

PATIENT SAFETY REPORT

QUARTERLY REPORT
Newsletter #19 - may 2021



TOWARD EXCELLENCE IN HEALTHCARE



I'M 100% FOCUSED ON SAFETY
BEYOND THIS GATE.

INTRODUCTION

Patient Safety Report
Newsletter #19 - may 2021

We will soon be celebrating the 20th newsletter and 5 years of existence of this platform. The past five years have shown us that the development of a safety culture, including initial and ongoing training, is essential to promote reporting on incidents and successes. That's why we decided to create the SafeTeam Academy in 2019. For those who've tested the module on the surgical checklist, the case was taken from one of the first newsletters. A similar case was recently reported and we've published it among the events in this issue.

But what is a safety culture? Is it good practices, procedures, policies, and philosophy (4P rule)?

Above all, a safety culture must be just and fair. This is what Sidney Dekker advocates in his various books.

He has kindly agreed to share his views on a just culture. The editorial, co-written with Wim Van Wassenhove, is rich in concepts and teachings. We recommend reading his various books, which have inspired a large number of safety specialists in the industrial world. By the way, [Sully Sullenberger, captain of the A320 Airbus that ditched on the Hudson River](#), had one of his books on board on the day of the accident.

Enjoy your reading

The Patient Safety Database Team



EDITORIAL

Credit : Ross Parmlly on Unsplash

«A JUST RESTORATIVE CULTURE» WIM VAN WASSENHOVE AND SIDNEY DEKKER

At the end of the last century and at the beginning of the 2000s, the awareness of the need to protect the feedback of information from the field was born in certain organizations (aeronautical but also medical). Feedback, especially feedback of operational information, is a key element in risk management which allows an organization to become more secure. To stimulate this feedback, it is necessary to maximize access to the system and above all to minimize the anxiety linked to the use of this system. To guarantee the sustainability of the system, feedback to users, wide involvement and proof that changes result from field-based operations, are necessary.

One of the responses to these barriers was the «no blame» culture. People who report their mistakes are thus protected from punishment. This approach is also motivated by the idea that factors contributing to human error are within the organization, within the system itself. This «no blame» approach has borne fruit, but it also has limitations, as individuals who engage in intentionally dangerous behavior cannot be prosecuted.

At the same time, we are also witnessing a significant increase in legal proceedings for security breaches. It is not uncommon for healthcare staff, for example, to be brought to court for accidents

involving patients and to be held accountable. The functioning of the justice system specifically seeks to apportion responsibility, to find a culprit for the harm caused.

Things become even more complicated when we look at the cognitive biases that are at work during accident analyses. Knowing the final outcome of an accident leads us to overestimate the perceived probability (retrospective bias). Causes, clues and data become obvious, decisions to be made at the time become «logical». Our judgment of the actions and deeds of the person at fault becomes more severe. It becomes all the more severe when the result of the accident has serious consequences (result bias).

As a conclusion to this multiple observation, we must re-examine the performance of the individual in an organization and more specifically how to address these individual errors. «Just culture» therefore appears as a solution: "Just culture is a culture where people are not punished for actions, omissions or decisions taken that are commensurate with their experience and training, but where gross negligence, deliberate violations and destructive acts are not tolerated." A just but punitive culture therefore seeks to know what rule has been transgressed, how serious the transgression was, and what the consequences should be.

This approach seems well adapted to address the above problems, but still poses a major challenge: who and how to draw a line between honest mistakes and negligence and deliberate violations? The nuance between an «honest» mistake, risky behaviour and conscious negligence is sometimes difficult to pin down, not least because they are subjective interpretations: What exactly is «cautious» or «below normal» or «reasonably competent»?

The problem becomes more complicated when we look at the number of rules and procedures to be followed by a professional. And the tendency of our safety management systems is rather to increase the number of rules as the only valid response to malfunctions. On average, a nurse must comply with 600 rules and procedures. It is estimated that an American anesthetist will need 2000 years to read all the rules and procedures of his profession.

The border between honest error and negligence does not exist until, in a particular case, it is drawn. The question that arises is therefore not where this boundary is, but who decides it. Such a «just» punitive culture is person-oriented and conducts investigations, interrogations, witnesses, allegations of recklessness, negligence or misconduct with disciplinary actions. Such justice will not be seen in the same way by the staff and by the hierarchy. It can thus again put a brake on the flow of information.

