

PIRS News

ANZCP PIRS has been variably restricted while

the ANZCP website was being rebuilt however we are now getting back into business and after starting 2017 with some new initiatives to get better feedback to perfusionists on reporting variances in practice.

We aim to publish summaries of reports more regularly but would welcome feedback from users on the ease of access - the form itself and any suggestions to PIRS@ANZCP.org

In addition we are setting up a bulletin **PIRS NEWS** with items on safety in perfusion and would welcome articles or commentary on safety initiatives you might be involved with or have seen elsewhere.

PIRS Ed

We encourage feedback and suggestions to PIRS@anzcp.org

this issue

New Safety initiatives P.1

SAFETY-2 and ANZCP EXPLORE P.2

PIRS Report of the Month P.3

Exploring new initiatives in safety and Reporting — Safety 1 and Safety 2

Traditional analysis of safety in healthcare including perfusion has focused exclusively on looking at what went wrong and finding the (root) cause then putting remedial processes in place. This is part of what is now termed Safety 1 and there has been extensive research and publications on error in healthcare and its avoidance. We talk about accidents and near miss, and PIRS has recently adopted the WHO definitions of incidents as either reaching the patient (Harm or No Harm) or not (Near Miss). It transpires that with these new definitions the vast majority of reports to PIRS are Near Miss (previously classed as "accident"). We know

that near miss data is the most useful in providing early warning of more serious incidents.

The emerging concept of Safety 2 focusses on what went right.

This is an area that ANZCP PIRS is looking to embrace in conjunction with the more traditional Safety 1 approach as these are

CUSTOM SOLUTIONS

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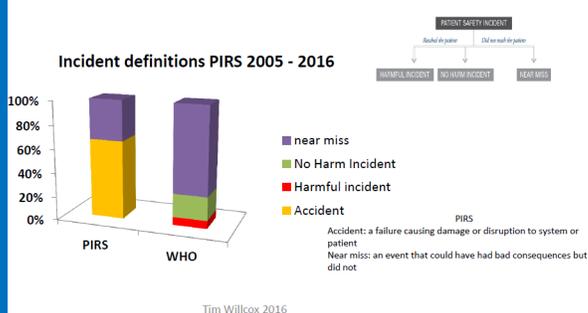
Use the following link to create a shortcut to PIRS page on you desk top

<http://anzcp.org/perfusion-incident-reporting-system-pirs/>

OR use the following link to create a shortcut direct to the PIRS Report Submission form to your desktop and hand held device

<http://anzcp.org/pirs-form/>

Near miss redefined



not mutually exclusive. The latest PIRS form introduces safety 2 with a narrative section asking 5) *What went well "GOOD CATCH" (key points of rescue actions that demonstrate resilience of the system)* - Every near miss has a good catch *Tim Willcox FAZNPC*



What is Safety 2 about?

Incident reporting in healthcare has been slow to emulate that in the aviation industry. The reasons are multi factorial but a combination of workplace culture and the design and management of reporting systems have resulted in a failure to reach the objectives set put in the Institute of Medicine publication *To Err is Human*.

ORIGINAL RESEARCH

Patient safety incident reporting: a qualitative study of thoughts and perceptions of experts 15 years after 'To Err is Human'

Imogen Mitchell,¹ Anne Schuster,² Katherine Smith,³ Peter Pronovost,⁴ Albert Wu²

- poor processing of incident reports (triaging, analysis, recommendations)
- inadequate engagement of doctors
- insufficient subsequent visible action
- inadequate funding and institutional support of incident reporting systems
- inadequate usage of evolving technology

Apart from re thinking our approach to PIRS and addressing the issues of engagement of the profession, ease of access, giving effective feedback we can start introduce Safety 2 thinking into our practice—both as part of PIRS (the Good Catch Question) and by looking to parallels where Safety 2 approaches have been effectively established in the health care setting. The author of Safety 2 is Prof Erik Hollnagel and his book Safety-1 and safety -2 sets out this emerging philosophy.

Safety 2 in action



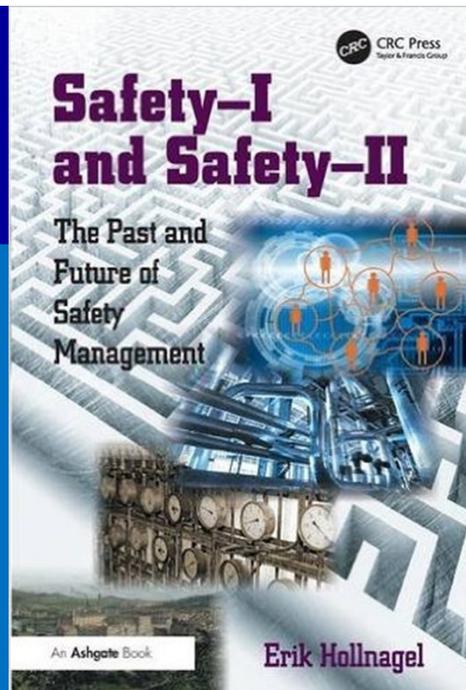
Dr Adrian Plunkett from Birmingham Children's ICU has introduced the concept of Learning from Excellence and is formally capturing and studying peer-reported excellence in healthcare (<http://learningfromexcellence.com/>).

