PIRS News

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ANZCP
Australian and New Zealand College of Perfusionists

PIRS

New ANZCP Website

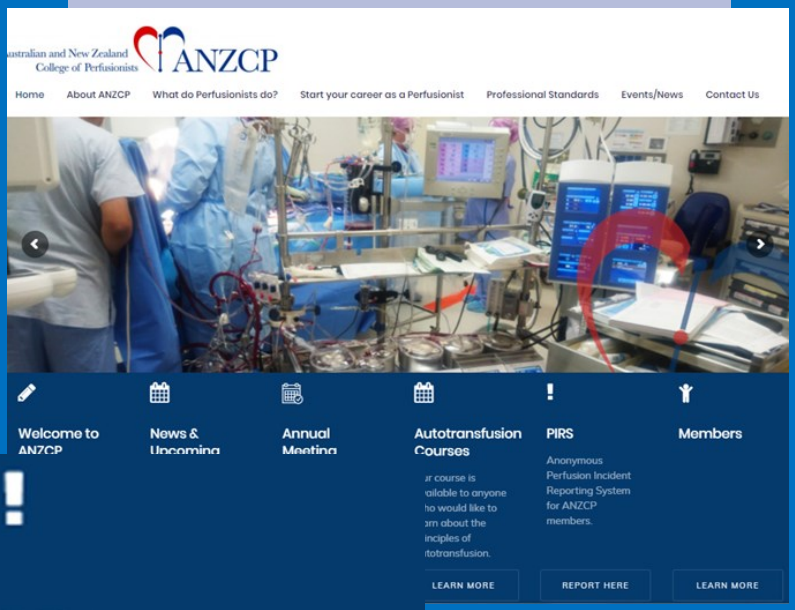
The new PIRS form is now available on the recently launched renewed ANZCP website.

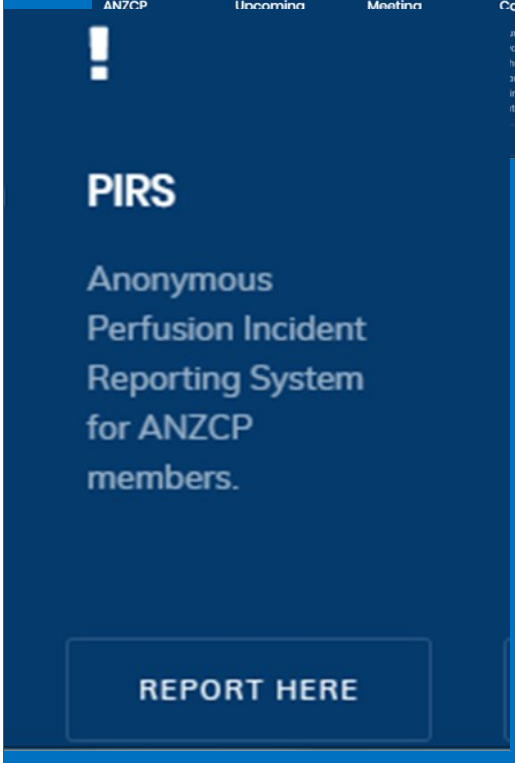
To file reports go to:

http://anzcp.org/

We encourage feedback and suggestions to PIRS@anzcp.org

this issue





NEW PIRS Submission Form.

Create a shortcut to you desktop or mobile device

http://anzcp.org/pirs/

To subscribe or unsubscribe from PIRSList email

PIRS@ANZCP.org

Updates to PIRS

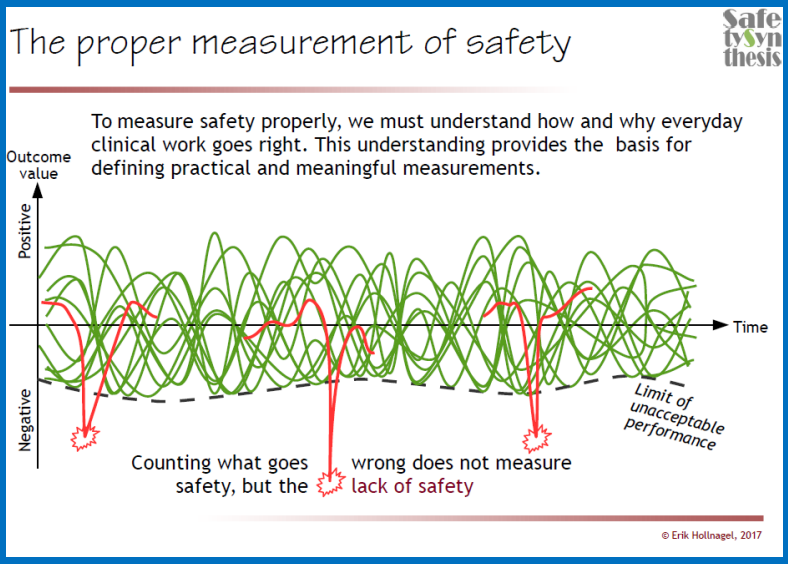
- We have added a free text box asking "*What could we have done better*?" This is a reflection on the immediate actions taken that may form part of a future preventive action plan and in addition to asking "*What went well*?" is part of the move to include Safety –II concepts .
- Summary reports by incident category for past years have been added under the PIRS Reports tab.

