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Risk Management in Practice

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German Coalition for Patient Safety

Founded on 11 April 2005, the coalition's headquarters are located in Marburg. It can be contacted at the following address:

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Membership at the end of January 2006 stood at 95 (institutions and individuals).

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This year's annual conference will be held in Bonn on 5 November 2006.

Since its publication in 1999, the report, "To Err Is Human" (Kohn 1999), the issue of patient safety - freedom from accidental injury – has risen to prominence both internationally and in Germany's health system. The 108th German Conference of Physicians held in May 2005 analysed the topic just a month after the German Coalition for Patient Safety was founded. This new body includes representatives of all health service stakeholders.

The frequency with which medical errors occur is a key issue in Germany. It is important, however, to differentiate between adverse events, medical errors and harm. An adverse event, defined in Kohn 1999 as an "injury resulting from a medical intervention", is the most common of the three categories. Although they affect between 5% and 10% of all hospital patients, medical error is the cause in only one third of cases, according to Baker (2004). Adverse events caused by error are defined as harm and affect between 2% and 4% of all hospital patients. On the basis of international data, it is possible to extrapolate that 0.1% of patients will die as a result of error (Ebbesen 2001, Lazarou 1998).

Understanding Errors is Indispensable to Prevention

The German Coalition for Patient Safety's overriding aim is to promote efforts to make practical improvements in patient safety based on an understanding of how errors occur and emphasising the value of communications, team and systemic factors and individual responsibility. Medical errors should not be taboo. On the contrary, as an intrinsic part of medicine they must be subjected to thorough analysis to prevent their recurrence. To this end, hospitals can avail of such tools as critical incident reporting systems, CIRS, an approach already widely employed in the aviation industry. The purpose of CIRS, which operates on a strictly confidential basis, is to utilise knowledge about errorprone situations – so-called near misses – and actual critical incidents to develop preventative measures. Feedback on the results of the CIRS should be provided immediately. Special techniques - root cause analysis and human factor analysis – must be introduced to analyse high-risk processes. These techniques identify organisational, team and systemic weaknesses and produce options for making improvements. Other management instruments, for instance complaint management and patient satisfaction surveys (including freetext reporting systems) may be introduced in conjunction with CIRS. Positive experiences with quality management projects facilitate the introduction of risk management,which should be integrated within the quality management system to avoid duplication of structures.

Introducing Risk Management in Hospitals: A Non-Punitive Approach

A medium-term timeframe is recommended for the introduction of risk management. The first step is to develop an implementation project which might include informing patients. Such an approach will help eliminate barriers to tackling issues with possible legal implications. The second phase involves introducing CIRS pilot projects which are co-ordinated by a risk management steering group. Hospital management must be seen not only to support the process but also to guarantee the implementation of any solutions to emerge and undertake notto impose sanctions on staff who report adverse events in the CIRS. This is known as the non-punitive approach. Further confidence building measures include the appointment of an ombudsman who would maintain confidentiality in all dealings with management.

Patient safety and risk management are the most practical expressions of differentiation in quality management: while all safety problems have quality repercussions, not all quality problems are pertinent to safety. It is imperative that risk management is introduced in Germany, if the country is to prevent the emergence of a malpractice crisis characterised by mounting compensation payments and premiums and poor insurability. The coalition for patient safety isdrafting recommendations on a series of practical problems, including wrong site surgery (Rothmund 2006), patient identification and medication errors. It is also developing standards for CIRS in hospitals and is in the process of establishing a training centre which will provide members of the healthcare community with opportunities to participate in training programmes on error analysis, human factor analysis and prevention strategies.

Recommendations on Preventing Wrong Site Surgery

It is a long road from recording near misses, medical errors and critical incidents in a CIRS to analysing cases of injury and harm to preventing errors and injury. One of the key prevention measures is to develop internal guidelines and care pathways which improve not only the medical care aspects of treatment but also its organisational implementation (Hansis 2001). A further, still underrated, approach is the development of sophisticated personnel development policies, which aim, as part of the hospital's human resource management, to provide continuing education for employees and a strong orientation towards the hospital's fundamental principles.

Disclosure of information on errors and complications remains a contentious issue. On the one hand, organisations fear that by placing this type of information in the public domain, they will undermine their competitiveness and economic development, while, on the other, they tend to emphasise the positive as they try to strengthen their public image and improve communications with the outside world. It is difficult to resolve the debate on the value of disclosure with any degree of authority using available empirical and scientific evidence (Marshall 2000). Despite this, there is no doubt that well-planned crisis management is crucial when critical incidents take place. External communications must be well co-ordinated and open and the public must not be given the impression that the hospital has shifted to defensive mode or is seeking to bury information. Internal competences must be clarified and the formation of crisis teams must be considered the norm.

References:

For references please contact: deutsch@hospital.be

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