There is an opportunity for the perfusion community to benefit from examples of excellence practiced in perfusion by engaging in actively reporting great things that go on at the sharp end, the coal face, but are frequently isolated to that practice. The idea is that we engage in a simple report form, similar to PIRS but much abbreviated where we share examples of perfusion related excellence in cardiac surgery. A reporting system is under construction that asks: Who did something excellent? What did they do? What can we learn from this? What might we do differently in the future?

We plan to call this EXPLORE— EXTending Perfusion-LearningfrOmReporting Excellence.

ANZCP EXPLORE is at a design stage however we anticipate being able to launch EXPLORE by the second half of the year.

Given Safety-1 and Safety -2 are not mutually exclusive but synergistic we will also select an EXPLORE report of the month for PIRS NEWS



Professor Erik Hollnagel Dr Erik Hollnagel, M.Sc., PhD, is Professor at the Institute of Regional Health Research, University of Southern Denmark (DK), Chief Consultant at the Centre for Quality, Region of Southern Denmark, Visiting Professor at the Centre for Healthcare Resilience and Implementation Science, Macquarie University (Australia), and Professor Emeritus at the Department of Computer Science, University of Linköping (S). He has through his career worked at universities, research centres, and industries in several countries and with problems from many domains including nuclear power generation, aerospace and aviation, software engineering, land-based traffic, and healthcare. His professional interests include industrial safety, resilience engineering, patient safety, accident investigation, and modelling large-scale socio-technical systems. He has published widely and is the author or editor of 22 books, including five books on resilience engineering, as well as a large number of papers and book chapters. The latest titles, from Ashgate, are "Safety-I and Safety-II: The past and future of safety management", "Resilient Health Care", "FRAM – the Functional Resonance Analysis Method", and "Resilience engineering in practice: A guidebook". Professor Hollnagel also coordinates the Resilient Health Care net (www.resilienthealthcare.net) and the FRAMily (www.functionalresonance.com)



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Perspectives on Quality



Perspectives on Quality

Resilient health care: turning patient safety on its head[†]

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[†]We describe a paradigm shift underway in health care. It is time to appreciate its nuances and help make it a success.

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Abstract

The current approach to patient safety, labelled Safety-1, is predicated on a 'find and fix' model. It identifies things going wrong, after the event, and aims to stamp them out, in order to ensure that the number of errors is as low as possible. Healthcare is much more complex than such a linear model suggests. We need to switch the focus to what we have come to call Safety-II: a concerted effort to enable things to go right more often. The key is to appreciate that healthcare is resilient to a large extent, and everyday performance succeeds much more often than it fails. Clinicians constantly adjust what they do to match the conditions. Facilitating work flexibility, and actively trying to increase the capacity of clinicians to deliver more care more effectively, is key to this new paradigm. At its heart, proactive safety management focuses on how everyday performance usually succeeds rather than on why it occasionally fails, and actively strives to improve the former rather than simply preventing the latter.

Key words: patient safety, resilient healthcare, Safety-1, Safety-II, human factors, health system reform

Perfusion Incident Reporting System – PIRS

Report of the month JAN 2017

Date	13/01/2017
Permission to print:	Yes
Incident type	No Harm Incident
Type of incident:	Management
Catagory	myocardial protection
Description:	X-clamp was applied and cold induction dose started. After 800ml of cardioplegia given the heart was still fibrillating. Concern was raised with surgeon. Continuation of cardioplegia given. I checked the water temperature (5.6 degrees) and flow/pressure ratio (300ml/min/200mmHg[line pressure]). All looked normal. Once the full dose was reached (1200ml) the heart was still fibrillating. Surgeon decided to reapply the x-clamp. At this time I noted that the induction bag was still full and my 5/16 cardioplegia line had blood in it [4:1 tubing through a single pump with Sorin CS14 BCD]. I notified the surgeon that I had a problem and called a perfusionist for help. The xclamp was taken off while I changed the 0.2 micron cardioplegia filter (thought to be blocked). The x clamp was reapplied and induction dose restarted. The induction cardioplegia solution [crystalloid] did not flow forward. I promptly increased my occlusions of the roller pump. This moved the clear induction fluid forward and the heart reached asystole. Total time from first xclamp application to asystole was 12 min. The xclamp was taken off intermittently for 2 min. Induction (blood alone) was given at 5.6 degrees celcius. HLM was an overnight set up and pre primed. I checked all occlusions. The cardioplegia occlusion I checked with pressure. This had a arterial pump pressure of 0 and a constant hold of 40mmHg on the cardioplegia roller pump. Therefore I did not increase my occlusion.
Preventive actions	Check the cardioplegia occlusion at an operating pressure (ie line pressure of 200-250) in a preprimed circuit. Secondly at the final main circuit occlusion pressure test confirm that the cardioplegia line pressure is not rising indicating under occlusion of the cardioplegia pump with backflow from the main circuit. Exclude under occlusion of the cardioplegia pump with failure to achieve asystole.
GOOD CATCH - what went	The availability of a colleague to help diagnose the problem
Protocol issue	No
Rule issue	Yes
Skill issue	Yes
Team Issue	No
Violation	No
Manufacturer advised:	No
Discussed with team:	Yes
Hospital incident filed:	No
Ext Authority Advised	No
Procedure acuity:	Elective