ANESTHESIA SAFETY NETWORK

QUARTERLY PERIOPERATIVE INCIDENTS REPORT

Newsletter #011 – april 2019

TOWARD EXCELLENCE IN HEALTHCARE

ANESTHESIA SAFETY NETWORK

INTRODUCTION

Anesthesia Safety Network
Newsletter #011 –april 2019

We are very pleased to announce that the ANESTHESIA SAFETY NEYWORK will release its e-learning platform to provide access to training tools through a serious game. This tool has been created to promote, by playing, the quality and safety of care.
In addition, it will allow us to continue to offer you, free of charge and without any advertisement, newsletters that we hope will be of high quality.
At the same time, we are conducting a participatory fundraising campaign. You have 48 hours left...
https://fr.ulule.com/securite_des_soins/

You hear every day about innovation, Deep Tech, Bigdata, AI... but not often enough teamwork yet.
However, it is certainly one of the cheapest and most promising innovations in medicine.

Over the past 20 years, the findings have been accumulating unnoticed. A new disease has silently appeared: «medical error». If we do not pay attention, it will threaten our Health System in the short term.
It is not a question of pointing fingers at caregivers but rather of becoming aware of our fallibility.
To reverse this trend, we must therefore take an interest in the human being.

AN INNOVATION IS NOT NECESSARILY
A TECHNICAL ACHIEVEMENT OR
A NEW DRUG WITH IMMEDIATE EFFECTS.

Dr MARTIN Frédéric – Anesthesia Safety Network
18 bis, rue des Vaussourds, 92500 Rueil-Malmaison // Mail : dr.martin.frederic@gmail.com // Site : anesthesiasafetynetwork.com

During a conference at the ASA Congress in Boston in 2017, Atul Gawande highlighted (speaking about the surgical checklist) the difficulty of implementing an innovation whose results are only visible at the level of the population. He compared the implementation of the surgical checklist and its difficult execution to the almost immediate adoption of Viagra by patients in 1998, creating a sudden queue in front of his father's urologist's office.
Evidence of the checklist's effectiveness has been documented since 2009. However, is it accepted and requested by caregivers? No. And why is that? No tangible results in the very short term.

IS IT NECESSARY TO HAVE MADE A RIGOROUS STUDY TO VALIDATE THE BENEFITS OF A SHOPPING LIST SO THAT NOTHING IS FORGOTTEN AT THE SUPERMARKET ?

The innovation we all expect has been there, right in front of our eyes, for years: teamwork. The skills it requires must be taught to all caregivers from the beginning of their initial training. Its effectiveness on the safety of care is major!
Our ability to work as a team, including patients and their relatives, is essential. As a team, we interact and detect a situation that could deteriorate earlier. Moreover, what could be better than a team to overcome its mistakes, a team with a common objective, a team whose members communicate securely, monitor each other with a leader and effective partners capable of expressing themselves without fear of criticism.

The team is also an excellent way to improve the quality of life at work. At a time when the degradation of caregivers' quality of work life is leading to depression, burn-out and suicide, the solution is probably based on this team of caregivers. Health simulation, sharing of experience, good use of tools such as the WHO surgical checklist can improve coordination, cooperation and communication.
The development of teamwork represents an historic step forward, and we are all at the cutting edge of this innovation.

Finally, a big thank you to all those who contributed to this newsletter: anonymous contributors and those who signed some articles. If you wish to participate, write to us!

Enjoy the articles

Frédéric Martin

Dr MARTIN Frédéric – Anesthesia Safety Network
18 bis, rue des Vaussourds, 92500 Rueil-Malmaison // Mail : dr.martin.frederic@gmail.com // Site : anesthesiasafetynetwork.com

With the permission of Robert Hackett – #THEATRE-CAPCHALLENGE https://www.psnetwork.org/ (Patient Safe Network)

I spoke with Robert Hackett, Australian Senior Anesthesiologist and webmaster of http://www.psnetwork.org/. This website shares original initiatives in the field of healthcare safety (for example, #TheatreCapChallenge). We were talking about innovation in healthcare safety and he made this observation that I will share with you:

« There is a whole area of safety science which has yet to be adopted to any perceptible level within healthcare. The science of human factors ergonomics waits to permeate throughout healthcare. The current structures of healthcare governance are generally resistant to change, especially where that change makes front line work easier – we are more likely to accept the complex, eg robotic surgery, irrespective of their benefit to patient care because they provide individuals and institutions with a competitive edge over their peers. They are seen as a way to advance reputation. Simplification of work interfaces is not. Well not yet at least. It will take the dedicated and passionate drive of many, particularly front line staff, patients, system safety experts and others to deliver human factors science into healthcare. Only then will we see an improvement in patient care.»

#Theatre-CapChallenge Some of the team members in the operating room of the Necker Hospital – sick children. Photographer: Clément Alméras

On his website, he reports cases of confusion in the individual's roles and qualifications? Some situations are without consequences, others can lead to severe damage or even patient death. This is the case of a patient who died in the early 2000s, following the lack of verification of the match of the transfused red blood cells with her blood type http://news.bbc.co.uk/2/hi/health/643329.stm. The culots had been requested by an anaesthetist who had recently arrived in the hospital during surgery for an intracranial aneurysm. They were brought back by a stretcher-bearer who was identified by the anesthesiologist as a nurse who checked the blood bags

Dr MARTIN Frédéric – Anesthesia Safety Network
18 bis, rue des Vaussourds, 92500 Rueil-Malmaison // Mail : dr.martin.frederic@gmail.com // Site : anesthesiasafetynetwork.com

You don't have to read because....
There's no need to check, because....
You don't have to get attention, because....

