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# ANESTHESIA SAFETY NETWORK

QUARTERLY PERIOPERATIVE INCIDENTS REPORT  
Newsletter #010 - January 2019



**TOWARD EXCELLENCE  
IN HEALTHCARE**

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# INTRODUCTION

Anesthesia Safety Network  
Newsletter #010 - January 2019

## **Best wishes for this New Year**

**This New Year 2019 promises to be full of new projects!**

**In 2018 we registered an extraordinary increase of reported events. We've had discussions with many of you. We ended this year with the WEARe 2018 congress in a splendid environment at the Niemeyer Center. Many important messages were delivered during this conference, like goodwill, safe communication and sharing our experiences.**

**In addition to the incident reporting system newsletters that are published quarterly, we have created an immersive serious game for healthcare professionals. The «trailer» will be released in the middle of January 2019 and presented in the USA during the 7th World Summit on Patient Safety, which is being co-organized by the ASA and ESA in Huntington Beach, California.**

**This serious game traces the path of a patient in the operating room from the point of view of the selected player (scrub nurse, CRNA, Anesthesiologist, Surgeon). It was shot at the CESITECH in the public hospital of Chalon / Saône thanks to the precious collaboration of Alexandre Benoist, Stéphane Kirche, Rachid Digoy, Julien Lecuelle, Maria Labille-Perri and the administration team from this hospital.**

**We must not forget the participation of Guillaume Tirtiaux, François Jaulin as well as the film crew Olivier, Frédéric and Laurent from Next Frame Prod.**

**The game will be finalised at the end of March 2019.**



The main goal is to underline that the WHO surgical checklist is more a cognitive aid dedicated to prevent human errors than an administrative document.

Finally, we are very pleased to announce that ASN will participate in the next few days in the 7th World Summit on Patient Safety, which is being co-organised by the ASA and ESA. ASN has signed commitment #OX2020. In a nutshell, it is about eliminating deaths due to preventable medical errors by 2020. This objective is very ambitious and even unrealistic for some!

We'll see, but can we just sit back and watch?



## THE WHO SURGICAL CHECKLIST IS PROBABLY ONE OF THE FIRST COGNITIVE AIDS AND CERTAINLY NOT AN ADMINISTRATIVE DOCUMENT.

Below is an example of a successful action reported by the Patient Safety Movement and forwarded to us.

We're looking forward to reading about your successes or hazardous events but please don't put the "skeleton in the closet", we need it to make our Healthcare safer !

Have a pleasant read of this newsletter!  
Frédéric MARTIN



**Patient Safety Success Story: Baylor University Medical Center dramatically reduces instances of Failure to Rescue: Opioid-Induced Respiratory Depression**

Although patient safety has been seen as a priority for years, medical errors still rank among the leading causes of preventable patient death both in the United States and around the world. And with the rising use of opioids, failure to rescue from opioid-induced respiratory depression is a growing return. But hospitals like Baylor University Medical Center are proving that prevention is possible. In 2009, Baylor University Medical Center recognized that they had a growing problem with opioid-induced respiratory depression and was routinely seeing more than 40 Rapid Response Team (RRT) calls on one floor each month as a result. The process they developed forms the basis for the Patient Safety Movement Foundation's free, evidenced-based Actionable Patient Safety Solutions (APSS) on Failure to Rescue: Opioid-Induced Respiratory Depression.

"We had some really bad situations regarding "near misses" and that was unacceptable. So we created the "Breathe Team" and brought together everyone involved in the care of the patient. This included doctors, nurses, physicians and patient advocates," recalls Dr. Michael A.E. Ramsay MD, FRCA Chairman, Department of Anesthesiology and Pain Management at Baylor University Medical Center.

The "Breathe Team" met weekly and looked at the causation for each failure to rescue event including what happened, and what could be done to prevent these events. The Breathe Team was able to identify specific process improvements for the hospital and educate staff. These improvements included:

- Standardized postoperative opioid (PCA) order sets. Over 50 different sets existed previously.
- Stopped continuous PCA in opioid naïve patients
- Instituted the "Oxygen Withdrawal Trial" in PACU – a test for respiratory depression.
- Screened pre-operatively for patients at increased risk for respiratory depression and applied a blueberry wristband

Among the new standardized protocols included continuously monitoring all patients. As a result of the changes, Baylor University Medical Center went from 40 rapid response team activations a month to three, and these are early calls. Due to the continuous monitoring of patients, staff is warned early enough to identify and treat patients, preventing costly returns to ICU. It has saved the hospital money and more importantly kept patients' safe.

