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QUALITÄT UND SICHERHEIT IN DER GESUNDHEITSVERSORGUNG /  
QUALITY AND SAFETY IN HEALTH CARE

# Who is responsible for a safe discharge from hospital? A prospective risk analysis in the German setting

*Wer ist verantwortlich für eine sichere Krankenhausentlassung?  
Eine prospektive Risikoanalyse*

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## KEYWORDS

Patient safety;  
failure mode and  
effects analysis;  
hospital discharge;  
quality assurance

## Summary

**Background:** A representative national survey on risk management in German hospitals has recently identified hospital discharge as a key area of attention. Based on the consensus in the literature about the need to address patient safety at system level, this paper does not only look at the processes of discharge designed by single hospitals, but also takes account of the broader legal and regulatory framework.

**Methods:** Failure Mode and Effects Analysis (FMEA) was applied for risk identification and assessment. For the analysis of the current status in hospitals, three hospitals were interviewed about their discharge processes. For the system perspective, the legislative and self-administrative framework specific for the German setting was reviewed.

**Results:** The FMEA allowed the identification of a number of actions for risk control in the responsibility of the hospitals and within the framework. Some risks are mainly caused by the legal framework, whereas others can only be addressed by the hospitals themselves. The continuity of drug treatment and the lack of back-up systems after discharge were identified as posing relevant risks to patient safety.

**Conclusion:** Rich interaction was found between the hospitals and the framework they work in impacting patient safety at hospital discharge. The contribution of the legal and regulatory framework to patient safety needs to be taken into account more actively by policy makers in the future.

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## SCHLÜSSELWÖRTER

Patientensicherheit;  
Fehlermöglichkeits-  
und Einflussanalyse;  
Krankenhausentlassung;  
Qualitätssicherung

### Zusammenfassung

**Hintergrund:** Eine 2012 erstmalig durchgeführte repräsentative Umfrage zum Risikomanagement an deutschen Krankenhäusern hat das Thema Krankenhausentlassung als eines der entscheidenden Handlungsfelder zur Verbesserung der Patientensicherheit identifiziert. Ausgehend von dem wissenschaftlichen Konsens, dass wesentliche Faktoren für die Patientensicherheit auf der Systemebene liegen, werden in diesem Beitrag nicht nur die Prozesse der Krankenhäuser bei der Entlassung eines Patienten nach Hause, sondern auch die vertraglichen und gesetzlichen Rahmenbedingungen für die Krankenhausentlassung im deutschen Gesundheitssystem analysiert.

**Methoden:** Zur Identifizierung und Bewertung der Risiken wird eine Fehlermöglichkeits- und Einflussanalyse (FMEA) angewandt. Zur Ist-Analyse der Prozesse bei der Krankenhausentlassung werden in drei Krankenhäuser in Baden-Württemberg relevante Dokumente ausgewertet und Experteninterviews geführt. Für die Systemanalyse auf der Makroebene werden die gesetzlichen und durch die Selbstverwaltung festgelegten vertraglichen Rahmenbedingungen im Land Baden-Württemberg untersucht.

**Ergebnisse:** Die Risikoanalyse der FMEA ermöglicht die Identifikation von Handlungsmöglichkeiten zur Verbesserung der Patientensicherheit sowohl in der Verantwortung der Krankenhäuser als auch bei den Rahmenbedingungen. Die Kontinuität der medikamentösen Behandlung und das Fehlen von Feedback-Systemen nach der Entlassung der Patienten aus dem Krankenhaus kristallisieren sich als wesentliche Risikofaktoren heraus.

**Diskussion:** Starke Wechselwirkungen zwischen den Aktivitäten der Krankenhäuser und den Vorgaben des Gesetzgebers und der Selbstverwaltung werden für die einzelnen Prozessschritte bei der Krankenhausentlassung deutlich. Der Einfluss der gesetzlichen und vertraglichen Rahmenbedingungen auf die Patientensicherheit bei der Krankenhausentlassung sollte in der Zukunft stärkere Beachtung finden.

## Introduction

One of the first prospective cohort studies on patient safety at hospital discharge back in 2003 concluded that an overall of 19% of patients experience adverse events after hospital discharge of which 6% are preventable and another 6% are amenable [1]. The avoidance of gaps in care delivery across the continuum of care is often regarded as one of the keys to achieve improvement of quality and safety for patients in the future [2 (page 4)]. Due to demographic and epidemiological changes combined with the ongoing pressure to reduce hospital length of stay, securing quality and safety at hospital discharge will inevitably become even more challenging in the future. A representative national survey on risk management in German hospitals recently identified hospital discharge as a key area of attention [3]. Despite the relevance of the topic, little research can be found in the German context. The whole topic of patient safety has only recently gained more attention in the German health care system [4]. In 2014, the Federal Joint Committee obliged a mandatory risk management for all hospitals and outpatient physicians [5]. The adoption of risk management as part of the Federal Joint Committee's directive for quality management also marks a more common understanding of patient safety as one dimension of quality in German health care. Following the definition by the German Coalition for Patient Safety, any patient safety activities aim to prevent adverse events [6].

This paper investigates patient safety at hospital discharge. A prospective risk analysis identifies and assesses possible risks at hospital discharge in the German context. This facilitates a mapping of appropriate actions and actors for improved risk control.

## Methodology

In literature, there is a consensus that patient safety issues need to be tackled at system level as opposed to the individual level of human failure [7,8]. The system level is usually defined as the meso-level of the organization as compared to the micro-level of a single individual within that organization, i.e. individual doctors and nurses working within a hospital. Following the systems approach by Leveson [9], this paper takes an even broader study perspective looking at the meso-level of the individual hospital on the one hand, and the macro-level of the legal and regulatory framework of the health system on the other hand.

Research on patient safety often draws on concepts and tools originally developed for risk management in other industries. The failure mode and effects analysis (FMEA) applied in this paper is a typical example. The FMEA is a tool for prospective risk analysis, which allows a proactive evaluation of vulnerabilities before actual adverse events occur. FMEA has been chosen as a tool, because a prospective risk analysis is regarded to be more appropriate than retrospective approaches for a system analysis and the FMEA offers a structured and systematic approach to the full cycle of risk analysis from the identification of risks to action to control those risks [10].

No standard tool is available to analyse the contribution of the legal and regulatory framework of health systems to patient safety issues. Thus, this exploratory study needs to adapt the FMEA considerably to this specific application. The FMEA here is based on the five steps of the HFMEA as described by DeRosier for the Veteran Affairs National Center for Patient Safety [11] (Graph 1).

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