# AVOIDING MISTAKES TOGETHER

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# Together
## Between patient and care





**Maintaining a positive and open culture in dealing with mistakes and errors is a top priority at Asklepios: The most important question is "What happened?" rather than "Who is to blame?". To identify mistakes and errors as early as possible, Asklepios uses the reporting and learning system "CIRS". Reiner Heuzeroth from the Quality division (KBQ) is a clinical risk manager, technical expert and patient safety manager at Asklepios. Together with his team colleagues, he has set up a comprehensive system of clinical risk management based around the flagship CIRS solution.**

„It is certainly no exaggeration to say that we are now extremely well networked nationwide", reports Heuzeroth, who is involved in various national expert groups focusing on the issue of patient safety. The successful roll-out of CIRS across the Group has seen Asklepios embrace innovative approaches. The interest from our hospitals in the innovative model from the Quality division has continued unabated since then. Heuzeroth confirms the intensive engagement with specialist colleagues in his assessment: "Asklepios is regarded by expert groups in many respects as a pioneer in the area of patient safety." In 2015, the "Asklepios CIRS Network" was even awarded the German Prize for Patient Safety by the German Coalition for Patient Safety.


> **Anyone can submit a report via CIRS in complete confidence and without fear of personal consequences**
>
> / Reiner Heuzeroth
> Quality division

## REPORTING ERRORS – YET REMAINING ANONYMOUS

But how does CIRS work exactly? The easiest way to explain it is to use an example: a patient is to be moved from the ward to the operating theatre. Since he is not wearing a patient wristband and is not asked to give his name, the wrong patient is collected. Fortunately, the error with potentially grave consequences is noticed in time during the surgical admittance procedure. But how could this happen in the first place? How can this type of confusion be avoided in future?

"It is important that errors are highlighted as soon as possible so that the causes can be eliminated in structural terms," says Reiner Heuzeroth. This is where CIRS is ideal as it allows every employee to submit a CIRS report using a web-based reporting form from every PC in his or her work area. All they need to do is to click on the relevant link and answer three questions: What happened? What led to the incident? How could the incident be avoided in future?

The report can then be sent completely anonymously – it is not possible to trace the source of the information. "It is essential to protect the employees," adds Reiner Heuzeroth. "What is at stake here is not sanctioning errors, but finding out where something is not being done correctly and could put the safety of patients at risk."

### *9,000 MEASURES FOR GREATER PATIENT SAFETY*

In the almost ten years during which the system has now been used, Asklepios employees have reported around 13,000 cases from which more than 9,000 measures have been derived. In other words: The CIRS system and the active involvement of all Asklepios employees in the medical area have already ensured several thousand times that something could be improved by these reports. A remarkable success. And new measures are being added daily.

With regard to issues of relevance to safety and insights from CIRS cases, the Quality division (KBQ) sends safety warnings entitled “Safety first” to all Asklepios employees several times per year. The cases prepared by technical experts contain specific recommended actions that can be implemented immediately in all areas.

A good example of a measure with an extremely useful benefit is the prevention project “Stop-Inject Check”. The name spells out the procedure, which requires employees to stop briefly before injecting a medication and asking themselves: “Am I really sure? Is this right patient, the right medication, and the correct dosage?” The medication should be injected only if these questions can be answered positively. Heuzeroth knows only too well that “the two-second pause saves lives”. In fact, as part of an initial evaluation conducted following the introduction, more than 20 percent of those surveyed reported having been confronted at least once with incorrect medication or almost incorrect medication that the “Stop-Inject Check” could have prevented. The procedure takes only a couple of seconds but can prevent thousands of potentially serious medication errors each year.