These temptations of ease and speed are very powerful behavioural automatisms in humans.
They are even more present as these people are trained, familiar, know each other...

But none of them act alone, no-one is the only one to decide, none is independent of other acts and decisions, upstream, which also result from behavioural automatisms.
They may or may not have been checked! because they are also carried out by professionals, trained, familiar.
These cases show that there are always strange ways for a patient not to be the right one, for a drug not to be in its place, for a tube to be cut. And this is more so as the sources of tension are stronger.

So, you will never be sure that the document is the right one, the dose is the right one, the patient is the right one until you have checked, read, asked for...
Reading takes 2 seconds, Checking takes 5 s, attracting attention effectively takes 10s.

The recovery of the consequences of errors will always take considerably more time than doubting, comparing, crossing, rereading, sharing...
Patient safety performance is collective and cooperative.

Claude VALOT Former researcher at the Institut de Recherche Biomédicale des Armées in Brétigny sur Orge and senior human factors consultant at DEDALE

In our operating room of six rooms at the Mother and Child Hospital of Limoges, we noticed non-optimal practices in the use of the checklist, and we wanted to evaluate its implementation in a precise way. It quickly became clear that the paper evaluation of the «ticked boxes» did not reflect the reality of the oral realization of the checklist.
We therefore decided to conduct this evaluation by direct observation, with an observer in the room. The achievement scores were extremely low! On average, we were less than 50% of the time talking about the items (while 90% of the boxes were checked).
We then decided to try to restore the original spirit of the checklist and to entrust its implementation to all the staff of this block (anaesthetists, surgeons, whether residents or senior citizens, anaesthetists, operating room nurses, nurses' assistants, etc.).
We obtained the authorization of the HAS to completely modify the checklist. Indeed, we noted that on the French version of the checklist proposed by WHO it reads: «Additions and modifications to adapt to local practice are encouraged. «whereas on the checklist proposed by the HAS version 2016 it read»...contains the essential elements (...) and, in this sense, is not modifiable». Even if there are nuances explained on the HAS website, we felt a shift in the state of mind of the application of this technique, without solid scientific data supporting the more strict and top-down approach of the HAS.
Similarly, the founders of the checklist had never mentioned the possibility of a signature and warned against using this tool, which should not become «just another administrative paper».
In order to empower the teams, to unite them around a common project, we applied a bottom-up change method. All operating room members received the results of the observation by email and were then offered a detailed questionnaire. Everyone had the opportunity to express themselves on the relevance of the items, on the realization of the checklist and on the changes to be made. Considering the opinions of everyone, the project leaders proposed six solutions. These solutions were voted on by all members of the block and the winning solution was implemented into practice. The main modifications were to remove the signature from the checklist and some items, to greatly simplify the formulation of the items and to differentiate between two checklists in this block (one global for obstetrics gynecology and one for pediatrics). The figure below shows the final checklist.
The results of this process have been spectacular with a doubling of the rate of oral checks. This work shows the team's appropriation of this tool that has become THEIR tool. This method is most likely replicated in other institutions and we encourage all teams to take full responsibility for their work tools.

Franck Pihan, Jérôme Cros, *author of the book «Better communication between caregivers: a major safety issue».*

CHU Limoges

Check-list de sécurité à l'HME – gynécologie

version 1.0 (26/03/2018)

Etiquette patient

Cocher la case ☐ quand l'item a été discuté. Date :

Avant l'induction

IBODE + IADE + Anesthésiste + Patiente :
1. Identité ☐
2. Intervention ☐
3. Côté ☐
4. Allergie ☐

IBODE + IADE + Anesthésiste :
5. Installation ☐
6. Equipement prêt
   a. Côté chirurgical ☐
   b. Côté anesthésique ☐

Anesthésiste :
7. Risque d'intubation difficile ou d'inhalation ☐

Avant l'incision

IBODE + Chirurgien + IADE ou Anesthésiste :
1. Intervention ☐
2. Voie opératoire et côté ☐
3. Points d'appuis vérifiés ☐
4. Antibioprophylaxie ☐

L'IBODE :
5. Dysfonctionnement matériel ☐

Chirurgien :
6. Temps difficiles ☐
7. Saignement attendu ☐
8. Durée d'intervention ☐

Anesthésiste / IADE :
9. Comorbidités / informations importantes ☐

Avant la sortie

Chirurgien + IBODE + Anesthésiste ou IADE:
1. Intervention réalisée ☐
2. Cicatrice infiltrée ☐

IBODE :
3. Compte final :
   a. Compresses ☐
   b. Aiguilles ☐
4. Identité inscrite sur les prélèvements ☐

Chirurgien + Anesthésiste / IADE :
5. Evènements indésirables ☐
6. Matériel défectueux ☐

