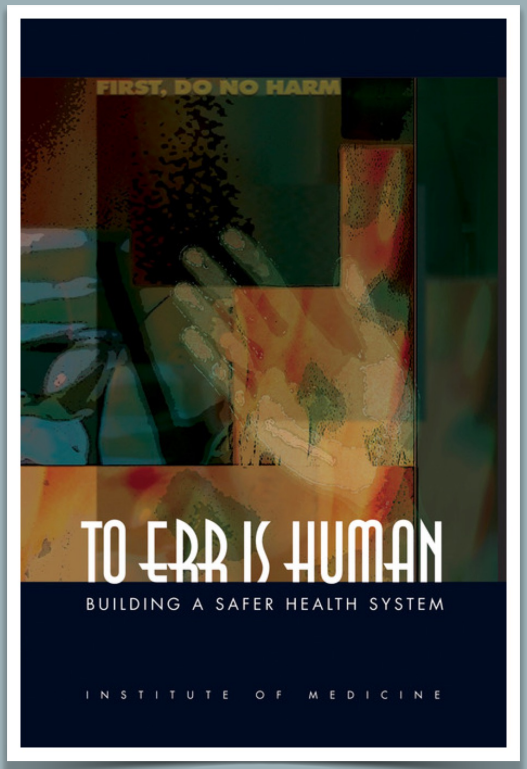
Simulation en santé
et innovations pédagogiques

To err is human

M. Mouhaoui

To err is human

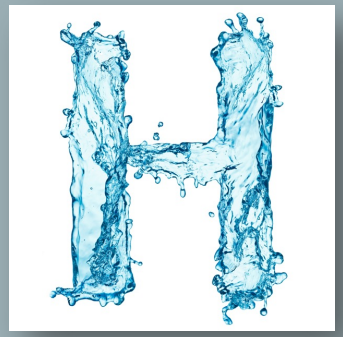


November, 1999

To err is human

- Health care in the United States is not as safe as it should 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.

To err is human



To err is human

- Medical errors can be defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.
- High error rates with serious consequences are most likely to occur in intensive care units, operating rooms, and emergency departments.

Types of errors

Diagnostic

- Error or delay in diagnosis
- Failure to employ indicated tests
- Use of outmoded tests or therapy
- Failure to act on results of monitoring or testing

Types of errors

Treatment

- Error in the performance of an operation, procedure, or test
- Error in administering the treatment
- Error in the dose or method of using a drug
- Avoidable delay in treatment or in responding to an abnormal test inappropriate (not indicated) care

Types of errors

Preventive

- Failure to provide prophylactic treatment
- Inadequate monitoring or follow-up of treatment

Types of errors

Other

- Failure of communication
- Equipment failure
- Other system failure

To err is human

Significant tolls

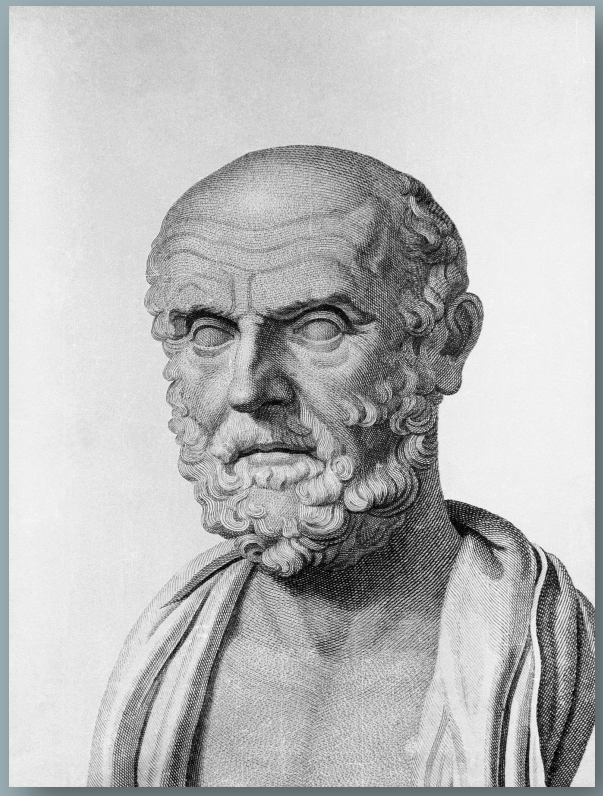
- Human lives
- Total costs
- Loss of trust in the health care system
- Decreasing satisfaction

