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PATIENTENSICHERHEIT

# **Patient Safety- do it yourself!**

## **How to learn about safer healthcare**

21. September 2011

**Workshop on Good Practices in Patient Safety**  
Zagreb

**Günther Jonitz, M.D.**

President of the Berlin Chamber of Physicians  
Member of the Board of the German Medical Association  
Chairman of the German Coalition for Patient Safety

→ „The Professional Approach“

**Quality and safety is the primary concern of medicine.**



**„Value based health care“**



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**Patient care has become  
a challenging and risky issue:**

**→ Quality and safety on the agenda**

# Prepositions



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- Comprehensive competencies for health care workers

***„Patient safety can be learned as a part of professionalism“***

# Education and training for Patient Safety



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➤ Knowledge

➤ Skills

➤ **Behaviour/ attitude!!**

➔ ***“Getting to the heart of the doctors.”***

Colin Feek, MinHealthNZ, 2006

# **Human Factors**

# **System failure**

# **Inadequate Training**

Source: Marcus Rall

- 70% of causes of accidents
- Not covered enough in medical training or education
- It´s not the bad doctor
- Complex, coupled, kybernetic
- Latent errors
- „predictably unpredictable“
- Current training does not reflect the real-world problems of the ill-structured patient care reality



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# Solutions/ Organisational level



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**Knowledge about dealing with incidents  
increases**

Inefficient organisational structures and lack of proper communication instead of „individual blame“

**„WHY“ not „WHO“**

**New procedures for incident prevention are  
available**

Critical Incident Reporting and Learning  
Systems

Professional Training, Education, Certification,  
Procedures...



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**...a holistic approach is needed!**

- broad range of contents!**
- all professions!**

# CPD/ Continous Professional Development

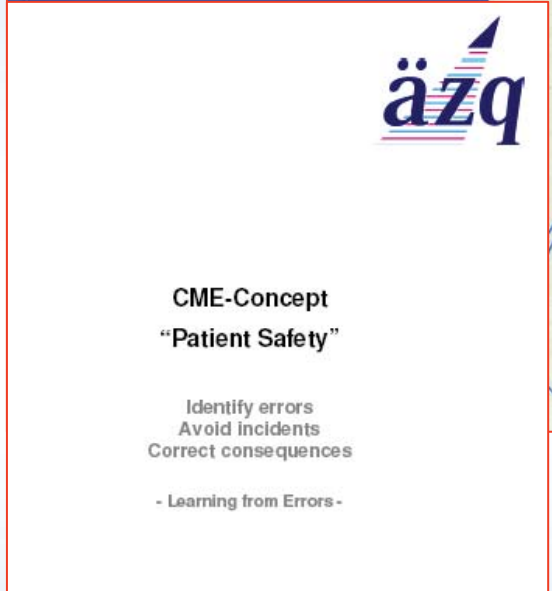


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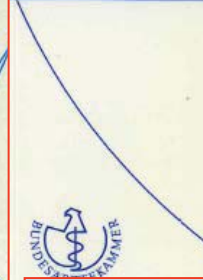


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- **Cooperation and teamwork**
- **Communication**
- **Leadership**
- **Management (of health care organisations)**
- **Knowledge-management**
- **Human Factor**
- **Empathy**
- ...



[http://www.forum-patientensicherheit.de/service/literatur/pdf/fbkonzert\\_patientensicherheit\\_english.pdf](http://www.forum-patientensicherheit.de/service/literatur/pdf/fbkonzert_patientensicherheit_english.pdf)



**German Curricula/ National level:**

- Quality Management
- Evidence Based Medicine
- Patient Safety
- Leadership
- Peer Review
- Managed Care

# Implementation/ Regional level: Examples from Berlin



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## Patientensicherheit lernen

### Intensivseminar Fallanalyse

Donnerstag 22.09.2011, 10:00 - 18:00 Uhr  
Freitag 23.09.2011, 09:00 - 18:00 Uhr  
Samstag 24.09.2011, 09:00 - 13:00 Uhr