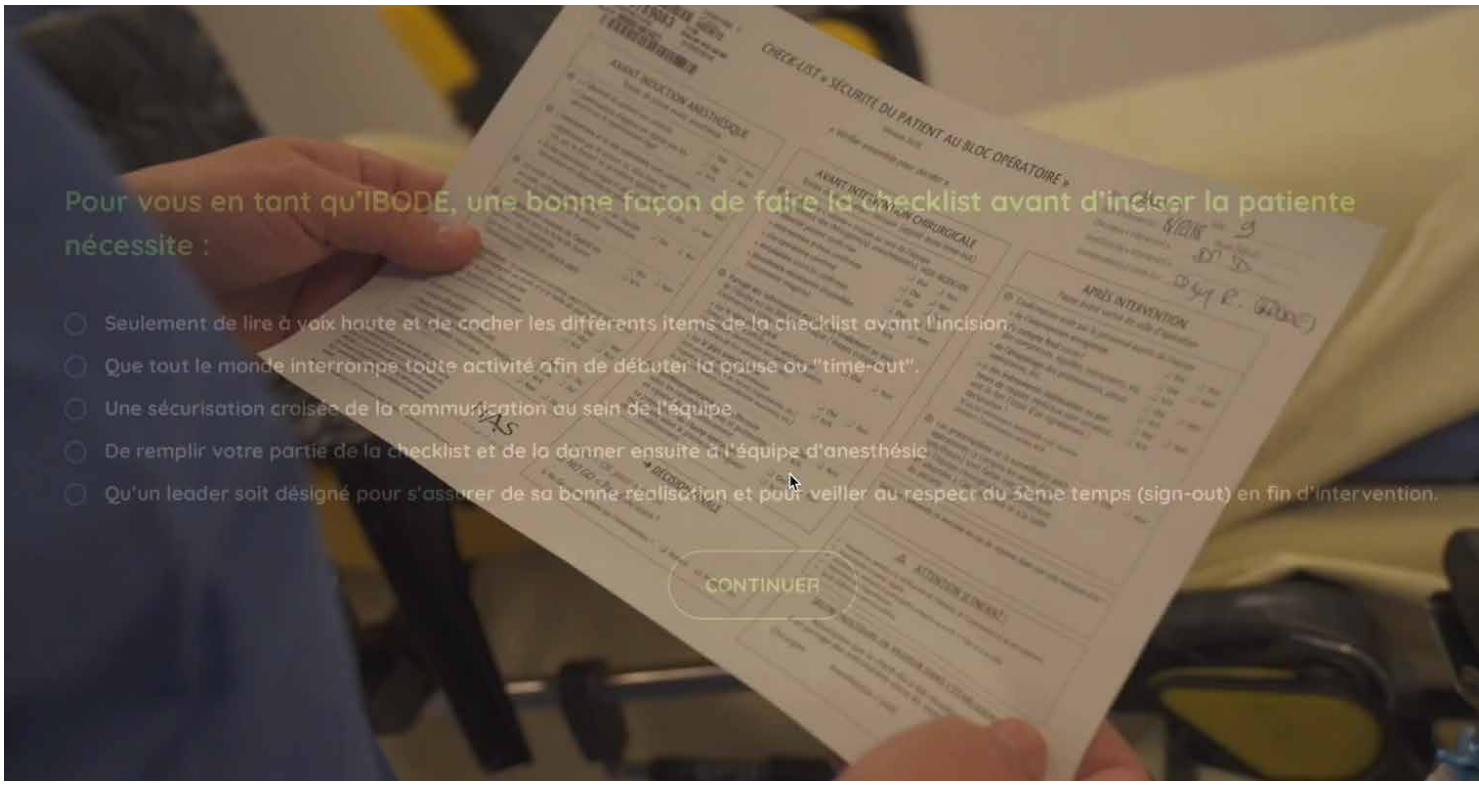
Dr MARTIN Frédéric – Anesthesia Safety Network
18 bis, rue des Vaussourds, 92500 Rueil-Malmaison // Mail : dr.martin.frederic@gmail.com // Site : anesthesiasafetynetwork.com

CHECKLIST AND OBSTETRIC

Morning C-section in a common block. admission of the patient in the OR with one part of the team (CRNA, anesthesiologist and scrub nurse). The obstetrician is in the ward. The anaesthetist team and the scrub nurse check identity, caesarean section indication, equipment, risks inherent to the patient (allergy, bleeding, Mallampati score: medical documents looking at difficulty of intubation, allergy,...). The anaesthesia team checks groupage and recent check-ups. The patient is positioned, the spinal anaesthesia is performed, the surgeon dressed and gloved. Post-spinal hypotension is controlled. Last check with the surgeon before the incision. At the time of the incision, the anesthesiologist realized that no one had thought to call the midwife who had to pick up the newborn and provide first aid. The midwife called is then busy on a delivery. The caesarean section is delayed (while spinal anaesthesia is administered) until a second midwife is called upon to free herself as soon as possible, go down to the OR, get dressed, prepare the newborn's room and join the team.

Good points : *Communication and team management of the unexpected*
Ways for improvement : *Integration of the midwife's call in systematic way into the procedures for the management of scheduled C-sections (who does what?) – adaptation of the checklist to the obstetrical context.*
KEY WORDS : checklist / caesarean section / team

Dr MARTIN Frédéric – Anesthesia Safety Network
18 bis, rue des Vaussourds, 92500 Rueil-Malmaison // Mail : dr.martin.frederic@gmail.com // Site : anesthesiasafetynetwork.com



SURGICAL CHECKLIST AND IDENTITY MONITORING

One morning during school holidays, two neighbouring operating rooms were occupied by a digestive surgeon and ENT specialist (which is rare in this structure). A stretcher bearer was absent and pediatric activity is «abnormally high» on that day. Child A must have tonsillectomy surgery in room 1 and child B must have umbilical hernia treatment in room 2. In a hurry and under great pressure, the stretcher-bearer delivered child A to ward 2.
He was agitated and screamed a lot. The team in room 2 took care of him and proceeded with his anaesthesia and applyed a mask. Once asleep, the surgeon performed an early para-ombilical analgesic block so that it was active at the incision. He then went to wash his hands. At the same time, child B had been brought to room 1. The team in room 1 performed the identity check and found that it was not the right child. They quickly understood the error and informed the team in the next room. The situation was resolved, and the two children were placed in the right intervention rooms. The room 2 team considered that the checklist was not useful for short procedures and that because the anaesthetist had made the pre-anaesthetic visit, the controls had been carried out..

