Patient Safety
-
Building a Safer Healthcare System

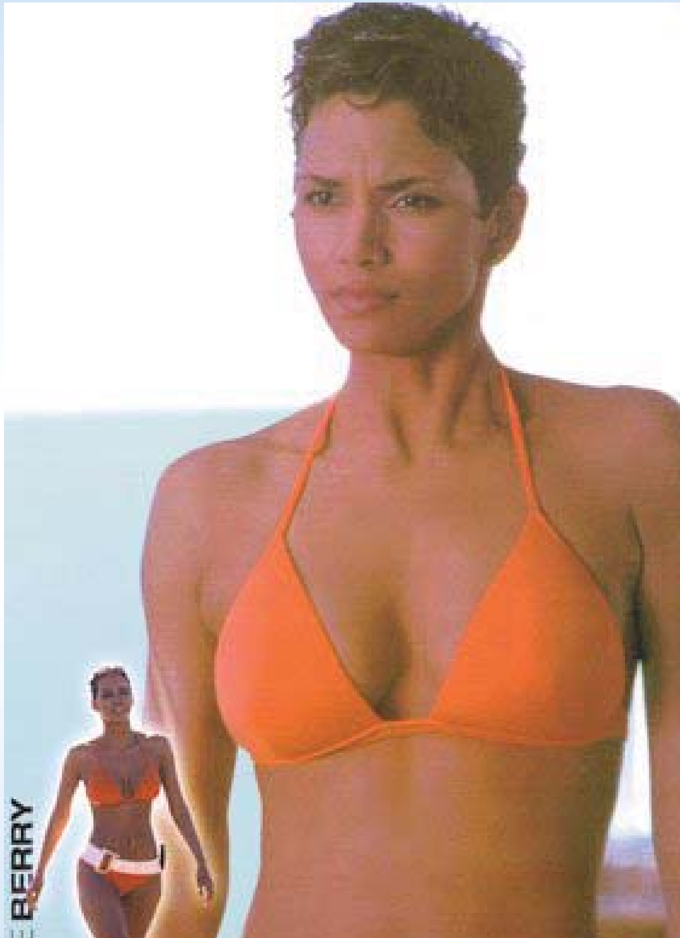
20. September 2011
Workshop on Good Practices in Patient Safety
Zagreb

Günther Jonitz, M.D.
President of the Berlin Chamber of Physicians
Member of the Board of the German Medical Association
Founding Member and former Chairman of the German Coalition for Patient Safety

Need for action

- **Medicine** Successful and complex
- **Patients** Multimorbid and demanding

„there is a problem…“



Diabetes mellitus Typ I

Cor pulmonale NYHA III

- **Medicine is a story of <u>success</u>!**

e. g.