PIRS NEWS - The value incident reporting and the case for perfusion registries

Reporting incidents has value especially reporting near miss situations where compensating practice variations have prevented a worse outcome - the so called "*good catch*" or "what went well" to prevent further badness occurring. The ANZCP PIRS reports where permission to print is given provides many novel solutions to situations that we might well encounter. These are summarized by category on the PIRS web page Reports tab.

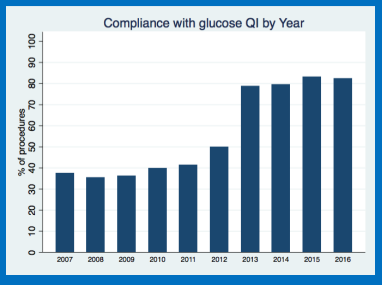
It is well established that incident reporting systems suffer from underreporting [1] and the PIRS estimates a capture of about 2% of incidents consistent with publications. Coupled with the option for reports to be published or not, the lessons from incident reporting are relatively few.

By comparison the ability to measure what goes right - the Safety II concept - provides infinitely more lessons for improvement as *what goes right* is constantly occurring or, in the words of Erik Hollnagel a dynamic non event (the green stuff on the slide).

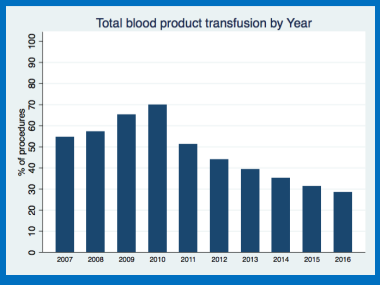


So how in perfusion does one measure dynamic non events—the stuff that goes right? One answer is registry databases. The ability of current perfusion data management systems to gather perfusion data in real time provides a powerful tool for amassing and analysing everyday clinical work that goes right. This provides the tools for benchmarking practice on centres and individuals with others and a basis for quality improvement.

The AMSECT PERForm registry and the Australia New Zealand Collaborative Perfusion Registry (ANZCPR— formerly the PDU research database) are examples of Safety II in action. The ANZCPR has demonstrated the value of this type of reporting in QA initiatives to reduce transfusion rates and improve glucose and temperature control.



From 2017 ANZCPR site data Report for Auckland City Hospital



[1] Hewitt TA, Chreim S. Fix and forget or fix and report: a qualitative study of tensions at the front line of incident reporting. BMJ Qual Saf. 2015;24(5):303-10.

PIRS NEWS REPORT OF THE MONTH

PIRS 2018

Permission to print:	Yes
Incident type	No Harm Incident
Type of incident:	Equipment
Catagory	Electrical / electronic
Description:	Stockert S5 HLM using CP5 centrifugal pump driver. The CP5 had an adaptor plate to drive the Affinity CP. Whilst on CPB - upon cooling in anticipation of DHCA - the CP5 console came up with an internal? error message and ceased to operate the driver -i.e., there was no rpm generated. The perfusionist clamped both the arterial and venous lines - informed the surgeon of the situation - then turned off the console and turned it back on again (i.e., rebooted the system). The rebooted console was functional and remained so for the duration of the case. A down time at 28 deg Celsius was about a minute. An explanation provided the the company is that the adaptor plate - which is not supplied by them (being supplied by the company supplying the Affinity CP disposable) - was the cause of the error signal, whereby the expected rpm do not match the actual rpms measured in the driver unit.
Preventive actions	A colleague was alerted to bring in a Medtronic biopump and driver - that was positioned adjacent to the now functioning CP5 driver; allowing the affinity CP to be re-positioned into this new driver rapidly. During DHCA the adaptor plate was swapped with another one. A manual pump driver was already available to the primary perfusionist.
GOOD CATCH - what went	The centrifugal pump system can rapidly be rescued by a standalone Medtronic biopump and associated driver
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	The use of centigugal pump adaptors to accommodate pump heads not compatible with the console is not uncommon, however the does introduce an added level of risk that may be difficult to defend in the event of a serious adverse event as a result of a pump failure. This report highlights the importance not only of a rescue plan that is practiced but also the importance of "N+1" perfusionists on site. PIRS Ed