Parallel-Session 2: Mehr Patientensicherheit, nachhaltig. Am Beispiel des Implementierungsprogramms progress! Sichere Chirurgie.

Nationales Symposium für Qualitätsmanagement im Gesundheitswesen

Simulationstrainings und Debriefing: Einen Methode zur Förderung der Nachhaltigkeit

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Überblick

Eine Methode zur Förderung der Nachhaltigkeit

- **Simulationstraining – Debriefing**
- **Warum Simulation - Ziele der Simulation?**
- **Erfahrungen und Nutzen – Wirkt das?**

Warum Simulation – woher sie kommt?

- Militär
  - Römer
  - 21. Jahrhundert





- Skills Training
  - ohne Eigengefährdung
  - Auto, Schiffe, Eisenbahn, Luftfahrt







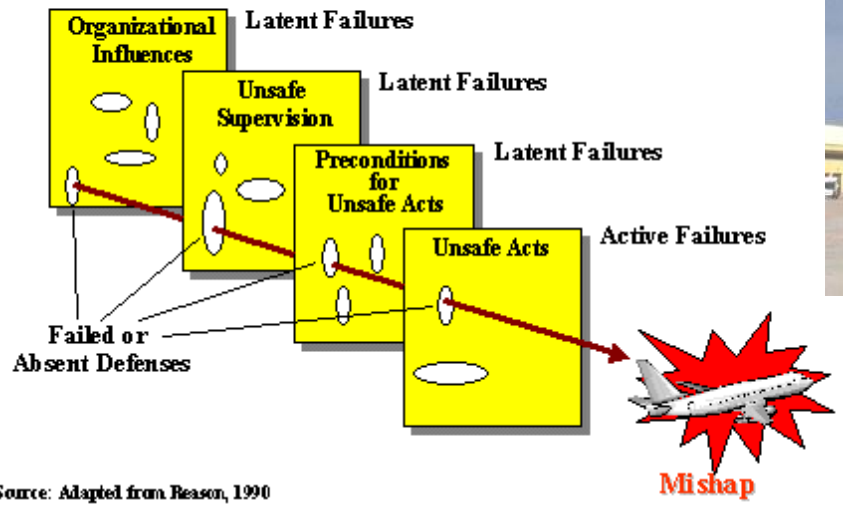
Human Error







The Reason Model and Accident Causal Chain



Source: Adapted from Reason, 1990

Human Error in Medicine



BMJ 2016;353:i2139 doi: 10.1136/bmj.i2139 (Published 3 May 2016)

ANALYSIS

Building
LT Kohn,
Institute o
National A
Washingt

Medical error—the third leading cause of death in the US

Medical error is not included on death certificates or in rankings of cause of death. **Martin Makary** and **Michael Daniel** assess its contribution to mortality and call for better reporting

Martin A Makary *professor*, Michael Daniel *research fellow*

Department of Surgery, Johns Hopkins University School of Medicine, Baltimore, MD 21287, USA

Human Error in Medicine

How big is the problem?

Table 1| Studies on US death rates from medical error since the 1999 IOM report and point estimate from pooled results

Study	Dates covered	Source of information	Patient admissions	Adverse event rate (%)	Lethal adverse event rate (%)	% of events deemed preventable	No of deaths due to preventable adverse event	% of admissions with a preventable lethal adverse event	Extrapolation to 2013 US admissions†
Health Grades[11]	2000-02	Medicare patients	37 000 000	3.1	0.7*	NR	389 576	0.71	251 454
Office of Inspector General[12]	2008	Medicare patients	838	13.5	1.4	44	12	0.62	219 579
Classen et al[13]	2004	3 tertiary care hospitals	795	33.2	1.1	100	9	1.13	400 201
Landrigan et al[14]	2002-07	10 hospitals in North Carolina	2341	18.1	0.6	63	14	0.38	134 581
Point estimate from all data	2000-08	—	—	—	—	—	—	0.71	251 454‡

NR=Not reported.

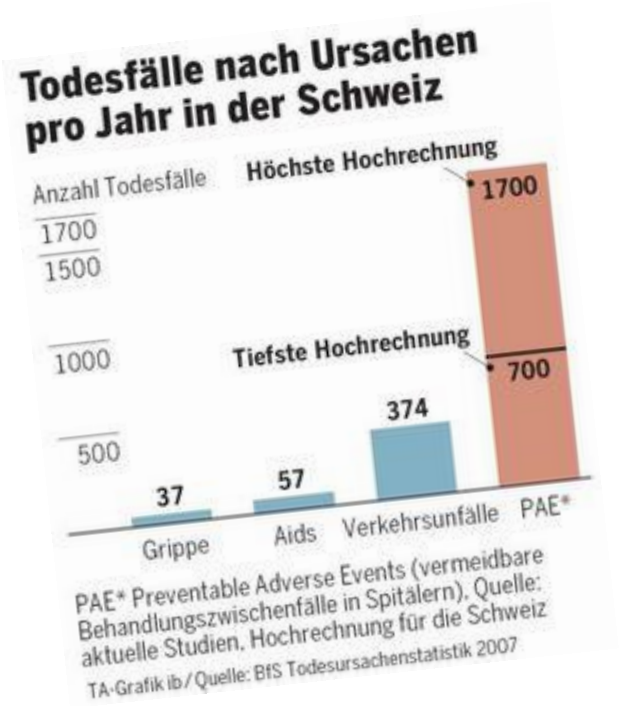
*All were considered preventable.