But isn't what we are looking for team learning, humanity and collegiality, forgiveness and understanding, reparation, healing and trust? Instead of asking what rule was transgressed, how serious the transgression was, and what the consequences should be, should we not be asking who is impacted, what their needs are, and who has an obligation to meet those needs? Our Western approach is unhelpfully oriented towards punitive justice.

BUT WON'T WE NEED MORE RESTORATIVE JUSTICE?

But won't we need more restorative justice? A process where everyone has the opportunity to discuss how they have been affected by an injustice and decide what needs to be done to repair the harm. We need to shift the emphasis from «responsibility» to «accountability». The person who has made a mistake reports on his or her mistake, shares lessons and expresses remorse, acknowledges responsibility, and proposes actions to prevent recurrence. The organization allows the employee to express himself or herself and shows that it is safe to recount events. The organization identifies the conditions that helped and led to the error and remedies it.

Many professionals experience error as a moral failure. In a culture of perfection, in which errors are not tolerated and in which a strong sense of personal responsibility for both errors and results is expected, it is not surprising that errors are difficult to deal with. Just, restorative culture focuses on the victims of the error but also on the secondary victims: the people involved in an accident that has (potentially) injured others, and for which these people feel personally responsible. It allows for the repair of injuries and focuses on the relationship between the people who are responsible and the victims and thus allows the people who are responsible to repair their mistakes.

BIOGRAPHIE



SIDNEY DEKKER

Sidney Dekker (PhD Ohio State University, USA, 1996) is Professor and Director of the Safety Science Innovation Lab at Griffith University in Brisbane, Australia, and Professor at the Faculty of Aerospace Engineering at Delft University in the Netherlands. Sidney has lived and worked in seven countries across four continents and won worldwide acclaim for his ground-breaking work in human factors and safety. He coined the term 'Safety Differently' in 2012, which has since turned into a global movement for change. It encourages organizations to declutter their bureaucracy and provide people freedom-in-a-frame to make things go well—and to offer compassion, restoration and learning when they

don't. An avid piano player and pilot, he has been flying a Boeing 737 for an airline on the side. Sidney is a bestselling author, which includes amongst his most recent works: *Foundations of Safety Science*; *The Safety Anarchist*; *The End of Heaven*; *Just Culture*; *Safety Differently*; *The Field Guide to Understanding 'Human Error'*; *Second Victim*; *Drift into Failure*; and *Patient Safety*. He has co-directed the documentaries 'Safety Differently,' 2017; 'Just Culture,' 2018, 'The Complexity of Failure,' 2018, and 'Doing Safety Differently,' 2019. His work has over 13,300 citations and an h-index of 50. More at sidneydekker.com

Wim Van Wassenhove is a research engineer at MINES ParisTech at the Centre for Risk and Crisis Research. He is an engineer in life sciences (Universiteit Gent) with a PhD in bio industrial engineering. His PhD subject was the development of a learning from experience method for the management of sanitary alerts. He is currently directing the advanced master program 'Maîtrise des Risques Industriels' (Management of Industrial Risks) at MINES Paristech. He is responsible for building an up to date study program for post-engineer students, to teach them the latest advanced risk techniques. He also is in close collaboration with the industry to identify the needs and the emerging issues in risk management in the field. His research themes are safety professionalization, learning from experience, accident analysis methods and restorative just culture.

He is the co-author of two books on learning from experience and risks at Editions Tec & Doc Lavoisier: « *Retour d'expérience et prévention des risques, principes et Méthodes* » and « *Retour d'expérience et maîtrise des risques, pratiques et méthodes de mise en œuvre* ». He has published in the international journals of Risk Research, International Journal of Risk Assessment and Management and Safety Science.

WIN VAN WASSENHOVE



FATIGUE AND DECISION MAKING PROCESS

An elderly male patient was operated for a staged cementoplasty for breast cancer at the end of the day. Once the patient was placed in prone position and the procedure had started, the respiratory pressures increased with discrete hypoxemia and necessitated an IV continuous infusion of norepinephrine due to refractory hypotension with numerous ESV. The procedure is continued and this hypotension remains alarming. My colleague was in charge of the patient and has called upon me to admit the patient into our ICU. He is known to be highly skilled and rigorous. He explains that the norepinephrine will be rapidly stopped and he will do a chest X-ray to eliminate a pneumothorax.

Finally, the procedure was completed and the patient was extubated in the OR. He remained in severe pain (high opioid consumption). My colleague tells me that he is being treated for his severe, unmanageable pain. I ask him about the chest x-ray and he answers that he did not do it because the patient was better.