In Kooperation mit dem  
Aktionsbündnis Patientensicherheit

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21. September 2011



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## Ärztliche Führung


nach dem Curriculum der  
Bundesärztekammer

### Ein praxisorientiertes Intensivprogramm

in vier Modulen

12. – 14. Mai 2011  
16. – 18. Juni 2011  
15. – 17. Sep. 2011  
09. Dez. 2011

Veranstalter: Ärztekammer Berlin



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## WEITERBILDUNGSKURS QUALITÄTSMANAGEMENT IM GESUNDHEITSWESEN

Ein Kursangebot mit drei  
Präsenzphasen in Berlin

21.02.-26.02.2011  
04.04.-09.04.2011  
20.06.-25.06.2011

für Ärztinnen und Ärzte  
zum Erwerb der Zusatzweiterbildung  
»Ärztliches Qualitätsmanagement«  
anerkannt

In Kooperation mit der  
Charité - Universitätsmedizin Berlin



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## Breaking Bad News

Die ärztliche Kunst,  
schlechte Nachrichten  
in der Medizin  
zu überbringen

ein Kurs der Ärztekammer Berlin  
für Ärztinnen und Ärzte  
in Klinik und Praxis

Freitag, 19. August 2011  
14.00 – 18.00 Uhr

Samstag, 20. August 2011  
10.00 – 17.00 Uhr

## One Example: Patient Safety Training



The poster features two logos at the top: 'AKTIONSBÜNDNIS PATIENTENSICHERHEIT' on the left and 'ÄRZTEKAMMER BERLIN' on the right. The main title is 'Patientensicherheit lernen' in a large, bold font. Below it, the seminar is identified as an 'Intensivseminar Fallanalyse'. A table lists the dates and times for three days: Thursday (22.09.2011, 10:00 - 18:00 Uhr), Friday (23.09.2011, 09:00 - 18:00 Uhr), and Saturday (24.09.2011, 09:00 - 13:00 Uhr). At the bottom, it states 'In Kooperation mit dem Aktionsbündnis Patientensicherheit' and provides the address 'Friedrichstraße 16 • 10969 Berlin • www.aerztekammer-berlin.de'.

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**Patientensicherheit lernen**

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Fallanalyse**

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Training course of 3,5 days duration, interactive seminar:

Case studies, lectures, group discussion, group work, group assignments

### Target group

- **All medical professions**, in particular those people concerned with accident analysis, incident analysis, incident reporting and quality assurance

### Learning outcomes

- **Ability** to analyse complex incidents on several levels; **knowledge** about human behaviour and human strengths/weaknesses (psychology of Human Factors)
- Aim: To give participants a systematic **understanding of how** incidents come about in complex organisations and how these incidents and potential damage might be analysed in order to develop preventive measures.
- Special attention is given to methods of **root cause analysis**, observation and analysis of **organisational factors** including **teamwork and communication** as well as factors conducive to a **safety culture**.

[www.german-coalition-for-patient-safety.org](http://www.german-coalition-for-patient-safety.org)

21. September 2011



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## Content: Root Cause Analysis

- Patient safety and concepts on safety
- Mistake development: models and **analysis methods**
- **Human Factors:**
  - **Team and leadership**
  - **Organisation environment and safety culture**
  - **Incident management and prevention**
  - **Conditions for incident analysis**
- Applied process analysis
- Models and methods
- **Communicating** analytic results
- **Communicating with patients and their families about incidents and analytic results**
- **Implementation** of analytic results



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21. September 2011

Dr. med. Günther Jonitz

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## Diversified teaching programs for Medical and nursing schools and Continuing professional development



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## A General Guide for Education and Training in Patient Safety



Diversified teaching programs for medical and nursing schools and continuing professional development

