



European Society for Quality and Safety
in Family Practice

A network organisation within WONCA Region Europe - ESGP/FM

PATIENT SAFETY WHAT ARE WE TALKING ABOUT?

WONCA ISTANBUL, 25 OCTOBER 2015

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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.

HISTORIC ROLE PLAYED BY MAJOR ACCIDENTS:

AWARENESS OF RISK AND THE IMPORTANCE OF PREVENTION



" 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)

November 1999

INSTITUTE OF MEDICINE

Shaping the Future for Health

TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM

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**



- **Technical training**
- **Health care providers skills**

The health system can improve only with deep changes

CLASSIC PAPER

Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study I*

TA Brennan, L Lapeere, M Laird, L Haber, A R Lucallo, A G Lawthers, J F Newhouse, P C Weiler, H H Hoot

Qual Saf Health Care 2004;13:e145-152

Background: As part of an interdisciplinary study of medical injury and malpractice litigation, we assessed the incidence of adverse events, defined as injuries caused by medical management, and of the subgroup of such injuries that resulted from negligence or substandard care.
Methods: We reviewed 29,127 randomly selected medical records from 51 randomly selected acute care, non-teaching hospitals in New York State in 1984. We then developed population estimates of injury and negligence rates according to the age and sex of the patients, as well as the location of the patients.
Results: Adverse events occurred in 3.7% of all hospitalizations (95% confidence interval 3.2 to 4.2), and 27.6% of the adverse events were due to negligence (95% confidence interval 22 to 32.6). Although 25.9% of the adverse events were due to negligence having had four or more months of potentially disabling injury and 13.6% had to die, the percentage of adverse events attributable to negligence increased in the proportion of more severe injuries (P=0.01, P<0.001, P<0.001). Using weighted tools we estimated that among the 2,473,843 patients discharged from New York hospitals in 1984 there were 18,609 adverse events and 27,120 adverse events involving negligence. About 64,000 negligence claims were filed in 1993-1995. The percentage of adverse events due to negligence was markedly higher among the elderly (P<0.001). There were significant differences in rates of adverse events among components of clinical specialties (P<0.001), but no differences in the percentage due to negligence.
Conclusions: There is a substantial amount of injury to patients from medical management, and many injuries are the result of substandard care.

See end of article for authors' disclosures.

Over the past decade there has been a steady increase in the number of malpractice claims brought against healthcare providers^{1,2} and in the monetary damages awarded to plaintiffs.^{3,4} This increase has prompted attention from program designers to monitor the number of claims and encourage providers to develop quality of care initiatives.^{5,6} Advances in cost review after the existing system of malpractice litigation is ineffective in compensating performance of poor quality care that is sometimes responsible for the original injury.⁷ Many believe that the use of arbitrators and periodic review of malpractice rates begins to decrease.^{8,9}

Concern over the extent of civilian law malpractice litigation moves without much explicit information regarding the epidemiology of poor quality care and the incidence of subsequent injury and substandard care were developed over 10 years ago.¹⁰ After several physicians identified poor quality care or adverse events, have been reviewed in representative samples of medical records.^{11,12}

To address the need for empirical information on undercounted in Harvard Medical Practice Study. A primary goal was to develop precise and more reliable estimates of the incidence of adverse events and negligence in hospitalized patients. We defined an adverse event as an injury that was caused by medical management (rather than underlying disease) and that prevented the hospitalized patient's discharge at the time of discharge, or both. We defined negligence as care that fell below the standard expected of physicians in their community. To estimate the incidence of these critical events, we reviewed a random sample of more than 11,000 hospital records using techniques we have previously described.¹³

METHODS

Sample selection and record review. We have presented the methods of record review and our sampling process to create a weighted sample of 14,629 records of hospitalized patients from a population of 2,473,843 nonoperative patients discharged from non-teaching acute care hospitals in New York State, the results were reported by trained nurses and medical records administrators in the previous study.¹⁴ In addition, the records were reviewed by trained nurses and medical records administrators to identify adverse events and negligence. In each case, when more than one reviewer was present, the reviewers were trained to review the medical records for evidence of adverse events and negligence (Appendix 1) and to grade their confidence that an adverse event had occurred on a scale of 0 to 3, the maximum score.

Because we were interested in estimating the statewide incidence of adverse events, the physician reviewers reviewed only adverse events that occurred and were documented during the index hospitalization, but also were asked for medical management before the index hospitalization and first documented during it to calculate incident rates not limited only events observed during the original index hospitalization. In including adverse events that occurred earlier but were first documented during the index hospitalization, we compensated for adverse events caused during the hospital stay that were not captured in our original study.¹⁵

*A reprint of this paper is included in the English journal of *Health Care*, 1993, Volume 13, page 2654. Copyright © 1993, Massachusetts Medical Society. All rights reserved.

