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40 **CLINICAL FEATURE**
   What’s in my buckets today? Foreseeing and forestalling patient harm - J Carthey
   Operating theatre teams work in an imperfect system characterised by time pressure, goal conflicts, lack of team stability and steep authority gradients between consultants and other team members. Despite this, they often foresee and forestall errors that could harm patients. The paper discusses the strengths and limitations of using Reason’s three buckets model of error prevention as a framework for training operating theatre staff how to foresee and forestall incidents.

45 **CLINICAL FEATURE**
   Violations and migrations in perioperative practice: how organisational drift puts patients at risk - JH Reid
   This article explores how organisational drift occurs and how practices can creep to unacceptable margins when pressurised staff migrate towards the boundaries of safe operations, which in turn erodes the margins of safety. If unchecked, violations become more frequent and more severe, so that the whole system drifts and hovers at the boundaries of safe practice, until an accident, near miss or worse occurs. Models are discussed and key messages given.

50 **OPEN LEARNING ZONE**
   The power of Elaine’s story: A personal reflection - J Kamensky
   There will be few perioperative students (nursing, ODP) or surgical and anaesthetic trainees, who will not have heard of the tragic case of Mrs Elaine Bromiley. A 37 year old mother of two, admitted for an elective endoscopic sinus surgery and septoplasty, Elaine suffered major complications during the induction of general anaesthesia that resulted in her death due hypoxic brain damage (Harmer 2005). As a student ODP, watching the DVD of the reconstruction of the events that contributed to Elaine’s death, the author is conscious of the profound impact it had on him and the key learning points for practice, discussed in this open learning zone article, which includes tasks for the reader.

56 **CLINICAL FEATURE**
   The trainee’s voice: recognising the importance of preoperative briefings for surgical trainees - R Bethune and NS Blencowe
   Preoperative briefings and the ‘time out’ component of the WHO surgical safety checklist offer unique opportunities to improve the technical and non-technical skills of surgical trainees. This article discusses the addition of a training briefing – a succinct adjunct to these processes – offering a novel method by which training opportunities can be maximised and learning needs better understood by theatre staff. However, more training is needed for staff in the use of briefings and checklists to achieve the best possible benefit for trainees and patients.

59 **CLINICAL FEATURE**
   Non-technical skills: enhancing safety in operating theatres (and drilling rigs) - R Flinn
   This article discusses the Deepwater Horizon drilling rig disaster and highlights failures, particularly to deficiencies in non-technical skills, asking what the relevance is to perioperative practice and identifies a number of similarities between an operating theatre team and a drilling rig crew. It highlights the SPLINTS (Scrub Practitioners’ List of Intraoperative Non-Technical Skills) system, which provides a structured framework and common terminology for discussing the non-technical skills, which all good scrub practitioners possess and use on a day-to-day basis.