To err is human

Contributing factors

- Fragmentation of the healthcare delivery system
- Lack of uncovering and learning from errors
- Weak financial incentive to improve safety and quality

IOM (institute of medicine) conclusions



Primum, no nocere

First, do no harm

IOM (institute of medicine) conclusions

- More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them.
- When an error occurs, blaming an individual does little to make the system safer and prevent someone else from committing the same error.

Strategy for improvement

1. Establishing a national focus to create leadership, research and protocols to enhance the knowledge base about safety
2. Identifying and learning from errors by developing a nationwide public mandatory reporting system

Strategy for improvement

3. Raising performance standards and expectations for improvements in safety
4. Implementing safety systems in health care organizations

Sécurité du patient

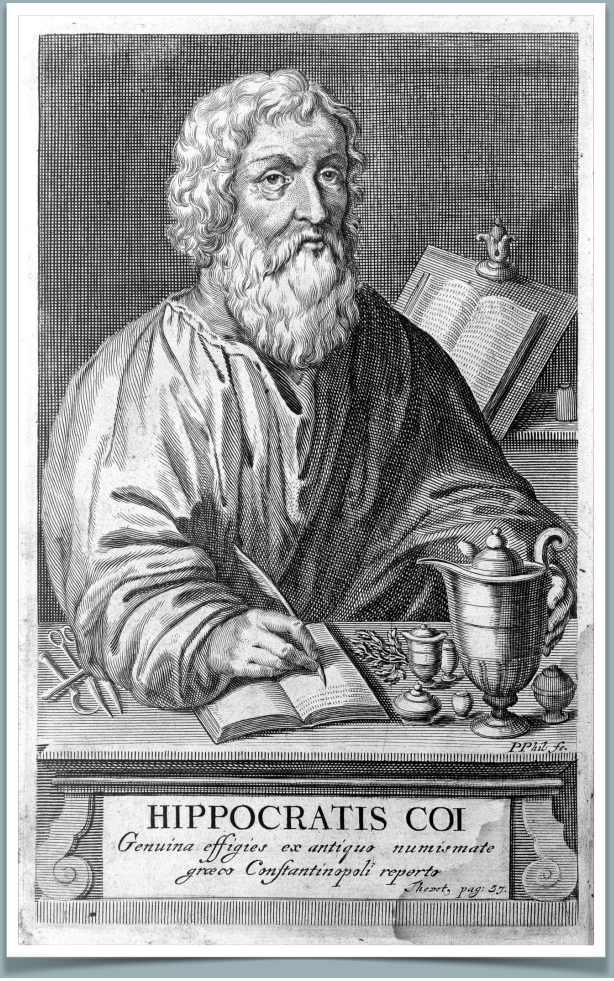
Sécurité du patient

Soins de santé
Complexes et hautement techniques

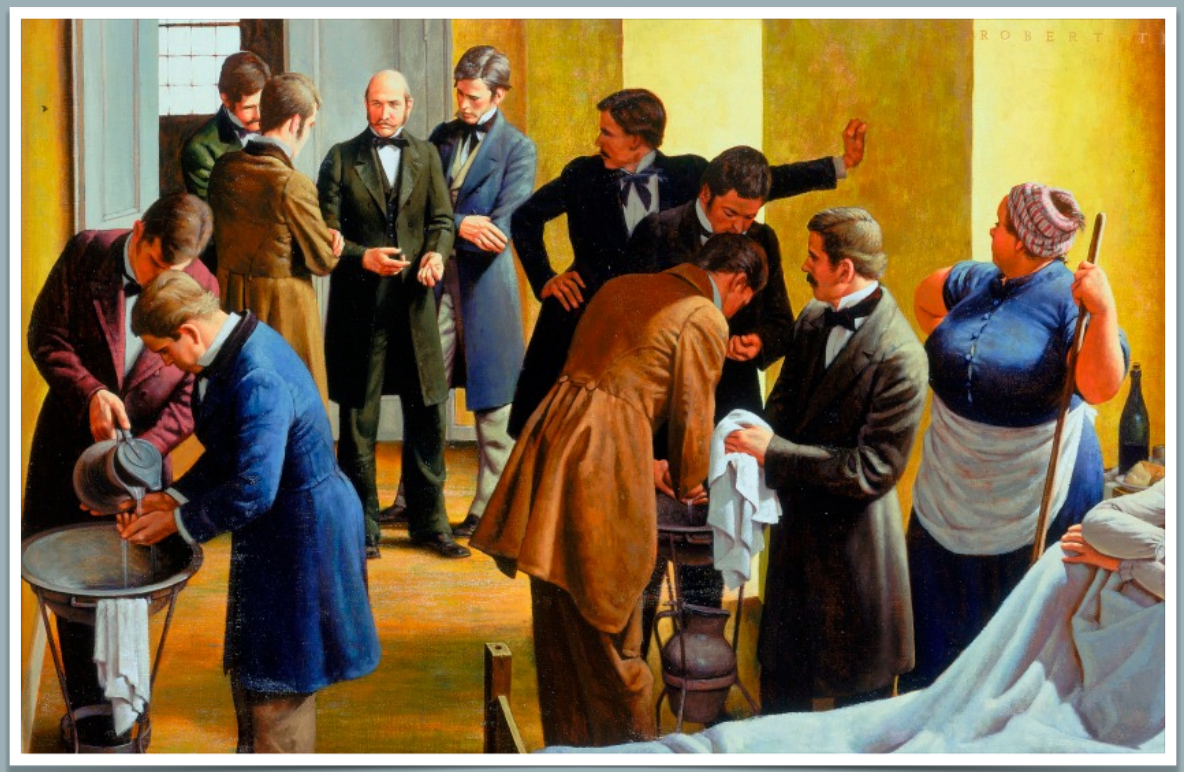
Quid de la qualité ?