Patient safety success stories like this will be the subject at the 7th Annual World Patient Safety, Science & Technology Summit in Huntington Beach, California on January 18-19. To register, please visit <https://patientsafetymovement.org/events/summit/world-patient-safety-science-and-technology-summit-2019/>.



## W.H.O. SURGICAL AS A FRIEND!

At 10:00 am, a woman was operated on for a left total hip replacement (THR). The check of the operating equipment and the set-up of the table needed a lot of attention from the surgical team (scrub nurse, surgeon, surgeon attendant and hospital porter). The surgical approach for THR was anterior. The hospital porter and the surgeon set up a table with a "boot". Although the side to be operated on was well identified in the medical documentation and confirmed by the patient before entering the operating room, the table was configured with the «boot» on the right side and not on the left as it should have been for a left THR. The surgeon put the X-rays on the light box (supposed to prevent side errors). The team was under pressure to proceed. The scrub nurse had been distracted several times and the anesthesiologist was monitoring a resident. The scrub nurse reported several task interruptions. The patient was asleep and had laid down on the table with a «boot» on the wrong side. Then the surgical site was prepared with skin disinfection and the surgical drapes were set up. The team did not perform the WHO checklist "time-out" and nobody spoke up. A few minutes after the skin incision, the surgeon attendant realised while he was watching the hip X-ray that the procedure had begun on the wrong side. He reported the mistake to the team. The surgeon closed the skin and operated on the right hip. During the debriefing close to the incident, the surgeon mentioned that when he put the "boot" his mind thought that it was the right side and he wasn't concerned about that. In post anesthesia care unit (PACU), after the surgery, the patient was informed about this event.

**Good points:** *Report this case / mitigation of this error impact / speak up in the room*

**Ways for improvement:** *checklist to be carried out = it's a cognitive aid and not an administrative document / Briefing with all team members before incision / Actions are strictly forbidden during time-out / reduce task interruptions*

**KEY WORDS:** *checklist / wrong surgical side / briefing*

## CONFIRMATION BIAS

It is « the tendency to search for or interpret information in a way that confirms one's preconceptions »<sup>1</sup>. We favor information that confirms our hypotheses, our opinions, our beliefs, and we give less weight to information that contradicts them. For instance, it is the "first impression" that defines the rest of the story: "Since the surgeon had put the foot in the boot, it was the right side for him".

Like every cognitive bias, it makes an executive decision for us: we are then in automatic mode. At first sight, we think "right", an element confirms "right", and our "machine for jumping to conclusions"<sup>2</sup> is then in control. This fast, automatic, easy, instinctive system, make us jump to conclusions, without going through the deep reflection square, which belongs to System 2 : slow, difficult, based on rules, and requiring effort. Time pressure favors the System 1, as well as unavailability of System 2 (multitasking, interruptions...)

### How to avoid this bias ?

Like mistakes, it is unavoidable! The most efficient approach is to learn how to detect bias and retrieve the situation. "The best professionals are not those who make less mistakes, but those who correct their mistakes"<sup>3</sup>.

Different types of answers:

- To take the time to force oneself to think differently helps to get the whole picture, to have a devil's advocate
- In a routine situation, we can double-check what we did, cross-check what the team did... The checklist is often an efficient barrier
- In an evidently critical situation, we have a strong signal. To raise the alarm as soon as possible can limit the consequences.
- In a doubtful situation, we then have a weak signal, a little feeling that bothers us, that makes us uncomfortable. We can then raise the doubt, that is to say, clarify the situation, express what bothers us. So if your light is on amber, perhaps there's a reason for that...

It may be the case here: at one point, the assistant surgeon who faced X rays had a doubt and analysed it. The doubt became an alert: « Wait ! Stop ! I think we got it wrong ! ». Field experts often dispel doubts, we can see that in the next examples : it is a real key for safety!  
You've got a doubt ? Dispel it !

