Ça n'arrive pas qu'aux autres: l'erreur médicale au cabinet

ERREUR MÉDICALE: ÉVOLUTION DES CONCEPTS EN MATIÈRE DE SÉCURITÉ DES SOINS
COLLOQUE DE MÉDECINE DE PREMIER RECOURS
13 AVRIL 2011

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Dimensions de la qualité des soins

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- Efficacité clinique
- Adéquation (avec normes professionnelles)
- Efficience (coût-efficacité)
- Sécurité
- Centré sur le patient (répond aux attentes)
- Accessibilité
- Equité
- Coordination

Le contexte

3

En Suisse

- 36 millions de consultations ambulatoires (2005)
  - 60% en médecine de base (21 Mio)
  - Tendance: +12% d'ici 2030 (+4 mio dont 3mio med de base)
- ± 1.3 millions admissions hospitalières[1]

Aux USA

- 956 millions de consultations ambulatoires[2]
- 35 millions de sortie

sources: [1] statistique médicale hospitalière, OFS, 2009
[2] http://www.cdc.gov/nchs/fastats/docvisit.htm (2008)

Sécurité des patients

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- Y-a-il un problème de sécurité des patients?

Définitions

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- **Adverse event (événement indésirable)**:
  - An injury related to medical management, in contrast to complications of disease. Medical management includes all aspects of care, including diagnosis and treatment, failure to diagnose or treat, and the systems and equipment used to deliver care. Adverse events may be preventable or non-preventable.
- **Preventable adverse event (événement indésirable évitable)**:
  - An adverse event caused by an error or other type of systems or equipment failure.

Hiatt H et al. A study of medical injury and medical malpractice. An overview. *New England Journal of Medicine* 1989, 321(7):480-484.

Evénements indésirables graves

6

évitables | non évitables

Selon les études

- 4 -17 % des patients (court séjour)
  - dont 27 à 51 % évitables

Etude ENEIS (France, Qual Saf Health Care 2007;16:369-77)

- 71 établissements (chir, méd), 8 754 patients,
- 6.6 EIG pour 1000 journées d'hospitalisation
  - en CH? estimation: 39600 EIG dont 35% évitables (13860 EIG évitables). En France: (120 000 à 190 000 EIG évitables)
  - Dans un CHU: med + chir 180'000 JH = 1200 EIG dont 400 évitables? 80 décès?
  - 0.2 décès associés à un EIG évitables /1000 journées = 1200 décès en CH

Quid de la sécurité des soins en médecine ambulatoire?

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- 2005-2010: seulement 10% des études en ambulatoire
- Admissions consécutives à un événement indésirable médicamenteux: environ 5-10%

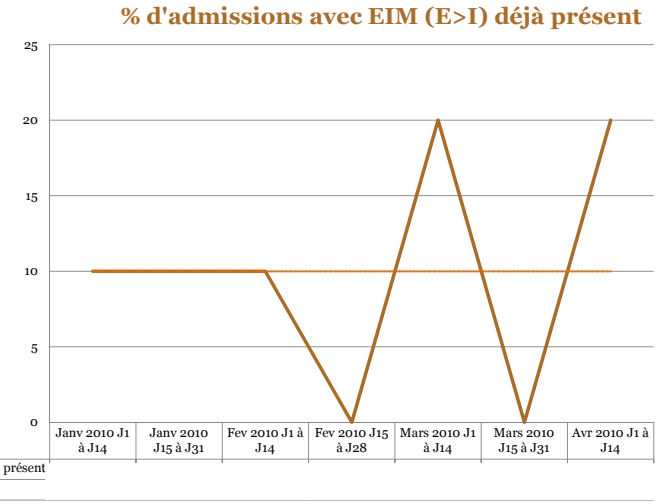
INSTITUTE FOR HEALTHCARE IMPROVEMENT

Trigger tool for Measuring Adverse Drug Events

Motifs d'hospitalisations :

- Hémorragie digestive par surdosage en Sintrom®,
- Excès de sédation par automédication,
- Diarrhées sous Laxobéron®,
- Chute à domicile sur prise opiacées et bzd,
- Intoxication à la Digoxine®,

✓NB : personnes âgées.