I was called to the PACU for this patient an hour later. When I arrived the nurse was «concerned» by the failure of the patient's analgesia and asked me what to do. I pointed out that the SaO_2 was 82%. She told me that this was an artifact (cold + norepinephrine + agitation). The patient was just asking for pain relief. I auscultated him and discovered a major murmur in the right lung area. The chest X-ray confirmed the diagnosis of compressive pneumothorax. Once drained, the patient was weaned off the norepinephrine.

Positive elements : *Evolution / Other diagnosis suspected.*

Ways to improve : *Cognitive Aids / Remove any doubts / Be aware of the impact of fatigue on the decision making process.*

KEYWORDS : *Cognitive Bias/ Confirmation / Pneumothorax.*



A VIGILANT NURSING AUXILIARY

I had taken in a patient with severe acute renal failure the evening before. His disease was due to an advanced prostate cancer. I've asked him about his treatment and medical history during the preoperative appointment. I didn't have any access to drug prescriptions. He had an ASA 4 physical status with a potential need for percutaneous nephrostomy. General anesthesia was provided with haemodynamic support by norepinephrine. Then the patient was admitted into the ICU with high fluid loading and continuous IV norepinephrine infusion (0.5 mg/h). On the next day, I visited my patient. There was an improvement of the renal function with polyuria. I talked with the nursing auxiliary and she told me that the patient had a fentanyl patch 75 microg/h in the back. I did not notice this.

Positive elements: *Physical examination/ "Speak Up" even for the nursing auxiliary / Share information promoted by the team leader.*

Ways to improve : *Importance of the role of each individual in speaking up/ Critical information have to be looked for.*

KEYWORDS: *Renal failure / Opioids / Transdermal patch.*

IV OR EPIDURAL ADMINISTRATION: THAT'S THE QUESTION!

I was working as an anesthesiologist in the Operating Room (OR). I was taking care of a 60 year old patient who was operated on an open nephro-ureterectomy. I've placed an epidural catheter for postoperative analgesia. The patient had intractable pain due to his cancer. The surgery was performed during the lunch time period. I transmitted the analgesia protocol to the CRNA that I was working with. I told him to inject an initial bolus of ropivacaine into the epidural followed by a continuous infusion. When I came back into the OR, my colleague informed me that he'd had to increase the hourly flow of the epidural analgesia due to an increase of blood pressure. The blood pressure was still high and I asked the CRNA to administer 100 mg of lidocaine. The CRNA proposed to add a clonidine bolus. I said that it would be the next step. The CRNA injected lidocaine through the venous access instead of what I was expecting (epidural administration). My prescription wasn't detailed enough.

Positive elements: *Self-analysis of medication error / Report of a at-risk practice.*

Ways to improve : *Avoid as much as possible numerous handovers / Lunch time is a critical period / Closed-loop communication.*

KEYWORDS: *Communication / Accurate / Epidural.*



THE COGNITIVE AID, THE FOLLOWER YOU NEED

The situation took place on a long Saturday. This case was the last patient operated in an emergency. I had to perform a locoregional anesthesia for a sore thumb. I had to administer 3 injections of a mixture of lidocaine 10 mg/mL and ropivacaine 4,75 mg/mL. 5 mL on each ulnar, radial, median nerve at the elbow and forearm. When I finished the procedure I asked the nurse to inject 2g of Augmentin for antibiotic prophylaxis. The patient remained in the PACU for 30 minutes and was then admitted into the operating room. I was called for help a few minutes later for a sudden bradycardia at 45 per min with suspected type II Auriculo-Ventricular Block. I thought that it was a vagal collapse with a blood pressure drop (50/25). Atropine was ineffective so I injected an ephedrine bolus. The situation remained critical with sinus tachycardia and persistent severe arterial hypotension. The pulseoxymetric signal was between 80 and 90 percent but was deemed unreliable (hypoTA, vasoconstriction, sweating). There was no dyspnea or sibilance on pulmonary auscultation and the patient was tired but conscious. We placed an oxygen mask on his face. I didn't understand anything at this time. The situation seemed different from a systemic local anesthetic intoxication but I asked for an injection of medialipid which had no effect and I called a colleague using my phone. While the situation seemed in a steady state, a diffuse erythema appeared. An anaphylactic reaction became the most relevant diagnosis and histamine tryptase blood samples were taken (allergy was confirmed a few days later). The scrub nurses in the operating room told me that the infusion of Augmentin was off on arrival in the OR and that they had opened it.