HIV,

Diabetes,

Anaesthesia,

Pediatric oncology,

Minimally invasive surgery

Accident and emergency medicine

Obstetrics

„High Risk“ Groups **(elderly, multimorbid, infants…)**

…

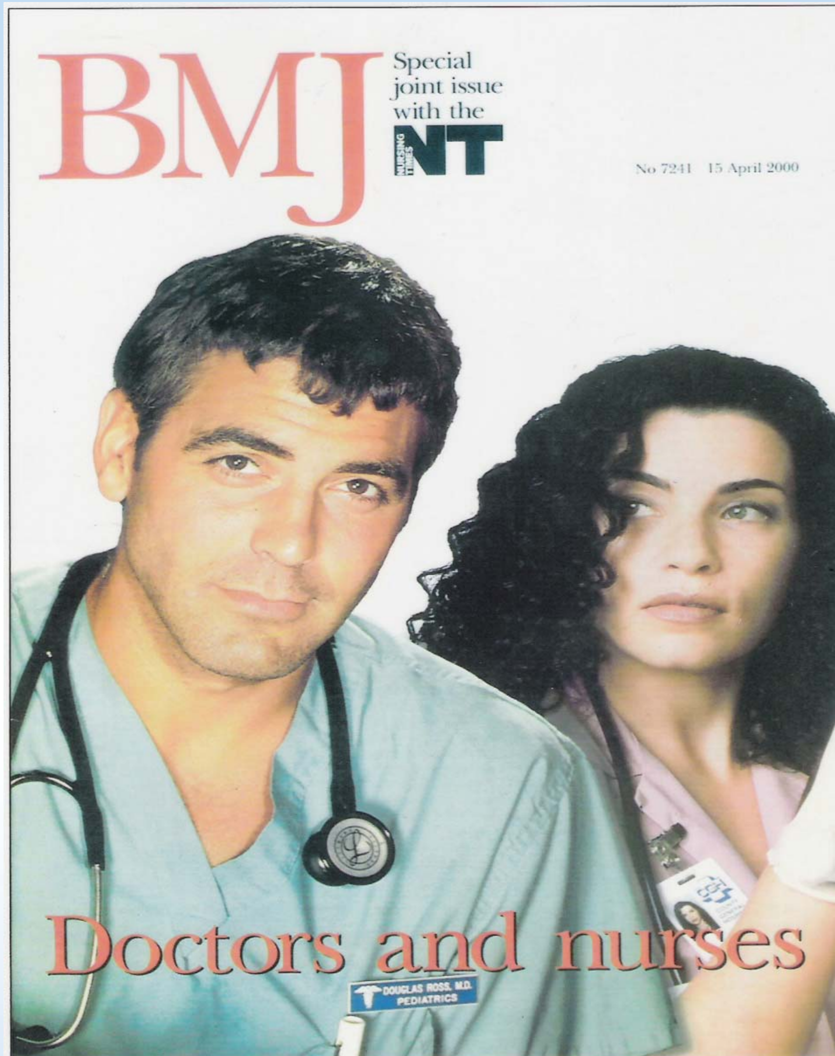
Need for action

Society Decreased funding and trust

bad working conditions

Lack of staff „Why are doctors so unhappy?“

BMJ May 2001



„overworked doctors are becoming a risk for patients"

No change:

➢ Principles of organisation!

- „assembly-line“
- no common responsibility
- competing interests
- „buck-stop-principle“
- no real leadership
- „just try harder“

„Why are doctors so unhappy?" Richard Smith, BMJ May 5th 2001

Positive change needs…

…orientation, goals, leadership and support!

This change **does not need:**

regulation, administration and control.

Re-engineering of Health Care Systems will strongly follow the key dimensions of QUALITY and PATIENT SAFETY!

Aims

Action for Patient Safety leads to

- Better confidence in health care
- Higher quality
- Less harm, pain and grief
- Lower costs

„win-win-win-situation“

AIMS- II

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- Better cooperation based on common sense and trust

- Evidence based health care
- Understanding of a better organization
- End of „passing the buck“
- More job satisfaction

What is needed: Transparency and Trust

- **No more taboos – speak out!**
- **No dramatizing or scandalizing**
- **No more abuse of Patient Safety**
- **Promote joint action**
- **Multidisciplinary approach**

Leadership !

- Trust concerning individuals and organisations!
- Think positive!

  First thinking about the good news/ about what can be done
- Value and solution orientation!
- Take action on Top Level

Promote acceptance

Patient Safety is as old as medicine itself

➔ ***„Don't panic!"***

It is not just a problem, it is a <u>chance</u> and invitation to take action

➔ ***„Good news!"***

80% of all harms are due to bad organization

➔ ***„Be honest but don't feel guilty!"***

Various institutions and people are there to help you acting on Patient Safety

➔ ***„You are not alone!"***

Key messages:

There is a problem! ***Be honest!***

There are solutions! ***Be positive!***

It‘s our common agenda! ***Be professional!***

Solutions/ Options of action

Better knowledge about errors in medicine

System failure, problems with communication rather than failure of individuals

➔ Asking *„Why"* instead of *„Who"* is to blame

„To know how"!

Tools and Instruments

- Critical Incident Reporting Systems,
- Root cause analyses
- A wide spread of learning activities (CPD, Simulation Training, „non-technical" skills)
- Management know how, tools und techniques (Quality Management, Risk Management, importance of role models and leadership in medical work etc.)