†Total number of US hospital admissions in 2013 was 35 416 020.[10]

‡Total number of people who died from a preventable lethal adverse event calculated as a point estimate of the death rate among hospitalized patients reported in the literature extrapolated to the reported number of patients hospitalized in 2013.

BMJ 2016;353:i2139 doi: 10.1136/bmj.i2139 (Published 3 May 2016)

Critical Incidence - Der Bund 26.11. 2010









Bis zu 1700 Kunstfehler pro Jahr in Schweizer Spitälern

- Jeder 20. Spitalpatient wird Opfer eines relevanten Fehlers.
- Die Spitäler schaffen es nicht, diese Fehlerquote zu senken.

Individual & System Errors

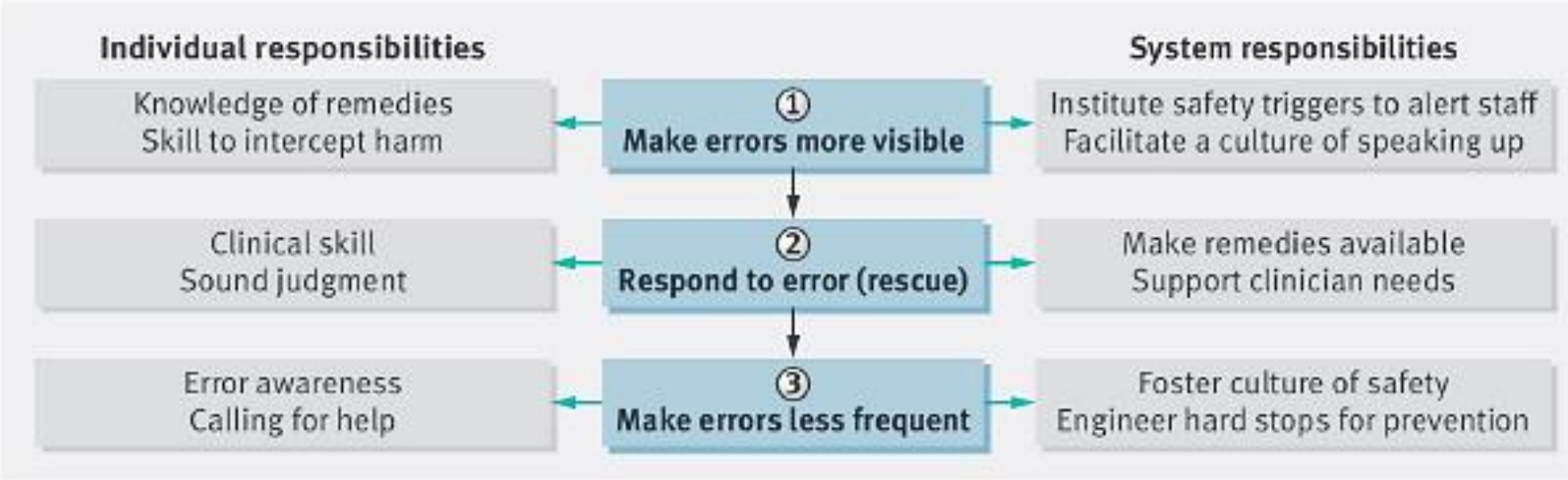
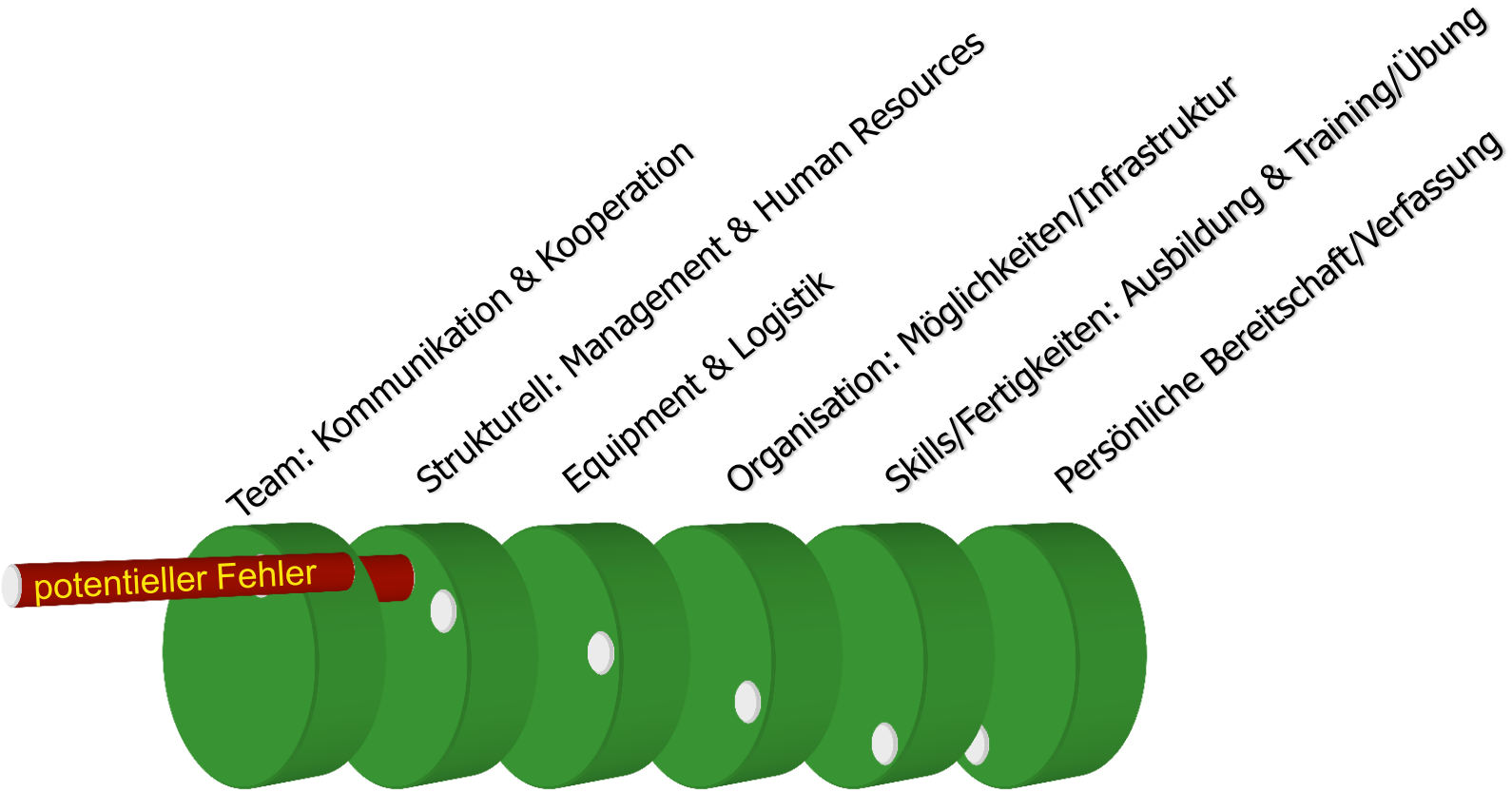


