



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

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

**Parallel session 4:
Promoting a learning culture of more patient safety and
better quality of care**

Ministerial conference
9.-10. September 2010
Brussels

→ Patient Safety

is a very unpleasant issue

But

→ Everybody knows about it



Patient Safety is

„good news“

→ You can take action!

SOLUTIONS!



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Solution 1:

You can learn „Patient Safety“

80% of all adverse events happen due to

- bad communication
- bad organisation

Patient Safety Competencies



Knowledge

- **Safety culture**
(= Patient centred health care, **system approach**, communication, teamwork and professional self conception)
- **Epidemiology/ Identification and measurement** of problem fields
(health care associated infections, medication errors, wrong site surgery,...)
- **Root Cause analyses** of adverse events and near misses
(e.g. differentiation of errors, adverse events, violations, system failures, near misses...)
- **Management** and coping with adverse events and near misses
- **Prevention** of errors, adverse events and near misses
- ➔ e.g. Human Factor Research, knowledge about high reliability organizations...



Patient Safety Competencies

Skills

→ How to apply the adequate methods and instruments for the

➤ **Identification/ detection**

➤ **management and**

➤ **prevention**

of unintended harm for patients, near misses and adverse events

→ e.g. how to implement CIRS, root cause analysis, analysis of medical records, Patient Safety Indicators, communication (“breaking bad news”) etc. ...



Attitude

Be honest: There is a problem

Be positive: There are solutions!

Be traditional: „PRIMUM NIL NOCERE“

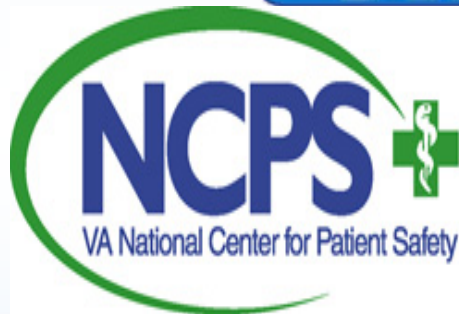
**Stay professional: It is your agenda and
credibility**



„You are not alone!“



Welcome to
National Patient Safety Foundation®



National Patient Safety Agency

www.npsa.nhs.uk



One stop for knowledge and
innovation for safer healthcare

www.saferhealthcare.org.uk

Dr. Günther Jonitz, 10.09.10

CPD - Example from Germany



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Bundesärztekammer

Texte und Materialien zur Fort- und Weiterbildung

**Fortbildungskonzept
„Patientensicherheit“**

Fehlerquellen erkennen
Unerwünschte Ereignisse vermeiden
Folgen korrigieren
-aus Fehlern lernen-

Herausgeber:
Bundesärztekammer
Kassenärztliche Bundesvereinigung
Ärztliches Zentrum für Qualität in der Medizin und
Expertenkreis Patientensicherheit

äzq

CME-Concept
“Patient Safety”

Identify errors
Avoid incidents
Correct consequences

- Learning from Errors

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Patientensicherheit Lernen

**Intensivseminar
Fallanalyse**

Donnerstag 17.12.2009 10.00 - 18.00 Uhr
Freitag 18.12.2009 09.00 - 18.00 Uhr
Samstag 19.12.2009 09.00 - 13.00 Uhr

*In Kooperation mit dem
Aktionsbündnis Patientensicherheit*

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Breaking Bad News

**Die ärztliche Kunst,
schlechte Nachrichten
in der Medizin
gut zu überbringen**

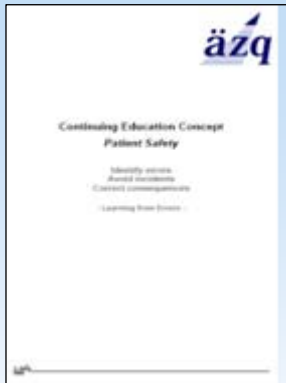
ein Kurs der Ärztekammer Berlin
für Ärztinnen und Ärzte
in Klinik und Praxis

**Freitag, 26. November 2010
14.00 – 18.00 Uhr**

**Samstag, 27. November 2010
10.00 – 17.00 Uhr**

**Training Course:
How can „my“ hospital learn
from mistakes?**

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Objectives of the CME–Concept



