CPB FMEA #39 Impaired perfusionist

Friends-

This is another FMEA that is difficult for me to write. It is easy to change a failing oxygenator or fix a broken pump. But how do you fix a broken perfusionist? Even more importantly, how do you know when a perfusionist is broken? The failure is in allowing a broken perfusionist to run the pump.

I have written FMEAs dealing with fatigue, fear and skills decay after a vacation. But this is different. Perfusionists have a responsibility to protect patients by recognizing their own impairment or by identifying impaired colleagues who are unable to practice with reasonable skill and safety. Perfusionists recognizing impairment in themselves or others should report concerns confidentially to an appropriate supervisor and seek guidance from Human Resources to comply with the many laws, regulations and corporate policies governing these situations.

One of the most difficult things to do is confront another perfusionist who is impaired. It is difficult to accuse a co-worker of substance abuse because of the fear of reprisal. Nonetheless, steps should be taken to confront a co-worker or notify the manager of the problem. That is why I think it is important for a Chief Perfusionist or other supervisor to maintain some level of aloofness with his/her staff. Leadership is not about making friends. This leadership aspect is about keeping patients safe, objectively assisting staffers when they need help or even terminating them when the situation warrants.

Self-identifying an impairment or accepting the recognition of an impairment from another is difficult because the manifestations vary and many professionals will typically suppress or deny any suggestion of a problem. Estimates are that about 10-15% of medical professionals will be impaired by alcohol or drugs at some point in their careers (not to mention all of the other factors that can lead to impaired clinical performance). This is the same percentage as the general population. So perfusionists are not immune.

I have had several encounters with impaired staffers over the years; most turned out well. Unfortunately, I had to terminate some. When I had to fire someone, I always felt that I wasn’t just terminating that individual, I was firing their spouse, their kids, their mortgage company, their health insurer, their college fund, etc. I hated to do that, and I resented the staffer when I was forced to do it.

One of the volunteer FMEA reviewers relayed this story to me: ”I and another perfusionist were called in on a Saturday many years ago on an emergency case. Everything seemed to be going well during set up and initiation but as you know there is a lull while distals are being attached. As I sat beside my partner who was primary I began to notice that he appeared drowsy. Rather than say anything to alarm I simply began to ask questions about the case and various other things to engage him in conversation. The case went well and after we were changing back into street clothes he came over and thanked me for saving his butt. It seems he had been in the habit of indulging in some of those funny cigarettes as we used to call them on the weekends and got caught high on an emergency. I was not aware he even did this up till then. When he realized what I was trying to do and how impaired he was it scared the hell out of him. To my knowledge he never did that again and learned his lesson and all ended well.” (Another good argument for having a second person on the case.-gg)

Another volunteer FMEA reviewer brought up the potential for hiring a perfusionist with a known, unresolved impairment. He became aware of a perfusionist being considered for a staff position who had a history of an unresolved impairment. The applicant characterized his problem as a "medical disability". The hospital was prepared to hire the applicant. Our reviewer encouraged the hospital to do a little more inquiry to this person's background. Evidence of misrepresentation and disciplinary action in another state was found online. Despite this particular case, many times healthcare workers with an unresolved impairment can move state to state to avoid detection because there is no central database. This is particularly true of perfusionists who are not licensed in all states.

Early intervention is the key in keeping patients safe and preventing an employee’s termination. So learn the symptoms well and maintain good situational awareness about someone’s behavior rather than just “letting it slide”. Let me know if you have any other ideas.

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CPB FMEA #39 Impaired perfusionist

FAILURE:

Failure to prevent an impaired perfusionist from performing clinical activities.

EFFECT:

1. The perfusionist is unable to practice with reasonable skill and safety.
2. The potential for a lethal complication is increased when a perfusionist is impaired.

CAUSE: Impairment is most commonly caused by:

1. physical illness
2. mental illness
3. emotional stress
4. loss of motor skills
5. loss of cognitive functioning
6. drug abuse
7. alcohol abuse

(Human fatigue, fear and skills decay can temporarily impair a perfusionist, but they are discussed in separate FMEAs.)

