PATIENT SAFETY
WHAT ARE WE TALKING ABOUT?

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LISTEN TO THESE SHORT STORIES
COULD IT HAPPEN TO YOU?

When you print the prescription for a 1 year old child, you realise that the dose of paracetamol is not the proper one according to the child’s weight. You did not open the right medical record...but his mother’s one!

The secretary gave a routine appointment for one week later to a patient. She did not realise it was urgent ... a pyelonephritis!

You cannot find the chest CT scan report for a smoking patient. The report was filed in another record of the same name.

A pharmacist phones you and says you have prescribed amoxicillin to a patient allergic to penicillin. After checking, the alert for « allergic to penicillin » was not in the record.
"The most obvious impetus of this renewed interest has been a growing public concern over the terrible cost of human error:

The Tenerife runway collision in 1977,
Three Mile Island two years later,
The Bhopal tragedy in 1984,
The Challenger and Chernobyl disasters in 1986,
The sinking of the Herald of Free Enterprise,
The subway fire at King's Cross station in 1987
The Piper Alpha oil platform explosion in 1988.

There is nothing new about the tragic accidents caused by human error. But in the past, the injurious consequences were usually confined to the immediate vicinity of the disaster. Now the nature and the scale of certain potentially hazardous technologies means that human error could have adverse effects upon whole continents over several generations.

James Reason (Human error)
Health care in the United States is not as safe as it should be--and can be. At least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented, according to estimates from two major studies. Even using the lower estimate, preventable medical errors in hospitals exceed attributable deaths to such feared threats as motor-vehicle wrecks, breast cancer, and AIDS.
To Err is Human: Building a Safer Health System

- Poor health system organization,
- fragmentation,
- lack of cooperation culture,
- complexity,
- strong hierarchy

The health system can improve only with deep changes

- Technical training
- Health care providers skills
1984 - Harvard Medical Practice Study
- The authors analysed the nature of injuries found in a cohort of hospitalized patients in New York
- 30121 randomized records from 51 hospitals

1992, similar survey in Utah and Colorado with 14 200 records

2 to 4% hospitalized patients experience a serious adverse event during their hospital stay with a death rate of 14%
= an airliner crash every day

'Up to 100 babies died needlessly'
Up to 100 babies may have died needlessly after undergoing complex heart surgery at Bristol Royal Infirmary, it has been claimed.
An organisation with a memory

An organisation with a memory
Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer
1999-2000: TWO MAJOR REPORTS

... only for hospitals!
In primary care

- a lower technology environment

But

- Millions of interaction occurring every day
- Heterogeneity in its organisation
- Complex and different organisational arrangements between primary and secondary care interface
The first study describing the incidence of GP-reported errors in a representative sample.

ASSOCIATE PROFESSOR MEREDITH MAKEHAM


The Threats to Australian Patient Safety (TAPS) study: incidence of reported errors in general practice.
Makeham MA1, Kidd MR, Saltman DC, Mira M, Bridges-Webb C, Cooper C, Stromer S.

Results:
« When an anonymous reporting system is provided, about one error is reported for every 1000 Medicare items related to patient encounters, and about two errors are reported for every 1000 individual patients seen by a GP. »
A 48 months program starting 01/03/2009

Keywords: • Patient Safety, • Primary Care.

Project web-site: http://www.linneaus-pc.eu/

Building a network of researchers and practitioners working on patient safety in primary care in the European Union.
WHAT DO WE KNOW ABOUT RISKS, ERRORS AND HARMS IN PRIMARY CARE?

• The majority of incidents can be categorised into 4 areas
  1. prescribing,
  2. diagnosis (missed and delayed),
  3. communication between clinicians and patients,
  4. organisational / administrative problems.

• Adverse events (AEs) are quite frequent:
  
  1AE /2days/GP
  
  with no harm for ¾ AEs
IT’S TIME FOR CLINICIANS TO GET STARTED

What happens in my practice?
What are the risks for patients?
Can we identify and learn from failures?
How to begin a constructive response?

IT’S TIME FOR CLINICIANS TO LEARN

What is an adverse event?
How to analyse it?
How to make recommendations for changes?

Let’s begin and talk about errors
« an adverse event is a event or a circumstance related to health care, that could cause or has caused harm to a patient and which we hope does not happen again. »

Please recall an adverse event that occurred in your own practice.
Please share your story with your neighbour and listen to each other and ask yourselves
what was the risk for the patient in the story?
what was the adverse event?
what was your feeling when telling your experience?
what was your feeling when listening?
If you want to know more about safety and quality,
If you want to learn or share your experience.

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