Source: G Dessard Choupay, S Le Du, Chopard P,. étude trigger tool en cours, HUG

Téléchargement des dernières applications

What happens between visits? Adverse and potential ...

Qual Saf Health Care 2010;19:223-228 doi:10.1136/qshc.2008.029116

Error management

What happens between visits? Adverse and potential adverse events among a low-incor urban, ambulatory population with diabetes

Table 5

Self-management domains for adverse and potential adverse events

111 patients, suivis 9 mois
86% pts ≥ 1 ADE
Medication use: 63%

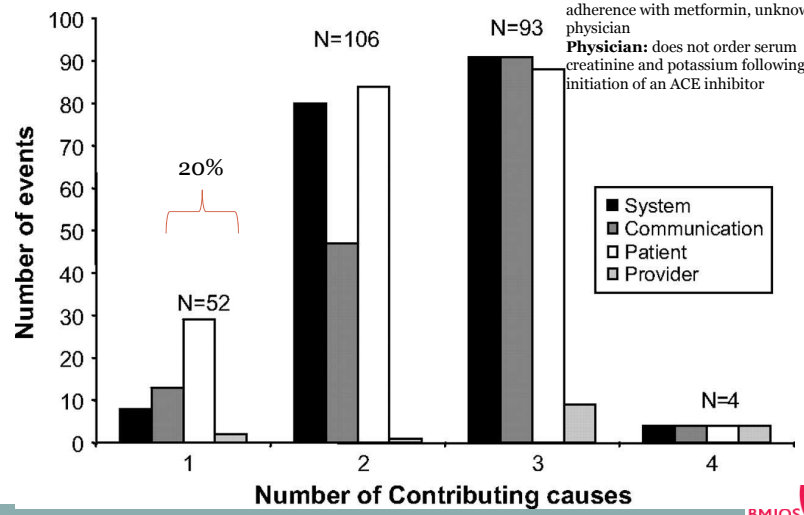
	AEs	PotAEs
	n (%)	n (%)
Medication use	66 (59)	100 (65)
Diet adherence	23 (21)	5 (3)
Symptom recognition	16 (14)	0
Glucose monitoring	1 (1)	46 (30)
Diabetes foot care	1 (1)	0
Appointment adherence	0	1 (1)
Unable to determine	4 (4)	1 (1)
Total	111	153

AEs, adverse events; PotAEs, potential adverse events.

Frequency and distribution of contributing causes for events (N=264).

Patient actions: 205 (77%)
Systems issues: 183 (69%)
Inadequate physician-patient communication: 155 (59%)
Primary care clinician: 16 (6%).

System: test results sent only to ordering clinicians, not to primary care providers
Communication: patient has significant gastrointestinal distress leading to non adherence with metformin, unknown to physician
Physician: does not order serum creatinine and potassium following initiation of an ACE inhibitor



Sarkar U et al. Qual Saf Health Care 2010;19:223-228

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BMJQS

Incidence and Preventability of Adverse Drug Events Among Older Persons in the Ambulatory Setting

N=27617 Medicare patients; followed during 12-month period

Table 3. Rates and Severity of Adverse Drug Events

	Type of Adverse Drug Event		
	Overall (N = 1523)	Preventable (n = 421)	Nonpreventable (n = 1102)
Rate per 1000 person-years (95% CI)	50.1 (47.6-52.6)	13.8 (12.5-15.2)	36.3 (34.1-38.4)
Category of severity, No. (%)			
Fatal	11 (0.7)	5 (1.2)	6 (0.5)
Life-threatening	136 (8.9)	72 (17.1)	64 (5.8)
Serious	431 (28.3)	167 (39.7)	264 (24.0)
Significant	945 (62.0)	177 (42.0)	768 (69.7)

Abbreviation: CI, confidence interval.