„You can do something"!

Political support

German Medical Association (BÄK), Federal Association of Registered Physicians (KBV), Working Group of Medical Societies (AWMF), Statutory Health Insurance (GKV), German Association of Hospitals (DKG), Patient Representatives, Nurses, German Coalition for Patient Safety (GCPS), Federal Ministry of Health (BMG), WHO, EU

„friends"

Germany - What did we do?

We did not start with frightening statistics.

We started with the everyday experience of everyone who is engaged in patient care.

(Ask anyone about his experiences and he/she will tell you enough stories to start to take action.)

Any action according to Patient Safety has to keep all human beings in mind, patients and professionals!

Meetings of Top Experts and Representatives of different institutions in Health care

What did we do?

2002 „Berliner Gesundheitspreis“
for Innovations in Health Care
(BCP and AOK, Statutory Health Insurance Company)

Public agenda

2004 Scientific Congress on Patient Safety
(Society for Quality Management in Health Care GQMG) ***Scientific agenda***

2004 Workshop of AOK (insurance) and BCP

➔ **Stepwise forward procedure, including people and organisations**

➔ *„No Big Bang“, no „King of Patient Safety“*

Network !!

2005:
„Year of Patient Safety in Germany“

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Foundation of GCPS

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Congress of the German Society of Surgeons

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Patientensicherheit: 108. Deutscher Ärztetag

108. DEUTSCHER ÄRZTETAG

TOP VII: Ärztliches Fehlermanagement/Patientensicherheit

Offenheit und Transparenz

Die Delegierten des 108. Deutschen Ärztetages haben sich für die Entwicklung von Fehlervermeidungsstrategien ausgesprochen.

Prof. Dr. M. Schrappe

108. German Medical Assembly
(Parliament of Doctors in Germany)

Unanimous vote for Patient Safety Resolution

2005-
Statement of the German Medical Assembly

- Action for patient safety is based on trust.
- A holistic approach which focuses on the improvement of the organization of health care
- Apart from the system appraoch, the individual responsibility of the health care professionals is untouched.
- Prevent scandalization.
- Support the building of a network organization

The German Coalition for Patient Safety

GCPS

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http://www.german-coalition-for-patient-safety.org/

Start of the German Network: GCPS (2004-5)

➔ Building a **network organisation**

Five meetings in preparation for the German Coalition for Patient Safety

Including - from the beginning – <u>all relevant players</u> of the German health care system

Actual number of members : 354

Individuals and Institutions:

Health Professional Organizations, Health Care Institutions (e.g. hospitals), Patients Organizations, Health Insurance Companies, Scientific Organizations,…

➔Working Groups are open for everyone,

not only for members!

Participation!!!

GCPS= Umbrella!

AKTIONSBÜNDNIS PATIENTENSICHERHEIT

- Common Sense,
- Common Aims,
- Common Responsibility
- Top Down – Bottom Up
- Network Organization
- Open Workshops and Working groups

GCPS-Characteristics

- Based on **voluntary**, honorary engagement and enthusiasm of members, activists and their organizations
- The persons and parties involved are of full **integrity**, recognized and competent
- **Credibility** based on indepence
- Bundling of **Know how**
- **Multidisciplinary** networking
- Based on **experience** „from practice for better practice"
- **Providing: trust, knowledge, tools, cooperations**

Leadership!

Support from the ministry of Health from the beginning on

„Patient Safety sometimes gets abused. Mrs Minister, you have never done that!“

Prof. Hoppe, President German Medical Association, 111. German Medical Assembly 2008

DO SOMETHING USEFUL!!