Positive elements: *Call for help.*

Ways to improve: *Faster call for help / Use of cognitive aid (hypotension) / Any effective response to three therapeutics = Consider other diagnosis.*

KEYWORDS: **Decision / Cognitive Aid / Stress.**

9 Hypotension

Unexplained drop in blood pressure refractory to initial treatment

START

- Call for help and a code cart**
 - ▶ **Ask:** "Who will be the crisis manager?"

- Check...**
 - ▶ Pulse
 - ▶ Blood pressure
 - ▶ Equipment
 - ▶ Heart rate
 - If BRADYCARDIA, *go to* ▷ CHKLST 3
 - ▶ Rhythm
 - If VF / VT, *go to* ▷ CHKLST 5
 - If PEA, *go to* ▷ CHKLST 4

- Run IV fluids wide open**

- Give vasopressors** and titrate to response
 - ▶ MILD hypotension:
Give ephedrine or phenylephrine
 - ▶ SIGNIFICANT/REFRACTORY hypotension:
Give epinephrine bolus, consider starting epinephrine infusion

- Turn FIO₂ to 100%** and **turn down volatile anesthetics**

- Inspect surgical field for bleeding**
 - If BLEEDING, *go to* ▷ CHKLST 8

- Consider actions...**

- ▶ Place patient in Trendelenberg position
- ▶ Obtain additional IV access
- ▶ Place arterial line

- Consider causes...**

- Operative field**
- Mechanical or surgical manipulation
 - Insufflation during laparoscopy
 - Retraction
 - Vagal stimulation
 - Vascular compression

Unaccounted blood loss

- Blood in suction canister
- Bloody sponges
- Blood on the floor
- Internal bleeding

Drugs / Allergy

- Anaphylaxis *go to* ▷ CHKLST 2
- Recent drugs given
- Dose error
- Drugs used on the field (i.e., intravascular injection of local anesthetic drugs)
- Wrong drug

DRUG DOSES and treatments

Ephedrine:	5 – 25 mg IV, repeat as needed
Phenylephrine:	80 – 200 mcg IV, repeat as needed
Epinephrine:	BOLUS: 4 – 8 mcg IV (dilute 1 mg in 250 mL = 4 mcg/mL) INFUSION: 0.1 – 1 mcg/kg/min IV

Breathing

- Increased PEEP
- Hypoventilation
- Hypoxia *go to* ▷ CHKLST 10
- Persistent hyperventilation
- Pneumothorax
- Pulmonary edema

Circulation

- Air embolism *go to* ▷ CHKLST 1
- Bradycardia *go to* ▷ CHKLST 3
- Malignant hyperthermia *go to* ▷ CHKLST 11
- Tachycardia *go to* ▷ CHKLST 12
- Bone cementing (methylmethacrylate effect)
- Myocardial ischemia
- Emboli (pulmonary, fat, septic, amniotic, CO₂)
- Severe sepsis
- Tamponade

All reasonable precautions have been taken to verify the information contained in this publication. The responsibility for the interpretation and use of the materials lies with the reader. Revised April 2017 (042417.1)

What is at stake for the ego, what are the risks for the patients?

Anne Rocher, Clinical psychologist in intensive care unit and executive coach

Medical studies and research foster individual competition, which is based on an idealized self-image, a need to surpass others and a desire for recognition.

This competition increases the risk of developing oversized egos (overconfidence bias), but also narcissistic flaws (lack of self-confidence) that can bias commitment and have an impact on the quality and safety of care.

This competition is also in opposition with cooperation, which is essential for coherent care. One of the obstacles to collaborative work is not feeling legitimate in one's contributions and/or fearing the critical gaze of others.

In our society, glory and error are still perceived as individual. A world first in transplantation remains the achievement of the surgeon who operates, with the work of the team relegated to anonymity. An error on the operating table is also attributed to the surgeon. Our society keeps an individual prism: it looks for heroes or scapegoats to simplify thinking, but the laurels of glory or the lacerations of guilt are indeed the two sides of the same reality that underestimates the systemic or interactional and collective dimension that can no longer be concealed.

Ego is not only bad, it also has another psychological meaning: «the self» which constitutes our way of being in the world, our personality. Ego is a system in balance which tries to arbitrate internal conflicts, impulses while taking into account the external reality.