Gurwitz, J. H. et al. JAMA 2003;289:1107-1116

JAMA

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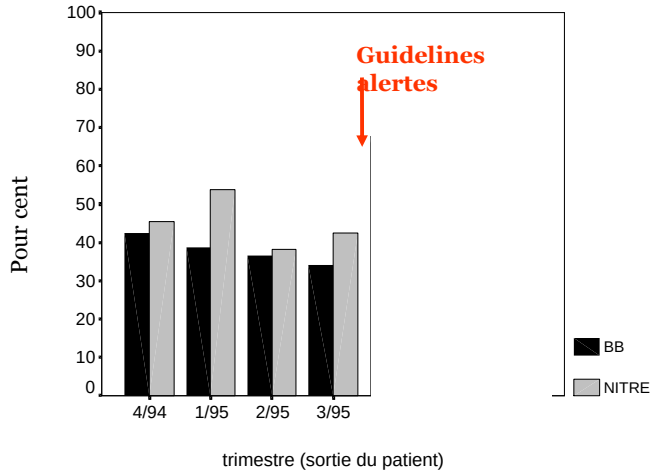
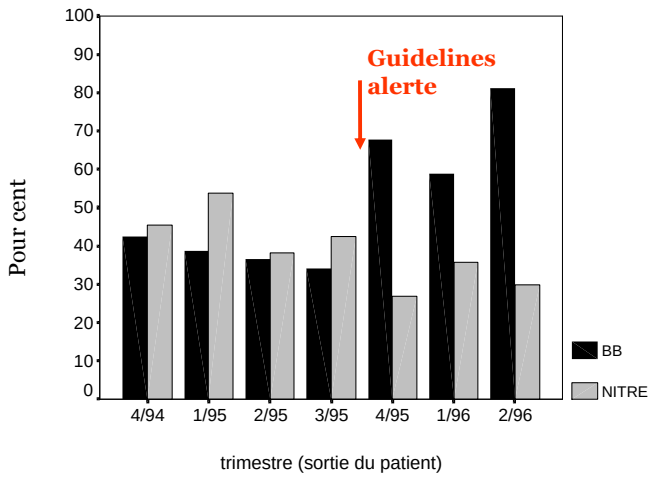
Prescriptions BB post-infarctus



Am J Med 1999;106:499-505

Prescriptions BB post-infarctus

13



Am J Med 1999;106:499-505

Adhésion aux recommandations dans l'IC

Luthi, J.C., et al Int J Qual Health Care, 2004;16:201-10

Recommandation	Cible	Pratique
Mesure de la FEVG (écho)	100%	69%
IEC*	100%	86% dont 54% dose-cible
Bêta-bloquants*	100%	env. 50%

*patients sans contre-indication

Not again!

Preventing errors lies in redesign—not exhortation

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« Exhortation does not help much, nor will suspending the doctors, nor will outrage in the headlines, nor even will guilt. Suspend every doctor today who makes an error today, and the error rates in the NHS tomorrow will be exactly the same as today's. »

Donald Berwick *BMJ 2001;322:247–8*

Perceptions de l'erreur médicale

16

Votre avis	N (%)
Quelle est la fréquence des erreurs médicales ?	
Très fréquente	
Fréquente	
Pas très fréquente	
Rare	

"Sometimes when people are ill and receive medical care, mistakes are made that result in serious harm, such as death, disability, or additional or prolonged treatment. These are called medical errors. Some of these errors are preventable, whereas others may not be."

Perceptions de l'erreur médicale*

17

	Médecins (N=831)	Public (N=1207)	P
Quelle est la fréquence des erreurs médicales ?	%		/
Très fréquente	1	10	<0.001
Fréquente	19	39	<0.001
Pas très fréquente	59	37	<0.001
Rare	21	8	<0.001
Pas de réponse	0	6	

80 % des médecins ≤ pas très fréquente

*N Engl J Med 2002;347:1933-40

Décès consécutifs à erreur

18

	Médecins (N=831)	Public (N=1207)	P
Combien de patients américains meurent à l'hôpital chaque année des suites d'une erreur médicale?	%		
500	17	24	<0.001
5000	46	36	<0.001
50'000	25	20	0.002
100'000	9	7	0.12
≥ 500'000	1	4	<0.001
Sans réponse	1	9	

