
Focus on patient safety

MEASURING & IMPROVING QUALITY

# French Emergency Medical Aid Service

## What if everyone played their part

20 January 2022

## It could happen to you too

Event 1

### DIAGNOSTIC ERROR LEADING TO THE PATIENT'S DEATH

*A 51-year-old female patient dials 18 for the fire ambulance service as she has chest pain and difficulty breathing. The call is transferred to the emergency ambulance service on line 15 without sending an on-call duty fire ambulance team. The medical dispatch assistant taking the call creates the medical dispatch record and notes her history of smoking and anxiety attacks. They transfer the call to the general practitioner dispatcher who after questioning issues the diagnosis of gastro-oesophageal reflux and the appropriate medicinal product prescription. There is another call to line 15 two hours after the first call. The medical dispatch assistant transfers the call to the general practitioner dispatcher who decides to send a private ambulance to her home which found the patient in cardio-respiratory arrest on arrival.*

**What happened?** *Immediate cause*

The general practitioner dispatcher made the wrong diagnosis.

**Why did it happen?** *Root causes, barriers absent or deficient*

- The second call was not transferred to the emergency dispatching physician.
- Procedures were not followed either by the 18 or 15 in light of the dyspnoea and chest pain.
- The medical decision remained focussed on the history of anxiety attacks.

HAS
HAUTE AUTORITÉ DE SANTÉ

Event 2

## ROLE OVERSTEPPED LEADING TO THE PATIENT'S DEATH

***A 69-year-old male patient dials 15 as they have had abdominal pain for 48 hours. The medical dispatch assistant decides to transfer the call to the general practitioner dispatcher, who, after brief questioning, decides to offer medical advice, tells them to contact their regular doctor and to call back if necessary. Another call is received 3 hours later. The medical dispatch assistant consults the previous record, does not create a new medical dispatch record and gives the contact details to SOS médecins. The patient is found dead at his home by his wife a few hours later.***

**What happened?** *Immediate cause*

The second call to number 15 was not transferred to the emergency dispatching physician.

**Why did it happen?** *Root causes, barriers absent or deficient*

- The questioning by the general practitioner dispatcher could not be used to confirm the diagnosis.
- The seriousness of the patient's condition was underestimated.
- The patient was not followed up.
- The medical dispatch assistant underestimated their own role and this led them to take a decision without consulting a doctor.
- The department procedures, recommending transfer to the emergency dispatching physician from the second call for the same dispatch record, were not followed by the medical dispatch assistant.

Event 3

## LACK OF DIRECT QUESTIONING OF THE PATIENT LEADING TO AN ERROR IN ASSESSMENT OF THE CLINICAL SEVERITY

***The wife of a 73-year-old male patient dials 15 as he has a sore throat. He saw his regular doctor the day before who prescribed him an antibiotic treatment. However his condition did not improve and even got worse. The medical dispatch assistant transferred the call to the general practitioner dispatcher who only spoke with the wife. After brief questioning, the general practitioner dispatcher advised them to see their regular doctor again. Thirty minutes later, the wife dialled 15 again as she is unable to get an appointment before the day after and she thinks that's too long to wait. The call is transferred to the same general practitioner dispatcher, who suggests the couple go to the accident and emergency department in their own car. On his arrival, the patient is in acute respiratory distress and needs to be intubated immediately and transferred to intensive care.***

**What happened?** *Immediate cause*

The general practitioner dispatcher underestimated the seriousness.

**Why did it happen?** *Root causes, barriers absent or deficient*

- The general practitioner dispatcher did not gather accurate information from the wife.
- The severity of the patient's clinical condition could not be properly ascertained.
- The patient went to the accident and emergency department by their own means without an ambulance being sent.

Key words: *Dispatch – Role of dispatching teams – Procedures – Team work – French Emergency Medical Aid Service*

## So it doesn't happen again

A little like how an orchestra works, each link in the medical dispatch chain must know and play their own part so as not to induce errors caused by overstepping their role or not following set procedures. The patient and/or their family are stakeholders and have a role to play in the team to ensure the response is tailored to the patient's situation. Levers for action must enable especially:

- action to be taken to be prepared individually and collectively by setting up briefings during which roles and responsibilities should be recalled;
- good practices to be recalled to maintain vigilance and ensure everyone can play their role;
- management of stress, knowing how to work under pressure and to tight schedules, managing fatigue during decision-making (e.g. health simulation);
- recordings to be played back to work on communication between professionals and with the patient and/or their family.

**An efficient medical dispatch team relies on team work and especially the distribution of roles between each person involved.**

# Focus on patient safety collection

The “Focus on patient safety” collection aims to draw the attention of and raise awareness among healthcare professionals as to risk management. Each focus covers a specific and recurrent risk based on care-related adverse events, identified and selected from national care-related serious adverse event reporting databases or doctors’ accreditation.

This focus on patient safety looks at adverse events caused by failings in the roles and responsibilities of the medical dispatch team members.

This guide relates events with which healthcare professionals have been confronted and which are always associated with a series of dysfunctions. For this specific focus on patient safety, and given the complex nature of the healthcare pathway, the events are not described in their entirety and the analyses reported focused on individual roles and communication.

## Find out more:


- Salas E, Shuffler M L, Thayer A L, Bedwell W L & Lazzara, E H (2015). Understanding and Improving Teamwork in Organizations: A Scientifically Based Practical Guide. Human Resource Management 54(4), 599–622.
- Leggat SG. (2007). Effective healthcare teams require effective team members: defining teamwork competencies. BMC Health Serv Res;7(1):17.
- Focus on patient safety. *www.has-sante.fr/jcms/p_3240311*
- Programme d’amélioration continue du travail en équipe : Pacte. *www.has-sante.fr/jcms/c_2831393*
- Briefing and debriefing. *www.has-sante.fr/jcms/c_2657908*
- French Emergency Medical Aid Service: care quality and safety improvement. Guide méthodologique. *www.has-sante.fr/jcms/p_3211255*



HAS HAUTE AUTORITÉ DE SANTÉ

Développer la qualité dans le champ sanitaire, social et médico-social