→ Increase patient safety through education and training



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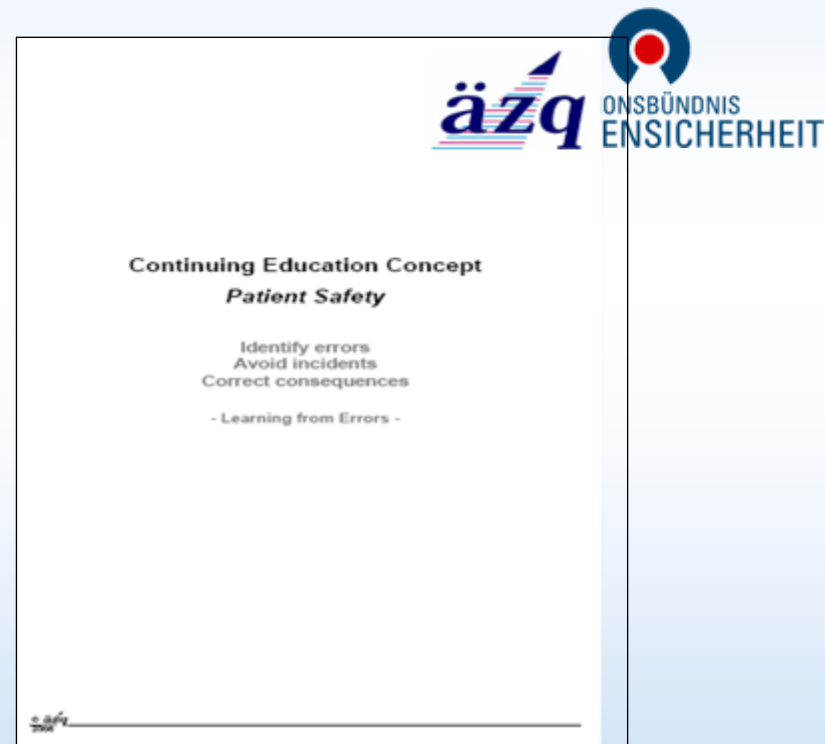
→ Encourage the development of safety culture and the awareness of potential adverse events and errors in medicine

→ Increase confidence when dealing with the subject of patient safety

Didactics



- Emphasis on experienced based learning
- Case studies
- Practical exercises
- Share of experience



<p style="text-align: center;"><u>I</u></p> <p style="text-align: center;"><u>Basic Knowledge</u></p>	<p style="text-align: center;"><u>II</u></p> <p style="text-align: center;"><u>Basic Skills Qualification</u></p>	<p style="text-align: center;"><u>III</u></p> <p style="text-align: center;"><u>Additional Qualifications</u></p>
<p style="text-align: center;">Fundamentals</p>	<p style="text-align: center;">Fundamentals</p>	
<p style="text-align: center;">Error research/ Psychology of Safety</p>	<p style="text-align: center;">Error research/ Psychology of Safety</p>	<p style="text-align: center;">Error research/ Psychology of Safety</p>
<p style="text-align: center;">Communication/ Team</p>	<p style="text-align: center;">Communication/ Team</p>	<p style="text-align: center;">Communication/ Team</p>
	<p style="text-align: center;">Instruments/ Implementation/ Training</p>	<p style="text-align: center;">Instruments/ Implementation/ Training</p>



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Module

Fundamentals (I, II)



Introduction and overview

- The topic patient safety and its importance for health care
- Available data, types and frequency of errors
- Case studies
- Patient safety initiatives
- Legal aspects

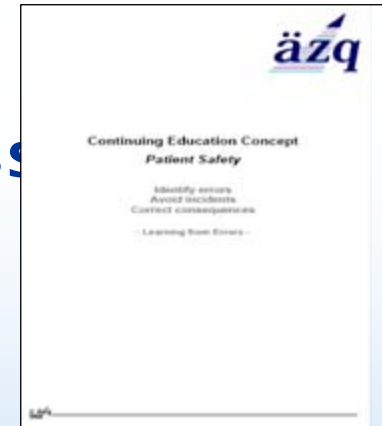


Module

Error Research/ Psychology of Safety (I, II, III)



- Theoretical approaches
- Psychology of Safety
(emotion, motivation, dealing with stress, awareness...)
- Safety in organizations
- Safety Culture, barriers and overcoming them



Module

Communication/ Team (I, II, III)

- Fundamentals of communication theory
- Function, standards and problems
- Team processes
- Decision making in teams
- Communication with patients and public about patient safety



Module

Instruments / Implementation / Training (II, III)



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- Incident reporting
- Instruments of error analysis
- Instruments for error avoidance
- **Simulator training**
- Human factor engineering
- Learning from errors
- Patients complaints



Pilot's Training for Doctors,
Hannover Airport
Dr.sc.mil. Goepfert, Dr. med. Rall

