Support for improving quality of healthcare and patient safety in Slovenia

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- Draft version -

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MINISTRY OF HEALTH

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Glossary

A list with the abbreviations that will appear in this documents is presented below:

- ***AHPEQS:*** *Australian Hospital Patient Experience Question Set*
- ***AQuAS:*** *Catalan Agency for Health Quality and Evaluation*
- ***CRM:*** *Clinical Risk Management*
- ***DDKM:*** *Danish Healthcare Quality Programme*
- ***DHW:*** *Department of Health and Wellbeing*
- ***DPSD:*** *Danish Patient Safety Database*
- ***GDP:*** *Gross Domestic Product*
- ***GRC:*** *Centre for Clinical Risk Management and Patient Safety*
- ***HIQA:*** *Health Information and Quality Authority*
- ***HSA:*** *Health and Safety Authority*
- ***IKAS:*** *Danish Institute for Quality and Accreditation in Healthcare*
- ***IRS:*** *Incident-reporting systems*
- ***ISO:*** *International Organization for Standardization*
- ***IT:*** *Information Technology*
- ***MEM:*** *Major Emergency Management*
- ***MoH:*** *Ministry of Health*
- ***NHQRS:*** *National Healthcare Quality Reporting System*
- ***NPSO:*** *National Patient Safety Office*
- ***NSQHS:*** *National Safety and Quality Health Service*
- ***OECD:*** *Organisation for Economic Co-operation and Development*
- ***PS:*** *Patient Safety*
- ***QoC:*** *Quality of Care*
- ***SLS:*** *Safety Learning System*
- ***SRSP:*** *Structural Reform Support Programme*
- ***TRI:*** *Thematic Research Index*
- ***WHO:*** *World Health Organization*
- ***XHUP:*** *Public hospital network*

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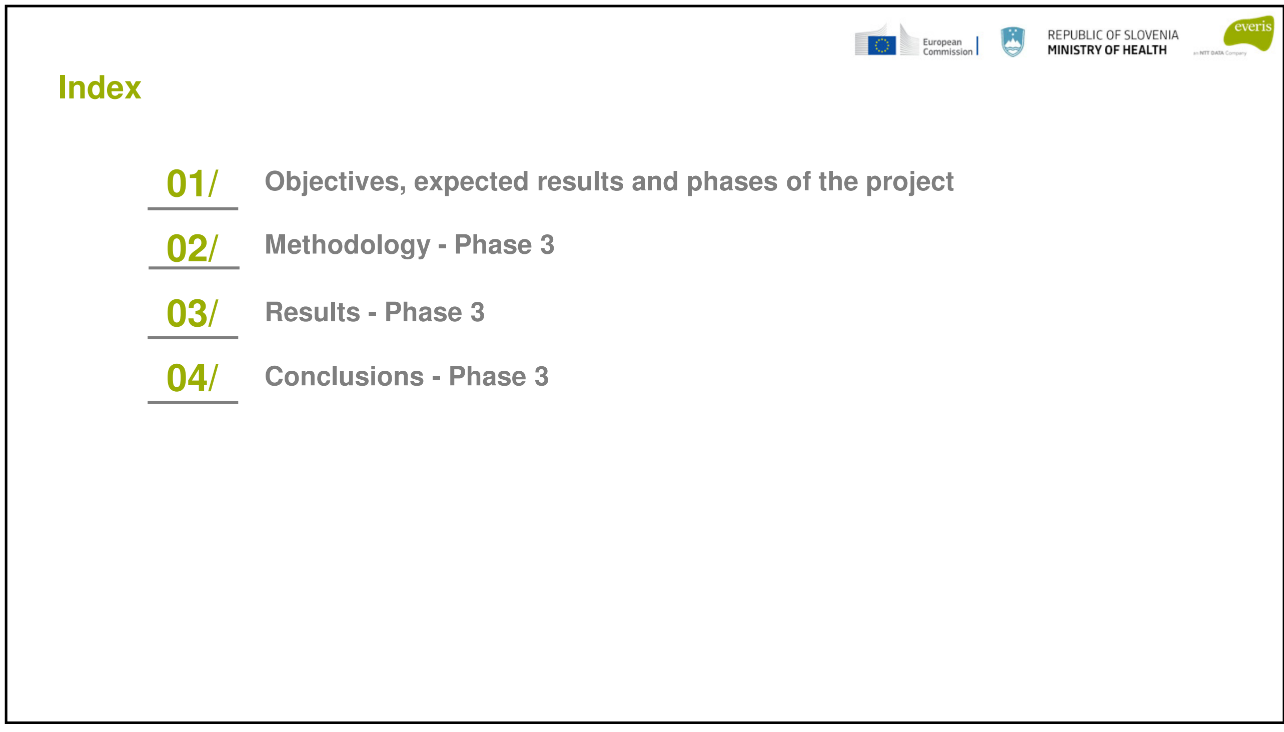

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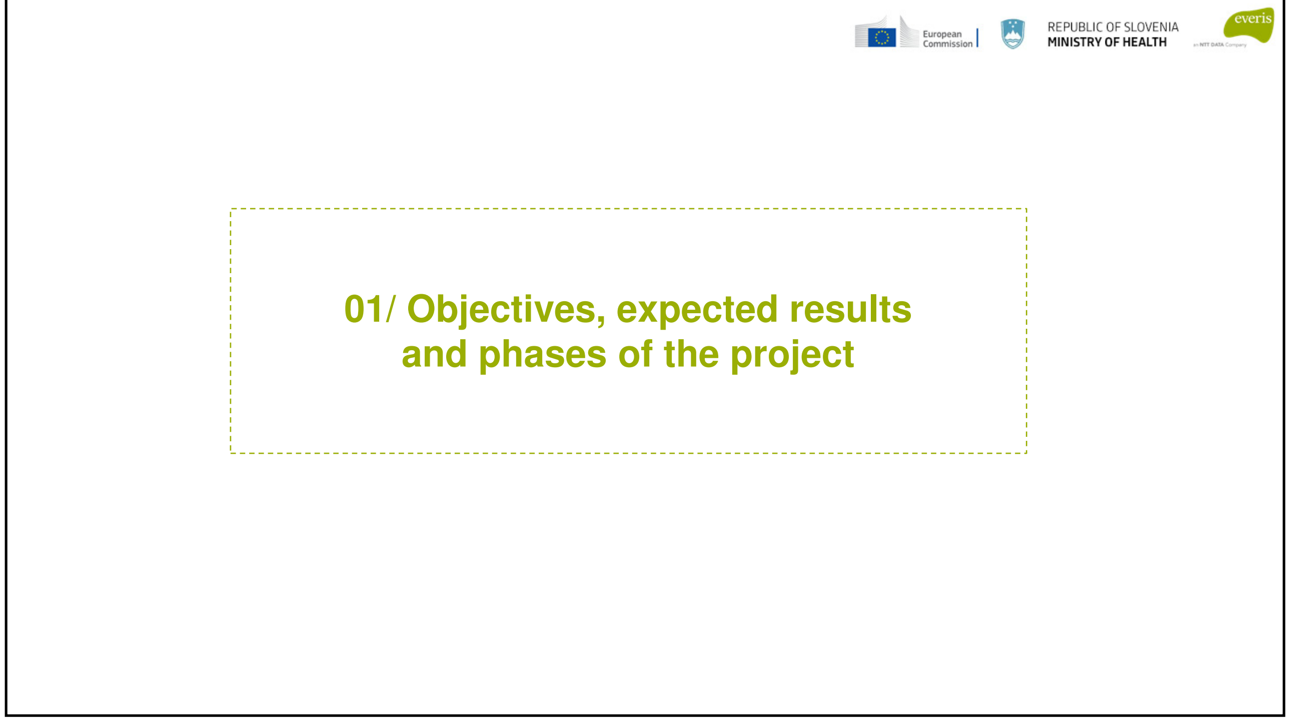

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01/ Objectives, expected results and phases of the project
General and specific objectives of the project

General objective

To contribute to **institutional, administrative and growth-sustaining structural reforms** in Slovenia, in line with **Article 4 of the SRSP Regulation**

Specific objectives

To support the initiatives of national authorities to design their reforms **according to their priorities,** taking into account **initial conditions** and **expected socioeconomic impacts**

To support the national authorities:
(1) in **enhancing their capacity** to formulate, develop and implement reform policies and strategies
(2) in **pursuing an integrated approach**, ensuring **consistency between goals and means** across sectors

In Slovenia, **to support the Slovenian Ministry of Health (MoH)** in capacity building to develop a National strategy on Quality of Care, Clinical Risk Management and Patient Safety, and a legal framework of non fault compensation model

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01/ Objectives, expected results and phases of the project
Expected results of the project

Direct results

Over the longer-term, to **contribute towards improving the quality of care and patient safety in Slovenia**

Indirect results

- **Improved knowledge** of challenges and opportunities in **patient safety and quality of care**
- Strengthened **patient safety culture** and **patient risk management**
- Improved **strategic planning and governance** of the quality of healthcare system
- **Revised set of indicators for quality of care for hospitals**, **specialist outpatient care** and **primary care** available, tested and communicated

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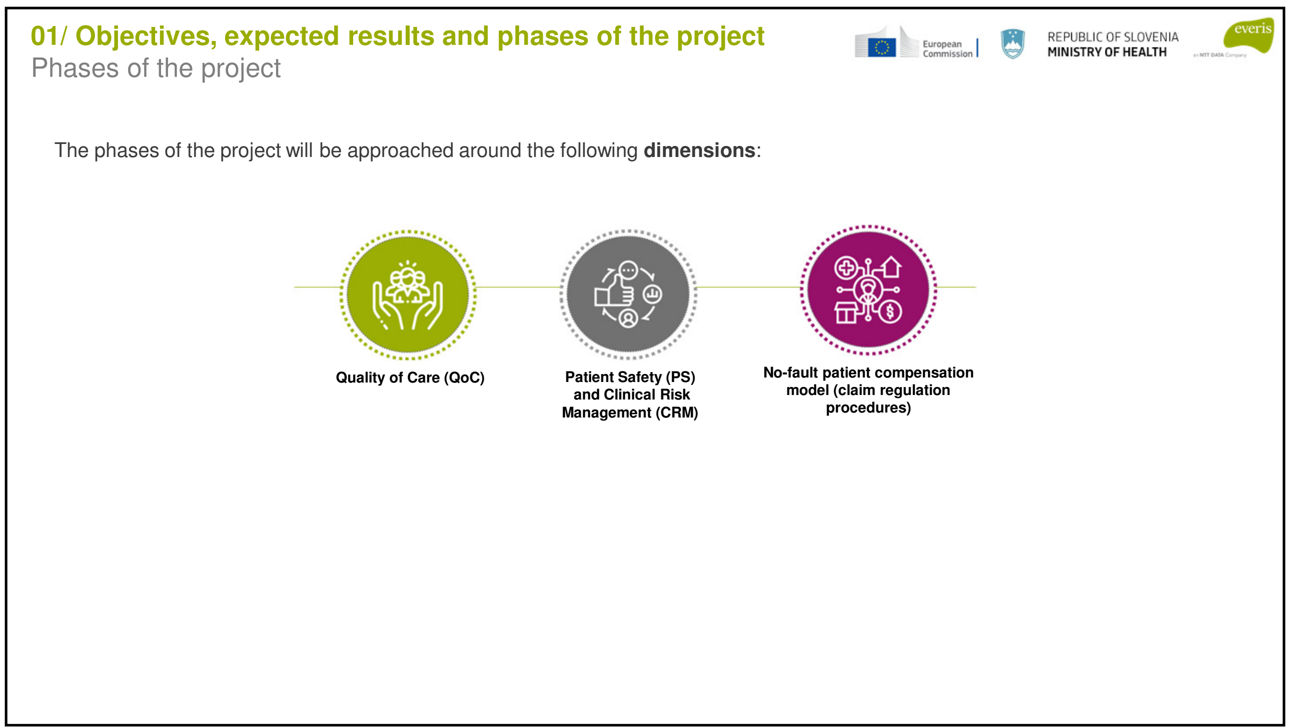

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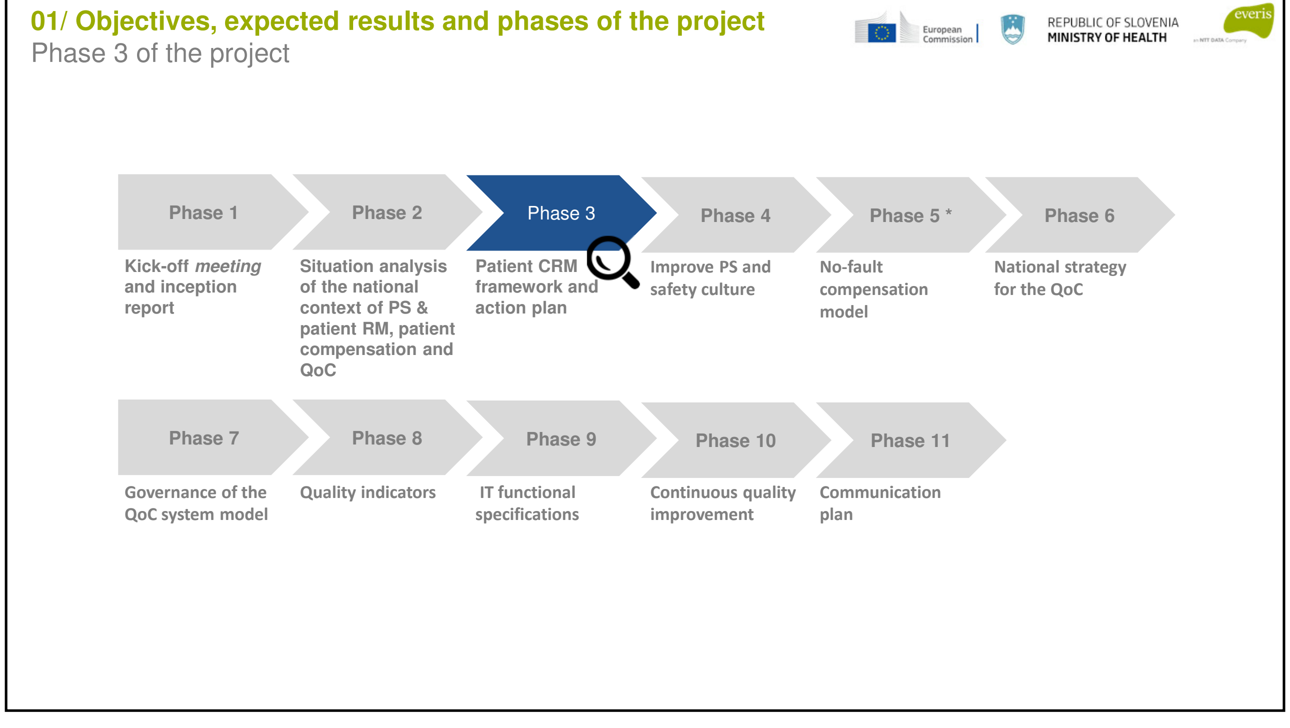

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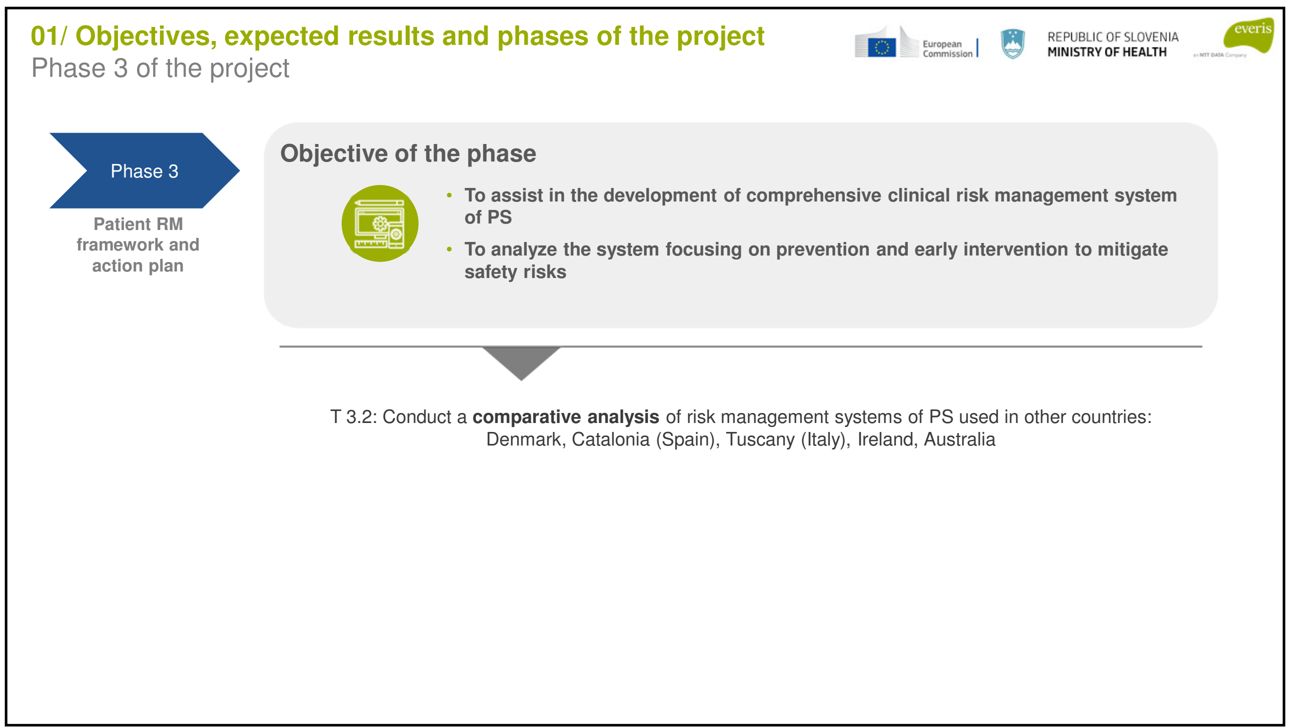