≥ 60 % des médecins estiment le nombre annuel de décès ≤ 5000

Causes d'erreurs médicales

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	Médecins (N=831)	Public (N=1207)
	%	
Manque d'infirmières	53	65
Surcharge de travail, stress…	50	70
Complexité des soins	38	62
Manque de temps consacré par les médecins aux patients	37	72
Manque « d'entraînement » des professionnels des soins	28	54
Manque de supervision des professionnels de soins	16	50
Manque de dossiers patients informatisés	13	35
…		

Arch Intern Med -- Robinson et al. 162 (19): 2186 Table ABLEIOI10641T3 - Windows Internet Explorer

http://archinte.ama-assn.org/cgi/content-nw/full/162/19/2186/TABLEIOI10641T3

Table 3. Colorado Physician and Public Agreement

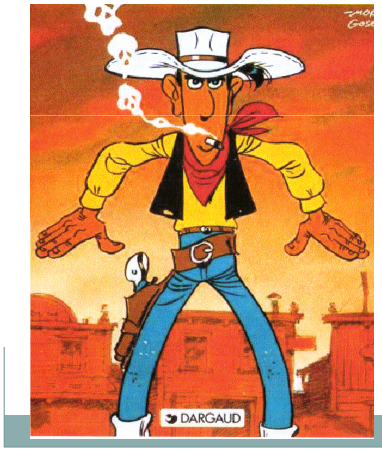
Statement	No. (%) Physicians (n = 594)	No. (%) Public (n = 500)	P Value
The quality of health care in the United States is a significant problem.	173 (29.1)	338 (67.6)	<.001
Our health care system does not match the safety record attained in other industries.	126 (21.2)	181 (36.2)	<.001
Error reduction in medical practice should be a national priority.	414 (69.7)	433 (86.6)	<.001
We need a national agency to provide leadership and research in reducing medical errors.	143 (24.1)	299 (59.8)	<.001
We should implement a system of mandatory reporting of serious medical errors (one that causes death or serious injury).	325 (54.7)	451 (90.2)	<.001
A recent estimate that medical errors kill 44 000 to 98 000 Americans yearly is accurate.	82 (13.8)	95 (19.0)	.02

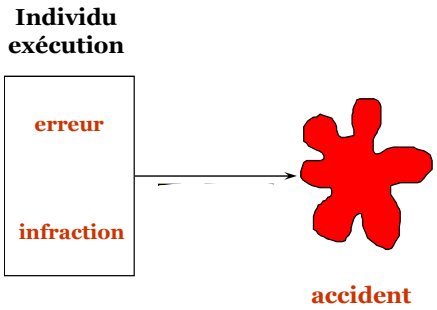
Arch Intern Med. 2002;162:2186-219

Table 3. Colorado Physician and Public Agreement

Cadre conceptuel « individuel »

21

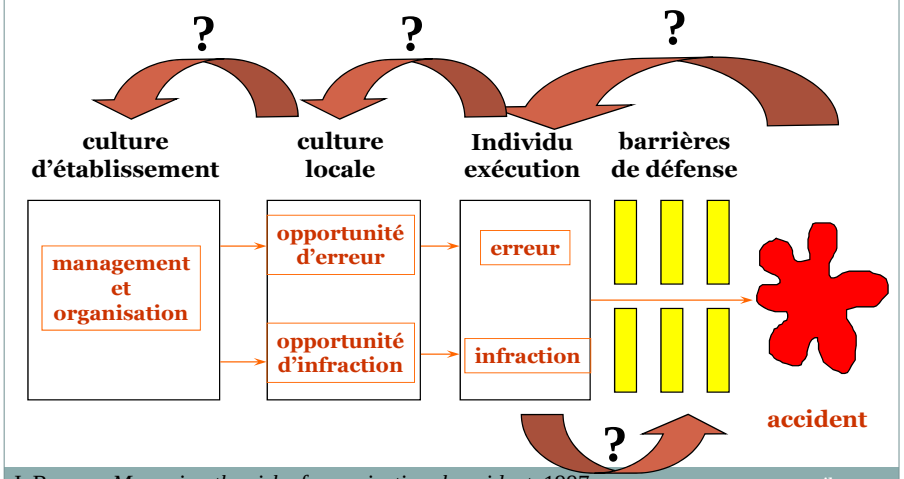




"Modèle du héros solitaire"