Good points : *error recovery*
Ways for improvement : *checklist development / stress management / reflection on safety model for the paediatric environment*
KEY WORDS : identitovigilance / time-out before anaesthesia / production pressure

HELL OF DONALD !

Beginning of the day with high hourly pressure. Technical platform with 4 rooms including 1 surgery room.
The staff planned on the schedule: 3 CRNA and one anaesthetist (MD). Arriving at 8am, I saw my colleague (F) in the corridor who was scheduled to work on the technical set in room 1 but was going in the opposite direction. Arrival at 8:05 am at the technical platform. A patient was already in Exam 1. Two colleagues scrub nurses (I) and radiographer (M) informed me that the operator (O) was in a big hurry and that they had brought in the first patient. «It's a dilated inflexible limb.» I told them that I was not in room 1 but that my colleague had arrived.

Dr MARTIN Frédéric – Anesthesia Safety Network
18 bis, rue des Vaussourds, 92500 Rueil-Malmaison // Mail : dr.martin.frederic@gmail.com // Site : anesthesiasafetynetwork.com

''He'll be here any minute''. (For information our arrival times was 8 am for a patient objective 8:15am in the room). A CRNA (E) student informed me that he arrived early and opened rooms 1 and 2. I opened and prepared the first anesthesia in room 3 based on the patient's chart I had consulted the day before. I and M asked me about the absence of F and insisted on the fact that O was in a hurry. Suspecting that F would move to another site (the technical platform was regularly stripped of its staff when a CRNA was missing on another site), I quickly consulted the manager who then confirmed F's moved. After a short briefing, he took care of room 3 alone while I took care of room 1 and then room 2. The other CRNA remaining as planned in the operating room.
Entrance to room 1 checked by E, I opened the computer (everything is computerized). I was reading the anesthesia consultation of the first patient. I asked «to the cantonade» (E, M, I, I, O and the patient are in the room) everyone busy at work (except the patient!) «It is indeed Mr J. Trump». Only O answers «yes, that's right». I: «Trump! Trump... like Donald? ». O: «Yes, it's spelled the same but I saw with the gentleman, it has nothing to do with it, it's not the same family! «I then asked E to program the IV automatic pump while I talked to the patient while scoping him. M Trump had been heart-kidney transplanted. I asked him «Did you take the anti-rejection drugs as usual? ». The patient» huh? The drugs? I've stopped everything. ». Then the classic questions about fasting, allergy... The procedure began. One hour later, when I was looking for labels for the traceability of narcotics, that I noticed that the patient in the ward was the second scheduled patient of the day and not the first.
The order of patients had been reversed by M. The first patient being a MRB carrier.
After discussing it with the team: M and I told me that they did not hear the question about the patient's identity. O who had answered me, told me «I thought I was talking about the second patient». E hadn't seen the identity problem. What about the patient? Didn't he hear that?

Good points : *no consequences due to ''luck*
Ways for improvement : *checklist / becoming aware of the weak signal « huh? The drugs? I've stopped everything. «/ structured SBAR transmission / increased risk awareness in the event of sudden reorganization / secure communication*
KEY WORDS : production pressure / time-out / communication

IT'S NOT THE RIGHT SURGICAL SITE !

During an emergency room shift on a Saturday, a patient was admitted into the OR for foot surgery (foreign body on the left foot). Activity was important in the operating room and the list went on. I was regularly interrupted while performing the anaesthesia consultation. I noticed a bandage on the patient's right hand. I guessed it was made in the emergency room. As the consultation was coming to the end, I recommended to the patient a truncular anaesthesia block and explained it quickly. The patient agreed with it. I set up to do a right axillary block when the surgical resident arrived and didn't understand what's going on. He told me that the patient was here for a foreign body on her left foot. She had been scratched by her cat 3 days earlier.

Good points : *recovery by the team*
Ways for improvement : *think about a surgical checklist designed for loco-regional anaesthesia / ask the patient clearly: «Why are you coming to the OR? »*
KEY WORDS : fixation error / locoregional anaesthesia / checklist

Dr MARTIN Frédéric – Anesthesia Safety Network

18 bis, rue des Vaussourds, 92500 Rueil-Malmaison // Mail : dr.martin.frederic@gmail.com // Site : anesthesiasafetynetwork.com

CROSS-CHECK

During the preparation of an analgesic locoregional anaesthesia realised in a sleeping patient (chest wall block), I usually ask the anaesthetist nurse (CRNA) to pour physiological saline into my 20ml syringe in order to dilute the 0.75% ropivacaine and obtain a concentration of 3.75 mg/ml.
The CRNA announced loudly and clearly «saline solution» and turned the label of the flapule so that I could confirm the identification of the product. As she began to pour the solution, I realized that it was not saline but water for injection. An immediate correction was made by discarding the few millilitres poured and taking the appropriate product.
It turned out that during the week the packaging of the EPPI flaps (water for injectable preparation) had changed and that the latter was identical to that of saline. In the past, the containers were different, making it easy to distinguish between them. The CRNA confirmed that he had not reviewed the label because only saline could be in such a container.
The systematic practice of cross-checking made it possible to avoid this error demonstrating its real interest. It also highlighted lack of information when commonly used drugs changed presentations.

