Patient safety strategies and measures at several levels

Berit Axelsson
Peter Kammerlind

Content

• Patient Safety

• Safe Health Care - every time, all the time

• Measurements
  – Macro
  – Micro
What is Patient Safety?

According to the new Patient Safety Law:

- **The definition of an adverse event** is suffering, physical or mental harm or illness and death that was **avoidable** if adequate steps had been done for the patient. An adverse event that is permanent or that have caused an considerable amount of care or have caused death is defined as a **serious harm**.
A measure of Adverse events

- 2000 records was reviewed 2003 - 2004
- Only Hospital care
- Special trained nurses and doctors reviewed the records

How often happens adverse events?

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA</td>
<td>3.2–5.4%</td>
</tr>
<tr>
<td>Australia</td>
<td>10.6–16.6%</td>
</tr>
<tr>
<td>UK</td>
<td>11.7%</td>
</tr>
<tr>
<td>Denmark</td>
<td>9%</td>
</tr>
<tr>
<td>New Zealand</td>
<td>12.9%</td>
</tr>
<tr>
<td>Canada</td>
<td>7.5%</td>
</tr>
<tr>
<td>Japan</td>
<td>11%</td>
</tr>
<tr>
<td>Sweden</td>
<td>8.6%</td>
</tr>
</tbody>
</table>
If we translate it to Jönköping County Council.....

(We have approximately 3.6% of the Swedish Population)

- We have almost 360 patients with a adverse event
- Almost 100 patients dies

Did someone react?

- The Newspapers wrote about it, one or two days, but it was never a Headline.
- The patients didn't .....hear about it.
Somebody cared....

Government

SKL
The Swedish Association of Local Authorities and Regions (SALAR).

Patientsäkerhetsutredningen

Patient Safety Law
(2010:659)
From 2011-01-01
The Caregivers responsibility

- Implement systematic Patient Safety Works and work preventative.
- They have an obligation to analyse adverse events
- They must inform patients and relatives as soon as possible due to harm. They shall also inform what they have done to prevent the same thing to happen again.
- The Patient and the relatives should be a part of the Patient Safety work

If something happens

- An report goes to The National Board of Health and Welfare (Socialstyrelsen) and they investigate the adverse event
- If necessary The National Board of Health and Welfare criticizes the Clinic.
- The National Board of Health and Welfare leave the report to HSAN (The Committee of responsibility in Health Care) with a request about disciplinary arrangement.
- HSAN acquit or give judgement.
Penalty

• Warnings and reminders are gone.
• Period of probation is to be used more often. A plan must be set by the Clinic together with the National Board of Health and Welfare.
• HSANs decision can be appealed against.
• … but not the decision made by the National Board of Health and Welfare
### Vision

**Patient Safety**

Create conditions to make it right from the beginning

---

#### Patient Safety programme

<table>
<thead>
<tr>
<th>Year</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leading for Patient Safety, National, number 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Riskanalysis FMEA 7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Riskanalysis FMEA 8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Root Cause Analysis 7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Root Cause Analysis 8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Safety and Medication for Children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Prevention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Related Infection in the region</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe Health Care – every time, all the time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measurement ADE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIE - GTT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Synergi – incident reporting system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Survey – Patient Safety culture</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

The Clinical Microsystem Festival – March 3-4 2011
Driver Diagram
Patient Safety

Aim: Safe Health Care All The Time

Primary drivers
- Reliability
- Competence and Skills
- Learning Organisation
- Leadership
- Patient involvement

Secondary drivers
- Standardize work routines
- Use Checklist
- Decrease variation
- Access
- Adaptability
- Improvement work
- Skill training
- Awareness of the current situation
- Incident reporting system
- Measurements
- Patient Safety Culture
- Motivation, action, follow up and feedback
- Challenge
- The process of patient Microsystem

Areas
- Safer Health Care – every time, all the time
- Leadership for Patient Safety
- Risk and root cause analysis
- Better use of medicine
- Open access
- National Quality register
- Measurements for management
- Leadership programme
- IT support
- HSMR
- Mortality
- AE - Globus Trigger Tool
- ADE
- Readmission
- Infections
- "Senior Alert"
- Costs per capita

Meetings and methods
Prevent Central Line infection

- A forum for people with great knowledge of central lines from different places in the county (from microsystem level)
  - The goal is to work safe and in the same way with central line in the whole county.
- Checklist
- Education
  - A movie for education
  - Skill center- Metodikum
- Information to the patient
Reduce Surgical Complications

- Following WHO’s Surgical checklist
- Checklist
  - Before operation
  - Preparation at the operation room
  - Time Out
  - Conclusion
- At all hospitals
- Pay for performance
  - > 80% = 100%
  - 70-80% = 50%

Reduce MRB infections

- Risk assessment (Checklist)
  - Visit in another country
  - Infected wounds
- Screening – samples
- Compliance to guidelines of Hand hygiene and Clothes
  - Pay for performance
    - > 85% = 100%
    - 80-85% = 50%
    - < 80% = 0%
Measurement for management

- Broad - two or more Perspectives/ dimensions
- Depth – links
- Time - dynamic
- Visualization – dashboard
- Improvements – PDSA cycles
Driver Diagram: Safe Health Care

Aim: Safe Health Care
Every time, all the time

Primary Drivers

- Avoid Health Care Associated Infections
  - Compliance bundle 1
  - Compliance bundle 2
  - Compliance bundle 14

- Avoid Adverse Drug Events
  - Compliance bundle Prevent ADE and harm from High Alert Medications

- Avoid Falls and Pressure Ulcer
  - Compliance bundle Prevent Pressure Ulcer and Falls

- Reliable Cardiac Care
  - Compliance bundle Evidence Based Care for AMI and CHF

- Leadership
  - Compliance bundle Develop Rapid Response Team

Secondary Drivers

- Compliance Hand Hygiene and Dress Code
  - Compliance bundle 4, 5, 6, 10 and 13

- Compliance bundle Prevent
  - Pressure Ulcer and Falls

- Compliance bundle Develop
  - Rapid Response Team

- Compliance bundle Get the Boards on Board

Adverse Events
Adverse Drug Events
Raw Mortality
Health Care Related Infections

Compliance relevant bundles

Process measure
Outcome measure

Macro level

Meso level

Microsystem
Följsamhet till riktlinjer, basala hygienrutiner

Vårdprevention, riskbedömning av fall, nutrition och trycksår

Mål: Säker vård

Övergripande resultatmått:
- Antal patientskador per 1000 patientdygn

Primära drivkrafter:
- Följsamhet område 3 och 7

Sekundära drivkrafter:
- Undvik vårdrelaterade infektioner
- Följsamhet basala hygienrutiner och rätt klädd
- Undvik läkemedelsrelaterade patientskador
- Undvik fall och trycksår
- Tillförlitlig hjärtsjukvård

Tillförlitlig stödjande ledarskap

Infections

Micro

WHO Checklist

Preventative Care

Central Line Associated infections

Indwelling urethral catheter (IUC)

Medication errors

Hand Hygiene and Dress Code

Central Lines Associated infections

Outcome Process Measure