

The Perfusion Improvement Reporting System

PIRS-II

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PIRS has changed

THE FOCUS IS ON PROCESS IMPROVEMENT HENCE THE NAME CHANGE TO

The Perfusion Improvement Reporting System

We have changed **THE INCIDENT REPORT FORM** further refocusing PIRS towards SAFETY-II concepts of capturing WHAT WENT WELL in situations of NEAR-MISS and NO-HARM INCIDENTS.

We have added **THE REFLECTION ON EXCELLENCE REPORT FORM** made available from the **LEARNING FROM EXCELLENCE** website

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

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The Good Catch Focus P.2

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this issue

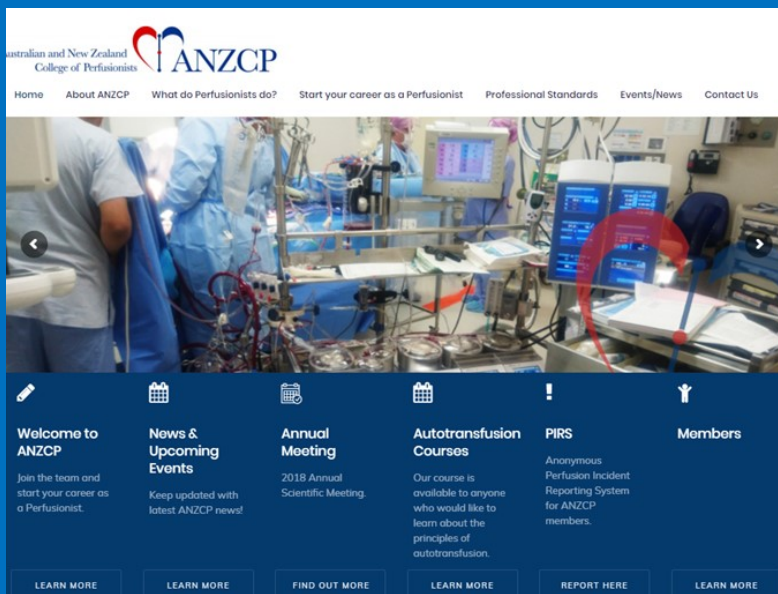
NEW PIRS Submission Form.

Create a shortcut to you desktop or mobile device

<https://anzcp.org/pirs-ii/>

To subscribe or unsubscribe from PIRSList email

PIRS@ANZCP.org



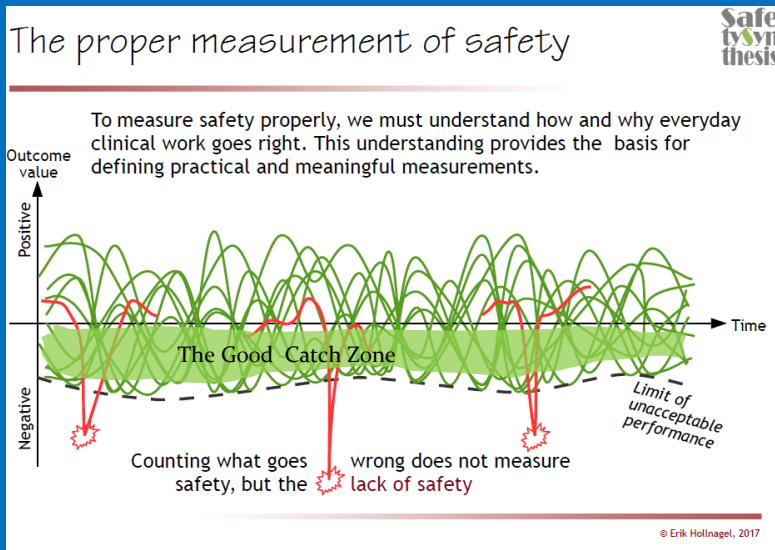
We encourage feedback and suggestions to PIRS@anzcp.org

PIRS-II The *Good Catch* Focus

PIRS is a unique voluntary perfusion reporting system providing a resource for clinicians to improve their practice by understanding how unintended events perioperatively have been managed. Since 2004 to 2016 PIRS focused on incident / accident reporting from a Safety-I perspective. Over the last 2 years we have moved to include Safety-II concepts both by promoting Safety-II theory in the PIRS NEWS bulletins and adding a section in the online PIRS report form for narrative on the *Good Catch*—what went well to avert further harm.



Reports to PIRS remain very infrequent and we know that the less serious the harm the less likely these are reported—the fix and forget phenomenon. However nearly these unintended events are associated with compensating *Good Catch* performance.



We can add a layer to Prof Erik Hollnagel's diagram The Proper Measurement of Safety between the baseline of negative performance and above the limit of unacceptable performance and call it *The Good Catch Zone*.

These are what we now are calling:

Good-Catch / Near Miss and

Good Catch / No Harm Incident - in

effect the zone of what went well in unintended events.

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

PIRS-II The *Reflection on Excellence* Focus



LEARNING FROM
EXCELLENCE

A CALL TO LEARN FROM WHAT
GOES WELL IN HEALTHCARE

Learning from Excellence is a concept developed by Dr Arian Plunkett and his team at Birmingham Children’s Hospital (UK). The LFE website—<https://learningfromexcellence.com/>

The LFE group has been capturing and studying peer – reported excellence in healthcare since 2014. *“We tend to regard excellence as something to gratefully accept, rather than something to study and understand. ... We believe that studying excellence in healthcare can create new opportunities for learning and improving resilience and staff morale”*

PIRS-II now includes a new report form provided by the LFE team that will enable perfusionists to report examples of observed excellence in practice that can be shared on the PIRS_II website and featured in PIRs-II NEWS bulletins.

“Excellence” is not predefined but as you see it. Many instances reported to LfE are examples of ‘everyday excellence’ - in essence smart ideas and “workarounds”.

The report form

PIR-II FORM 2 REFLECTION ON EXCELLENCE REPORT

1) Describe the excellence you wish to reflect on (please be careful not to include any patient identifying information):

2) What was particularly good?

3) How did it feel to be involved / to witness this episode?

4) How could this excellence be re-created / amplified?

5) What will you do differently as a result of this reflection?

“Have you seen everyday excellence recently? Try actively looking for it, by watching your colleagues go about their work; and you might be pleasantly surprised about how much you learn.”

Adrian Plunkett