Good points : *cross-check / reporting of this incident*
Ways for improvement : *fallibility of the reading process / ALR cart specific to this practice /*
KEY WORDS : almost accident / cross control / medication

Dr MARTIN Frédéric – Anesthesia Safety Network
18 bis, rue des Vaussourds, 92500 Rueil-Malmaison // Mail : dr.martin.frederic@gmail.com // Site : anesthesiasafetynetwork.com

HYPOXEMIA DURING ANESTHESIA INDUCTION

After anaesthetic induction, the patient was placed under controlled assisted ventilation on a laryngeal mask (left testicular ectopy cure). Rapid onset of hypoxia in the patient. The oxygenation was switched back to the accessory circuit. We then looked for the defect on the respirator and there, we discovered that the flowmeter hose next to its connection behind the respirator was cut off!!!!!!
We fixed the problem and then the system was switched back to the main circuit. It worked... The resident had noticed a major leak when he checked the anaesthesia station in the morning but didn't report it to his senior.

Good points : *discovery of the failure*
Ways for improvement : *effective pre-oxygenation validated by FeO_2 > 0.9 / promoting speak up culture / NO GO in case of equipment problem / debriefing with the team / use of hypoxemia cognitive aids*
KEY WORDS : hypoxia / leak / anaesthesia station

Dr MARTIN Frédéric – Anesthesia Safety Network
18 bis, rue des Vaussourds, 92500 Rueil-Malmaison // Mail : dr.martin.frederic@gmail.com // Site : anesthesiasafetynetwork.com

FATIGUE AT THE END OF LONG SURGERY

7:00 pm. End of a heart surgery case. A patient was operated on for multiple coronary bypass surgery. It had been a busy day with two emergencies. After removing sterile surgical drapes, we discovered that the peripheral venous catheter (VVP) used for induction had been partially stripped. It was removed and the central venous catheter (VVC) placed in the internal jugular remained the only venous access.
We moved the patient from the OR to his bed before admitting him into the Intensive Care Unit (MD, CRNA, scrub nurse, stretcher-bearers). The paramedical team, relaxed after a busy day, began talking about personal problems. The patient was transferred into his bed with the help of a «rollerblade» (CRNA at the head). When the stretcher-bearer removed the rapid rollerball from the central line, the patient was left without any venous access. Hopefully, the patient didn't need continuous IV infusion of sympathomimetic drugs (only a propofol syringe for IV sedation). The CRNA inserted quickly a new peripheral venous catheter without any consequences for the patient.

Good points : *No bad outcomes*
Ways for improvement : *limit distractions / stay focused until the patient is transferred to the other team / identified leader coordinating the transfer / briefing with the leader to define mission before transfer (goals, risks,...)*
KEY WORDS : hazardous event / distraction / fatigue

AT NIGHT, ALL CATS ARE GREY

This case took place during a digestive endoscopy shift in the middle of the afternoon.
The session was busy. The room was in the dark to optimize the visualization of the images on the control TV screens. A patient required midazolam before IV induction because she was very anxious. While trying to prepare the product, I discovered an atracrium cartridge among the midazolam ampoules. I noticed it just before I broke it.

Good points : *near miss*
Ways for improvement : *teamwork and discussion about the organisation of the endoscopy anaesthesia cart (need for myorelaxant drugs in the endoscopy room?) / ergonomics of the room and trolley (lights,...) / significant proximity to the accident (number of failed barriers)*
KEY WORDS : myorelaxant / error / storage

Dr MARTIN Frédéric – Anesthesia Safety Network
18 bis, rue des Vaussourds, 92500 Rueil-Malmaison // Mail : dr.martin.frederic@gmail.com // Site : anesthesiasafetynetwork.com

DELAYED CALL FOR HELP AND STRESS

This case took place early at the beginning (8:00 am) of the shift while I was checking the equipment for epidural analgesia, and C-section. I had a phone call at 8:10 am from the midwife asking me to come because a woman was bleeding just after the delivery. She told me that she had done the blood test and couldn't get a second large venous access. I instantly got angry on the phone asking the midwife why she hadn't called me sooner (patient gave birth at 7:40). The colleague on duty hadn't told me about this patient.
When I arrived, the patient had lost approximately 850 cc. The uterine revision had been performed by the obstetrician who had now left the hospital. Antibioprophylaxis was performed. The reoccurrence of bleeding was the reason for the call. So I decided to call for help (3 people), and I asked for the haemorrhaging cart. I inserted a 2nd venous access with some difficulties due to numerous puncture sites (previous attempts).
We picked up the cognitive aid (postpartum haemorrhage: PPH) and then called the obstetrician back.
After the epidural injection of 2% lidocaine with epinephrine (10 cc), the obstetrician checked the genital track as recommended in the guidelines and he discovered a tear in the cervix. The bleeding stopped (Hemocue 8.4 g/dl. Initially 11.5 g/dl). Good outcome.
The midwife asked me why I thought she had called me late. We decided to debrief. She explained to me that she wanted to start the first actions in order to show me that she had acted. She confirmed that she was aware of the situation (haemorrhage after delivery). She was concerned about giving the impression that she had been passive (memories from a past incident and argument with colleagues). For this reason, she had decided to postpone the call for help. By decontextualizing, she became aware of the importance of calling for help early because the workload was very heavy on its own. I realized the importance of commission bias (To do something (technical issue) instead of calling for Help(non-technical issue)).