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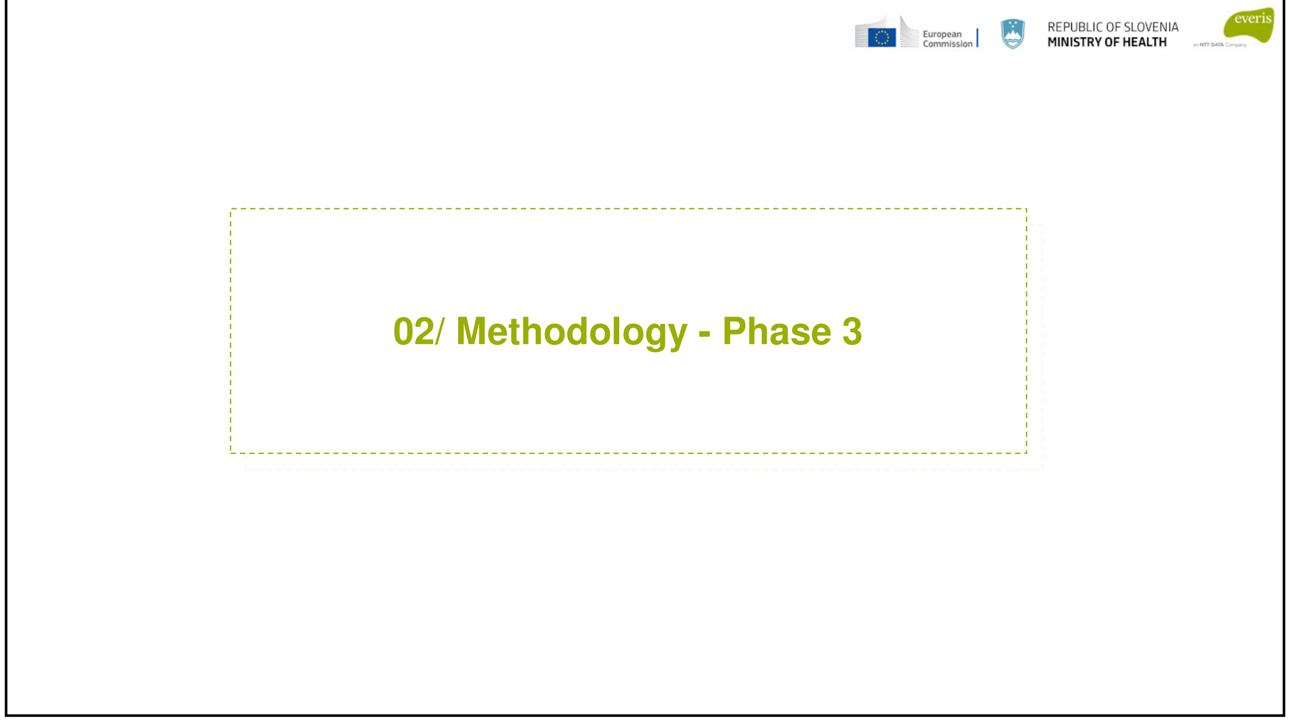

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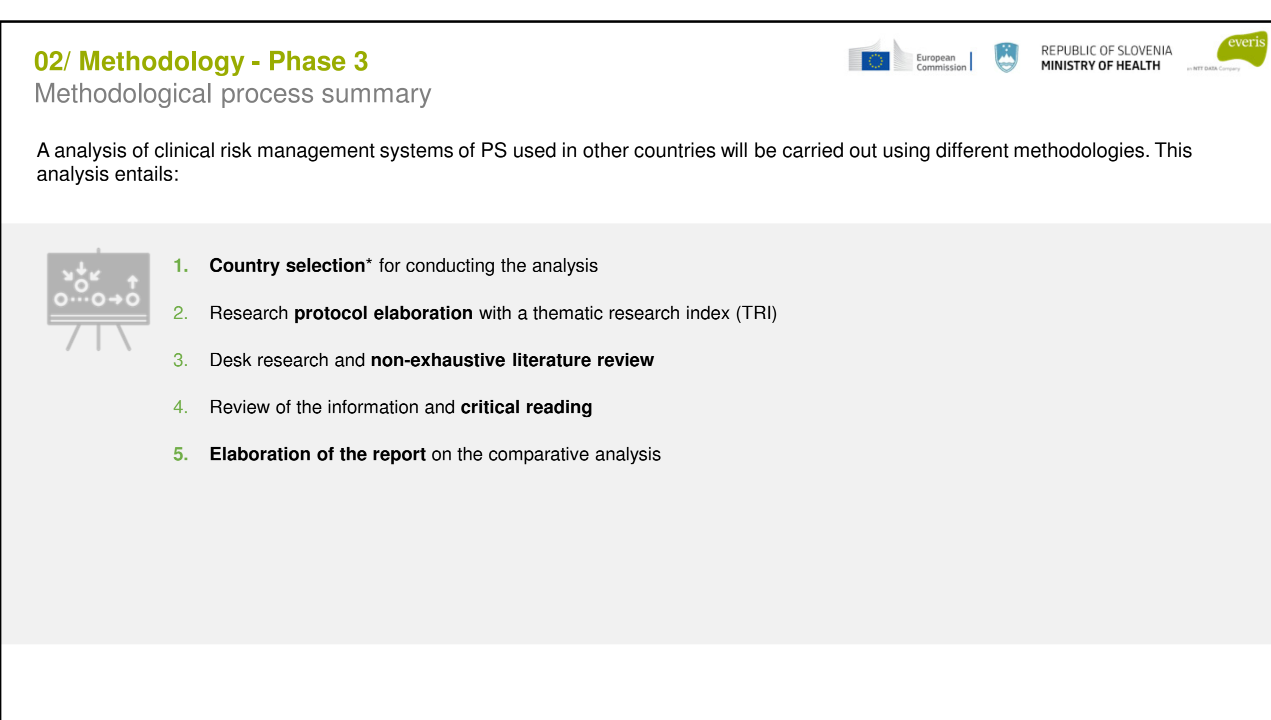

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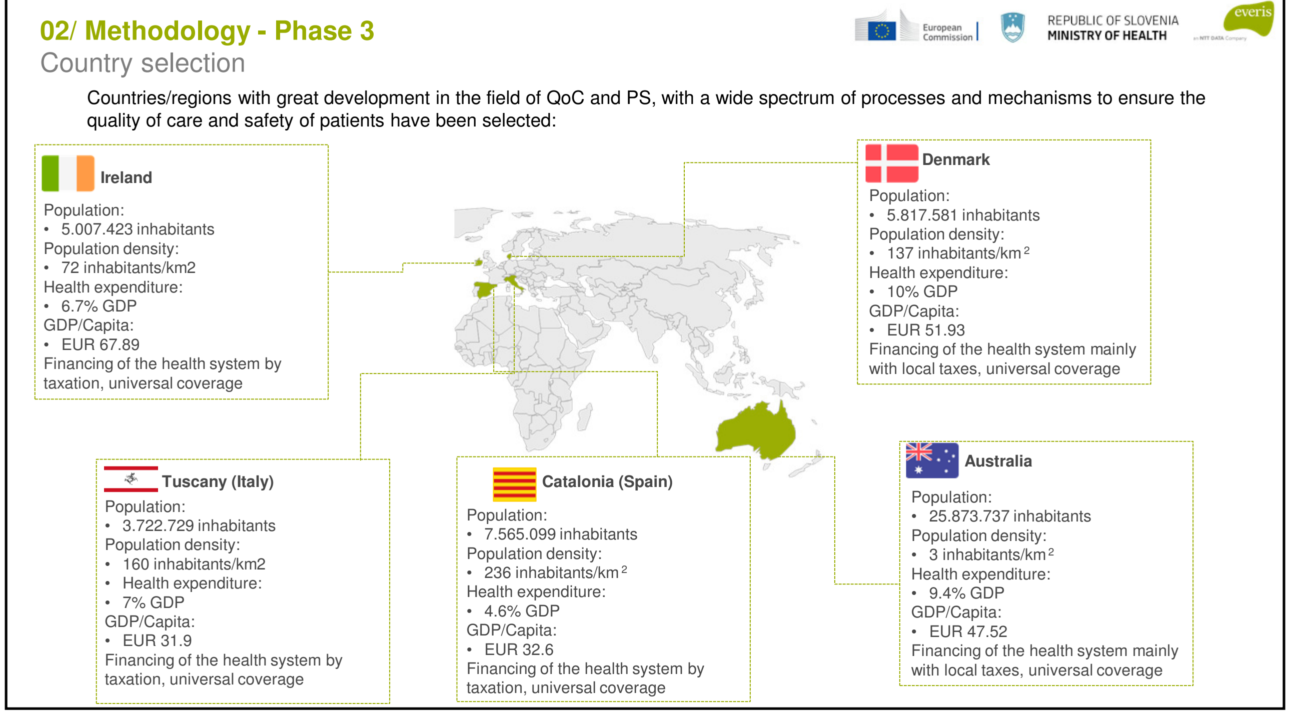

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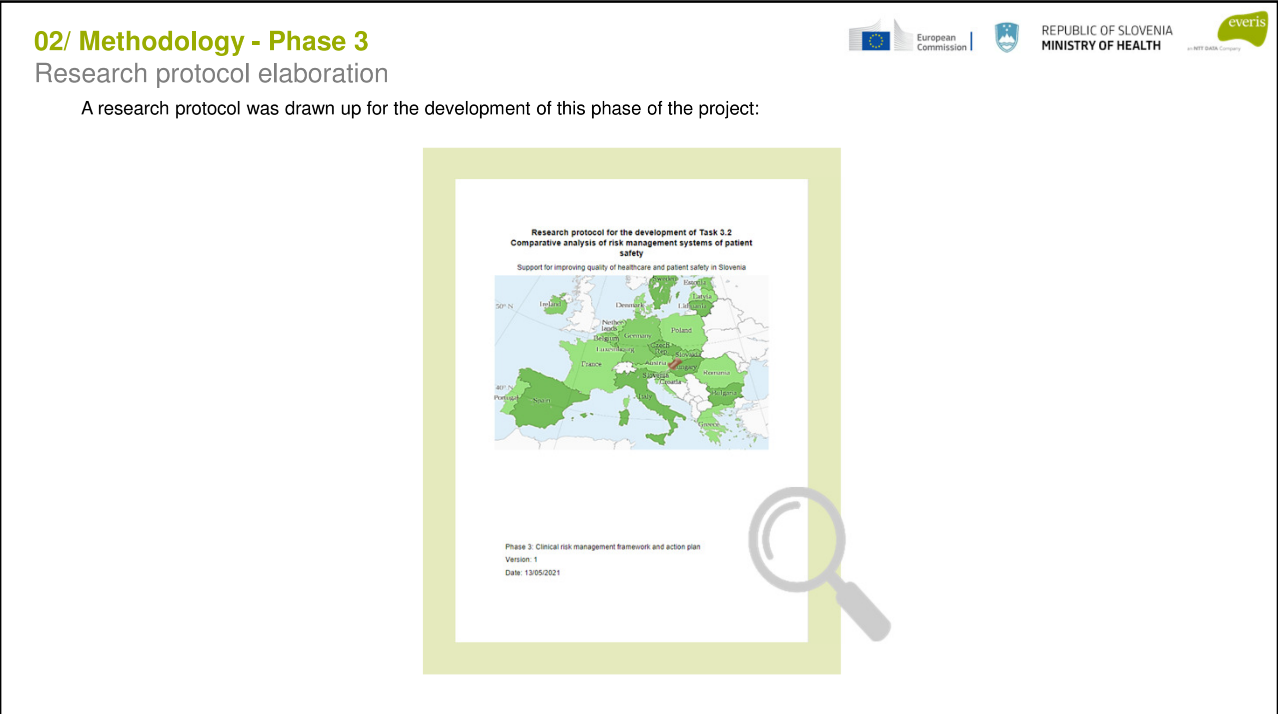

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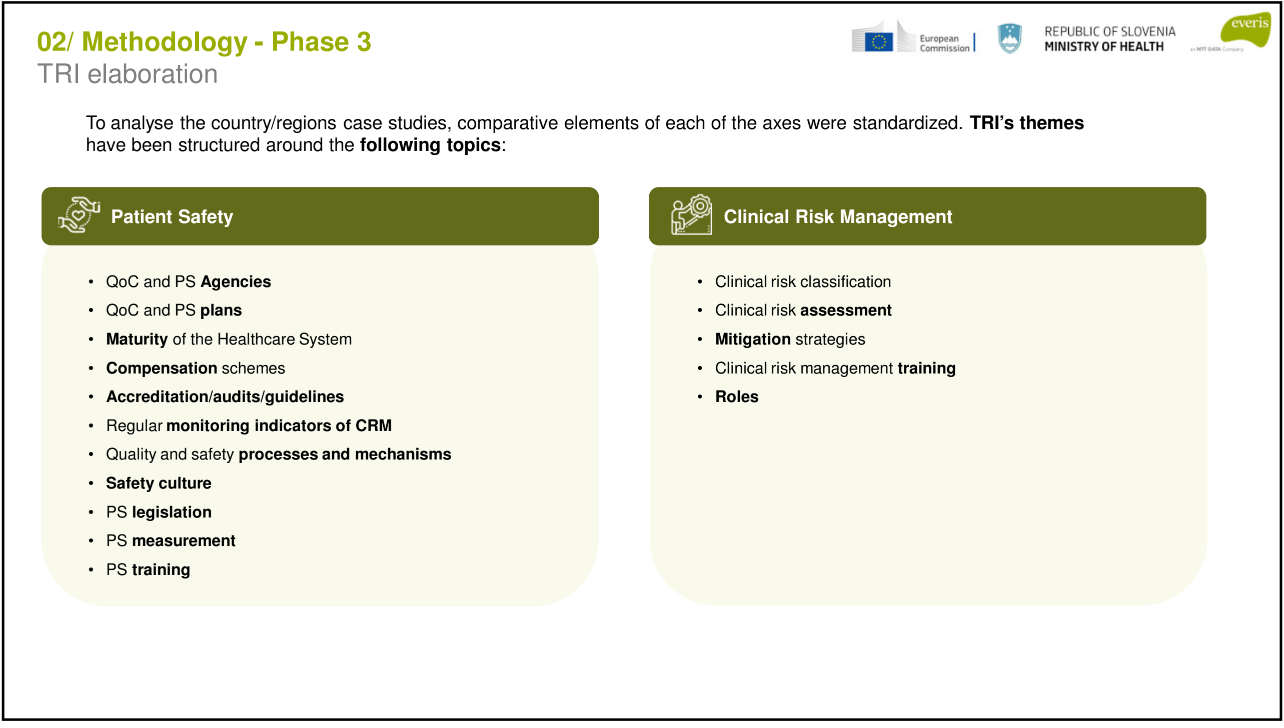