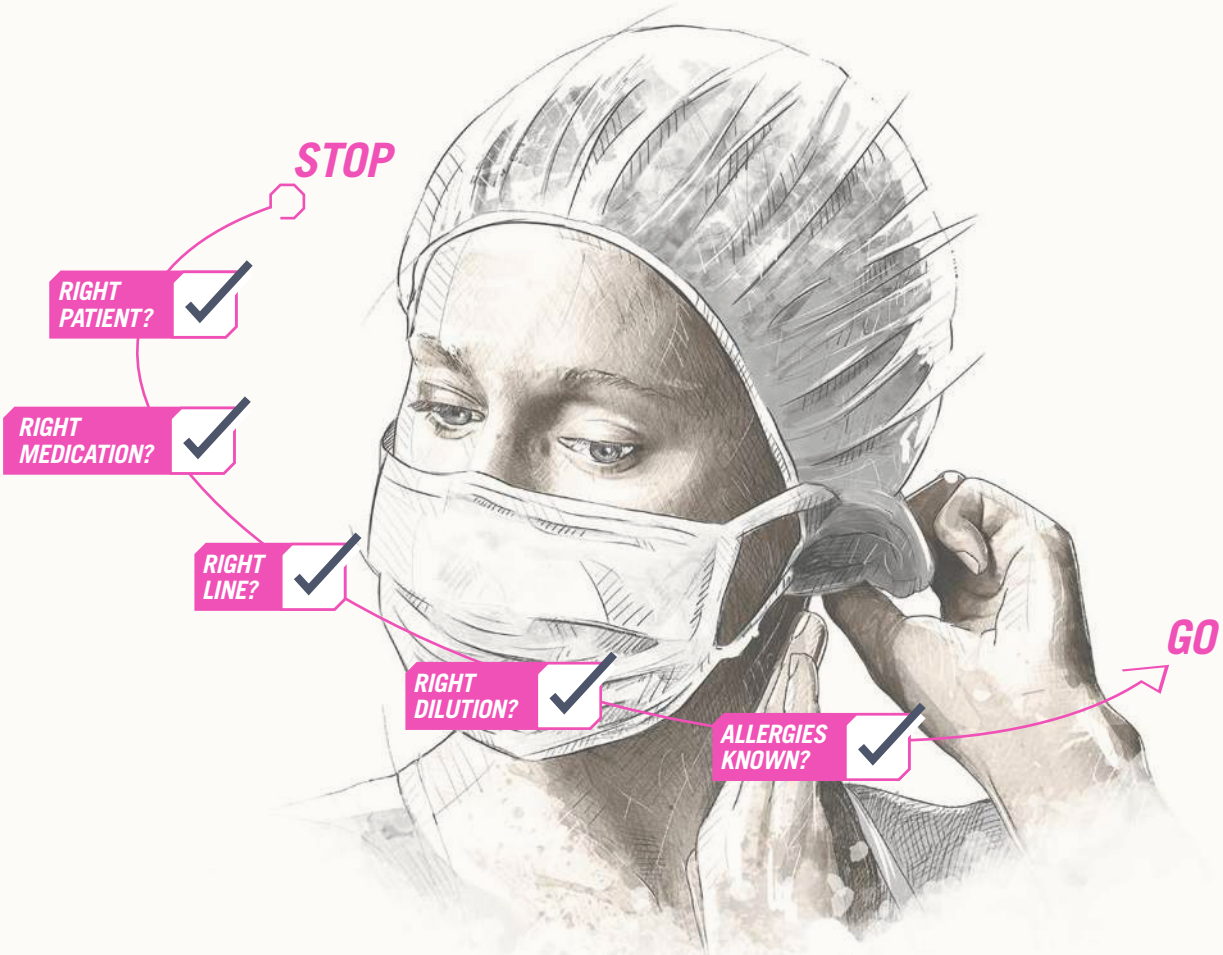
## A two-second pause saves lives.

/ Reiner Heuzeroth
Quality division

### *PATIENT SAFETY WILL ALSO BE CONTINUOUSLY IMPROVED IN THE FUTURE*

Attention is drawn to “Stop-Inject Check” throughout Asklepios with the help of signs and adhesive labels in the hospitals. The creation of safety standards, instructional material, videos, brochures as well as continuous training are essential elements of the work by Reiner Heuzeroth and the team from the Quality division. The “Asklepios Programme for Patient Safety” developed back in 2008 contains numerous methods for identifying risks, informing and involving patients and qualifying employees. These include special risk audits in particularly critical areas such as surgery, the emergency department, obstetrics and intensive care wards. If an incident giving rise to a claim has occurred, Quality employees carry out a “systematic case analysis”. The focus is on carrying out an in-depth analysis of the event and the mistakes that were made.

Patient safety will also be one of the key Group objectives at Asklepios going forward. “Our long-term goal is to bring together the results and risk analyses from the various sources both at Group as well as at hospital and department levels so that we can take action even more quickly,” says Heuzeroth. “This will allow us to continue increasing the level of safety of our patients.”




# STOP INJECT

## AVOIDS MEDICATION ERRORS

# CHECK

## TO ADMINISTER MEDICATION SAFELY!