

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

Reporting trends P.1

Report of the month P.3

CUSTOM SOLUTIONS

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.

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

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

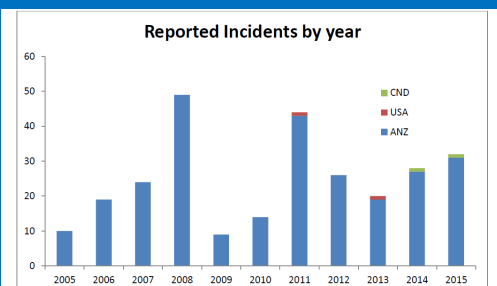
OR use the following link to create a shortcut direct to the PIRS Report Submission form to your desktop and hand held device

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

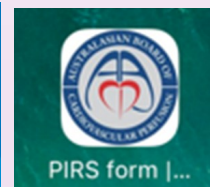
INCIDENT REPORTING TRENDS:

“All that we do as health and disability professionals should be patient focused, and nothing is more important than ensuring the safety of the people in our care”. Professor Alan Merry, Commission Chair HQSC New Zealand.

The manner in which we achieve that aim is a continuing source of debate. The current approach to patient safety labelled Safety-1 that focuses on reducing the number adverse outcomes with a so called find and fix approach is being challenged by the Safety-2 concept of a ground up approach to reconcile work-as-imagined and work-as-done. Incident reporting is not mutually exclusive to either concept. Barriers to reporting are no surprise and include, lack of feedback, complexity of the system, medico-legal fears, time constraints, triviality, no point in reporting near misses, mistrust of the hospital reporting systems, paucity of peer-reviewed literature substantiating incident reporting, blame deflection and probably most commonly a fix and forget culture. Nurses are more likely than doctors to know how to access a report, to have ever completed a report and to know what to do with the completed

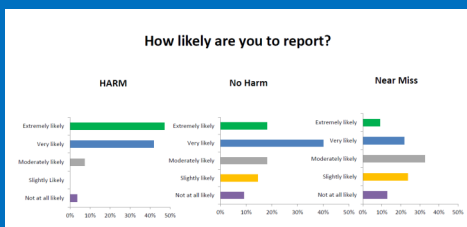


report. In Australia and New Zealand where PIRS has been available on line since 2005 incidents reported is in the order of 0.04-0.2% of CPB. The year to year variability (see graph) is in part a result of how PIRS has been “marketed” but the afore mentioned barriers apply.

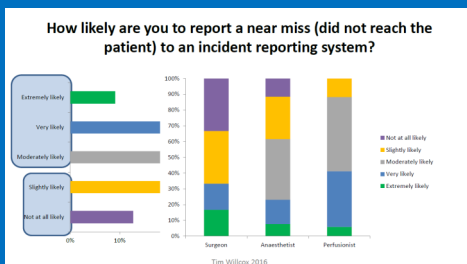


How can we make reporting more relevant?

In July 2016 a short survey that was designed to look at current attitudes to incident reporting by New Zealand perfusionists, cardiac surgeons and cardiac anaesthetists working in the five District Health Boards across the country. The aim was to ascertain whether the intent to report unintended events in New Zealand cardiac surgery differ across profession and region. The secondary aim was to gather qualitative information on reasons to report or not to report to institutional or to external incident reporting systems. The 10 question survey was sent to 31 perfusionists, 48 anaesthetists and 16 surgeons. The results of the survey were presented and discussed at the Perfusion Downunder Meeting and the National Canadian Perfusion Meeting in August and October last year will be submitted for publica-



tion. Overall, NZ surgeons, anaesthetists and



	Not likely	Likely	Chi-Square P-value
Anaesthetist	10 (38%)	16 (62%)	0.0098
Perfusionist	2 (12%)	15 (88%)	
Surgeon	8 (67%)	4 (33%)	

perfusionists were more likely to report more serious incidents. The comparatively high "intent to report" near miss, no harm and harmful incident by perfusionists is not reflective of the actual frequency of reports to ANZCP PIRS. This may be explained by a higher tendency to report by New Zealand perfusionists compared to their Australian counterparts. The reasons for this disparity have not been investigated. While



the New Zealand no faults Accident Compensation legislation that precludes expensive litigation for medical misadventure may lower the threshold for reporting harmful incidents, the vast majority of incidents are near miss and are the most useful in accident prevention.