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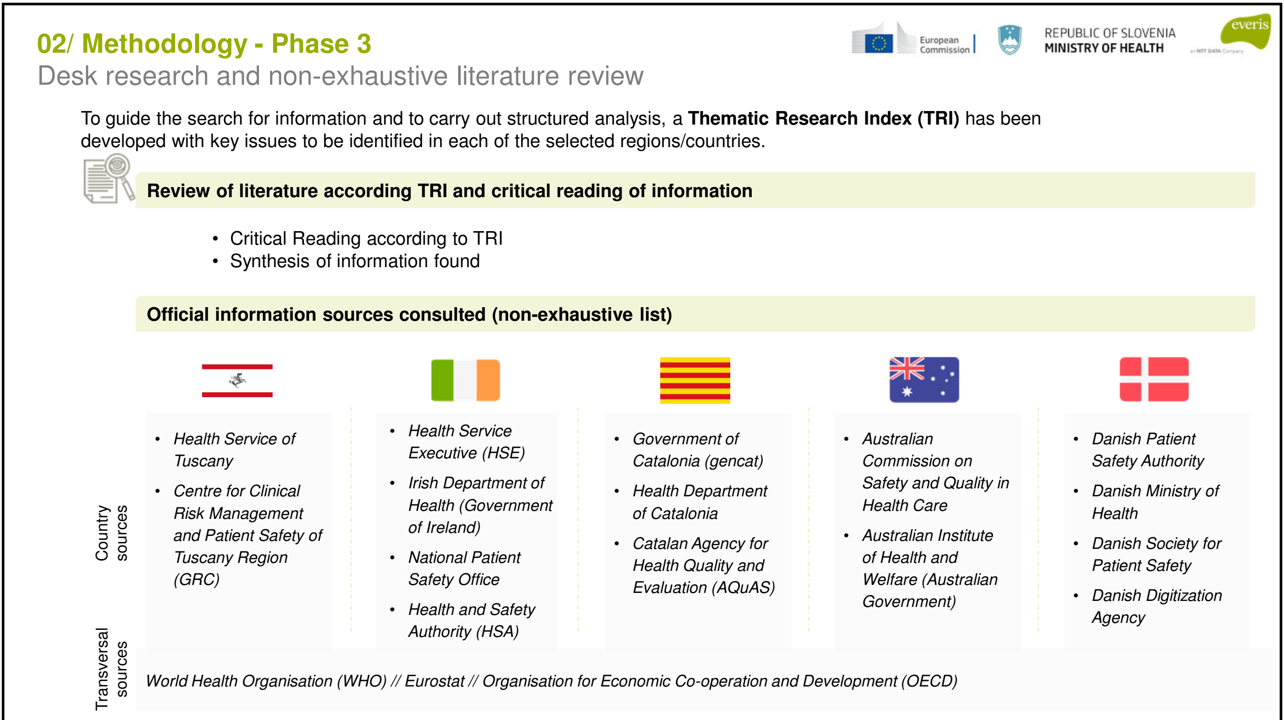

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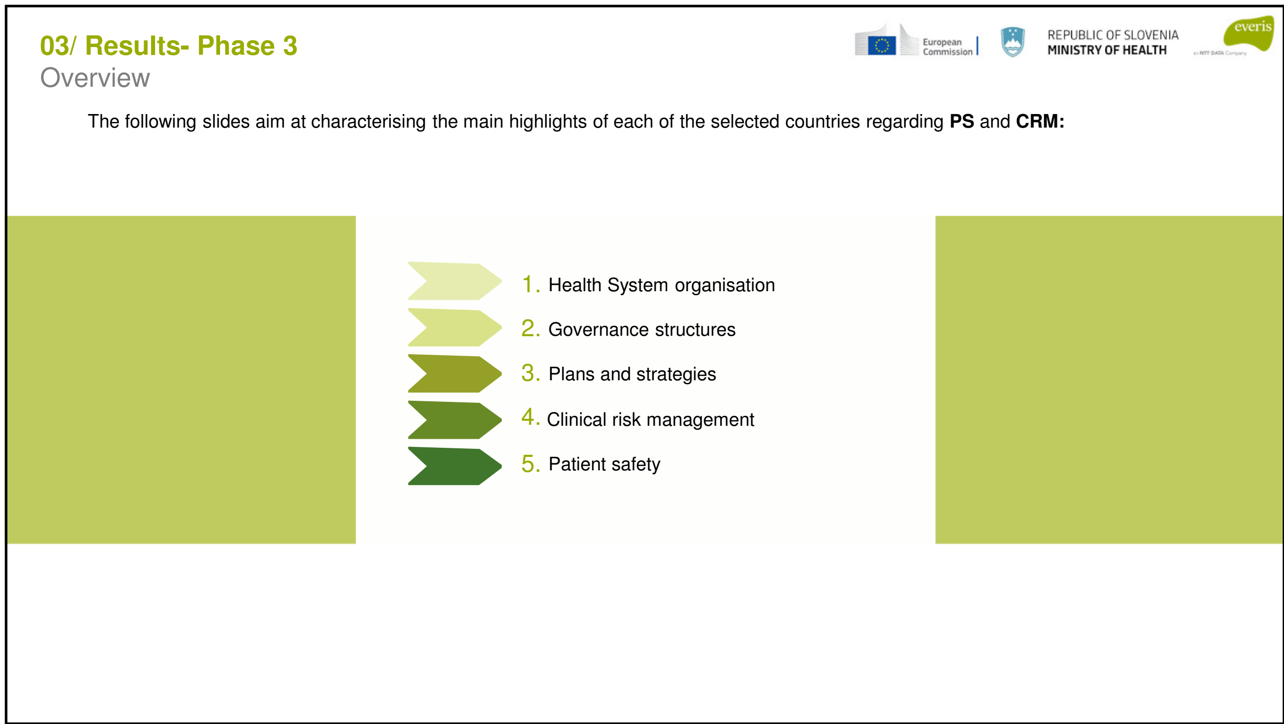

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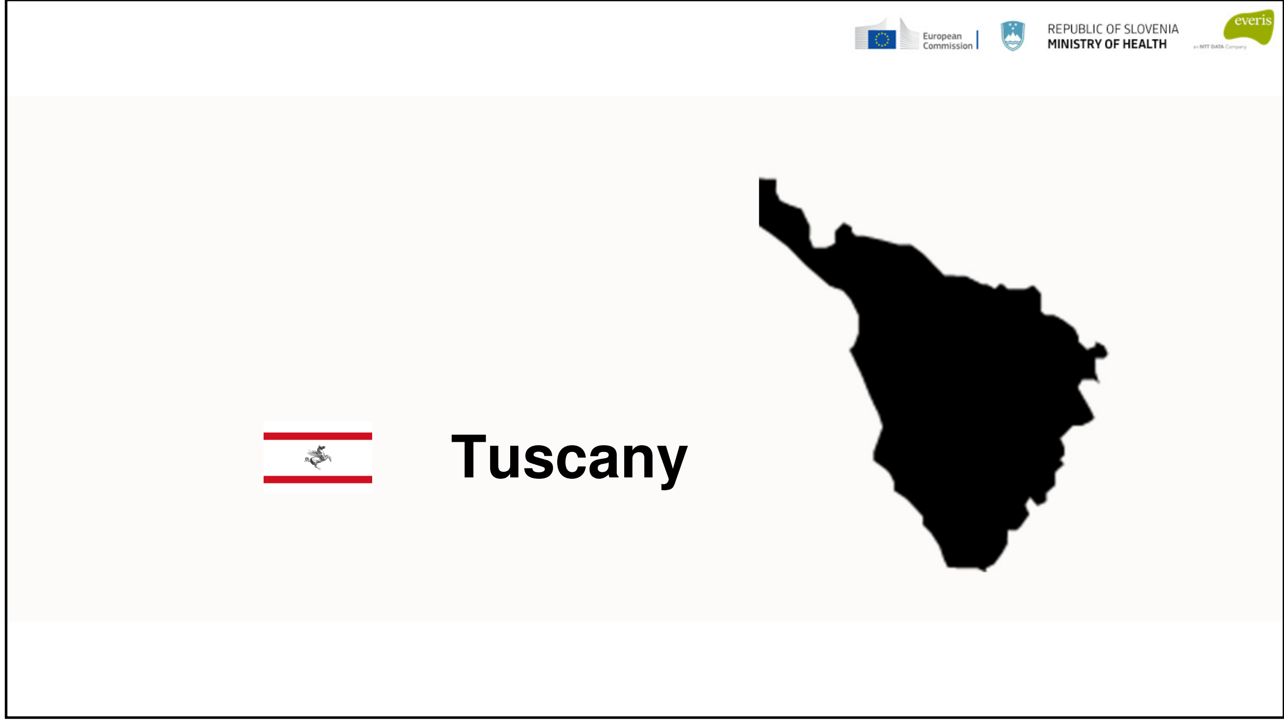

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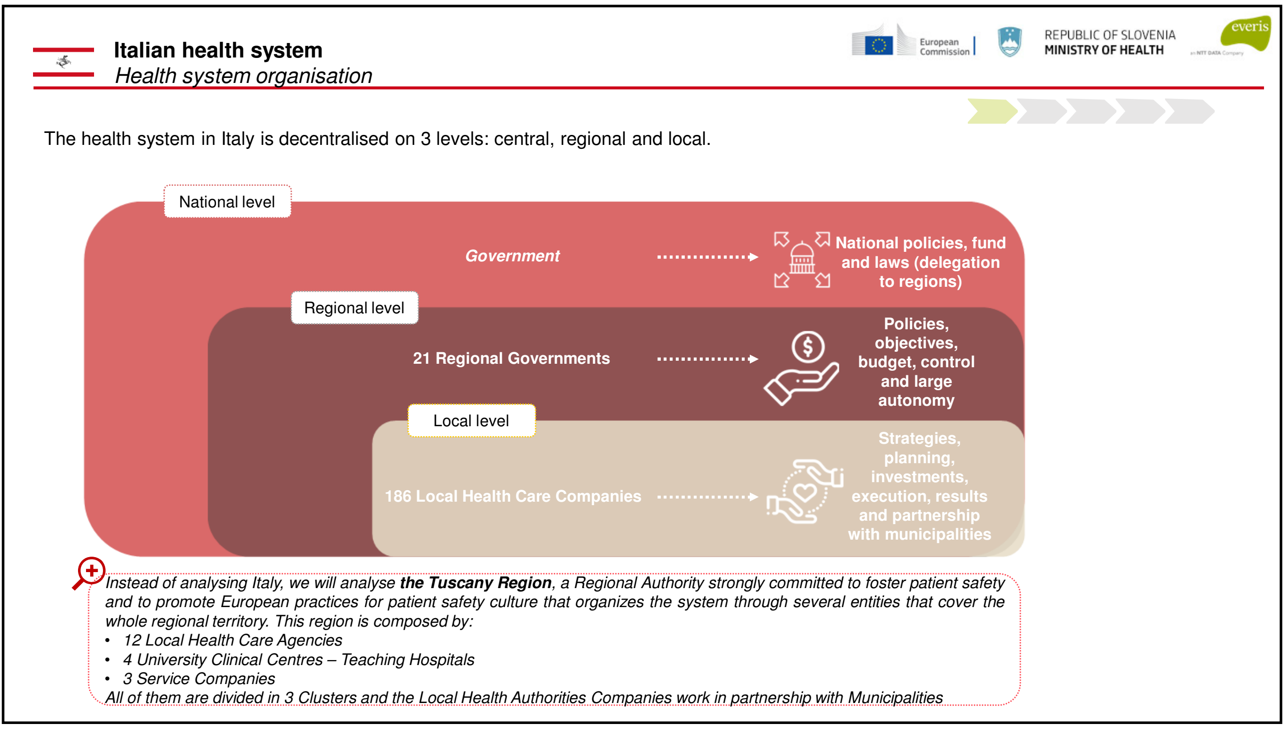

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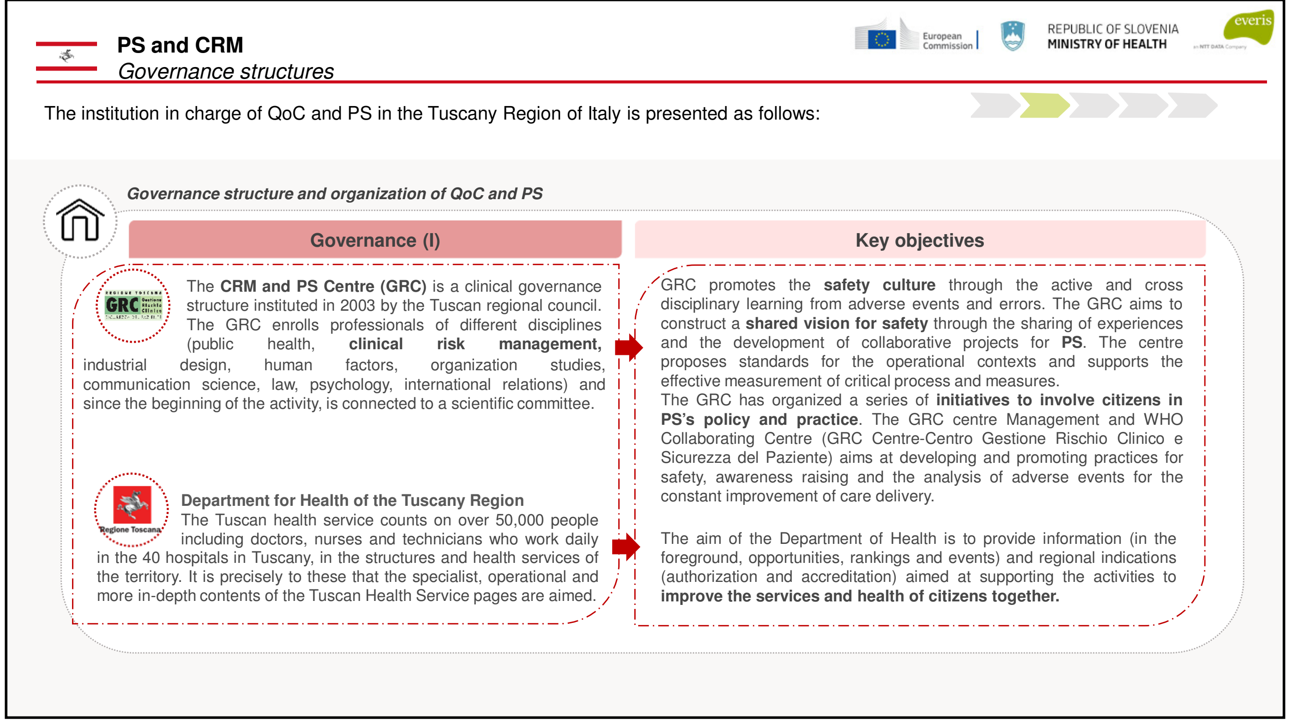

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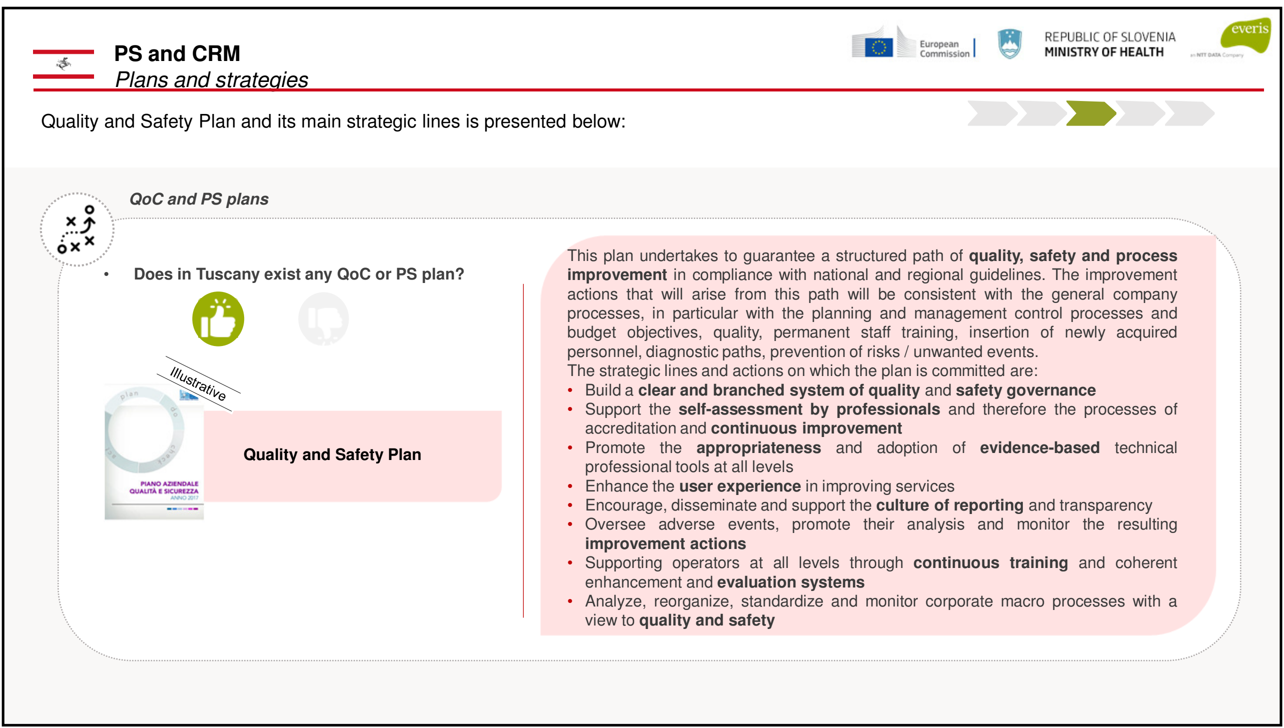

