

# Erreur de coté ou d'étage

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Rémi Cavagna

# Situation

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- Le sujet peut faire sourire et pourtant :
  - aucun chirurgien n'est à l'abri de cette erreur...

# Situation

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- France :
  - Sou médical (Ch Sicot) 1993-2002
    - 49 erreurs/ 497 déclarations
      - Personne 2
      - Intervention 9
      - Coté 31
      - Étage rachis 4
      - Doigts 3

# Situation

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- France

- Exercice 2005 (sou medical, ch Sicot)
  - Erreur de coté 2 (genou)
  - Erreur d'orteil 1 (H Valgus)

# Situation

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- Symposium SFA 2001 (H Coudane, Ph Buisson)
  - 11% des chirurgiens confrontés à une erreur de coté (0,005% des arthroscopies réalisées)

# Situation

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- Les assurances sont sensibilisées à ce problème
- Prix SHAM 2005 principe de vérifications croisées et notées

# Équivalent anglo-saxon :

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- Wrong-side/wrong-site, wrong-procedure and wrong-patient adverse events.

« WSPEs »

# Situation

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- Canada W Beilby : Canadian Medical Protective Association (CMPA)
  - 01/90-12/99 : erreur de coté, erreur de patient, erreur de niveau 5%.

# Situation

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- USA : Arch Surg 2006,141:931-939

## WSPEs

- National practitioner data bank (NPDB) 1300 à 2700 cas par an aux USA

# Situation

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- Angleterre ,New Zealand, Japan ...
  - Situation identique...

# Situation

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- Position indéfendable du chirurgien responsable
- Médiatisation : France 2007, USA etc.
  - Coût pour l'assurance et coût de l'assurance pour le chirurgien

# Solutions

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- Vérifications croisées



# Causes identifiées

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- Erreur de patient
  - Homonymie
  - Brancardage
  - Surmenage, suractivité
  - Absence de curiosité ou de communication

# Causes identifiées

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- Erreur de coté
  - Absence de documents : programme...
  - Suractivité
  - Absence de repères
  - Absence de communication : patient, équipe.
  - Erreur d'examen Rx etc...
  - Absence de dossier clinique

Surmenage

# Causes identifiées

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## ■ Erreur de niveau

- Absence de vérification pré opératoire
- Anomalie anatomique (étage transitionnel)
- Absence de dossier
- Erreur de documents
- Absence de communication
- Absence de vérification per opératoire (ampli)

Surmenage

# Causes identifiées

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- Erreur d'intervention
  - Homonymie
  - Suractivité
  - Erreur dossier
  - Erreur Rx

# Solutions

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## Check list avant chirurgie



# Solutions

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## ■ Aéronautique

- Check list : vérifications croisées
- Facteurs humains : **équipe, temps de travail**
- Savoir arrêter une action avant la catastrophe...

# Solutions (Canadian Orthopaedic Association)

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## ■ Wrong Sided Surgery in Orthopaedics

The COA's position on a standardized procedure for reducing the incidence of wrong sided surgery. **Committee on Orthopaedic Practice & Economics (COPE)**

**Position Paper on Wrong Sided Surgery in Orthopaedics**  
**Prepared for the Canadian Orthopaedic Association June 1994**  
**Paul H. Wright, M.D., FRCSC**  
**Burnaby, BC**

# Solutions

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- **“OPERATE THROUGH YOUR INITIALS”**



# Solutions

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- CMPA (canada) 1993 : initiale sur le côté à opérer
- COA en 1990 11 cas; en 2000 5 cas

# Solutions

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- **Bulletin of the American College of Surgeons**  
Vol.87, No. 12, December 2002

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- If the patient is scheduled for multiple procedures that will be performed by multiple surgeons, all the items on the checklist must be verified for each procedure that is planned to be performed.
- Conduct a final verification process with members of the surgical team to confirm the correct patient, procedure, and surgical site.
- Ensure that all relevant records and imaging studies are in the operating room.
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- In the event of a life- or limb-threatening situation, not all of these steps may be followed.

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# Solutions

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- **2003 ASA abstracts**

**Wrong Sided Anesthetic and Surgical Procedures:  
Why Do They Continue To Happen?**

**Samuel C. Seiden, B.A., Coleen Kivlahan, M.D., Bill Runciman,  
M.D., Ph.D., John Gosbee, M.D., Paul Barach, M.D., M.P.H.  
Pritzker School of Medicine, University of Chicago, Chicago, Illinois.**

# Solutions

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## Factors Contributing to Laterality Errors

- **Human Factors:** High workload, fatigue, multiple team members, diffusion of authority/lack of accountability
- **Patient Factors:** Sedation or anesthesia, Patient not consulted before block
- **Procedure Factors :** Wrong side draped/prepped, No team communication or cross checking
- **Laterality Factors** Not observing marked site/not marking wrong site, not checking consent form

# The royal college of surgeons of england (Mars 2005)

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## Check 1

- Check the patient's identity
- Check reliable documentation and/or images to ascertain intended surgical site
- Mark the intended site with an arrow using an indelible pen

## Check 3

- In the anaesthetic room and prior to anaesthesia, the mark is inspected and checked against the patient's supporting documentation
- Re-check imaging studies accompany patient or are available in operating theatre or suite
- The availability of the correct implant (if applicable)

## Check 2

- Prior to leaving ward/day care area the mark is inspected and confirmed against the patient's supporting documentation
- Relevant imaging studies accompany patient or are available in operating theatre or suite

## Check 4

- The surgical, anaesthetic and theatre team involved in the intended operative procedure prior to commencement of surgery should pause for verbal briefing to confirm:
- Presence of the correct patient
  - Marking of the correct site
  - Procedure to be performed

# North american spine society (NASS) 2001

## **Sign, Mark & X-ray (SMaX)**

### ***A Checklist for Safety***

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  - o Informed consent
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- o Consider having your assistant or scrub nurse always stand opposite the side where the surgeon should stand.
- o Consider or suggest an intraoperative X-ray during surgery, after exposure using markers that do not move to confirm the vertebral level to be operated. Consider a radiology reading.

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- o Involve the patient in confirming the operative site either through informed consent or during the actual marking. Surgeons are encouraged to personally obtain informed consent. Copies of the operative permit/informed consent form should state the site and side of surgery and be shared with the patient, surgeon, anesthesiologist, assistant or scrub nurse and circulating nurse.
- o Sign your name to the operative site.
- o Each member of the operative team should verify the correct site.
- o Verify that X-rays and medical records are for the correct patient, as well as confirming the identity of the patient.
- o Each of the following items should be double-checked against the marked site:
  - o Medical record
  - o X-rays and other imaging studies (marked “L” or “R” to prevent being placed backwards on the light box)
  - o Informed consent
  - o Operating room/anesthesia record
- o **Consider having your assistant or scrub nurse always stand opposite the side where the surgeon should stand.**
- o Consider or suggest an intraoperative X-ray during surgery, after exposure using markers that do not move to confirm the vertebral level to be operated. Consider a radiology reading.

# North american spine society (NASS) 2001

## Sign, Mark & X-ray (SMaX)

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# Solutions

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- La chirurgie à l'endroit: le bon site, du bon coté
  - JL Meakings can j surg vol 46;2 April 2003, pp 87-89

# Solutions

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- Créer une Check list reproductible .
- Le chirurgien est responsable, mais peut s'appuyer sur une procédure efficace.
- S'inspirer en adaptant ce qui fonctionne déjà.
- Changer les mentalités *(ce qui n'est pas le plus simple...)*