Sécurité du patient

Primum no nocere



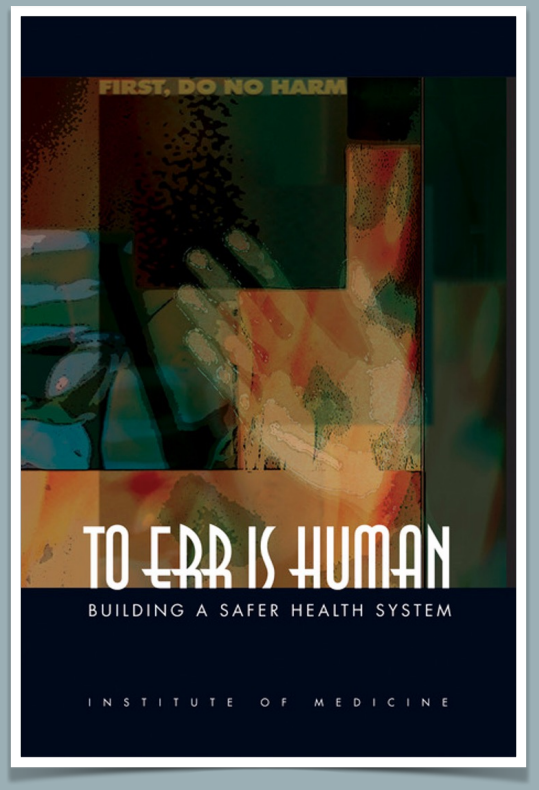
Sécurité du patient



Ignace Philippe Semmewels

Sécurité du patient

44 000 à 98 000
erreurs médicales fatales
Facteurs humains 70%



Analyse de l’erreur

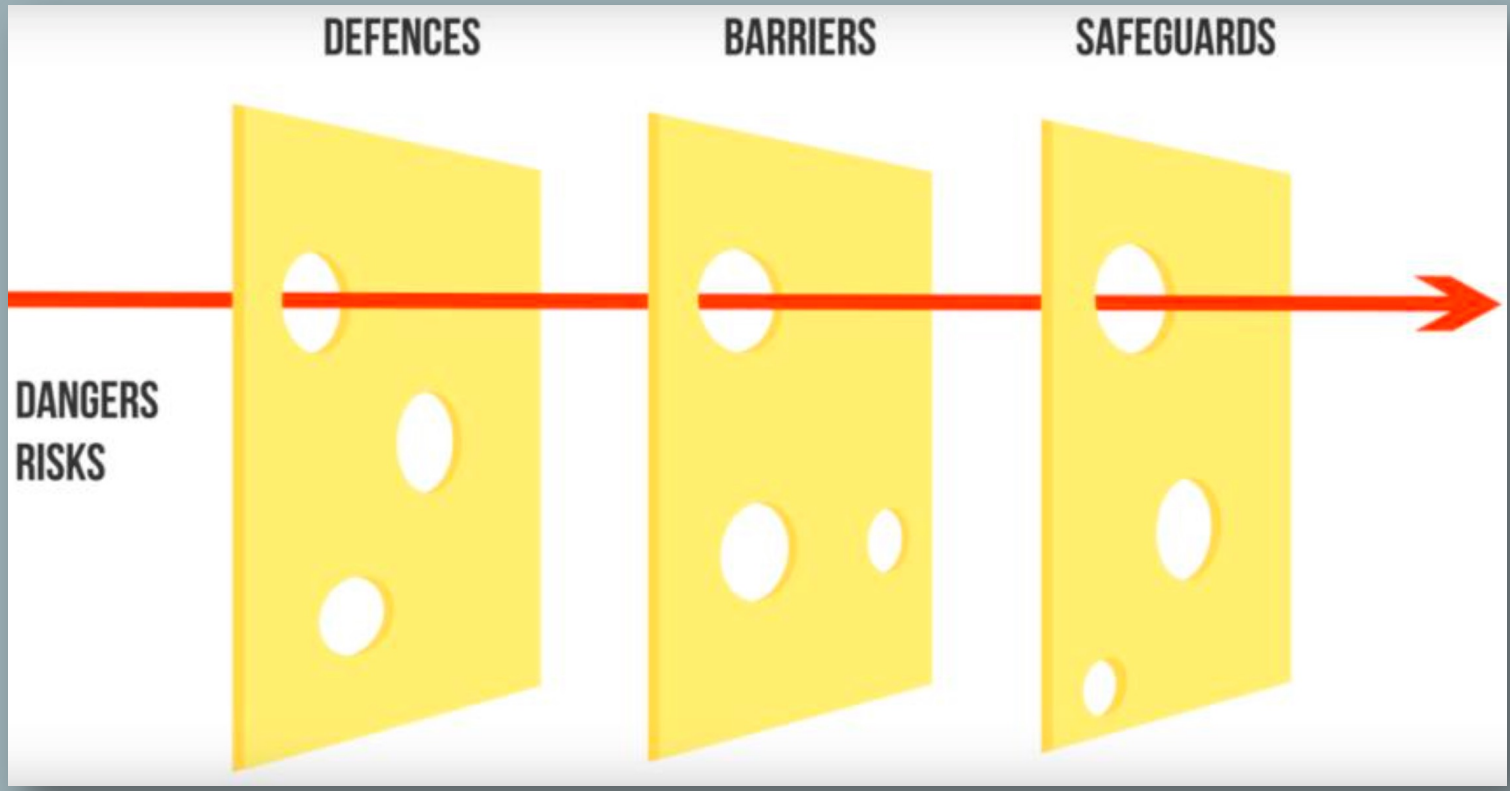

Juge 2
Juge 1
Procureur 1
Accusé(e)
Public
Procureur 2
Avocat 2
Avocat 1

Analyse de l'erreur

Fromage suisse
de James REASON

