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# The Experience Feedback Committee (EFC) : an innovative safety enhancement tool in hospital setting?

Kevin Kamalanavin

## ► To cite this version:

Kevin Kamalanavin. The Experience Feedback Committee (EFC) : an innovative safety enhancement tool in hospital setting?. Political science. 2017. dumas-01785364

**HAL Id: dumas-01785364**

**<https://dumas.ccsd.cnrs.fr/dumas-01785364>**

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UNIVERSITE GRENOBLE ALPES

Institut d'Etudes Politiques

Kevin KAMALANAVIN

**THE EXPERIENCE FEEDBACK COMMITTEE (EFC),  
AN INNOVATIVE SAFETY ENHANCEMENT TOOL  
IN HOSPITAL SETTING ?**

*Année 2016-2017*

*Master : « Politiques publiques de santé »*

*Sous la direction de Claire DUPUY*



**Kevin KAMALANAVIN**

## **The Experience Feedback Committee (EFC), an innovative safety enhancement tool in hospital setting?**

(Titre Français : Le Comité de Retour d'Expérience (CREX) :

Un outil de gestion du risque innovant en milieu hospitalier ?)



(PAYNE Marc-Antony, *Photo of the British Airways Flight BA38 crash in London Heathrow (LHR)*, 17 January 2008, Creative Commons Attribution 3.0 Unported license)

**2017**

**Master 2 Politiques Publique de Santé**

**Sous la direction de la docteure Claire DUPUY**

Epigraphe

« La vérité de demain se  
nourrit de l'erreur d'hier »

Antoine de Saint-Exupéry, *Pilote de Guerre*,  
Gallimard, France, 1942

## **Remerciements**

Je souhaite remercier en premier lieu la Docteure Claire Dupuy, qui a accepté d'encadrer ce mémoire, pour son accompagnement, ses remarques, son aide, ses encouragements et sa bienveillance à mon égard.

Je souhaite également remercier le Docteur Guillaume Richalet et Madame Elisabeth de Carvalho pour m'avoir, lors de mon premier stage, transmis cette passion pour le milieu de la santé, de la qualité et de la gestion des risques, puis pour m'avoir accueilli de nouveau au sein de la Clinique des Cèdres.

Je remercie également le Professeur Patrice François et le Docteur Bastien pour m'avoir offert l'opportunité de réaliser deux stages très formateurs au sein du CHU Grenoble Alpes ainsi que pour leur rigueur méthodologique.

Enfin je remercie bien évidemment Monsieur Jacques Lockwood qui a bien voulu accepter la tâche ardue de corriger les erreurs d'anglais avant le rendu de ce mémoire.

Sur un plan plus personnel je souhaite remercier toute l'équipe de l'UQEM ainsi que celle de la Clinique des Cèdres pour leur accueil chaleureux et amical.

J'ai également une pensée amicale pour mes amis de Contre-Courant, pour toutes nos discussions enflammées qui m'ont permis d'apporter un autre regard sur mon sujet de mémoire.

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## Introduction

The report *To Err is Human* published in 1999 by the Institute of Medicine was a turning point in the way quality was approached. Indeed, this report was a deep shock, stating that between 44,000 to 98,000 people died each year in the United States due to medical errors<sup>1</sup>. With the publication of these figures, immediate actions were taken to make the western health system safer. In the years following this publication, experts proposed several tools and published many works to assess quality and safety in healthcare and to improve it. In 2000, in Great-Britain, the report *An Organisation with a Memory* was published which emphasized on the importance of Experience Feedback and sharing information and experience<sup>2</sup>. In the United States, the Agency for Healthcare Research and Quality (AHRQ) developed the Hospital Survey On Patient Safety culture (HSOPS) questionnaire in order to assess the level of safety culture of a setting<sup>3</sup>. Safety culture was defined as “*the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization’s health and safety management*”<sup>4</sup>, and it was supposed that settings with higher level of safety culture had better performances in ensuring quality and safety. Yet, despite these different actions in favor of a safer health system, in May 2016, the *BMJ* published an article by Makary and Daniels which stated that medical errors were the third cause of death in the United States. According to their estimation, 250,000 deaths are imputable to medical error each year in the United States<sup>5</sup>. In France, no such study exists to assess the number of medical-error-related death. However, a 2009 study estimated that 6.2 serious adverse event occurred for 1000 hospitalization days<sup>6</sup>. These figures show that quality and safety of care are still a concern even in western health system. They also show that even the safer systems will inevitably fail at some point and that a constant concern and attention must be kept on maintaining high level of safety. As such, safety should never be taken for granted.

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<sup>1</sup>KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages

<sup>2</sup>NATIONAL HEALTH SERVICE, *An Organisation with a Memory Report of an expert group on learning from adverse events in the NHS*, NHS, 2000, 108 pages

<sup>3</sup>SORRA Joann, NIEVA Veronica, « Hospital Survey on Patient Safety Culture », AHRQ Publication No. 04-0041, Agency for Healthcare Research and Quality, September 2004, 74 pages, p.1

<sup>4</sup>*Ibid*

<sup>5</sup>MAKARY Martin A, DANIEL Michael, « Medical error – the third leading cause of death in the US», *TheBMJ2016 353*, 2016

<sup>6</sup>MICHEL P *et al.*, « Les événements indésirables graves dans les établissements de santé : fréquence, évitabilité et acceptabilité », *Drees, Études et Résultats n° 761*, 2011

But we could wonder why quality and safety are so important. Firstly, we must raise a moral and ethical issue. Given the tremendous human cost underlined by the different studies, implementing defenses against medical error is critical to prevent such event and their disastrous consequences. Furthermore, *primum non nocere* (First do no harm) is one of the most important principles in health care and is a part of the Hippocratic Oath. Ensuring safety is thus an ethical and moral imperative for all health systems. But morals and ethics are not the only issues that justify the need to study quality and safety management in our health systems.

Research in the field of social sciences justifies our interest in the question of quality and safety in health care. How does a risk emerge in healthcare and more precisely in hospitals? How do the professionals frame this risk? How do they design and implement tools to manage it? All these questions call for answers coming from the fields of risk sociology, sociology of organizations, management, etc. Analyzing quality, safety, and tools such as the Experience Feedback Committee (EFC) might help answer these questions and provide a better understanding of the framing of risks and safety enhancement tools in such high-risk environment.

Thirdly, a financial and economic issue appears. Indeed, many studies highlighted the unacceptable high cost of errors for health care. The report *To Err is Human* evaluated the total national cost of medical errors (including direct and indirect cost such as compensation for disability, loss of production and work hours, etc.) “to be between \$17 billion and \$29 billion”<sup>7</sup>. In France, a study evaluated the hospitalization over cost for 9 categories of preventable adverse event to be as high as 700 million euros each year<sup>8</sup>. The authors recognize the limits of the study and most notably the fact that it only focuses on 9 categories of adverse events and excludes drug related adverse event. As such the total cost of medical errors in France is unknown but we can assume that it is unacceptably high. Judging by these figures, ensuring quality and safety thus appears as a necessity and we can even suppose that the cost of poor quality and safety of care is higher than the cost required to improve quality and safety.

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<sup>7</sup>KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages, Executive Summary p.2

<sup>8</sup>NESTRIGUE Clément, OR Zeynep, « Surcoût des événements indésirables associés aux soins à l’hôpital : Premières estimations à partir de neuf indicateurs de sécurité des patients », *Questions d’économies de la Santé* n°171-Décembre 2011, IRDES

A fourth issue is an institutional issue. Quality and safety must be ensured to protect the setting and the system. As a matter of fact, it is necessary to protect hospitals from the loss of trust, the fear, the legal prosecution and the other risks associated with the occurrence of an error.

Finally, we can mention a “prestige” issue. Health care is an important part of the international impact of a country. Achieving a high level of safety and quality of care would undoubtedly bring prestige to our health system and may attract skilled practitioners, famous teachers and researchers eager to exchange knowledge. This issue is especially important for our University Hospitals.

But before further exploring the topic, several terms should be defined.

First, “*an error is defined as the failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning).*”<sup>9</sup>

A risk is the “*the likelihood, high or low, that somebody or something will be harmed by a hazard, multiplied by the severity of the potential harm*”<sup>10</sup>.

Adverse event is the occurrence of an undesirable outcome (notably an injury) affecting the patient. Not all adverse events are preventable.<sup>11</sup>

Serious adverse events are adverse event with serious consequences such as temporary or permanent disability or harm, an increased length of hospital stay, or the death of a patient.

Finally, near misses are events which had the potential to cause harm to the patient but hopefully for different reasons had no consequences. Adverse events and near misses are mostly caused by errors<sup>12</sup>. Finally, quality process must be understood as the whole process and means of action put in place to ensure quality and safety in a given setting (including its quality and risk

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<sup>9</sup> REASON James, *Human Error*, Cambridge University Press, 1990 cité dans:

KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages, p.28

<sup>10</sup>NATIONAL HEALTH SERVICE, *An Organisation with a Memory Report of an expert group on learning from adverse events in the NHS*, NHS, 2000, 108 pages, p.13

<sup>11</sup>KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages

NATIONAL HEALTH SERVICE, *An Organisation with a Memory Report of an expert group on learning from adverse events in the NHS*, NHS, 2000, 108 pages

<sup>12</sup>*Ibid.*

management structures, its safety enhancement tools, its processes and protocols to manage different situations, etc.).

Now that issues have been discussed and that the main concepts of quality and safety have been defined, we can focus on the safety enhancement tools. More precisely the subject of this research paper will be the Experience Feedback Committee or EFC. It is a recent safety enhancement tool developed in France. This method is increasingly used by French hospitals and clinics. EFC is a *a posteriori* safety enhancement tool, which means it is based on the analysis of near-misses and adverse events to learn from errors and make the system safer<sup>13</sup>. According to Bird's pyramid, the occurrence of a serious adverse event or major accident is preceded by the occurrence of 600 near misses<sup>14</sup>. Consequently, learning from errors enables to identify the weaknesses of our system, to correct them and to delay the occurrence of a serious adverse event. Indeed, the goal of zero accident and adverse event is idealistic and unrealistic. However, we can implement safety enhancement tools reducing the risks of errors and decreasing their likelihood or their severity<sup>15</sup>. Moreover, the reports *To Err is Human* and *An Organisation with a Memory*, underlined the importance of experience feedback and of learning from errors to make our systems safer. Judging from these facts, we suppose that Experience Feedback Committees could be an effective safety enhancement tool.

Several issues justify our interest in this tool. Firstly, research papers and works about EFC are scarce. This tool has, for now, only been implemented in France where it was designed. Few evaluations of its efficiency have been published but we must underline the works of the team of the University Hospital of Grenoble and more particularly of Professor Patrice François and Doctor Bastien Boussat. Thus, this study may contribute to the about knowledge about Experience Feedback Committee and to better understand the strength and limits of this tool.

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<sup>13</sup>BOUSSAT Bastien *et al.*, « Experience Feedback Committee: a management tool to improve patient safety in mental health », *Annals of General Psychiatry*, 2015, 23 pages

<sup>14</sup>DEBOUCK F. *et al.*, « De la mutualisation des comités de retour d'expérience (Crex) à l'audit des pratiques cliniques », *Cancer/Radiothérapie*, Volume 14, Issue 6, 2010Pages, 571-575

<sup>15</sup>DEBOUCK F. *et al.*, « De la mutualisation des comités de retour d'expérience (Crex) à l'audit des pratiques cliniques », *Cancer/Radiothérapie*, Volume 14, Issue 6, Pages 571-575, 2010

KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages

NATIONAL HEALTH SERVICE, *An Organisation with a Memory Report of an expert group on learning from adverse events in the NHS*, NHS, 2000, 108 pages

But more importantly, this study may approach this issue from the angle of social sciences. Contrary to the existing studies on EFC, we will analyze the way the risk was raised and framed; the way professionals appropriated this framing; and finally, the consequences of this framing on the design of this tool and its adoption by the staff and management.

Secondly assessing the effectiveness of quality and safety processes is necessary to aim at the constant amelioration of our health system. Finally, this study has a personal and professional interest for me. As a future risk manager, studying this tool might help me better understanding the issues and difficulties of quality and safety management and enable me to better design and implement safety management and culture, and safety enhancement tools in my setting.

Experience Feedback Committee is thus a recent and promising safety enhancement tool. The choice of this subject for this research paper justifies itself by the need to assess the effectiveness of this tool and the lack of general knowledge about it. The main goal of this work will therefore be to understand how risks emerge in hospital settings and how tools are designed to manage these risks. We also seek to determine the reasons explaining the effectiveness of the Experience Feedback Committee, to understand how it affects staff perceptions and patient safety, and particularly the social science mechanism explaining its impact. Our research question is thus the following: **Under which conditions can Experience Feedback Committee be an effective and innovative safety enhancement tool?**

To answer this question, we conducted a qualitative study in two acute-care hospitals serving a French agglomeration of 675,000 inhabitants. The first study site is an 1800-bed public University hospital while the second one is a 165-bed private clinic. The surveyor conducted three waves of semi-directive interviews among eligible staff. Eligible staff members for the interviews were management, medical staff (physicians, midwives, pharmacists, etc.) and paramedical staff (nurses, head nurses, etc.) with at least 6 months of seniority in the setting. 36 interviews were conducted. The first wave focused on patient safety and the factors influencing it (including the impact of Experience Feedback Committees). The second wave focused on Experience Feedback Committees, Morbidity and Mortality Conferences, and their differences. Finally, the third wave focused on Experience Feedback Committees, their impact on the second study site and on patient safety. While “snowballing” method was used in the first two waves, direct contact was favored for the third wave. In addition to the interviews, the

surveyor observed and participated in several Experience Feedback Committees in both study sites to better understand the tool and its method, to collect information and data about it, and finally to confirm or infirm the data collected in the interviews. Interviews were recorded and transcribed with the consent of the investigated staff members. All files were strictly anonymized. The transcripts were submitted to a deductive horizontal and vertical textual analysis. The methods used in this study will be further detailed in part I.

In the second part, some theoretical concepts about risk management will be developed. More precisely, we will seek to explain the risk extraction in the field of health care, we will also explain the human error model to fully understand how errors occur and how to manage them. These concepts will be confronted to our results to determine the healthcare professionals' knowledge as well as their adhesion to these concepts. We will try to underline how risk extraction and human error model influenced the construction of the notion of risk and the design of quality and safety approaches in health care.

Eventually, in our third part, we will focus on Experience Feedback Committees to highlight the specificity, strength and limits of this tool. We will seek to explain its effectiveness and to understand how it produces its effect on patient safety and on staff perceptions and behaviors.

We will thus test the following hypotheses:

1/The effectiveness of the Experience Feedback Committee can be explained by its design and depends on its capacity to create adhesion and to bring about the implementation of action plans.

Specifically, we suppose that Experience Feedback Committee creates adhesion through the legitimization and implication of the staff members and compels the management to act as part of the need to manage associated risks.

This hypothesis is based on several reports and works, such as *To Err is Human, An Organisation with a Memory*, or James Reason's work, which recommend the implementation of experience feedback tools and system approach to make the health system safer<sup>16</sup>. It is also

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<sup>16</sup> KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages  
NATIONAL HEALTH SERVICE, *An Organisation with a Memory Report of an expert group on learning from adverse events in the NHS*, NHS, 2000, 108 pages  
REASON James, « Human error: models and management », *BMJ Volume 320*, 18 mars 2000, p.768-770

based on risk sociology literature and on works dealing with the delegation of the expertise, the structuration of expert groups, the support coalitions, and management of political and reputational risk<sup>17</sup>. These topics are notably detailed in the book of Olivier Borraz: *Les politiques du risque*<sup>18</sup>.

This hypothesis will be tested in chapter 3: Experience Feedback Committees and their effectiveness.

2/ In settings with low level of safety culture and quality approach, the Experience Feedback Committee loses effectiveness or fails.

Safety culture is defined as “*the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization’s health and safety management.*”<sup>19</sup>. Furthermore, works on safety and safety culture highlight the importance of management support, non-punitive response to error and system approach in quality and safety<sup>20</sup> as we have discussed previously.

We think that low safety culture impacts the effectiveness of Experience Feedback Committee through the behavior of the management which creates unfavorable conditions for the success of Experience Feedback Committees. This hypothesis is based on risk sociology literature, namely works on risk disownership by Borraz<sup>21</sup> and works on produced ignorance by Dedieu and Jouzel<sup>22</sup>

This hypothesis will be tested in chapter 4: Are Experience Feedback Committees influenced by the safety culture and quality approach of the setting?

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<sup>17</sup>BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages  
HENRY Emmanuel, GILBERT Claude, JOUZEL Jean-Noël, MARICHALAR Pascal (sous la direction), *Dictionnaire critique de l’expertise*, Paris, Presses de Sciences Po (P.F.N.S.P.), « Références », 2015, 376 pages

<sup>18</sup>BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

<sup>19</sup> SORRA Joann, NIEVA Veronica, « Hospital Survey on Patient Safety Culture », AHRQ Publication No. 04-0041, Agency for Healthcare Research and Quality, September 2004, 74 pages, p.1

<sup>20</sup> KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages

NATIONAL HEALTH SERVICE, *An Organisation with a Memory Report of an expert group on learning from adverse events in the NHS*, NHS, 2000, 108 pages

REASON James, « Human error: models and management », *BMJ Volume 320*, 18 mars 2000, p.768-770

<sup>21</sup>BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

<sup>22</sup>DEDIEU François, JOUZEL Jean-Noël, « Comment ignorer ce que l’on sait ? La domestication des savoirs inconfortables sur les intoxications des agriculteurs par les pesticides », *Revue française de sociologie* 2015/1 (Vol. 56), p. 105-133.

JOUZEL Jean-Noël, DEDIEU François, « Rendre visible et laisser dans l’ombre. Savoir et ignorance dans les politiques de santé au travail », *Revue française de science politique* 2013/1 (Vol. 63), p. 29-49.

3/ Morbidity and Mortality conferences facilitated the implementation of Experience Feedback Committee which methodology trickled down over Morbidity and Mortality Conferences.

Morbidity and Mortality Conference is another safety-enhancement tool, resembling the Experience Feedback Committee, whose analyses poor outcome and adverse event to enhance quality and safety of care<sup>23</sup>. Despite this similarity, it has been found that several units in different hospitals use both this method jointly. This observation raised questions about the relationship between these two tools.

We thus suppose that a phenomenon of path dependence enabled easier implementation of a new tool. Besides, we suppose that the trickle down of the Experience Feedback Committee methodology over Morbidity and Mortality conferences might be the consequence of organization change in risk management. We base our hypothesis on literature about political science and path dependence<sup>24</sup> but also on literature about culture, organization culture, and organizational learning<sup>25</sup>.

This hypothesis will be tested in chapter 5: Experience Feedback Committees and Mortality and Morbidity Conferences: superfluous tools or complementary ones?

4/ Experience Feedback Committees improves the safety culture of staff members, prompt the staff to adopt safety-favorable behaviors and thus improves global quality and safety in their units.

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<sup>23</sup>ORLANDER JD, BARBER TW, FINCKE BG, « The morbidity and mortality conference: the delicate nature of learning from error », *Academic medicine : journal of the Association of American Medical Colleges* 77(10), 2002, pages 1001-1006

ABOUMATAR HJ, *et al.*, « A descriptive study of morbidity and mortality conferences and their conformity to medical incident analysis models: results of the morbidity and mortality conference improvement study, phase 1 », *American journal of medical quality : the official journal of the American College of Medical Quality*, 2007 Jul-Aug, 22(4), pages 232-238

<sup>24</sup>Bruno Palier, « Path dependence (dépendance au chemin emprunté) », in Laurie Boussaguet *et al.*, *Dictionnaire des politiques publiques*, Presses de Sciences Po (P.F.N.S.P.) « Références », 2014 (4e éd.), p. 411-419.

<sup>25</sup>WEICK Karl E., « The Nontraditional Quality of Organizational Learning », *Organization Science*, 1991, p.116-124

KOENIG Gérard, « L'apprentissage organisationnel. Repérage des lieux », *Revue française de gestion*, 8/2015 (N°253), p.83-95

GUILHONA, TREPO G, « Réussir les changements par le développement de l'apprentissage organisationnel les leçons du cas de Shell », *Gérer et Comprendre*, septembre 2001, 65, p 41-54

BEN ABDALLAH Lotfi, BEN AMMAR-MAMLOUK Zeineb, « Changement organisationnel et évolution des compétences. Cas des entreprises industrielles tunisiennes », *La Revue des Sciences de Gestion*, 2007/4 (n°226-227), p. 133-146.



We suppose that this improvement in safety culture and quality and safety is achieved through raising awareness on error causation, quality and safety, and through improving knowledge about quality and safety. We base this hypothesis on different works focused on the emergence of the notion of risk<sup>26</sup>, on works on quality and safety approaches<sup>27</sup> and finally on works dealing with organizational learning<sup>28</sup>.

This hypothesis will be tested in chapter 6: Does the Experience Feedback Committee influence staff members' perception and safety culture?

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<sup>26</sup>BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

<sup>27</sup>KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages

NATIONAL HEALTH SERVICE, *An Organisation with a Memory Report of an expert group on learning from adverse events in the NHS*, NHS, 2000, 108 pages

REASON J., CARTHEY J., DE LEVAL M.R., « Diagnosing "vulnerable system syndrome": an essential prerequisite to effective risk management », *Quality Health Care*, 2001, 10 suppl 2, p. 21-25

<sup>28</sup>WEICK Karl E., « The Nontraditional Quality of Organizational Learning », *Organization Science*, 1991, p.116-124

KOENIG Gérard, « L'apprentissage organisationnel. Repérage des lieux », *Revue française de gestion*, 8/2015 (N°253), p.83-95

GUILHONA, TREPO G, « Réussir les changements par le développement de l'apprentissage organisationnel les leçons du cas de Shell », *Gérer et Comprendre*, septembre 2001, 65, p 41-54

BEN ABDALLAH Lotfi, BEN AMMAR-MAMLOUK Zeineb, « Changement organisationnel et évolution des compétences. Cas des entreprises industrielles tunisiennes », *La Revue des Sciences de Gestion*, 2007/4 (n°226-227), p. 133-146.

## I) Methods

This study was an interview-based qualitative study and an observational study. We conducted 36 interviews in two study sites. Interviews conducted during wave 1 and wave 3 were semi-directive interviews, while interviews conducted during wave 2 were directive. In addition to the interviews, the surveyor participated in several Experience Feedback Committees of different units to observe them, acquire first-hand knowledge and a better comprehension of this tool. Furthermore, the observation allowed verifying the assessment of the interviewed staff members.

The most obvious way to assess *a posteriori* safety-enhancement tool effectiveness might seem an evaluation of their effect on occurrence and recurrence of adverse events and on patient outcome. However, this method would be especially difficult and would present many methodological issues: as Lecoanet *et al.* explained “*low incidence of specific events would lead to a lack of statistical power*”<sup>29</sup>. Consequently, the effectiveness of such tool is often evaluated via the perception of their participant<sup>30</sup>. This fact thus explains our choice to conduct a qualitative interview-based study.

Both study sites serve the same predominantly urban agglomeration of 675,000 inhabitants in France. The first study site is a public University hospital with a capacity of around 1800 beds. The second one is a private clinic with a capacity of 165 beds. Three waves of interviews were conducted, the first two in the University Hospital and the third one in the private clinic. For the three waves of interviews, eligible staff members were management, medical and paramedical professionals having worked in the setting for more than 6 months. Among medical staff, midwives, physicians (including surgeons) and pharmacists were interviewed. Among paramedical staff, only the participation of nurses and affiliated staff (anesthesia nurse, operating theater nurse, etc.) and head nurses was researched. A nursing aid spontaneously

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<sup>29</sup> LECOANET André *et al.*, « Assessment of the contribution of morbidity and mortality conferences to quality and safety improvement: a survey of participants' perceptions », *BMC Health Services Research*, 2016, p.2

<sup>30</sup>*Ibid.*

ABOUMATAR HJ, *et al.*, « A descriptive study of morbidity and mortality conferences and their conformity to medical incident analysis models: results of the morbidity and mortality conference improvement study, phase 1 », *American journal of medical quality : the official journal of the American College of Medical Quality*, 2007 Jul-Aug, 22(4), pages 232-238

asked to be investigated and thus was included, but nursing aids' participation was not further researched.

A first wave of interviews was conducted in the University hospital on the topic of safety culture. During these interviews, the topic of Experience Feedback Committee was raised by the investigator. A second wave took place once again in the University hospital on the more specific topic of the relation between MMC and EFC. A third wave took place in the private clinic on the topic of EFC and its impact on patient safety. For the first and second wave, due to the size of the setting, few eligible participants were identified and contacted. Then, the investigator used the “snowballing” method to reach other participants.

**Table 1: Characteristics of respondents**

	First wave	Second wave	Third wave	Total
<b>Characteristics N (%)</b>	19 (100)	14 (100)	3 (100)	36 (100)
<b>Occupational group</b>				
<b>Head Nurse</b>	6 (31.6)	5 (35,7)	0 (0)	11 (30,6)
<b>Nurse</b>	3 (15.8)	3 (21,4)	2 (66,6)	8 (22,2)
<b>Nursing assistant*</b>	1 (5.3)	0 (0)	0 (0)	1 (2,8)
<b>Physician</b>	7 (36.8)	5 (35,7)	0 (0)	12 (33,3)
<b>Other medical Professionals</b>	2 (10.5)	1 (7,1)	0 (0)	3 (8,3)
<b>Quality and Risk manager*</b>	0 (0)	0 (0)	1 (33,3)	1 (2,8)

\* During the first wave study, a nursing assistant spontaneously proposed to be interviewed. Being a paramedical professional, the nursing assistant was eligible and thus was interviewed even if nursing assistant participation was not formally sought.

\* Management in the first setting refused to be interviewed.

(Author: Kevin KAMALANAVIN)

The interviews were recorded and transcribed with the consent of the interviewees. All transcriptions were anonymized and no element allowing identification of the respondents was collected (age, seniority, name, etc.).

## First wave

The interviews were conducted with 19 professionals from different units of the first setting described earlier: Neuropsychiatry, Emergencies, Geriatrics and Rehabilitation care, Operating Theater and Intensive Care Unit (ICU), and others (medical and technical units). Several Emergency units were present in the setting, two on the main site, and a third on a second site. The two units on the first site had the same characteristics and thus only one was investigated (unit A). However, the unit of the second site was very different from the units of the main site and was thus included in our survey as a second Emergency unit (Unit B). The average duration of the interviews was 40 minutes (minimum: 23:08, maximum 1:19:51)

The main question of the interview guide was the following : *“Pouvez-vous me parler, s’il-vous plaît, de la sécurité des soins dans l’établissement et des principaux facteurs ayant, selon vous, une influence sur celle-ci ?”* (What can you tell me about patient safety in the setting and about the main factors influencing it?). The complete interview guide is available in Appendix 1. As explained earlier, the interviews were recorded with the consent of the interviewees and transcribed. One interviewee refused to be recorded and thus the surveyor took written notes during the interviews. These notes were then submitted to the interviewee who accepted their use.

Both units with Experience Feedback Committees and units without Experience Feedback Committees were eligible for our study. Questions about EFC were systematically asked to the investigated staff members regardless of the fact their unit had or had not an EFC. Indeed, in the units without EFC, we tried to assess their knowledge of the tool, and whether staff members would like to have it implemented in their unit.

Given the size of the setting and the size of its staff (about 5000 paramedical and medical staff members), direct contact was nearly impossible. Thus, the “snowballing” method was used. A few identified staff members were contacted by mail to participate in the study. Regardless of their participation or their refusal, they were asked to recommend eligible professionals. The surveyor also asked some interviewed staff member whether they knew someone who would be interested in participating in the study. Selection bias was avoided by widening the entry

base of the snowballing (12 staff members were asked to recommend participants). The survey was stopped at 19 participants since saturation was achieved at the 16<sup>th</sup> interview.

**Table 2: Characteristics of first wave respondents**

<b>Characteristics N (%)</b>	<b>19 (100)</b>
<b>Occupational group</b>	
<b>Head Nurse</b>	6 (31.6)
<b>Nurse</b>	3 (15.8)
<b>Nursing assistant</b>	1 (5.3)
<b>Physician</b>	
<b>Other medical</b>	2 (10.5)
<b>Professional</b>	
<b>Units</b>	
<b>Neuropsychiatry</b>	3 (15.8)
<b>EmergenciesUnit A</b>	4 (21.0)
<b>EmergenciesUnit B</b>	3 (15.8)
<b>Geriatrics and Rehabilitation care</b>	3 (15.8)
<b>Operating theater and ICU</b>	2 (10.5)
<b>Others</b>	4 (21.0)
<b>Units with EFC</b>	14 (73.7)
<b>Units without EFC</b>	5 (26.4)

(Author: Kevin KAMALANAVIN)

## Second wave

Directive interviews were conducted with 14 professionals of the first setting. As the aim of this wave of interview was to test the relation and interactions between Experience Feedback Committee and Mortality and Morbidity Conference, only units using simultaneously these two tools were eligible. 5 units used both EFC and MMC; all were included in the study. These units were: Pediatrics and Obstetrics, Intensive Care Unit (ICU) and Anesthesiology, Digestive Surgery, Intern Medicine, Neuropsychiatry. Professionals were included regardless of their participation to one, both or none of these tools. Indeed, we wanted to assess their knowledge of these tools, their perception of the impact of the tool on their unit, etc. Interviews were recorded and transcribed with the consent of the interviewees.

The Interview guide was reduced to a more specific and directive in order to reduce the average length of an interview. Our aim in doing this was to increase participation in the survey and more specifically nurses' participation. Indeed, during the first wave, it was found that nurses were reluctant to participate for several reasons including the lack of time, understaffing, and the interview length. We thus hoped that by reducing this length nurses would be more willing to participate.