GCPS: Recommendations

- **WG Registry for Medical Errors**
- **WG Critical Incident Reporting Systems** (work completed)
- **WG Wrong Site Surgery** (work completed)
- **WG Patient Identification**
- **WG Forgotten Foreign Bodies after Surgery**
- **WG Patients for Patient Safety** (information-advice-decision)
- **WG Medical Devices**
- **WG Drug Safety**
- **WG Education and Training**
- **WG Communication after Adverse Event** (“Reden ist Gold”)
- **WG Patient Safety and Senior Citizens**
- …

Recommendations – one example:
Wrong site surgery

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Empfehlungen zur Prävention von Eingriffsverwechslungen

1 Identifikation Patient

wer?
- Operateur, aufklärender Arzt, voll informierter Arzt

wann?
- Aufklärungsgespräch vor oder nach Aufnahme

was?
- **Richtiger Patient**
  - Namen und Geburtsdatum sagen lassen und prüfen
- **Eingriffsart**
  - im Gespräch mit dem Patienten bestätigen
- **Eingriffsort**
  - aktiv fragen und zeigen lassen
  - Angehörige einbeziehen (vor allem bei Kindern und nicht urteilsfähigen Patienten)
- **Abgleich mit Akten und Bildern**

⚠ Jede Unstimmigkeit sofort klären

2 Markierung Eingriffsort

wer?
- Operateur, aufklärender Arzt, voll informierter Arzt

wann?
- außerhalb des OPs
- bei wachem Patienten

was?
- **Abgleich mit Akten**
  - richtiger Patient
  - Eingriffsart
  - Eingriffsort
- **Patienten aktiv einbeziehen**
  - Eingriffsort zeigen lassen
  - Angehörige einbeziehen
- **Markierung**
  - nur Eingriffsort
  - eindeutige Zeichen (Kreuz, Pfeil, Initialen)
  - nicht abwischbarer Stift
  - mehrere Eingriffsorte: alle markieren

⚠ Jede Unstimmigkeit sofort klären

3 Zuweisung zum richtigen OP-Saal

wer?
- definierte, verantwortliche Person

wann?
- unmittelbar vor Anästhesieeinleitung **und** vor Eintritt in den Saal

was?
- **Patientenidentität**
  - Namen und Geburtsdatum prüfen
- **Eingriffsart**
  - prüfen und bestätigen
- **Eingriffsort**
  - prüfen und bestätigen
- **Markierung prüfen**
  - mit Aktenabgleich
  - wenn möglich aktive Befragung des Patienten
- **Saalcheck**
  - Zuweisung zum OP-Saal überprüfen

STOP Ohne Markierung keine Anästhesie

4 Team-Time-Out vor Schnitt

1. ☑
2. ☑
3. ☐

wer?
- OP-Team
- initiiert durch definierte, verantwortliche Person

wann?
- unmittelbar vor Schnitt

was?
- **Letztes Innehalten – letzte Richtigkeitsprüfung**
- **Mittels Minicheckliste**
  - richtiger Patient (Namen und Geburtsdatum)
  - Eingriffsart
  - Eingriffsort
  - Aufnahmen bildgebender Verfahren
  - Richtige Implantate verfügbar
- **Alle Punkte durch OK bestätigen**
- **Durchführung des Team-Time-Out dokumentieren**

STOP Bei Unstimmigkeiten kein Schnitt

AKTIONSBÜNDNIS PATIENTENSICHERHEIT · DEUTSCHE KRANKENHAUS GESELLSCHAFT DKG · AOK

Cooperation with the

- **German Society of Surgeons** and
- **German Hospital Association** (~2300 Hospitals)

WG „Forgotten Foreign Bodies"

"As a consultant of orthopedic and accident surgery for many decades I do not tend to become nervous easily, but after talking for 4 hours with representatives from the Emergency Association of Adverse Event Victims, I became very thoughtful indeed."

Prof. Dr. Siebert, M.D.

General Secretary of the German Society for Trauma Surgery and Orthopaedics

Member of the GCPS-Board

11th March 2009

Safety culture: Going Public

Booklet 2008
„Learning from errors“
My mistake!