Good points : *benevolent debriefing*
Ways for improvement : *avoid putting others under stress / initial management of post-partum haemorrhage / communication within the team / anticipation / call for help*
KEY WORDS : haemorrhage / call for help / debriefing

Dr MARTIN Frédéric – Anesthesia Safety Network
18 bis, rue des Vaussourds, 92500 Rueil-Malmaison // Mail : dr.martin.frederic@gmail.com // Site : anesthesiasafetynetwork.com

Debrief and share

It is remarkable that this midwife inquired about the reasons that made her colleague react in such a way to her call for help. This led to a debriefing – this practice is not limited to simulation – and allowed the midwife to understand and further develop her skills. In the future, it's a safe bet she will call for help sooner.

Taking the time for a debriefing has two main virtues. On the one hand, it allows the team's performance to be reviewed as a whole, which helps reinforce good habits and make adjustments for the future.
On the other hand, sometimes the team has encountered a difficult situation or even a failure. In this case, it is crucial :

- to give everyone the opportunity to get rid of any **emotional burden** which might be due to the situation and ;
- to ensure that everyone involved **understands** what has happened.

For the leader, a debriefing is also a good opportunity to solicit or offer feedback and to thank his team.

I sometimes hear that the length of the debriefing should depend on the performance achieved ; that it can be succinct in case of success and that it will have to be longer if problems have arisen. But it is sometimes useful to understand why performance was achieved despite meeting difficulties. This will help learn from success in order to **avoid succeeding by chance.**

After a complicated event, it is important to **allow the required time for the debriefing**. Indeed, it is necessary to first take time to deal with the emotions before starting a rational analysis of the situation. As a matter of fact, as long as our emotions overwhelm us, it is our limbic system alone that is at the controls of our brain. Our neocortex – the part of our brain that is able to analyse and understand – is disconnected.

This latter type of debriefing is especially important. Indeed, let's imagine that the midwife had not asked her colleague for feedback and remained on a negative feeling. What would be her reaction to a similar complication in the future ? Would she dare call sooner, or is there a risk she dares not call at all?

Finally, there is one last question to ask at the end of a debriefing: « Should we share this experience ? » In the present case, it was the choice made by the people involved, and we can thank them for it.

Good practices

- Take time to debrief, especially if performance was not met
- Take time to share your experience

Written by **Guillaume Tirtiaux**, Training and Development Director at REPORT'in

REPORT'in

Additional information regarding the case of «THE GREAT TIDE» reported in newsletter #010

I am an anaesthesiology and intensive care medical doctor at the University Hospital of Lille. I have been working in a department that has had a long experience of caring for patients with oesophageal and gastric disorders. I read carefully the incident report about aspiration during a gastric endoscopy (published in newsletter #10). Patients with oesophageal achalasia are probably among the most at risk of inhalation. There are other similar situations such as patients who have had an esophagectomy with intrathoracic gastroplasty, patients with acute upper intestinal obstruction or epistaxis with a lot of blood ingested. I'm sure you all know these situations.

Regarding our experience we have put in place complementary strategies to limit the risk of pulmonary aspiration. I suggest you think about it with your team :

- Look at the images or talk to the surgeon about possible gastric or intestinal dilation (corollary: training on ultrasound to evaluate the pylorus)
- Erythromycin, 250 mg IV as a pre-medication
- Gastro-intestinal tube in suction at – 20 cm H20 before arriving in the OR (beware of the distance to the nostril if achalasia or gastroplasty, rather 40 cm than the usual 60 cm)
- Allocate roles if regurgitation, name the person who controls the operating table
- deeper than usual induction with anticipation of hemodynamic degradation using a vasopressor as soon as induction occurs. I personally use highly diluted norepinephrine (16 gammas/ml) between 20 and 40 ml/h (0.3 to 0.6 mg/h) during IV induction.
- some people talk about intubating first into the oesophagus with a large tube to direct vomiting out of the patient's mouth, to discuss
- surgical suction cannula (Yankauer type) in aspiration in the oropharynx upon laryngoscopy, to be wedged on the left side of the laryngoscope.