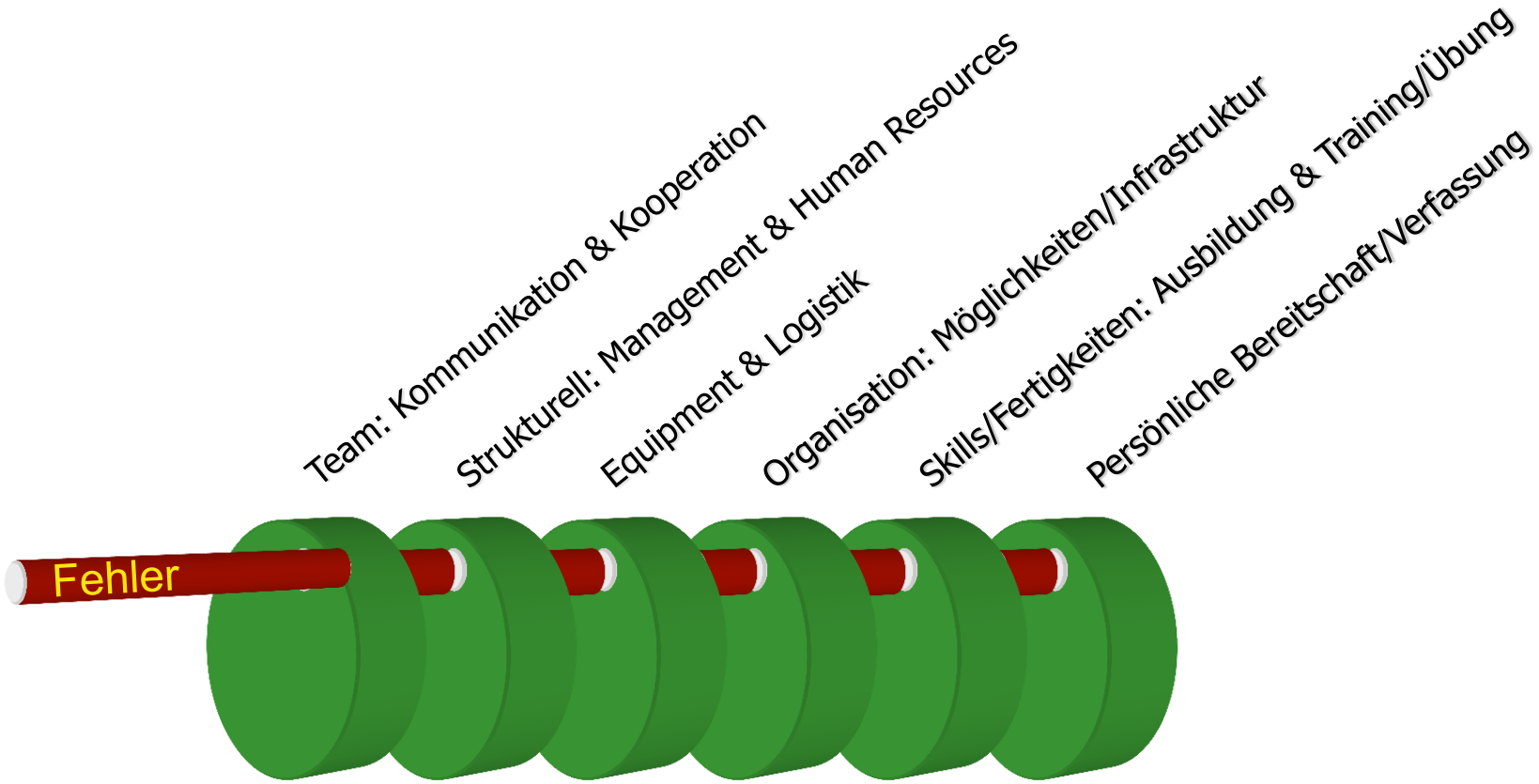
Fig 2 Model for reducing patient harm from individual and system errors in healthcare