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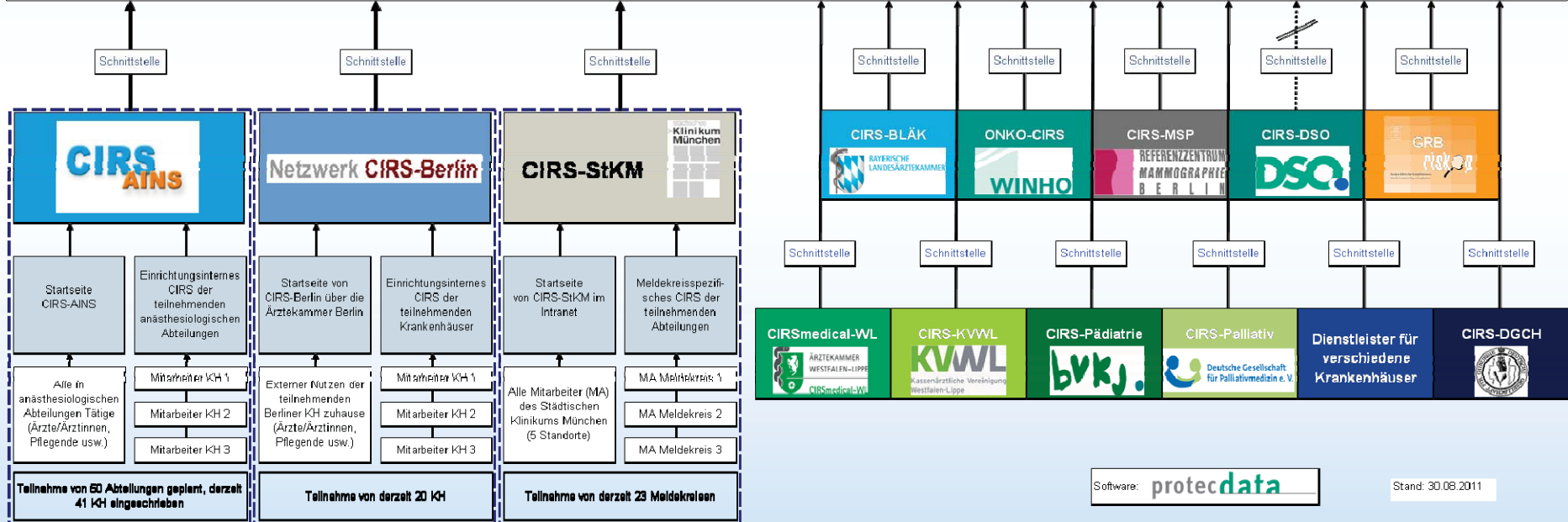
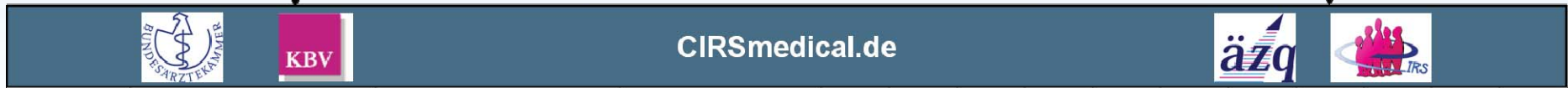
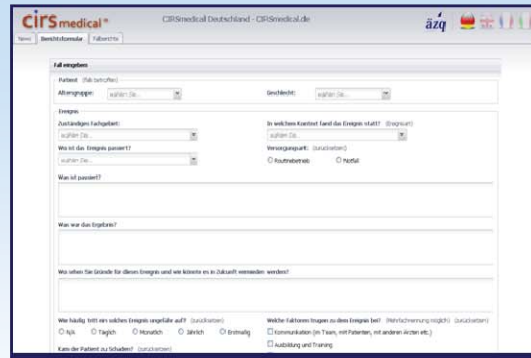


**EUNETPAS-REPORT: [www.eunetpas.eu](http://www.eunetpas.eu)**

# Netzwerk CIRSmedical.de

**Fachbeirat**  
52 Experten aus 47 Institutionen  
(Fachgesellschaften, Berufsverbände u.a. Institutionen)

Offener Zugang für alle im Gesundheitswesen tätigen Ärzte/Ärztinnen,  
Pfleger, usw.



