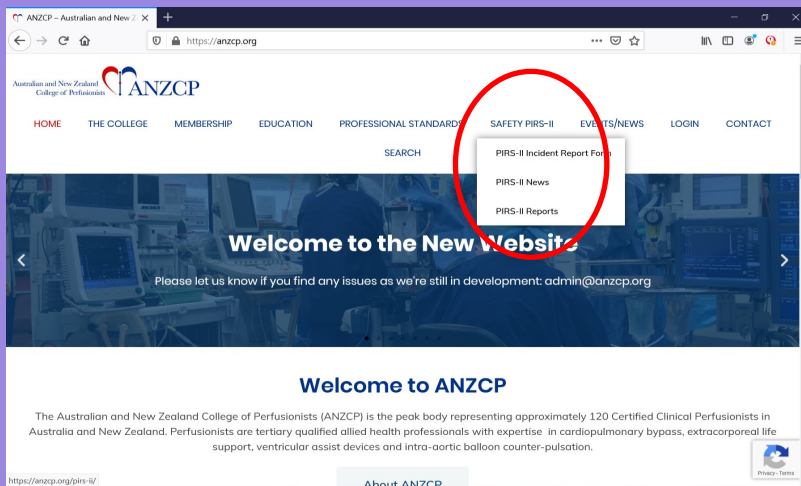


## The Perfusion Improvement Reporting System

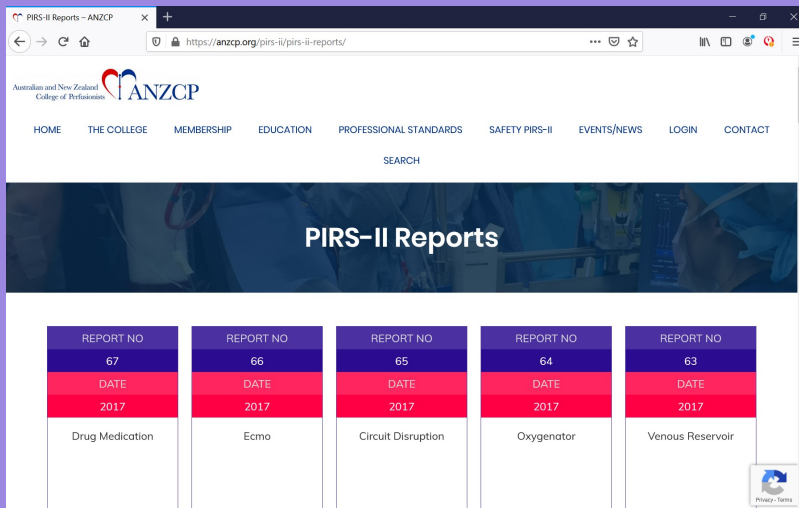
# PIRS2

## PIRS2

The ANZCP has a new website and the PIRS pages have been updated with the primary link



We are in process of updating past reports to a more reader friendly format and will be adding 2018-20 reports shortly. Additional pages with human factors data and resources are planned.



We encourage feedback and suggestions to [PIRS@anzcp.org](mailto:PIRS@anzcp.org)

this issue

NEW WEBSITE  
PIRS2 PROJECT –CHECKLIST SHARE  
PIRS2 SURVEY PUBLISHED

### NEW PIRS Submission Form.

Create a shortcut to you desktop or mobile device

<https://anzcp.org/pirs-ii/> To subscribe or unsubscribe from PIRSList email

[PIRS@ANZCP.org](mailto:PIRS@ANZCP.org)

## PIRS2 Project—*Checklist Share*

**A** review of all incidents reported to PIRS2 over the last 2 years reveals—not unsurprisingly - that the majority of good catches (near miss / no harm incidents) were associated with pre CPB HLM checklists. Either the issues was captured by the pre bypass checklist or the incident resulted in a recommendation to add or change the existing checklist.

There is little recent published information on checklists in perfusion, however checklists in perfusion are ubiquitous. Perfusion professional bodies provide recommendations for checklists in perfusion and the ANZCP recommendations are currently under review (personal communication President ANZCP).

Perfusion checklists vary widely in detail and these may be electronic or paper based, be phased by location (pumproom pre op / OR etc), essential and full check or other iterations to meet local requirements.

Importantly checklists are adapted to react to local incidents that may not be reported widely.

### PIRS2 Project—*Checklist Share*

is an initiative to provide examples of checklists in current use on a dedicated page on the ANZCP Safety PIRS2 website.

We invite you to email a copy/screenshot of the checklists you use to [PIRS@anzcp.org](mailto:PIRS@anzcp.org)

Provide a brief description of how this is used.

# PIRS2 SURVEY Published in JECT

In late August we surveyed 200 subscribers to PIRS-2

The survey set out to get feedback on who is likely to report good catch near-miss and no harm incidents and the value of reports to individual and unit practice. We explored barriers to reporting and what would facilitate reporting with a view to understanding constraints and working to overcome these. The full paper is reprinted with permission in the up coming ANZCP Gazette

*J Extra Corpor Technol. 2020;52:7-12  
The Journal of Extracorporeal Technology*

## Original Articles

### Incident Reporting in Perfusion: Current Perceptions on PIRS-2

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**Abstract:** The Australia and New Zealand College of Perfusionists' (ANZCP) Perfusion Incident Reporting System was established in 1998 and has evolved to an open access on-line incident perfusion reporting system (PIRS-2). Changes were made to PIRS-2 to promote learning from what went well in unexpected situations. A 9-question survey was e-mailed to the PIRS-2 contact group to elicit feedback on attitudes to voluntarily reporting perfusion-related incidents and near-miss events to PIRS-2. In August 2019, a 9-question survey using SurveyMonkey® (San Mateo Ca) was e-mailed to 198 perfusionists currently on the ANZCP PIRS-2 e-mail contacts group. Responses for all responding practicing perfusionists were totaled and expressed as a percentage of the total number of respondents. The respondents were then grouped by region and responses were expressed as a percentage of respondents from each region as well as for grouped responses from Australia/New Zealand (ANZ) and non-ANZ respondents. The response rate was 49.5% with 95 practicing perfusionists

completing the survey. In the 12 months before the survey, 22% of respondents had submitted reports to PIRS-2, whereas 79% had read e-mailed reports. Unit culture was the most frequently cited barrier to reporting from all respondents (19%; 0% to 40% by region). Twenty-five percentage of Australian respondents cited unit culture as a barrier to reporting vs. 0% of New Zealand respondents. A combination of concern of discovery and identification of region ranked second as a barrier for 17% of all respondents. The open access ANZCP PIRS-2 voluntary incident reporting in perfusion was widely viewed as relevant and beneficial to both individual practice and to team performance. A high likelihood to considering reporting incidents is tempered by the well-established barriers of ease of the reporting system, the fix and forget phenomenon, concerns of discovery, and a defensive unit culture. **Keywords:** safety, perfusion, cardiopulmonary bypass, incidents, reporting. *J Extra Corpor Technol. 2020;52:7-12*

We encourage your reports of GOOD CATCH/NEAR-MISS and GOOD CATCH/NO-HARM incidents and invite you to engage in sharing your reflections on observed examples of excellent performance

HELP BUILD RESILIENCE INTO YOUR PRACTICE

Understanding and sharing *what went well* adds resilience to one's practice and to the health care system. Adding resilience is an improvement process.