Opening lines/questions/ Will they be ok? He was started the operation Competent but never es anxious about the awak	perienced similar incident, so	L J C		
Actions Can point out ECG morp beginning of surgery	phology looks different to			
Guidance for Role e.g. l	TU/Anaesthetic Senior	C		
Expectations/actions Support depending on level of participant				
		C		
		F		
Session Objectives				
	Management of a patient wit	'h		
Clinical	Management of a patient wit	h		
	Management of a patient wit Coordinating activity of the te assessing capabilities and utili support junior staff	ea		
Clinical Non-technical skills	Coordinating activity of the te assessing capabilities and utili support junior staff Planning and preparing for ne Following guidelines for mana team members to complete v	ea isir ext		
Clinical Non-technical skills Teamworking	Coordinating activity of the te assessing capabilities and utili support junior staff Planning and preparing for ne Following guidelines for mana	ea isir ext igi va rec 9 I		
Clinical Non-technical skills Teamworking Task management	Coordinating activity of the te assessing capabilities and utili support junior staff Planning and preparing for ne Following guidelines for mand team members to complete v closed loop communication t Gathering information – during	ea sir ext igi va ec g I		

Opening lines/questions/cues/key responses

Can I sit up a little (initially vague symptoms, building

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# Critical Incidents

#### Guidelines

Association of Anaesthetists QRH handbook Cardiac ischaemia

https://anaesthetists.org/Portals/0/PDFs/QRH/QRH 3-12 Cardiac ischaemia v2.pdf?ver=2019-08-23-113328-

#### Guidance for Patient Role

Relevant HPC / PMH Chest pain in latter stages - similar to last MI that needed PCI

#### Actions

As chest pain starts to build, can get increasingly agitated and then drowsy

Guidance for Surgeon

Unaware of patient concern until declared Joint decision making to pause surgery or rapid closure

Guidance for cardiology (by phone)

Would be a candidate for PCI, stabalise and transfer to cath lab – would you be able to

anaesthetise/provide sedation if they are unstable? (prompting discussion about support for non-theatre activity)

Additional challenges

Patient increasingly agitated

#### th intra-operative cardiac ischaemia

eam, exchanging information with different teams, ising the team to complete tasks/manage patient,

ext steps such as transfer, management in angio. iging IHD, identifying and utilising resources such as various tasks, ensuring good communication such as techniques

g patient assessment, recognising deteriorating

MDT decision making, continuous re-evaluation