Einführung

Behandlungsfehler vermeiden - Was gehört auf die Agenda?

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Leiter Stabsstelle Patientensicherheit

11. Mai 2016, Berlin

MDS MEDIZINISCHER DIENST DES SPITZENVERBANDES BUND DER KRANKENKASSEN

… ohne Sicherheitskultur

… mit Sicherheitskultur

Gesundheitsberichterstattung des Bundes

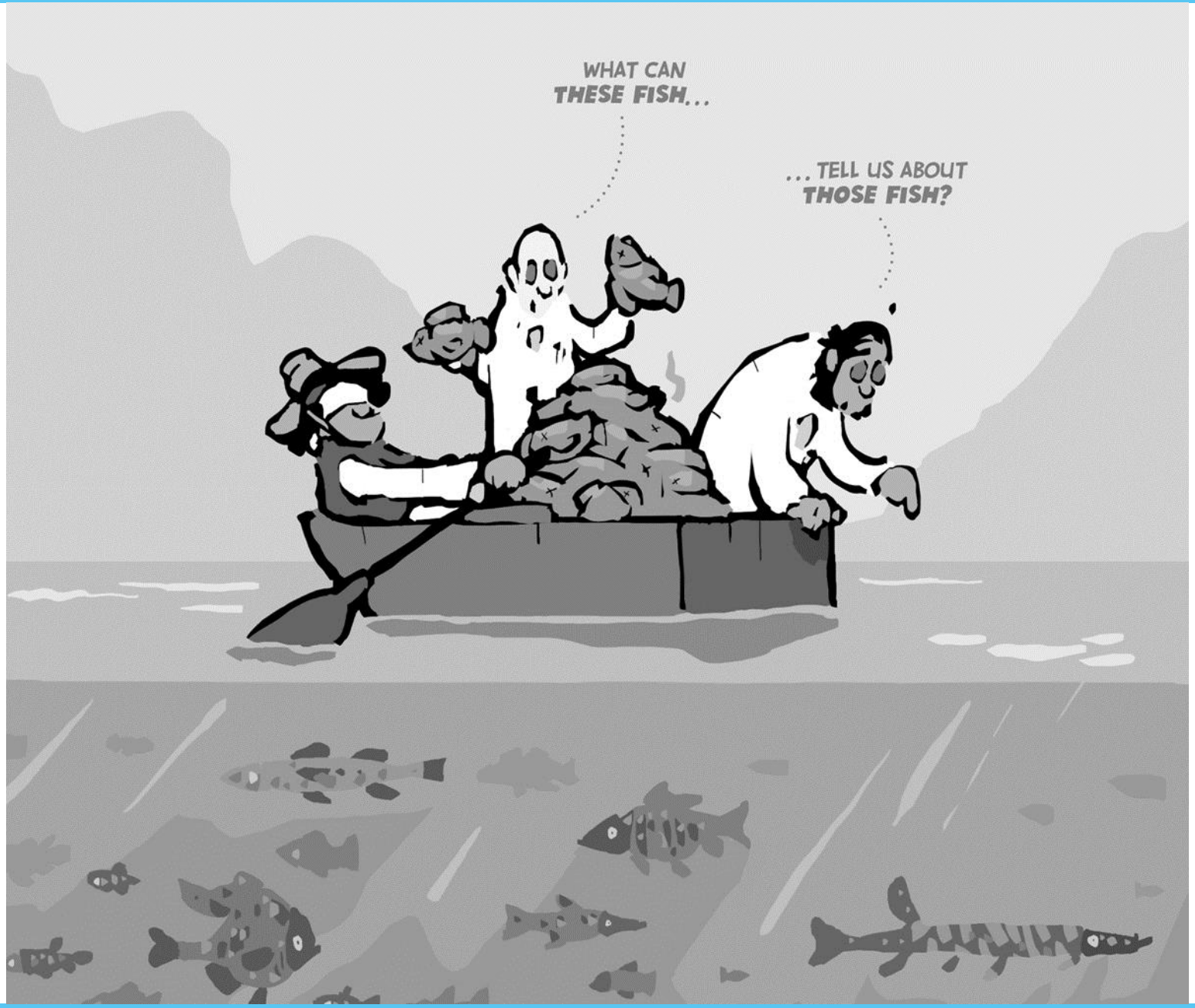
Kapitel 4.3.5: Transparenz und Patientensicherheit [Gesundheit in Deutschland, 2006]

*„**Bisher fehlen zuverlässige Zahlen zur Häufigkeit von Behandlungsfehlern**. Behandlungsfehler, Versorgungsfehler und Organisationsmängel sind in den vergangenen Jahren international zunehmend ins Zentrum des Interesses gerückt. **Allerdings fehlt in Deutschland eine einheitliche und zusammenfassende Darstellung** der Zahl vermuteter oder tatsächlich nachgewiesener medizinischer Behandlungsfehler. Die Zahlen der Haftpflichtfälle der Versicherungen oder der von den Gutachterkommissionen und Schlichtungsstellen der Landesärztekammern behandelten Vorwürfe besitzen eine große Dunkelziffer.“*

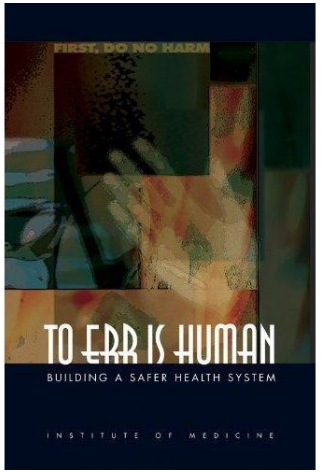
Und 10 Jahre später …?