Cadre conceptuel systémique

22



J. Reason, *Managing the risk of organizational accident*, 1997

Identification des facteurs contributifs d'un problème de prise en charge

23

au patient	état de santé, personnalité, attitude, aptitude à communiquer, observance,...
à l'environnement de travail	horaires de travail, charge de travail, éclairage, bruit, éléments de distraction, ergonomie,
au matériel (instruments, outils, documents)	maintenance du matériel, panne, organisation du stockage, accès à la documentation
au soignant(s)	savoir, savoir faire, savoir être, santé physique ou mentale, fatigue, formation,
A la tâche ou à l'activité	instructions de travail et autres documents (clarté, exactitude, lisibilité), ergonomie, conception des soins et planification
à l'équipe soignante	taille, composition, communication écrite ou orale, supervision, assistance entre collègues, conflits
Au contexte institutionnel / managérial	politique qualité, gestion des risques, formation/engagement du personnel…

Ch Vincent et al. How to investigate and analyse clinical incidents.BMJ 2000. 320:777-781

Système d'annonce des incidents

24

ce système devrait :

- *a.* être non punitif et juste dans sa finalité;
- *b.* être indépendant des autres mécanismes de régulation ;
- *c.* être conçu de façon à encourager les soignants et les personnels de santé à signaler les incidents de sécurité (démarche volontaire, anonyme et confidentielle, notamment, chaque fois que cela est possible) ;
- *d.* instaurer un système permettant la collecte et l'analyse au niveau local des rapports concernant les événements indésirables et, en cas de besoin, leur synthèse au niveau régional ou national [...]

Recommandation Rec(2006)7 du Comité des Ministres aux Etats membres (CONSEIL DE L'EUROPE)

Loi sur les produits thérapeutiques art. 59

Obligation d'annoncer pour les professionnels de la santé

[3] Est aussi tenu d'annoncer tout effet indésirable grave ou jusque-là inconnu et tout incident ou défaut, quiconque, à titre professionnel, administre des produits thérapeutiques à l'être humain ou aux animaux ou en remet.

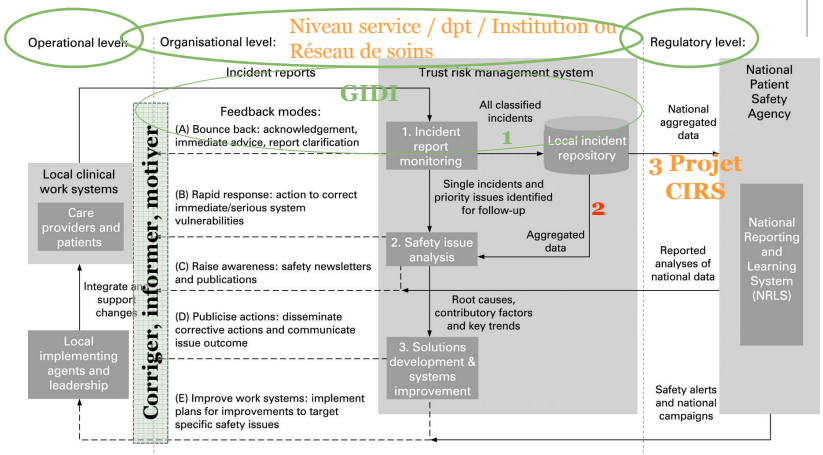
[4] Les consommateurs, les patients et leurs organisations ainsi que les tiers intéressés peuvent annoncer à l'institut les effets indésirables de produits thérapeutiques et les incidents qui leur sont imputables.

Loi sanitaire genevoise (loi K1 03)

Art. 106 Contrôle de qualité

- [1] Les institutions de santé prennent les mesures nécessaires pour répertorier les incidents survenus dans le cadre de leur mission de soins.
- …

Framework for Safety Action and Information Feedback from Incident Reporting (SAIFIR), developed through synthesis of information gained from multiple sources during the review.