Our aim was to interview at least three professionals per unit: a doctor, a nurse and another professional. For the same reasons, as for the first wave, the snowballing method was chosen. At least one professional was identified in each unit and asked to recommend eligible participants. Average duration of the interviews 18 minutes 40 seconds (minimum 8:29, maximum 30:57).

The main question of the guide was the following: "*Votre service organise à la fois de RMM et des CREX, que pouvez-vous nous dire sur ces deux outils, leur organisation et apports ?*" (Your unit organizes both Morbidity and Mortality Conferences and Experience Feedback Committees, what can you tell us about these tools?). The complete interview guide is available in appendix 2.

**Table 3: Characteristics of second wave respondents**

<b>Characteristics N (%)</b>	<b>14 (100)</b>
<b>Occupational group</b>	
Head Nurse	5 (35,7)
Nurse	3 (21,4)
Physician	5 (35,7)
Other medical Professional	1 (7,1)
<b>Units</b>	
Pediatrics and Obstetrics	3 (21,4)
ICU and Anesthesiology	4 (28,6)
Digestive Surgery	1 (7,1)
Intern Medicine	3 (21,4)
Neuropsychiatry	3 (21,4)

(Author: Kevin KAMALANAVIN)

### Third wave

Interviews were conducted with 3 professionals of the second setting, a 165-bed private clinic. The aim of this wave was to assess perception of the staff on the impact of Experience Feedback Committees over quality of care and patient safety. Eligible professionals for this wave were medical and paramedical professionals who participated in the Experience Feedback Committee, regardless of their unit.

The interview guide was focused on Experience Feedback Committee and quality and safety. The main question was : “*Que pouvez-vous me dire sur le Comité de Retour d’Expérience et sur la qualité et la sécurité des soins ?*” (What can you tell me about Experience Feedback Committee and its impact over quality of care and patient safety?). Complete interview guide is available in Appendix 3.

Given the smaller size of the setting and the inclusion criterion, direct contact was favored. The surveyor contacted the eligible staff members and explained them the study and its goal. The interviews were recorded and transcribed with the consent of the interviewees. The first interview was 49:24 long, the second one was 22:12 long, and the third one was 55:24 long. The average duration of an interview was 42 minutes.

**Table 4: Characteristics of third wave respondents**

Characteristics N (%)	(100)
<b>Occupational group</b>	
<b>Head Nurse</b>	0 (0)
<b>Nurse</b>	2 (66,6)
<b>Physician</b>	0 (0)
<b>Other medical Professional</b>	0 (0)
<b>Quality and Risk managers</b>	1 (33,3)

(Author: Kevin KAMALANAVIN)



## **Analysis**

The interviews were recorded and transcribed except when consent was not obtained. Transcripts of the interviews were submitted to a deductive content analysis. Each transcript was thoroughly read and cut in several verbatim. Each verbatim was coded with a topic and keywords according to its content. The selected topics were the one of the interview guide. They were further refined by using keywords allowing quick and easy identification of the meaning of the verbatim. Several keywords could be inferred from the verbatim.

Once the coding of the transcripts ended, the surveyor analyzed the resulting data. This method was used for the three waves of interviews. The first analysis was mainly a “horizontal” analysis: for each topic, the surveyor sought to identify recurring themes, converging and diverging points of view. The aim of this analysis was to identify the strength and weaknesses of the tools, their differences, the opinion of the staff, etc. The analysis then tried to determine the reasons and factors explaining these statements.

For the first wave, a “vertical” analysis was also performed between three categories of staff members: medical professionals, head nurses, and nurses. The aim of this “vertical” analysis was to assess their opinions and knowledge on the concept of quality and safety of care and their adhesion to these models. The surveyor sought to identify differences of perception between professional categories and to determine a typology of staff members.

For the second wave, an additional “vertical” analysis was performed on the transcripts. For each unit, the transcript of all investigated staff members of the unit were gathered and analyzed to establish a typology of Morbidity and Mortality Conference and Experience Feedback Committees. This allowed both identification of methodological variation for the same tool but also comparisons of the MMC of each unit and between MMC and EFC.

## **Observation of Experience Feedback Committees**

Beside the interview based study, the surveyor observed several Experience Feedback Committees to familiarize himself with its method (ORION© method), its organization, its functioning, etc. More precisely, during the three waves of interviews, the surveyor observed and participated in different EFC.

In the first setting, the surveyor participated in 2 EFC: pediatrics and internal medicine. For the pediatric EFC, the surveyor was asked by voting of the members of the committee to analyze an event and to make a report for the next meeting. For the internal medicine EFC, the surveyor only observed the EFC. In this setting, the surveyor attended 5 meetings (4 in pediatrics and 1 in internal medicine).

In the second setting, the surveyor participated in the setting's EFC and attended all meetings

This observation and participation in Experience Feedback Committees allowed the surveyor to gain first-hand experience about the tool and thus to better understand and better interpret the results of the interviews. In addition, it enabled him to confirm some information given by interviewed staff member about the Experience Feedback Committees, its functioning, its strengths and limits

## II) What is a risk in hospital setting?

As we explained earlier, a risk is “*the likelihood, high or low, that somebody or something will be harmed by a hazard, multiplied by the severity of the potential harm*”<sup>31</sup>. Due to the difficulties associated to their activity, hospitals are high-risk settings: the condition of the patient, the organizational difficulties, the high-level of skill required, all increase the likelihood of the occurrence of an error. As we detailed earlier, several issues justify managing the risks in health care. But in this part, we will put the justification of risk management apart to focus on more concrete considerations.

Firstly, to fully understand risk management in a hospital setting, we must understand how the notion of risk emerged. In this prospect, we will detail mechanisms of the emergence of the risks notion and then explain how risk extraction occurred in the specific field of healthcare.

But understanding the emergence of this notion of risk is useless without understanding how risks materialize and how errors occur. This question of the error occurrence will be dealt with on our second chapter. In this chapter, we will try to highlight the mechanisms leading even the best people to make the worse errors and as such we will turn our attention to the model of human error in James Reason’s works. We will also try to determine how much the healthcare professionals know about this model and whether they adhere to it or not. To conclude this second chapter, we will detail the consequences of the level of knowledge and adhesion to the model on the actual risk management.

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<sup>31</sup>NATIONAL HEALTH SERVICE, *An Organisation with a Memory Report of an expert group on learning from adverse events in the NHS*, NHS, 2000, 108 pages, p.13

## 1) How does a risk emerge?

Many works on the sociology of risk have explained the emergence of risk. The first step in the emergence of risk is the loss of familiarity. Indeed, the more an activity is distant and badly known, the more people fear this activity. When an unusual event (such as a technician repairing a strange device in the neighborhood during a week-end), an annoyance (such as an unpleasant smell or a loud noise) or worse, an accident happens, and people tend to lose familiarity with an activity<sup>32</sup>. Coupled with fear, this loss of familiarity results in the extracting the activity from its context and the emergence of the perception of risk among these people. As such, bad experiences highlight the potential risks (real or alleged) associated to an activity<sup>33</sup>. But the loss of familiarity is not enough to make a risk emerge. This first step must be followed by the gathering of opposing experts<sup>34</sup>. The aim of these expert is to gather knowledge and expertise to underline the state of uncertainty about the innocuousness of the activity. In parallel, the opponents must continue to gather supporters to go beyond the local scale and mobilize its resources to attract the medias' attention. Mobilizing the medias' attention is essential to cause a risk extraction in the public and to force the authorities to put this problematic on the agenda<sup>35</sup>.

The risk belongs to the group which seizes it, publicizes it and makes it visible. This ownership of the risk allows the people owning it to frame the analyses and perception of this risk around a given topic, for instance the consequences on health, the economic consequences, etc. However, some actors refuse to acknowledge the risk for several reasons. Firstly, they may not be aware of this risk. Secondly, they may not be willing to acknowledge it because they do not see the uncertainties surrounding an activity as implying a risk. Finally, some actors do not want to acknowledge a risk to avoid having to manage it. This strategy has yet several limits. Not only does risk disownership allow other groups to take the ownership of the risk but also it allows these groups to frame it around their own issues and can make the risk even harder and costlier to manage. Owning a risk is thus capital to define the way the risk is framed and managed.

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<sup>32</sup>BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

<sup>33</sup>*Ibid.*

<sup>34</sup>*Ibid.*

<sup>35</sup>BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages  
JACQUOT Sophie, « Approche séquentielle (stages approach) », in BOUSSAGUET Laurie *et al.*, *Dictionnaire des politiques publiques*, Presses de Sciences Po (P.F.N.S.P.) « Références », 2014 (4e éd.), p. 82-90.

Up to a recent past, in the field of health care, the risk of medical error was widely ignored by the public. The reason is maybe to be found in the risk extraction: it was expertise-based and not based on collective action. Indeed, in the field of quality and safety of care, the loss of familiarity and the extraction of the activity from its context came when the report *To Err is Human* was published in 1999. This report was a deep shock for health care providers highlighting the impact of medical errors. Indeed, the authors estimated that between 44,000 and 98,000 Americans died each year due to medical errors and that the total cost of preventable adverse events was between 17 and 29 billion dollars annually<sup>36</sup>. In France, the tainted blood scandal and the overdosed radiotherapy irradiation scandal at the Epinal hospital also played a role in raising awareness about risks in hospital. Nevertheless, whereas telephone antennas and wastewater sludge became public problems when the public lost familiarity with these activities<sup>37</sup>, the issue of patient safety was raised by an expert group and never reached the status of public issue. In France, the two cited scandals raised awareness about specific activities but not about the global quality and safety of French hospitals. Furthermore, the death toll due to air crashes or nuclear disasters are often high which makes them very visible. Telephonic antennas and wastewater sludge affect many people in their day-to-day life. On the other hand, medical errors often lead to one or few victims at a time, making them less visible. In addition, health care is considered as naturally risked due to the conditions of patients and accidents are rarely reported in the press reducing even more their visibility<sup>38</sup>. These factors explain why, despite the importance of this risk, it is still underestimated and ignored by the public and why authorities did not set this risk on the agenda. The main variable explaining the lack of interest of public opinion and of many healthcare professionals about this issue is the lack of knowledge. Indeed, as we explained, medical errors suffer from low visibility and lack of media coverage. Consequently, the public opinion has very limited knowledge about the frequency, gravity and criticality of medical errors. It is thus especially difficult for victims, their relatives and patients' associations to gather supporters and extract the risk. We can also wonder how much healthcare professionals know about mortality associated to medical errors. If these professionals are

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<sup>36</sup>KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages

<sup>37</sup>BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

<sup>38</sup>KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages

REASON James, « Understanding adverse events: human factors », *Quality in Health Care* June 1995 4(2), p.80-89

certainly involved in quality and safety of care, we suspect that they are unaware of the real impact of medical errors.

Despite the lack of interest of the authorities and the public in the risks in health care, the emergence of this issue led to a second phase in risk construction the gathering and the production of an important amount of expertise about this issue<sup>39</sup>. Indeed, the report *To Err is Human* urged the professionals and the experts to further assess the extent of the risk, to find solutions to reduce risks. Following its publication, many studies were launched to assess the extent of medical-error related incidents in different countries, other reports and work suggested new ways to improve quality and safety, new management approaches were also developed by experts. The report *To Err is Human* was the one that extracted the risk but also highlighted fundamental ways of improvement which are still considered as basics in risk management<sup>40</sup>. Among the important works published to enhance quality and safety of care or to assess the extent of the risk, we can cite the report *An Organisation with a Memory*<sup>41</sup>, the works of James Reason<sup>42</sup>, the works aiming to develop and assess safety culture<sup>43</sup>, etc. Nowadays, the amount of available information about the issue and about ways of improvement is significant: new studies are regularly published and new tools are developed. The authorities mainly legislate in terms of responsibility of the actors and by giving them objectives in terms of security and quality.

A fact that must be underlined is the delegation of the decision about risk management to official expert groups (such as the *Haute Autorité de Santé* in France) and the importance of collaboration with other fields (such as the nuclear or aviation industry) and the private sector in developing safety enhancement tools. The role of the *Haute Autorité de Santé* is to produce

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<sup>39</sup>BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

<sup>40</sup>KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages

<sup>41</sup>NATIONAL HEALTH SERVICE, *An Organisation with a Memory Report of an expert group on learning from adverse events in the NHS*, NHS, 2000, 108 pages

<sup>42</sup>REASON James, *Human Error*, (traduction : *L'Erreur Humaine*), traduction HOC Jean-Michel, Presses des Mines, 2013, 404 pages, titre original [*Human Error*]

REASON James, « Human error: models and management », *BMJ* Volume 320, 18 mars 2000, p.768-770

REASON James, Understanding adverse events: human factors, *Quality in Health Care* June 1995 4(2), p.80-89

REASON J., CARTHEY J., DE LEVAL M.R., « Diagnosing "vulnerable system syndrome": an essential prerequisite to effective risk management », *Quality Health Care* 2001, 10 suppl 2, p. 21-25

<sup>43</sup>SORRA Joann, NIEVA Veronica, « Hospital Survey on Patient Safety Culture », AHRQ Publication No. 04-0041, Agency for Healthcare Research and Quality, September 2004, 74 pages

guidelines and good practice recommendations, to give accreditation to hospitals and clinics, and to implement compulsory continuous professional training. These guidelines are based on scientific consensus discussed during meetings of frontline professionals and experts<sup>44</sup>. The *Haute Autorité de Santé* also define eligibility conditions for training programs. The aim of these guidelines, recommendations and trainings are to improve the quality of the patient pathway in the health system and to improve the safety and reliability of French hospitals. Nevertheless, we can deplore the fact that these actions are somehow cut off from the reality in the field. Indeed, these guidelines can be inappropriate or inapplicable in some situations. Several limits in the accreditation process and of the training programs are also observed. For instance, some adverse event analyses are eligible as training programs, however, no control is applied over the method, content or even functioning of these analyses. In the field of cooperation and method transfer between health care and other high-risk activities, we can cite the example of Experience Feedback Committee. The Experience Feedback Committee has been developed in France thanks to the help of a private consulting society coming from the aviation sector<sup>45</sup>. This sharing of method and tools is enabled by the structuration of the risk management of these different activities around a common base. This common base, James Reason's model of human error, allows adapting the tools of one field to another despite their specificities. Using these tools, designed for another high-risk activity, enables the adoption of a new point of view and an outsider's view on the way risks are managed. This sharing is thus advantageous for both the donor and receiver by creating a benchmark between different sectors of activity. It also allows the strengthening of the relationship between those organizations and it creates an experience feedback on safety management.

As we have seen, the extraction of risk in health care was incomplete due to the absence of collective action and public interest. The ownership of the risk is mainly distributed between the authorities (which set the objectives and the responsibilities in case of error), the experts (including official administrative expert groups, experts and private sector entities which produce knowledge about this risk and develop tools to manage it and the actors of health care (who act in accordance with objectives set by the authorities and recommendation given by experts). Another aspect of risk management is the management of associated risks which are

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<sup>44</sup>CASTEL Patrick, CRESPIEN Renaud, « Bonne pratique médicale », in Emmanuel Henry *et al.*, *Dictionnaire critique de l'expertise*, Presses de Sciences Po (P.F.N.S.P.) « Références », 2015, p. 57-64.

<sup>45</sup>BOUSSAT Bastien *et al.*, « Experience Feedback Committee: a management tool to improve patient safety in mental health », *Annals of General Psychiatry*, 2015, 23 pages

a strong incentive to reduce the medical errors and to improve the quality of care. Associated risks are reputational or institutional (legal, financial, etc.) risks associated with the occurrence of an incident or accident. As such, public authorities and health care providers fear more the associated risk than the risk itself and as such seek to manage the associated risk more than the actual risk<sup>46</sup>. Several tools exist to manage associated risks and managing the associated risks in health care may be beneficial to the patients as it is a strong incentive for both the authorities and the provider to better manage the risk of medical error. Indeed, should they fail to ensure an appropriate level of safety, costly repercussions are to be expected, such as heavy compensations and damages, loss of income due to a deteriorated image, legal prosecution, forced resignation or electoral setbacks.

Once again, this assessment must be qualified since the interest of public authorities in safety is limited. Indeed, the lack of agenda setting of this risk tends to decrease the associated risks and to make them acceptable and manageable. The strength of this incentive is therefore reduced. A second limit to the interest of public authorities in patient safety is the competition between opposing objectives. Indeed, with the current context of economic and budgetary crisis, western governments focus more and more on budget control and cost cutting. On the other hand, quality and safety enhancement is seen as a costly objective and is often set aside in favor of the economic objectives. This phenomenon is observed both at the authority level and at the structure level. Indeed, with the *Tarification à l'activité* (T2A/ Price per activity) hospitals are more and more incited to raise their activity and improve their efficiency with constantly decreasing resources<sup>47</sup>. This goal is often achieved at the expense of the interest of the patient, of quality and safety of care, and the deleterious effect of the T2A are documented<sup>48</sup>. For instance, Angelé-Halgand and Garrot explain in their article how a project to improve operating rooms to reduce serious hospital-acquired infections was abandoned because it would have deprived the hospital of the resources coming from the readmission of these patient for the treatment of their hospital acquired infection<sup>49</sup>.

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<sup>46</sup> BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

<sup>47</sup> ANGELÉ-HALGAND Nathalie, GARROT Thierry, « Les biens communs à l'hôpital : De la " T2A " à la tarification au cycle de soins », *Comptabilité - Contrôle - Audit*, 3/2014 (Tome 20), p. 15-41

<sup>48</sup> ANGELÉ-HALGAND Nathalie, GARROT Thierry, « Les biens communs à l'hôpital : De la " T2A " à la tarification au cycle de soins », *Comptabilité - Contrôle - Audit*, 3/2014 (Tome 20), p. 15-41

PIERRU Frédéric, « Hospital Inc. Les professionnels de santé à l'épreuve de la gouvernance d'entreprise », *Enfances & Psy* 2009/2 (n° 43), p. 99-105

<sup>49</sup> ANGELÉ-HALGAND Nathalie, GARROT Thierry, « Les biens communs à l'hôpital : De la " T2A " à la tarification au cycle de soins », *Comptabilité - Contrôle - Audit*, 3/2014 (Tome 20), p. 15-41



Eventually, one last element tends to reduce the interest of public authorities and health care providers in quality and safety: a strategy of risk disownership<sup>50</sup>. In fact, and because of the low public awareness of medical error risk, some health care providers choose to ignore the risks to avoid blame. This risk disownership is based on the idea that it is preferable to ignore the risk than to raise the issue, to acknowledge the weakness of the system and face the associated risk mentioned earlier<sup>51</sup>. This strategy exists for instance in some settings where reporting an error is strongly discouraged and where people reporting such events face reprisals. We can assume it is rare but cannot exclude the existence of such a strategy. This strategy has, as we have seen earlier, several limits. However, due to the lack of interest of the authorities and public opinion in this matter, disowning the risk does not expose the health care providers to any drawback. Indeed, few groups are aware of the existence of this risk and even fewer are powerful and organized enough to seize its ownership. As such, should health care providers disown the risk, it is unlikely that another group might seize the ownership of the risk. However, this strategy of risk disownership is highly deleterious for quality and safety. As a matter of fact, if a problem does not exist, there is obviously no need to manage it. Thus, risk disownership prevents the implementation of quality and safety management in settings where the risk was not acknowledged or dismissed as meaningless and unimportant.

To conclude, in health care the notion of risk emerged following the publication of the report *To Err is Human* in 1999. This publication caused a loss of familiarity in health care providers and public authorities. However, this loss of familiarity and risk extraction did not occur in public opinion. As such, the risk was not set on the agenda and the interest in its management remained weak. This interest was further weakened by the importance of budget control and cost reduction in western health systems and the fact that quality is perceived as an over-costly goal. After having seen how the notion of risk emerges, we will now see how error occurs. Thus, we will now look upon and try to explain the model of human error of James Reason.

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<sup>50</sup> BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

<sup>51</sup>Ibid.

## 2) James Reason and the model of human error

High risk settings and difficult processes are known to favor the emergence of human error. As such health and more particularly hospital settings are highly vulnerable to human error<sup>52</sup>. But to analyze these errors and to prevent them, we must understand how human error happens. In this chapter, we will explore the works of James Reason and his famous Swiss Cheese Model, which are considered as basics in risk management. Indeed, James Reason's model, and the subsequent system approach, is the basis used by quality and risk managers to structure the quality approach and safety management in hospitals, and in many high-risks setting. Moreover, several tools, including Experience Feedback Committees, are based on this approach. As such, understanding this model will enable us to better understand the way safety enhancement tools are designed and used to improve quality and safety.

Errors find their origin in two different mechanisms. Indeed, James Reason differentiates the active error and the latent factors<sup>53</sup>. Active errors are unsafe, ruthless behaviors or wrong decisions or acts of the agents (nursing aids, nurses, doctor, etc.) which result in errors. They are the ones that create the adverse event. However, James Reason explains that a "person approach" of the error should not be used to analyze the accidents since it would lead to an ignorance of the latent factors which are more dangerous for the system than active errors<sup>54</sup>. Indeed, latent factors not only make the error possible but provoke or favor it. These latent factors are weaknesses in the system such as material, organizational, or management issues but more generally systemic conditions or failure<sup>55</sup>. To explain the influence of both latent factors and active errors in the occurrence of an adverse event or near miss, James Reason developed the Swiss Cheese Model (Figure 1).

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<sup>52</sup>KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages

NATIONAL HEALTH SERVICE, *An Organisation with a Memory Report of an expert group on learning from adverse events in the NHS*, NHS, 2000, 108 pages

<sup>53</sup>REASON James, *Human Error*, (traduction : *L'Erreur Humaine*), traduction HOC Jean-Michel, Presses des Mines, 2013, 404 pages, titre original [*Human Error*]

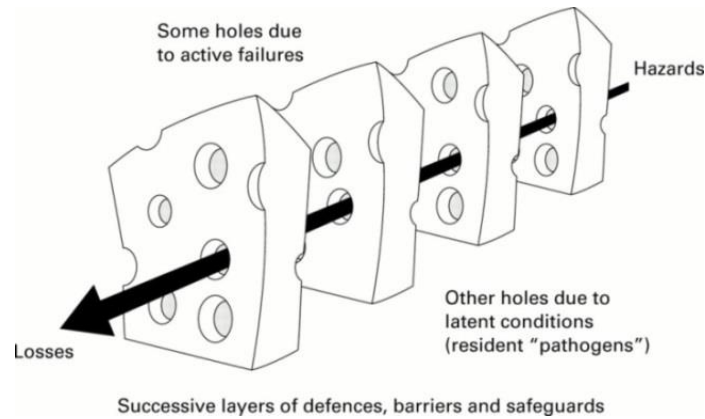
REASON James, « Human error: models and management », *BMJ Volume 320*, 18 mars 2000, p.768-770

REASON James, « Understanding adverse events: human factors », *Quality in Health Care*, 1995,4(2), p.80-89

REASON J., CARTHEY J., DE LEVAL M.R., « Diagnosing "vulnerable system syndrome": an essential prerequisite to effective risk management », *Quality Health Care*, 2001, 10 suppl 2, p. 21-25

<sup>54</sup>*Ibid.*

<sup>55</sup>*Ibid.*



**Figure 1: The « Swiss Cheese Model », James Reason:**

REASON J., CARTHEY J., DE LEVAL M.R., « Diagnosing "vulnerable system syndrome": an essential prerequisite to effective risk management », *Quality Health Care* 2001, 10 suppl 2, p. 21-25

In this model, each slice is a barrier defense put in place to avoid the occurrence of an accident. However, each barrier has weaknesses; these holes are mostly latent factors existing in the system. These holes open and close depending on the situation. When several holes line up, the active error of agents can go through several barriers. Should enough latent factors be assembled all the defense barriers would be rendered useless and the accident would happen as illustrated in the figure<sup>56</sup>. Latent factors are thus especially dangerous for the system because of their tendency to weaken defense barriers and to lead even the best agents to commit active errors<sup>57</sup>. In addition, it is necessary to be aware of hindsight bias and to avoid it at all cost to fully understand the error causation. Hindsight bias is the tendency to blame person the responsible of the error because it was foreseeable, that this decision was obviously bad, that the solution was crystal clear and simple<sup>58</sup>.

<sup>56</sup>REASON James, *Human Error*, (traduction : *L'Erreur Humaine*), traduction HOC Jean-Michel, Presses des Mines, 2013, 404 pages, titre original [*Human Error*]

REASON James, « Human error: models and management », *BMJ Volume 320*, 18 mars 2000, p.768-770

REASON James, « Understanding adverse events: human factors », *Quality in Health Care*,1995,4(2), p.80-89

REASON J., CARTHEY J., DE LEVAL M.R., « Diagnosing "vulnerable system syndrome": an essential prerequisite to effective risk management », *Quality Health Care*, 2001, 10 suppl 2, p. 21-25

<sup>57</sup>*Ibid.*

<sup>58</sup> KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages

NATIONAL HEALTH SERVICE, *An Organisation with a Memory Report of an expert group on learning from adverse events in the NHS*, NHS, 2000, 108 pages

REASON James, *Human Error*, (traduction : *L'Erreur Humaine*), traduction HOC Jean-Michel, Presses des Mines, 2013, 404 pages, titre original [*Human Error*]

REASON J., CARTHEY J., DE LEVAL M.R., « Diagnosing "vulnerable system syndrome": an essential prerequisite to effective risk management », *Quality Health Care*, 2001, 10 suppl 2, p. 21-25

However, when an error occurred, those who acted and failed did it without all the information on or knowledge of the outcome. In addition to the question of knowledge, we can mention the impact of human factors and ergonomics in the production of error. Unergonomic tools or process or stress and tiredness can influence the decision-making for better or more probably for worse. Thus, it is always easier to see the errors, the bad decisions after they occurred than before<sup>59</sup>. Hindsight bias is especially harmful for safety systems as it tends to mask the influence of latent factor and to create a blame culture which dissuades staff members to speak about errors, to analyze their causes and to enhance safety by correcting latent factors. It also creates a denial culture inside the setting, convincing staff members and management that there is no safety problem only unskilled and unqualified staff<sup>60</sup>.

To illustrate the influence of latent factor over the error production and the role of hindsight bias in error analysis, we will use two examples, a medical one and an aviation one.

The first one is the use of vinca alkaloids (such as vincristine) through intrathecal (spinal) way. Vincristine is a chemotherapy used for instance in the treatment of leukemia. It is well-known by medical staff that vinca alkaloids should be used intravenously and should never be given via intrathecal way. In fact, vinca alkaloids are nearly always lethal if injected intrathecally. Though, in England and Wales between 1985 and 2000, drugs were maladministered intrathecally 13 times (almost once a year), and 12 instances of these maladministration involved vinca alkaloids<sup>61</sup>. Were these people completely stupid? Well, this question illustrates by itself the tendency to hindsight bias and the answer is obviously no. The best people can sometimes fail should the correct factors be assembled. When vinca alkaloids maladministration are reviewed, several latent factors are identified. The main cause of these errors is the fact the combined use of another drug which is to be injected intrathecally (for instance the methotrexate). Here we can see how a latent factor in the organization of care can lead to an error. Indeed, should they be injected the same day, Methotrexate and Vincristine might be administrated via the wrong way if injected the same day. Moreover, several other factors influence the emergence of an error such as time restrictions, poor label placement, poor

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<sup>59</sup>*Ibid.*

<sup>60</sup>*Ibid.*

<sup>61</sup>NATIONAL HEALTH SERVICE, *An Organisation with a Memory Report of an expert group on learning from adverse events in the NHS*, NHS, 2000, 108 pages

REASON J., CARTHEY J., DE LEVAL M.R., « Diagnosing "vulnerable system syndrome": an essential prerequisite to effective risk management », *Quality Health Care*, 2001, 10 suppl 2, p. 21-25

packaging, stress, understaffing, lack of experience, task interruption or even tiredness. Poor label placement could mask the name of the drug or the warning about its lethality if injected intrathecally. Packaging the two drugs together coupled to understaffing, tiredness, lack of time or task interruption could lead the staff to pick the drug and to forget the final verification before injecting it especially when as mentioned earlier two drugs with different routes are injected the same day. We could list many more factors but the point is that this example enabled us to show how latent factors can lead even the best to fail tragically. Lessons have been learned from such accidents as several authorities including the French Agency for the Safety of Health Products (ANSM) now forbid the injection of vinca alkaloids and another drug the same day or the packing of it in the same packaging<sup>62</sup>.

The second example is the Flight AF447 air disaster<sup>63</sup>. During a flight from Rio to Paris, a pilot error occurred and the consequent stall led to the loss of the plane and its passengers. When an aviation disaster occurs due to pilot error, the medias often focus on the human error. Pilots are being blamed for poor decision making and for failing to make the right decision to avoid the accident. This tendency is the perfect example of hindsight bias. Indeed, even if the pilots failed, their failure and inability to correctly understand the situation and to make the good decision is dependent on several factors. In the case of flight AF447, one of the main causes of the disaster was the failure of the pilots to identify the stall situation and to correct it<sup>64</sup>. Nevertheless, several factors influenced their decision-making ability. At first, one of the most important is the icing of the Pitot tube. It caused inconsistencies in airspeed measurement which caused autopilot to disconnect and information to be lost about the airspeed of the plane. The disconnection of autopilot created panic in the crew which reduced their situational awareness and cognitive capacity. Furthermore, Air France pilots were insufficiently trained to cope with such situations. The panic, the absence of reliable airspeed information, the lack of training misled the pilots into not understanding the stall alert and to make the active error which caused the disaster<sup>65</sup>.