Der vielzitierte Eisberg

* Nachzulesen bei:
Matthias Schrappe. Qualität 2030.
Download verfügbar unter
www.gesundheitsstadt-berlin.de


WHAT CAN
THESE FISH...
...TELL US ABOUT
THOSE FISH?

IOM-Report „To err is human“



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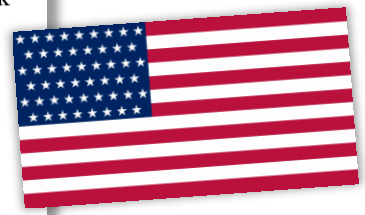
„A nationwide mandatory reporting system should be established that provides for the collection of standardized information by state governments about adverse events that result in death or serious harm.“

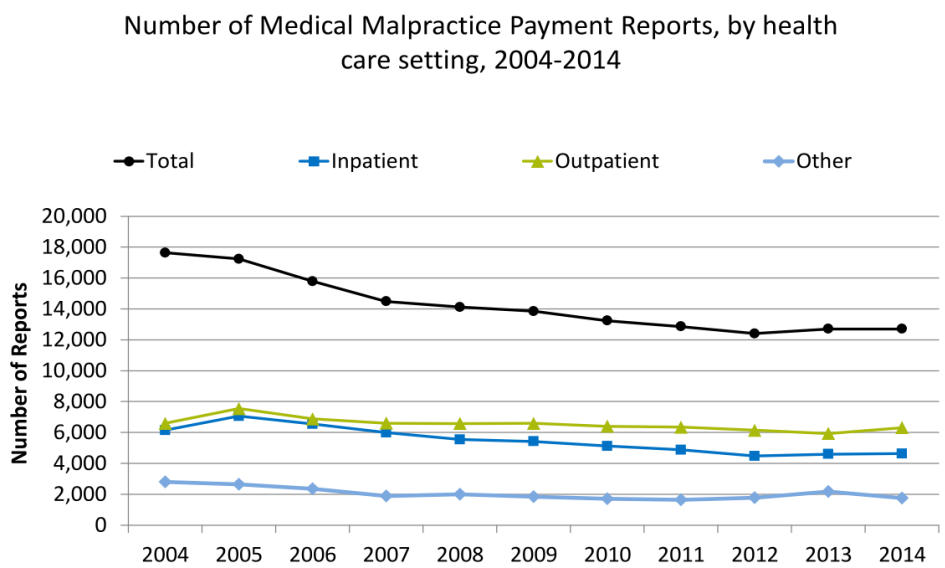
Erfassung fehlerbedingter Schäden international ...

National Practitioner Data Bank

- Medical malpractice actions are one way to flag potential medical errors.
- Medical Malpractice Payment Reports are submitted to the National Practitioner Data Bank by medical malpractice payers:
  - Report of a monetary exchange made for the benefit of a physician, dentist, or other health care provider
  - Result of a settlement or judgment of a written complaint or claim based on that provider's delivery of or failure to deliver health care services



Number of Medical Malpractice Payment Reports, by Setting



Source: National Practitioner Data Bank (NPDB) Public Use Data File, Health Resources and Services Administration, Bureau of Health Professions, Division of Practitioner Data Banks, 2004-2014.
Note: Health care setting was not collected by the NPDB for 2,104 reports in 2004. "Other" includes Medical Malpractice Payment Reports related to unknown settings as well as those for a combination of inpatient and outpatient settings. Reports pertain to patients of any age.

NHS England

Provisional publication of Never Events reported as occurring between 1 and 31 March 2016

