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Check for updates

Commentary: A checklist is nothing without simulation training and collaborative culture

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I have carefully reviewed this article, and I must congratulate the authors because their manuscript gives us the opportunity to reflect on some extremely interesting topics.[1] In itself, the clinical case is not particularly rare because, although the foreign body was of an iatrogenic nature, the removal method is entirely consistent with traditional rigid bronchoscopy procedures. The type of foreign body—the wire of the biopsy needle—is unusual and can certainly help to remind operators to be extra vigilant during procedures.

However, I very much appreciated the article in its conclusions when the authors introduce periprocedure checks as an instrument to prevent errors. To gauge the extent of the problem, it is enough to consider that "Over 200 million surgical procedures are performed each year globally, and despite awareness of adverse effects, surgical errors continue to occur at a high rate. Surgical errors account for a significant number of adverse events."[2]

But why are errors made during surgery? According to the 2017 National Healthcare Quality and Disparities Report, mistakes during surgery develop from the interaction of multiple individuals and pieces of equipment. To decrease surgical errors, providers need to know when and where mistakes may occur. It is common experience that to prevent surgical errors and enhance patient safety, hospitals have introduced several checklists of items that must be verified prior, during, and after procedures. In 2014, Collins and colleagues[3] well described surgical safety
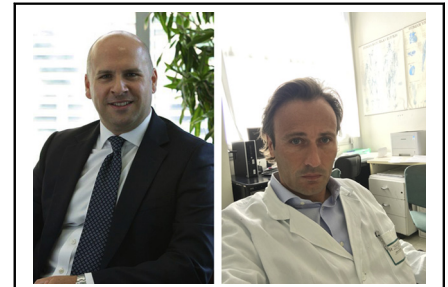
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CENTRAL MESSAGE

Checklists are an essential safety tool; however, they must be implemented together with other instruments such as simulation programs and a culture of error reporting to prevent mistakes.

checklists as being a successful intervention in reducing the recurrence of errors in the operating room. However, checklists alone will not prevent all mistakes. Indeed, fundamental requirements for successful implementation include the engagement of key stakeholders, a culture of trust, a shared vision for safety, and active communication.

In this regard, I suggest reading articles by Rinieri and colleagues,[4] Baste and colleagues,[5] and Dixon and colleagues.[6] The authors concur that checklists need to be implemented with other tools and describe how they successfully established at their institutions a comprehensive simulation program with crisis resource management and the introduction of multimedia support.

To conclude, although Bushra and colleagues did not run into an error but rather an adverse event or even a near miss, this case highlights the function of reporting errors. Indeed, it is common experience that fear of disciplinary or legal action makes health care professionals reluctant to report errors. Conversely, failing to report contributes to the likelihood of serious patient harm.

Therefore, I congratulate the authors once again for their article and encourage the audience to make a further effort in improving errors prevention at their institutions, always keeping in mind that mistakes can be avoided with better communication and cooperation between all persons involved and that mistakes represent an opportunity for constructive changes and improved education in health care delivery.

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