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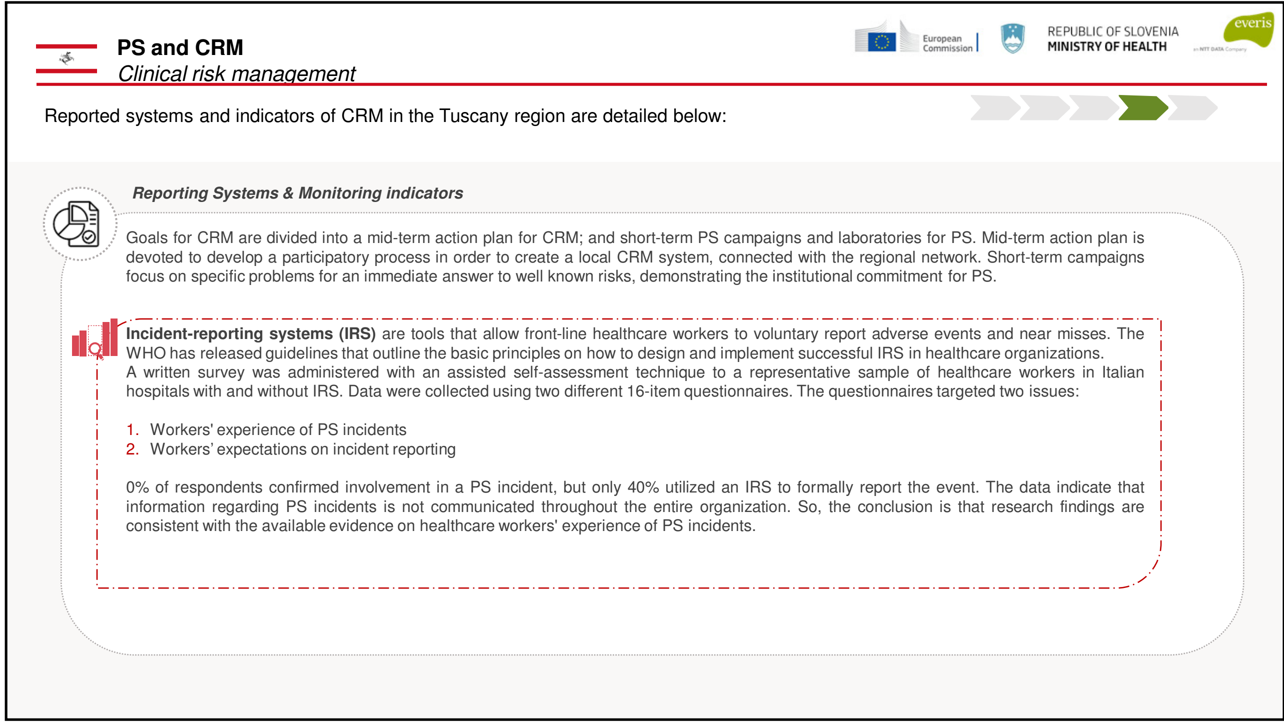

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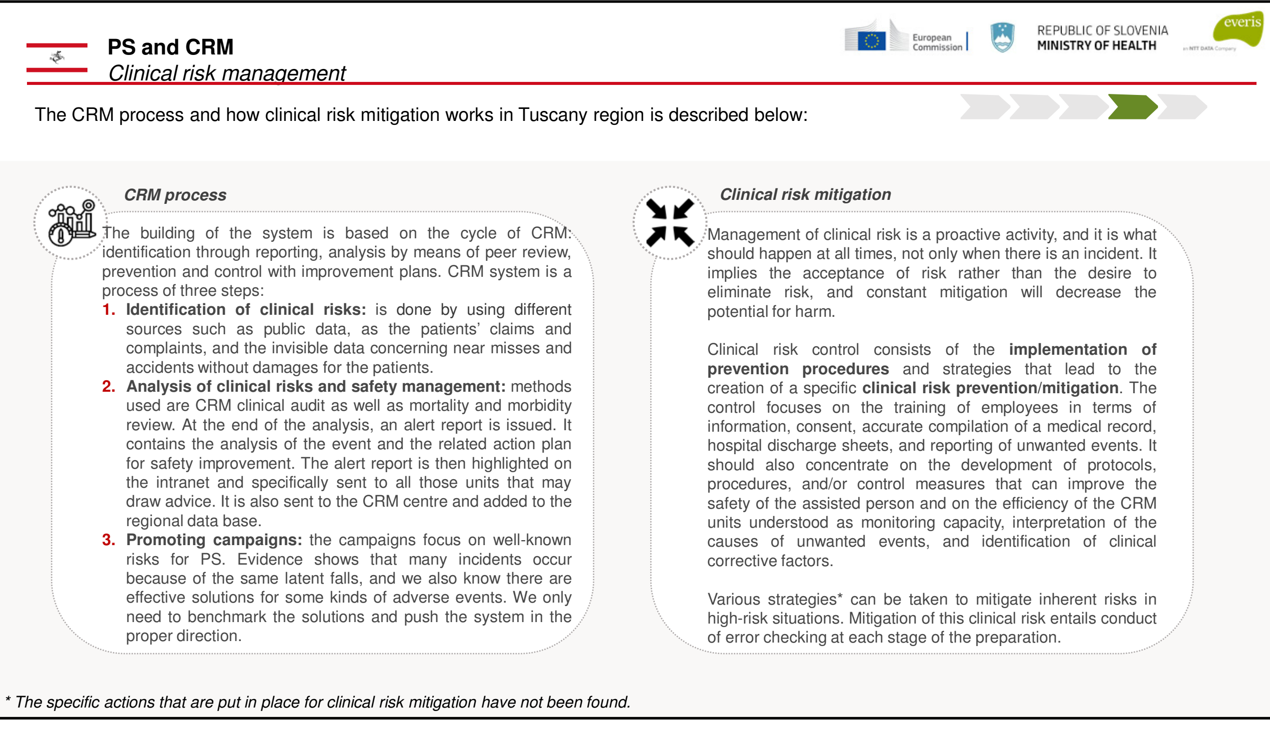

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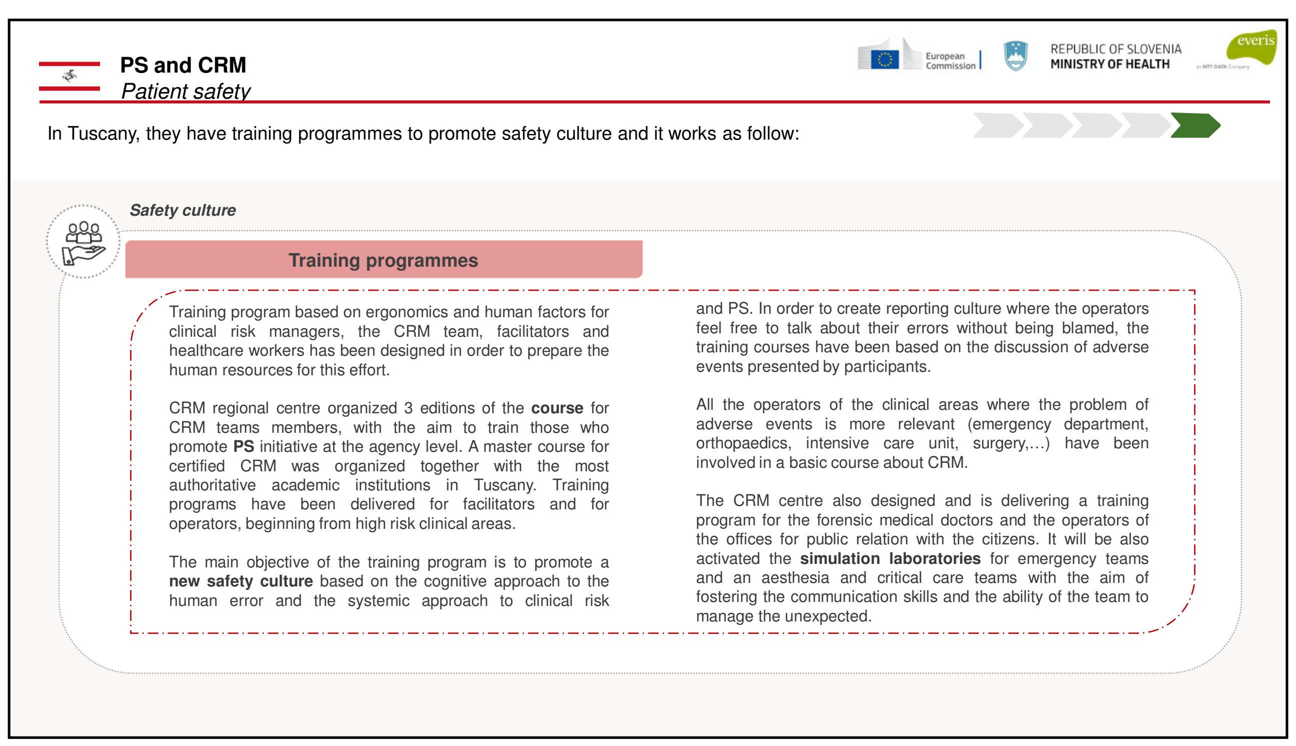

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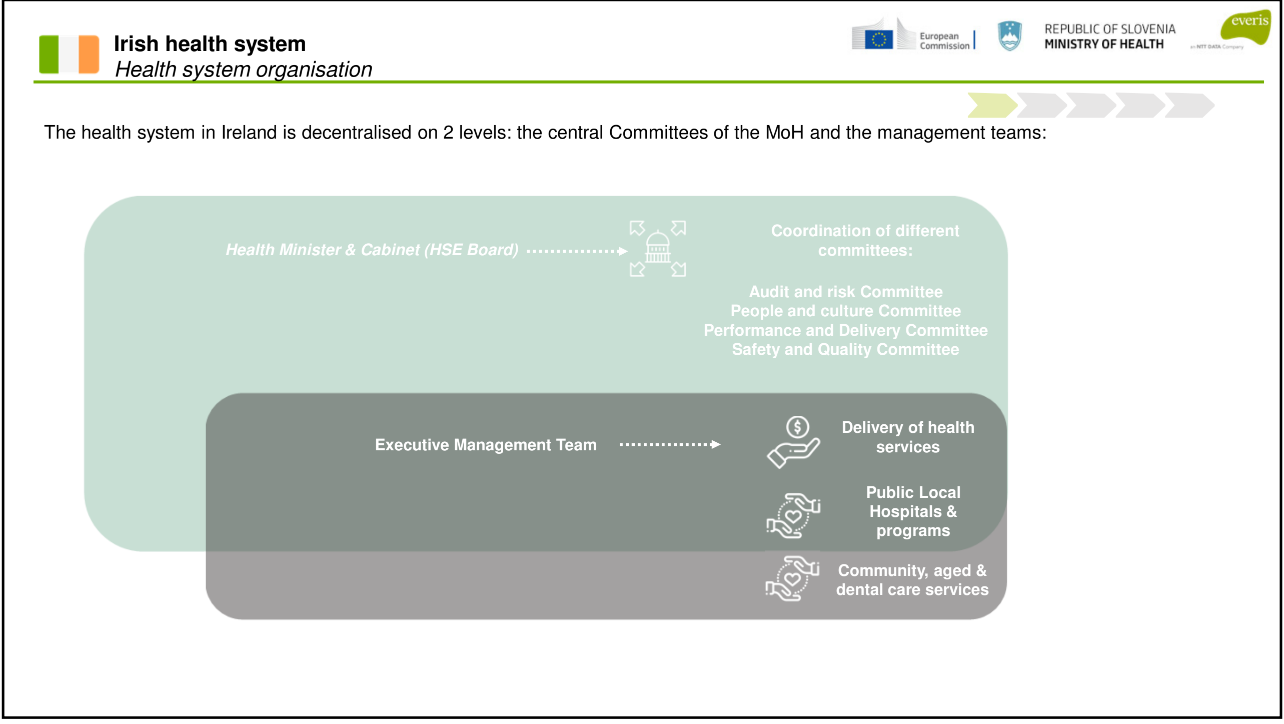

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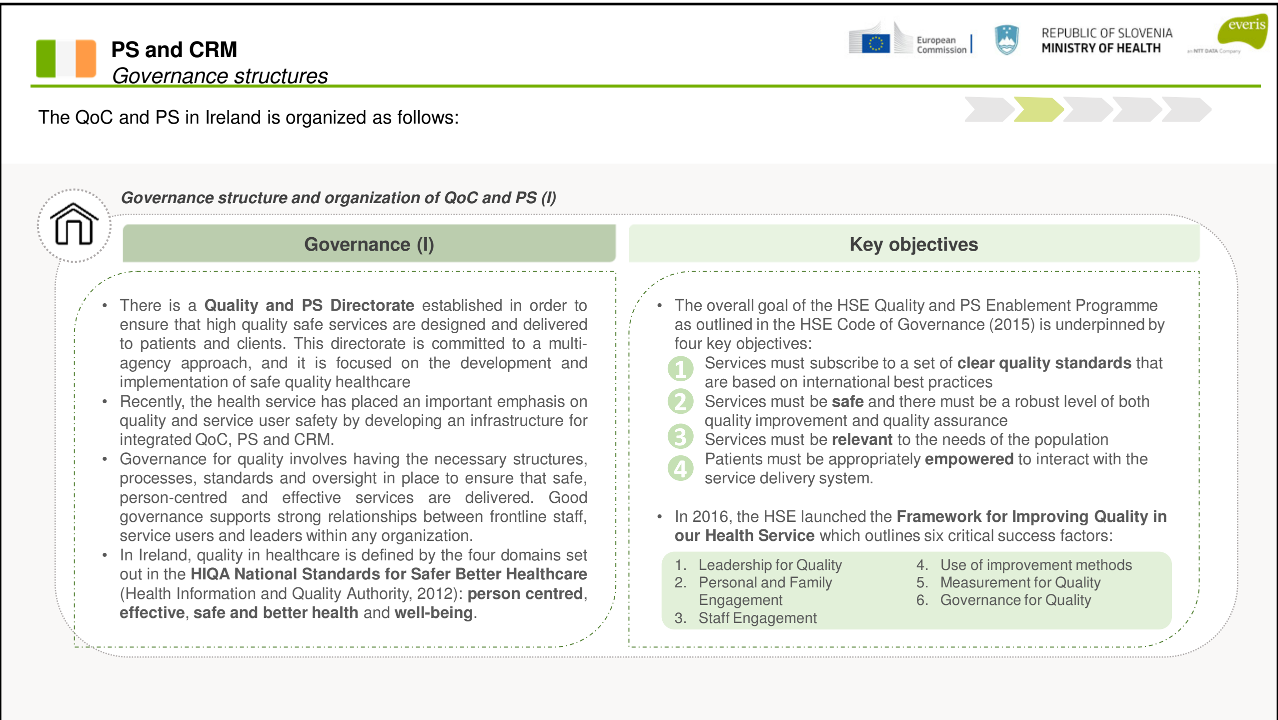

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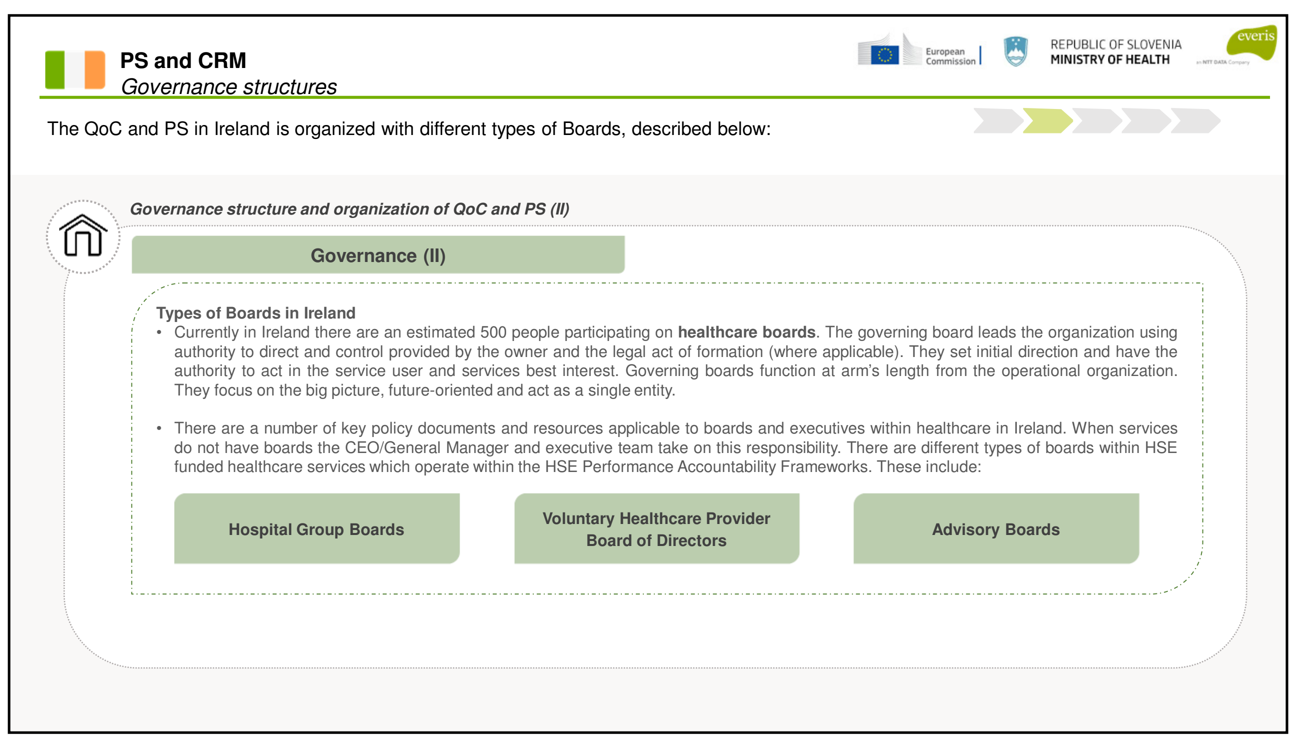