Ego reveals its true face in the relationship with others, where it can be muted with the philanthropic goal of helping others, an altruistic perspective that can be developed/strengthened with Taoist rules, simple to understand, but not always easy to apply:

- Never assume that the other person knows what you are thinking
- Never make a decision when you are in a state of emotional distress or fatigue
- Accept the fact that we are 50% responsible for the quality of all our relationships
- Develop kindness, without judging ourselves in word or in thought
- Regularly put yourself in the other person's shoes to understand their reactions and motivations
- Be prepared to trust yourself.



NEW DEVICES AND REFLEX ACTIONS

A patient was admitted into the endoscopy room with a CRNA. She refused general anesthesia so the CRNA called me. We decided to switch rooms so I could take care of this «difficult» patient. The patient was perfused and she finally agreed to a general anesthesia. I was really upset and set up the monitoring device and injected IV propofol (50 mg) in a dark room. A dramatic hypoxemia occurred because I had forgotten to put on the oxygen supply. I was not very familiar with the ventilation system and was not able to use it under pressure. The anesthesia tubes were coiled and not equipped with a facial mask. The ventilator has two external switches leading to a stressful situation (where's the good one? Which one do I have to switch on or off?). I was overwhelmed by stress and the sensation of losing control. The situation was fixed after untangling the respirator tubes and opening the drawers to recover and connect a mask. We proceeded with the endoscopy without any further complications.

Positive elements: *Keep calm even in a stressful situation.*
Ways to improve : *Visual flow before starting general anesthesia / Short checklist before GA induction / TEM (Threat & Error Management) briefing: What's the situation? What could be the main problem that we might encounter? How to deal with an expected problem? / Training using mental rehearsal (short actions to perform for setting up effective oxygenation.*

KEYWORDS: Hypoxemia / Communication / Switch.



THE MENTAL REHEARSAL USED BY FIGHTER PILOTS

Credit : Cédric Dhaenens on Unsplash

Pascal BERRIOT was a fighter pilot on Mirage and instructor in the Air Force flight schools (1982 - 2012). He is the author of "Élèves Pilotes. Améliorez l'apprentissage du vol par la technique de répétition mentale" - Pascal Berriot. Éditions Cépactuès. 29 may 2019

I want to share with you a finding that has helped many of us to improve learning and self-confidence. It is about self-improvement techniques used by top athletes: visualization, preactivation and mental rehearsal (MR).

When I started as a student pilot, I found that the repeated simulation of the gestures and procedures of piloting associated with the mental unfolding of the steps of the flight made it possible to gain confidence and reduce stress.

Later, I was given the opportunity to train to teach POT (Potential Optimization Techniques) to student pilots. I discovered MR among the many POT tools. This technique is based on mental imagery allowing to improve the anchoring of technical gestures in order to reproduce them in cognitively challenging situations with high safety issues.

What is it about more precisely?

« MR is a technique that consists of rehearsing, in a relaxed state, a technical gesture, a sequence of several movements or actions, or an activity in its entirety, in order to reproduce them correctly. You mentally reproduce, better if necessary, a gesture that

you have actually performed before. This requires a minimum of knowledge about the skill to be developed. » (Comprendre et pratiquer les Techniques d'Optimisation du Potentiel - Edith Perreault-Pierre, InterEditions 2012).

