Disclosures

1. ICEBP Committee
“Research organizations, advocacy organizations, professional specialty societies, and care delivery organizations should facilitate the development, accessibility, and use of evidence-based and harmonized clinical practice guidelines.”
Blue Print for a Perfusion Service-AmSECT Standards & Guidelines for Perfusion Practice.

Standard 1: Development of Institutionally-based Protocols
Standard 2: Qualification, Competency and Support Staff
Standard 3: Perfusion Record
Standard 4: Checklist
Standard 5: Communication
Standard 6: Safety Devices
Standard 7: Monitoring
Standard 8: Anticoagulation
Standard 9: Blood Management
Standard 10: Gas Exchange
Standard 11: Blood Flow
Standard 12: Blood Pressure
Standard 13: Quality Improvement
Standard 14: Maintenance
Standard 15: Duty Hours
1. ENTIRE document is perfusion related!
2. List format
3. Evidence based, expert opinion and consensus by peers
4. Endorsed by AmSECT
Standard 1.1

As a mechanism for applying each standard to clinical practice, an institution or service provider shall develop and implement an operating procedure (protocol) for each of the standards.
Standard 2.2

Perfusionist competency shall be assessed annually to evaluate compliance with departmental protocols.
Standard 2.3

The perfusionist shall attend, participate, and engage annually in perfusion-related continuing education.
Standard 5.1

A patient-specific management plan for the CPB procedure shall be prepared and communicated to the surgical team either during the pre-operative briefing or prior to beginning the procedure.
Standard 7.6

Blood Gas analyses shall be monitored continually or at regular intervals during CPB.
Guideline 7.4

Continuous in-line blood gas monitoring should be used during CPB.
Hematocrit (or hemoglobin) shall be monitored continually during CPB.
Standard 9.1

The perfusionist shall participate in efforts to minimize hemodilution and avoid unnecessary blood transfusions.
Standard 9.2

The perfusionist shall minimize the cardiopulmonary bypass (CPB) circuit size to reduce prime volume.
Standard 9.3

The perfusionist shall calculate and communicate to the surgical team prior to initiating CPB, a patient's predicted post-dilutional haemoglobin or hematocrit.
Guideline 9.1

Minimize hemodilution by:

Matching the size of the CPB circuit to the size of the patient

Autologous priming of CPB circuit, including retrograde arterial and venous antegrade priming

Biocompatible coating on the surface of all CPB components

Perioperative blood cell recovery and reinfusion after being appropriately processed.

CPB circuit blood salvage at the end of the procedure.
Guideline 9.2

Point-of-Care hemostasis monitoring should be utilized to minimize blood loss. Monitoring may include:
- International normalized ratio (INR)
- Partial thromboplastin time
- Prothrombin time
- Thrombin time
- Thromboelastography/Thromboelastometry
- Platelet count
- Platelet function analysis
Do AmSECT’s Standards & Guidelines for Perfusion Practice help or hinder the progress of reducing hemodilution?
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1. Vague
2. No specifications
3. No standard calculations
4. THERE ARE NO NUMBERS!!!
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WE NEED MORE!!

• How?
• What will I need?
• Expectations?
• Normals?
• Quick
• Specific
• Evidence Based
thank you!