### Florence-Marie Jégoux

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## PEROPERATIVE BLACK HOLE

CAAn 83-year-old patient was operated on for spinal surgery. The induction of the general anesthesia was performed without any incident. Then the patient was placed in a prone position needing to stop the cardio-pulmonary monitoring for a few seconds. The monitoring machine was restarted but curiously the Non Invasive Blood Pressure (NBIP) was still set on "manual". The surgery began and the physician left because he was called to sign a discharge in the PACU. When he came back into the OR he noticed that the blood pressure was still at 130/80 mm Hg. Ten minutes later, after he had finished the postoperative prescription he realised that the BP value hadn't change. The NIBP was set in manual mode (small message: "last BP 25 minutes"). When he had disconnected the NIBP, the program had shifted from automatic to manual mode. He restarted the NIBP and the first measurement was 60/40 mm Hg. He acted as fast as he could, turning off the anesthetic inhaled agents and injecting vasopressors and fluids. He was really concerned about potential brain damage. Hopefully the patient recovered without any immediate consequences.

**Good points :** *No damage*

**Ways for improvement:** *Situation point after moving patient / human-machine interactions / lack of alarm in case of the automatic NIBP has been switched off*

**KEY WORDS:** **Human - machine interaction / cardio-respiratory monitoring**



## DEEP ARTERIAL DESATURATION IN OXYGEN DURING INTRAVENOUS INDUCTION

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The OR checklist and the anesthesia station had been validated at the beginning of the day. This situation happened at the end of the 2<sup>nd</sup> case. It was an emergency procedure that could have been postponed.

The medical documentation was incomplete. Before admitting the patient into the OR, a discussion had begun about the risk-benefit balance of the procedure between the surgeon and the anesthesiologist. Other ethical considerations had been discussed regarding information, consent of the family and the choice of surgical and anaesthetic techniques. Finally, the patient was admitted into the OR with a baseline arterial blood saturation in oxygen close to 90%.

Induction started with a rapid onset of hypoxemia. The CRNA reported that she didn't have any working pressure and no ETCO<sub>2</sub> curve. A quick check of the breathing circuit discovered an important leak.

The breathing circuit was torn before even starting the induction. An a posteriori investigation pointed out that the cleaner had possibly damage the circuit but did not dare to report it.

*Good points : rapid discovery of the cause*

*Ways for improvement: systematic check of the breathing circuit just before using it / Check FeO<sub>2</sub> before anaesthetic induction / resist pressure to proceed / Promote "speak up" concept in your team / cognitive aid / report to manufacturing company*

**KEY WORDS: breathing circuit / anxiety / hypoxemia**





## UNSCHEDULED EXTUBATION DURING A TRANSFER

An ASA IV patient was transferred from the OR to the PACU. During his transfer, the tracheal tube was accidentally removed. The patient was still anesthetised with an unknown myorelaxant status. Immediately the PACU nurse called for help and the anesthetist in charge decided to reintubate the patient using a videolaryngoscope without performing any manual ventilation. At the same time the oxygen blood concentration had dropped significantly. The physician was shocked and unable to think, trying several times to intubate his patient. He was completely blinded and unaware of the situation. Moreover, the cardio-pulmonary monitor was turned toward the patient's feet and even if the alarm was ringing he didn't take it into account. At that moment, one of the PACU nurses was concerned and she asked for another anesthesiologist. The "rescue physician" inserted a supraglottic airway device quickly fixing the problem with a return to a normal situation. The patient woke up without any complications.

**Good points :** *call for help when the nurse realised that the anesthetist in charge was stuck.*

**Ways for improvement:** *continuous monitoring with delivery of oxygen especially during / Always consider supraglottic airway devices in case of extubation or mask ventilation failure (Vortex approach) / Importance of task distribution by leader (monitoring, alert threshold, call for help) / cognitive aids.*

**KEY WORDS:** **unplanned extubation / call for help / tunnelisation**

## VAGINAL BLEEDING DURING LATE PREGNANCY AND BRIEFING

During a Sunday shift I was called for a caesarean section on a Placenta Previa covering cervix and bleeding in a patient. The vital signs of the patient were normal and the bleeding had stopped when I arrived. The surgeon seemed to be anxious and in a hurry. He insisted that the patient be admitted into the OR. I just wanted to stop and prepare the patient for potential massive bleeding (two large venous accesses, check the blood transfusion documents and the blood and fluid heating system). Both physicians were stressed by the situation and having a heated argument. Finally, they decided to call for help due to the high risk of bleeding. When the other team members arrived they carried out a briefing with all the stakeholders (including the scrub nurse and mid-wives). Curiously, they discovered that nobody knew what was the real location of the placenta (Anterior or posterior). So an abdominal ultrasound revealed a posterior placenta. Finally, the C-section was performed under spinal anesthesia with bleeding of approximately 500 ml. No bad outcome.