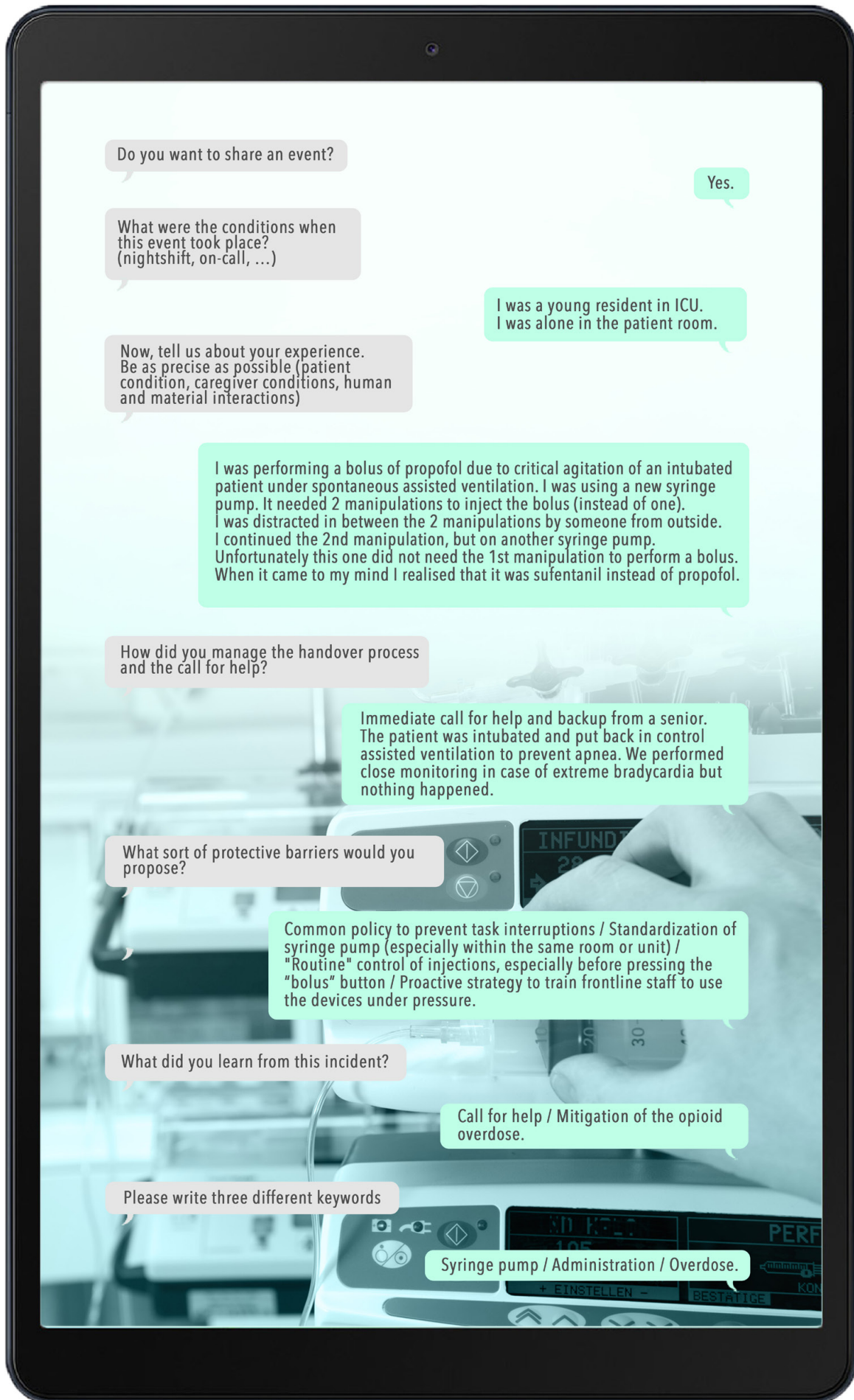
Sitting on a chair, calm, eyes opened or closed, RM consists in mimicking all the piloting gestures corresponding, for example, to the landing circuit. Sitting (mentally) on the windward/backward position, with one hand on the throttle and the other holding the stick, the goal is to reproduce precisely the chronological sequence of actions and gestures, without omitting head and eye movements to check the parameters in the cabin and the outside surroundings.



Credit : Pascal Berriot

For a beginner, MR allows us to more quickly liberate the mental load and to dedicate our attention to the management of the environment and to decision making.





POTENTIAL SAFETY LESSON

The first patient was operated on for a hydrocele cure on this Friday morning. The right side was mentioned on the anesthesia and surgery records while the patient announced left. We checked and the surgeon said he couldn't establish the facts. As a result, he will operate on both sides. I suggested reporting an adverse event but the surgeon did not feel it was necessary because he did not understand the problem as he himself didn't know. I answered that it was a safety issue because we should be able to inform the team of the problem. He explained further: «In this case, it's hard to be wrong».

Positive elements : *Share information in the whole team.*

Ways to improve : *Potential safety issue because safety barriers seemed not reliable (possibility to arrive in the OR with different information written in the patient records / Develop and enhance safety culture.*

KEYWORDS: *Surgery / Medical documentation / Safety barriers.*



YOU JUST HAVE TO READ IT!

A few years ago now. 4am, cat. 2 LSCS (Lower Segment Caesarean Section), planned to give augmentin after delivery of baby. ODP (Operating Department Practitioner) gave me a cardboard drug tray with a 20ml syringe labelled augmentin and an empty drug vial. I gave the drug and the patient went to sleep, I realised it was thiopentone – the syringe was labelled augmentin but the vial was in fact thiopentone. We gave oxygen and cricoid pressure and very soon the patient awoke with no sequelae. The patient was anxious and I was concentrating on reassuring her. I thought I had checked the vial but I clearly didn't. There were many contributing factors. I was tired and felt sick. I was pregnant at the time. It was also my birthday and I was looking forward to finishing my shift. I felt awful once the event occurred. Once it was noted the ODP also felt awful and luckily there was a second ODP who could take over her duties.