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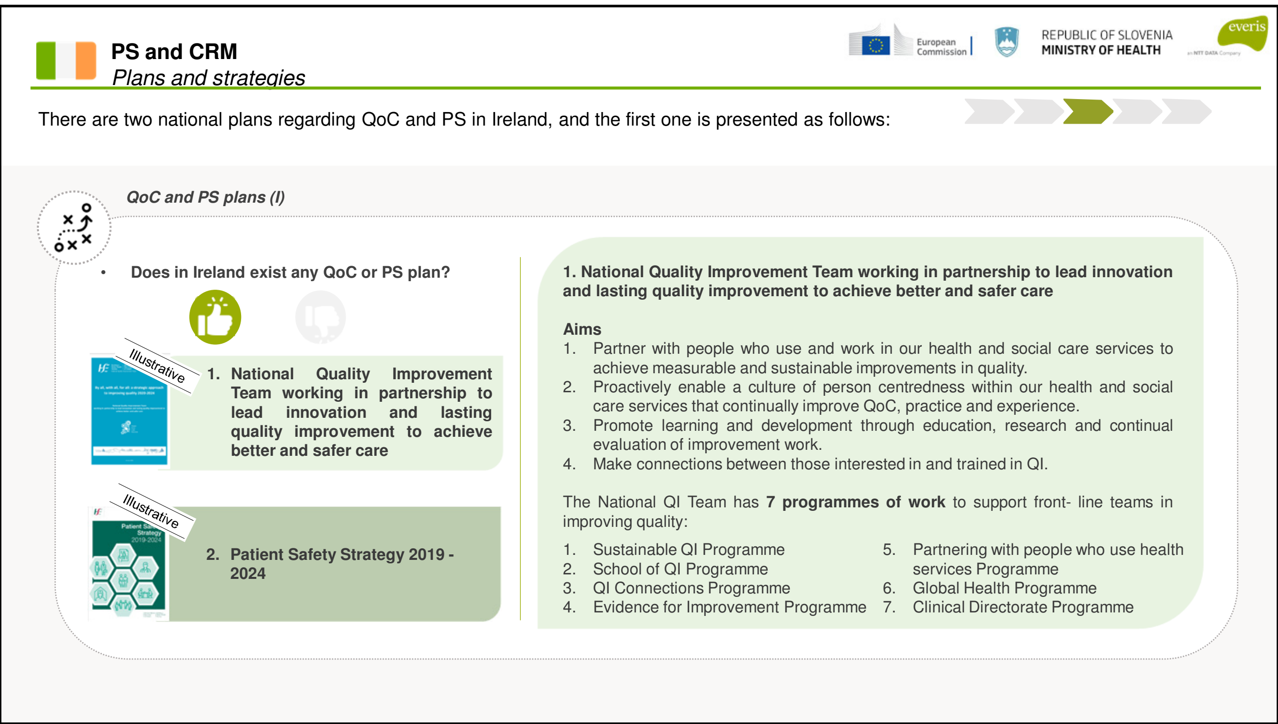

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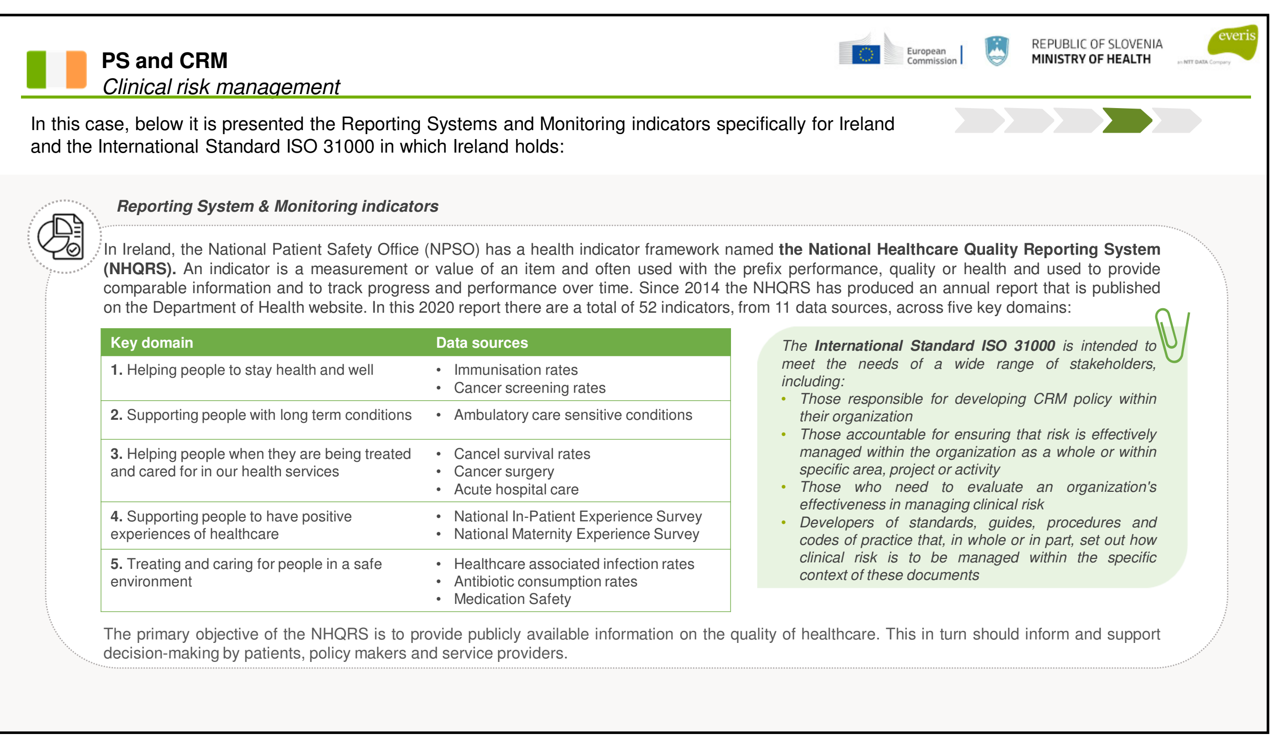

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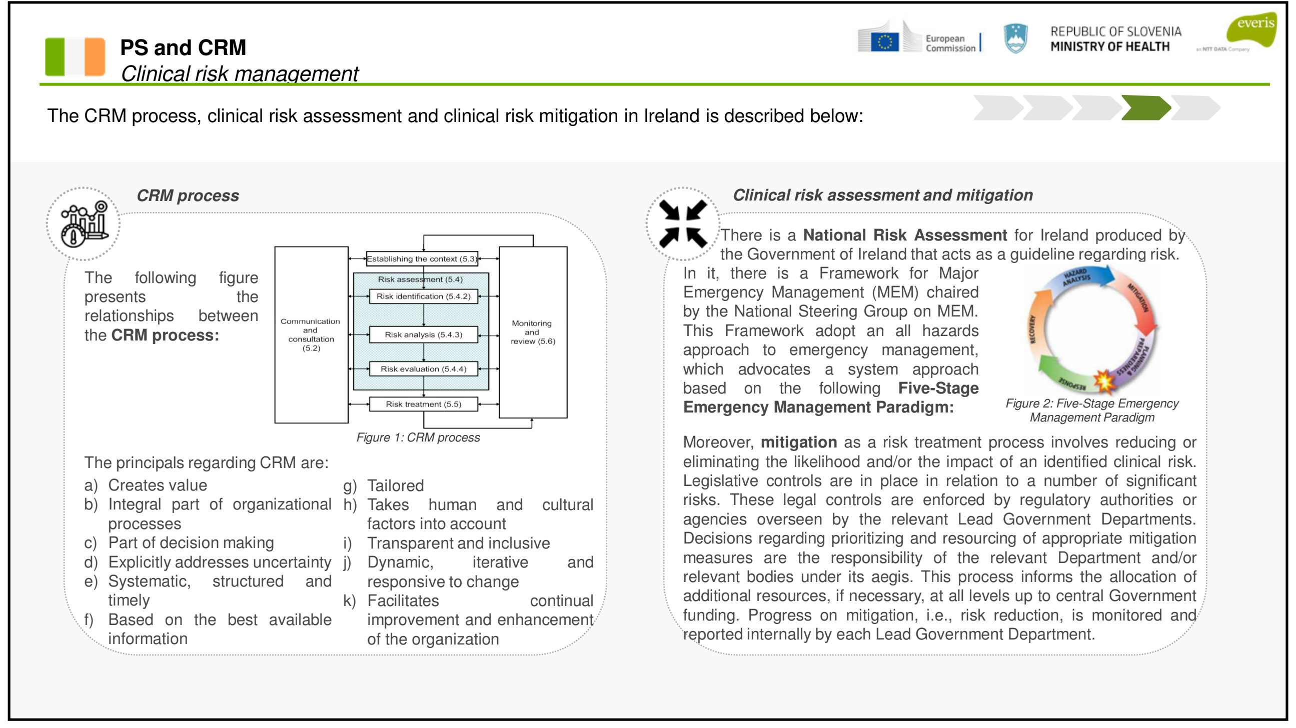

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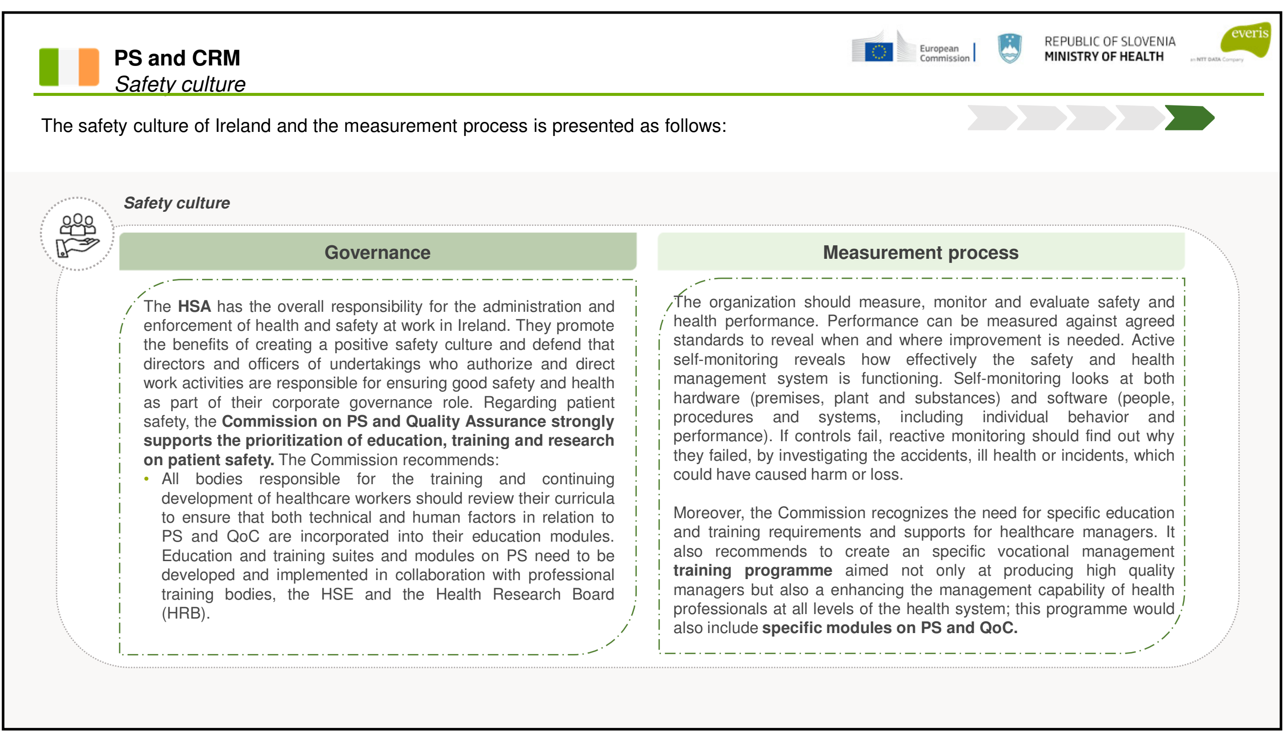

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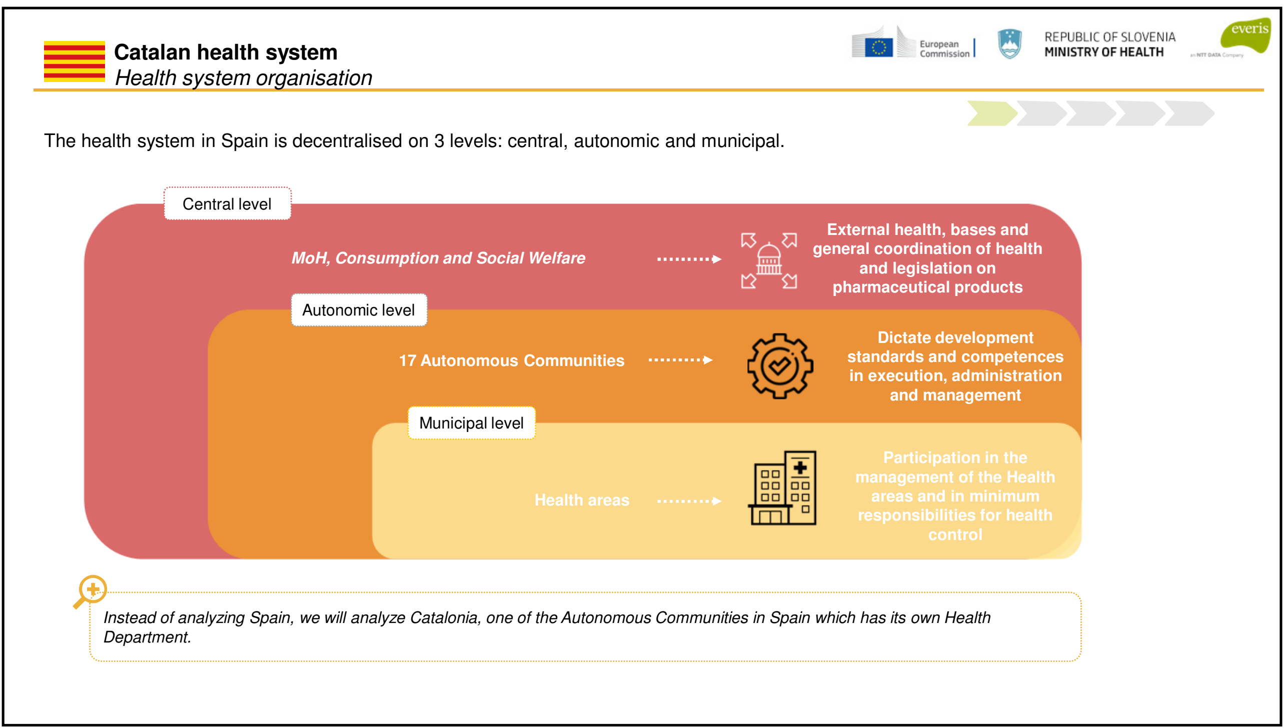