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2 insurance companies surveys

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

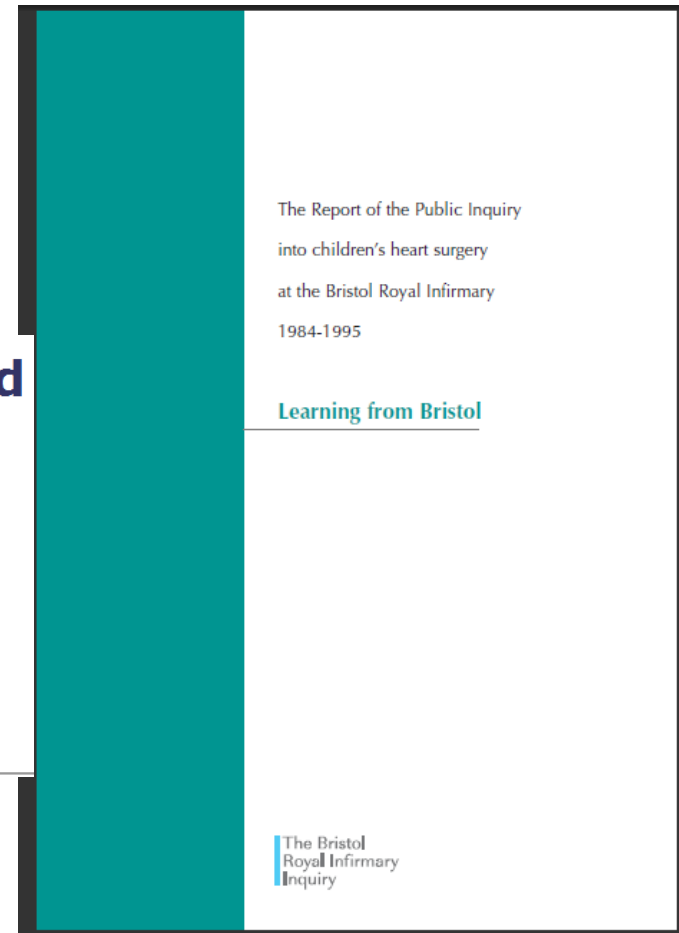


UK: « *The Report of The Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary: 1984 – 1995* »

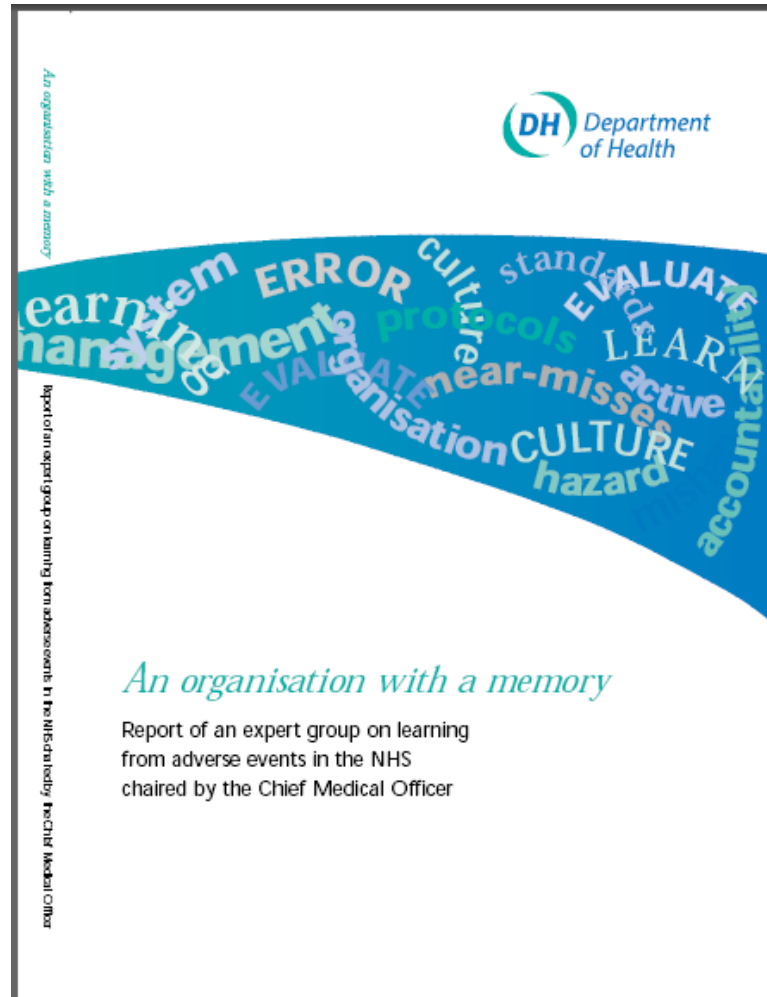


'Up to 100 babies died needlessly'

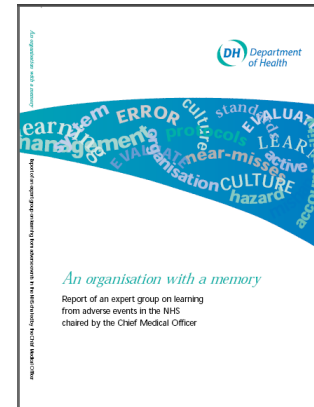
Up to 100 babies may have died needlessly after undergoing complex heart surgery at Bristol Royal Infirmary, it has been claimed.