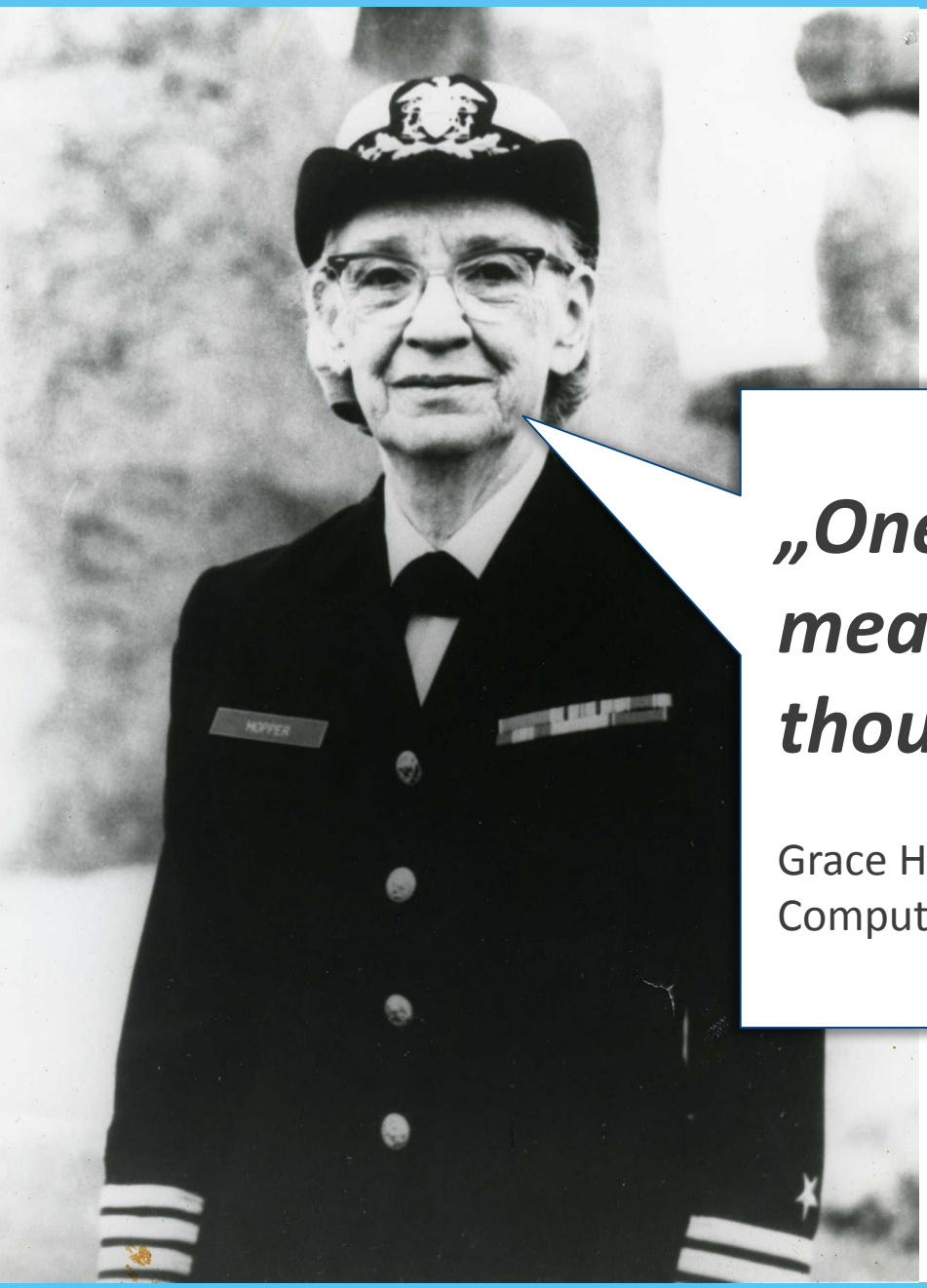
Please note: as of 1 April 2016 Patient Safety is now part of NHS Improvement. All future Never Events data publications will therefore be published on the NHS Improvement website.

TABLE ONE: Never Events 1 to 31 March 2016 by type of incident with additional detail

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Type *and brief description* **of Never Event**	**Number**
Wrong site surgery	**16**
PICC line inserted that was intended for another patient	1
Wrong area of kidney biopsied	1
Wrong area of thyroid biopsied	1
Wrong incision for harvest of bone graft	1
Wrong procedure - Gastroscopy rather than Colonoscopy	1
Wrong side block	7
Wrong side chest drain	1
Wrong side nephrostomy and stent	1
Wrong tooth/ teeth removed	2
Retained foreign object post procedure	**9**
Guide wire - CVC line	1
Guide wire - urethral catheter	1
Part of a guide wire - ACL guide wire	1
Part of surgical instrument	1
Protective corneal shield	1
Surgical instrument - hip guide	1
Throat pack	2
Vaginal swab	1
Wrong implant/ prosthesis	**4**
Hip prosthesis	3
Lens	1
Misplaced naso or oro gastric tube	**4**
NG tube in respiratory tract	4
Transfusion or transplantation of ABO incompatible blood components or organs	**2**
Incorrect unit of platelets transfused	1
Wrong blood transfused	1
Failure to install functional collapsible shower or curtain rails	**1**
Anti ligature blinds failed to collapse	1
Total	**36**

Note As described above, two reported serious incidents were duplicate entries, 4 reported serious incidents occurred before March 2016 (see table 3) and one was still in draft form and has not been confirmed as a Never Event

Der Eisberg liegt im Nebel



„One accurate measurement is worth a thousand expert opinions.“

Grace Hopper, Pionierin der Computerwissenschaften und Navy-Admiralin

Patientensicherheit – der Weg ist das Ziel

Auf die Agenda?

Mehr Transparenz über Anzahl, Art und zeitliche Entwicklung anerkannter Behandlungsfehler

Vielen Dank!

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