Positive elements : *Teamwork was good and obstetric colleagues supportive / no patient harm / I communicated the issue quickly and debated whether to intubate or just hold cricoid.*

Ways to improve : *Check the vial / Double check / Awareness that awake patients are distracting, we must ensure we do not deviate from essential safety tasks / A reminder that a cursory glance is not enough and perhaps that we should draw up our own drugs.*

KEYWORDS: *Drug error / Anaesthesia / LSCS.*



PROCEDURE AND CONSTANT PREOCCUPATION

A woman was operated on for an annexectomy and for an inguinal hernia by laparoscopy under general anaesthesia. The team was composed of a CRNA, a scrub nurse, an assistant and two surgeons (a gynecological surgeon and the visceral surgeon). The visceral surgeon began his procedure with the operating assistant. The gynecological surgeon was dressed sterilely and did not take part in this procedure. The two surgeons and the operating assistant were laughing a lot.

The OR manager came just before the end of the first procedure to let the scrub nurse have lunch. They began a handoff. The scrub nurse came back in the OR forty-five minutes later and the surgery was almost finished. The operating assistant was closing up and the compress count was good.

The surgeon and the OR manager left the operating room without any handover.

So the scrub nurse decided to go through the third step of the surgical checklist (sign-out). She could not find the surgical specimen. The operating assistant asked the CRNA not to wake the patient up. He was concerned and called the surgeon who decided to check if it had been forgotten into the abdomen. Laparoscopy was restarted to remove the collection bag containing the specimens.

Positive elements: *Report of this event / Responsiveness of the team / Respect of the third step of the WHO surgical checklist.*

Ways to improve: *WHO surgical checklist completed by the whole OR team / Stay focused on the main goal (safe surgery) / Sterile cockpit.*

KEYWORDS: **Distraction / Checklist / Specimen.**



BEWARE OF THE COLOR CODE !

I was asked to prepare a training course on the practical realization of electrocardiograms (EKG) by associating a theoretical and a practical part. The theoretical part aimed at explaining what was an EKG and why the correct placement of the electrodes was so important. The practical workshop took place in a scientific research ward used to perform EKGs. This department has 2 EKG devices. We planned four training courses and I asked the trainees to perform a first so-called

normal EKG on themselves followed by a second EKG after having reversed the electrodes. The main purpose was to show «false EKG abnormalities» due to the wrong positioning of the electrodes. The «usual» EKG device was used on a real patient during the last session so we had to get a second EKG. The trainees performed both EKGs, first the normal EKG and then the one with reversed electrodes. When analyzing the 2 EKGs, I did not understand why the first tracing showed signs of infarction, while the second one seemed normal. The people who usually worked in this department explained to me that this second device was only used when the first one was unavailable. The main reason was the need to follow the code for the correct positioning of the electrodes noted on a post-it note taped to the device. I then discovered that the 4 main electrodes of the 4 limbs must be positioned according to a code specific to this device (cf photo): the red electrode on the left leg, the green one on the right leg, the black one on the left arm and the white one (no yellow) on the right arm. How many EKG's have been performed with a bad positioning of the electrodes since then? Was this specificity known to all users of this device, including neighboring departments? A new wire was ordered.

BASIC ERGONOMICS, OR HOW TO MAKE YOUR LIFE EASIER

I am not an ergonomist. However, as I grew up in a professional environment that took this notion very seriously, I developed certain habits. And when I witness situations that lack ergonomics, I can't help but notice.

Who's who?

This is the first question I asked myself the first time I set foot in an operating room to observe a procedure. How do all these people recognize each other? Where are the distinctive signs? The color of the blouses? Yes, except when nurses borrow theirs from doctors because they are warmer...

That same day, the patient had just been put to sleep when the surgeon, to whom I had not yet had the opportunity to introduce myself, burst into the room. He immediately began to verify the correct positioning of his client. When he looked up, satisfied, his gaze met mine and he said, « It's okay. Let's go wash our hands! » He mistook me for a surgical assistant. Since then, in the theaters taking part in the #TheaterCapChallenge, physicians, nurses and visitors are identifiable by their name and their function.