« An organisation with a memory » june 2000



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**

Med J Aust. 2006 Jul 17;185(2):95-8.

**The Threats to Australian Patient Safety (TAPS) study:
incidence of reported errors in general practice.**

[Makeham MA](#)¹, [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. »

LINNEAUS EURO –PC 2009 - 2013

Learning from International Networks about Errors and Understanding Safety in Primary Care

A 48 months program
starting 01/03/2009

Keywords: • Patient Safety,
• Primary Care.

Project web-site:

[http://www.linneaus-
pc.eu/](http://www.linneaus-pc.eu/)

Building a network of researchers and practitioners working on patient safety in primary care in the European Union.

The screenshot shows the website's header with navigation links: Home, News & Events, GP & Patient Tools, Research Outputs, LINNEAUS Network, and LINNEAUS Project. The main content area is titled 'About the LINNEAUS Euro-PC Project' and includes sections for 'Why the focus on primary care?' and 'Why we need to study patient safety in primary care?'. The 'About' section discusses the prevalence of primary care in Europe and the UK, noting that in the UK, nearly 750,000 patients consult their GP daily, and in Germany, there are nearly 1.5 million visits per day. It also mentions that primary care accounts for nearly 80% of health concerns in the EU, compared to 5% for hospital care. The 'Why we need to study patient safety' section states that there are 5-80 safety incidents per 100,000 consultations in the UK, which translates to 37-600 incidents per day. It categorizes incidents into diagnosis, prescribing, communication, and organisational issues, noting that 50% are of no consequence, 20% result in non-clinically relevant delays, and 10% result in serious consequences. The 'Why we need to study patient safety in primary care?' section highlights that research on patient safety has been focused on hospital/specialist care, while primary care is more heterogeneous and complex, with multiple sites and interfaces between primary and specialist care.

Contact | Forum

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- Home
- News & Events
- GP & Patient Tools
- Research Outputs
- LINNEAUS Network
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[Home](#) » [About LINNEAUS Project](#)

IN THIS SECTION

- » [About LINNEAUS Project](#)
- » [Why the focus on primary care?](#)
- » [Why we need to study patient safety in primary care?](#)
- » [The LINNEAUS collaboration](#)
- » [Objectives](#)
- » [Participants](#)

RELATED SECTIONS

- » [Work Packages](#)

About the LINNEAUS Euro-PC Project

Why the focus on primary care?

In many countries in Europe, access to specialist care occurs through the medium of primary or generalist care. In the UK for example nearly 750,000 patients consult their GP each day. In Germany there are nearly 1.5 million visits per day to primary care and in the Netherlands every citizen has nearly 3 consultations with their GP each year. Primary care is therefore a vast organised sector for health care with millions of interaction occurring every day throughout the European Union. Primary care accounts for nearly 80% of the health concerns reported to a physician compared to 5% for hospital care.

Evidence suggests that there are between 5-80 safety incidents per 100,000 consultations which in the UK would translate to between 37-600 incidents per day. The vast majority of incidents can be categorised into 4 main areas covering diagnosis, prescribing, communication between health care providers and patients, and organisational. Although the potential for error is great, research also suggests that 50% are of no consequence, 20% result in non-clinically relevant delays in diagnosis, 10% result in upset patients but more significantly 20% of errors could have serious consequences. Therefore, even if the overall risk is lower, the potential for harm is significant.

Why we need to study patient safety in primary care?

The vast majority of research on patient safety has up to now, focused almost exclusively on hospital/specialist care. There is perception of primary care as a low technology environment where safety is not a problem. Primary care is also a much more heterogeneous in its organisational arrangements and in virtually all European countries the organisational arrangements between primary and secondary care are different and complex. There is a multiplicity of sites where primary care is carried out (the clinician's office, the telephone and the patients' home). The interfaces between primary and specialist care are hugely important and vary

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 :

Michel P, Mosnier A, Kret M, Chanelière M, Dupie I, Haeringer- Cholet A, Keriel-Gascou M, *et al.* Étude épidémiologique en soins primaires sur les événements indésirables associés aux soins en France (Esprit 2013). Bull Epidemiol Hebd. 2014; (24-25):410-6

1AE /2days/GP

with no harm for $\frac{3}{4}$ AEs

2015



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

AUTHORS



« 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?



EUROPEAN SOCIETY FOR QUALITY & SAFETY IN GP/FM

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If you want to learn or share your experience.**

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working groups and discount on the EQuiP conferences.**