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<sup>62</sup> ANSM, « Rappel des recommandations visant à prévenir les risques d'administration intrathécale de vinca-alcaloïdes », In ANSM.Sante.fr [en ligne], 24/03/2009, Disponible sur < <http://ansm.sante.fr/S-informer/Informations-de-securite-Autres-mesures-de-securite/Rappel-des-recommandations-visant-a-prevenir-les-risques-d-administration-intrathecale-de-vinca-alcaloïdes> >, [Consulté le 10/02/2017]

<sup>63</sup> BEA, « Rapport final Accident survenu le 1er juin 2009 à l'Airbus A330-203 immatriculé F-GZCP exploité par Air France vol AF 447 Rio de Janeiro – Paris » [en ligne], juillet 2012, Disponible au format PDF sur Internet <<https://www.bea.aero/docspa/2009/f-cp090601/pdf/f-cp090601.pdf>>, consulté le 10/02/2017

<sup>64</sup>*Ibid.*

<sup>65</sup>*Ibid.*

Other causes and factors played a role in the disaster<sup>66</sup>. However, this summary illustrates well the tendency to hindsight bias and the role of latent factor in the happening of an accident.

We have demonstrated the influence of latent factors on the emergence of errors, adverse events, near misses and accidents. Therefore, active error and failing people should not be blamed. James Reason and several experts explained the importance of a “system approach” and of non-punitive response to error systems to prevent the emergence of error or reduce its frequency<sup>67</sup>. James Reason highlighted this need writing: “*We cannot change the human condition, but we can change the conditions under which humans work*”<sup>68</sup>. The system approach focuses on the contribution of latent factors in error causation and aims to identify them as much as possible to eliminate them. This system approach is based on systematic analysis of error and adverse events to learn from them. Thus, it supposes a non-punitive culture in the setting to incite the staff to report such events. System approach is based on the idea that punishing the error and ignoring the latent factors is useless as all contributing factors will still be present. These factors will undoubtedly line up sooner or later to cause the same or a similar adverse event again. Learning from error is therefore of the utmost importance.

This system approach does not aim to underestimate or ignore the role of active error in accident causation, or to remove all notion of responsibility of the professionals. However, it aims to better understand all the factors and the root cause(s) (causes directly responsible for the occurrence of the accident such as Pitot tube failure in our example) concurring to the occurrence of an error to prevent its recurrence by learning from it. It also aims to develop a more accurate notion of responsibility in error, which means a professional cannot bear sole responsibility for the accident or be the scapegoat, but still has a share of responsibility in terms of legal prosecution. However, risk managers and global management should not emphasize

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<sup>66</sup>*Ibid.*

<sup>67</sup>KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages

NATIONAL HEALTH SERVICE, *An Organisation with a Memory Report of an expert group on learning from adverse events in the NHS*, NHS, 2000, 108 pages

REASON James, *Human Error*, (traduction : *L'Erreur Humaine*), traduction HOC Jean-Michel, Presses des Mines, 2013, 404 pages, titre original [*Human Error*]

REASON James, « Human error: models and management », *BMJ Volume 320*, 18 mars 2000, p.768-770

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REASON J., CARTHEY J., DE LEVAL M.R., « Diagnosing "vulnerable system syndrome": an essential prerequisite to effective risk management », *Quality Health Care*, 2001, 10 suppl 2, p. 21-25

<sup>68</sup>REASON James, « Human error: models and management », *BMJ Volume 320*, 18 mars 2000, p.768-770, p.769

active error but latent factors, instead a non-punitive response to error should be implemented to favor the reporting of errors, near-misses and adverse events.

Nevertheless, to fully understand quality and risk management in a hospital setting, understanding Reason's model is insufficient, we must also wonder whether the professionals know it, what they understand about latent factors and errors, and if all the categories of professionals adhere identically to this model. To answer these questions, we used the information collected during the interviews. We conducted a vertical analysis of interviews to determine to their knowledge of James Reason's work, their awareness about latent factors, their adhesion to or their use (conscious or not) of the system approach. It must be underlined that few interviewed staff members directly mentioned concepts of quality and safety management or Reason's works. However, the analysis of their statements allowed us to determine their understanding of these concepts and the way it structured their practice. 5 types of staff members were identified based on several variables. The selected variables were the most significant ones to explain the adhesion to the model and thus the participation in quality approach. These most significant variables are the relation to quality, the importance given to quality and safety during initial training, the knowledge of the model. These variables tend to explain the implication of the category in quality and safety management tools, and their attitude toward the management of the hospital.

A separate model was created for the managers. We identified 2 types based on their adhesion and support of quality and safety management. We decided to create this second model to fully represent the different logics of quality and safety management, one coming from the management, a top down logic, and one coming from the staff a bottom up logic. These two logics combine to design the safety culture and approach of the setting. As such these two different logics must be acknowledged to fully understand the structuration of quality approach in a given setting.

### ***The Quality-Concerned Physician*** (4 physicians, 1 pharmacist)

These doctors know James Reason's model well, some even mention it. They understand as well, the impact of latent factors. They adopt a system approach in their work and are conscious of the diversity of latent factors and of their nature. They insist on the fact quality and safety enhancement can only be achieved by the elimination of latent factors and improvement in the work environment (organization, equipment, staffing, etc.).

For instance, about working conditions and lack of equipment (in this case a special type of ultrasound scanner) a doctor declared:

*“si les soignants se sentent pas bien, on ne peut pas prendre en charge correctement les patients dans l'endroit”* Wave 1 Doctor 2

*“je trouve que ça désorganise le parcours patient, parce que moi, par exemple, l'échographie ça m'orienterait le devenir du patient, alors que là ça laisse le patient dans la nature sans savoir ce qu'il devient pendant quelques jours en errance diagnostic et en sachant que c'est vrai que le résultat de l'échographie nous permet d'orienter le patient”* Wave 1 Doctor 2

These doctors disagree with the cost-reduction objective. They do their best to improve quality and safety in their unit and are always willing to further implement quality approach. They also mostly insist on the need of multidisciplinary team to work on quality and safety issues. Many of them insist on the importance of initial formation and of continuous training of the staff to make the system safer.

### ***The Rebellious Physician*** (4 physicians)

The rebellious physicians know Reason's model as well as quality concerned physicians. They also heavily insist on the impact of latent factors and on the importance of system approach and quality approach. These physicians underline the role of budget cuts and the subsequent latent factors (lack of equipment, understaffing, high level of stress, tiredness, and thus absenteeism, etc.) in the current degraded situations of their unit.

These doctors are appalled by the management's behavior. They explain that the management focuses only on financial objectives and does not care for quality and safety, thus ignoring latent factors and issues in the hospital. Most of these rebellious physicians are disheartened by this situation and declare having totally given up hope to improve quality and safety. Yet, they still



participate in quality and safety improvement initiatives, meetings or tools (such as Experience Feedback Committees) because of their commitment and ethics. Most of them envisage leaving the setting because of the situation. They oppose as much as they can the decisions taken by the management (for instance by denouncing corridor beds) and try to develop their own safety enhancement tools in their unit to improve the practices of their teams. They are in direct and claimed opposition to hospital management, and do not hesitate to openly and severely criticize budget restrictions, current public health policies, and behavior of both the managers and political decision-makers.

*“Je sais que certains collègues en ont quitté le CHU pour ça, parce qu'ils n'arrivaient plus à offrir des soins satisfaisants aux malades et qu'ils préféraient quitter cette structure, aller dans une autre structure qui leur permette d'offrir une meilleure qualité de soins”* Wave 1 Doctor 3

*“Je pense que c'est globalement la démarche qualité dans un CHU qui est pas bien perçue à part comme inutile. Je pense que c'est un problème de culture.”* Wave 1 Doctor 4

### ***The frontline professionals*** (5 nurses, 1 nursing aide, 1 midwife)

This category of staff members is mostly composed of nurses, but also some intermediate medical professionals. People in this category mostly do not know Reason's model. However, they are conscious about the fact that quality and safety of care are influenced by several latent factors, which they identify as organizational, environmental, material, etc. issues. If, as we explained, people in this category have basic knowledge about quality and safety concepts, their degree of knowledge is more variable than in other categories, ranging from basic knowledge that some latent factor may cause an error, and a lack of knowledge of the system approach to an extensive level of knowledge about latent factors and system approach.

Their understanding of quality and safety can be explained by their position as frontline professionals. Being frontline professionals they are more frequently confronted with latent factors, organization and systemic failure and are more frequently confronted with errors. As such, they have an intuitive understanding of the system approach.

The degree of knowledge depends on the initial and continuous training the staff had undertaken. The implication of the staff member in quality approach and/or in safety enhancement tools also impacts their knowledge of Reason's model and system approach. The more they participate in quality approach, the more they know about quality and safety.

However, in this category, knowledge seems to be more commonly shared between members than in the others. Thus, the participation of a nurse, for instance, to a quality or safety enhancement tool tends to raise awareness about quality and safety among the unit or at least the nurse's coworkers. As such, another determinant variable influencing the level of knowledge of this category is the level of implication of the unit and of their coworkers in quality and safety approach.

Some nurses are appalled by the lack of interest of management in quality and safety and by their working conditions. Like the rebellious physician, these nurses envisage leaving the setting. This category insists more heavily than others on the importance of adequate staffing, equipment and resources to make the system safer.

*“Moi personnellement, je trouve que le mot qualité des soins c'est un mot à la mode, on en entend bien parler. Moi ça fait 2 ans que j'ai été diplômé, à l'école on nous en parle, et pour les urgences je trouve qu'on manque de moyen pour être optimal. On pourrait être meilleurs mais on manque de monde pour y arriver...”* Wave 1 Nurse 2

### ***The Head Nurse in charge of quality*** (6 head nurses)

This professional category knows the model very well. Some head nurses even cite the name of the model. They are fully aware of the impact of latent factors on the safety of their unit. Head nurses insist on the fact that all factors must be acknowledged even if some are more important in their own unit. They use the system approach to understand the problems of their unit and the adverse events.

This knowledge and their focus on system approach are explained by the training they have undertaken. Indeed, a part of this training focuses on quality and safety of care. Moreover, they are often designated to be a quality manager in the unit. However, head nurses are forced by their role to consider other management issues. They try their best to reconcile quality and safety with the management imperatives. Some head nurses declare they are appalled by the choices made by the management and especially the cost-cuts which are said to badly affect quality and safety of care.

*“C'est vraiment le modèle de Reason tel qu'on le voit : le gruyère percé, on se rend compte qu'à un moment l'environnement dysfonctionne, la procédure a merdé, et puis au bout du bout*

*du bout on est tous passé à travers le gruyère et on arrive à quelque chose qui n'aurait pas dû arriver.”* Wave 1 Head Nurse 5

***The Uninterested Staff Members*** (3 head nurses, 1 physician, 1 nurse)

Uninterested staff members are found in different categories of medical or paramedical professionals (physicians, head nurses, etc.). They are mildly invested in quality approach and lack in interest for quality and safety of care. They have a poor knowledge of quality and safety concepts. As such they do not know (or barely know) the model of James Reason or the system approach. If prompted they may recognize the role of latent factors but do not apply system approach in their own initiative. Some of these professional (a head nurse and the physician) favor the person approach and blaming culture to “manage” the errors.

Their poor knowledge can be explained by the lack of initial training on quality and safety of care, especially for some older staff members (the physician and a head nurse). In addition to this lack of initial training, communication in the setting and units about quality and safety approach (especially for the nurse and a young head nurse) is lacking. Finally, a lack of continuous training in the setting does not enable the staff to address this lack of knowledge.

*“Ce qui conduit à des EI [événements indésirables], c'est l'incompétence des gens”* Wave 1 Doctor 1

As the management of the first setting refused to participate in our survey, the following categories of management will be based on observations of several settings, theoretical concepts, statements of staff members and HSOPS based surveys on the first setting.

***Efficiency-based management***

Efficiency-based management focuses on management and financial objectives over quality and safety objective. We suppose that given the fact that hospital management in France learn quality issues at the *Ecole des Hautes Etudes en Santé Publique*, they know or at least they have heard of James Reason's model but that this knowledge of the model is confronted with their other management objectives.

Coupled with an important number of uninterested staff members, this category of management leads to a weak quality approach used mainly to comply with the requirements of the supervising authorities such as the *Haute Autorité de Santé*. Such a quality approach is however useless to improve quality and safety significantly.

The situation is slightly better when the staff members are involved in quality and safety. However, such a situation creates human resources problems and more specifically dissatisfaction of the staff members, professional suffering, burn out risks, high level of turn over, etc. In this type of setting, many rebellious physicians or rebellious nurses can be found.

### ***Quality-based management***

Quality-based management focuses on quality and safety of care; they thus become the main objectives of the setting. Furthermore, the management in this category uses quality and safety enhancement tools and quality and safety indicators as management tools. Such managers would obviously be aware of James Reason's model and of the system approach. Achieving this degree of management is one of the objectives of the French *Haute Autorité de Santé*, but settings with such management are still rare in France, but more frequent in the United States given the efforts of the expert groups (Institute of Medicine and AHRQ). We suppose that in such settings, rebellious physicians become quality-concerned physicians and that the number of uninterested staff members declines. Indeed, as quality becomes a major tool of management in such settings, it raises awareness about quality and safety among the staff and creates adhesion around the setting's project and approach. Moreover, quality and safety trainings improve knowledge of the uninterested staff members and help them get involved in quality approach. Thus, even if this type of management is still dependent on quality-invested staff members to implement its quality approach, we believe that these managers are able to initiate an organizational culture shift and to convince the staff to support their quality approach.

As such, quality-based management would lead to the adoption of a comprehensive quality approach using safety-enhancement tools both *a priori* (such as cartography of risks) and *a posteriori* (Experience Feedback Committee and/or Morbidity and Mortality Conference). Furthermore, this comprehensive quality approach would focus on achieving high level of quality, safety, patient satisfaction, staff satisfaction, ... Non-punitive response to error and openness would also be favored in such settings to encourage reporting of near-misses and adverse events. Finally, in quality-based management, quality and safety are seen as an

approach needing the contribution of every staff member and not just of elite high-ranking professionals (such as management and physicians).

This quality-based management is thus to be compared to High Reliability Organizations (HRO), which are organizations working in high-risk environments (nuclear industry, aviation, military settings such as aircraft carriers, etc.) but renowned for their capacity to achieve high safety and low numbers of accidents despite their environment. According to Weick and Sutcliffe, HRO have five main characteristics: preoccupation with failure (by an *a priori* and *a posteriori* safety approach and thorough analysis of near misses and adverse events), reluctance to simplify (which means adopting a system approach and root cause analysis), sensitivity to operations, commitment to resilience, deference to expertise (including expertise of lower-ranking staff members)<sup>69</sup>. As such, achieving quality-based management in health care would bring hospitals closer to the organizational culture of these HRO. It would thus be a major advance in making our health systems safer.

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<sup>69</sup>WEICK Karl E., SUTCLIFFE Kathleen M., *Managing the Unexpected: Sustained Performance in a Complex World*, 3<sup>ème</sup> edition, Wiley, 2015, 224 pages

In this part, we saw how risk emerges in our society and more particularly in healthcare. Understanding the way risk was extracted in health care is necessary to fully understand risk management in our health systems. Furthermore, we explained James Reason's model and the system approach, which is a basis in risk management, and the appropriation of these models by the staff. France, on the field of quality and safety in health care is behind compared to Anglo-Saxon countries and more specifically the United States, for which quality and safety of care have become a major issue with the publication of the report *To Err is Human*<sup>70</sup> and the different initiatives to develop tools to make the system safer or to assess the safety culture of a setting<sup>71</sup>.

On the other hand, several highly symbolic accidents occurred in France. We can cite two such accidents. The tainted blood scandal was exposed in 1991 and was caused by the distribution of Human Immunodeficiency Virus infected blood products to patients in 1984 and 1985. It was proven that these blood products were knowingly distributed to patients suffering from hemophilia. The second scandal we can cite is the overdosed radiotherapy irradiations in Epinal hospital which happened in the early 2000s. Following multiple errors, up to 5,500 patients were over-irradiated during radiotherapy treatments, 24 were highly irradiated and 5 died due to the overdose. These scandals helped raise awareness about quality and safety of care due to their highly sensitive nature, and the emergence of Experience Feedback Committees must be seen in this light

Considering their method and organization, these EFC might be an adequate answer to such adverse events in healthcare. We will thus further explore, in the following third part, the question of Experience Feedback Committees and the reasons explaining their effectiveness in hospital settings.

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<sup>70</sup>KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages

<sup>71</sup>SORRA Joann, NIEVA Veronica, « Hospital Survey on Patient Safety Culture », AHRQ Publication No. 04-0041, Agency for Healthcare Research and Quality, September 2004, 74 pages

### **III) Experience Feedback Committee, a new effective safety enhancement tool?**

Experience Feedback Committee (EFC) is a recent *a posteriori* safety enhancement tool which aims to improve quality and safety of care by analyzing adverse events and near misses and implementing corrective actions. In 2003, this project, based on the experience on civil aviation and developed with the help of Air France Consulting, was launched by the *Mission nationale d'expertise et d'audit hospitalier* (MeaH)<sup>72</sup>. This tool was first implemented in radiotherapy before being extended to other specialties<sup>73</sup>.

These Experience Feedback Committees consist in a multidisciplinary team (physicians, nurses, quality engineers, etc.) monthly meeting. During EFC, a selection of adverse events or near misses is presented to the members who decide which one will be investigated for the next meeting. Most often, investigated events are chosen due to their frequency, their gravity or their criticality (frequency and gravity). This choice is validated by consensus or a vote of the members and an analysis pilot (and possibly an assistant) is designated to investigate the event. Then the analysis report of the event chosen at the previous meeting is presented by its analysis pilot and corrective actions are proposed to the committee. Ideally, some corrective actions (between 1 and 3) are selected. To ensure the implementation of the corrective actions, a time limit is set for each action and a person in charge of its implementation is designated. Clear objectives for each action are set to allow effectiveness evaluation. To conclude the meeting, ongoing corrective actions are monitored to assess their implementation and their effectiveness<sup>74</sup>. Concerning the event investigation, the designated analysis pilot uses the six steps ORION© method. At first information about the selected event are collected. The pilot can for instance look for information through patient case, document analysis, interviews, etc.

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<sup>72</sup> FRANCOIS Patrice *et al.*, « Le comité de retour d'expérience (CREX) : une méthode pour l'amélioration de la sécurité des soins », *Revue d'Epidémiologie et de Santé Publique* 61 (2013) 155–161

DEBOUCK F. *et al.*, « Méthode Orion® : analyse systémique simple et efficace des événements cliniques et des précurseurs survenant en pratique médicale hospitalière », *Cancer/Radiothérapie*, Volume 16, Issue 3, Pages 201-208, 2012

<sup>73</sup> LECOANET André *et al.*, « Experience feedback committee in emergency medicine: a tool for security management », *Emergency Medicine Journal* 31, 2014, p. 894-898

BOUSSAT Bastien *et al.*, « Experience Feedback Committee: a management tool to improve patient safety in mental health », *Annals of General Psychiatry*, 2015, 23 pages

<sup>74</sup>*Ibid.*

In a second step a chronological timeline of the event is established. For each step of the timeline, the pilot must determine whether or not the actions of the staff conform with internal (protocols for instance) and external (laws, recommendations, etc.) guidelines. Third, the causes of the event must be identified and described. Fourth, the factors having contributed to the occurrence of the event must be identified. In the third and fourth steps, the pilot must focus on latent factors over active errors. Even if active errors are reported in the analysis, the aim of EFC is to identify latent factors favoring or causing errors to eliminate them and enhance the safety of the systems. The cause of the third step is the direct cause of the accident whose removal prevents the occurrence of the error while factors are latent conditions which may influence or contribute to the event but with a lesser link of causation (which means that factors removal does not always prevent the occurrence of the error but may reduce its frequency or gravity). The fifth step of the analysis is to propose corrective actions which are then chosen by the committee as detailed before. Finally, after the meeting a written report of the analysis is to be established<sup>75</sup>. This written report is an essential document to assess the activity of the EFC and to monitor corrective actions and safety enhancements.

The objective of this analytic study is to better understand Experience Feedback Committee, its effects and functioning. More precisely we want to explain the impact of the Experience on the staff, their adhesion to this tool, the impact on other existing tools, and how these effects are produced. We hope that this analysis will eventually enable us to conclude on the effectiveness of Experience Feedback Committee and the interest of furthering its implementation. Following the results of the analytic study, we may propose recommendations to improve the functioning of the tool.

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<sup>75</sup> DEBOUCK F. et al., « Méthode Orion® : analyse systémique simple et efficace des événements cliniques et des précurseurs survenant en pratique médicale hospitalière », *Cancer/Radiothérapie*, Volume 16, Issue 3, Pages 201-208, 2012

LECOANET André et al., « Experience feedback committee in emergency medicine: a tool for security management », *Emergency Medicine Journal* 31, 2014, p. 894-898

BOUSSAT Bastien et al., « Experience Feedback Committee: a management tool to improve patient safety in mental health », *Annals of General Psychiatry*, 2015, 23 pages



Our hypotheses are:

1/ The effectiveness of the Experience Feedback Committee can be explained by its design and depends on its capacity to create adhesion and to bring about the implementation of action plans.

Specifically, we suppose that Experience Feedback Committee creates adhesion through the legitimization and implication of the staff members and compels the management to act as part of the need to manage associated risks.

This hypothesis is based on several reports and works, such as *To Err is Human, An Organisation with a Memory*, or James Reason's work, which recommend the implementation of experience feedback tools and system approach to make the health system safer<sup>76</sup>. It is also based on risk sociology literature and on works dealing with the delegation of the expertise, the structuration of expert groups, the support coalitions, and management of political and reputational risk<sup>77</sup>. These topics are notably detailed in the book of Olivier Borraz: *Les politiques du risque*<sup>78</sup>.

This hypothesis will be tested in chapter 3: Experience Feedback Committees and their effectiveness.

2/ In settings with low level of safety culture and quality approach, the Experience Feedback Committee loses effectiveness or fails.

Safety culture is defined as “*the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management.*”<sup>79</sup>. Furthermore, works on

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<sup>76</sup> KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages

NATIONAL HEALTH SERVICE, *An Organisation with a Memory Report of an expert group on learning from adverse events in the NHS*, NHS, 2000, 108 pages

REASON James, « Human error: models and management », *BMJ Volume 320*, 18 mars 2000, p.768-770

<sup>77</sup>BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

HENRY Emmanuel, GILBERT Claude, JOUZEL Jean-Noël, MARICHALAR Pascal (sous la direction), *Dictionnaire critique de l'expertise*, Paris, Presses de Sciences Po (P.F.N.S.P.), « Références », 2015, 376 pages

<sup>78</sup>BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

<sup>79</sup> SORRA Joann, NIEVA Veronica, « Hospital Survey on Patient Safety Culture », AHRQ Publication No. 04-0041, Agency for Healthcare Research and Quality, September 2004, 74 pages, p.1

safety and safety culture highlight the importance of management support, non-punitive response to error and system approach in quality and safety<sup>80</sup> as we have discussed previously.

We think that low safety culture impacts the effectiveness of Experience Feedback Committee through the behavior of the management which creates unfavorable conditions for the success of Experience Feedback Committees. This hypothesis is based on risk sociology literature, namely works on risk disownership by Borraz<sup>81</sup> and works on produced ignorance by Dedieu and Jouzel<sup>82</sup>

This hypothesis will be tested in chapter 4: Are Experience Feedback Committees influenced by the safety culture and quality approach of the setting?

3/ Morbidity and Mortality conferences facilitated the implementation of Experience Feedback Committee which methodology trickled down over Morbidity and Mortality Conferences.

Morbidity and Mortality Conference is another safety-enhancement tool, resembling the Experience Feedback Committee, whose analyses poor outcome and adverse event to enhance quality and safety of care<sup>83</sup>. Despite this similarity, it has been found that several units in different hospitals use both this method jointly. This observation raised questions about the relationship between these two tools.

We thus suppose that a phenomenon of path dependence enabled easier implementation of a new tool. Besides, we suppose that the trickle down of the Experience Feedback Committee methodology over Morbidity and Mortality conferences might be the consequence of organization change in risk management. We base our hypothesis on literature about political

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<sup>80</sup> KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages  
NATIONAL HEALTH SERVICE, *An Organisation with a Memory Report of an expert group on learning from adverse events in the NHS*, NHS, 2000, 108 pages

REASON James, « Human error: models and management », *BMJ Volume 320*, 18 mars 2000, p.768-770

<sup>81</sup>BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

<sup>82</sup>DEDIEU François, JOUZEL Jean-Noël, « Comment ignorer ce que l'on sait ? La domestication des savoirs inconfortables sur les intoxications des agriculteurs par les pesticides », *Revue française de sociologie* 2015/1 (Vol. 56), p. 105-133.

JOUZEL Jean-Noël, DEDIEU François, « Rendre visible et laisser dans l'ombre. Savoir et ignorance dans les politiques de santé au travail », *Revue française de science politique* 2013/1 (Vol. 63), p. 29-49.

<sup>83</sup>ORLANDER JD, BARBER TW, FINCKE BG, « The morbidity and mortality conference: the delicate nature of learning from error », *Academic medicine : journal of the Association of American Medical Colleges* 77(10), 2002, pages 1001-1006

ABOUMATAR HJ, *et al.*, « A descriptive study of morbidity and mortality conferences and their conformity to medical incident analysis models: results of the morbidity and mortality conference improvement study, phase 1 », *American journal of medical quality : the official journal of the American College of Medical Quality*, 2007 Jul-Aug, 22(4), pages 232-238

science and path dependence<sup>84</sup> but also on literature about culture, organization culture, and organizational learning<sup>85</sup>.

This hypothesis will be tested in chapter 5: Experience Feedback Committees and Mortality and Morbidity Conferences: superfluous tools or complementary ones?

4/ Experience Feedback Committees improves the safety culture of staff members, prompt the staff to adopt safety-favorable behaviors and thus improves global quality and safety in their units.

We suppose that this improvement in safety culture and quality and safety is achieved through raising awareness on error causation, quality and safety, and through improving knowledge about quality and safety. We base this hypothesis on different works focused on the emergence of the notion of risk<sup>86</sup>, on works on quality and safety approaches<sup>87</sup> and finally on works dealing with organizational learning<sup>88</sup>.

This hypothesis will be tested in chapter 6: Does the Experience Feedback Committee influence staff members' perception and safety culture?

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<sup>84</sup>Bruno Palier, « Path dependence (dépendance au chemin emprunté) », in Laurie Boussaguet *et al.*, *Dictionnaire des politiques publiques*, Presses de Sciences Po (P.F.N.S.P.) « Références », 2014 (4e éd.), p. 411-419.

<sup>85</sup>WEICK Karl E., « The Nontraditional Quality of Organizational Learning », *Organization Science*, 1991, p.116-124

KOENIG Gérard, « L'apprentissage organisationnel. Repérage des lieux », *Revue française de gestion*, 8/2015 (N°253), p.83-95

GUILHONA, TREPO G, « Réussir les changements par le développement de l'apprentissage organisationnel les leçons du cas de Shell », *Gérer et Comprendre*, septembre 2001, 65, p 41-54

BEN ABDALLAH Lotfi, BEN AMMAR-MAMLOUK Zeineb, « Changement organisationnel et évolution des compétences. Cas des entreprises industrielles tunisiennes », *La Revue des Sciences de Gestion*, 2007/4 (n°226-227), p. 133-146.

<sup>86</sup>BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

<sup>87</sup>KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages

NATIONAL HEALTH SERVICE, *An Organisation with a Memory Report of an expert group on learning from adverse events in the NHS*, NHS, 2000, 108 pages

REASON J., CARTHEY J., DE LEVAL M.R., « Diagnosing "vulnerable system syndrome": an essential prerequisite to effective risk management », *Quality Health Care*, 2001, 10 suppl 2, p. 21-25

<sup>88</sup>WEICK Karl E., « The Nontraditional Quality of Organizational Learning », *Organization Science*, 1991, p.116-124

KOENIG Gérard, « L'apprentissage organisationnel. Repérage des lieux », *Revue française de gestion*, 8/2015 (N°253), p.83-95

GUILHONA, TREPO G, « Réussir les changements par le développement de l'apprentissage organisationnel les leçons du cas de Shell », *Gérer et Comprendre*, septembre 2001, 65, p 41-54

BEN ABDALLAH Lotfi, BEN AMMAR-MAMLOUK Zeineb, « Changement organisationnel et évolution des compétences. Cas des entreprises industrielles tunisiennes », *La Revue des Sciences de Gestion*, 2007/4 (n°226-227), p. 133-146.

### 3) Experience Feedback Committees and their effectiveness

Experience Feedback Committees are recent safety enhancement tools. As we have seen earlier, assessing the effectiveness of safety enhancement tool by their effect on the recurrence of adverse events is not possible<sup>89</sup>. However, in this chapter we will try to demonstrate that an Experience Feedback Committee is an effective safety enhancement tool but above all to understand the mechanisms explaining its effectiveness. We suppose that its effectiveness is produced by its specific multidisciplinary approach, which leads the emergence of an important adhesion of staff members to quality and safety and thus implicating them in risk management. We suppose that its effectiveness might also be explained by its capacity to extract the risk and to raise awareness of the staff about the safety issues. We will first present the theoretical arguments justifying its effectiveness. Secondly, we will try to determine the staff perceptions about this tool and its effectiveness. The aim of this approach is to test our hypothesis and to bring to light the mechanism explaining how the theoretical strengths of the Experience Feedback Committee materialize in the facts.

