ECRI Institute PSO
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PSO Monthly Brief

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Crash Carts Shouldn't Crash the System

Imagine a code is called over the hospital's public address system: The emergency response team assembles, heads to the location to stabilize the patient, and grabs the necessary supplies from the crash cart. Now, imagine that the patient needs to be intubated. A staff member pulls open the drawer on the cart, removes the laryngoscope…and the batteries are dead. The staff member scrambles for replacement batteries. They're dead too. What happens to the patient?

You might say that ECRI Institute is familiar with the crash cart—after all, our founder designed and patented the first one in 1965. And crash carts are called crash carts for a reason—they are intended to be used to keep patients from crashing. However, ECRI Institute PSO has seen far too many events in which necessary supplies are not present on crash carts when a code is called, or when the wrong item has been restocked and cannot be used.

The hypothetical situation above is not hypothetical—it is an actual event received by ECRI Institute PSO. When crash carts are left depleted, when the wrong items are restocked, or when items are not reviewed regularly, it becomes likely that the cart will not suffice when a patient needs an emergency response. When that happens, staff members need to grab another cart in the hope that it has the necessary supplies.

Crash cart supplies should be standardized, as should the layout of the supplies in the cart, across the organization to ensure that staff members can quickly access needed items or medications. Likewise, a process must be established to regularly check cart contents and to maintain vigilance in the face of what can become a monotonous daily routine.

Checklists, such as this one from the Pennsylvania Patient Safety Authority, can help to verify the presence of all supplies. When supplies are restocked, ensure that the exact items are included, as well; ECRI Institute PSO has seen an event in which, for example, the defibrillator pads restocked in the cart were incompatible with the defibrillator on board.

If an error stocking a crash cart contributes to an adverse event, the organization should do everything it can to learn from the event. What factors led to or compounded the event? What prevention strategy can be implemented so that the same event is unlikely to happen again? Don't let the crash cart crash the system; ensure that an emergency response can always proceed uninhibited.

Contact us, and let us demonstrate how we can help you.

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How Can We Help You?

Whether you have questions about the final rule or want to learn more about ECRI Institute PSO and/or support for other PSOs, we would be happy to hear from you. Please contact ECRI Institute at pso@ecri.org or call (610) 825-6000, ext. 5558.