Cooperation with AOK, Health Insurance Company

Personal Reports from
17 doctors, nurses, therapists

- Analyses of causes of errors
- Personal lessons to learn
- Add on: Infomation about reporting and learning systems

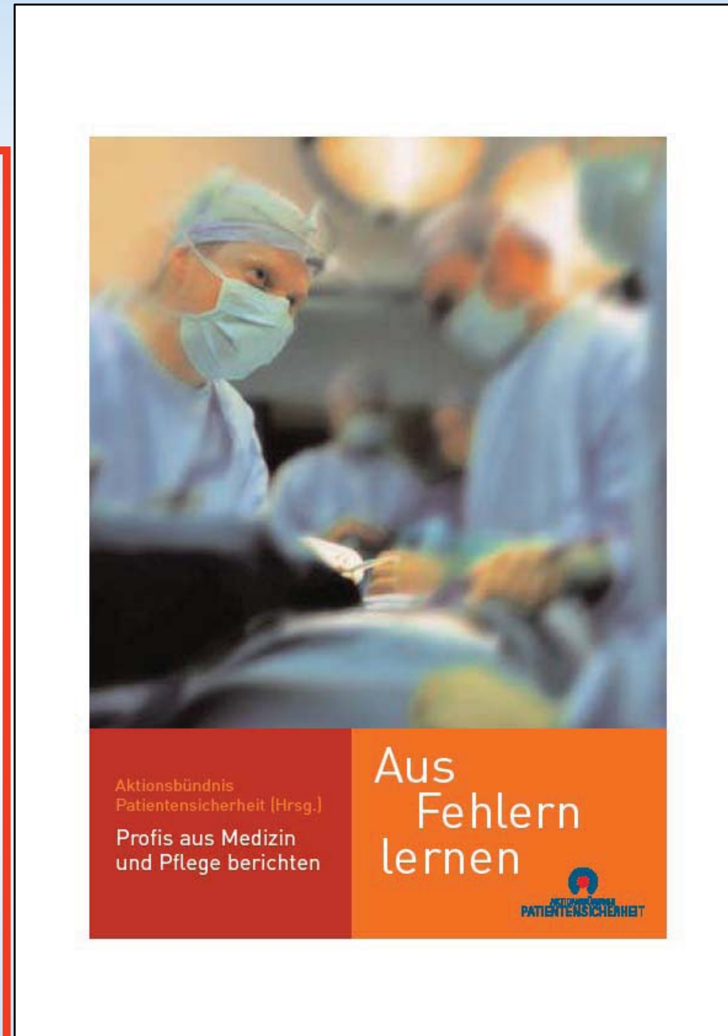
Be honest! Be courageous!

Going Public

"In a safety culture,
the telling of stories is viewed as having greater importance than mere data collection,

because it is in the story where the knowledge and the emotion lies,
not in the numbers."

University of Michigan Hospitals and Health Centers 2002



Ärzte-Fehler

Klemme vergessen
Prof. Matthias Rothmund (65), Marburg

Keine Hilfe gerufen
Prof. Christel Bienstein (56), Witten/Herdecke

Harnleiter verletzt
Prof. Joachim Dudenhausen (64), Berlin

Knie verwechselt
Prof. Bertil Bouillon (50), Witten/Herdecke

Falsches Antibiotikum
Dr. Günther Jonitz (49), Berlin

Lunge angestochen
Dr. Marita Eisenma[-]-Klein (60), Rege[n]sburg

Donnerstag, 28. Februar 2008 50/9 0,50 €

Bild

Erstmals sprechen Mediziner über ihr Versagen!

Sie sind die mutigsten Ärzte Deutschlands: Erstmals geste- [...]en Mediziner in einer Broschüre eigene Behandlungsfehler ein. Mit der Aktion wollen sie für mehr Qualität in deutschen Kliniken sorgen. Ihre Geständnisse – S. 3

FOTOS: ULLSTEIN, ALT..., ...EL GUYONNET, LAIF, DPA, FRANK SENFTLEBEN, VISUM

„These are the most courageous doctors in Germany".