An Experience Feedback Committee is a *a posteriori* safety-enhancement tool based on experience feedback, learning from error, and a system approach to improve quality and safety of care. This tool is based on James Reason's model developed in chapter 2<sup>90</sup>. Several works including the reports *To Err is Human* and *An Organisation with a Memory*, recommended the implementation of experience feedback tools and learning from error to enhance quality and safety in healthcare<sup>91</sup>. Moreover, these reports insist on the importance to develop a system approach and root cause analysis based on James Reason's work detailed on chapter 2. Finally, several works underline the importance and contribution of multidisciplinary teamwork to

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<sup>89</sup>LECOANET André *et al.*, « Assessment of the contribution of morbidity and mortality conferences to quality and safety improvement: a survey of participants' perceptions », *BMC Health Services Research*, 2016

<sup>90</sup>BOUSSAT Bastien *et al.*, « Experience Feedback Committee: a management tool to improve patient safety in mental health », *Annals of General Psychiatry*, 2015, 23 pages

DEBOUCK F. *et al.*, « Méthode Orion® : analyse systémique simple et efficace des événements cliniques et des précurseurs survenant en pratique médicale hospitalière », *Cancer/Radiothérapie*, Volume 16, Issue 3, Pages 201-208, 2012

FRANCOIS Patrice *et al.*, « Le comité de retour d'expérience (CREX) : une méthode pour l'amélioration de la sécurité des soins », *Revue d'Epidémiologie et de Santé Publique* 61,2013, p.155–161

<sup>91</sup>KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages

NATIONAL HEALTH SERVICE, *An Organisation with a Memory Report of an expert group on learning from adverse events in the NHS*, NHS, 2000, 108 pages

reduce adverse events, improve quality and safety and identify latent factors weakening the system<sup>92</sup>. As such, the design of the Experience Feedback Committee matches the prerequisite of the effective safety enhancement tools, and is methodologically strongly justified by the literature about quality and risk management<sup>93</sup>. In accordance with theoretical expected results explained previously, one of the main strengths of the Experience Feedback Committee, praised by the investigated staff members, is its non-conflictual, systemic root-cause analysis. This analysis allows to move from a person approach based on blame to a system approach based on the analysis of latent factors in the organization.

*« Moi je suis dans un service où a été créé le premier CREX en 2009, et il vit encore. Donc ça aussi la culture qualité c'est aussi à apprendre aux gens à dédramatiser les fautes et à déculpabiliser les erreurs pour pouvoir les analyser et travailler dessus, et ne pas le vivre comme quelque chose de mal. L'intérêt c'est d'analyser, de voir ce qu'on peut modifier dans l'organisation et d'admettre que l'erreur est humaine et que y'a peut-être des facteurs qui favorisent cette erreur et travailler sur les facteurs qui peut-être favorisent ces erreurs humaines. » Wave 1 Head Nurse 2*

This analytical method helps identify the weaknesses of the system and address them. The observation of Experience Feedback Committees evidenced that this tool meets a willingness to scientifically assess risks. Indeed, the selection of the risk is often implicitly based on its criticality, that is the product of the frequency of the event and its gravity. In addition, the criticality of the risks is most often implicitly discussed during the first time of the meeting. This assessment of the risk is based on the Failure Modes, Effects and Criticality Analysis

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<sup>92</sup>JONES KJ, *et al.*, « A theory-driven, longitudinal evaluation of the impact of team training on safety culture in 24 hospitals », *BMJ Quality & Safety*, 2013, 22, p.394-404

NEILY J, *et al.*, « Association Between Implementation of a Medical Team Training Program and Surgical Mortality ». *JAMA*, 2010, 304(15), p.1693-1700

SCHMUTZ J., MANSER T., « Do team processes really have an effect on clinical performance? A systematic literature review. », *British Journal of Anaesthesia*, 2013, 110 (4), p.529-544

<sup>93</sup>See articles and reports aforementioned in the chapter and :

REASON James, *Human Error*, (traduction : *L'Erreur Humaine*), traduction HOC Jean-Michel, Presses des Mines, 2013, 404 pages, titre original [*Human Error*]

WEICK Karl E., SUTCLIFFE Kathleen M., *Managing the Unexpected: Sustained Performance in a Complex World*, 3<sup>ème</sup> édition, Wiley, 2015, 224 pages

REASON James, « Human error: models and management », *BMJ Volume 320*, 18 mars 2000, p.768-770

REASON James, « Understanding adverse events: human factors », *Quality in Health Care*, 1995, 4(2), p.80-89

REASON J., CARTHEY J., DE LEVAL M.R., « Diagnosing "vulnerable system syndrome": an essential prerequisite to effective risk management », *Quality Health Care*, 2001, 10 suppl 2, p. 21-25

(FMECA) which is a recognized method for risk analysis<sup>94</sup>. Both this systemic analysis and scientific evaluation of risks enables the identification of the root causes of the adverse events, a better understanding of the risks and the failure modes, and to address the identified safety issues. Consequently, it brings back familiarity after the initial loss of familiarity caused by the adverse event<sup>95</sup>. Implementing corrective actions and bringing back familiarity are essential prerequisite to make the system safer and restore confidence of both the patients and the professionals on the incriminated activity<sup>96</sup>. However, an essential condition of the effectiveness of a safety enhancement tool is the adhesion of the healthcare professionals. We will thus try to evaluate this adhesion and to explain it.

### **Do professionals adhere to the Experience Feedback Committee?**

During our investigations, we observed a strong adhesion to the tool and its method. Furthermore, interviews conducted with staff members confirmed this adhesion. The professionals attending an EFC are mainly convinced by the tool, while the professionals who do not attend the EFC report being willing to participate: *« je serais intéressée à y aller moi... »* (Wave 2 Nurse 2), *j'avais pas pu rejoindre ce CREX, mais là en tant que cadre, je serais intéressée »* (Wave 2 Head Nurse 1). Furthermore, even non-participating staff members show curiosity about the EFC and its results: *« même pour le CREX, je sais que par exemple les infirmières du service quand elles font une fiche QUALNET, bah souvent elles me demandent « Ah mais est-ce que vous avez eu l'occasion de regarder la fiche ? Quelle était conclusion ? », tout ça, donc y'a quand même une demande, y'a quand même une demande. »* Wave 2 Doctor 1

This adhesion is found in all the occupational groups investigated in our survey, a doctor explained us: *« c'est un des premiers CREX au CHU qui a été mis en place. Il a été impulsé au départ par la cadre, la surveillante, qui était Mme X, qui m'en a parlé et j'ai tout de suite adhéré au fait de mettre en place ce CREX. »* (Wave 1 Doctor 2). Head nurses often give the momentum to an EFC, as evidenced by the former verbatim, and, most frequently, this category of staff strongly adhere to the method. Finally, investigated nurses knowing the EFC reported appreciating the method:

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<sup>94</sup> DEBOUCK F. *et al.*, « Méthode Orion® : analyse systémique simple et efficace des événements cliniques et des précurseurs survenant en pratique médicale hospitalière », *Cancer/Radiothérapie*, Volume 16, Issue 3, Pages 201-208, 2012

<sup>95</sup> BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

<sup>96</sup> BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

*« on m'avait proposé il y a 3 ou 4 ans maintenant de participer au CREX pour remplacer une collègue qui partait dans un autre service. J'avais accepté volontiers et j'ai jamais regretté » (Wave 1 Nurse 1), « l'expérience d'avoir participé à une réunion du CREX était enrichissante, voilà, que je trouve que c'est très utile » (Wave 3 Nurse).*

However, professionals adhering the Experience Feedback Committee's method most often are professionals with at least some basic knowledge about quality and safety of care or professionals attending it. For instance, professionals who attends other safety enhancement committees (such as hygiene vigilance committee) are more inclined to adhere with the EFC method. Staff members less interested in quality and safety are less likely to attend EFC or to adhere to its method, some contacted professionals in the first setting explained us refusing to be interviewed because of a low interest in quality, safety, and in EFC. But, as we will see in chapter 6, the EFC tend to globally raise awareness in a setting about quality and safety of care, and thus to make quality approach and safety culture more natural, spontaneous and easy even to professionals with less knowledge.

The main strength of the tool identified by the staff members is its multidisciplinary approach which allows the participation of both paramedical and medical staff and thus imply all categories of professionals in risk management.

*« Le CREX, je vous l'ai déjà dit mais il a apporté vraiment une autre dimension, de pluridisciplinarité mais acté de base, déjà dans le fonctionnement du CREX » Wave 2 Head Nurse 4*

The EFC is also praised by the professionals for its method which favors non-conflictual resolutions of the adverse events, and for its capacity to favor discussion and create better work relationships and cooperation inside the units.

[About EFC] *« c'était vraiment pour instaurer une démarche qualité dans l'établissement, pour instaurer de la confiance aussi par rapport à cette méthode de résolution de problèmes et du coup pour aider à... pour aussi avoir un espace de parole pour l'équipe. » Wave 2 Head Nurse 3*

Finally, the ORION© root cause analysis method is said by the investigated staff members to favor the identification of latent factors in the organization and to implement a non-blaming response to error by inciting the staff members to adopt a critical eye on the practices, self-

critique, objectivity and hindsight on the adverse events, but most importantly by making them aware of the role and importance of latent factors in error causation.

*« je trouve que c'est très intéressant d'avoir une critique sur ce qu'il peut se passer dans son propre service, sur l'analyse de certaines situations qui peuvent tous nous arriver, faut juste arriver à être un peu en retrait et pas dans le jugement, il y a certaines situations qui parfois font bondir et malheureusement, bah quand c'est nous qui nous retrouvons avec la blouse blanche bah ça nous arrive à nous aussi et entre le vécu et l'écrit, y'a souvent un grand écart mais je trouve que c'est quelque chose de très intéressant de pouvoir parler de certaines situations pour pouvoir les améliorer ou à défaut de les améliorer pouvoir les analyser pour voir ce qui peut être envisagé et moi c'est une pratique que j'ai particulièrement apprécié » Wave 1 Nurse 1*

Judging from those results, we must wonder why the Experience Feedback Committee creates adhesion in all staff categories and how it produces its effect.

### **The multidisciplinary approach and arena design: the main strength of the Experience Feedback Committee?**

An important factor explains the Experience Feedback Committee effectiveness, according to the risk management literature, is its multidisciplinary approach and its capacity to legitimate the professionals in risk management regardless of their profession or their rank. The importance of this approach has been spontaneously confirmed both by nurses and head nurses:

*« le CREX il a amené de la légitimité aux soignants. Aux infirmiers, aux cadres, voilà. [...] les CREX ont amené les médecins sur le terrain des infirmiers en fait. C'est-à-dire que ce que les médecins entendaient ou peu quand les infirmiers disaient « ah mais vous savez là on a un problème avec le matériel, là c'est ça, là c'est comme ça, quand vous faites ça ça a telle conséquence » bah ça a apporté du crédit à la parole des infirmiers. Et du coup ... c'est ça qui était très intéressant en fait. » Wave 2 Head Nurse 4*

[About EFC] *« Ben, tu sais, c'est bien. Moi, j'aime beaucoup, alors, que ce soit avec ma cadre ou avec les médecins, on discute très facilement. Moi, j'ai pas de souci, on a l'équipe, on a pas de problème, alors on a une équipe qui est, on a une bonne équipe, donc pour ce qui est discuter, je trouve que c'est bien. Euh, non, c'est pas, ben ouais, je pense que c'est vraiment libre de paroles. Ça permet aussi des fois de mettre juste à plat, c'est-à-dire qu'on est tous, on est, c'est un comité des fois réduit, bon les RMM un peu moins, mais le CREX, c'est réduit, ben on parle directement quoi. Je parle à ma cadre de certains problèmes, je parle à mon médecin de problèmes. Y a vraiment pas de souci de communication, je trouve en fait. C'est vraiment libre et tout le monde est avenant, tout le monde entend les choses et*



*donc ça, je trouve ça bien fait. Tout le monde est professionnel, à ce moment-là et du coup, c'est facile, facile de communication en fait.* » Wave 2 Nurse 3

This design favoring the participation and the input of all staff categories is one of the main strengths of the tool and is comparable to an arena as defined by Borraz<sup>97</sup>. The characteristics of arenas, according to Borraz, are to gather different actors from various backgrounds to manage a given risk. To make the risk manageable, a common framing of this risk is adopted by the actors participating in this arena<sup>98</sup>. The Experience Feedback Committee corresponds to this definition. Indeed, the Experience Feedback Committees analyzes adverse events during monthly meetings of healthcare professionals from different professional background. Experience Feedback Committees are structured around a common understanding of quality and safety: a system approach and a root cause analysis heavily influenced by the model of human error of James Reason<sup>99</sup>. This common framing of quality and safety is further reinforced by the training of the staff attending the Experience Feedback Committee in its analysis method (ORION©) and in basic knowledge on quality and safety (including James Reason model)<sup>100</sup>. During those trainings, the staff is presented basic information about latent factors, the impact of these factors on safety barriers and their role in error causation, and the importance to acknowledge the systemic root causes to correctly understand and address adverse events and safety issues. In a second time of the training, the staff members are properly trained to the ORION© method and root causes analysis. They are trained to investigate the events by following the ORION© multistep method: establishing a chronology and identifying non-compliance with professional guidelines and internal protocols (through a review of the

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<sup>97</sup>BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

<sup>98</sup>BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

<sup>99</sup>REASON James, *Human Error*, (traduction : *L'Erreur Humaine*), traduction HOC Jean-Michel, Presses des Mines, 2013, 404 pages, titre original [*Human Error*]

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FRANCOIS Patrice *et al.*, « Le comité de retour d'expérience (CREX) : une méthode pour l'amélioration de la sécurité des soins », *Revue d'Epidémiologie et de Santé Publique 61*, 2013, p.155-161

<sup>100</sup>BOUSSAT Bastien *et al.*, « Experience Feedback Committee: a management tool to improve patient safety in mental health », *Annals of General Psychiatry*, 2015, 23 pages

DEBOUCK F. *et al.*, « Méthode Orion® : analyse systémique simple et efficace des événements cliniques et des précurseurs survenant en pratique médicale hospitalière », *Cancer/Radiothérapie*, Volume 16, Issue 3, Pages 201-208, 2012

FRANCOIS Patrice *et al.*, « Le comité de retour d'expérience (CREX) : une méthode pour l'amélioration de la sécurité des soins », *Revue d'Epidémiologie et de Santé Publique 61*, 2013, p.155-161

medical file and interviews of staff members implicated in the events). They are also trained to correctly classify latent factors as human factors, technical factors, organizational factors, environmental factors, etc. Finally, the trainings are often concluded by simulations and role-plays during which the professionals are asked to investigate events both from healthcare and from other industries based on real-life events. For instance, during a training supervised by the surveyor, staff members were asked to investigate a nuclear accident (which turned out to be the Chernobyl disaster) and to identify as many contributing factors as they could.

This design of arena legitimizes all the actors attending it and thus favors the adhesion of the paramedical staff to quality and safety management. Indeed, it seeks the participation of nurses and other paramedical staff and by putting them on an equal footing with doctors and head nurses. For instance, in several EFC, we observed nurses spontaneously speaking up, and other members of the EFC carefully listening to their contribution. The EFC members' contributions are acknowledged in the final report regardless of rank or occupational group. In addition to these observations, a nurse explained us:

*« moi, je suis quelqu'un qui aime parler, qui aime débattre, donc voilà, c'est quelque chose qui m'intéresse énormément, sachant qu'en plus j'ai pas ressenti, ce qui était intéressant, je ne suis qu'un infirmier, voilà, j'ai pas ressenti le fait quand j'ai proposé deux- trois choses, « bon tais-toi, t'es qu'un infirmier, enfin, t'es pas un cadre, t'es pas un médecin, qu'est-ce que tu t'y connais ? » Donc c'était plutôt un bon retour. » Wave 3 Nurse*

The arena not only involves the actors on risk management but also takes account of their frontline experience of quality and safety. The account of this experience is especially important since paramedical staff and nurses benefit from a profane expertise of quality and safety as explained by Borraz<sup>101</sup>. Indeed, nurses and paramedical staff, despite lacking formal and theoretical knowledge on quality and safety models, have important experience-based knowledge on quality and safety gathered throughout their professional frontline practices. The arena design of the Experience Feedback Committee permits to make the most of this profane expertise to identify different and sometimes unexpected factors contributing to the occurrence

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<sup>101</sup>BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

of an adverse event but also to develop innovative solutions adapted to the needs and specificities of all staff categories. An operative theater nurse explained us:

« je pense que c'est vraiment pas mal et puis ça permet aussi que ce soit les personnes concernées qui creusent le problème. Donc la recherche de solutions, elle est plus, elle est plus évidente, je pense, que quand on est, quand on est dans le bureau et qu'on ne connaît pas, par exemple, le fonctionnement du bloc, personnellement je m'occupe du bloc, le fonctionnement spécifique du service de soins dans lequel est l'infirmière qui va s'occuper de l'analyse, je pense que oui, voilà. Pour moi, le CREX, c'est ça ; ça a permis d'avancer sur ça. » Wave 3 Operating Theater Nurse

This acknowledgement of the experience of paramedical staff, and thus of profane expertise, is an important strength of the Experience Feedback Committee and explains the importance of multidisciplinary analysis of adverse events recommended by the literature on risk management<sup>102</sup>. Finally, one last observed and reported strength of the Experience Feedback Committee, explained by its arena design, is its capacity to gather all categories of healthcare professionals around a common framing of quality and safety, and to help them cooperate. Both the legitimization of all categories of staff members in quality and safety management, and the common framing allow the staff members to better identify and understand their common interest. It also favors solidarity between staff categories, and favors compromise between them. This last characteristic of the Experience Feedback Committee allowing non-conflictual

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<sup>102</sup>BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages  
REASON James, *Human Error*, (traduction : *L'Erreur Humaine*), traduction HOC Jean-Michel, Presses des Mines, 2013, 404 pages, titre original [*Human Error*]  
WEICK Karl E., SUTCLIFFE Kathleen M., *Managing the Unexpected: Sustained Performance in a Complex World*, 3<sup>ème</sup> édition, Wiley, 2015, 224 pages  
REASON James, « Human error: models and management », *BMJ Volume 320*, 18 mars 2000, p.768-770  
REASON J., CARTHEY J., DE LEVAL M.R., « Diagnosing "vulnerable system syndrome": an essential prerequisite to effective risk management », *Quality Health Care*, 2001, 10 suppl 2, p. 21-25  
JONES KJ, *et al.*, « A theory-driven, longitudinal evaluation of the impact of team training on safety culture in 24 hospitals », *BMJ Quality & Safety*, 2013, 22, p.394-404  
NEILY J, *et al.*, « Association Between Implementation of a Medical Team Training Program and Surgical Mortality ». *JAMA*, 2010 ,304(15), p.1693-1700  
SCHMUTZ J., MANSER T., « Do team processes really have an effect on clinical performance? A systematic literature review. », *British Journal of Anaesthesia*, 2013, 110 (4), p.529-544  
KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages  
NATIONAL HEALTH SERVICE, *An Organisation with a Memory Report of an expert group on learning from adverse events in the NHS*, NHS, 2000, 108 pages

resolutions of problems is perfectly illustrated by the following statement of a head nurse managing an Emergency Unit.

*« Donc on a aussi un CREX dans le service qui vit depuis longtemps, on l'a un peu enrichi avec la radiologie : on s'est aperçu qu'il y avait beaucoup de signalements qui concernaient les patients des urgences qui allaient en radiologie. Chaque fois que la radiologie rédigeait une fiche de signalement, que je renvoyais ça aux urgences, les urgences me disaient : « ouais, ils exagèrent, nous aussi si on veut on peut en faire des fiches de signalements », enfin chacun restait sur sa position, et j'ai dit peut être que la solution c'est qu'on travaille ensemble, parce que comme ça une fois on travaillera sur un dysfonctionnement concernant l'identité-vigilance des patients des urgences qui vont en radiologie, mais la fois d'après, on travaillera peut-être sur la qualité de la radiologie par rapport à ce qui est demandé... Si les acteurs travaillent ensemble, d'abord ils se connaissent mieux et leur intérêt après est commun, et pas de chacun défendre son territoire, de dire « c'est pas moi, et puis eux aussi ils en font de fautes ». C'est le plus difficile dans la culture qualité, c'est que ça ne soit pas vécu comme quelque chose de péjoratif mais que ça soit valorisé et dans l'intérêt d'améliorer des choses quand même. »*

Wave 1 Head Nurse 2

From those elements, we can conclude that the Experience Feedback Committee benefits from a large support coalition. EFC is indeed supported and attended by most categories of staff members, including nursing aids, nurses, head nurses, physicians, quality and safety managers, all gathered around a common framing of quality, safety, and error causation. A last reason that might explain the Experience Feedback Committee has been identified through observation by the surveyor. This reason is the management of associated risks by the hospital management. Associated risks, as explained in chapter 1, are reputational, institutional, legal or other similar risks which are associated to the original risk, for instance the risk of legal prosecution following an accident<sup>103</sup>. Since Experience Feedback Committees highlight safety issues in the setting, the management is forced to give an account of these risks and to provide solutions and safety enhancements. Indeed, should an accident happen due to these identified and known safety issues, the management could be blamed for its inaction and risk legal prosecution, disciplinary sanctions, loss of reputation, etc.<sup>104</sup>. These associated risks might incite the hospital management to act and to report safety issues to avoid negative repercussions both for them

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<sup>103</sup>BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

<sup>104</sup>BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

and for the hospital. However, this last assertion should be moderated by the fact that management can be tempted to undermine the EFC to prevent it from raising sensitive issues. This behavior will be further discussed in the following chapter.

As a conclusion, Experience Feedback Committees are praised by all categories of staff members for their innovative approach and method. This assertion, in some low safety-culture low quality approach settings, is to be qualified as management voluntary deters staff members from attending the Experience Feedback Committee as we will demonstrate in the following chapter. The design of this tool, resembling an arena, permits an easier identification of latent factors favoring the errors, a non-conflictual, non-blaming approach of error, and the elaboration and implementation of common and consensual solutions to improve quality and safety. The main strength of this tool is to legitimate every staff members in risk management, regardless of their occupational groups or ranks and to put the staff on an equal footing. The tool also allows a brief scientific assessment of the risks by an informal use of FMECA to determine the criticality of the risks during the first step of the meeting. Furthermore, it has been observed that both the discussions occurring during Experience Feedback Committees (and the subsequent Experience Feedback Committee report) and the analysis report are used by quality and risk managers to implement their risk cartography. This use of the knowledge produced by Experience Feedback Committee furthers the scientific assessment of risk and creates a virtuous circle. Indeed, this use of Experience Feedback Committee data allows it to participate in *a priori* risk management by identifying risks and assessing their frequency, gravity and thus criticality. Furthermore, this use of Experience Feedback Committee data tends to interest participating staff members in *a priori* risk management, and thus participate in a global reinforcement of the quality approach of the setting. Finally, the production of knowledge about risks might also in some cases incite hospital management to act in favor of quality and safety to avoid being blamed for inaction, and to prevent associated risks from occurring.

#### **4) Are Experience Feedback Committees influenced by the safety culture and quality approach of the setting?**

We suppose that in settings with a low level of safety culture and quality approach, the Experience Feedback Committee loses effectiveness or even fails and disappears. Indeed, a low score at HSOPS questionnaire and a low level of quality approach often are indicators of a lack of involvement of the staff or of the management in quality and safety<sup>105</sup>. This lack of implication thus undermines the EFC and prevents it from effectively functioning. In this chapter, we will try to determine the organizational conditions, under which the Experience Feedback Committee is able to be effective and to produce its effects. We suppose that a lack of effectiveness of the EFC can sometimes be explained by the lack of implication of the frontline staff members and unit managers. We also suppose that the main reason explaining the failing of the EFC is the deleterious behavior of the hospital management. This deleterious behavior of the management is found in settings with a low-level of quality approach and safety culture as defined by the AHRQ: “*the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization’s health and safety management*”<sup>106</sup>.

#### **The lack of dissemination of safety culture**

One of the bases of *a posteriori* risk management is the reporting of adverse events and near misses. However, in several units a lack of reporting is observed.

« *Point critique du CREX, faut que les gens déclarent, et ça c’est pas toujours évident quand on sait qu’en moyenne on doit avoir une 20aine d’erreurs humaines par jour et qu’on se retrouve des fois à un CREX où on a que 6 ou 7 événements sur le mois...* » Wave 1 Pharmacist 1

« *le CREX je regrette qu’on ait pas plus de déclarations spontanées.* » Wave 2 Doctor 3

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<sup>105</sup>OCCELLI Pauline *et al.* *Mesure de la culture de sécurité des soins en milieu hospitalier Guide d’utilisation de l’outil de mesure version mai 2010*, CCECQA, 2010, 24 pages

SORRA Joann, NIEVA Veronica, « Hospital Survey on Patient Safety Culture », AHRQ Publication No. 04-0041, Agency for Healthcare Research and Quality, September 2004, 74 pages

WEICK Karl E., SUTCLIFFE Kathleen M., *Managing the Unexpected: Sustained Performance in a Complex World*, 3<sup>ème</sup> édition, Wiley, 2015, 224 pages

<sup>106</sup>SORRA Joann, NIEVA Veronica, « Hospital Survey on Patient Safety Culture », AHRQ Publication No. 04-0041, Agency for Healthcare Research and Quality, September 2004, 74 pages

This lack of adverse events reporting badly impacts the EFC, which is dependent on reporting to produce analyses and feedbacks<sup>107</sup>. This lack of reporting has several explanations. Firstly, not all the personnel is able to report adverse events. For instance, it is observed that if nursing aid could theoretically report adverse events, they were hindered by the fact they did not use computers in their work and thus could not access the reporting program.

*« Par exemple certaines catégories socioprofessionnelles, comme les ASH ou les aides-soignantes touchent moins l'informatique que les infirmières, donc elles osent pas déclarer déjà parce qu'elles ont pas forcément l'accès à l'ordinateur ou qu'elles savent pas faire »* Wave 2 Head Nurse 1

Secondly, we suppose from observations, statements from interviewees and informal discussions that some do not fully understand the importance of error reporting and see tools such as EFC as useless and time consuming. For instance, one solicited nurse answered us that he did not want to be interviewed because he did not feel concerned by quality and safety and did not understand the interest of EFC.

*« Le deuxième frein c'est qu'elles disent qu'elles ont suffisamment de travail et que déclarer ça encore en plus, je vous dis ce qu'elles disent hein, ça leur donne une charge de travail en plus et qu'elles ont pas envie... »* Wave 2 Head Nurse 2

This lack of willingness can partly be explained by a lack of time but also by the fact that quality and safety is barely taught in medical and paramedical studies and that continuous training on these matters is insufficient, as illustrated by the following statement:

*« Quand même, y a peu d'informations, y a t'as une formation, t'as une formation ou deux, mais y a peu, y a pas l'accent qui est mis sur l'importance de la qualité en fait, la démarche qualité. Et à l'école, je trouve que c'est pas... parce que en soi on voit dans le module Gestion des risques, y a un module Gestion des risques où on reprend des situations, en fait mais ça reste, ça reste léger et on voit ça qu'un semestre en fait, c'est pas pendant 3 ans, et là on parle de qualité, en fait, c'est pendant un semestre sur une unité d'enseignement. Donc c'est un problème parce que théoriquement, ça devrait être global en fait. »* Wave 2 Nurse 3

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<sup>107</sup>BOUSSAT Bastien *et al.*, « Experience Feedback Committee: a management tool to improve patient safety in mental health », *Annals of General Psychiatry*, 2015, 23 pages  
FRANCOIS Patrice *et al.*, « Le comité de retour d'expérience (CREX) : une méthode pour l'amélioration de la sécurité des soins », *Revue d'Epidémiologie et de Santé Publique* 61,2013, p.155–161  
LECOANET André *et al.*, « Experience feedback committee in emergency medicine: a tool for security management », *Emergency Medicine Journal* 31, 2014, p. 894-898

The implication or lack of implication of the local managers is crucial in the success or failure of the Experience Feedback Committee. We observed that local managers with less knowledge about quality and safety and lower level of safety culture tend not to get involved in Experience Feedback Committee or worse to discourage their staff to attend EFC or to report adverse events. A nurse explained us:

*« Pour te dire, y a des cadres qui veulent pas que leur équipe fasse des fiches UMAGRIS. On en est encore là quoi ! Je veux dire, on est en 2017, faut pas déclarer d'événement indésirable. Quand c'est ton chef qui te dit « tu fais pas ». Ah voilà, y a un problème, quoi y a un problème, pour moi. Donc on en est encore loin et là... Et ben ces cadres-là, des fois, souvent, c'est, quoi d'anciens cadres souvent, qui n'ont pas eu de nouvelles formations, des choses comme ça, ils c'est ça et ben, c'est un peu ce genre de cadres souvent qu'on retrouve à l'école des fois et du coup qui n'ont pas cette démarche, qui n'ont pas ces trucs. Moi, j'en ai même vu qui « Ah, non, y a pas d'erreur. Ça existe pas les erreurs, c'est que les nuls qui en font ! », des choses comme ça. » Wave 2 Nurse 3*

We suspect that two main reasons explain the lack of implication of the managers. The first one is the lack of knowledge of and interest in quality and safety. As we explained earlier, during the initial training of head nurses, quality and safety is not always approached. These matters are also insufficiently taught during medical training. Another reason explains the lack of participation of both staff members and unit managers in Experience Feedback Committee and the lack of adverse events reporting. Staff members in most units fear reprisal should they report an adverse event: *« Après pour un soignant je pense qu'il y a toujours la peur de se faire taper dessus si ils auraient causé ou fait une erreur, enfin voilà... »* (Wave 2 Nurse 2). This fear of being blamed for reporting or for making an error is especially strong for nurses: *« Alors, la peur ! Ben clairement, c'est la peur qu'on se fasse voilà de se faire engueuler »* (Wave 2 Nurse 3). This fear of reporting can partly be reduced by training about quality and safety and by a good communication in the setting as evidenced by the following statement of a physician.

