

## Frequently Asked Questions to the AmSECT Standards and Guidelines

**Q: Standard 1.3 says emergency protocols should be accessible to help guide the user during an event, what format should they be available?**

A: Your institution should determine what is the best format to be easily accessible, whether that's written, electronic, or another method. It is up to your institution to determine what 'events' require a protocol; The protocols should help guide the user during an event, users should already be familiar with and understand the protocols in place (see Standard 1.1, Standard 1.2, and Standard 2.2).

**Q: Why did you remove annual competencies from Standard 2.5?**

A: During our review and revision process, the 'annual competencies' was removed as this standard was meant for onboarding and initial training of staff (see [AmSECT Clinical Resources webpage](#) for resources on orientation and onboard training). The annual competencies and CEUs are still addressed in Standard 2.1 and Standard 2.2.

**Q: What does a post-procedure debrief entail, what if we don't have time for it? (Guideline 3.3 to Standard 3.3)**

A: A post-procedure debrief does not have to be lengthy or formal to be effective (e.g., an effective debrief may occur during chest closure). A debrief provides an opportunity at the end of every case for anyone in the room to voice safety events, equipment issues, changes to surgeon protocol, post-operative instructions, or even positive events (e.g., "good catches"). Importantly, debriefing is likely already occurring in your operating room using the criteria mandated by the [World Health Organization](#).

A: A formal handoff should be performed during any transfers of care. AmSECT provides an example of how perfusionists may standardize communication when transferring primary perfusionist role See "[I PASS THE CLAMP](#)". The active perfusionist at the time of the debrief should be the one to participate in the post-procedural debrief.

**Q: Does AmSECT's Guideline 3.4 now mean that I am supposed to discuss every change I make with my surgeon?**

A: Guideline 3.4 is meant to encourage discussion with the surgical team in the event there are changes to the patient's intended care plan. The specifics regarding how your team implements Guideline 3.4 (e.g., the treatment plan and what counts as a deviation) may be specified through an institutional protocol (i.e., Standard 1.1).

**Q: Standard 7.8 says I should continually monitor oxygen fraction and gas flow rates, what does that mean?**

A: Continually in this document is intended to describe an action that recurs frequently or regularly, as compared to the word 'continuously' that describes an action that occurs without ceasing. In this instance, your FiO<sub>2</sub> and gas flow rate should be observed frequently, note that monitor does not imply documentation.

**Q: How am I supposed to calculate my DO<sub>2</sub> on pump without buying new equipment or being distracted by calculating a long formula (i.e., Standard 9.2)?**

A: Please reference the DO<sub>2</sub> chart, on the [AmSECT Clinical Resources webpage](#), to assist with estimating DO<sub>2</sub> while on bypass without using additional monitors or calculators. This Standard does not address that the number be recorded, the frequency of estimation or threshold of DO<sub>2</sub> prior to any action, as these specifics should be specified through an institutional protocol (i.e., Standard 1.1). Please see Standard 9.2 footnotes for relevant references.

**Q: How long am I supposed to keep my circuit setup according to Standard 14.4?**

A: No specific duration is listed with this Standard, as the implementation of this Standard should be done at the local level through a protocol (i.e., Standard 1.1). The important part here is that your institution acknowledges the setup process (e.g., aseptic technique) and storage location (e.g., high traffic area, movement or transport of HLM, humidity controlled environment) and then determines the best protocol for your center.

**Q: In the N+1 Model mentioned in Guideline 15.1, do students count? Do standby cases count within the N+1 Model?**

A: Perfusion students and assistants do not count towards qualified staff. Non-qualified staff members (e.g., students or staff who have not completed training adequate to meet the requirements of the activity) should not be included in calculating the minimum safe number of staff.

A: Yes, standby cases contribute to the N+1 model and count towards the required 'N'. In other words, each standby case must have a dedicated perfusionist, this is reference to Standard 14.2, which states that "one Perfusionist shall be assigned for each such standby procedure". Standby procedures are defined by 14.1 as "procedures identified preoperatively to be at elevated risk of requiring conversion to an extracorporeal support procedure shall have a protocol for transition to such procedures."

**Q: Does the 60-minute call window mentioned in Guideline 15.2, refer to hospital travel time or pump ready time?**

A: Guideline 15.2 does not specify this level of detail. We encourage centers to implement this guideline through internal service line discussions to meet your local patient safety needs.

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**Q: What type of data registry do I have to use for Standard 17.2?**

A: A clinical registry or database is a collection of information relevant to perfusion metrics that can be reviewed and analyzed to help advance perfusion quality and outcomes. The data may be collected or and/or analyzed at any level (i.e., local, state, national, or international). While the specific registry or database is not specified in Standard 17.2, AmSECT's official perfusion registry is the PERForm registry (see <https://mstcvs.org/home/perform-registry/> for more details).

**Q: Does Guideline 19.2 mean that I have to purchase double stock for every disposable?**

A: 'Identify' here means to find an alternative vendor that you could use in advance of an issue. This guideline does not mean you have to purchase and stock backup supplies. We intend that the local institution makes its own determination regarding the number of days on hand of any particular product. The nature of the guideline speaks to the identification of alternate disposable sources should specific manufacturer products become abruptly unavailable. (See Supply Management Resource on the [AmSECT Clinical Resources webpage](#) for more information)