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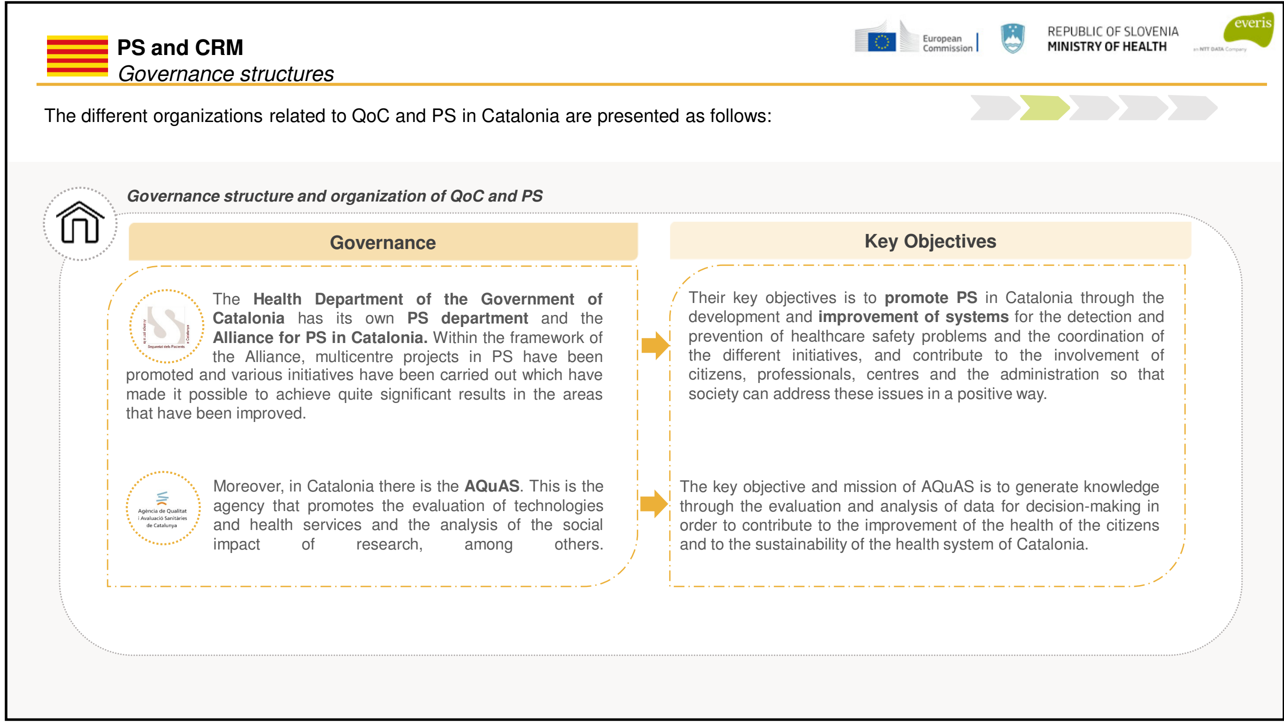

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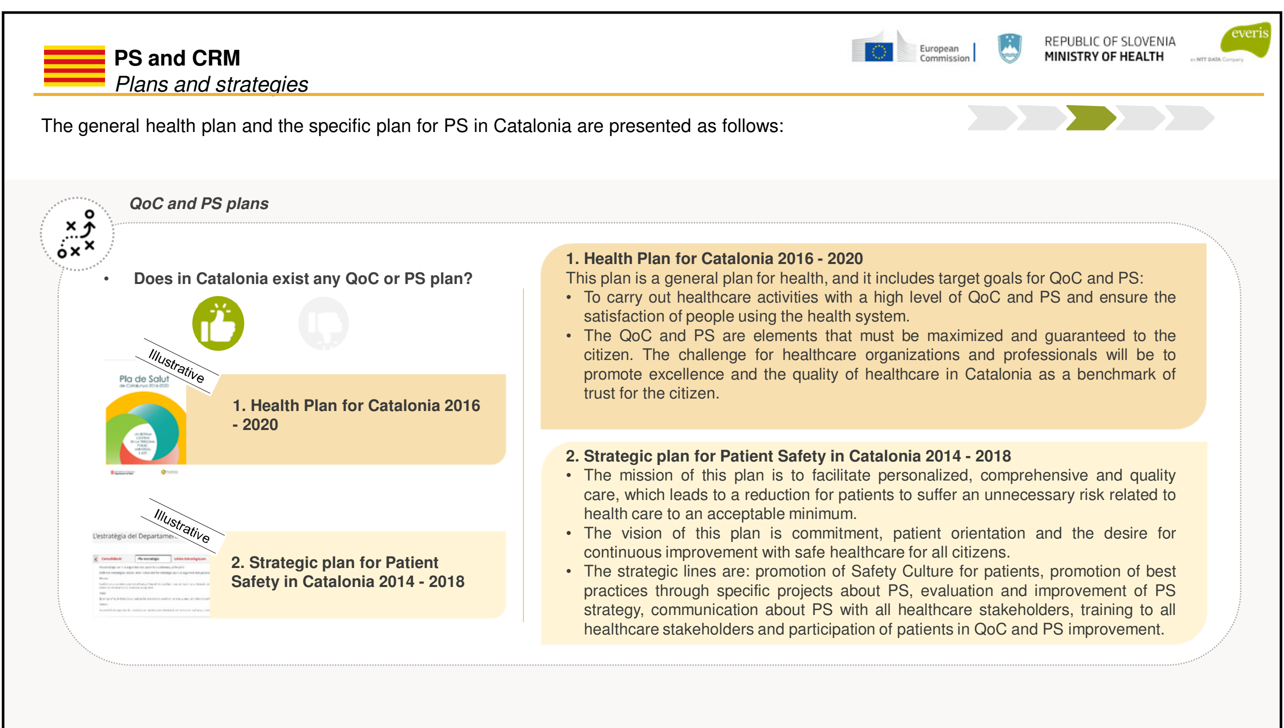

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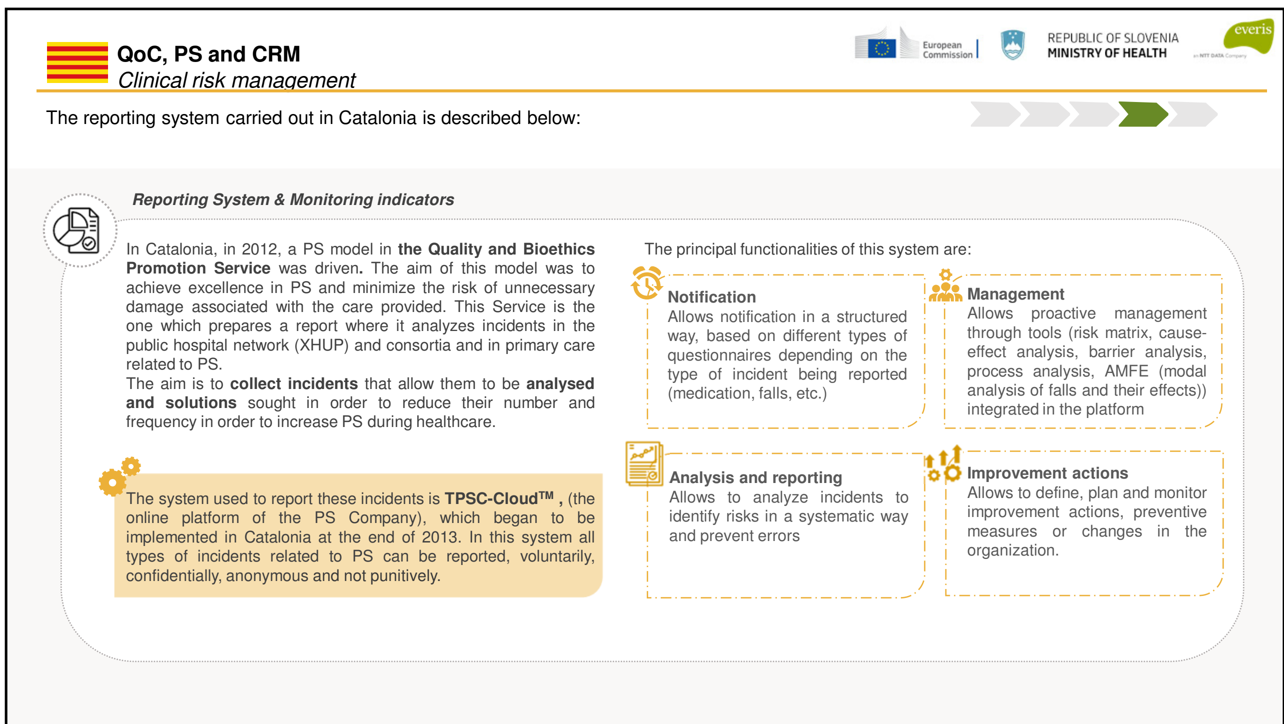

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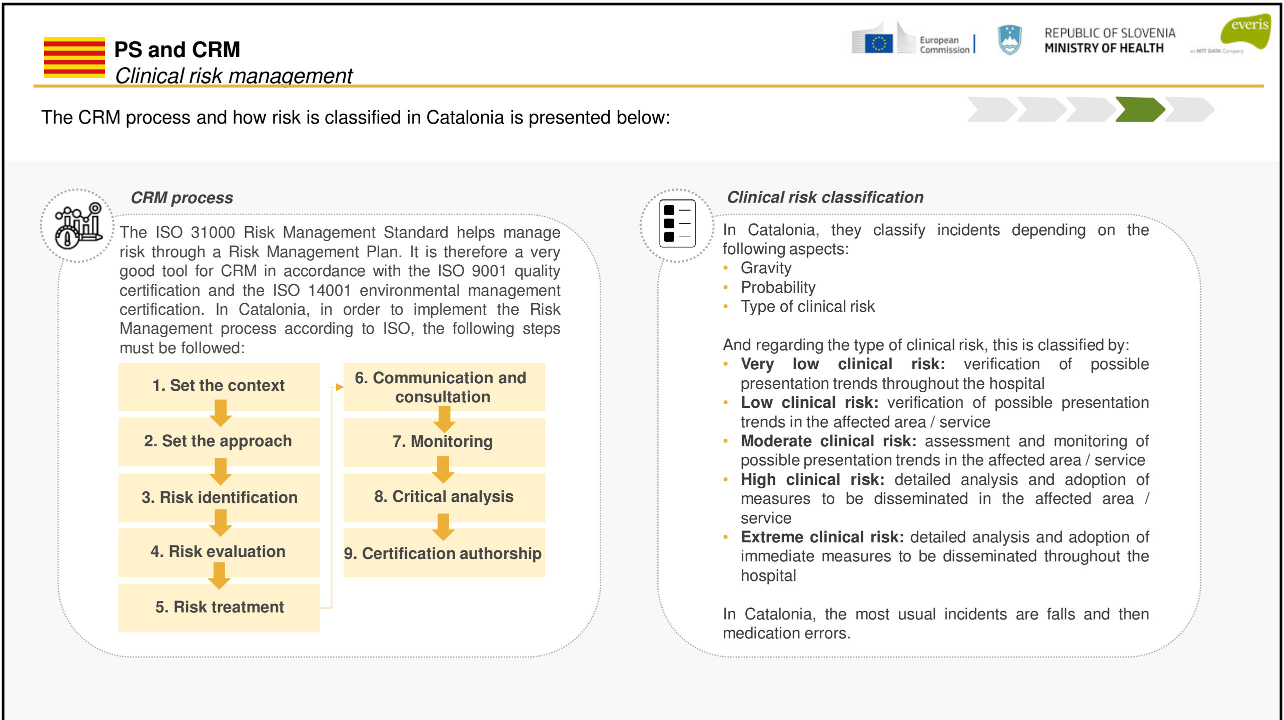

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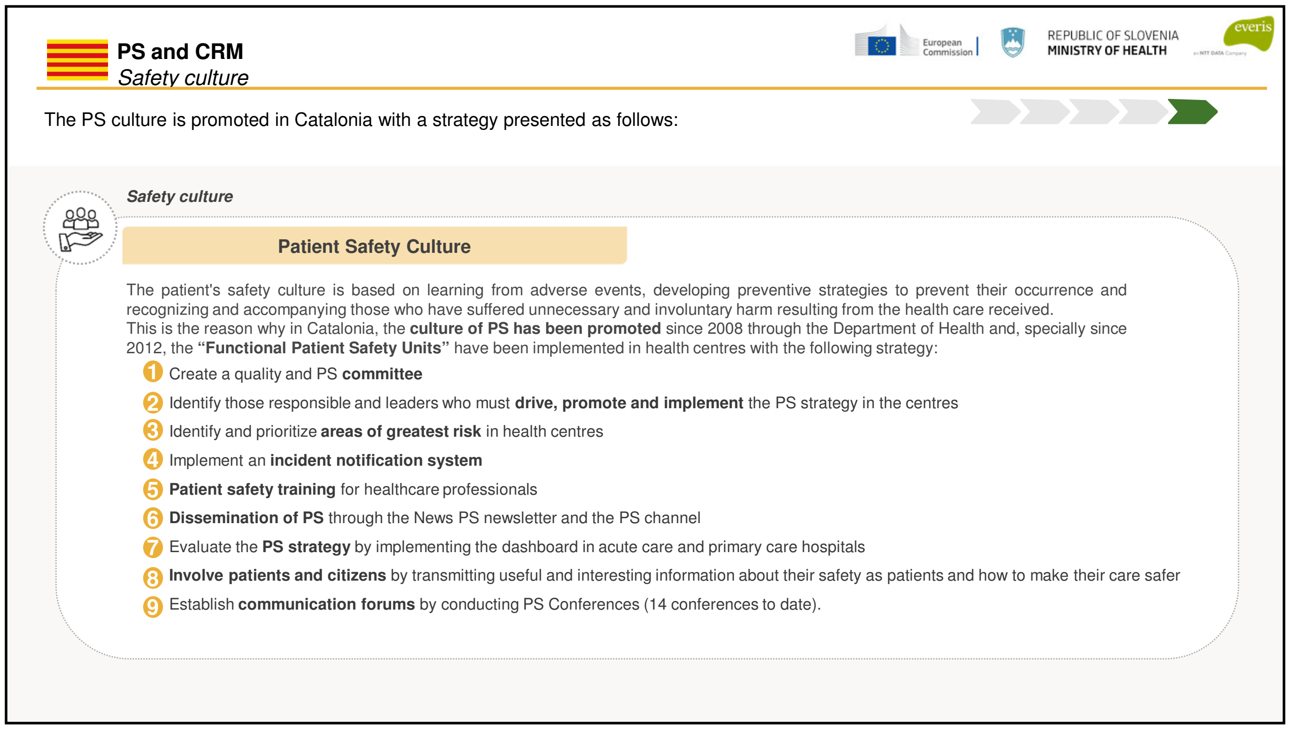

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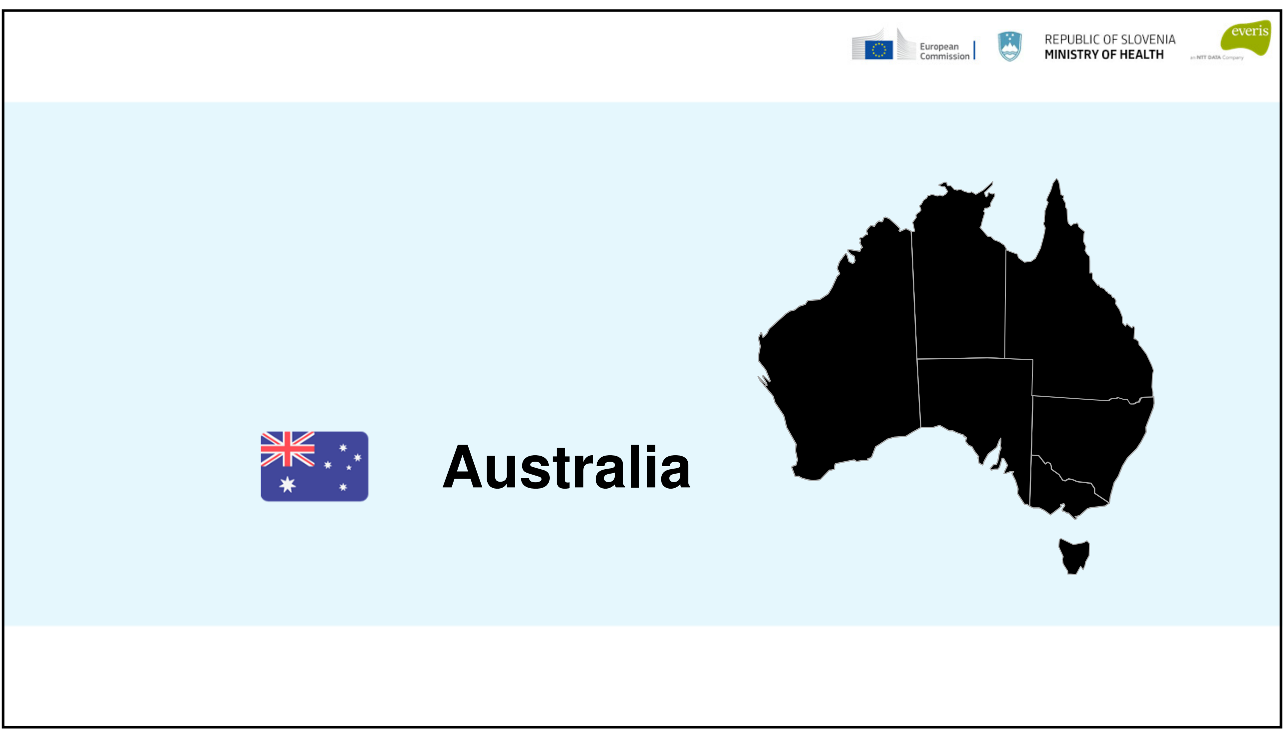