**Good points :** *resist production pressure / Team briefing to plan and anticipate possible difficulties, misunderstandings, share concerns / coordination / mobilise resources early.*

**Ways for improvement:** *staff education to apply the «Ten seconds for Ten minutes» concept<sup>4</sup>*

**KEY WORDS:** **briefing / leadership**

### Organizing the team in a crisis situation

On November 4th, 2010, an Airbus A380 from Qantas suffered significant damage as a result of the explosion of engine number 2 (left inboard) shortly after taking off from Singapore. This explosion was «non-contained», which means that engine debris was projected in different directions, causing several major failures. Among these, they suffered a fuel leak, multiple electrical and hydraulic failures, degraded operation on engines number 1 and 4, reduced efficiency of some flight controls, and damage to some high lift surfaces on the wings' leading edges. The crew had to sort through more than sixty abnormal checklists displayed by the aircraft systems. After taking the time to assess the situation and prepare for landing, the crew successfully made it back to the departure airport.

The crew was unusual that day. In addition to the captain and two co-pilots, two check pilots were in the cockpit at the time of the incident.

Concerning the management of the incident, two important lessons may be learned :

1. After securing the flight path of the aircraft, the crew gave itself time to analyse the situation. The captain subsequently reported that their ability to **keep their stress under control** and to initially « **sit on their hands and do nothing** » contributed to the safe landing.
2. The crew decided not to redistribute the roles in the cockpit, despite the fact that two very experienced pilots occupied observer seats. Which means that they discussed **the opportunity of a redistribution of roles**.
3. The reason they made this choice was that the two pilots who were at the controls when the incident happened felt **capable of fulfilling their duties** ; and that the two experts may have been more useful in a **support** function allowing them to **step back and see the big picture**.

At each stage, the crew took the time to **evaluate the different options**, as well as the associated **risks** and **opportunities** associated, before making any **decisions**.

Often, when we are faced with a complicated situation, we tend to act too quickly. This gives us the feeling that we are getting closer to the solution. When our actions are appropriate, this is indeed the case. But when our awareness of the situation is wrong, leading to inappropriate decisions and actions, this eagerness is often destructive.

#### **Good practices**

Once the vital actions have been completed:

- Sit on your hands and give yourself time to think through the situation
  - Limit the number of stakeholders and consider a redistribution of roles
  - Appoint a coordinator among the team, whose role is to take a step back and keep a global view of the situation.
- Ensure that someone ensures this essential function at all times.

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





## ONE MYORELAXANT DRUG CAN HIDE ANOTHER...

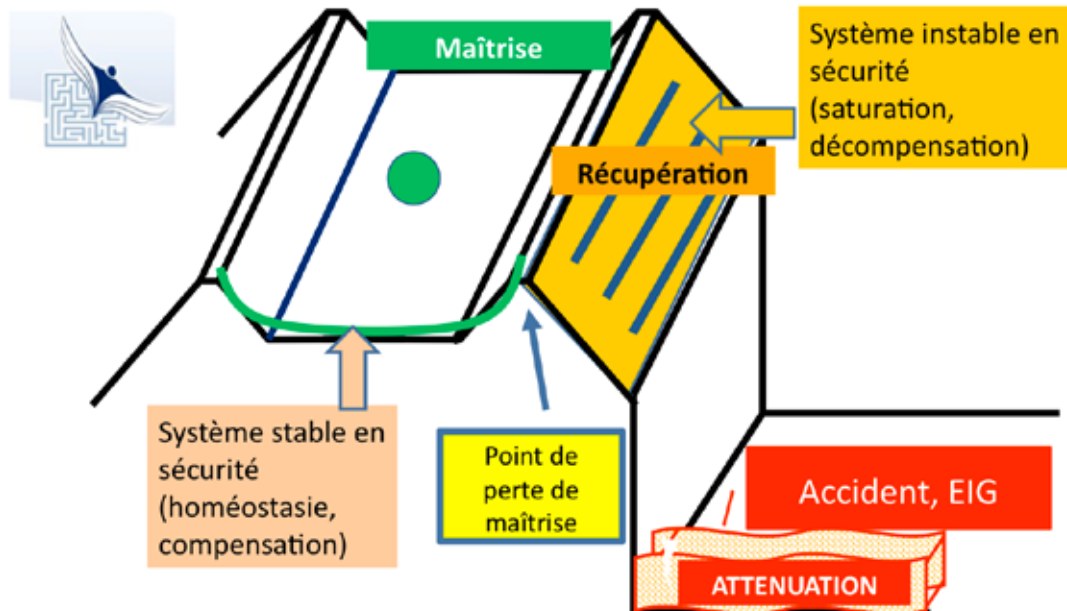
A 18-year-old patient was being managed for uncontrollable acute pain with conventional analgesics and synthetic opioids in the case of an acute sickle cell crisis. The analgesic management in the intensive care unit (ICU) was difficult with a heavy emotional burden for caregivers and significant pressure from the patient's father who was present throughout the care. The patient was then transferred from the ICU to another one to proceed with general anaesthesia for analgesic purposes.