Analyse de l’erreur

James REASON



James **REASON**

Défaillances actives

Conditions latentes

James **REASON**

Défaillances actives

- Dérapage
- Défaillance
- Erreur
- Violation

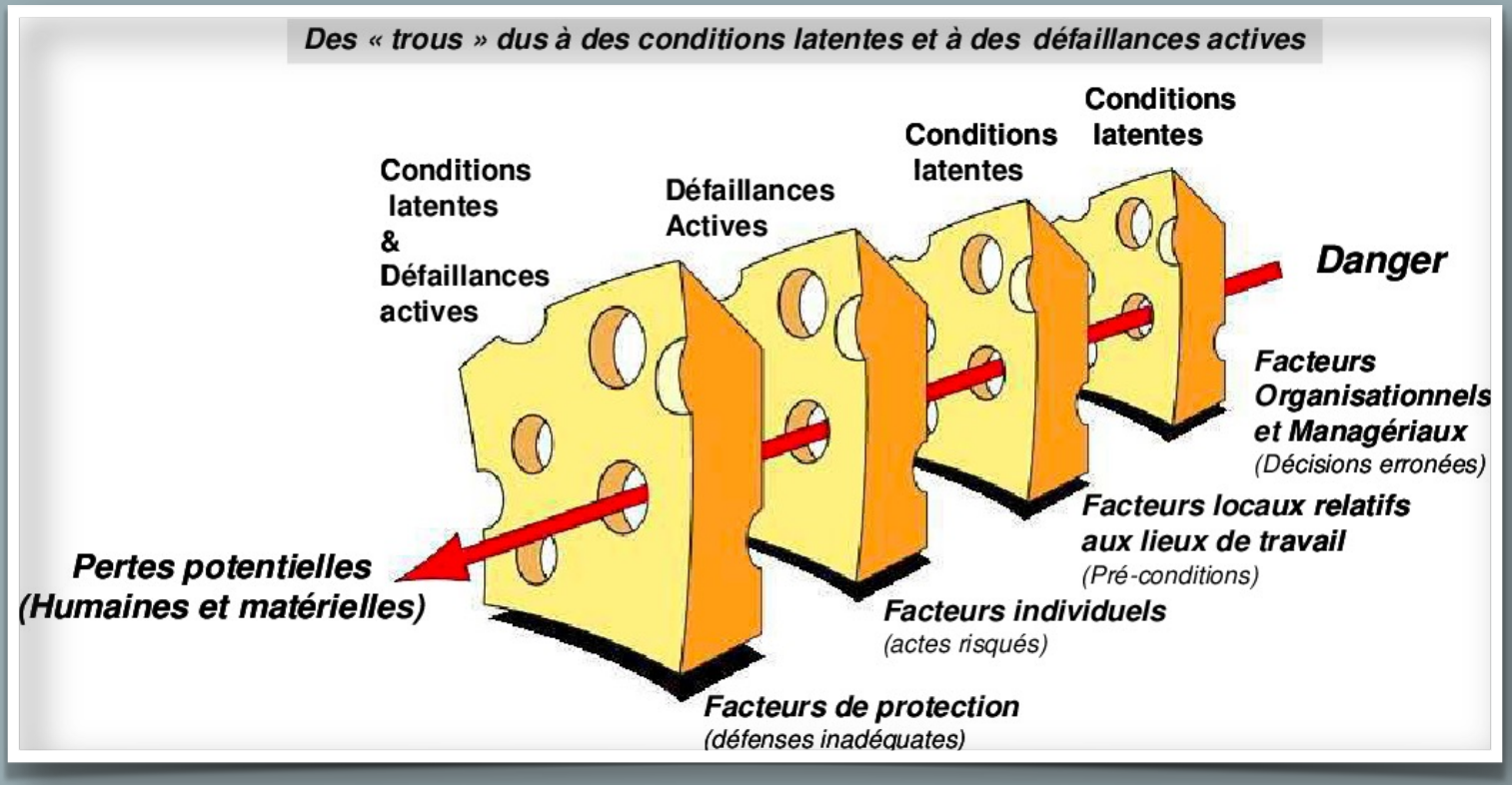
Conséquence directe
Courte durée

James REASON

Conditions latentes

- Formation inefficace
- Supervision inadéquate
- Communication suboptimale
- Logistique insuffisante
- Pénurie en personnel

James REASON



James **REASON**

3 enseignements principaux

- Absence d'erreur ≠ Absence d'accident
- Professionnel ≠ Système
- Plaque ≠ Différentes plaques (en amont+++)

James **REASON**

Les conséquences d'un évènement dépendent :

- Danger considéré
- Système exposé au danger
- Contexte

James **REASON**

Analyse de l'erreur

- ~~Qui ?~~
- Pourquoi ?
- Comment ?