BMJ 2016;353:i2139 doi: 10.1136/bmj.i2139 (Published 3 May 2016)

Einflussfaktoren im Alltag



Mechanismen von Critical Incidents



Nachhaltiges Lernen (21. Jahrhundert) = Teamerfolg

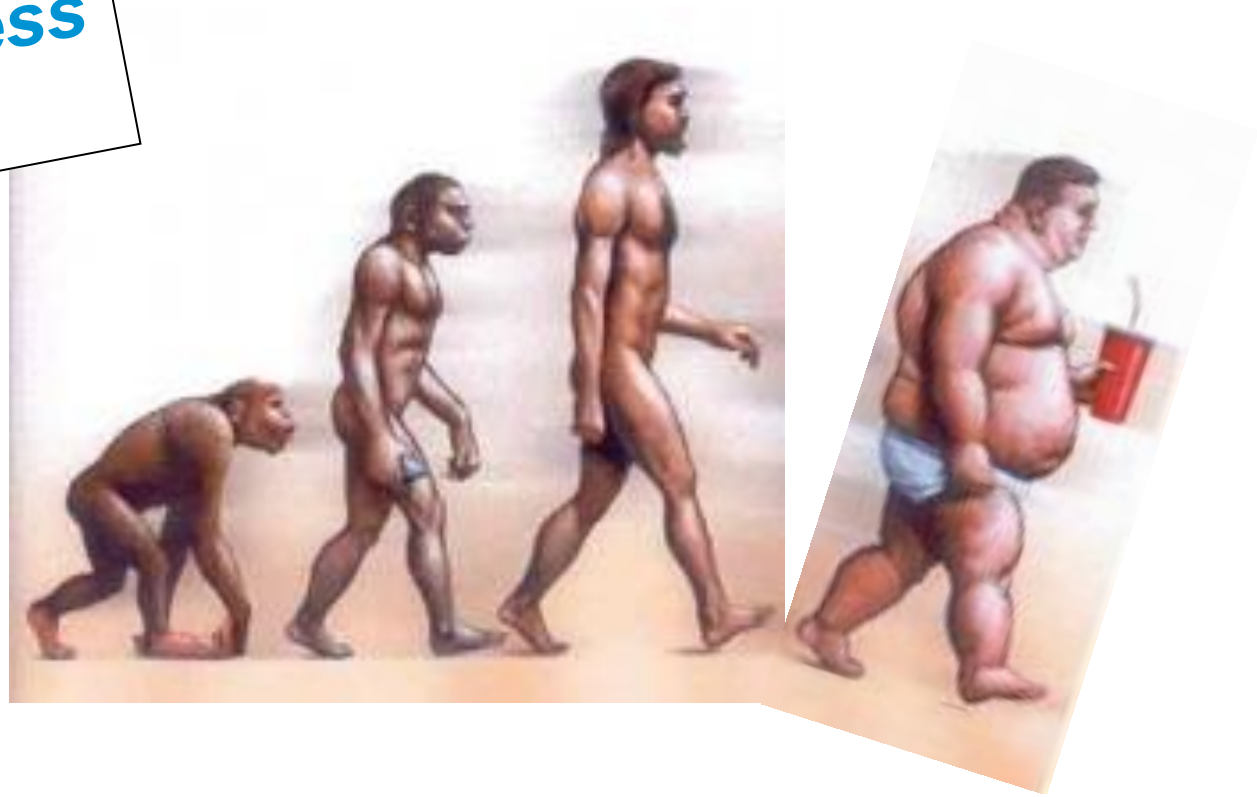
Shift vom individuellen
"Airway Hero"
zur Gruppenleistung