äzq

Continuing Education Concept
Patient Safety

Identify errors
Avoid incidents
Correct consequences

Learning from Errors

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First Examples of activities „education and training for patient safety“

Country	number of questionnaires/ examples
Austria	2
Denmark	3
Ireland	2
Romania	2
Cyprus	1
Spain	10
Germany	17

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

A General Guide
for Education and Training
in Patient Safety



Report 1: A general guide

Aim:

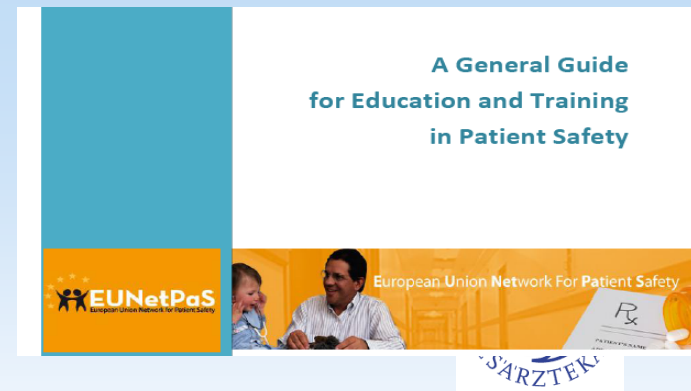
General Framework which suggests basic

- areas
- principles
- competencies

which addresses to all EU-Member States/ different Health Care Systems.

Patient Safety Competence:

Knowledge, skills and attitudes/ Behaviours concerning



- **Learning:**
Engagement in learning from errors and near misses
- **Change:**
Promoting innovation, identification of opportunities for change and improvement
- **Improvement:**
Applying improvement principles and utilising tools and techniques of systems improvement
- **Self reflection and personal development:**
 - Engagement in individual personal development
 - Recognises organisational and individual roles and responsibilities for patient safety



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

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

EUNetPaS/ Report 2: 4 Examples of diversified teaching programmes

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

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National courses, Spain	

EIT

 **EUNetPaS**
European Union Network for Patient Safety



<http://eunetpas.eu/>

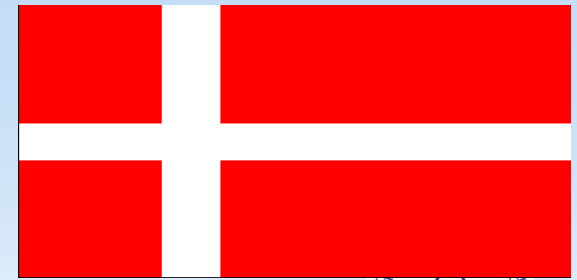


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Example from Denmark



What/ content?

- Module 1: Learning the Root Cause Analysis-method
- Modul 2: Field work – conducting a RCA on own hand ‘at home’.
- Module 3: Exchanging experiences of how to conduct RCA’s, legal aspects and the system perspective.



How?

- Lectures, workshops, field work; the three master classes ran over six months in 2004 and 2005
- Full education in three modules (7½ days in all plus 40 hours of field work) with focus on patient safety and risk management at hospital level.

Example from Germany

Human Factors Training, Dr. Hofinger



How?

- Training course of 3,5 days duration, interactive seminar: Case studies, lectures, group discussion, group work, group assignments



For whom/ target group?

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



What/ 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

Dr. Günther Jonitz, 10.09.10

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



One example from SPAIN



What/ content?

- Risk Management and Patient Safety Improvement Tool

How?

- Short courses (3 months), e-learning/ online-course, 120 hours (9.3 credits)

For whom/ target group?

- MD, nurses, pharmacists, managers and other health professionals

What/ learning outcomes ?

- The professionals use the tools in the management of the adverse events.
- Around 100 projects were designed by the students related with problems in different settings (intensive care units, emergency room, surgery unit, primary care and others). A free data base is designed in order to include all the projects, performed in the courses, as examples for other professionals.

<http://www.seguridaddelpaciente.es/formacion/tutoriales/MS-C3/cd3.htm>

Dr. Günther Jonitz, 10.09.10



Chance of EU



Strategic leadership!

- Promote engagement for Patient Safety!
- Support national and local initiatives!
- Promote knowledge, experience and trainings
- Respect the variety of health care systems in Europe



Patient Safety promotes the
change from
authoritarian Systems
to
„learning“ Systems
based on
primary virtues.





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

...thank you!

Dr. Günther Jonitz, 10.09.10

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