

## Perfusion Safety References

1. Stoney WS, Alford WC Jr, Burrus GR, Glassford DM Jr, Thomas CS Jr. Air embolism and other accidents using pump oxygenators. *Ann Thorac Surg.* 1980;29:336–40.
2. Power G, Miller A. Preliminary analysis of perfusionists' strategies for managing routine and failure mode scenarios in cardiopulmonary bypass. *J Extra Corpor Technol.* 2007;39:160–7.
3. Kurusz M, Conti VR, Arens JF, Brown JP, Faulkner SC, Manning JV Jr. Perfusion accident survey. *Proc Am Acad Cardiovasc Perfusion.* 1986;7:57–65.
4. Jenkins OF, Morris R, Simpson JM. Australasian perfusion incident survey. *Perfusion.* 1997;12:279–88.
5. Svenmarker S, Haggmark S, Jansson E, Lindholm R, Appelblad M, Aberg T. Quality assurance in clinical perfusion. *Eur J Cardiothorac Surg.* 1998;14:409–14.
6. Runciman WB. Report from the Australian patient safety foundation: Australasian incident monitoring study. *Anaesth Intensive Care.* 1989; 17:107–8.
7. Svenmarker S, Haggmark S, Jansson E, Lindholm R, Appelblad M, Aberg T. Quality assurance in clinical perfusion. *Eur J Cardiothorac Surg.* 1998;14:409–14.
8. Mejak BL, Stammers A, Rauch E, Vang S, Viessman T. A retrospective study on perfusion incidents and safety devices. *Perfusion.* 2000;15:51–61.
9. Bartels CMD, Gerdes AMD, Babin-Ebell JMD, et al. Cardiopulmonary bypass: Evidence or experience based? *J Thorac Cardiovasc Surg.* 2002;124:20–7.
10. Palanzo DA. Perfusion safety: Defining the problem. *Perfusion.* 2005;20:195–203.
11. Evans SM, Berry JG, Smith BJ, et al. Attitudes and barriers to incident reporting: A collaborative hospital study. *Qual Saf Health Care.* 2006; 15:39–43.
12. Charriere JM, Pelissie J, Verd C, et al. Survey: Retrospective survey of monitoring/safety devices and incidents of cardiopulmonary bypass for cardiac surgery in France. *J Extra Corpor Technol.* 2007;39:142–57
13. Kurusz M. Invited commentary: Re: A retrospective survey of monitoring/safety devices and incidents of cardiopulmonary bypass for cardiac surgery in France. *J Extra Corpor Technol.* 2007;39:158–1559.
14. Merry AF. Human factors and the cardiac surgical team: A role for simulation. *J Extra Corpor Technol.* 2007;39:264–6. Willcox TW, Baker RA. Surveys and safety in perfusion practice. *J Extra Corpor Technol.* 2007;39:139–41.
15. Willcox TW, Baker RA. Surveys and safety in perfusion practice. *J Extra Corpor Technol.* 2007;39:139–41.
16. Merry AF. Safety in anaesthesia: Reporting incidents and learning from them. *Anaesthesia.* 2008;63:337–9.
17. Bilimoria KY, Kmiecik TE, DaRosa DA, et al. Development of an online morbidity, mortality, and near-miss reporting system to identify patterns of adverse events in surgical patients. *Arch Surg.* 2009;144: 305–11;
18. Groenenberg I, Weerwind PW, Everts PA, Maessen JG. Dutch perfusion incident survey. *Perfusion.* 2010;25:329–36.

19. Matte GS, Riley D, LaPierre R, et al. The Children's Hospital Boston non-routine event reporting program. *J Extra Corpor Technol.* 2010;42:158–62
20. Spiess BD, Wahr JA, Nussmeier NA. Bring your life into FOCUS! *Anesth Analg.* 2010;110:283–7.
21. Wadhwa RK, Parker SH, Burkhart HM, et al. Is the 'sterile cockpit' concept applicable to cardiovascular surgery critical intervals or critical events? The impact of protocol-driven communication during cardiopulmonary bypass. *J Thorac Cardiovasc Surg.* 2010;139:312–9.
22. Martinez EA, Thompson DA, Errett NA, et al. Review article: High stakes and high risk: A focused qualitative review of hazards during cardiac surgery. *Anesth Analg.* 2011;112:1061–74.
23. Hicks GL, Jr., Gangemi J, Angona RE, Jr., Ramphal PS, Feins RH, Fann JI. Cardiopulmonary bypass simulation at the Boot Camp. *J Thorac Cardiovasc Surg.* 2011;141(1):284–92.
24. Health Quality & Safety Commission. Making Our Hospitals Safer: Serious and Sentinel Events reported by District Health Boards in 2010/11. Wellington, New Zealand: Health Quality and Safety Commission; 2012.
25. Levinson D. Hospital Incident Reporting Systems Do Not Capture Most Patient Harm. Washington, DC: US Department of Health and Human Services, Office of the Inspector General; 2012. Contract No.: Report No. OEI-06-09-00091.
26. Willcox TW. D'ou venons-nous/que sommes nous/ou allons nous? Accidents are inevitable. *J Extra Corpor Technol.* 2012;44:P2–5.
27. Petrik EW, Ho D, Elahi M, Ball TR, Hofkamp MP, Wehbe-Janeck H, et al. Checklist usage decreases critical task omissions when training residents to separate from simulated cardiopulmonary bypass. *J Cardiothorac Vasc Anesth.* 2014;28(6):1484–9.
28. Braithwaite J, Wears RL, Hollnagel E. Resilient health care: Turning patient safety on its head. *Int J Qual Health Care.* 2015;27: 418–20.
29. 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;24:303–5.
30. Mitchell I, Schuster A, Smith K, et al. Patient safety incident reporting: A qualitative study of thoughts and perceptions of experts 15 years after 'To Err is Human'. *BMJ Qual Saf.* 2016;25:92–9.
31. Willcox TW, Baker RA. Incident Reporting in Perfusion: Current Perceptions on PIRS-2. *J Extra Corpor Technol.* 2020;52(1):7-12.

### **ON LINE Perfusion Safety Resources**

<https://www.amsect.org/page/perfusion-safety>

<https://www.scps.org.uk/safety/safety-archive>

<https://learningfromexcellence.com/>

<https://www.youtube.com/watch?v=VZio7lfyDOU>

(Erik Hollnagel Video on delivering resilient healthcare)

Please contact Tim Willcox via [pirs@anzcp.org](mailto:pirs@anzcp.org) for further information.