Das meiste Lernen geschieht in Gruppen

- Menschen sind gerne zusammen,
- um zu arbeiten, zu leben, zu lernen
- seit tausenden Jahren,
- um zu überleben

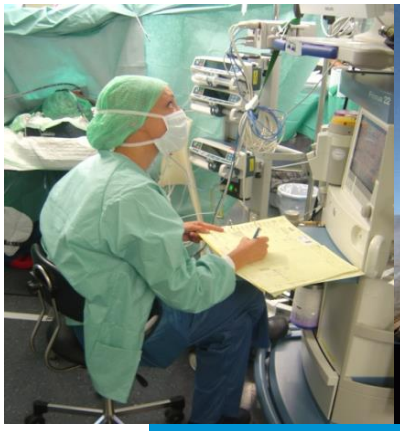
Without Progress Decline





“if we do not abandon our common ways we never find new paths to other targets”

Komponenten – Nicht-technische Fertigkeiten

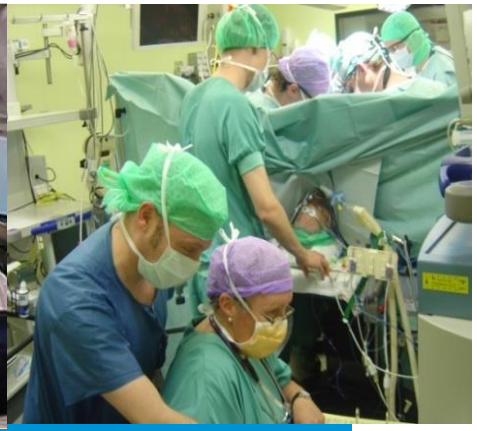




Individuelle & kognitive Elemente

- Limitation Mensch (Human Factor) Multitasking, Aufmerksamkeit zugeteilt, Gedächtnisstützen, Checklisten
- Dynamic Decision Making
- Planung & Antizipation
- Ausnutzen aller verfügbaren Informationen
- Fixierungsfehler





Team Management & Kommunikation

- Leadership & Mitarbeiter
- Durchsetzungsfähigkeit
- Verteilung der Arbeitsbelastung
- Frühzeitiges Hilfe holen
- Ausnutzung aller verfügbarer Ressourcen
- Effektive Kommunikation (!) – „speak-up“

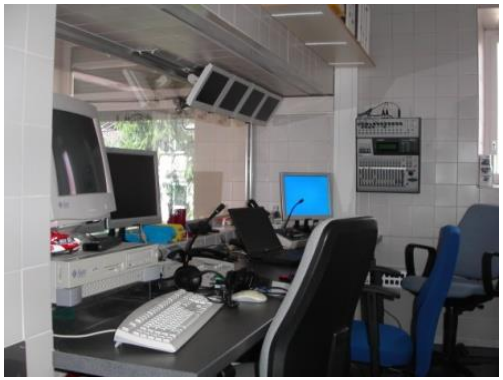
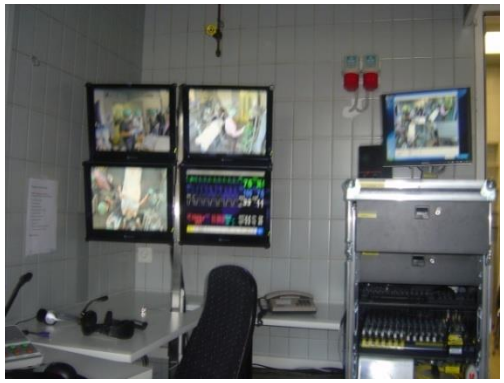
Nicht Technische Fertigkeiten (Skills - NTS)