*« Il faut qu'il y ait quand même une éducation quand même de qualité et sécurité. Dans nos secteurs de réanimation c'est... c'est ... on y échappe pas et donc le gens sont assez sensibilisés mais certains pourraient encore être un peu réfractaires par rapport au côté un peu punitif. »* Wave 2 Doctor3

This fear is explained by a lack of trust in the global hospital management and its non-punitive response to error, especially because of a lack of communication on this issue as evidenced by the former nurses' statements. Moreover, in several units, a blaming culture is reported and observed: staff members signaling errors and adverse events are blamed and shamed. In some units, professionals making errors are blamed for the error and play the role of scapegoats. This



kind of blaming culture is especially deleterious since professionals making errors tend to hide the error and keep it secret out of fear of blame or disciplinary sanctions.

*« Et on voit bien quand il y a un problème, un événement indésirable grave, c'est souvent à chaque fois, les verrous ont sauté à plusieurs niveaux. C'est vraiment... La méthode permet aussi de voir ça ... de se rendre compte qu'effectivement, admettons, je vous donne un exemple, on avait eu un problème d'administration de médicament, normalement qui passait par la bouche et qui a été injecté. La patiente est pas décédée, heureusement. Et en fait, l'histoire c'est : une infirmière qui préparait le traitement, qui a été interrompue par un élève infirmier en dernière année, dernier stage, parce qu'il n'arrivait pas à piquer un patient. Donc elle lui a dit : « tiens je te laisse aller administrer le traitement à la patiente » et elle est allée piquer l'autre patient. Et on voit bien tout le long... et donc finalement l'élève il a injecté le produit qui était buvable. C'est pas la même histoire là... parce que le produit il est bien épais, et on a eu de la chance elle est pas morte, elle a fini en réa mais sans séquelles. Et en fait les verrous ils ont été : l'interruption de tâche de l'infirmière, elle n'avait pas utilisé le bon matériel pour prélever la solution buvable, elle avait pris une seringue injectable au lieu de prendre une seringue à gavage... Mais parce qu'on ne savait pas qu'on avait le droit de commander de petites seringues pour la pédiatrie. Donc on est... vous voyez... Donc interruption de tâche, pas le bon matériel utilisé, elle n'avait pas, comme elle avait été interrompue, elle n'avait pas inscrit ce que c'était, par quel mode d'administration sur la seringue. L'étudiant n'avait pas vérifié la prescription et le dernier verrou ça a été quand la patiente a dit : « Bah c'est bizarre ça, c'est vraiment blanc, puis ça sent un goût de fraise, c'est bizarre que vous l'injectiez... » Donc en fait, y'a eu 5-6 verrous qui auraient pu éviter, et qui n'ont pas été... et qui ont...Donc l'étudiant je vous rassure, il a pas été diplômé ! » Wave 2 Head Nurse 2*

The opportunity to learn from this error and to improve the system is thus lost, and the event is not presented at the EFC, thus creating in some units a real Omertà on quality and safety issues. Staff and unit managers' participation to EFC is thus hindered by a lack of knowledge and training, a lack of resources, and a lack of non-punitive response to error. This global context raises the question of the implication of the hospital management in quality and safety, their level of safety culture, and their role in the success or failure of EFC.

## **The role of the hospital management: between inadequate measurement tools and voluntary ignorance**

As we have seen, in our first setting, several Experience Feedback Committees are hindered by the lack of training and knowledge in quality and safety, and the lack of non-blaming culture. This lack of non-punitive response to error is partly attributable to the hospital management through a lack of communication on non-punitive response to error, and through the occurrence of disciplinary sanctions we discussed formerly. Furthermore, management seems to put barriers to the functioning of the Experience Feedbacks Committees on purpose, and thus to prevent them from working and to undermine their power which may lead to their failure. The first barrier is deterrents to the staff participation, and mostly a lack of time dedicated to quality and safety of care: *« Ça demande du temps mais ce temps on en manque... Donc on manque du temps pour travailler la qualité et la sécurité. »* Wave 1 Doctor 5. This information has been confirmed by several staff members of different occupational groups. Firstly, staff members willing to attend EFC meeting cannot do it on their working time and must come back on their rest time.

*« Ils participent pas parce que c'est souvent la même chose hein, manque de temps, machin... L'infirmière bah qui finit son service à 7h30 du matin, il y a le CREX à 13h, elle va pas revenir pour le CREX à 13h... Et qui travaille la nuit, donc vous voyez c'est un petit peu ça ... »* Wave 2 Doctor 1

*« la contrainte que j'ai moi sur ce secteur-là, c'est que la plupart des secteurs sont en 12 heures, qui dit 12 heures, dit faire revenir des gens pour revenir au CREX, en termes de soignant c'est compliqué... Sachant qu'on a du mal à extraire des gens qui sont en poste donc ça veut dire forcément faire revenir des gens à d'autres moments »* Wave 1 Head Nurse 5

Secondly, there is a lack of valorization of the participation to Experience Feedback Committee by the hospital management. Indeed, when professionals come back to attend the EFC, these hours are not paid. These hours are sometimes, theoretically, given back to the professionals. However, in accordance with the national context, and as explained by a nurse, it is impossible in fact to take a leave or a day off.

About participation to EFC] *« Alors ça non ça ça ne sera pas payé en heures sup... ça ça n'existe...non, ça c'est mort ça... Alors le problème c'est, oui c'est des heures qui sont sur un compte d'heures, donc théoriquement qu'on pourra récupérer. Dans la réalité des choses, c'est qu'on a des comptes d'heures qui sont pleins... A titre personnel, j'ai un compte d'heures qui a plus de 200 heures. Des heures qu'on peut pas prendre parce qu'on a pas le personnel pour prendre des heures. Donc oui, ces heures ont pourrait théoriquement les récupérer, en réalité j'aimerais bien savoir quand ! [rires] Voilà ! Même si*

*c'est pas la faute de la cadre parce qu'elle fait ce qu'elle peut ce qu'elle peut et tout ça, mais voilà... »*

Wave 2 Nurse 3

Another barrier to the EFC effectiveness is the lack of listening to and the lack of assistance of the support units when assistance on a specialized matter is required by the unit or pole organizing the EFC. Indeed, the EFC sometimes lack knowledge on specialized topic such as legal issues, logistic, specialized guidelines, etc. Ideally, in such situations, the competent service should give support to or answer the question of the EFC, however, on repeated occasions a lack of support of specialized units has been observed.

*« Sur le CREX, les actions pour l'instant elles sont légères parce qu'on se on se bloque certains problèmes avec... nos problèmes des fois on a besoin d'avoir ... je sais pas, je prends un truc tout bête mais on avait besoin d'avoir un avis de la, de... du service juridique de l'hôpital, par exemple. ah ça... Plein de coups de téléphone, plein de mails, pas de réponse. Ben on bloque, on va pas, on n'avance pas, Y a des choses en fait, on bloque quand ça touche à notre service, enfin du moment que ça touche en fait, même si on a besoin, c'est pour nous qu'on adapte notre façon de faire, on a besoin d'un avis, ça bloque en fait, ça c'est chiant. Du coup, on a plus la ... »* Wave 2 Nurse 3

In addition to these issues, an overall lack of consideration toward the EFC, a lack of listening to, and a lack of interest in its recommendations has been observed and evidenced by interviews. This problem is especially deleterious to the EFC effectiveness, as it totally undermines the tool's interest, usefulness and credibility for the staff members. Even worse, it tends to discourage staff members attending it and to erode the good intentions.

*« On a eu un souci avec les épicerâniennes, nos aiguilles pour faire des bilans sanguins simples, qui nous ont été changé pareil alors qu'on avait rien demandé, ça avait été remonté en CREX, ça avait été remonté auprès du pharmacien, la dernière réponse que j'avais puisque je fais partie du CREX, c'est que oui finalement ce matériel avait été discrédité dans plusieurs service qui devait être changé... Puis bah finalement on est à plusieurs mois voire bientôt un an de cette nouvelle comme qui on nous remettrait les anciens et on les a toujours pas. Alors est-ce qu'ils écoulent les stocks, ou est-ce qu'ils ont attendu qu'on s'apaise pour nous faire passer la pilule... mais ça c'est vraiment dommage parce que quand on a un matériel avec lequel on travaille bien et qu'on est habitué à ce matériel et qu'on nous le change par quelque chose qui souvent est moins bien, parce que c'est souvent ça, c'est dommage... C'est dommage, on veut bien entendre qu'il y a une part financière derrière, sauf que nous c'est notre outil de travail au quotidien et du coup c'est déjà suffisamment difficile pour qu'on nous change ce qui marche. »* Wave 1 Nurse 1

Finally, we also observed a lack of communication around the Experience Feedback Committee and its actions, evidenced by the fact that 2 investigated staff members during Wave 2 did not know of this tool despite the fact it was implemented in their pole, and also by the following statements from different categories of staff members:

« *Le CREX... c'est pareil au niveau soignant, je vois pas le retour parce que justement on a pas de retour, après l'erreur elle est peut-être là... en tout cas moi à mon niveau j'ai jamais vu de retour...* » Wave 2 Nurse 2

« *Donc sur la communication justement, c'est là où on pêche.* » Wave 2 Head Nurse 3

This lack of communication is attributable to a lack of available resources and time to write and send the EFC reports, to design and display didactic communication posters about the EFC or the reporting of adverse events, etc.

« *Après idéalement, comme j'ai dit tout à l'heure, c'est d'avoir un vrai pas service, mais de vrais moyens de communication et de pouvoir faire à la fin de chaque CREX un poster disant : Voilà on a analysé tel événement, voilà les conclusions. Et que les gens puissent être au courant de leurs démarches, où ça a, qu'est-ce que ça a donné.* » Wave 2 Doctor 1

Communication about EFC could be favored by the presence of a secretary during the meetings or by dedicating time for quality managers to work on communication vectors. However, the hospital management is not willing to dedicate more quality manager time, or secretary time to the EFC for several reasons, including the cost in working hours.

As the management of the first setting refused to be interviewed, our explanations will only be based on the observations of the surveyor and on the statements of interviewed staff members.

The first reason explaining this behavior from hospital management is ignorance. As explained by Dedieu and Jouzel, to measure risk, the authorities tend to use indicators<sup>108</sup>. In agriculture, exposure doses are used to measure the toxicity of pesticides for agricultural workers. However, indicators only show a part of the problem and may hide several aspects of the problem<sup>109</sup>. For

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<sup>108</sup>DEDIEU François, JOUZEL Jean-Noël, « Comment ignorer ce que l'on sait ? La domestication des savoirs inconfortables sur les intoxications des agriculteurs par les pesticides », *Revue française de sociologie* 2015/1 (Vol. 56), p. 105-133

JOUZEL Jean-Noël, DEDIEU François, « Rendre visible et laisser dans l'ombre. Savoir et ignorance dans les politiques de santé au travail », *Revue française de science politique* 2013/1 (Vol. 63), p. 29-49.

<sup>109</sup>*Ibid.*

instance, an exposure dose only takes into account the use of a single product and the exposure during its spraying. However, the exposure doses do not consider the fact that several pesticides might be mixed and that the agricultural workers may be exposed during the days following the spraying. As such, pesticides considered as non-toxic for agricultural workers by the indicators may prove harmful in actual fact<sup>110</sup>. The indicators thus produce ignorance and may create a false impression of safety. In the field of healthcare, the most used indicators in France are the *Indicateurs Pour l'Amélioration de la Qualité et de la Sécurité des Soins*. These IPAQSS evaluate for instance the accuracy and completeness of the medical file including the traceability of pain evaluation, or the traceability of the decubitus ulcer risk evaluation. If it is important to keep a good traceability on these matters, these indicators do not allow a full measurement of the quality of the medical care. Indeed, in a given setting, the traceability of the pain evaluation may be perfect while the management of pain is awful. On the contrary, nurses in another setting may forget to trace pain evaluation but perfectly manage it. A nurse said during an interview « *Nous on a du mal avec ces indicateurs, ces chiffres là, ça reflète pas notre quotidien en fait.* » (Wave 1 Nurse 2). As such, if these indicators are the only measurement tool considered by the management they may create a false impression of safety and hide the real issues in the setting. In France for instance, indicators are published each year, but data about the frequency, criticality and cost of adverse events are scarce. The last evaluation of the frequency of serious adverse events in France dated from 2009<sup>111</sup> and only one incomplete evaluation of the cost of adverse events has been published recently in France<sup>112</sup>. We can thus suspect that IPAQSS led to the production on ignorance on the real quality and safety of care in France. In this context, the aforementioned evaluations and Experience Feedback Committees might prove useful by complementing the information given by the indicators. However, when data conflict, people tend to fall under the influence of confirmation bias, which makes them choose and favor information confirming and reinforcing their point of view<sup>113</sup>. In this case, we suspect that, because of confirmation bias, the hospital

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<sup>110</sup>*Ibid.*

<sup>111</sup>MICHEL P, *et al.*, « Les événements indésirables graves dans les établissements de santé : fréquence, évitabilité et acceptabilité », *Etudes et résultats*, DREES, N° 761, mai 2011

<sup>112</sup>NESTRIGUE Clément, OR Zeynep, « Surcoût des événements indésirables associés aux soins à l'hôpital : Premières estimations à partir de neuf indicateurs de sécurité des patients », *Questions d'économies de la Santé n°171-Décembre 2011*, IRDES

<sup>113</sup>DEDIEU François, JOUZEL Jean-Noël, « Comment ignorer ce que l'on sait ? La domestication des savoirs inconfortables sur les intoxications des agriculteurs par les pesticides », *Revue française de sociologie* 2015/1 (Vol. 56), p. 105-133

JOUZEL Jean-Noël, DEDIEU François, « Rendre visible et laisser dans l'ombre. Savoir et ignorance dans les politiques de santé au travail », *Revue française de science politique* 2013/1 (Vol. 63), p. 29-49.

BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

management chooses to trust the indicator results and to dismiss the result from the Experience Feedback Committee as useless and inaccurate.

But the ignorance may also be voluntary. Indeed, confronted to uneasy knowledge such as safety problem in the setting, the management can be tempted to ignore it and to make the EFC fail<sup>114</sup>. Indeed, by preventing EFC from functioning and the reporting of adverse events, the management would be able to hide the problems of the setting. This idea is supported by the fact that several interviewed staff members declared fearing to report adverse events thus participating in the introduction of a real Omertà in the setting around safety problems. As we previously evidenced in the chapter, this Omertà is the product of a global lack of trust in the management, a lack of communication but above all of the potential disciplinary sanctions we illustrated at the beginning of the chapter. Furthermore, deterring the staff members from attending Experience Feedback Committees is also a way to favor their failure. But to fully understand this deterrence and Omertà, we need to understand why the management tends to adopt such a behavior.

We suspect that one reason for this behavior is a strategy of risk disownership. Owning a risk allows framing it and defining how to manage this risk. However, it sometimes implies facing associated risks such as legal prosecution, reputational damage, economic cost, etc. Risk disownership is based on the idea that it is preferable to ignore a risk than to report it, and thus to recognize the weakness of the system and face the associated risk<sup>115</sup>. An example of this strategy, cited by Borraz, is the refusal of public authorities and of mobile phone operators to acknowledge the risk of mobile phone antennas to avoid the questioning of the activity<sup>116</sup>. This strategy, as we will see later in this chapter, shares some characteristics with blame avoidance.

On the topic of quality in healthcare and of Experience Feedback Committee, risk disownership supposes hindering the EFC functioning and the reporting of adverse event to conceal safety issues in the setting and thus to avoid the institutional risks associated to the discovery of safety

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REASON James, *Human Error*, (traduction : *L'Erreur Humaine*), traduction HOC Jean-Michel, Presses des Mines, 2013, 404 pages, titre original [*Human Error*]

<sup>114</sup>DEDIEU François, JOUZEL Jean-Noël, « Comment ignorer ce que l'on sait ? La domestication des savoirs inconfortables sur les intoxications des agriculteurs par les pesticides », *Revue française de sociologie* 2015/1 (Vol. 56), p. 105-133

JOUZEL Jean-Noël, DEDIEU François, « Rendre visible et laisser dans l'ombre. Savoir et ignorance dans les politiques de santé au travail », *Revue française de science politique* 2013/1 (Vol. 63), p. 29-49.

<sup>115</sup>BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

<sup>116</sup>*Ibid.*

issues. Indeed, this discovery of safety issues could cause damage to the reputation of the setting, lead to a loss of public trust in this hospital and its professionals, lead to the administrative closing of the hospital or to legal prosecution. As explained by Borraz, these associated risks are sometimes more feared than the actual risks as they may endanger the survival of the setting<sup>117</sup>. As such, ignoring safety issues and undermining the EFC and the adverse event reporting might be a way to manage associated reputational, institutional and legal risks<sup>118</sup>. This strategy might be associated to a strategy of blame avoidance. Blame avoidance is a concept of political science which describes a set of strategy used to avoid or deflect blame<sup>119</sup>. Because of negativity bias, the public opinion is more inclined to blame the decision-makers for inappropriate or unpopular actions than to recognize their successes or achievements. In this context, one way to avoid the blame is to postpone the making of the decision after the elections or to simply cancel it. Another way to avoid the blame is to deflect it on another actor such as the former government held responsible for the bad situation of the country, the opposition blocking reforms, or the European Union imposing its regulations<sup>120</sup>. We suspect that the management of the first setting adopts both strategies. Firstly, hindering the staff participation to EFC and its functioning enables to avoid safety issues being found and corrective actions being implemented. The management thus avoids being blamed by the public opinion for their previous management of safety issues and for inappropriate implemented actions plans. Furthermore, should a safety issue be discovered by the public opinion the management deflects the blame on another actor, by blaming the “faulting” nurse, the “reckless” physician, the “incompetent” intern or surgeon, etc. It should nevertheless be noted that, since the management of the first setting refused to be interviewed, this paragraph is only based on the staff statements, on the observation of the surveyor including the persistence of a blame culture in several units, and on the theoretical literature on the topic. If these elements do not allow us to claim with certainty that the management adopts strategies of risk disownership and blame avoidance, they form an important array of presumptions. Furthermore, it should also be noted that these strategies presumably concerns only the most critical and sensitive issues, and that common issues are properly analyzed and managed without interferences.

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<sup>117</sup>*Ibid.*

<sup>118</sup>*Ibid.*

<sup>119</sup>BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages  
CAUNE Hélène, « Blame avoidance (évitement du blâme) », in BOUSSAGUET Laurie *et al.*, *Dictionnaire des politiques publiques*, Presses de Sciences Po (P.F.N.S.P.) « Références », 2014 (4e éd.), p. 114-123

<sup>120</sup>*Ibid.*

Finally, the main reason explaining this behavior of the management is the problem of competitive objectives and more precisely the opposition between the economic objective including cost reduction and the objective of quality and safety. Many staff members reported equipment's problem related to the budget cuts with an important impact on their working conditions and on the quality of care.

*« je pense que la culture de sécurité c'est une culture qu'on développe de plus en plus à l'hôpital mais que du coup comme il y a une culture de l'économie qui se greffe en parallèle, les soignants des fois et même nous on a l'impression d'être face à une injonction de sécurité qui nous semble être de bon sens mais qu'on a de plus en plus de mal à mettre en œuvre parce qu'on manque de moyens que ce soit humain ou matériel, parce qu'on a régulièrement des changements de marché avec le matériel qu'on met en œuvre tous les jours, avec du matériel qui doit sûrement être moins cher ou plus intéressant à l'achat, mais qui sont tout à fait inadapté aux soins... » Wave 1 Head Nurse 4*

As we have previously seen, when such issues are raised by the Experience Feedback Committee, the hospital management tends to disregard it. This point is evidenced by the previously quoted statement of nurse 1 of our first wave, which explained that problems with needles were raised by the unit EFC, and that the management told the EFC these needles were to be changed without actually changing them. Investigated staff members in the first setting clearly identify the deleterious impact of the economic objective over quality and safety.

*« le problème c'est qu'ils sont entre les demandes des patients, des familles, des soignants et les choses imposées par la politique et l'économie, et il faut qu'ils fassent entre les deux et ça c'est compliqué je pense... » Wave 1 Doctor 3*

*« on est dans des systèmes où il faut faire des économies ce qui est très bien, sauf que pour moi on est arrivé au bout de ce qu'on peut faire en terme d'économies... la population elle vieillie, le besoin de soin va être de plus en plus important, on peut se réorganiser, on peut se réformer, mais je pense que ça fait bientôt plus de 10 ans qu'on sait que la santé a un coût et je sais pas si on pourra continuer à aller toujours aussi chaque année avec un ONDAM qui diminue, je sais pas si on pourra continuer. » Wave 1 Head Nurse 5*

In this context of budget restrictions, the hospital management favors economic objectives over quality and safety objectives. Experience Feedbacks Committees mobilize resources, including the attendance of several medical and paramedical professionals, without producing visible economic benefits. Furthermore, EFC recommendations and improvement plans often imply mobilizing resources, the creation of workgroups or even some investments (for instance buying new equipment, etc.). As such, the Experience Feedback Committee is probably seen



by the hospital management as a costly and barely useful tool, inconsistent with their own objectives which accounts for the deterrence to participation and the lack of consideration and interest in the EFC and its recommendation. In general, the deleterious impact of the budget cuts and of *Tarifification à l'Activité* over the quality and safety of care, and even the ethics, on France is broadly discussed in the literature<sup>121</sup>. Angelé-Halgand and Garrot relates the impact of the T2A over the quality and safety of care in a hospital where the management refused to implement a plan to improve the safety of the operating theater to avoid the loss of income associated to a decrease of hospital-acquired infections:

*« Ci-après nous présentons un dernier cas qui met également à mal l'éthique des soignants. Il est directement issu de la pression mise sur les établissements pour l'amélioration de leur efficacité et relayée à destination des professionnels de santé. Le cas suivant en fournit un exemple particulièrement éclairant. Un médecin, responsable du CLIN (Comité de Lutte contre les Infections Nosocomiales), cherche à réduire les infections déclarées au bloc opératoire, ayant constaté que leur nombre excédait de quatre fois la moyenne nationale. Avec son équipe, il cherche alors des solutions. Une cinquantaine de patients par an sont identifiés pour lesquels les conséquences sont très lourdes, tant sur le plan de la dégradation de la qualité de vie, que sur celui de leur employabilité future. En cohérence avec l'evidence-based medicine (recommandations de bonnes pratiques par les sociétés savantes des disciplines médicales concernées) sur le sujet, un plan d'actions est élaboré, un budget est établi pour un montant de 8 000 € et le tout est soumis au contrôle de gestion central. Le contrôleur revient alors vers le médecin en notant que le coût du plan n'intègre pas les pertes de recettes générées par la ré-hospitalisation des 50 patients infectés, ces séjours donnant lieu à des tarifs de T2A particulièrement rémunérateurs. Au final, le plan fut rejeté, le médecin et son équipe en ressortirent amers et révoltés. »*

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Such a set of behaviors from the management is all the more deleterious and damaging as it causes a global loss of trust of the staff members in its capacity to manage the hospital and in the quality approach. It has been observed that nurses and doctors are the categories of staff in which this loss of trust and rebellion against the management is the most important.

*« Donc je vous dis vraiment le fond des choses, c'est que je n'ai plus confiance en personne au CHU à part une ou deux personnes... J'ai entièrement confiance dans le professeur Y parce que quand il dicte*

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<sup>121</sup>ANGELÉ-HALGAND Nathalie, GARROT Thierry, « Les biens communs à l'hôpital : De la " T2A " à la tarification au cycle de soins », *Comptabilité - Contrôle - Audit*, 3/2014 (Tome 20), p. 15-41  
PIERRU Frédéric, « Hospital Inc. Les professionnels de santé à l'épreuve de la gouvernance d'entreprise », *Enfances & Psy*, 2009/2 (n° 43), p. 99-105

<sup>122</sup>In ANGELÉ-HALGAND Nathalie, GARROT Thierry, « Les biens communs à l'hôpital : De la " T2A " à la tarification au cycle de soins », *Comptabilité - Contrôle - Audit*, 3/2014 (Tome 20), p. 15-41, citation page 27

*une ligne je sais qu'on peut la suivre et malheureusement avec d'autres j'ai appris la politique et quand ils montrent blanc, ils font noir, et malheureusement, donc j'ai plus du tout confiance, et ça c'est quand même un gros problème pour l'avenir. C'est-à-dire qu'on veut faire notre travail au mieux, mais ne plus avoir confiance dans ceux qui dirigent au niveau administratif le bateau c'est compliqué. » Wave 1 Doctor 2*

Several staff members confided us that this situation raised serious ethical problems and had disastrous effects on working conditions and on the overall morale of the staff. Some staff members reported problems of professional suffering and deep self-questionings.

*« je veux pas être complètement négative, mais moi quand je pars du service, je suis pas très contente du travail que j'ai fourni... je trouve que de plus en plus y'a un gouffre entre ce qu'on m'a appris à l'école, la bonne théorie et la réelle pratique. Sauf qu'on nous demande d'exercer cette théorie qui est impraticable en réalité. On fait de notre mieux, vraiment, je pense vraiment qu'on fait de notre mieux mais, là en tout cas pour ma part, je suis arrivé au bout de ce que je pouvais fournir, je suis pas satisfaite des soins que je donne... je crois vraiment qu'on nous en demande trop et qu'on a plus assez de moyens pour faire face à toutes les difficultés d'un service d'urgences telle qu'on le connaît... C'est assez inconfortable de pas avoir l'impression de faire au mieux. Y'a pas très longtemps, on a eu une remarque d'une famille, et la famille avait complètement raison hein... une petite dame qui demandait le bassin pour uriner, et a priori, je dis bien a priori parce que j'étais pas là, mes collègues étaient débordés, ils ont demandé à la dame d'uriner dans sa protection en lui promettant de venir la changer vite après parce qu'ils ne pouvaient pas se libérer pour mettre un bassin, et, pour vivre ces situations au quotidien, c'est très critiquable mais c'est vraiment la réalité, on peut pas s'occuper de quelqu'un en urgences pour suspicion d'AVC et la collègue à côté un infarctus et tout arrêter et aller mettre un bassin à une dame sachant qu'on a pas d'AS pour nous aider sur ces tâches là, dans ce secteur-là en tout cas... C'est réellement critiquable. Au point de vue théorique, c'est tout ce qu'on ne doit pas faire et du point de vue moral, on peut décemment pas dire aux gens : « Pissez vous dessus, je viens vous changer après »... et malheureusement c'est ce qu'on vient à faire a priori, je pense vraiment qu'on a pas une qualité de soin adéquate et exceptionnelle et ça c'est vraiment dommage, ça nous use en plus de tous les à-côtés qui ne sont déjà pas facilitants... » Wave 1 Nurse 1*

We suspect that the situation is especially harmful for the EFC, the quality approach, and the global quality and safety of care. Indeed, these problems tend to favor high turn-over rates and absenteeism as evidenced in the paragraph about rebellious physician in chapter 2 and by the following statement:

[about the emergency unit] *« tout ça au sein d'équipes où le travail qui est produit est fatigant, un turn-over d'équipes qui est conséquent, un maintien des compétences qui pour moi est un vrai problème du*

*quotidien, savoir comment on va continuer à assurer de la qualité avec un turn-over de soignants qui s'usent, et sur une équipe de 58, j'ai à peu près 10 à 12 personnes qui partent chaque année* » Wave 1 Head Nurse 5.

This point of skill conservation raised by this head nurse is critical as no long-term approach can be built without team stability. Judging from those facts we can fear that the Experience Feedback Committee and the quality approach in such units might decline due to a lack of team consistency, a lack of leaders and quality advocates due to the high turn-over rate, the constant necessity to train new staff members to EFC and quality and safety without being sure they will stay, etc. Building a strong quality program based on the reporting and analysis of the adverse events, and around an active and dynamic Experience Feedback Committee in this environment appears highly unlikely. This situation is all the more paradoxical considering the probable enormous cost implied by similar turn-over rates evidenced by Waldman *et al*<sup>123</sup>, the negative impact on patient satisfaction, and on quality and safety established respectively by Vahey *et al.*<sup>124</sup> and by Aiken *et al*<sup>125</sup>. In this context, all the aforementioned barriers and the management tend to create a vicious circle in which the deterioration of quality and safety of care, and of working conditions favors turn-over, which in turn lead to the deterioration of quality, safety of care and of working conditions. The turnover is thus both a consequence and a cause of the failure of the quality approach and of the EFC.

We have thus seen that the main limit undermining the effectiveness of the Experience Feedback Committee is the lack of support of the hospital management. This lack of support is characterized by a lack of valorization of the participation in Experience Feedback Committees, or even deterrence to participation, a lack of consideration of the Experience Feedback Committees or its recommendations, and a global lack of support from the management. This behavior is mainly explained by competitive objectives and the current importance of the economic objectives. In addition, this problem also finds its source in ignorance of safety issues, partly produced by insufficient and inadequate indicators. Finally, we can suspect that, in some settings, the management might be tempted to prevent the Experience Feedback Committees to conceal serious and sensitive safety issues and to avoid or deflect a possible blame. Judging from the facts exposed on this chapter, we can conclude that in settings with lower level of

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<sup>123</sup>WALDMAN JD *et al.*, « The shocking cost of turnover in health care. », *Health Care Manage Rev.* 2004;29(1):2-7

<sup>124</sup>VAHEY DC, et al. « Nurse Burnout and Patient Satisfaction », *Medical care.* 2004;42(2 Suppl)

<sup>125</sup>AIKEN LH *et al.*, « Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Jama.* 2002 Oct 23-30;288(16):1987-93.

quality approach and safety culture, the management tries to undermine the Experience Feedback Committees effectiveness for the aforementioned reasons. The Experience Feedback Committee is thus impacted by the level of safety culture and of quality approach of the setting, and support from the management seems to be an essential prerequisite to the success of the Experience Feedback Committee.

