

Table 2. Pennsylvania Patient Safety Authority Missing Items and Equipment with Suggested Action Plan, 2008

TYPE	ISSUE*	SUGGESTED ACTION
Airway	No Ambu bag available (2) Ambu bag missing mask (2) No stylet in intubation box (3) Bronchial set missing prisms Missing blade sizes (2) Airway box missing endotracheal tube and outdated No adult bag mask available No suction machine available on unit (4) Suction machine failed Oxygen tank empty Missing spigot on oxygen tank	Include on crash cart inventory checklist Include expiration date checks on inventory checklist Make sure inventory checklist includes all required sizes Identify locations/areas for accessible suction equipment Include testing of suction equipment during crash cart checks Include oxygen tank level checks as part of cart checklist Include all parts in oxygen checklist (tank, tubing, spigot)
Cardiac	Red respiratory box unlocked and dirty Defibrillator paddle failed Defibrillator did not have pacing capabilities Defibrillator battery dead (3) Pacemaker wire and introducer mislabeled and not compatible	Set frequency of box/cart checks Include testing of defibrillation equipment during crash cart checks Consider purchase of defibrillation equipment with pacing capabilities Include testing of defibrillation equipment during crash cart checks Include on crash cart inventory checklist
Medication	No monitor available on unit Cardiac monitor failed (goes blank) Intravenous (IV) pump channel failed to deliver medication No IV pump available No IV tubing available No IV supplies available No central line insertion kits available No propofol or succinylcholine on cart Insufficient amount of adenosine on cart to comply with American Heart Association protocols† No amphodextrose on cart No vasopressin on cart No triple lumen tray on cart No epinephrine on cart Mislabeled ephedrine versus epinephrine No atropine syringes available Wrong doses of epinephrine stocked on cart Lack of knowledge in use of calcium gluconate	Identify locations/areas for accessible monitors Include testing of monitors during crash cart checks Include testing of IV pumps during crash cart checks Identify locations/areas for accessible IV pumps (including backups) Include on crash cart inventory checklist Include on crash cart medication inventory checklist Educate staff on sound-alike, look-alike medications Specify type(s) and dosages on the medication crash cart inventory checklist Include medication guidelines (dosage) in crash cart
Communication/Training	Busy signal when trying to call code blue (2) Code intercom announcement not heard in all units Pagers did not notify all code responders Inadequate training in an emergency	Include testing of communication system as part of mock drill Develop and review training to a rapid response with identified staff
Other	Used medications found in crash cart Incomplete crash cart (not restocked after last emergency) (6) Unlocked cart (2)	Include disposal of equipment/medications as part of postcheck following a rapid response Set time frames for exchanging and restocking crash carts within facility Include locks with numbers as part of the crash cart inventory checklist

* Number in parentheses signifies the number of reports or the number of times that the issue was identified, if greater than one.
 † The 2005 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care are discussed in context in the main article.