## CIRS-NETWORK GERMANY, [www.cirsmedical.de](http://www.cirsmedical.de)

[www.cirsmedical.de](http://www.cirsmedical.de)



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## Round about 2450 reports

(in all groups, without excluding double reports)

### Report groups:

- **CIRSmedical.de**
- **CIRS-AINS/ Anaesthesiology: 60 hospitals**
- Report Network Berlin: 20 hospitals
- **Report Network Munich: 5 hospitals**
- Other report groups: 11 hospitals
- 9 further groups for different health care institutions



German Coalition of Patient Safety

→ Working Group „Education and Training“



present activity:

Draft version of a „**Curriculum Patient Safety**“

→ all health care professions

→ practical orientation!

...work in progress...

# Simulation Training to enhance patient safety



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## „Video-assisted Debriefing“



The Heart and  
Soul of Sim-  
Training

Debriefing can  
„make or break“  
the sim session

<http://www.tupass.de/>

**Marcus Rall**


**TüPASS**

**Centre for Patient Safety and  
Simulation Tübingen**

**since 10 years**

**Department of Anaesthesiology  
and Intensive Care Medicine  
University of Tübingen, Germany**






Home

Registration

Contact

supported by  
European Society of Anaesthesiology 

Last Update: 28th July 2009

## EUROPEAN PATIENT SAFETY COURSE 2011

*«The Helsinki Declaration on Patient Safety in Anaesthesiology<sup>1</sup> was a landmark publication and consensus in Europe. The EPSC covers all topics of the Declaration and gives examples of the state-of-the-art in patient safety.. »*

In connection with Euroanaesthesia 2011, an extracurricular course will be offered by the ESA and its Subcommittee Patient Safety in collaboration with the international faculty.  
Learn about how errors evolve in medicine, what the root-causes are and how patient safety can be improved on a systematic level!

The one-day post graduate European Patient Safety Course provides you with a very intensive insight into the general topics of patient safety as endorsed by the ESA and EBA (UEMS) in the Helsinki Declaration on Patient Safety in Anaesthesiology<sup>1</sup>. International experts will give you an overview of why things go wrong, what works in practice to reduce errors and enhances the safety culture to make patient care safer.

The course is intended for all physicians and nurses in anaesthesiology and intensive care medicine as an overview and perhaps as a primer to start working systematically on patient safety and to start achieving the goals of the Helsinki Declaration on Patient Safety in Anaesthesiology [1]. The course also gives you the unique opportunity to exchange and network with colleagues from all over Europe.

We look forward to welcoming you at our course!

Initiated by: Marcus Rall (EPSC Course Director)  
Planned by: ESA Subcommittee 17 Patient Safety  
Sven Staender (Chairman), Marcus Rall, François Clergue, Doris Østergaard, Tanja Manser, Ravi Mahajan, Filippo Bressan, Maurice Lamy, Sven Eric Gisvold, Lazlo Vimlati, Andrew Smith and Peter Dieckmann.

# „Aviation meets Medicine“



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## Airport Hannover

Picture:

**Dr. sc. mil. Goepfert,  
Dr. med. Rall**

## Steps:

- **Briefing**
- **Checklist**
- **Feedback**
- **Debriefing**

## Key factors



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# Safety and Learning Culture:

Reflective practice at  
the system and at the individual level

- „Learning“ system
- Responsibility
- Cooperation
- Value based leadership



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No more management by  
„mechanisation“  
but  
„humanisation“ !!