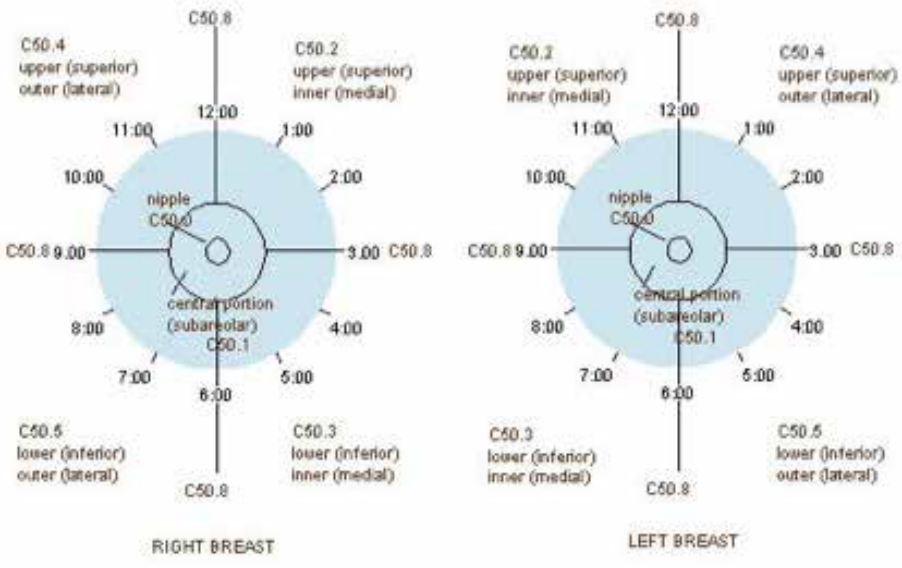
Rémi Fackeure, blog www.nfkb0.com

Dr MARTIN Frédéric – Anesthesia Safety Network
18 bis, rue des Vaussourds, 92500 Rueil-Malmaison // Mail : dr.martin.frederic@gmail.com // Site : anesthesiasafetynetwork.com

WHITE PART AFTER LUMPECTOMY AND MISREGISTRATION

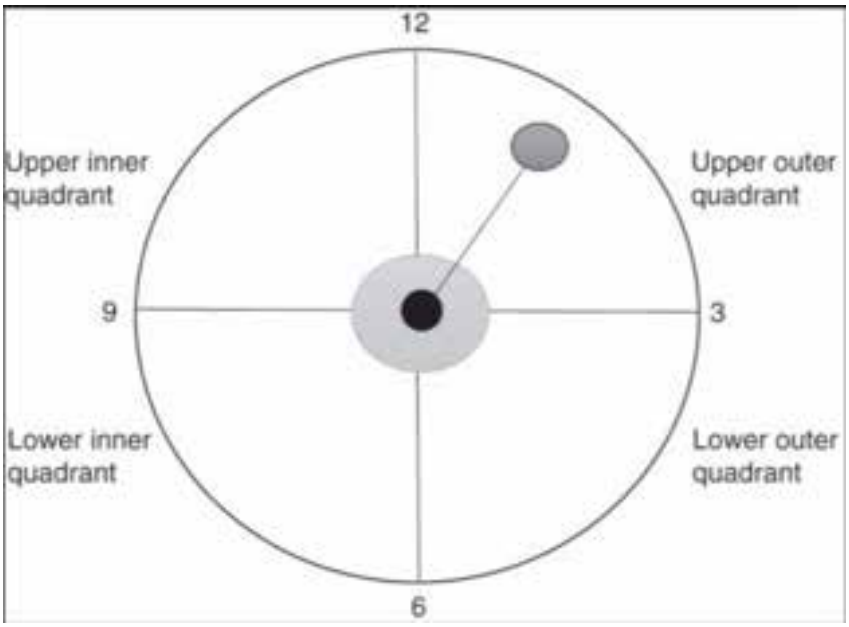
A 50-year-old patient consulted for a breast cancer discovered following left axillary adenopathy and right breast adenofibroma. The clinical examination found a palpable lesion in the upper external quadrant (UEQ) of the left breast and left axillary adenopathy.
Imaging (ultrasound and MRI) showed one lesion on the left (at 9:00 am) and two lesions on the right (11:00 am and 1:00 am). A left lumpectomy and left axillary cleaning and right lumpectomy with radiological identification of the clip were planned. In the operating room, only the right register shot was displayed.
The patient was operated on by her (senior) doctor assisted by a resident. Bilateral surgery was confirmed by the patient in the OR, without further clarification, and then confirmed with the team filling the sign-in and time-out frame of the WHO checklist. During the operation, the right lumpectomy was performed by the senior and then a left lumpectomy of the UEQ (palpable lesion) + left axillary cleaning (palpable adenopathy) was performed by the resident supervised by the senior. The anatomopathological analysis confirmed the absence of a cancerous lesion found in the left lumpectomy. New imagery revealed that the lesion was still present between the 8:00 am and 9:00 am radius, or UIQ.

This clinical case allowed the following points to be discussed: the 3 steps of the WHO checklist were carried out in accordance with the procedure. However, it appears that the preoperative verification of the location of the tumour in the left breast quadrants was not carried out with the patient who knew the location of the tumour on the left and who did not dare to report during the various clinical examinations that the cancer lesion was not in the palpated quadrant (she was working as a healthcare giver). It should also be noted that there was no quadrant marking and no preoperative ultrasound identification requested on the left UIQ lesion (because it is visible on the MRI). Note the senior's focus on lesions on the right ++++ (fixation error), entrusting the removal of the palpable lesion in the left UEQ to the junior.
It should also be noted that the radiological record in the operating room was incomplete even though the answer to the question on the presence of the documents was "yes" during the time-out (only the right breast identification picture was displayed). There is the question of the display of the MRI (available?).
The lack of radio/clinical consistency control did not prevent the error. Finally, different location codes between radiosenologist (Clock Code) and surgeon (anatomical code), is a possible additional source of error.