NTS = Rahmen: beschreibt & klassifiziert spezifische beobachtbare Verhalten

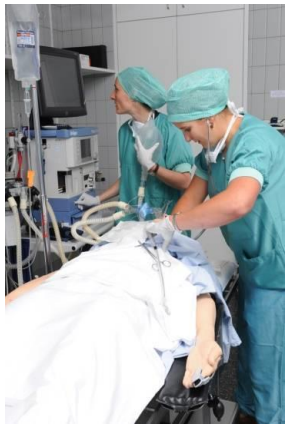
Aufgabenmanagement 1. Planen und Vorbereiten 2. Prioritäten setzen 3. Standards beachten und einhalten 4. Ressourcen erkennen und nutzen	**Teamarbeit** 1. Tätigkeiten im Team koordinieren 2. Informationen austauschen 3. Autorität einsetzen & durchsetzen 4. Fähigkeiten einschätzen 5. Andere unterstützen
Situationsbewusstsein 1. Informationen sammeln 2. Erkennen und Verstehen 3. Antizipieren	**Entscheidungsfindung** 1. Optionen erkennen 2. Risiken abwägen & Optionen auswählen 3. Reevaluieren

Anaesthesists' Non-Technical Skills (ANTS):evaluation of a behavioural marker system. Fletcher G, BJA 2003: 580

High Fidelity Simulation







Lernen erfolgt im videounterstützen Debriefing









Lernen aus Fehler - Debriefing

= “one-time, semi-structured conversation to reduce psychological harm”
= kurz, direkt nach den Ereignissen, vertrauliche Atmosphäre

Ziel: Handlungshintergründe erforschen ⇒ Verhaltensänderung initieren

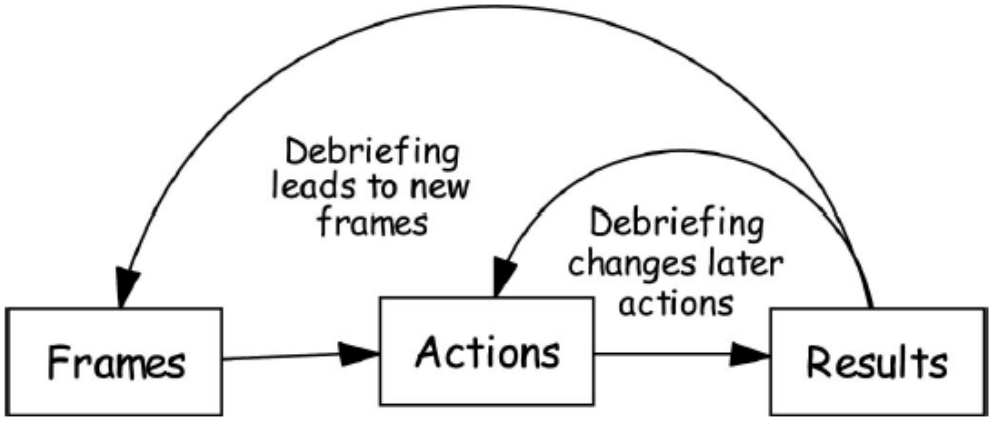


FIGURE 1. Frames are invisible, but inferable; they are in the mind of trainees and of instructors. Actions (including speech) are observable. Most results (e.g., vital signs, order/chaos) are also observable.

JW Rudolph, et al., There’s No Such Thing as “Nonjudgmental” Debriefing: A Theory and Method for Debriefing with Good Judgment. Simul Healthcare 2006;1:49–55

Nützt das Lernen im Simulator was ?



JAMA®

Online article and related content current as of January 13, 2010.

Solutions for Improving Patient Safety

Edward H. Livingston

JAMA. 2010;303(2):159-161 (doi:10.1001/jama.2009.2010)

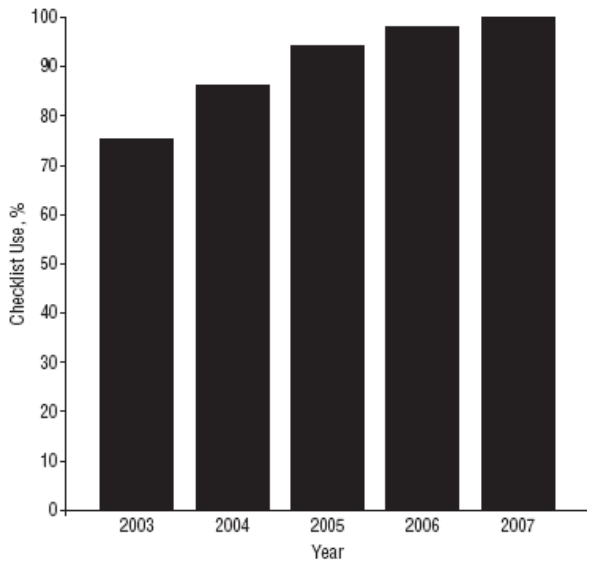
http://jama.ama-assn.org/cgi/content/full/303/2/159

Can Aviation-Based Team Training Elicit Sustainable Behavioral Change?