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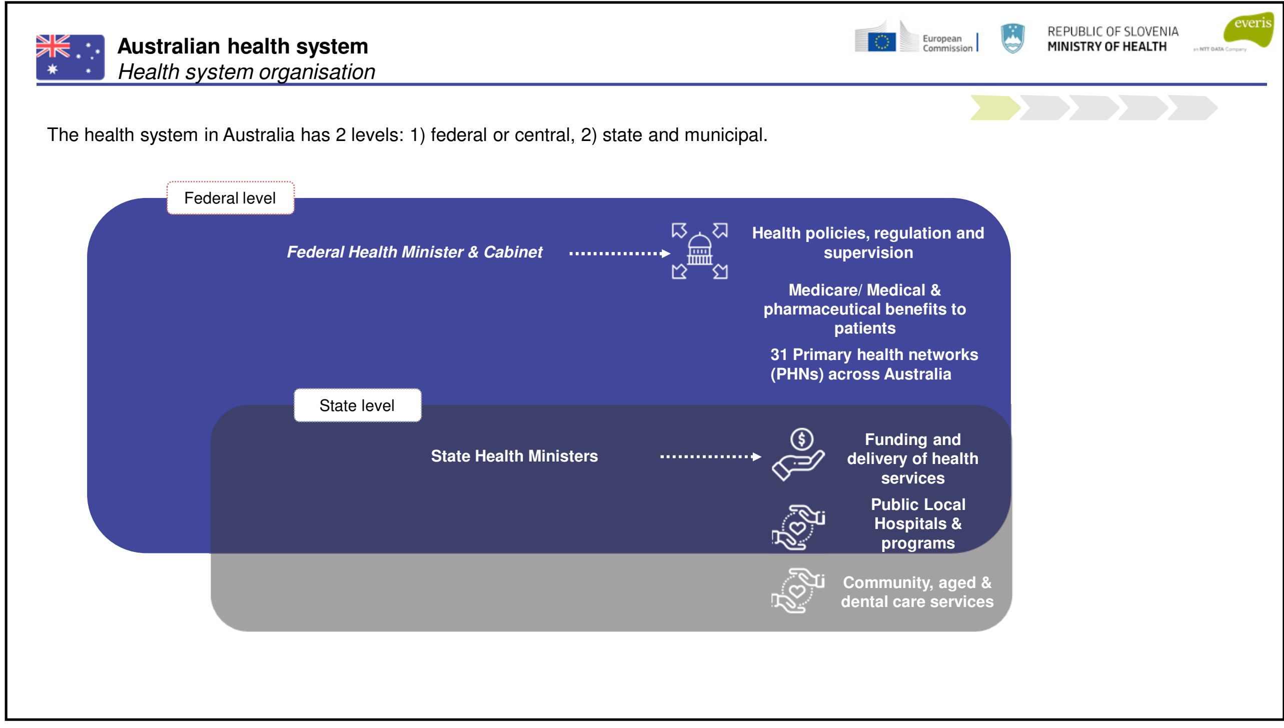

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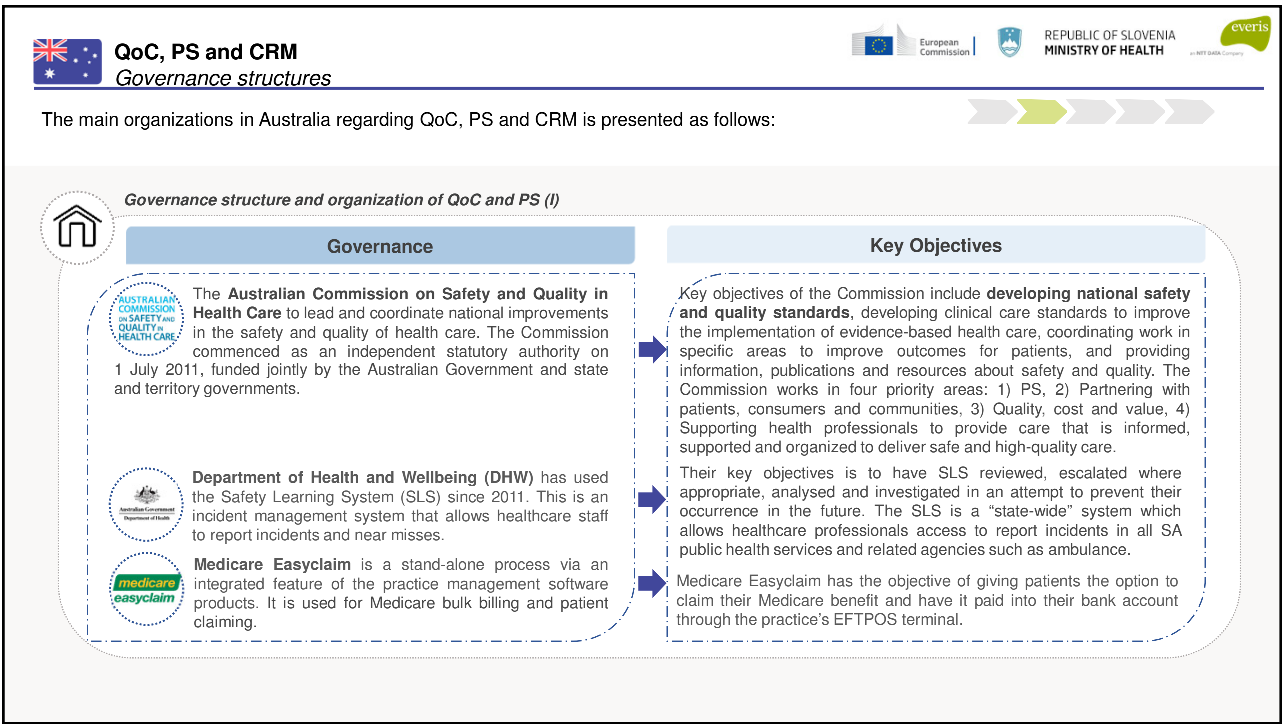

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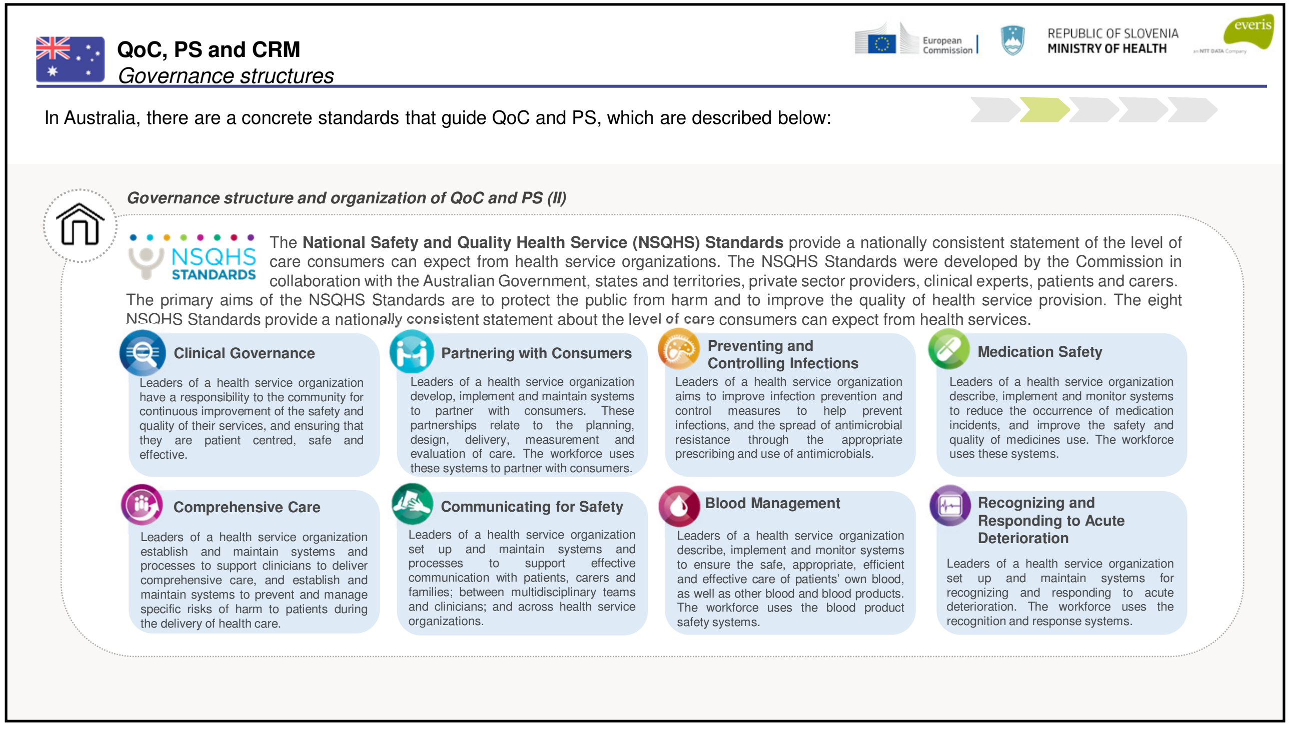

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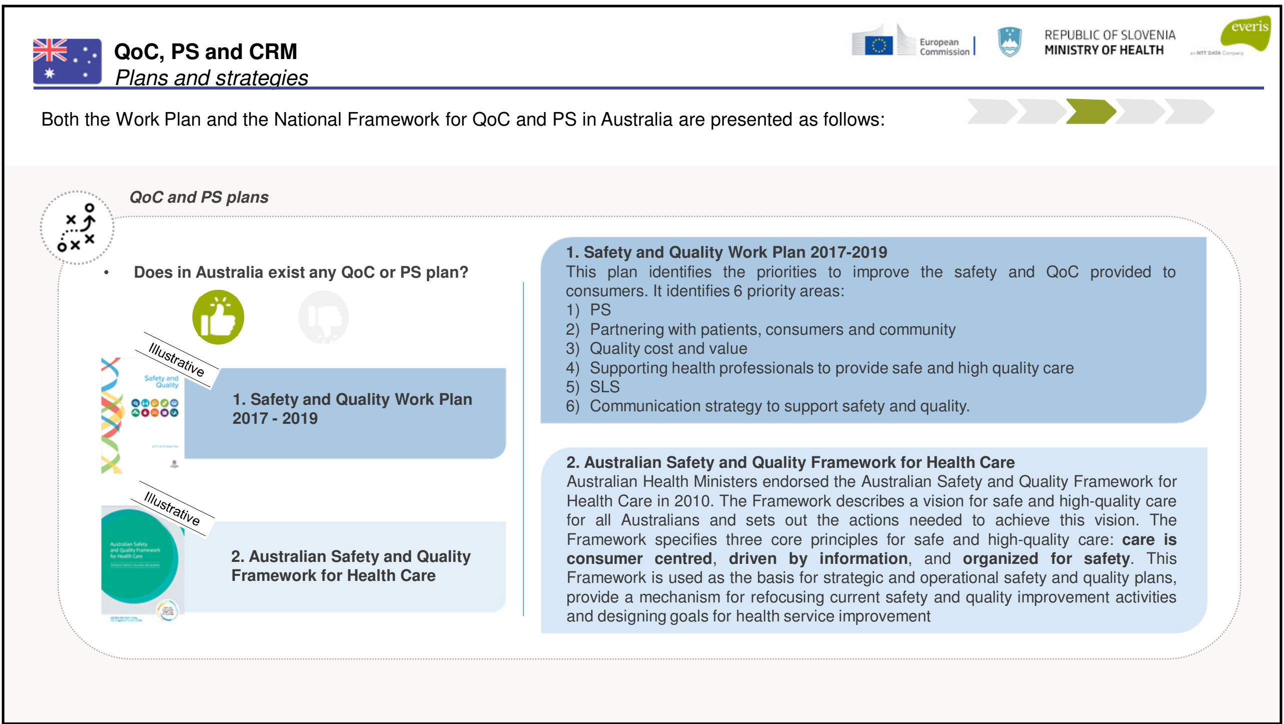

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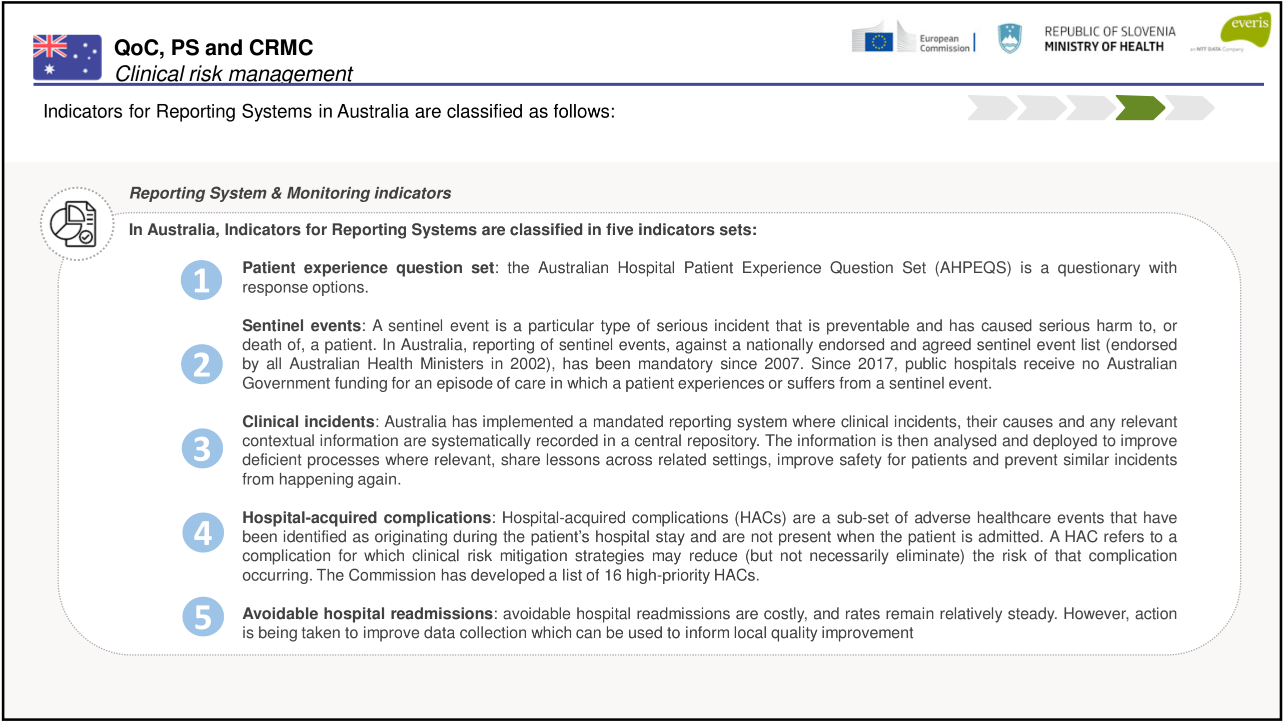