Benn J et al. Qual Saf Health Care 2009;18:11-21

QSHC

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Annonce de l'erreur au patient

Table 2. Clinical Scenarios

Type of Scenario	Description
Medical	
Insulin overdose (more apparent error)	You have admitted a diabetic patient to the hospital for a COPD exacerbation. You handwrite an order for the patient to receive "10 U" of insulin. The "U" in your order looks like a 0. The following morning, the patient is given 100 U of insulin, 10 times the patient's normal dose, and is later found unresponsive, with a serum glucose level of 35 mg/dL (1.94 mmol/L). The patient is resuscitated and transferred to the intensive care unit. You expect the patient to make a full recovery.
Hyperkalemia (less apparent error)	You administer a new medicine with a common adverse effect of increasing the potassium level to an outpatient with hypertension. The patient's baseline potassium level is normal (4.0 mEq/L). You order a repeat blood test to measure potassium level, to be drawn the next week, but forget to check the laboratory results. Two weeks after the patient begins taking this new medicine, the patient starts feeling palpitations and goes to the emergency department. In the emergency department, the patient experiences an episode of ventricular tachycardia, requiring cardioversion. The patient's potassium level at this event is 7.5 mEq/L. The patient is hospitalized for 4 days, and makes a full recovery. The patient returns to your office for a follow-up visit. On reviewing the patient's chart, you see the overlooked laboratory results, which showed the patient's potassium level had increased substantially from 4.0 to 5.6 mEq/L. Had you seen this elevated potassium level earlier, you would have discontinued the new medicine and treated the hyperkalemia, likely avoiding the life-threatening arrhythmia.
Surgical	
Retained sponge (more apparent error)	You are seeing a patient 3 weeks after elective splenectomy for ITP. The splenectomy was technically challenging because of the patient's obesity, but seemed uncomplicated. At this follow-up visit, the patient complains of vague persistent LUQ pain. You send the patient for an abdominal x-ray film, which shows a foreign body consistent with a retained surgical sponge in the patient's LUQ. You remember that the sponge count was correct at the end of the procedure. However, you also remember that you packed off a small bleeding vessel near the stomach with a sponge, and do not recall removing this sponge. When you review the postoperative records, you observe that a math error was responsible for a falsely correct sponge count. You believe a subsequent operation to remove the retained sponge is indicated, and expect the patient will make a full recovery.
Bile duct injury (less apparent error)	You are performing a laparoscopic cholecystectomy. In the informed consent before surgery, you explicitly told the patient that an open procedure might be required. A surgical device representative has asked you to try a new coagulation/dissection device. He mentions in passing that the tip of the device can get hot. You are dissecting with the new device, and the procedure is going smoothly. A surgical resident asks you a question. With the dissection device off, you look in the resident's direction to answer the question. When you turn back to the operative field, you realize the tip of the dissection device is resting against the common bile duct, which has been burned. You did not realize that this new device could cause such tissue damage even when turned off. You convert the procedure to an open cholecystectomy and repair the injured common bile duct. The remainder of the procedure is unremarkable, and you expect the patient to make a full recovery.

Gallagher, T. H. et al. Arch Intern Med 2006;166:1585-1593.

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Abbreviations: COPD, chronic obstructive pulmonary disease; ITP, idiopathic thrombocytopenic purpura; LUQ, left upper quadrant.

NE

Clinical Scenarios

Table 2. Clinical Scenarios

Description

You have admitted a diabetic patient to the hospital for a COPD exacerbation. You handwrite an order for the patient to receive "10 U" of insulin. The "U" in your order looks like a 0. The following morning, the patient is given 100 U of insulin, 10 times the patient's normal dose, and is later found unresponsive, with a serum glucose level of 35 mg/dL (1.94 mmol/L). The patient is resuscitated and transferred to the intensive care unit. You expect the patient to make a full recovery.