*„Patient safety is not about constructing a machine, but growing  
a garden!“*

*Günther Jonitz*

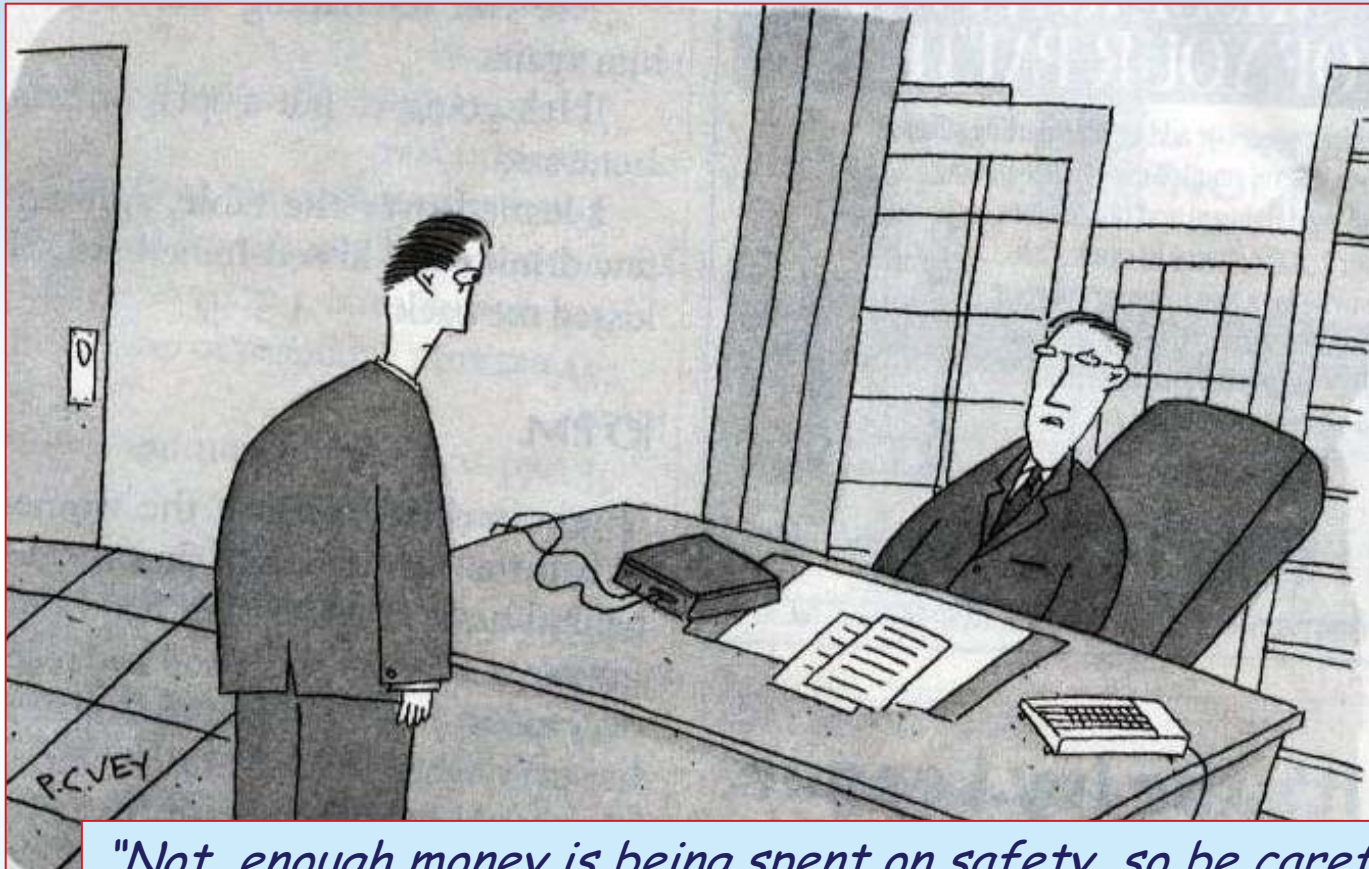


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**Quality Assurance  
and  
Patient Safety  
is the re-discovery  
of primary medical virtues  
on systematic ground.**



*"Not enough money is being spent on safety, so be careful."*



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**THANK YOU!**

21. September 2011

**[g.jonitz@aekb.de](mailto:g.jonitz@aekb.de)**