Clock Code (Radio Sénologue)

Dr MARTIN Frédéric – Anesthesia Safety Network
18 bis, rue des Vaussourds, 92500 Rueil-Malmaison // Mail : dr.martin.frederic@gmail.com // Site : anesthesiasafetynetwork.com



Localisation Anatomique

9:00 on the right breast corresponds to the external quadrants
9:00 on the left breast corresponds to the internal quadrants

Improvement actions decided in RMM

Several corrective actions were proposed during the morbi-mortality review:
Use the same terminology: talk in quadrants and radii (radial and distance) Secure communication between surgeons and physicians (patients for complex cases). Ensure the results of biopsies performed urgently, between image review and intervention. Computer archiving of the description of radiographic markings (TDM paper file in the computerized patient file)
If palpable lesion: surround the lesion BEFORE the operating room with confirmation of location by the patient (cross check)
Display extension check-up in the room: MRI, CT (and not just mammography, tracking)
Precise and fine anatomopathological proofreading when the expected lesion is not found.

Dr MARTIN Frédéric – Anesthesia Safety Network
18 bis, rue des Vaussourds, 92500 Rueil-Malmaison // Mail : dr.martin.frederic@gmail.com // Site : anesthesiasafetynetwork.com

A nightshift, a on-call duty,..... Phew a book!

Thinking, Fast and Slow
Written by Daniel Kahneman,
Professor of cognitive psychology and behavioural economics,
Nobel Prize in Economics in 2002.

A major reference in the field, Kahneman's book is the synthesis of his life's research on our mental functioning, and the cognitive biases that affect our judgment.
He describes two systems of thought, System 1 and System 2. System 1 is our «machine for drawing hasty conclusions», it is fast, intuitive, automatic, and makes us jump to conclusions faster than our shadow... (2+2=?) To have this outstanding efficiency, it is subject to biases, which in rare cases mislead it. System 2 is slow, thinks deeply, logically, and requires effort... (397x589= ?). Uncertainty and doubt are its responsibility, but he can be a little lazy... Or thrifty? Kahneman gives us concrete examples to demonstrate many of our cognitive biases that deflect our judgment, both in the professional and personal environments. For example, the availability of information in our memory leads to memory bias. It shows us that we are not very good at making probabilities, especially for rare events. Our brains also tend to replace complicated questions with simple questions at a glance, but without informing us! Moreover, we cannot always trust the intuition of experts, which is also biased, and excessive self-confidence can cause disasters in our judgments.
Finally, it analyses risk policies, which can also be biased, for example by our loss aversion, and nudge systems can lead us to make better decisions. To sum up, it is a book that helps to better understand the brain, in depth, and even if it cannot be read like a novel, this little paving stone is accessible. These two systems are likely to be talked about for a long time!

Enjoy this book!

Florence-Marie Jégoux
Human Factors and Organizational Factors Specialist
Former nurse, private pilot and air traffic controller
www.developpement-systemique-humain.com

TAKE HOME MESSAGES ABOUT SURGICAL CHECK-LIST

- **It's a cognitive aid... like any other.**
- **it is a briefing that promotes communication between the stakeholders (goals and possible difficulties needed to be anticipated)**
- **it's also a debriefing to make sure everything went well and will go well.**
- **it's effective**

What are we waiting for to adopt it and use it?

OUSTANDING WEBSITES TO DISCOVER

(1) http://www.psnetwork.org/
Rob Hacket – website sharing different experiences and innovative tools to improve patient safety

(2) https://www.youtube.com/channel/UCXRx2Vq521jeo9o4l0Kt0CA
YouTube channel «Les enfants du facteur» broadcasts short videos to raise awareness of the impact of human factor in Healthcare. A good idea to learn French !

UPCOMING CONGRESSES

(1) **International Forum on Perioperative Safety & Quality** will take place on Friday, May 31, 2019, the day before the ESA Congress. Come a day earlier to listen to the leaders in this field (Rhona Flin, ...). I will attend. Do not hesitate to contact me to schedule an appointment. https://www.asahq.org/ifpsq/esa/agendafull

(2) Presentation of the serious game on surgical checklist to the **ESA Quality and Patient Safety Committee** during the ESA 2019 Congress.

(3) The **Clinical Human Factor Group** is organising a day-long event in London on 12 June 2019 in the presence of Martin Bromiley, focusing on the impact of ergonomics and human factors on the safety of care. I will attend. Feel free to contact me to schedule an appointment. https://chfg.org/chfg-open-seminar-healthcare-human-factors-design-and-procurement-london-2019/

(4) The **ICMAsim 2019 congress** will be held in Angers from 8 to 10 October 2019. Anesthesia Safety Network supports this congress, which will focus on simulation in different professional environments (Healthcare, Transport, extreme environments,...). Come and talk with us by registering https://www.icmasim2019.com/

(5) Presentation of the serious game during the **Institute for Healthcare Improvement** congress in December 2019 in Orlando (pending confirmation) http://www.ihi.org/education/Conferences/National-Forum/Pages/default.aspx

1ST INTERNATIONAL CONFERENCE FOR MULTI-AREA SIMULATION

#ICMASim 2019

8-10 OCT. 2019 ANGERS FRANCE

Call for abstract :

https://www.icmasim2019.com/abstracts-submission-icmasim?utm_source=sendinblue&utm_campaign=Newsletter_ICMASim2019_3_ABSTRACT_SUBMISSION&utm_medium=email

Previsionnal program :

https://www.icmasim2019.com/program-themes-icmasim?utm_source=sendinblue&utm_campaign=Newsletter_ICMASim2019_3_ABSTRACT_SUBMISSION&utm_medium=email

Registration :

https://conference-for-multi-area-simulation.site.calypso-event.net/en/

Création graphique : Julie LAGARDE – +33 6 28 45 51 35 – j.lagarde.crea@gmail.com