Arch Surg. 2009;144(12):1133-1137

Harry C. Sax, MD; Patrick Browne, BMil; Raymond J. Mayewski, MD; Robert J. Panzer, MD; Kathleen C. Hittner, MD; Rebecca L. Burke, RN, MS; Sandra Coletta, MBA

Conclusions: Crew resource management programs can influence personal behaviors and empowerment. Effects may take years to be ingrained into the culture.



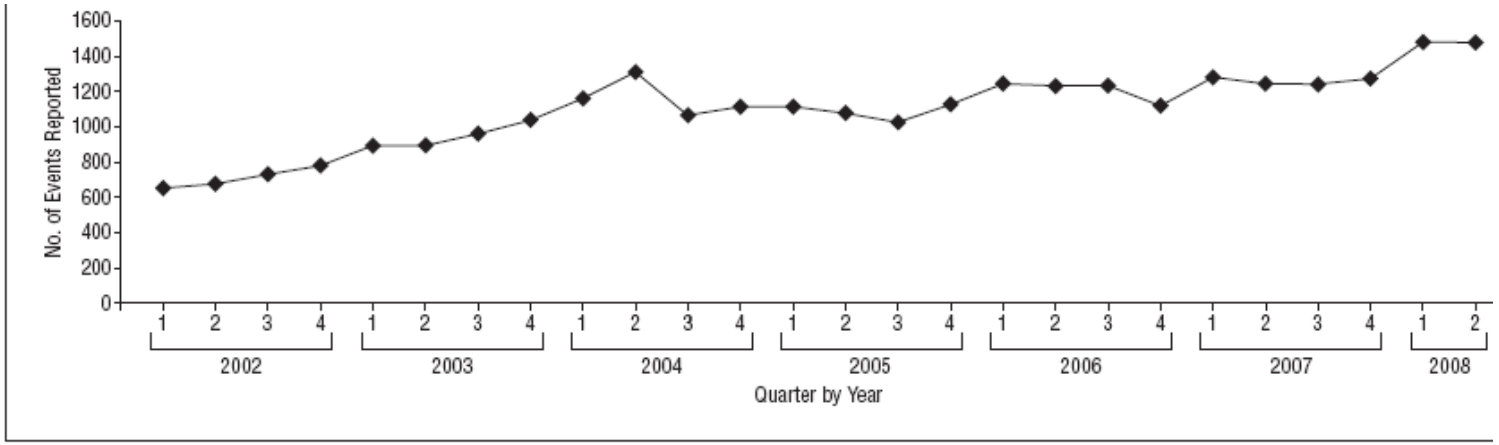


Figure 3. Reports of incidents at Strong Memorial Hospital over time. This includes all levels of severity.