BILD 28. 2. 2008

Safety Culture on Top Level

Engagement of GCPS – international Level

High 5s

Joint Commission on Accreditation of Healthcare Organizations (JCAHCO) und Joint Commission International (JCI) (WHO Collaborating Centre on Patient Safety)
Operating Agency in Germany:
www.aqumed.de

EUNeTPaS 2008-2010

Operating Agency in Germany:
➔ Berlin Chamber of Physicians

Up to 2012? EU: Joint Action?

www.eunetpas.eu

Council of the European Union

Council recommendation on patient safety
5 June 2009

Representatives of the German Medical Profession

Implementation of Patient Safety in Germany

Council Recommendation on Patient Safety

Council of the European Union Council recommendation on patient safety (Brussels, 5 June 2009)	Representatives of the German Medical Profession Implementation of Patient Safety in Germany
1. Support the establishment and development of national policies and programmes on patient safety by	
a) Designating the competent authority or authorities or any other competent body or bodies responsible for patient safety on their territory	▸ The competent authorities are the State Chambers of Physicians (SCPs) and Associations of Statutory Health Insurance Physicians (ASHIPs) ▸ which support the German Coalition for Patient Safety (GCPS)
b) Embedding patient safety as a priority issue in health policies and programmes at national as well as at regional and local levels	▸ 2002: National Action Plan for Patient Safety and Error Prevention, managed by the Agency for Quality in Medicine (AQUMED), a join institution of the German Medical Association (GMA) and National Association of Statutory Health Insurance Physicians (NAS ▸ 2004: The GMA and NASHIP support the establishment of a network providing a central base for enhanced patient safety ▸ 2005: 108 th German Medical Assembly: Initiatives of members of the medical profession to promote patient safety, including network establishment ▸ 2005: Establishment of the network hosted by the German Coalition for Patient Safety (GCPS)
c) Supporting the development of safer and user-friendly systems, proc tools, including the use of information and communication technolo	

2. Empower and inform citizens and patients by:	
a) Involving patient organisations and representatives in the development of policies and programmes on patient safety at all appropriate levels	▸ Patient representatives in relevant organisations of the German Medical Profession (Patient Forum of the GMA, Management staff u Patient Guidance of NASHIP, AQUMED and GCPS, etc.)
b) Disseminating information to patients on	▸ Patient portals: www.forum-patientensicherheit.de, www.patienten-information.de (with patient guidelines), and patient information
▸ patient safety standards which are in place ▸ risk, safety measures which are in place to reduce or prevent errors and harm, including best practices, and the right to informed consent to treatment, to facilitate patient choice and decision-making	▸ Measures prescribed by employment law (provision of patient information on procedures and alternatives)
▸ complaints procedures and available remedies and redress and the terms and conditions applicable	▸ Expert commissions and arbitration boards of the State Chambers of Physicians ▸ Patient information centres of the State Chambers of Physicians and Associations of Statutory Health Insurance Physicians ▸ Advisory services of health insurance companies
c) Considering the possibilities of development of core competencies in patient safety namely, the core knowledge, attitudes and skills required to achieve safer care, for patients.	▸ Patient guidelines ▸ Structured treatment programmes (including patient trainings)
3. Support the establishment or strengthen blame-free reporting and learning systems on	
a) Provide information on the extent, types and causes of errors, adverse events and near misses	▸ Medical Error Reporting System (MERS): System for documentation of alleged medical treatment errors by the expert commissions and arbitration boards of the State Chamb Physicians ▸ www.cirsmedical.de: Reporting and learning system for critical incidents and errors in medicine within the German Medical Profession (national and regio networks / projects)

Success factors in Germany

- ✓ **Leadership !** (not duties and bureaucracy)
- **Bad issue but „good news"!!**
- **Taking action!**
- **Participation, honesty, appreciation, support, friendliness, cooperation, confidence**
- **Free access and share ware** of know how and products/ materials (recommendations, scientific results, reports, informations…)
- **Involve leading stakeholders**

Strategy?!

Humanistic

versus

Mechanistic

thinking!

Participation/

Self determination

versus

Regulation

(➔ „ I want you to do…“!)

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

GJ

Thank you!
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