APS-Weißbuch Patientensicherheit

Sicherheit in der Gesundheitsversorgung: neu denken, gezielt verbessern

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Gliederung

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Abkürzungen

ACSC	*Ambulatory Care Sensitive Conditions* (ambulant-sensitive Krankenhausaufenthalte)
AHRQ	*Agency for Health Care Research and Quality*
AMTS	Arzneimitteltherapiesicherheit
APS	Aktionsbündnis Patientensicherheit e.V.
CAS	*Complex Adaptive Systems*
CDC	*Centers of Disease Control*
CIRS	*Critical Incident Reporting System*
CLABSI	*Catheter-Associated Bloodstream Infections*
CMS	*Centers for Medicare and Medicaids Services*
CPOE	*Computer-assisted Physician Order Entry System*
CSRS	*Quality and Safety Reporting System*
DMP	*Disease Management Programme*
EBM	Evidenz-basierte Medizin (*Evidence Based Medicine*)
EHR	*Electronic Health Record*
FQWG	GKV-Finanzstruktur- und Qualitäts-Weiterentwicklungsgesetz (2014)
G-BA	Gemeinsamer Bundesausschuss
GKAR	Gesetz über Kassenarztrecht (1955)
GKV-2000	GKV-Gesundheitsreformgesetz 2000
GQMG	Gesellschaft f. Qualitätsmanagement in der Gesundheitsversorgung e.V.
GMG	Gesundheitsmodernisierungsgesetzt (2003)
GRG	Gesundheitsreformgesetz (1989)
GSG	Gesundheitstrukturgesetz (1993)
GTT	*Global Trigger Tool*
HACRP	*Hospital Acquired Condition Reduction Program*
HIT	*Health Information Technology*
HMPS	*Harvard Medical Practice Study*
HRA	*Human Reliability Assessment*
HRO	*High Reliability Organization*
HRRP	*Hospital Readmission Reduction Program*
HSOPSC	*Hospital Survey on Patient Safety Culture*
IOM	*Institute of Medicine* (USA)
IQTIG	Institut für Qualität und Transparenz im Gesundheitswesen
IQWIG	Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen
KHG	Krankenhaus-Finanzierungs-Gesetz (1972)
KHSG	Krankenhaus-Strukturgesetz (2015)
MPSMS	*Medicare Patient Safety Monitoring System*

MRSA	Methicillin-resistente *Staphylococcus aureus*
MSI	*Modified Stanford Patient Safety Culture Survey Instrument*
MVZ	Medizinisches Versorgungszentrum
NAE	*Negligent Adverse Event* (Sorgfaltsverletzung, Behandlungsfehler)
NPSA	*National Patient Safety Agency (UK)*
NPSF	*National Patient Safety Foundation (USA)*
NQF	*National Quality Forum*
P4P	*Pay for Performance*
PRA	*Probabilistic Risk Assessment*
PROM's	*Patient Reported Outcome Measures*
PSCHO	*Patient Safety Culture in Healthcare Organizations Survey*
PSI	Patientensicherheits-Indikatoren
QI	*Quality Improvement*
QSRS	*Quality and Safety Review System*
RCA	*Root Cause Analysis*
SAQ	*Safety Attitudes Questionnaire*
VBP	*Value-Based Purchasing*-Programm
VSG	GKV-Versorgungsstärkungsgesetz (2015)
VUCA	*Volatility, Uncertainty, Complexity, Ambiguity*
WSG	Wettbewerbsstärkungsgesetz

Der Autor

Prof. Dr. med. Matthias Schrappe, Jahrgang 1955, war in den Jahren 2005 bis 2009 Vorsitzender des Aktionsbündnis Patientensicherheit e.V. und von 2009 bis 2011 Direktor des Institutes für Patientensicherheit der Rheinischen Friedrich-Wilhelms-Universität Bonn. Er war bis 1996 klinisch als Internist mit dem Schwerpunkt Klinische Infektiologie tätig, leitete das Qualitätsmanagement der Universitätsklinik Köln, war Ärztlicher Direktor und Vorstandsvorsitzender der Universitätsklinik Marburg, Dekan an der Universität Witten-Herdecke und Generalbevollmächtigter des Aufsichtsrates der Universitätsklinik Frankfurt. Seit 1997 lehrte er Qualitätsmanagement, EbM und bis heute Patientensicherheit an der Universität Köln, er war u.a. Mitglied des Sachverständigenrates zur Begutachtung der Entwicklung im Gesundheitswesen (von 2007 bis 2011 als Stellv. Vorsitzender), von 2001 bis 2007 Vorsitzender der Gesellschaft für Qualitätsmanagement in der Gesundheitsversorgung (GQMG), Vorstandsmitglied im Deutschen Netzwerk Versorgungsforschung und im Deutschen Netzwerk Evidenzbasierte Medizin. Neben zahlreichen wissenschaftlichen Publikationen hat er in den letzten Jahren mehrere Lehrbücher zu den Themen Versorgungsforschung, Gesundheitsökonomie, EbM, Qualität und Patientensicherheit verfasst und herausgegeben.

Klappentext

Knapp 20 Jahre nach Erscheinen von "*To Err Is Human*" legt das Aktionsbündnis Patientensicherheit e.V. mit dem "APS-Weißbuch" eine grundlegende Analyse der Situation und konkrete Forderungen zur Verbesserung der Patientensicherheit vor. Der Autor, Prof. Dr. Matthias Schrappe, war selbst Gründungsvorsitzender des APS und hat nicht nur die theoretischen Grundlagen, die Erhebungsmethodik, die Daten zur Häufigkeit und die ökonomischen Implikationen aufgearbeitet, sondern daraus auch ein innovatives Konzept entwickelt, das als Basis für die weitere praktische Enwicklung und die gesundheitspolitische Bewertung des Themas dienen kann. Die zentrale Botschaft lautet: mehr Patientensicherheit ist machbar, wenn man die richtigen Methoden zur Verbesserung in Anwendung bringt.