PRE-EMPTIVE:

1. Each perfusionist should review the organization’s policy and procedures (P&P) for identifying the impaired perfusionist.
2. P&P should contain steps to relieve an impaired perfusionist from duty if necessary.
3. P&P should contain a substance abuse and employee assistance program referral process.
4. Maintain situational awareness of staff members for impairment symptoms as follows:

Immediate physical symptoms

a. In ability to stand or walk normally

b. Red or watery eyes

c. Stuffy, draining nose or excessive sneezing

d. Slow, slurred, garbled or rapid speech

e. Excessive fidgetiness

f. Discolored, pale or red face or skin

g. Altered mental state or demeanor

h. Loss of bowel or bladder control

i. GI disturbances leading to vomiting.

j. Smell of alcohol

k. Overt intoxication

l. Needle marks

Work-related symptoms:

a. Late to appointments; increased absences; unknown whereabouts

b. Unusual pump set-up times, either very early or very late

c. Increase in OR/surgical staff complaints

d. Increase in secrecy

e. Decrease in quality of care; careless decisions

f. Incorrect or incomplete charting

g. Decrease in productivity or efficiency

h. Increase in conflicts with other perfusionists or OR/surgical staff personnel.

i. Increase in irritability and aggression

j. Failure to respond to “on call” situations

k. Past erratic job history

Home related symptoms:

a. Withdrawal from family, friends, and community

b. Legal trouble (i.e, DUI, drug or domestic violence arrest)

c. Increase in accidents

d. Increase in medical problems and doctor's visits

e. Increase in aggression, agitation, and overt conflict with family and friends

f. Financial difficulties

g. Deterioration of personal hygiene

h. Emotional disturbances; depression, anxiety, and moodiness

5. Institute a system utilizing a secondary perfusionist capable of recognizing and relieving and impaired perfusionist or use specially trained perfusion assistants who can actively seek help and notify management.

MANAGEMENT:

1. Carefully document any changes in the suspected impaired perfusionist’s behaviors.
2. Avoid any enabling behavior such as frequently covering call or completing work details for the impaired perfusionist.
3. Confront the perfusionist or notify the manager of suspicions. Any confrontation should include resources to aid the impaired perfusionist.
4. Relieve an impaired perfusionist from duty if necessary. There are many laws and regulations pertaining to temporarily removing an employee from duty as a result of impairment. The assistance of Human Resources (HR) should always be sought in these situations.
5. Resuming clinical duty may require a Fitness-for-Duty Certification. <http://mrsc.org/getmedia/0EC1F355-A290-484F-8659-ECC9E0404BA8/m58fitness.aspx>.
6. Consider other issues
7. Loss of confidentiality
8. Loss of trust and respect of manager or other perfusionists
9. Fear of losing job and license
10. Stigma of having a physical, mental, emotional or addictive impairment
11. Reluctance of other perfusionists to get involved.
12. If behavior is repeated and the situation warrants it, be prepared to terminate the impaired perfusionist’s employment by proper procedure under the direction of HR.

RISK PRIORITY NUMBER (RPN):

A. Severity (Harmfulness) Rating Scale: how detrimental can the failure be:

1) Slight, 2) Low, 3) Moderate, 4) High, 5) Critical (I would give a Critical RPN, 5.)

B. Occurrence Rating Scale: how frequently does the failure occur:

1) Remote, 2) Low, 3) Moderate, 4) Frequent, 5) Very High. (The Occurrence is Remote, the RPN would be a 1.)

C. Detection Rating Scale: how easily the potential failure can be detected before it occurs:

1) Very High, 2) High, 3) Moderate, 4) Low, 5) Uncertain. (The Detectability RPN equals 4. This failure can be difficult to detect because the perfusionist may be able to hide the impairment.)

D. Patient Frequency Scale: 1) Only a small number of patients would be susceptible to this failure, 2) Many patients but not all would be susceptible to this failure, 3) All patients would be susceptible to this failure. (All patients would be at risk for this failure so the Patient Frequency RPN would be 3.)

Multiply A\*B\*C\*D = RPN. The higher the RPN the more dangerous the Failure Mode. The lowest risk would be 1\*1\*1\*1\* = 1. The highest risk would be 5\*5\*5\*3 = 375. RPNs allow the perfusionist to prioritize the risk. Resources should be used to reduce the RPNs of higher risk failures first, if possible. (The total RPN for this failure is = 5\*1\*4\*3 = 60. The total RPN (60) is based on the presence of secondary personnel participating during CPB. If the perfusionist is working solo without secondary personnel the Occurrence and Detectability RPNs would both be increased by 1 to give a Total RPN of 5\*2\*5\*3 = 150.)