

# PIRS 2016 - Communication

Permission to print:	Yes
Incident type	Near Miss
Type of incident:	Management
Catagory	Communication
Description:	<p>Our unit performs a number of ECLS procedures each year and it is standard practice to always have an emergency circuit set up and primed ready for use. It policy for the- 1st on-call perfusionist to notify the 2nd on-call perfusionist as soon as there is confirmation that a retrieval off campus is taking place so that they can assist with the set up of a new emergency ECLS circuit and resume 1st on-call duties for the duration that the other perfusionist is away from the hospital on the ECLS retrieval. On this occasion in no replacement emergency ECLS circuit was set up available in-house and the 2nd on-call perfusionist not knowing that the 1st on-call perfusionist had left the city with the only available circuit. [The occurrence] was after hours/late evening and time constraints potentially distracted the staff member following the procedure. A patient subsequently arrested in the ICU and a code ECMO was initiated - this led to the 2nd on-call perfusionist being called to the hospital and was required to set up a new circuit without knowing any of the background with a resulting delay to completion of setup. The patient who arrested subsequently was resuscitated without the use of ECMO</p>
Preventive actions	The staff concerned were asked to read and sign/date existing protocols stating that the content is understood and all staff were reminded of the protocols for ECLS and communication requirements in such emergencies.
GOOD CATCH - what went	
Protocol issue	No
Rule issue	Yes
Skill issue	Yes
Team Issue	No
Violation	Yes
Manufacturer advised:	No
Discussed with team:	Yes
Hospital incident filed:	No
Ext Authority Advised	No
Procedure acuity:	Emergent
Commentary	