A new fellow in this ward admitted him into the ICU with a resident in anaesthesiology and a recent graduated ICU nurse.

The other members of this medical team were busy taking care of a patient with unexplained acute respiratory distress. The intravenous (IV) administration of hypnotic drugs and endotracheal intubation were simple without any difficulty. Then the IV sedation was injected but the nurse reported that there were some leaks in the ventilation system that weren't fixed by overinflating the tracheal tube cuff. The physician decided to change the tracheal tube for a bigger size. In order to secure this procedure the fellow asked for the IV injection of a myorelaxant drug.

He told the nurse to inject a 50 mg bolus of atracurium. She confirmed that she had listened to his order and answered: «ok I will do it» without cross checking. She revealed after the event that she was concerned but didn't speak up. She said: «It was very strange to inject 5 ampoules».

She administered the IV bolus and at the same time that the senior physician came into the room (highly skilled and long experience in this unit). He was very surprised because there wasn't any atracurium ampoule in the ICU. After checking the labelling on the ampoules, it appeared that 50 mg of cisatracurium had been injected (5 times the normal dosage).

MINOS<sup>5</sup> analysis carried out with the support of DEDALE (Jean Pariès)**Choice of the system to be studied:**

- Emergency drug administration process
- **Context:** on-call environment / time pressure / inexperienced team (nurse, fellow and resident) / stressful situation
- Managed risks / concerns: remove endotracheal tube / intrapulmonary aspiration / acute respiratory distress..

**Safety model:****CONTROLLED :**

- The drug prescription of the doctor in charge is correct
- The drug is consistent with the expected goal
- The drug prescription of the doctor in charge is correct
- ***The drug is available in the ICU***
- The prescription of the doctor in charge is given verbally to the nurse using secured communication and it is understood by the nurse:
  - It is communicated precisely and clearly
  - ***It is formulated according to a standard format (Patient identity, ICD prescription, route of administration, dosage) and familiar for the nurse***
  - ***The team uses cross-check***
  - ***The team uses the loop communication process so errors are detected and corrected***
  - ***The prescription of the doctor in charge is correctly understood by the IDE***
  - ***The extemporaneous administration is carried out by the nurse according to the physicians prescription***
- Only one myorelaxant drug is available in the ICU
- The name of the prescribed drug is checked against the ampoule labels and ***molecule / dose deviations are detected***
- ***In case of doubt, the nurse stops and asks the doctor for confirmation***

**Point of loss of control:** preparation by the nurse of a drug that is not the right one.

**RECUPERATION :**

- Ultimate control before administering by the nurse: the nurse reads and announces the drug and dosage in order to ***detect the error.***

**ATTENUATION :**

- The administering error is detected before leading to bad outcome
- The patient receives compensatory care to mitigate the deleterious effects of wrong drug administered

**What have we learned about our safety model?**

The ***bold and italicised*** elements above in the safety model did not work as expected.

- The medical doctor in charge prescribed a drug not available in the ICU (atracurium instead of cisatracurium);
- Secured communication was not used.
- The oral prescription had not been correctly understood by the nurse.
- The extemporaneous preparation was not carried out by the nurse in accordance with the prescription
- The nurse was concerned but did not report it
- The final check before injection was not performed by the nurse so nobody could detect the mismatch.
- The senior physician in the ICU detected the mistake too late
- No mitigation action was required

**Reflection on the security model, taking into account the event:**

- Secured communication was not used. This effective practice allows enhancing the reliability of communication (gain of up to 10 times). It is highly unlikely that it would have detected the error in this case (cisatracurium and atracurium).
- The nurse is described as "inexperienced». The main question is to know how informed she is regarding the different kind of myorelaxant drug in the ICU.
- She prepared in this case what she had understood (the myorelaxant used in this ICU) and her reading process was influenced by her heuristic and her memory. She was concerned about the dosage indicating that she probably knew «her» myorelaxant). However, this feeling was not effective to cross the alarm threshold. Her lack of experience or the hierarchical gradient could have contributed to this situation.
- The doctor's oral prescription of a drug that is unavailable, but with a name very similar to that used in the ICU and with a very different dosage, thus creates a common mode of failure throughout the following safety chain: understanding, preparation, ultimate control.