Despite this context in the first setting, we observed several Experience Feedback Committees effectively working. One of them and perhaps the most noticeable was the one of Internal Medicine. Indeed, in this unit, the local management is highly involved in quality and safety of care, and incites the staff to attend the safety enhancement meetings.

*« le fait qu'on ait une nouvelle cadre qui soit vachement qualité, qu'on reprenne un petit peu à plat les choses, qu'il y ait une motivation, c'est-à-dire que XX [anonymisation] qui est là est référent qualité sur le pôle au niveau médical et YY[anonymisation] qui est cadre est référente qualité sur le pôle [rires]. Donc on a deux référents qualités là d'un coup, donc je pense que ça ça a motivé à faire. »*

Wave 2 Nurse 3

Furthermore, a specific organization was implemented to circumvent the lack of time and of resources. Firstly, in this unit, a rotation between EFC and MMC has been implemented.

*« Nous on a pris le parti de faire, d'alterner un mois sur l'autre, donc globalement on fait 6 CREX théoriquement pour 6 RMM. »* (Wave 2 Doctor 2).

Secondly, while EFCs are restricted to staff members trained to the ORION© method, Morbidity and Mortality Conference are opened to all staff members participation.

*« Donc la RMM elle est ouverte à tous [...] pour le CREX du coup c'est les autres mois. Donc là c'est du formel, euh du personnel formé. »* (Wave 2 Nurse 3).

The analysis method used for this MMC is a systemic root-cause analysis. Some tools such as the Ishikawa method (also called Fishbone diagram or cause-and-effect diagrams) are also used to find and assess the root causes of the adverse events. Staff members attending the MMC are free to choose their favored analysis method, as long as it is a root-cause analysis. *« Bah on va peut-être pas utiliser les méthodes de recherche de cause. Par rapport au CREX on part en général sur la méthode ORION© pour analyser effectivement les causes et essayer ensuite d'avoir un plan d'action derrière. Pour la RMM, on va utiliser d'autres méthodes de recherche mais au final quoi qui se passe on va rechercher les causes dans les deux cas. Après est-ce que ça va être les mêmes causes, ça dépend du problème, ça dépend de l'origine du problème. Mais quoi qu'il se passe, on va regarder pareil si y'a eu des... on va utiliser, enfin si je prends par exemple, le diagramme d'Ishikawa, on va regarder pareil les causes matérielles, organisation, méthodes, procédures, enfin oui dans les deux cas on va regarder... »* Wave 2 Head Nurse 3

The approach of this MMC thus highly resemble the EFC, and the chronological reconstructions of the events followed by a root-cause analysis is very close to the ORION© method.

*« Pour la RMM, il n'y a pas la méthodologie, c'est pas aussi, comment dire, méthodologiquement structuré, mais c'est vrai qu'on en vient toujours un peu à une méthode qui en revient un peu à la méthode ORION©. » Wave 2 Doctor 2*

This organization seems especially relevant as it allows the unit to develop a quality approach based on the analysis of adverse events and on learning from errors. This approach also favors the quality of the meetings over their frequency, thus requiring a lower investment of the staff members which lowers the barrier to EFC effectiveness. Finally, the role of leader of the head nurse and referring doctor of the unit allows counteracting some deterrents to participation by creating important team cohesion and by creating both interest and healthy emulation around quality and safety issues in the unit. This specific organization between two resembling tools raise questions on their use and the relationship they have. We will thus investigate the relationship between these tools in the next chapter.

Finally, in our second setting, if the management does not strongly support the Experience Feedback Committee, no such deterrents to participation were either observed or reported by investigated staff members. The absence of deterrents allowed the EFC to function and its continuation is evidenced by the fact it still meet monthly after one year of existence.

*« Le Comité de Retour sur Expérience, c'est assez récent, à la clinique, ça a été mis en place il y a une petite année, vu qu'on vient de fêter son anniversaire. C'est vrai que ça a permis d'avoir plus de retour et plus de réflexion sur les événements indésirables qu'il pouvait y avoir à la clinique et plus d'implication dans les équipes, je pense. Je pense que... C'est vrai que c'était géré avant vraiment par le service qualité, des fois par des cadres de service et y avait pas vraiment de retour, après, nous, sur les équipes, sur ce qu'on avait déclaré ou .... Non, je pense que c'est vraiment pas mal et puis ça permet aussi que ce soit les personnes concernées qui creusent le problème. » Wave 3 Operating Theater Nurse*

The relative lack of support from the management did not enable it to achieve its full potential. But the EFC still produced interesting and useful results as evidenced by the following statement of a nurse:

*« Par exemple dans les superpositions d'urgences, on a eu un problème de césarienne, c'était un des premiers CREX qu'on a faits, la césarienne en extrême urgence qui survient alors que la salle de césarienne est occupée, ben ça, ça a mené à une grosse réflexion en profondeur, à l'élaboration d'un protocole, d'une procédure en cas de césarienne en extrême urgence avec même la possibilité de faire la césa en salle de naissance. Ça, c'est quelque chose, on n'avait zéro procédure, on s'est retrouvé démuni le jour où c'est arrivé parce que personne savait comment réagir. Et ben a priori, ça n'arrivera plus. » Wave 3 Operating Theater Nurse*

## **5) Experience Feedback Committees and Mortality and Morbidity Conferences: superfluous tools or complementary ones?**

Mortality and Morbidity Conferences (MMC) are *a posteriori* safety-enhancement tools which analyzes adverse patient outcome to improve quality and safety of care. They appeared in the twentieth century in the United States and have since diffused in western countries<sup>126</sup>. These MMC are used in different specialties ranging from intensive care to internal medicine<sup>127</sup>. In France, MMC have been implemented since the 1990s and have been made compulsory for surgery, cancerology, anesthesia and intensive care<sup>128</sup>. Since their first implementation, Mortality and Morbidity Conferences and Experience Feedback Committees have been widely diffused and are now jointly used in different setting. As such, we tried to determine the reasons explaining this joint use, its impact and the relationship between the tools. Our second wave of interview aimed to answer this interrogation. The issue of this question is to understand whether the previous existence of tool facilitate the furthering of the quality approach, and whether a new tool can alter previous method to improve them. As such, this issue is about the ability of quality systems to produce continuous improvements in quality and risk management.

Interviewed staff members highlighted the fact that on the one hand Experience Feedback Committee was a multidisciplinary tool, involving nurses, head nurses, physicians and other professional categories. Moreover, EFC is based on a systemic, root causes, analysis of reported adverse events or near misses in the service. On the other hand, Mortality and Morbidity Conferences are mostly attended by medical staff (physicians and midwives). Paramedical staff rarely attend these meetings. The analysis is mainly based an analysis of medical practices and not on a system approach as defined in chapter 2. Chosen events for MMC were mainly trigger event such as patient death, medical or surgical complication, intensive care unit admission

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<sup>126</sup> FRANCOIS Patrice, BOUSSAT Bastien, « Gérer la sécurité du patient en équipe : la revue de morbidité et mortalité (RMM) et le comité de retour d'expérience (Crex) », *Techniques Hospitalières 755 Janvier-Février 2016*, FHF, p. 32-35

<sup>127</sup> PIERLUISSI E, *et al.*, « Discussion of medical errors in morbidity and mortality conferences ». *Jama* 290(21), 2003, pages 2838-2842

LECOANET André *et al.*, « Assessment of the contribution of morbidity and mortality conferences to quality and safety improvement: a survey of participants' perceptions », *BMC Health Services Research*, 2016

<sup>128</sup> FRANCOIS Patrice, BOUSSAT Bastien, « Gérer la sécurité du patient en équipe : la revue de morbidité et mortalité (RMM) et le comité de retour d'expérience (Crex) », *Techniques Hospitalières 755 Janvier-Février 2016*, FHF, p. 32-35

LECOANET André *et al.*, « Assessment of the contribution of morbidity and mortality conferences to quality and safety improvement: a survey of participants' perceptions », *BMC Health Services Research*, 2016

(ICU), etc. Thus, the main differences between EFC and MMC is the selection of analyzed events, the type analysis and the goal. Indeed, while EFC aims to make system improvements by the identification and elimination of latent factors, MMC aims to improve medical practices and medical staff education and training.

*« Les RMM permettaient d'avoir un regard sur les pratiques du service et puis d'être un outil aussi pédagogique, rendu obligatoire pour les médecins en formation, les jeunes, les juniors en formation, les internes et les chefs de clinique et assistants, pour devenir plus élargi à l'ensemble de l'encadrement médical. Donc c'est surtout un outil pédagogique puis c'est aussi une façon de réactualiser un petit peu et de revenir sur les procédures pour lesquelles on serait pas au point » Wave 2 Doctor 3*

*« Sur la RMM, on fait une RMM mensuelle, essentiellement sur des problèmes médicaux, comme toute réunion morbi mortalité, des transferts en réanimation, des décès, des problèmes de garde où un praticien est seul. Donc très médical ... et le CREX depuis sa formation, bah comme tous les CREX c'est beaucoup plus pluridisciplinaire, où on voit plus des problèmes de fonctionnement de service, de dysfonctionnement de service, en réunion également plutôt mensuelle. » Wave 2 Doctor 4*

About MMC : *« Sur le plan intellectuel, je trouve que c'est intéressant de se pencher sur les dossiers qui ont posé problème et de réfléchir ensemble à ce qui s'est pas bien fait, à ce qui s'est bien fait aussi parfois. Et puis, individuellement dans ma pratique moi ça m'a aidée. Alors, je travaille plus en salle d'accouchement maintenant, mais depuis que je participe à ces RMM, en fait, ça m'a aidée par exemple dans la prise en charge de l'hémorragie de la délivrance. On a mis en place des protocoles et pour moi dans ma tête c'était beaucoup plus clair. » Wave 2 Midwife 1*

Specifically, these two tools analyze different adverse events on different scopes. The Morbidity and Mortality Conferences focuses on the practices and an adverse outcome. Its analysis is centered on the medical practices, basing itself on practices guidelines, on the state of the art, etc. MMC are often based on scientific data and publications, and have a pedagogical interest. Indeed, they allow training of young professionals and underline the importance of experience feedback, but also allow other professionals updating their knowledge and keep their practices up to date according to the newest professional guidelines. However, MMC lack system analysis which does not allow the identification of latent factors over the occurrence of errors in medical practices. The Experience Feedback Committee focuses on the analysis of adverse events occurring during the stay of the patient but not necessarily linked to medical

practices but rather to the wider process of care and specifically on systemic and organizational failure. For instance, these adverse events can be related to medication circuit (prescription, dispensing, etc.), logistical process (equipment maintenance, equipment and consumables delivery, waste management, etc.), communication in the unit and between the units, patient transport, correct identification of the patient, etc. As explained in the literature and mentioned in previous chapters, one of the main strength of EFC is its system approach based on the works of James Reason<sup>129</sup>.

« le CREX ça reste plus comment dire, organisationnel, alors que je dirais que la RMM c'est plus versant clinique. » Wave 2 Doctor 1

« le CREX c'est tout simplement une transversalité, on peut analyser l'événement, je sais pas, de l'enfant qui est arrivé dans la rue qui a eu un truc, voilà l'exemple de l'ambulance tout ça, jusqu'à l'erreur médicamenteuse, voilà. Alors que la RMM c'est plus une réunion interne et qui va plus s'attacher à on va dire à tout ce qui est clinique et problème interne. Par exemple dans une RMM on va pas aller analyser ce qui s'est passé à l'extérieur, dans une ambulance, un autre service. Voilà donc c'est vraiment de la transversalité. Après ça n'empêche que certaines RMM, comme par exemple, la RMM du laparoscisis où ça réunit différents acteurs, par exemple c'est le nouveau-né avant la naissance c'est-à-dire les gynécologues, les obstétriciens, la salle de naissance, la réanimation néonatale, le bloc opératoire, la chirurgie, donc ça fait que y'a quand même plusieurs intervenants dans cette chaîne, alors que le CREX c'est plus organisationnel, voilà. » Wave 2 Doctor 1

« Bah le RMM c'est vraiment une revue morbidité mortalité sur des... ils prennent des dossiers patients et ils vont analyser les dossiers patients. Donc on est vraiment axé sur un patient avec un événement, un problème de prise en charge en soin médical et tout ça, tandis que le CREX on va être plus sur des choses plus général, enfin on va avoir une patiente admettons on s'est trompé d'administration d'un traitement ça on va le prendre en CREX mais on va pas être sur une revue : bah voilà tant de patients sont décédés ce mois-ci dans le service, ça vient de quoi. Enfin... On va analyser ... En CREX ça va être plus de l'analyse de transport, de chute, de problèmes de risque infectieux, de risque médicamenteux, de violence... C'est pas les mêmes thématiques finalement. » Wave 2 Head Nurse 2

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<sup>129</sup> REASON James, *Human Error*, (traduction : *L'Erreur Humaine*), traduction HOC Jean-Michel, Presses des Mines, 2013, 404 pages, titre original [*Human Error*]

REASON James, « Human error: models and management », *BMJ Volume 320*, 18 mars 2000, p.768-770

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BOUSSAT Bastien *et al.*, « Experience Feedback Committee: a management tool to improve patient safety in mental health », *Annals of General Psychiatry*, 2015, 23 pages

DEBOUCK F. *et al.*, « Méthode Orion® : analyse systémique simple et efficace des événements cliniques et des précurseurs survenant en pratique médicale hospitalière », *Cancer/Radiothérapie*, Volume 16, Issue 3, Pages 201-208, 2012



Both these tools therefore participate to constant amelioration of quality and safety of care and are rather complementary. Besides, it should be noted, that neither of these tools can be used as the sole safety management tool in a setting. Indeed, quality and safety management must be based on both *a priori* (such as risk mapping) and *a posteriori* safety enhancement tools and must belong to a wider comprehensive quality approach. It should be noted that MMC are mostly attended by doctors and medical staff (midwives, etc.) which appreciate this method while nurses and paramedical staff do not really perceive its interest. This lack of interest of nurses and paramedical staff is explained by the fact that they rarely participate to this tool and that their practices are not analyzed by the tool. On the contrary, as we explained in a previous chapter, we observe a wider support of all categories of professionals for the Experience Feedback Committee.

*« la RMM c'est uniquement la neurologie, c'est pas pôlaire, c'est par service, donc là c'est tous les médecins séniors et internes du service avec une cadre qui représente les cadres de santé. »* Wave 2  
Doctor 4

About the impact of MMC *« Le Mor Mor [les RMM NDLR] ? Pff... niveau soignant nul... Peut-être, j'espère au niveau des patients sur le Mor Mor ça a un impact, mais nous on le voit pas au niveau des soignants... Je pense que ça ressemble pas mal à des réunions de concertation en fait... »* Wave 2  
Nurse 2

Now we discussed the complementarity of Experience Feedback Committees and Morbidity and Mortality Conferences, and the need of a comprehensive quality approach, we can interest ourselves on the question of the relationship between these two tools. Since, Mortality and Morbidity Conferences were implemented even before the design of Experience Feedback Committees, we suppose that their existence in a unit facilitated the implementation of EFC. We also suppose that the methodology of EFC trickled down on MMC thus improving their design. Indeed, the implementation of Experience Feedback Committee was decided as a way to learn from error and to further the quality approach of the setting.

## **Did the existence of Mortality and Morbidity Conferences facilitated the implementation of Experience Feedback Committees?**

As we explained previously, we suppose that MMC facilitated the implementation of EFC in a phenomenon of path dependence. Path dependence is a concept in social sciences, which explains that current decisions are influenced by past decisions due to investment cost, knowledge and skills, etc.<sup>130</sup> Paul Pierson explained that increasing returns in terms of collective action process, interpretation and anticipation process and institutional development process make a change costly and unlikely<sup>131</sup>. An organizational change would imply a change in relationship between the different actors, training to create and diffuse knowledge about the new organization, and finally would imply to modify the rules and institutional framework to adapt to the new system. For instance, changing safety enhancement tools in a hospital would imply training the staff, establishing new structural relationships between staff members, and set up new programs validation procedure to acknowledge the new tool<sup>132</sup>.

Indeed, MMC and EFC share a similar basis of *a posteriori* analysis of bad outcomes or adverse events and monthly meetings. In addition, both MMC and EFC answer to an imperative of improving quality and safety, and thus we can suppose that MMC raise awareness about these in issues in units where it is implemented. As such, we can see EFC not as shift in how risks are managed in the unit but as a deepening of the current logic of the MMC. Thus, the previous existence of Morbidity and Mortality Conference should reduce the need of training and investment in this unit and facilitate the deployment of Experience Feedback Committee.

Data collected during the second wave of interviews tend to disprove this hypothesis. Most investigated staff members reported that the existence of Morbidity and Mortality Conferences in the unit did not impact the implementation of Experience Feedback Committee because of differences in their goal and method as highlighted previously.

*« Facilité... euh non, mais c'est deux démarches parallèles, la RMM existait bien avant le CREX donc la RMM je crois que c'était depuis 2004 ou 2005 qu'on a lancé la RMM dans le service. Euh après*

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<sup>130</sup> Bruno Palier, « Path dependence (dépendance au chemin emprunté) », in Laurie Boussaguet *et al.*, *Dictionnaire des politiques publiques*, Presses de Sciences Po (P.F.N.S.P.) « Références », 2014 (4e éd.), p. 411-419.

<sup>131</sup> *Ibid.*

<sup>132</sup> FRANCOIS Patrice *et al.*, « De l'évaluation des pratiques professionnelles au développement professionnel continu : engagement et opinion des praticiens hospitaliers dans les activités d'évaluation des pratiques professionnelles », *Santé Publique*, 2015/2 (Vol. 27), p. 187-194

*l'implantation du CREX ça c'est fait euh... on va dire en parallèle, l'un n'empêche pas l'autre. Mais facilité je dirais pas. Je dirais les personnes étaient un petit peu plus sensibilisées... » Wave 2 Doctor 1*

**« Eq 12 : Et est-ce que l'existence préalable des RMM a favorisé l'implantation préalable du CREX ?**

*En 12 : Euh, non, non... c'est... en fait ça a été un concours de circonstances et une opportunité qui nous a été donnée via les pharmaciens à l'occasion d'un audit qui était national et qui a surtout été fait sur [l'hôpital (anonymisation)]. Y'a eu un audit à un moment donné sur les secteurs de la pharmacie, et donc à l'occasion de cet audit on a eu une formation, une petite sensibilisation qui finalement a perduré parce qu'on se l'est appropriée » (Wave 2 Doctor 3)*

However, in a unit investigated during second wave, the Experience Feedback Committee of the unit failed because of the non-compliance to the methodology of the tool. In this unit, EFC was not multidisciplinary and did not use system approach and root cause analysis of the event.

*« Au niveau des CREX, il y avait effectivement des CREX, il y a 2 ans avec une rencontre régulière, mais ça a été abandonné, il n'y a plus de CREX depuis 1 an et demi, 2 ans... »*

**Eq 2 : Et pourquoi ça a été abandonné ?**

*En 2 : Euh ... parce que... j'ai pas l'explication vraiment... En tout cas, je pense que le bénéfice du CREX tel qu'il était organisé n'était pas optimal. [Le téléphone sonne. Coupure et reprise de l'enregistrement.] Donc je disais que le CREX tel qu'il était organisé pour moi, le bénéfice qu'il y avait pour moi n'était pas optimal parce que trop éloigné du terrain, je pense.*

**Eq 2.1 : Vous pouvez m'en dire plus sur ce point-là ? Le fait que ce soit trop éloigné ? que le bénéfice n'était pas optimal ?**

*En 2.1 : Alors moi j'étais pas... j'étais un peu en... j'étais pas du même avis que ma chef dans le sens où ma chef voyait que chaque problématique qu'on rencontrait à l'intérieur de nos unités concernait forcément, cette problématique était forcément présente dans une autre unité. Et que le fait de pouvoir en discuter entre cadres, parce que le CREX était uniquement réservé aux cadres et à un médecin mais pas aux infirmiers et aides-soignants, permettait un partage d'expérience et de trouver des solutions derrière... [...] De plus, je pense que l'expertise elle est sur le terrain, et que le cadre et le cadre sup n'a pas la même expertise que les personnes qui sont sur le terrain, donc forcément on doit pouvoir s'appuyer sur les gens du terrain pour avoir l'analyse. Sans eux on peut pas faire d'analyse. Et tel qu'il était organisé, il n'y avait pas d'analyse de faite auprès du personnel de terrain.*

***Eq 3 : Et quelle méthodologie utilisiez-vous lors de ce CREX du coup ?***

*En 3 : Oh bah, c'était une analyse... rien de formalisée, il n'y avait pas d'analyse, je sais plus comment elle s'appelle l'analyse qu'on utilise pour les CREX normalement, je l'ai vue utilisée dans d'autres services. Mais nous non, c'était de l'analyse de ... comment dirais-je ... pas très poussée on va dire... Pas très structurée voilà plutôt... pas très structurée. »*

Wave 2 Head nurse 5

We suppose that the non-compliance to the EFC methodology, illustrated by the statements of Head Nurse 5 of the Wave 2, is explained by path dependence. Indeed, as this head nurse explains, the pole manager was not willing to include nurses in EFC, thus keeping the staff composition of the MMC. One investigated nurse in this unit (Wave 2 Nurse 1), knew nothing about EFC confirming that nurses were not invited and talked about this EFC.

***« Eq 4.1 : Et avez-vous entendu parlé du CREX ?***

*En 4.1 : J'en ai entendu parler mais j'y ai jamais assisté.*

***Eq 4.2 : Est-ce que vous connaissez ce genre de réunions ?***

*En 4.2 : Non non c'est très approximatif, très flou. Enfin, je sais que nous on était plutôt convié sur les RMM, et les CREX c'était... »*

***« Eq 9 : Que pouvez-vous me dire comme ça à la volée sur le CREX, de ce que vous avez pu entendre ?***

*En 9 : Je sais juste comme vous avez-dit que c'est une réunion et que on prend les événements indésirables. Après, non je connais pas assez ... » Wave 2 Nurse 1*

Furthermore, no systemic root cause analysis was implemented (« *c'était une analyse... rien de formalisée* » Wave 2 Head Nurse 5), even though such an analysis method is fundamental prerequisite for EFC<sup>133</sup>. This lack of analysis method is however commonly found in MMC as

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<sup>133</sup> BOUSSAT Bastien *et al.*, « Experience Feedback Committee: a management tool to improve patient safety in mental health », *Annals of General Psychiatry*, 2015, 23 pages  
DEBOUCK F. *et al.*, « Méthode Orion® : analyse systémique simple et efficace des événements cliniques et des précurseurs survenant en pratique médicale hospitalière », *Cancer/Radiothérapie*, Volume 16, Issue 3, Pages 201-208, 2012

detailed in the scientific literature<sup>134</sup>. In this pole, EFC organization thus seemed to be altered to correspond to the organization of MMC. From this conclusion, the statements of these two investigated staff members and from observation of the surveyor in the pole, we suppose that, in this pole, the head nurse managing the unit presumably considered the EFC methodology to be too difficult to implement and that the investment cost was too high, thus altering the EFC method to correspond the MMC one. Specifically, we suspect from the observations and the reported lack of system analysis and inclusion of the nurses in the EFC that the management was not willing to train staff members to ORION© method. Moreover, we might suspect that these problems may also be linked to the behaviors of the physicians in this pole. Observations and declarations of the investigated head nurses and nurses in the hospital highlight the fact that MMC is a tool favored by medical staff. Physicians, in this pole, may have perceived the implementation of EFC and its multidisciplinary approach as a challenge and a weakening of their authority and they may have feared a loss of legitimacy. They were probably not willing to accept the participation and input of paramedical staff, as observations in the and some cited statements suggest.

As such, the implementation of the Experience Feedback Committee has probably been perceived as a shift in the taken path. Fully implementing EFC would have implied training the staff, involving nurses and paramedical staff and redefine the relation framing between paramedical and medical staff in quality and risk management. This investment was probably deemed too high, both in terms of economic cost and in terms of institutional cost as the EFC method would have implied to redistribute power between staff categories during EFC meetings. Since the management (head nurse) and physicians in this pole were not willing to shift path, they adjusted the EFC to the path they had chosen but thus making it ineffective and useless, and thus setting it up for failure. This example shows how the existence of MMC may

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<sup>134</sup> ABOUMATAR HJ, *et al.*, « A descriptive study of morbidity and mortality conferences and their conformity to medical incident analysis models: results of the morbidity and mortality conference improvement study, phase 1 », *American journal of medical quality : the official journal of the American College of Medical Quality*, 2007 Jul-Aug, 22(4), pages 232-238

FRANCOIS Patrice *et al.*, « Characteristics of morbidity and mortality conferences associated with the implementation of patient safety improvement initiatives, an observational study », *BMC Health Services Research*, 2016

LECOANET André *et al.*, « Assessment of the contribution of morbidity and mortality conferences to quality and safety improvement: a survey of participants' perceptions », *BMC Health Services Research*, 2016

ORLANDER JD, BARBER TW, FINCKE BG, « The morbidity and mortality conference: the delicate nature of learning from error », *Academic medicine : journal of the Association of American Medical Colleges* 77(10), 2002, pages 1001-1006

PIERLUISSI E, *et al.*, « Discussion of medical errors in morbidity and mortality conferences ». *Jama* 290(21), 2003, pages 2838-2842

hinder the deployment of EFC. In such pole or unit, the head nurses and physicians managing the unit are uninterested staff members and thus have low knowledge or interest in quality and safety, thus explaining the lack of willingness to fully implement EFC and to shift the path they had chosen.

Even though investigated staff members did not identify an influence of previous existence of MMC over the implementation of EFC and despite the negative impact we discussed, we suppose that the existence of MMC in a unit may still facilitate the implementation of EFC. As a matter of fact, several professionals who attended several Morbidity and Mortality Conferences often are more open-minded about experience feedback and more aware of quality and safety issues. When Experience Committees are implemented in their unit, these staff members often importantly contribute to the committee. These professionals often are quality-concerned physicians or quality-responsible head nurse who play a leading role in these new EFC and who create a team dynamics enabling their effective deployment. Without these staff members, the implementation of EFC would have been harder in these units and we suppose that their participation to MMC encouraged them to take an active role when EFC were implemented.

We must conclude this section on the statement that our data do not provide conclusive proofs that the existence of Morbidity and Mortality Conference in a unit facilitate the implementation of Experience Feedback Committee. It is certain that the previous existence of Morbidity and Mortality Conference in unit where management is mostly composed of uninterested staff members often leads to the failure of Experience Feedback Committee. However, in other units our data are conflicting: the interviews conducted among staff members in these units tend to disprove the existence of an influence but our observations tend to suggest the contrary. There may not be a direct influence but an indirect influence is not to be excluded.

### **Does the implementation of Experience Feedback Committee impact the organization or the method of Morbidity and Mortality Conference?**

As the implementation of Experience Feedback Committee in a unit causes an organization change, we suppose that this change favors organizational learning and thus favors a methodological and organizational transfer between the tools. However, in four of the five units where these two tools are deployed, no interaction, relation, or methodological or organizational

transfer was observed by the surveyor or reported by the staff members. Investigated staff members talk about parallel method and did not report interaction even when asked by the investigator. In two units, the EFC failed thus preventing any relationship or interaction with the MMC. A methodological and organizational transfer was yet observed in only one specific internal medicine unit.

« *Donc le CREX, en fait, de façon claire, y'en a plus... depuis environ deux ans.* » Wave 2 Doctor 5

« **Eq 10 : Et du point de vue des relations entre ces deux outils ?**

*En 10 : [Hésitation] Dans quel sens ?*

**Eq 10.2 : Ce qu'il vous vient.**

*En 10.2 : Je dirais une démarche parallèle, une démarche parallèle et voilà, oui le CREX ça reste plus comment dire, organisationnel, alors que je dirais que la RMM c'est plus versant clinique.* » (Wave 2 Doctor 1)

« **Eq 7 : Et au niveau de la mise en place du CREX dans le service est-ce que vous pensez que l'existence préalable des RMM l'a facilitée ?**

*En 7 : Disons que c'était une introduction* » (Wave 2 Head Nurse 4)

« *le fait d'avoir eu la méthodologie ORION© nous a fait réfléchir sur la manière qu'on avait de faire nos RMM et de dire que c'était pas forcément adapté comme on le faisait* » Wave 2 Doctor 2

This lack of interaction between the tools and the lack of existence of methodological and organizational transfer; in most units; has thus been investigated. We suspect that different reasons might explain it. The first one is the fact that organizational change in the quality approach of these units and its perception by the staff was insufficient to provoke an organizational learning<sup>135</sup>. Indeed, the two approaches are perceived by most the staff as parallel and complementary with different goals. The closeness in the methodology is underlined by the fact that some investigated staff members consider the MMC as an introduction to the EFC. As such the organization change and methodological transfer from one tool to the other might have been considered of little interest. The second reason that can be evoked is a phenomenon of

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<sup>135</sup> KOENIG Gérard, « L'apprentissage organisationnel. Repérage des lieux », *Revue française de gestion*, 8/2015 (N°253), p.83-95

GUILHON A, TREPO G, « Réussir les changements par le développement de l'apprentissage organisationnel les leçons du cas de Shell », *Gérer et Comprendre*, septembre 2001, 65, p 41-54

BEN ABDALLAH Lotfi, BEN AMMAR-MAMLOUK Zeineb, « Changement organisationnel et évolution des compétences. Cas des entreprises industrielles tunisiennes », *La Revue des Sciences de Gestion*, 2007/4 (n°226-227), p. 133-146.

path dependence<sup>136</sup>. In these units, the staff may have preferred not to change the methodology used for Morbidity and Mortality Conference because the investment cost and the need of training was deemed too high to be worth it. Besides, we can suppose that Morbidity and Mortality Conferences being attended mostly by medical staff, these professionals did not want to alter the methodology of the tool because they feared they would lose legitimacy if they changed it.