You administer a new medicine with a common adverse effect of increasing the potassium level to an outpatient with hypertension. The patient's baseline potassium level is normal (4.0 mEq/L). You order a repeat blood test to measure potassium level, to be drawn the next week, but forget to check the laboratory results. Two weeks after the patient begins taking this new medicine, the patient starts feeling palpitations and goes to the emergency department. In the emergency department, the patient experiences an episode of ventricular tachycardia, requiring cardioversion. The patient's potassium level at this event is 7.5 mEq/L. The patient is hospitalized for 4 days, and makes a full recovery. The patient returns to your office for a follow-up visit. On reviewing the patient's chart, you see the overlooked laboratory results, which showed the patient's potassium level had increased substantially from 4.0 to 5.6 mEq/L. Had you seen this elevated potassium level earlier, you would have discontinued the new medicine and treated the hyperkalemia, likely avoiding the life-threatening arrhythmia.

You are seeing a patient 3 weeks after elective splenectomy for ITP. The splenectomy was technically

Résultats

31

- Wide variation!!
- 42% would use the word "error," while 56% mentioned the adverse event but not the error
- 50% would disclose specific information about what the error was, while 13% would not volunteer any details unless asked by the patient
- 94% would apologize,
  - with 61% offering an expression of regret ("I am sorry about what happened")
  - 33% choosing an explicit apology ("I am so sorry that you were harmed by this error")
- error prevention:
  - 9% would provide no information unless asked,
  - 54% chose a general pledge to prevent recurrences,
  - 37% would discuss detailed plans for preventing recurrences

Gallagher, T. H. et al. Arch Intern Med 2006;166:1585-1593.

Communication avec le patient et ses proches à la suite d'un incident

32

- Premières règles
  - Éviter des préjudices supplémentaires
  - Communiquer seulement les incidents qui ont des conséquences pour le patient
  - Approche coordonnée
- Quand: tôt (<24h)
- Qui: membre de l'équipe médicale
- Où: endroit calme, confidentiel

www.patientensicherheit.ch

Communication avec le patient et ses proches à la suite d'un incident

33

- Expliquer ce qui s'est passé (les faits, pas les suppositions)
- Exprimer clairement son regret
- Expliquer les conséquences médicales
- Offrir la possibilité de changer d'équipe de soins
- Montrer comment le service tirera les conséquences de l'erreur
- Informer le patient sur les développements ultérieurs

Pour en savoir plus: When things go wrong. A consensus statement of the Harvard Hospitals. March 2006

Perspectives

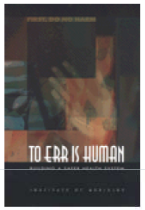
34

- Modifier la culture de la sécurité
  - Mesurer la culture de la sécurité
  - Collecter « l'évidence »
    - Développer les systèmes de déclaration d'incidents
    - Impliquer les organisations faîtières
    - Assurer une formation
      - Processus
      - Analyse cause-racine
      - Amélioration continue de la qualité
- Participer au système national « CIRS »
- Mettre en place des structures/groupes de gestion de la qualité
- Développer des indicateurs de qualité des soins

Pour en savoir plus

35

Les « fondamentaux »



Free Executive Summary

To Err Is Human: Building a Safer Health System

Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, Editors; Committee on Quality of Health Care in America, Institute of Medicine

ISBN: 978-0-309-06837-6, 312 pages, 6 x 9, hardback (2000)

Free Executive Summary

Crossing the Quality Chasm: A New Health System for the 21st Century

Committee on Quality of Health Care in America, Institute of Medicine

ISBN: 978-0-309-07280-9, 364 pages, 6 x 9, hardback (2001)

36

- Articles:

- Staeger, P et al. (2007). "[Error in ambulatory medicine: how to deal with it?]." Rev Med Suisse 3(135): 2702-4, 2706-9.

-Forster AJ. The Incidence and Severity of Adverse Events Affecting Patients after Discharge from the Hospital. Ann Intern Med. 2003;138:161-167.

-Gurwitz H. Incidence and Preventability of Adverse Drug Events Among Older Persons in the Ambulatory Setting. JAMA 2003;289:1107-1116

- *Gallagher Th. et al.* Choosing Your Words Carefully. Arch Intern Med 2006;166:1585-1593.