### Conclusions

- Failure of a drug prescription in a crisis situation due to misunderstanding of the prescription
- The safety system is not very robust regarding the situation encountered: initial prescription of a drug not available in the ICU but with a very similar name and very different dosage to that commonly used.

### Proposal for corrective actions:

- Provide a list of available drugs to unfamiliar doctors
- Secure the drug prescription (patient identity, ICD prescription, route of administering, dosage)
- Secure communication.
- Foster the speak up process



## **PRIMUM NON TACERE** *Jérôme Cros*

What if doubt was a powerful ally to communicate effectively in healthcare? Yet it often faces a formidable enemy; silence.

Indeed, how can we imagine that doubt has never entered the minds of the actors in this situation? In the mind of the doctor, who prescribes this medication for the first time in this department, in the mind of the nurse who prepares for the first time 5 blisters of a medication of which no more than one ampoule is injected at a time? So how do you deal with doubt? First of all, it is necessary to investigate, by being attentive to non-verbal communication and by accepting uncertainty. Also, you have to verbalise it as soon as it appears; the nurse could have said: "So that's 5 blisters?".

Once the doubt has been expressed, it therefore initiates an exchange between caregivers for which the medical phraseology guide provides tools<sup>6</sup>. Actors can «climb the ladder of precision» by a succession of simple and precise questions and answers. They then reach a shared mental model of the situation.

This case highlights the importance of a saying close to the «primum non nocere» but more recent: «primum non tacere»<sup>7</sup> which could be translated as «First of all, do not remain silent». For this reason, it is necessary to culturally welcome in the care all expressions of doubt with kindness.

## THE IMPORTANCE OF RELIABLE PREOXYGENATION

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A 55-year-old patient was operated on for a T12-sacrum arthrodesis surgery (metastatic spine). A senior and an anaesthesiology resident comprised the team. The anesthesia station auto-test had been performed previously with a leakage less than 200 ml/min. The preoxygenation procedure revealed an unusual capnography curve. The resident suggested the presence of leaks due to the patient's beard. I validated this assumption but I was uncomfortable with it. The intubation was simple (cormack 2). Shortly after the beginning of the mechanical ventilation the physician viewed an unusual shape of the capnography curve with 12 mm Hg of capnia over several cycles. He controlled the breathing circuit and looked for a low BP but it was close to 85/55 mm Hg.

In order to discover what the problem was, he called for help. The surgeon wanted to begin the surgery as soon as possible but the physician decided to postpone the skin incision until the problem was fixed (No Go). He decided to change the anesthesia station and new equipment was set up. The capnography was normal (approximately 38 mm Hg with an «usual» shape) and then the procedure began.

After investigation, the technician discovered that the D-Fend had been dismantled and that one of the plastic rings wasn't correctly inserted, leading to a "micro" leak.

Good points: *No Go*

Ways for improvement: *Consider confirmation bias / Consider what is acceptable for a device and what is a "safety issue" / cognitive aids "hypocapnia"*

**KEY WORDS: D-Fend / unexplained hypocapnia**

## LET'S GO FISHING!

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The team had inserted a nasogastric tube into a child's stomach.

While they were trying to remove it at the end of the kidney transplantation, they realised that it was wrapped around the tracheal tube in the oropharynx. The tracheal tube was caught by a kind of lasso that had «tied» the tube.

When they decided to pull out the nasogastric tube, the patient extubation occurred leading to a deep hypoxemia and laryngeal bleeding. No bad outcome reported.

Good points: *sharing this case*

Ways for improvement: *In case of a doubt: Stop and think / handoff between care givers / check the right position of nasogastric tube*

**KEY WORDS: nasogastric tube / unplanned extubation / hypoxemia**

## ULTIMATE CONTROL BEFORE INDUCTION

I was working in the operating room. One of my colleagues admitted a patient into "my" OR because I needed a coffee break. The patient was already lying down on the table when I came back. I checked all medical documents and my colleague told me what he'd already done. I didn't check the venous catheter placed in the ward (24 hours ago). Five hundreds millilitres of Ringer Lactate (RL) had been connected to the IV line.