What do you consider to be the Principal reasons that you would NOT report an EXTERNAL incident reporting system (College / professional affiliated / other)?

Perfusionists

- Ease of reporting
- Confidentiality/trust

distraction
nil
not-much-faith-in-the-process
time it-takes
There-is-no-reason-not-to
no-harm
unnecessary

Tim Willcox 2016

The perfusionists reasons for not reporting to PIRS summarized in the graphic are consistent with current published data on barriers to reporting in healthcare

In any near miss there has been a practice variation that had prevented escalation to harm. This is what Dr Adrian Plunkett - (<http://learningfromexcellence.com/>).

refers to as a GOOD CATCH. PIRS now captures "GOOD CATCH" where we ask what went well - points of rescue actions that demonstrate resilience of the system.

The relative simplicity of ANZCP PIRS coupled with the anonymity of de-identification provides a ready vehicle for reporting. The challenge is to demonstrate the value of reporting by providing timely useful feedback.

Tim Willcox FANZCP - PIRS Ed

Have a look at the UK initiative Learning From Excellence

from the LFE website

Safety in healthcare has traditionally focused on avoiding harm by learning from error. This approach may miss opportunities to learn from excellent practice. Excellence in healthcare is highly prevalent, but there is no formal system to capture it. We tend to regard excellence as something to gratefully accept, rather than something to study and understand. Our preoccupation with avoiding error and harm in healthcare has resulted in the rise of rules and rigidity, which in turn has cultivated a culture of fear and stifled innovation. It is time to redress the balance. We believe that studying excellence in healthcare can create new opportunities for learning and improving resilience and staff morale.

We have been capturing and studying peer – reported excellence in healthcare for over 2 years. This site is a source of open – access resources and ideas to promote this initiative and share experiences.

Additional information and resources are now available on the resources page. For our latest messages please visit our blog page.

<http://learningfromexcellence.com/blog/>

Contact
PIRS@anzcp.org

Reports to

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

Perfusion Incident Reporting System – PIRS

Report of the month - Feb 2017

Permission to print:	Yes
Incident type	No Harm Incident
Type of incident:	Equipment
Catagory	Venous Reservoir
Description:	After approx. 10 mins on bypass (AVR + MVR + myectomy) I noticed that I had blood leaking from around the cardiotomy turret (Inspire 6 - LivaNova). I called the co-ordinating perfusionist who happened to be one of the most experienced perfusionists in the universe. After a brief discussion of options (adding a second reservoir and rerouting the suckers) He suggested applying bone wax around the join. This worked really well, and there was no further leaking during the case.
Preventive actions	Discussed with manufacturer and advised this was a known problem related to the gasket lubricant and reservoir moulding that was undergoing a 2 stage fix (stage 1 new lubricant , stage 2 revised moulding - still in process. If recurrent then consider using a dual reservoir that has not had the same problem until the new moulding fix is in place. Of interest was the fact that as users of the product we were unaware of this same fault having occurred elsewhere.
GOOD CATCH - what went	Team collaboration to find an effective minimalist solution of applying bone wax to a minor leak and avoiding any interruption to the procedure
Protocol issue	No
Rule issue	No
Skill issue	No
Team Issue	No
Violation	No
Manufacturer advised:	Yes
Discussed with team:	Yes
Hospital incident filed:	No
Ext Authority Advised	No
Procedure acuity:	Elective
Commentary	This is the second report of this problem in quick succession to PIRS. While this was a relatively minor incident, a particular point of interest is the fact that the user was not aware of a previous rash of reports of the same issue with the same device in the same region. The explanation for not sharing this knowledge was that it was thought to be isolated to one centre. There had been no previous reports to PIRS of this gasket leak - neither from the centre where it occurred nor from the supplier. Under reporting is well known however this raises the opportunity for a closer partnership with the industry in voluntary reporting of near miss and other product related issues. PIRS is looking to initiate a dialogue with the corporate sector on how this might be usefully progressed - PIRS Ed

PIRS NEWS REPORT OF THE MONTH