*« La RMM, j'avais l'impression que les médecins avaient besoin de se poser un petit peu entre eux. Et c'était un espace un petit peu privilégié, pour eux. Pour moi c'était leur espace. Et dans cet espace-là, étaient invités les infirmiers qui avaient participé à la prise en charge. »* (Wave 2 Head Nurse 4)

Finally, we can suspect that the lack of methodological transfer is to be explain by the lack of implication of the MMC managers (head nurses and physicians) and the fact they did not impulse the change. In some obstetrics units, for instance, midwives do not necessarily know the Experience Feedback Committee of the pole.

*« Eq 9 : Que pouvez-vous me dire sur le CREX du pôle ?*

*En 9 : Alors je ne savais pas, enfin je ne sais pas [rires] ce que c'est le... Enfin si les retours sur expérience, mais je ne vois pas bien la différence. Donc moi j'ignore ça. »* Wave 2 Midwife 1

This lack of knowledge was all the more surprising that this midwife was strongly invested in quality and safety management. It was later observed by the surveyor that no information was given by the manager about the EFC, and that midwives knowing the EFC were forbidden to attend its meeting. This information was confirmed in an informal discussion with a quality manager. In another pole, as explained by the head nurse 5 of this second wave, before the failing of the EFC, the superior head nurse of the pole refused to allow nurses and nursing aid to attend the EFC. The managers previously invested in MMC thus refused to impulse the change probably because of a lack of knowledge and engagement in quality and safety approach (thus being uninterested staff members) and probably because of fear of a loss of legitimacy.

This lack of transfer and interaction can be regretted since we suspect that the methodological and organizational sharing between those tools could be extremely positive for both. Indeed, Morbidity and Mortality Conference effectiveness could be enhanced by including system analysis and both could profit of a sharing of communication channel and of common resources

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<sup>136</sup> Bruno Palier, « Path dependence (dépendance au chemin emprunté) », in Laurie Boussaguet *et al.*, *Dictionnaire des politiques publiques*, Presses de Sciences Po (P.F.N.S.P.) « Références », 2014 (4e éd.), p. 411-419.



such as expertise, equipment, or even support staff such as secretaries. This profit is highlighted by the specific organization of the internal medicine unit where the implementation of the Experience Feedback Committee caused an organizational and methodological change in Morbidity and Mortality Conference. In this unit, following the implementation of EFC, MMC became multidisciplinary and integrated a part of system analysis. This change improved the MMC effectiveness and created a widespread adhesion of the staff to the tool, even in paramedical staff. But we must wonder why in this unit a change occurred while in other units no change is observed. The success in organizational change in this unit is explained by the important role of the management of the unit (the head nurse and the referring physician). In this unit, the head nurse and referring doctor drove the change and had a role of knowledge activists by favoring the development and coordination of the tools, but also a role of conversation managers by encouraging participation and establishing the framework of the unit's quality approach<sup>137</sup>. The organizational change caused by the implementation of the EFC in the unit was a window of opportunity to alter the MMC methodology. Thanks to their active role in quality and safety, they were able to drive the change and to introduce both multidisciplinary meetings and system analysis in MMC. The nurse investigated in the unit underlined their contribution in the change and improvement of MMC.

*« le fait qu'on ait une nouvelle cadre qui soit vachement qualité, qu'on reprenne un petit peu à plat les choses, qu'il y ait une motivation, c'est-à-dire que XX [anonymisation] qui est là est référent qualité sur le pôle au niveau médical et YY[anonymisation] qui est cadre est référente qualité sur le pôle [rires]. Donc on a deux référents qualités là d'un coup, donc je pense que ça ça a motivé à faire. On a une équipe qui est assez motivée, qui est assez motivée. » Wave 2 Nurse 3*

Furthermore, the interview of the referring doctor enabled the surveyor to deduce that this physician belongs to the category of quality-concerned physician. The interview with the head nurse of the unit highlighted the fact that she is a quality-responsible head nurse but also that she is specialized in quality and safety of care and thus has intensive knowledge about risk management and human error model.

*« Moi je sors d'un master qualité et management et ingénierie en santé, donc c'est comme ça que j'ai été formée. En étant référente cadre et en sortant effectivement de la faculté, c'est les outils que j'utilise parce que c'est les outils que j'ai appris. Après si on demande aux collègues,*

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<sup>137</sup> TEBOURBI Nadia, SAID Karim, « Les rôles des cadres intermédiaires dans l'apprentissage organisationnel : une étude exploratoire au sein d'un cabinet de conseil », *Management & Avenir*, 6/2010 (n° 36), p. 54-76.

*ils vont peut-être pas utiliser ces méthodes-là, ils vont peut-être utiliser d'autres méthodes...  
Oui, c'est surtout des analyses systémiques ça c'est clair. » Wave 2 Head nurse 3*

Therefore, this part of the hypothesis is partly confirmed. We observe a methodological and organizational transfer from Experience Feedback Committee to Morbidity and Mortality Conference but only when the managers play an active role in organizational change. This organizational learning thus requires the presence of both a quality-concerned physician and a quality-responsible head nurse to occur. When the managers of the unit are insufficiently invested in the implementation of the new tool and on quality and safety of care, there is no transfer or interactions between the tools. Furthermore, when the management of the units is composed of uninterested staff members, the implementation of the Experience Feedback Committee is hindered by the previous existence of Morbidity and Mortality Conference and the EFC eventually fails.

The success of this unit of internal medicine proves the importance of the training of the intermediate level managers and safety. Moreover, the model of organization implemented in this service must be underlined. Indeed, by introducing multidisciplinary meetings and system approach in the MMC they tended one of the main weakness of the tool. Furthermore, in this unit MMC and EFC alternatively, once per two months. While EFC are dedicated to trained staff members, MMC are open for the participation to all the staff of the units. This organization allows the unit to dispose of both a strategic monitoring of the organizational failure of the unit (the EFC) and of a forum where the patient care is discussed and where not only medical practices but also systemic issues are discussed (the MMC). The alternating between EFC and MMC also allows them to reduce the need of time of these tools which is one of the main challenges for these tools. This approach emphasizes on the quality of the meetings over their frequency.

**6) Does the Experience Feedback Committee influence staff members' perception and safety culture?**

We assume that the implementation of the Experience Feedback Committee in a unit or a pole influences the staff members' perception and the way they interpret and analyze adverse events. Consequently, it should favor the development of safety culture as defined by the AHRQ: *“the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management”*<sup>138</sup>. Finally, we suppose that the EFC prompts the staff to adopt behaviors favorable to an improvement of quality and safety. We suspect that this effect is achieved through raising awareness of the staff on matters of quality and safety, and through organizational learning.

**Raising awareness and extracting the risk?**

Several investigated staff members explained us that the Experience Feedback Committee was raising awareness about the issues of quality and safety.

*« depuis qu'il y a eu le CREX, il y a quand même une sensibilisation de toutes les équipes et toutes les catégories de soignants. »* Wave 2 Doctor 1.

This increased awareness about quality and safety translate into a better understanding of the importance of the quality approach, of the factors favoring the occurrence of errors, but also leads into adopting a system analysis of the errors:

*« Moi je suis dans un service où a été créé le premier CREX en 2009, et il vit encore. Donc ça aussi la culture qualité, sert aussi à apprendre aux gens à dédramatiser les fautes et à déculpabiliser les erreurs pour pouvoir les analyser et travailler dessus, et ne pas le vivre comme quelque chose de mal. L'intérêt c'est d'analyser, de voir ce qu'on peut modifier dans l'organisation et d'admettre que l'erreur est humaine et que y'a peut-être des facteurs qui favorisent cette erreur et travailler sur les facteurs qui peut-être favorisent ces erreurs humaines. »* Wave 1 Head Nurse 2

The Experience Feedback Committee actually helps disseminating information about the quality approach and knowledge about the model of human error of James Reason. The

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<sup>138</sup>SORRA Joann, NIEVA Veronica, « Hospital Survey on Patient Safety Culture », AHRQ Publication No. 04-0041, Agency for Healthcare Research and Quality, September 2004, 74 pages

dissemination of this knowledge thus allows the implementation of a better safety culture by favoring communication openness, the reporting of adverse events, and feedback and communication about errors which are 3 important dimensions of a high-level safety culture as explained by Sorra and Nieva<sup>139</sup>. But we could wonder whether this improved safety culture translates into actions, and evidence tends to show it does. Firstly, staff members attending the EFC, and especially nurses, declare reporting more adverse events following their first participation in a meeting:

*« déclarer les événements indésirables EI, j'ai un peu plus pris conscience de l'importance que ça avait. Donc peut-être que je déclare plus facilement qu'avant. »* Wave 3 Operating Theater Nurse

*« Non, sur le CREX, c'est vraiment cette démarche qualité, ça impacte un petit peu après parce qu'en plus voilà, ça fait des gens qui regardent un peu plus quand il y a des fiches indésirables, ça impacte aussi sur la déclaration. [Sur le ton de la confiance] Moi, je suis un pro de la fiche UMAGRIS [rires], franchement, je vais battre des records »* Wave 2 Nurse 3

The surveyor observation confirmed, with these statements, better reporting rates and better understanding of and awareness about quality and safety among staff members attending the EFC meetings. This increased knowledge about quality and safety, better safety culture and better reporting of adverse events can be explained by a phenomenon of risk extraction and loss of familiarity, two mechanisms explained in our first chapter. Indeed, as all the adverse events of the month are discussed during the EFC meeting, it can act as a realization of the weaknesses of the system and a loss of familiarity with their professional activity, which is no longer seen as harmless but as involving risks<sup>140</sup>. After this initial loss of familiarity, the professionals being thus aware of the risk take ownership of it by gathering knowledge through the EFC and through a better reporting of adverse events. This better reporting rate allows the professional to better know the risk, and to adopt a near-scientific approach of this knowledge through the assessment of its frequency, gravity, and thus criticality by the informal use of FMECA (as evidenced in chapter 3). This better knowledge of the risk can then be used to create a risk cartography and to bring back familiarity with the professionals' activity<sup>141</sup>.

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<sup>139</sup>SORRA Joann, NIEVA Veronica, « Hospital Survey on Patient Safety Culture », AHRQ Publication No. 04-0041, Agency for Healthcare Research and Quality, September 2004, 74 pages

<sup>140</sup>BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

<sup>141</sup>*Ibid.*

Through this loss of familiarity and risk extraction the EFC forces the staff members to own the risk and thus participate in its management. The aim of this approach and rise in awareness is to make quality and safety management normal, understandable and commonplace for frontline staff members, but also to downplay the adverse event reporting.

**« Eq 8 : Et vous pensez que cet outil, le CREX en particulier permet une sensibilisation du personnel à la question... »**

*En 8 : Ouais à fond, à fond, à fond, à fond, à fond ! C'est le nerf de la guerre. Puisqu'en plus les agents, ce qui a été intéressant c'est qu'au départ c'est moi qui auditaient, tout seul dans mon coin. Et là c'est les pairs qui sont venus auditer. Donc les copines. Donc c'est des copines qui ont interrogé leurs copines. Mais dans le cadre du CREX. Et là, ça a apporté de la légitimité, ça a dédramatisé en fait ! Ça a démystifié cette histoire, il y avait toujours la crainte d'être remis en question, la crainte de la sanction, vous voyez ? En particulier de ma part, parce que les médecins n'avaient pas à sanctionner les infirmières, ils n'en sont pas les supérieurs hiérarchiques. Mais bon voilà c'est les copines. Du coup elles se sont arrangées. C'est-à-dire de la convocation dans mon bureau, parce que c'était ça et quand il fallait tirer les trucs au clair, je prenais les rendez-vous avec tous les agents concernés, on se voyait dans mon bureau, je faisais un compte-rendu, ça prenait une heure, deux heures par agent. Vous voyez ? Puis fallait être très neutre, très factuel, voilà ! Et puis j'étais tout seul, vous voyez ? Et après on est passé à un stade où c'était les copines et voir c'était dans le cadre d'une soirée Tupperware quoi. Enfin vous voyez, on a vraiment dédramatisé le truc, on l'a banalisé. On l'a banalisé mais pas avec les effets pervers quoi. C'est-à-dire qu'on a fait rentrer dans des habitudes et dans la culture le CREX. »* Wave 2 Head Nurse 4

The aim of this logic to make quality and safety commonplace is to prompt the staff members to appropriate quality and safety and thus to shift from a top-down logic in which quality and safety are enforced by the management, the public authorities, etc.; to a bottom-up logic in which quality and safety are a shared interest and equally come from the frontline staff members.

### **Implementing organizational learning**

As we have just seen, the Experience Feedback Committee tends to improve safety culture by making quality and safety more understandable and common for attending staff members and by favoring the reporting of adverse events. The Experience Feedback Committee thus influences the perception and attitude of the staff towards quality and safety.

« *Le CREX, mais de manière générale la ... en fait ce que ça change, à mon sens, c'est la vision et la mentalité de l'équipe face à la qualité et à la sécurité du soin. C'est plutôt ça que ça change.* » Wave 2  
Doctor 2

But beyond this change in the understanding of quality and safety, and the change of attitude towards this matter, we could wonder whether there is an influence of the Experience Feedback Committee on the behavior of the staff members, and on team behavior. On this matter, our observations and some interviews bring some evidence. It seems that the Experience Feedback Committee favors the emergence of proactive behaviors in terms of quality and safety. It has been observed in several units that staff members, both attending and not attending the EFC, changed their behaviors towards adverse events. As we have seen, previously adverse events are more commonly reported thanks to EFC, but this improvement is the only one observed. In several units, we observed that the staff was willing to analyze and debrief the event via a systemic root-cause analysis, even outside the Experience Feedback Committee. Such events also more often resulted in change and enhancements in the organization and functioning of the unit than in units or poles without EFCs. Furthermore, staff members in units where the EFC is deployed are more inclined to get involved in the global quality approach of the setting. This change in approach observed by the surveyor is also confirmed by the following statement of an operative theater nurse interviewed in the second setting:

« **Eq 8 : D'accord. Tu penses que le CREX a un impact en termes de qualité et de sécurité des soins ?**

*En 8 : J'espère que oui. [rires] J'espère que le travail qu'on fait est utile et qu'il sert à quelque chose. Mais oui, sincèrement, je pense que oui parce que ça met une dynamique de remise en question. Alors, ça marche pas forcément sur tout le monde, tout le monde n'est pas forcément réceptif, mais dans l'ensemble, je trouve qu'il y a quand même une dynamique de remise en question, de pas prendre la faute pour soi comme un reproche, mais comme une perspective d'amélioration. Ça fait réfléchir, je pense qu'on a, la dynamique est différente que avant la création du CREX. Maintenant, quand y a des problèmes, on est plus amené à réfléchir, à chercher les solutions qu'à dire : « Zut, y a eu un problème ! »[ ...]*

**Eq 17 : Et sur ta pratique personnelle, tu as commencé à aborder le sujet, mais qu'est-ce que le CREX a changé sur ta pratique personnelle, sur tes perceptions ?**

*En 17 : C'est ce que je disais, je pense que j'ai pris conscience de beaucoup de choses et que je suis beaucoup plus impliquée dans la, dans le fonctionnement général, dans la globalité du fonctionnement de la clinique pour ident... voilà quand il y a un souci, à plus rechercher d'où ça vient et à plus chercher*

*des solutions, je pense que et puis à plus m'investir quand j'ai un problème pour arranger la situation. Je pense que ... oui, voilà, je pense que ... je pense que ça a changé ça. » Wave 3 Operating Theater Nurse*

Judging from those elements, we will try to understand how the Experience Feedback Committee manages to influence both the staff attitude and behaviors. We already evidenced in this chapter that this tool played a role in the awareness of the staff on quality and safety by extracting the risk from their activity, but we suppose that the design of the tool also plays a part in the development of new skills. Indeed, the Experience Feedback Committee is based on organizational change: the transfer of a part of the quality and risk management prerogatives of adverse events analysis to the staff members and frontline team. The emergence of this tool and of this joint management of quality and safety thus creates a phase of organizational learning<sup>142</sup>. This organizational learning is both transformative and reproductive as it aims first to incite staff members to develop new skill previously owned by quality and risk managers, and to maintain this skill by the continuous training of the staff members (direct via organized training and indirect via participation to the EFC) and trickling-down of skills and knowledge from the staff members attending EFC to the other staff members of the unit<sup>143</sup>. The aim of the EFC is thus also to train leaders in the matter of quality and safety whose objective will then be to transmit and reproduce their newly acquired skills to their unit. The EFC allows the development of individual skills in quality and safety (analysis skill, human error knowledge, easier identification of potential latent factor, easier identification of errors and precursors of errors, etc.) but also collective skills (shared analysis method, better team cooperation, capacity to identify team weaknesses, capacity to support other team members, non-conflictual resolution of conflicts, team introspection process, etc.). This tool is also part of the second loop of organizational learning<sup>144</sup>. Indeed, the aim of the tool is not only to give knowledge and

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<sup>142</sup> KOENIG Gérard, « L'apprentissage organisationnel. Repérage des lieux », *Revue française de gestion*, 8/2015 (N°253), p.83-95

GUILHON A, TREPO G, « Réussir les changements par le développement de l'apprentissage organisationnel les leçons du cas de Shell », *Gérer et Comprendre*, septembre 2001, 65, p 41-54

<sup>143</sup> BEN ABDALLAH Lotfi, BEN AMMAR-MAMLOUK Zeineb, « Changement organisationnel et évolution des compétences. Cas des entreprises industrielles tunisiennes », *La Revue des Sciences de Gestion*, 2007/4 (n°226-227), p. 133-146.

<sup>144</sup> KOENIG Gérard, « L'apprentissage organisationnel. Repérage des lieux », *Revue française de gestion*, 8/2015 (N°253), p.83-95

REASON J., CARTHEY J., DE LEVAL M.R., « Diagnosing "vulnerable system syndrome": an essential prerequisite to effective risk management », *Quality Health Care*, 2001, 10 suppl 2, p. 21-25

REASON James, *Human Error*, (traduction : *L'Erreur Humaine*), traduction HOC Jean-Michel, Presses des Mines, 2013, 404 pages, titre original [*Human Error*]

ready-to-use solutions, but above all to give them a shared easy-to-implement root-cause analysis method and quality approach. The goal of this approach is to teach the staff how to learn. By giving them the ORION© method and the EFC, the aim is to make them able to learn from errors, by analyzing adverse events and identifying latent factors and weakness in their organization in order to address them<sup>145</sup>. As a conclusion, with the implementation of the Experience Feedback Committee, we move from a top-down logic, in which quality and safety as well as system improvements were imposed from the management, to bottom-up logic in which not only the staff participate in the analysis of issues but also design innovative solutions taking into account their ground expertise.

### **A breakthrough limited to the few privileged ones?**

If we showed that Experience Feedback Committee favored the development of a better safety culture and influenced the perceptions, attitudes and behaviors of the staff, the effect on staff members not attending the Experience Feedback Committee is not assured. In some units, the professionals reported that they did not observe any impact of the deployment of the Experience Feedback Committee on their unit.

[About EFC and MMC] *« je suis pas sûre qu'il y ait un impact énorme sur l'ensemble de l'équipe... j'en suis pas sûre... »* Wave 2 Midwife 1

*« Eq 8 : Est-ce que tu peux m'en dire un peu plus sur l'impact des outils ?*

*En 8 : L'impact des outils ? [sur le service et le pôle...] Des fiches UMAGRIS ? [Du CREX et des RMM] ah des outils... franchement ? Le Mor Mor ? Pff... niveau soignant nul [...] Le CREX... c'est pareil au niveau soignant, je vois pas le retour parce que justement on a pas de retour, après l'erreur elle est peut-être là... »* Wave 2 Nurse 2

We suspect several limits prevent the role of teaching of the Experience Feedback Committee to be implemented in some units. The first limit, hinted by the second nurse of the second wave is a global lack of communication around the Experience Feedback Committee. As we explained in the previous chapter, communication around the Experience Feedback Committee is lacking in the first setting:

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<sup>145</sup> *Ibid.*



**« En13 : Connaissez-vous le CREX ?**

*Eq13 : Oui, j'ai pas énormément participé, moi j'ai jamais fait de fiche CREX mais ça a l'air plus intéressant et faudrait qu'on en fasse plus mais après on a pas énormément de retour dessus. C'est comme les fiches UMAGRIS on les fait, mais on a pas de retour, on a une réponse sur le plan très théoriques mais on sait pas sur quoi ça aboutit, sur une enquête, sur...» Wave 1 Nurse 2*

Furthermore, in some units, staff members do not know about their EFC. In this context, the dissemination of knowledge and safety culture through the Experience Feedback Committee is rather complex as the unit professionals are not aware of its actions and aim.

A second identifiable limit is the high turn-over rate: in one emergency unit, the head nurse reports for instance a high turn-over rate.

*« [Il y a] un turn-over de soignants qui s'usent, et sur une équipe de 58, j'ai à peu près 10 à 12 personnes qui partent chaque année » Wave 1 Head Nurse 5*

The problems of skill conservation associated to this turn-over is clearly showed by this statement of a nurse in the same unit:

*« On a quelques formations plâtres, mais c'est pareil, c'est au compte-goutte et malheureusement, les personnes qui sont sélectionnées pour ces formations sont des gens qui, les choses ont été mal-faites, sont parti rapidement par la suite, donc il y a eu une perte d'information. » Wave 1 Nurse 1*

This high turn-over is especially problematic for the EFC: the constant changes of staff prevent the emergence of EFC leaders capable of creating a real dynamic around the tool and of training the other staff members of its unit. Furthermore, the turn-over also implies to continuously train newcomers with few or none stable leaders which could prove especially demanding for EFC leaders and could exhaust them. All these factors can also demand an even higher level of personal investment and lead to burn-out or may lead these professionals to leave the unit. Generally, in units with high turn-over rate, we fear that the resignation of a leader would probably lead to the failure of the Experience Feedback Committee. This issue of turn-over is an important limit for the EFC, as it prevents the implementation of a long-term approach of quality and safety and of the training of the staff via the Experience Feedback Committee. This problem of lack of long-term approach is exacerbated in high-specialty units such as operating theater, where teams are often very cohesive and where the departure of one team member often leads to the departure of most of the team. In such units, turn-over is catastrophic as with each

wave of turn-over, the whole process of quality approach, involvement of staff and training is to be started again from the scratch.

*« Alors vous avez des blocs qui tournent peu, qui changent peu de personnel. Le problème, c'est quand il y en a une qui part, c'est en général y en a 2, puis 3, puis 4, et vous assistez à un changement d'équipe. C'est des équipes, en fait c'est toujours comme ça, vous arrivez à avoir un certain nombre d'infirmières pour une équipe, l'équipe se stabilise et puis y en a une qui part, qui quitte la ruche et puis, hop, tout le monde suit et de nouveau vous êtes obligés de reconstruire une équipe » Wave 1 Head Nurse 6*

A third reason that might explain the lack of impact of the Experience Feedback Committee on the non-attending staff members, might be, as mentioned by a nurse in the second setting, the reluctance of the staff to change its way of working, approach, methods, etc.

*« Alors, j'espère que ça peut avoir un impact sur les pratiques sachant que le personnel soignant est une créature d'habitude, c'est très très difficile de faire – je parle pour moi aussi – c'est très très difficile de faire que ce soit médecins, infirmiers, aides- soignants de faire changer les pratiques parce que ça va être beaucoup, « ça fait 20 ans qu'on fait comme ça, ça fait 20 ans que ça marche, c'est pas pour une fois où ça n'a pas fonctionné qu'on va tout changer. » C'est sûrement dommage parce que la fois où ça n'a pas fonctionné peut se reproduire ; donc ça permet de rediscuter, de se dire : « Ah, ça peut, on peut faire autrement donc. » Mais on est des créatures d'habitude, alors c'est aussi une sécurité pour nous d'avoir des habitudes, d'avoir des protocoles puisque ça nous permet de savoir ce qu'on doit faire, ça nous permet de, que chaque patient reçoive entre guillemets « les mêmes conditions de soins » » Wave 3 Nurse*

This reluctance to change attitudes and working methods is attributable to a phenomenon of path dependence<sup>146</sup>, whose mechanism has been explained in chapter 5. Indeed, in this situation, the staff is reluctant to change methods that were working. In such organizations, habits are seen as reassuring routines and defense barriers, and changing these habits is perceived as a total reconsideration of the previous work. The staff, even though they know that the organization is not error-proof prefers to keep this organization with its limits, but also with the historic of good functioning, instead of switching to a new form of organization. Indeed, switching to a new organization would imply high costs: designing this new organization, drafting protocols to frame the practices, learning the new way of working and training the staff accordingly. On the contrary, to staff members this new organization provides few or no

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<sup>146</sup> Bruno Palier, « Path dependence (dépendance au chemin emprunté) », in Laurie Boussaguet et al., *Dictionnaire des politiques publiques*, Presses de Sciences Po (P.F.N.S.P.) « Références », 2014 (4e éd.), p. 411-419.

guarantee of safety and effectiveness. Switching to this new organization is thus for the paramedical staff a leap in the unknown which is deeply feared, and to avoid this leap, the staff sometimes prefer to keep the old ways despite their limits.

We finally suspect that staff members who do not attend the Experience Feedback Committee might not perceive the actual influence on their perceptions and on their safety culture, but that influence still exists. Indeed, we suspect from observation in units where an EFC is deployed that the staff members who do not attend it are affected by a negativity bias. According to works in social science and psychology, people are more inclined to notice the losses imputable to an action or the cost of this action than to notice its benefits<sup>147</sup>. For instance, people using a computer are more inclined to get irritated by the fact that the interface requires them to confirm their orders but do not recognize the fact that this confirmation prevents errors and mistakes. In the political field, the European Union is often blamed for its supposed technocracy, for constraining standards, etc. but rarely acknowledged for its achievements, for its Regional policy, or for the PEACE programs in Northern Ireland<sup>148</sup> which aims at reconciling communities, addressing economic and social issues which contributed to The Troubles, and that aims, in its last occurrence, to bring communities together and to strengthen the links between the younger generation both Catholic and Protestant, Republican and Unionist. On the matter of EFC and its impact on non-attending professionals, we suspect that these professionals ascertain the implication of their colleagues, the required personal and professional investment but do not notice the impact on their day-to-day practice or the impact on the knowledge sharing from their colleagues and the subsequent impact on their perceptions and their safety culture.

However, we lack data to definitively answer the question of the influence of the Experience Feedback Committee on the knowledge and perceptions, and on the safety culture of non-participating staff members. One limit of this chapter is that the data are non-conclusive with the conflicting results on the matter of staff members working in units where the EFC is implemented but who do not attend its meeting. We, however, strongly suspect from our data and observation that the tool has an indirect influence, notably through the sharing of experience

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<sup>147</sup>CAUNE Hélène, « Blame avoidance (évitement du blâme) », in BOUSSAGUET Laurie *et al.*, *Dictionnaire des politiques publiques*, Presses de Sciences Po (P.F.N.S.P.) « Références », 2014 (4e éd.), p. 114-123

BORRAZ Olivier, *Les politiques du risque*, Paris, Presses de Sciences Po (P.F.N.S.P.), 2008, 296 pages

<sup>148</sup> Information about the PEACE program can be found on the dedicated page on the European Parliament website: EUROPEAN PARLIAMENT, IN European Parliament, , “Northern Ireland PEACE programme” [en ligne], Disponible sur : <[http://www.europarl.europa.eu/atyourservice/en/displayFtu.html?ftuId=FTU\\_5.1.9.html](http://www.europarl.europa.eu/atyourservice/en/displayFtu.html?ftuId=FTU_5.1.9.html)>

and knowledge sharing by professionals, but that this influence might be limited by a lack of communication around the EFC.

A further study on the matter could be envisaged to better assess the impact of the Experience Feedback Committee on non-attending staff members. This study could take the form of an assessment of professional practices and on knowledge assessment on quality, safety and human error model. This study should be conducted with different groups to compare the knowledge depending on the existence of an EFC in the unit/pole and the attendance to the tool all other factors being equal: 1/ professionals attending EFC, 2/ professionals not attending EFC in a unit/pole where the tool is deployed, 3/ professionals not attending EFC in a unit/pole where the tool is not deployed, 4/ possibly professionals not attending EFC in a unit/pole where the tool is not deployed but where at least one professional attended one or several EFC in a previous position.

Nonetheless, a strong indicator of the educational potential of the Experience Feedback Committee is the fact the *Haute Autorité de Santé* recognizes this tool as an eligible method for its continuous professional training program: the program of *Développement Professionnel Continu* (DPC)<sup>149</sup>.