We started the IV induction and the anaesthetist felt some resistance with the injection of propofol. After the injection of 10 ml the patient was in pain and the anesthesiologist discovered a propofol extravasation in the left arm. At the same time, the patient began to fall asleep with some difficulty in breathing. The CRNA decided to take matters into his own hands and inserted a second IV catheter, while the anaesthetist tried to maintain correct oxygenation. Once everything had been fixed the patient became difficult to intubate (Eschmann tracheal tube introducer and two attempts for laryngoscopy)

**Good points :** *resilience / workload distribution*

**Ways for improvement:** *systematic IV catheter check before use / if you're concerned (weak signal)*

*=> remove the doubt*

**KEY WORDS:** *extravasation / induction / ventilation*



## THE GREAT TIDE !

At the end of the morning, a patient needed an upper digestive endoscopy under general anesthesia. He had an achalasia of the oesophagus. We were very tired because there had been a lot of work to do. We needed to perform an IV crush induction as confirmed by the gastroenterologist. The preoxygenation took longer than usual (5 minutes in a half sitting position). We injected the general anesthesia drugs and when we did the laryngoscopy we found that gastric fluid with food pieces were flooding the back of the throat. The suction tube was immediately blocked and the use of the endoscopy suction tube was also ineffective. The «tide» was still rising. The CRNA decided to blindly intubate while the other team members tried to find a solution. The tube was placed into the oesophageal and was partially blocking the upwelling flow. We connected the suction instrument to this tube. The second attempt for a laryngoscopy was successful with the use of an Eschmann tracheal introducer. We immediately administered a 20 ml bolus of saline solution and the suction instrument brought back a clear fluid (lowest SpO<sub>2</sub> measured at 75%). The postoperative chest X-Ray performed in the PACU was normal. No bad outcome occurred.

**Good points :** *awareness of the aspiration risk / sort of briefing before general anesthesia / resilience / preoxygenation*

**Ways for improvement:** *anticipate before the GA (workload distribution) / use of a suction system that remains functional in the event of «large size» food fragments / prevention of aspiration*

**KEY WORDS:** *aspiration / briefing*



## TAKE HOME MESSAGES

- **Think about the WHO surgical checklist as a cognitive aid.**
- **If you're worried, speak up!**
- **If I'm concerned, I call on the team members to eliminate the doubt.**
- **Once the patient is safe for a few seconds, step back to analyse your decision making process (advocate for the devil, question the team, verbalise aloud your decision making process, your vision of the situation and your plan).**

### BIBLIOGRAPHY

- (1) Jenicek M: Medical Error and Harm : Understanding, Prevention, and Control. Productivity Press, 2010  
doi:10.1201/9781439836958
- (2) Kahneman D: Thinking, Fast and Slow. New York, Farrar Straus Giroux, 2011
- (3) Amalberti R: Piloter la sécurité : Théories et pratiques sur les compromis et les arbitrages nécessaires. Dordrecht, Springer Verlag France, 2012
- (4) Rall M, Glavin R, Flin R: The '10-seconds-for-10-minutes principle.' Bull R Coll Anaesth 2008;2614–6
- (5) Pariès J, Rome F, Pibarot M-L, Tassaux D: Événements indésirables en médecine -  
[http://www.chu-nimes.fr/docs/nlm/Evenements\\_indesirables.pdf](http://www.chu-nimes.fr/docs/nlm/Evenements_indesirables.pdf)
- (6) Cros J: Mieux communiquer entre soignants. Un enjeu majeur de sécurité. Guide de phraséologie médicale., 1st edition. Arnette, 2018
- (7) Dwyer J: Primum non tacere. An ethics of speaking up. Hastings Cent Rep 1994; 24:13–8

### PARTICIPATION OF PLATFORM IN THE FOLLOWING UPCOMING EVENTS:

**7th Annual World Patient Safety, Science & Technology Summit co-organisé avec l'ESA et l'ASA  
– 18 et 19 Janvier 2019 – Huntington Beach – California – USA –**

<https://patientsafetymovement.org/events/summit/world-patient-safety-science-and-technology-summit-2019/#overview>