Mishmash

At times, I am amazed at the tangle of pipes and cables covering the patient, until it becomes too difficult to figure out what is connected to what. A long and tedious disentangling ensues. At that moment, I can't help but think, « Wouldn't color coding make things easier? » An end-to-end orange pipe, a blue cable, etc ...

Speaking of color, a heart surgeon friend shared the following thought with me. He suggested that for convenience (no, that's not always a bad word), Resano forceps, DeBakey forceps, or toothed forceps be assigned color codes. They would become the blue forceps, the red forceps and the green forceps, which would make communication easier with the instrumentalists.

Will you fall for it?

I will not spread on the subject of similarities between drugs containers. How many more accidents will it take before manufacturers take responsibility? The answer that « it's the staff's job to read carefully » is to deprive the system of precious material barriers.

How about you? Do you recognize yourself in these situations? What strategies have you put in place?

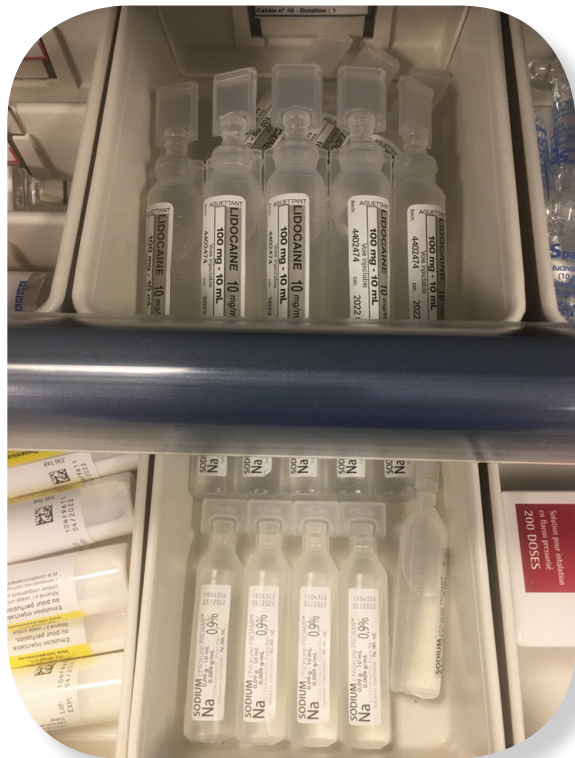
Guillaume Tirtiaux, author of « Mieux Réussir Ensemble »

WHERE'S WALLY?

Credit : Véronique Normier



Credit : SafeTeam Academy



UPCOMING EVENTS

- **21 - 24 June 2021**

The Naturalistic Decision Making movement and the Resilience Engineering Association have decided to open the border between the decision-making landscape and the country of resilient trade-offs, and to make their next biannual meetings (15th NDM and 9th RE) a joint event, with the support of FonCSI and ICSI. To find out more, [visit their website](#).

- **12 November 2021**

15th meeting ABASS: Simulation, Human Factor and Communication with the participation of Pr Rhona Flin.

To find out more about this event, [click here](#).

To register to this meeting in Bourgogne (France), [click here](#).

WHAT WE HAVE LEARNED

*

A just culture is a culture where people are not punished for actions, omissions, or decisions made that are reasonable within their experience and training. On the other hand, serious negligence, deliberate violations and reckless behaviour are not tolerated.

*

Reading is not 100% reliable. Relying on this procedure to ensure medication safety is prone to errors.

*

To react faster in critical situations, you can train yourself to experience them mentally and to perform the required reflex actions. This is particularly effective when you use new devices

Frédéric Martin
François Jaulin
Nathalie Robinson
Guillaume Tirtiaux
Claude Valot
Anne Rocher
Julie Lagarde

15^e journée de l'ABASS

Association Bourguignonne
des Acteurs de la Simulation en Santé

Organisme de formation n°26210348521
Référéncé Datadock n°0065662



SIMULATION FACTEURS HUMAINS et COMMUNICATION

Vendredi 12 novembre 2021
Palais des Congrès de BEAUNE

19 av. Charles de Gaulle 21200 Beaune / Accueil dès 8h00

Inscription et règlement : www.simulationsante.eu

OU par mail avant le 29 octobre 2021 : assobass@gmail.com

Tarifs : 30 € / gratuit pour les membres de l'ABASS

Règlement par chèque à l'ordre de l'ABASS à adresser à ABASS 6 rue de la chaume -21140 Montigny-sur-Armançon