Facteurs humains

Facteurs humains

Relation - Individu - Système

Environnement
Technologie

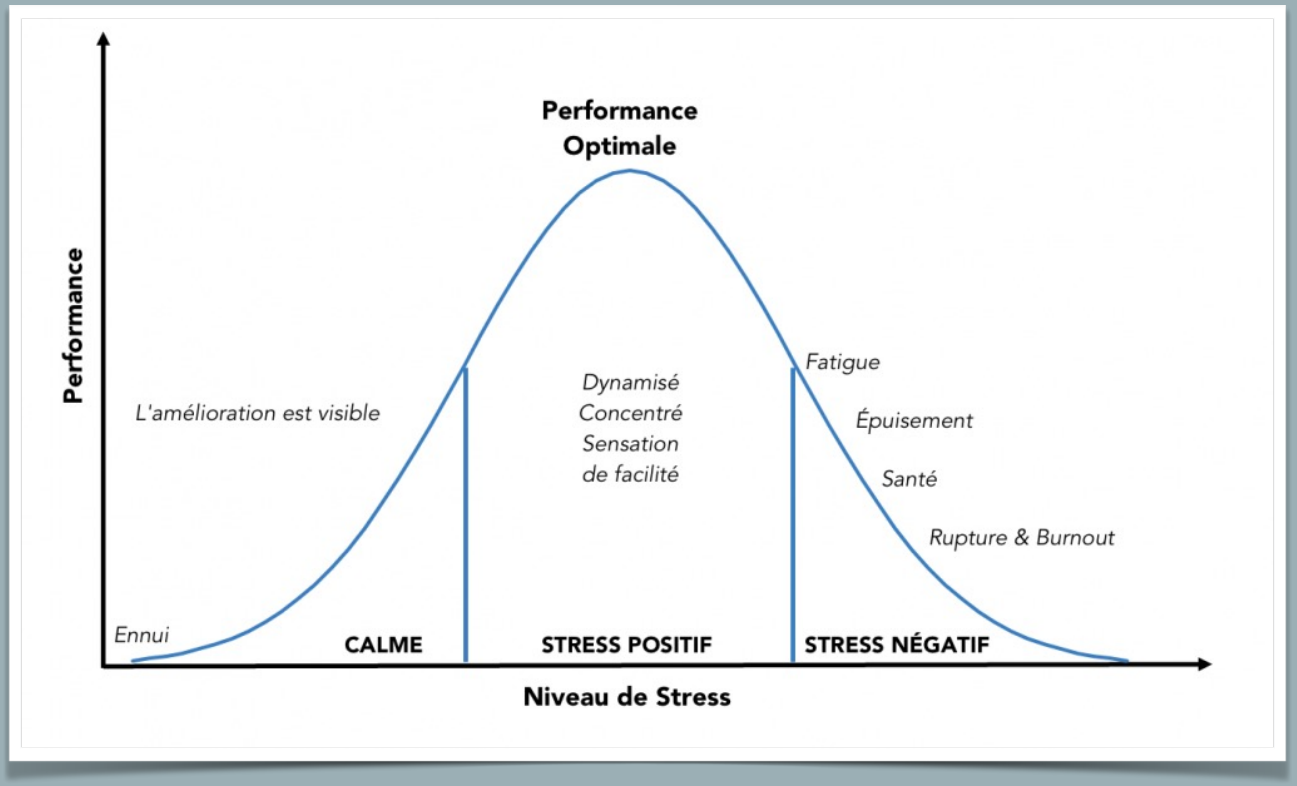
Efficacité ↑ Erreurs ↓

Facteurs humains

Classification

- Facteurs intrinsèques : état permanent +++
- Relation avec l'environnement
- Facteurs extrinsèques : état temporaire

Facteurs humains



Facteurs humains

HALT

- Hungry
- Angry
- Late
- Tired

I'M SAFE

- Illness
- Medication
- Stress
- Alcohol
- Fatigue
- Emotion

Facteurs humains

Approche systémique

vs

Approche culpabilisante

Faible taux de signalement des erreurs

Facteurs humains

Culture sécuritaire

- Cultiver le concept de l'erreur positive
- Prendre en compte des facteurs sous-jacents
- Donner de la transparence à la qualité des soins
- Ne pas enlever la responsabilité médico-légale

Place de la simulation ?