N ENGL J MED 368;3 NEJM.ORG JANUARY 17, 2013

Simulation-Based Trial of Surgical-Crisis Checklists

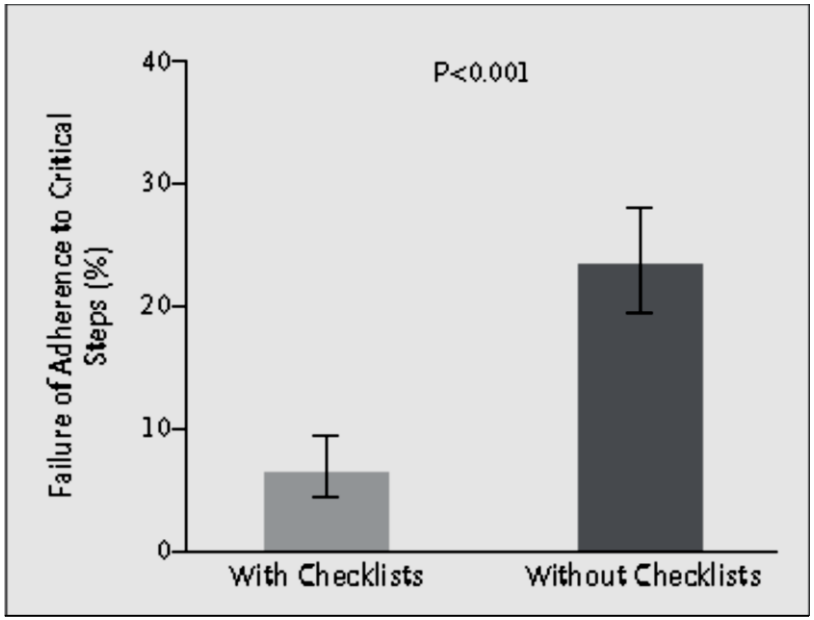
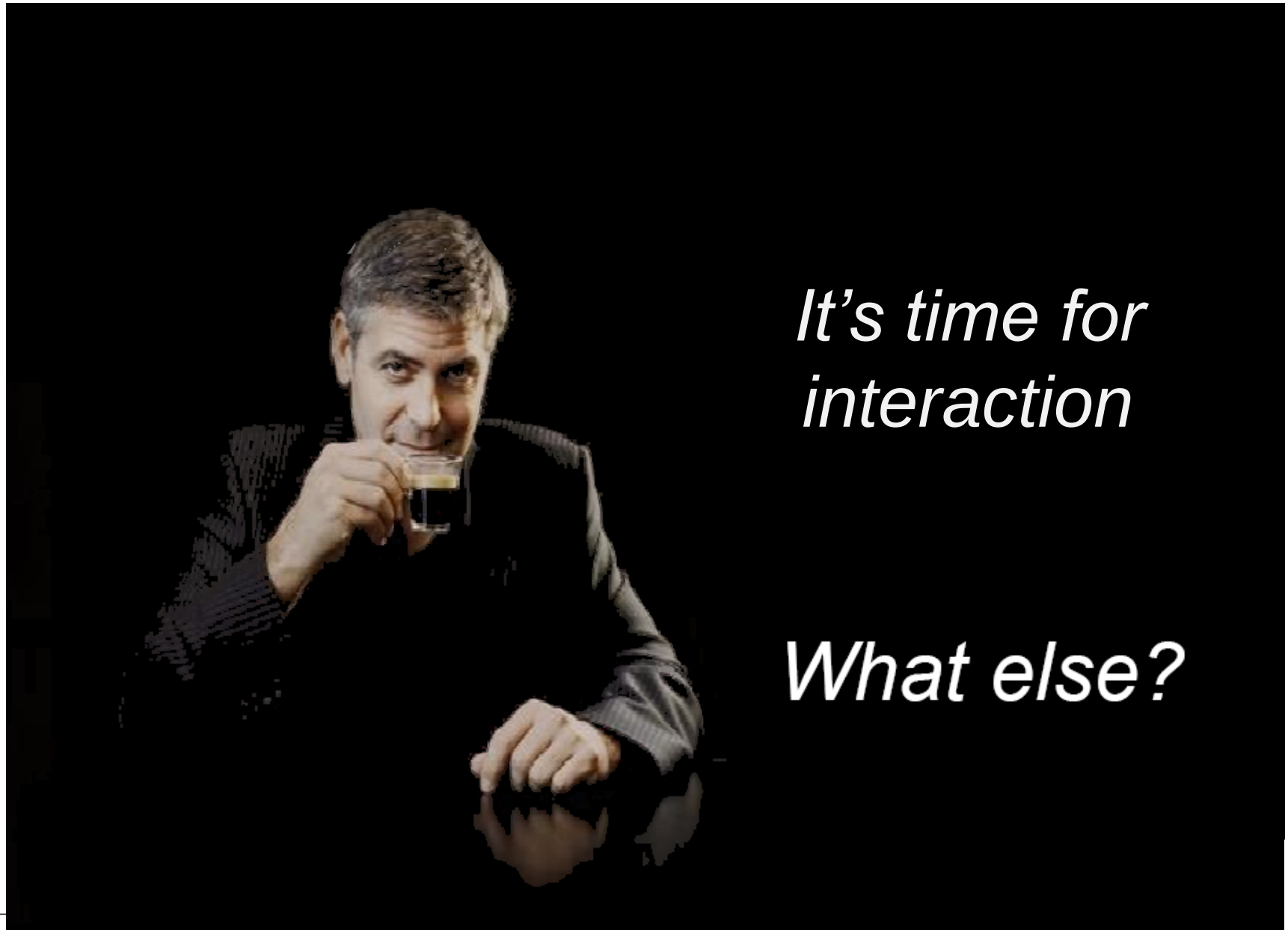


Figure 1. Association between Use or Nonuse of Operating-Room Crisis Checklists and Failure to Adhere to Critical Steps in Management.

75% reduction in failure in management of surgical crises,
24 (6%) were missed with checklists,
89 of 379 steps (23%) missed when checklists were not available.

CONCLUSIONS

In a high-fidelity simulation study, checklist use was associated with significant improvement in the management of operating-room crises. These findings suggest that checklists for use during operating-room crises have the potential to improve surgical care. (Funded by the Agency for Healthcare Research and Quality.)


It’s time for interaction
What else?

Übung für Sie:



2 Beobachtungen: Was geschieht?
Was ist der Unterschied?





Übung:

Diskutieren Sie mit Sitznachbarn:

Was schafft Effektivität & anhaltende Performanz?