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<sup>149</sup>FRANCOIS Patrice, *et al.* « De l'évaluation des pratiques professionnelles au développement professionnel continu : engagement et opinion des praticiens hospitaliers dans les activités d'évaluation des pratiques professionnelles », *Santé Publique*, vol. 27, no. 2, 2015, p. 187-194  
FRANCOIS Patrice, BOUSSAT Bastien, « Gérer la sécurité du patient en équipe : la revue de morbidité et mortalité (RMM) et le comité de retour d'expérience (Crex) », *Techniques Hospitalières* 755 Janvier-Février 2016, FHF, p. 32-35

## Conclusion

### **Errare humanum est, perseverare diabolicum<sup>150</sup>**

To err is human and countless incidents are caused each day by human errors. Some are harmless, as for instance the milk left on fire which will spill over, and some result in catastrophic failures, one of the most famous being the Chernobyl disaster. However, as we explained, if human errors are most often the last active error which creates the accidents, these errors are often made possible or even favored by latent factors in the organization, which act as latent pathogens in the system undermining the effectiveness of the defense barrier supposed to intercept errors and prevent accidents from happening<sup>151</sup>. These latent factors are the real threats that need to be eradicated, and as James Reason explained: “*We cannot change the human condition, but we can change the conditions under which humans work*”<sup>152</sup>. The aim of risk management is thus to improve the system in which humans work to act as real safety barriers and not as weaknesses favoring human errors.

If the Chernobyl operators erred and caused the disaster, they were unknowingly doomed to fail by an accumulation of latent factors and serious weaknesses in their organization. Indeed, the reactor had several design flaws which were exacerbated when the operators were asked to perform a hazardous test of emergency restart. This test was poorly prepared by the engineers and the management. Several emergency-stops and defense barriers were shut-down to perform the test. The test was so hazardous that three other power plants using the same reactor type refused to perform it for safety reasons (Leningrad, Kursk and Smolensk). All day long, the reactor built-up xenon, and began intoxicating itself. This xenon build-up had the side effect to make the already hard to control reactor harder to control at low power. The test was conducted by the night shift which was insufficiently trained. The test implied lowering the power of the reactor. At this point, the operators made an error in their command, several alarms sounded, but the operators, due to their lack of training, obliviousness to danger, and insistence of the

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<sup>150</sup> Latin phrase: translation “To Err is human, to persist in error is diabolical”, French: “L’erreur est humaine, persévérer dans l’erreur est diabolique”

<sup>151</sup> REASON James, *Human Error*, (traduction : *L’Erreur Humaine*), traduction HOC Jean-Michel, Presses des Mines, 2013, 404 pages, titre original [*Human Error*]

REASON James, « Human error: models and management », *BMJ Volume 320*, 18 mars 2000, p.768-770

REASON James, « Understanding adverse events: human factors », *Quality in Health Care*, 1995,4(2), p.80-89

REASON J., CARTHEY J., DE LEVAL M.R., « Diagnosing "vulnerable system syndrome": an essential prerequisite to effective risk management », *Quality Health Care*, 2001, 10 suppl 2, p. 21-25

<sup>152</sup> REASON James, « Human error: models and management », *BMJ Volume 320*, 18 mars 2000, p.768-770

direction carried on with the tests. As the results of the test were not the expected ones, the operators pushed the reactor harder, lowered the last defense barriers and tried to force the emergency restart. The point of no return was then reached, and after several explosions the reactor blew up, causing the worst nuclear disaster in the history and one of the only two level 7 accidents on the International Nuclear and Radiological Event Scale (the second one being the Fukushima Daiichi nuclear disaster)<sup>153</sup>. As evidenced by this short summary of the accident, several factors of different natures combined to cause the accident. We will thus classify these factors according to ORION© method:

- Human factors: several human errors, including wrong commands, the fact of ignoring alarms, the lack of attention, and the fact that the operators did not recognize early signal of the reactor's intoxication which should have led them to stop the test.
- Organizational factors: insufficient training of the operators, voluntary violations of the protocol both by the management and the operators, insufficiently prepared test.
- Technical factors: design flaws which made the reactor highly instable, removable safety barriers, lack of automatic and non-removable kill switch, insufficiently prepared test incompatible with the reactor characteristics.
- Environmental factors: lack of safety culture of the management, lack of supervision by public authorities, political pressure to conduct the test.

This summary is not exhaustive, and some contributing and influential factors are missing, but the fact is the error of operators itself would not have been enough to cause the accident in a normal situation. As the analysis shows, the error of the operators was made possible and favored by several latent factors in the system which combined to cause the reactor failure. Even worse, these latent factors contributed in this case to make the accident even more disastrous. Although the operators made several errors, such pathogens in the system would have inevitably led to a disaster sooner or later.

The Chernobyl case is especially interesting, even in the field of health care, as it shows that errors are often the consequences of the accumulation of factors of different nature (human, organizational, technical and environmental). Furthermore, some factors which contributed to the Chernobyl disaster are not specific to the nuclear industry but can also be found in health care. For instance, two of these factors played a major role in two famous health care scandals: political pressure contributed to the tainted blood scandal in France, while design flaws were

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<sup>153</sup>REASON James, *Human Error*, (traduction : *L'Erreur Humaine*), traduction HOC Jean-Michel, Presses des Mines, 2013, 404 pages, titre original [*Human Error*]

determinant in the over-irradiation of several patients caused by the Therac-25 in the United States and Canada<sup>154</sup>.

In some industries, this realization of the fallibility of the humans has been recognized and system improvements have been made to prevent human errors resulting in serious accidents. These industries, called High Reliability Organizations, work in high-risk environment and yet achieve high-level of safety and reliability<sup>155</sup>. These High Reliability Organizations all share five main characteristics: constant preoccupation with failure, reluctance to simplify interpretations, sensitivity to operations, commitment to resilience, and deference to expertise<sup>156</sup>. The most famous HROs are the nuclear and aviation industry, we could also cite the military aircraft carriers which achieve unexpected level of safety despite hostile environment. In the field of healthcare, the publication of the report *To Err is Human* by the Institute of Medicine in 1999 was a deep shock which prompted the authorities to adopt the approach of HRO<sup>157</sup>. However, health care is still late behind other industries such as the nuclear industry.

### **The Experience Feedback Committee**

It is in this global context and on a more local context of successive health scandals in France (tainted blood in the 1990's and Epinal's over irradiation in the 2000's) that the Experience Feedback Committee was developed between 2003 and 2005 with the assistance of Air France Consulting, and is since being deployed<sup>158</sup>. This tool is a *posteriori* safety enhancement tool

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<sup>154</sup> REASON James, « Understanding adverse events: human factors », *Quality in Health Care*, 1995, 4(2), p.80-89

<sup>155</sup> REASON James, « Human error: models and management », *BMJ Volume 320*, 18 mars 2000, p.768-770  
WEICK Karl E., SUTCLIFFE Kathleen M., *Managing the Unexpected: Sustained Performance in a Complex World*, 3<sup>ème</sup> édition, Wiley, 2015, 224 pages

<sup>156</sup> WEICK Karl E., SUTCLIFFE Kathleen M., *Managing the Unexpected: Sustained Performance in a Complex World*, 3<sup>ème</sup> édition, Wiley, 2015, 224 pages

<sup>157</sup> KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages

<sup>158</sup> FRANCOIS Patrice *et al.*, « Le comité de retour d'expérience (CREX) : une méthode pour l'amélioration de la sécurité des soins », *Revue d'Epidémiologie et de Santé Publique 61 (2013) 155–161*

DEBOUCK F. *et al.*, « Méthode Orion® : analyse systémique simple et efficace des événements cliniques et des précurseurs survenant en pratique médicale hospitalière », *Cancer/Radiothérapie*, Volume 16, Issue 3, Pages 201-208, 2012

LECOANET André *et al.*, « Experience feedback committee in emergency medicine: a tool for security management », *Emergency Medicine Journal* 31, 2014, p. 894-898

BOUSSAT Bastien *et al.*, « Experience Feedback Committee: a management tool to improve patient safety in mental health », *Annals of General Psychiatry*, 2015, 23 pages

based on a root-cause analysis of adverse events and near misses. These characteristics correspond with a constant preoccupation with failure and a reluctance to simplify interpretations, which we identified as two important characteristics of High Reliability Organizations.

In this work, we tried to determine whether or not the Experience Feedback Committee is an innovative effective safety enhancement tool. We thus tested our four following hypotheses:

1/ The effectiveness of the Experience Feedback Committee can be explained by its design and depends on its capacity to create adhesion and to bring about the implementation of action plans.

2/ In settings with low level of safety culture and quality approach, the Experience Feedback Committee loses effectiveness or fails.

3/ Morbidity and Mortality conferences, that are pre-existing instruments aimed at enhancing safety, facilitated the implementation of Experience Feedback Committee whose methodology trickled down over Morbidity and Mortality Conferences via the organizational change caused by their implementation which then created organizational learning.

4/ Experience Feedback Committees improve the safety culture of staff members, prompt the staff to adopt safety-favorable behaviors and thus improve global quality and safety in their units.

We found that the Experience Feedback Committee is an effective tool based on a strong theoretical basis of risk management literature. Furthermore, the adhesion of the staff and its design are its main strengths. Indeed, its arena design legitimates all attending professionals regardless of their occupational group and their rank in the setting, thus legitimizing the paramedical staff and their profane expertise. In addition, this design favors non-conflictual and non-blaming resolution of problems and favors the identification by the staff members of their converging interests. A last strength of the tool is its capacity to force the hospital management to act to avoid associated risks, and especially legal prosecution, administrative sanctions and reputational risks. Indeed, should an accident happen, the Experience Feedback Committee reports could be used by the victims, for instance, to prove that the management was careless, which would expose it to associated risks. These findings validated our first hypothesis.



However, we evidenced that in some cases the correct functioning of the Experience Feedback Committee is prevented by barriers inside the setting. This barrier could be a lack of dissemination of safety culture, causing among other thing a lack of reporting of adverse events. This lack of reporting of adverse events is mostly imputable, in such settings, to a lack of initial and continuous training in quality and safety and to the management's behavior, which does not promote non-punitive response to error and non-blaming culture. We also observed that the management is deterring staff members from attending the Experience Feedback Committee. This behavior is partly explained by the use of inaccurate and inadequate indicators by the management which produce ignorance of actual safety issues. However, we found that the management may also in some cases voluntary ignore safety issues in a strategy of risk disownership. The aim of this strategy is to produce ignorance, and to avoid and deflect the blame in order to avoid having to manage associated risks. In addition, due to competing interest, in some settings, management tends to favor economic objectives over quality and safety. These findings validated our second hypothesis.

About our third hypothesis, we found that Morbidity and Mortality Conferences and Experience Feedback Committee are complementary safety enhancement tools. We tried to determinate whether the previous existence of Morbidity and Mortality Conference favored the implementation of the Experience Feedback Committee in a unit or a pole or hindered it. We found that in some cases the previous existence of Morbidity and Mortality Conference was an important barrier to the implementation of the Experience Feedback Committee due to a phenomenon of path dependence. Indeed, the unit management and doctors, in some places, are reluctant to change the way risk management is set in their unit, because of the cost of changing ways, and most notably the training costs. Furthermore, they may be reluctant to let nurses participate in risk management as they perceive it as a loss of their legitimacy to manage the risks in their units. On the contrary, our data were conflicting on the fact that the existence of the Morbidity and Mortality Conference facilitates the implementation of the Experience Feedback Committee, and we lack conclusive data to prove a direct influence. We originally supposed that the previous existence of the Morbidity and Mortality Conference would raise awareness about the importance of quality and safety among the staff, and would provide the Experience Feedback Committee already trained professionals who would attend both tools, and would favor thus favor its implementation. We suspect that there may be an indirect influence but as explained, the lack of data and the conflicting data do not allow us to affirm it with certainty. Concerning the second part of the hypothesis, we found that there was mostly

no influence of the Experience Feedback Committee over the Morbidity and Mortality Conference except in a specific unit. This phenomenon is explained by an insufficient organizational change and by path dependence. Our third hypothesis is thus only partly confirmed, first because of a lack of conclusive data and as the hypothesis is confirmed but only under specific conditions.

Finally, about our fourth hypothesis, we found that indeed, the Experience Feedback Committee positively influenced the perceptions, behaviors and safety culture of its member through a phenomenon of risk extraction and organizational learning. However, the impact on staff members who do not attend Experience Feedback Committee seems limited, if it exists at all. This lack of impact on non-attending professionals might be explained by a lack of communication about the Experience Feedback Committee and its action. We also suspect that the non-attending professional underestimate the impact of the tool on the safety culture of the setting and on their knowledge about quality and safety, and human error. On the matter of the impact on non-attending staff member, we lack conclusive data to definitively assess the existence of an impact on those staff members or on the absence of impact. This hypothesis is thus partly confirmed as we found an impact on the perception behaviors and safety culture of staff members attending the Experience Feedback Committee but we cannot conclude for staff members not attending it.

We also observed during our survey a specific organization between Experience Feedback Committee and Morbidity and Mortality Conference, as developed in chapters 4 and 5. In this unit of internal medicine, Morbidity and Mortality Conference were modified, following the method of the Experience Feedback Committee, with the implementation of a system and root-cause analysis. While all the unit's staff members are free to attend Morbidity and Mortality Conferences, the Experience Feedback Committee is reserved to trained staff members. A monthly rotation is set up between those tools with one meeting of the Experience Feedback Committee the first month, one meeting of Morbidity and Mortality Conference the next month, etc. This organization, as we already explained, presents several advantages, including a lower required involvement of the staff members, apart from those attending the Experience Feedback Committee, and the presence of two safety enhancement tools based on system approach in the unit. This organization also ensures at least monthly debriefs, and root-cause analysis of adverse events in the unit, whether through the Experience Feedback Committee or through the Morbidity and Mortality Conference.

This research contributes, at its level, to the risk sociology by showing how these concepts translate into facts, and how they can be used practically by professionals to develop tools and achieve the better use of the theoretical concepts to improve quality and safety of care on the field. But this work also contributes to the literature of quality and risk management, by stepping back from the evaluation of the effectiveness of the tool to the understanding of the mechanisms explaining its functioning, which is often not evoked by articles dealing with quality and safety management in health care. Consequently, judging from our findings, we recommend a further deployment of the tool with a wider support from management to improve quality and safety in French hospitals. Furthermore, we recommend the test of deployment of the tool in other settings, such as in the medico-social sector. Finally, the implementation of this tool in other industries can be envisaged. To consult a complete list of recommendations, please refer to the Recommendation part.

## **Limits**

The first identified limit of this research is the low participation of nurses in the first setting. Despite the use of the snowballing method and in a second time of the global nurse mailing list to contact as many nurses as possible, the surveyor could only interview 6 nurses in the first setting. However, this poor response rate may be interpreted as a result on its own. Indeed, this result shows the necessity of an appropriate, and frequent communication around quality and safety, and around safety-enhancement tools (and more specifically Experience Feedback Committee) to draw the paramedical staff's interest in these matters. We suppose that medical staff is more aware about quality and safety despite the lack of communication due to the obligation of professional introspection and continuous training, including in quality and safety, set up by the program of *Développement Professionnel Continu*<sup>159</sup>. Furthermore, some nurses explained us they refused to be interviewed out of fear of being blamed. We suppose that the medical staff is less worried about blame and disciplinary sanctions due for their higher hierarchical position. This element shows the importance of non-punitive and non-blaming culture inside the setting to implement a comprehensive quality approach involving all professional categories. Finally, this result reinforces the information about weaknesses in the

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<sup>159</sup> FRANCOIS Patrice *et al.*, « De l'évaluation des pratiques professionnelles au développement professionnel continu : engagement et opinion des praticiens hospitaliers dans les activités d'évaluation des pratiques professionnelles », *Santé Publique*, 2015/2 (Vol. 27), p. 187-194

safety culture (and especially the non-punitive response to error, and communication openness) and quality approach of the first setting. These weaknesses tend to indicate a lack of support of the management to the quality approach, and a global lack of interest in quality and safety. In our second setting, the nurse response rate was 100%, which can be partly explained by the fact the investigator directly contacted the nurses thanks to the smaller size of the structure. However, the better safety culture, and non-blaming culture of the setting also probably favored the participation of nurses.

A second limit of our study is the fact that the management of the first setting refused to be interviewed. However, this refusal tends to confirm that the management of the first staff is uninterested in quality or could prove their embarrassment toward the topic of the research. Another research could be conducted to evaluate how the management of different settings perceive this tool, and if they support it. This research could also evaluate the level of involvement of French hospitals, both public and private, in quality and safety, and to assess the impact of the *Tarification à l'activité* upon the implementation of quality approaches.

### **Quality and safety in France: situation and perspectives**

Achieving a high level of quality and safety in healthcare is a key challenge in France for the future. Indeed, as we explained in the introduction, the report *To Err is Human* in the United States showed that medical errors were responsible for between 44,000 to 98,000 deaths each year<sup>160</sup>. A more recent study in the United States estimated that medical errors were actually the third leading cause of mortality in the country, with more than 251,000 casualties each year<sup>161</sup>. The direct and indirect cost of medical errors were estimated in 1999 to be as high as \$29 billion each year. In France, no such study exists, the only available study being ENEIS 1 and 2 which showed that for 1000 days of hospitalization, 6,2 serious adverse events occurred<sup>162</sup>. In addition, another study estimated that 700 million Euros of overhead cost were

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<sup>160</sup> KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages

<sup>161</sup> MAKARY Martin A., DANIEL Michael, « Medical error – the third leading cause of death in the US », *TheBMJ2016* 353, 2016

<sup>162</sup> KOHN Linda T., CORRIGAN Janet M., DONALDSON Molla S., *To Err Is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Institute of Medicine, 1999, 312 pages

attributable each year to 9 categories of preventable adverse events<sup>163</sup>. This study being based on only 9 categories of adverse events and excluding drug-related adverse events, the total over cost of medical errors in France must be much higher. Judging from those facts, it appears necessary to maintain the efforts made on quality and safety, and to get closer and closer to the model of High Reliability Organizations. There is also a real need for serious studies over the impact of poor quality of care in terms of mortality and morbidity, consequences for the patient, and economic cost (direct and indirect). Furthermore, hospital financing should be rethought, as evidenced by Angelé-Halgand and Garrot, to act as a better incentive towards quality and safety<sup>164</sup>. The initial and continuous training of the healthcare professionals must also be rethought to better acknowledge the issues of quality and safety, and to raise awareness among the professionals on the importance of adverse events reporting, non-punitive response to error and non-blaming culture, root-cause analysis, and on the global quality approach. This path toward a safer health system is thus a long term and comprehensive effort, which must be made on several aspects of our health systems: the training, the financing, the management, etc. However, the current context is highly unfavorable to quality and safety improvements due to budget cuts in health care, increasing understaffing, and political challenges. If financial issues seem to be an increasingly important constraint for the hospitals, both public and private, and for the health systems, we should wonder about the real cost of poor quality of care. Specifically, the questions are: Is the investment required to improve quality and safety really costlier than poor-quality of care? And are the budget cuts in the health systems really significant worthwhile saving, both economically and ethically?

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<sup>163</sup> NESTRIGUE Clément, OR Zeynep, « Surcoût des événements indésirables associés aux soins à l'hôpital : Premières estimations à partir de neuf indicateurs de sécurité des patients », *Questions d'économies de la Santé* n°171-Décembre 2011, IRDES

<sup>164</sup> ANGELÉ-HALGAND Nathalie, GARROT Thierry, « Les biens communs à l'hôpital : De la " T2A " à la tarification au cycle de soins », *Comptabilité - Contrôle - Audit*, 3/2014 (Tome 20), p. 15-41

## **Recommendations**

Following the conclusions of this study, we propose several improvement recommendations to enhance the effectiveness Experience Feedback Committee, to promote the adherence and the participation of the staff members, and to further the relationship between the Experience Feedback Committee and the global quality approach.

1. Our first recommendation is to develop a real communication strategy around the Experience Feedback Committee. It has been observed that some professionals did not know the Experience Feedback Committee at all despite it being implemented in their unit. Furthermore, there is a global lack of knowledge around the actions and role of the Experience Feedback Committee as well as around the possibility to attend its meetings. Since lack of communication is identified as one of the main issues in both our setting, we recommend developing communication chains based on a wide variety of support ranging from the diffusion of the report of the meeting to the creation and display of clear and bullet-point posters. This action is very easy to implement and costless, the only costs being 1 or 2 hours of work to design a poster, and impression costs on A3 size for poster and A4 size for reports.
2. In addition of this need of communication, we advise involving the staff members in managing quality and safety. In order to achieve this goal, it is necessary both to train and to propose the staff members to participate in work groups on safety issues (such as identity vigilance and blood products vigilance), to perform internal audits but most of all to attend Experience Feedback Committees. The aim of this approach would be to interest them in quality and safety, and to raise awareness on the matter in frontline units. The long-term aim of such a policy would be to make quality and safety natural and easy for all categories of staff members. This action is also easy to implement as staff members could be trained in-house by the quality and risk management unit. Furthermore, training materials are easily and freely available online. Outsourced training is also possible but more expensive. The cost of this action can be limited if the management opt for in-house training.

3. Another essential improvement to enhance the effectiveness of the Experience Feedback Committees and to favor participation would be to reward participation in this tool both locally (inside the setting) and nationally. This could be done through several incentives: first if professionals come back on their resting time to attend EFC meeting, this time should be either paid or given back. Nationally, we recommend better recognition of the Experience Feedback Committee as a professional development tool and not just for physicians. Finally, the implementation of the Experience Feedback Committee could be valued in the calculation of financial incentives for quality and safety of care. More incentives could be developed such as “pizza-beer” meetings, etc. depending on the context of the settings. At the setting level, pizza-beer meetings could be a cost-efficient measure to boost attendance. Payment of extra-hours is costlier but more effective. At a national-level, a costless measure would be to make EFC eligible for validation of acquired experience and continuous professional training, including for nurses. Another, more effective but costlier incentive would be a financial incitation to quality which would be paid to the setting implemented EFC and that could be used to improve working conditions. Finally, the current Scope-santé website giving information about each hospital in France could take into account quality and safety enhancement deployment to set-up a “hit-parade” of the most safety and quality concerned settings.
  
4. Management should be more and better involved in quality and safety of care to avoid deterrents to staff participation in Experience Feedback Committee and in quality approach. In order to make the involvement of management in quality and safety more positive, financial incentives to quality and safety could be further implemented. Current financial incentives towards quality and safety could be reinforced through penalties for settings with low-level of quality and safety and on the contrary, higher rewards for settings which achieve a higher level of safety. The cost of such a measure is hard to estimate. Financial incentives are costly, but poor-quality of care creates important over-costs which are an important potential saving source. For instance, financially rewarding a setting which reduces the frequency of hospital-acquired infections could actually result in savings considering the costs of these infections. But the most important measure to enhance the management involvement in quality and safety is to rethink the managers’ training to put more emphasize on the importance of

these matters, by dedicating more time to these topics, and by implementing practical training and through simulation of events analysis, etc. The cost of this measure would be limited as it would mostly consist in a reorganization of the current hospital management training.

5. A sharing of Experience Feedback Committees analyses and conclusions should be implemented at different levels: inside the setting and between its units, regionally and nationally. The aim of this sharing could be summarized by the following quotation of Eleanor Roosevelt: *“Learn from the mistakes of others. You can’t live long enough to make them all yourself.”* Sharing information about errors could indeed help identify common weaknesses in different organizations and could bring an important and beneficial feedback. Moreover, it could create more cohesion and favor better cooperation between units in a same setting, or between settings. Finally, both the regional and national quality-support organizations could benefit from these feedbacks to identify improvement opportunities, sensitive points which need further vigilance, and finally to develop innovative and adequate solutions and good practice recommendations to enhance the quality and safety of our health system. Developing inter-hospital centers Experience Feedback Committees could be envisaged, which would benefit from outlooks on a given setting organization. At a local level, networks could be created between the quality and risk management units of the different settings of a given agglomeration. At a regional and national scale, quality-support organizations already exist. As experience feedback is strictly anonymized, it can be shared in online supports (mail, cloud computing, website of regional or national quality-support organization, etc.). This measure is totally costless for all the actors, and should thus be a priority given the expected results.
6. In settings or units where time and resources are lacking, and according to the needs of these setting or units, a similar organization to the one of the internal medicine unit, discussed in chapter 3, could be implemented. Precisely, when time and/or resources are lacking, we suggest implementing an MMC and an EFC, both based on a root-cause analysis of adverse events, with a monthly rotation between those tools. While all



professionals would be free to attend MMC, EFC would be reserved to staff members trained to the ORION© method. This organization would greatly benefit such settings/units as they would both benefit from a strategic group analyzing the most problematic organizational failures (the EFC) and an open discussion group where all staff members could discuss problems and adverse events (the MMC), all of this without extensive requirements in terms of time, resources, training programs, etc. The approach of these tools favors the quality of the meetings over their frequency, and is susceptible to be better accepted both by staff members and by the management. Given the potential cost and resources savings of such an organization, this action is a priority in settings where the implementation of such tools is prevented by the lack of time and resources. However, it should not be a backward step for settings with higher level of quality and safety and it should be reserved to struggling units or settings.

7. Finally, we advise testing the implementation of the Experience Feedback Committee in other sectors. At first in other health sectors, such as the medico-social sector, then in other industries where the frontline staff members are not involved in quality and safety management. Given the fact that medico-social settings face more and more quality and safety obligations, we recommend implementing EFCs in these settings. We consider that this method is the most cost-effective tool for these settings which cannot afford having a dedicated quality and risk management unit.

## **Abbreviation list:**

AHRQ: Agency for Healthcare Research and Quality

ANSM: *Agence Nationale de Sécurité du Médicaments et des produits de santé*

EFC: Experience Feedback Committee

FMECA: Failure Modes, Effects and Criticality Analysis [*Français: AMDEC : Analyse des Modes de Défaillances, de leurs Effets et de leur Criticité*]

HAS: *Haute Autorité de Santé*

HRO: High Reliability Organisation

HSOPS: Hospital Survey On Patient Safety culture

ICU: Intensive Care Unit

IOM: Institute of Medicine

Meah : *Mission nationale d'expertise et d'audit hospitalier*

MMC: Morbidity and Mortality Conference

NHS: National Health Service

## **Appendixes**

### **Appendixes table**

Appendix 1: First wave interview guide

Appendix 2: Second wave interview guide

Appendix 3: Third wave interview guide

## **Appendix 1: First wave interview guide**

**Pouvez-vous me parler, s'il-vous plaît, de la sécurité des soins au CHU de Grenoble et des principaux facteurs ayant, selon vous, une influence sur celle-ci ?**

Résumé des thèmes

- 1) Participation aux CREX (Comité de retour d'expérience) ou à d'autres structures impliquées dans la qualité des soins et la gestion des risques
  
- 2) Sécurité du personnel
  
- 3) Conditions de travail
  
- 4) Organisation et coopération
  
- 5) Politique de qualité et de sécurité des soins ?
  
- 6) Matériel et environnement
  
- 7) Perspectives d'amélioration
  
- 8) Souhaitez-vous ajouter quelque chose ?

## **Appendix 2: Second wave interview guide**

**Votre service organise à la fois de RMM et des CREX, que pouvez-vous nous dire sur ces deux outils, leur organisation et apport ?**

- I) Connaissance des outils
- II) Méthodologie et organisation
- III) Impact/Apport/Résultat des 2 méthodes
- IV) Raison de la coexistence des 2 outils
- V) Mise en place du CREX dans le service
- VI) Souhaitez-vous ajouter quelque chose ?

### **Appendix 3: Third wave interview guide**

**Que pouvez-vous me dire sur le Comité de Retour d'Expérience et sur la qualité et la sécurité des soins ?**

- I) Qu'est-ce qu'un CREX ?
  
- II) Possibilité de participation au CREX ?
  
- III) Occurrence et causes d'un EI ?
  
- IV) Facteurs favorisant les erreurs ?
  
- V) Impact du CREX en termes de qualité et de sécurité ?
  
- VI) Impact du CREX sur le personnel ?

## **Illustration**

### **Illustration table:**

Illustration 1: *Photo of the British Airways Flight BA38 crash in London Heathrow (LHR)*

Illustration 2: Table 1: Characteristics of respondents

Illustration 3: Table 2: Characteristics of first wave respondents

Illustration 4: Table 3: Characteristics of second wave respondents

Illustration 5: Table 4: Characteristics of third wave respondents

Illustration 6: Figure 1: The « Swiss Cheese Model », James Reason

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## **Abstract**

La qualité et la sécurité des soins sont devenues depuis une vingtaine d'années une préoccupation majeure des systèmes de santé. Dans cette optique, différents outils de gestion des risques *a priori* et *a posteriori*, basés sur les travaux de James Reason, ont donc été mis en place. C'est dans ce contexte qu'en 2003 a été développé le Comité de Retour d'Expérience (CREX) en se fondant sur l'expérience de l'aviation civile. Ce mémoire s'appuie sur des entretiens semi-directifs réalisés auprès de 36 professionnels de santé dans 2 établissements de la même agglomération française. L'objectif de ce mémoire est de comprendre les mécanismes de fonctionnement du CREX et ses fondements en sciences sociales afin de mieux saisir comment celui-ci produit ses effets sur le personnel de ces établissements et ainsi affecte la qualité et la sécurité des soins dans ces mêmes établissements. Nos résultats nous ont ainsi permis de déterminer que, sous certaines conditions, le Comité de Retour d'Expérience est un outil innovant et efficace de gestion des risques. Suite à ce constat, nous établissons donc plusieurs recommandations afin d'en améliorer l'efficacité et la mise en place.

Quality and safety have become major issues for nearly two decades. Several *a priori* and *a posteriori* safety tools based on James Reason's Swiss Cheese Model have thus been implemented. In France, a new safety-enhancement tool based on the experience of civil aviation was developed in 2003: the Experience Feedback Committee. We realized a qualitative interview-based study in two different settings. 36 health care professionals were interviewed. The aim of this study is to understand the social sciences mechanisms explaining the effects produced by Experience Feedback Committees and their impact over quality of care and patient safety. Our results indicate that under certain conditions the Experience Feedback Committee can be used as an innovative and effective safety enhancement tool. These results prompted us to produce recommendations to improve its effectiveness and facilitate its further deployment.