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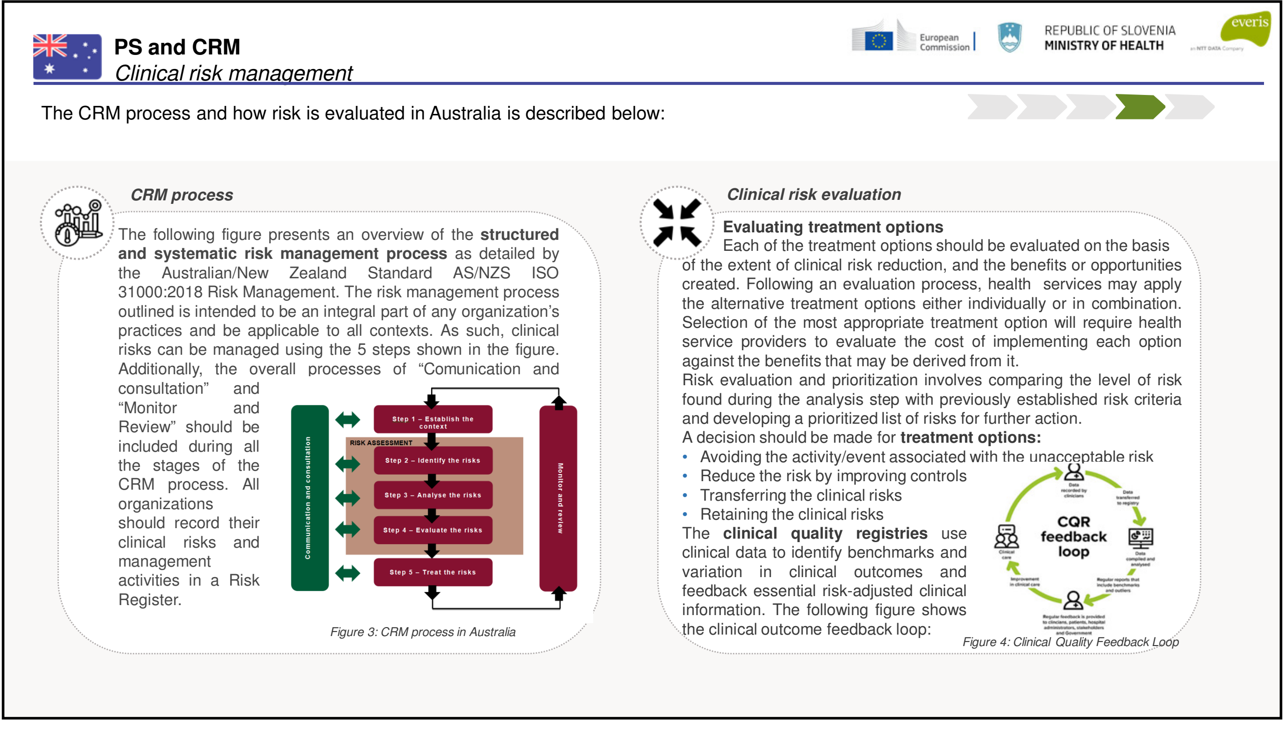

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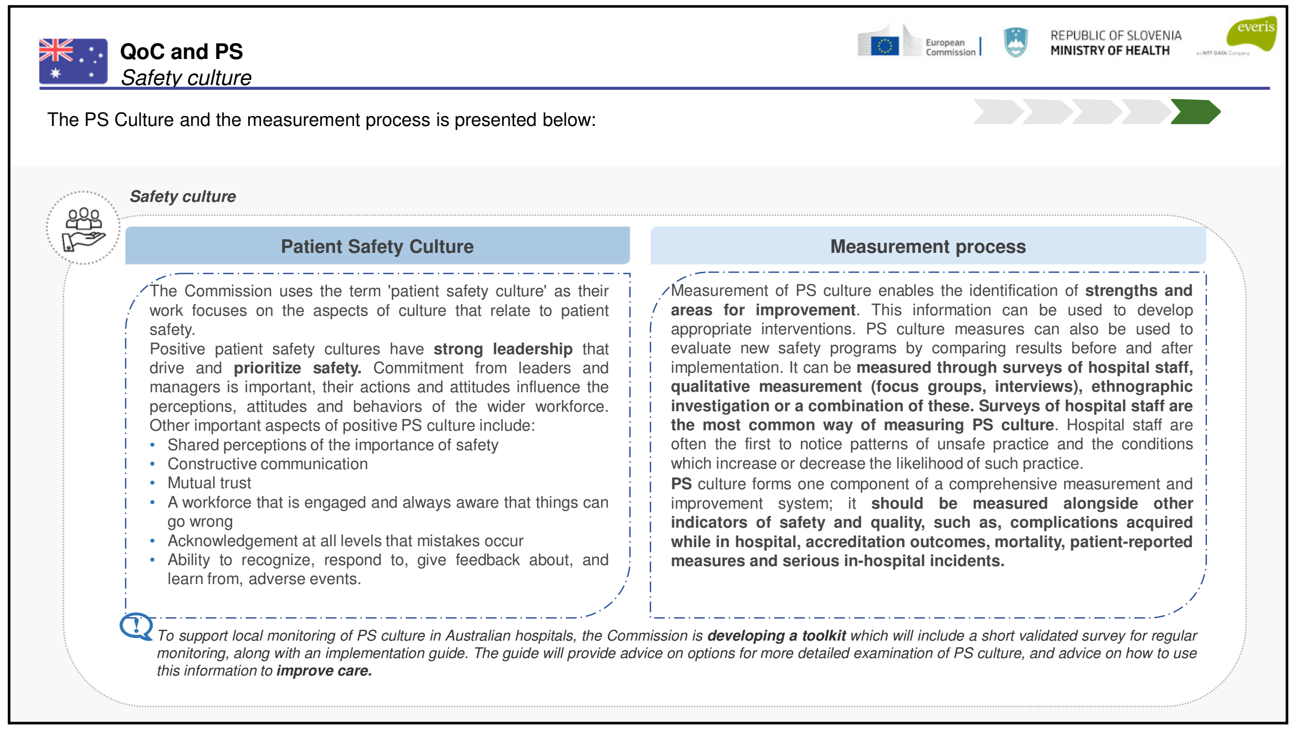

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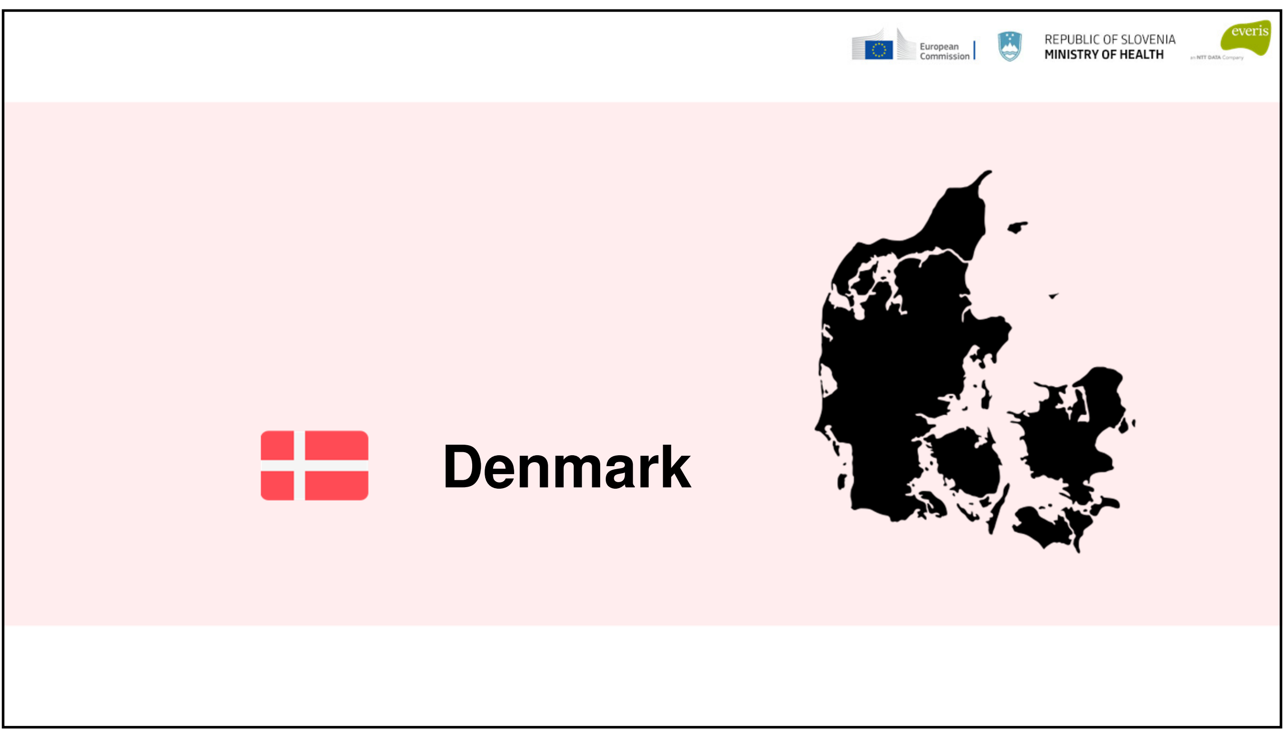

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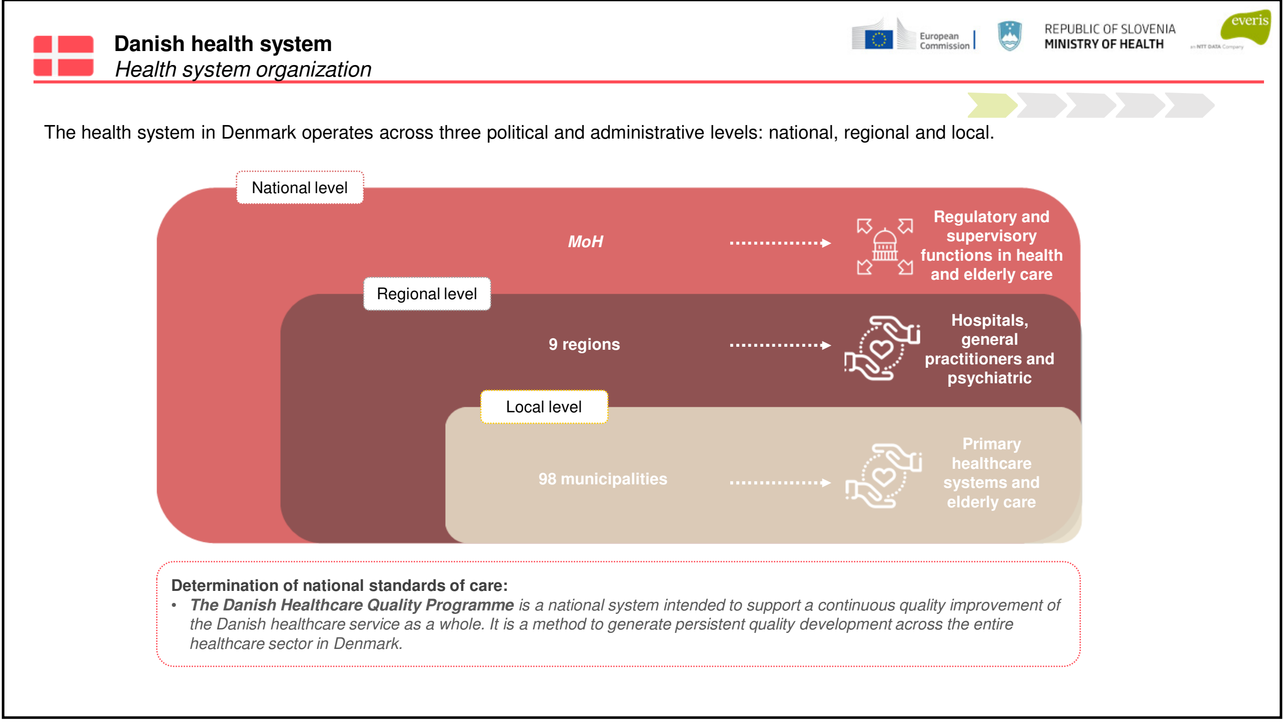

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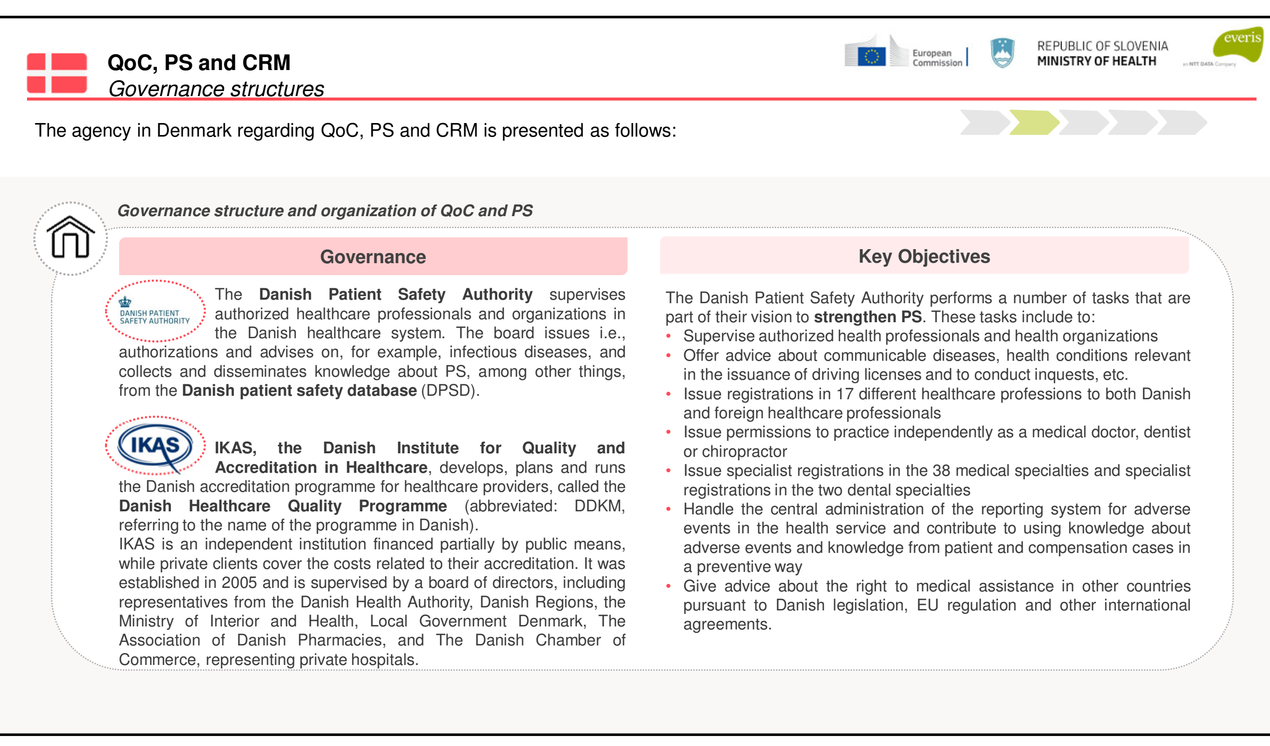

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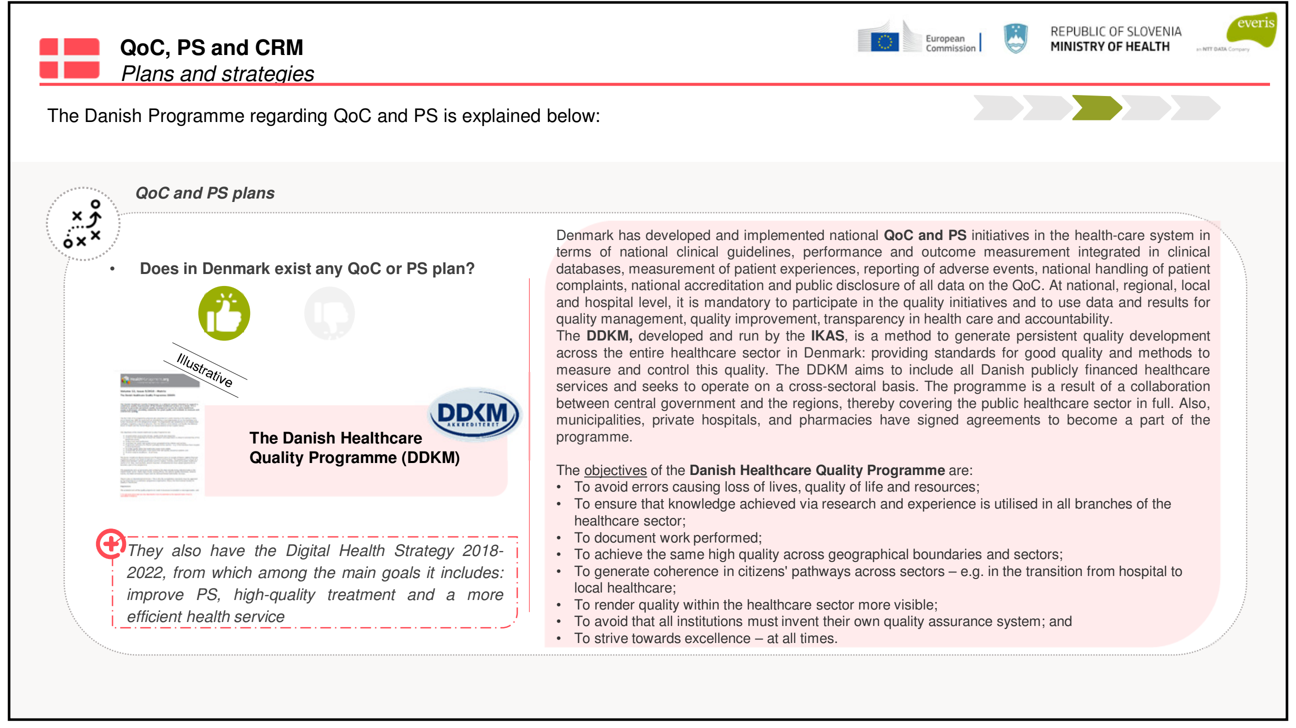

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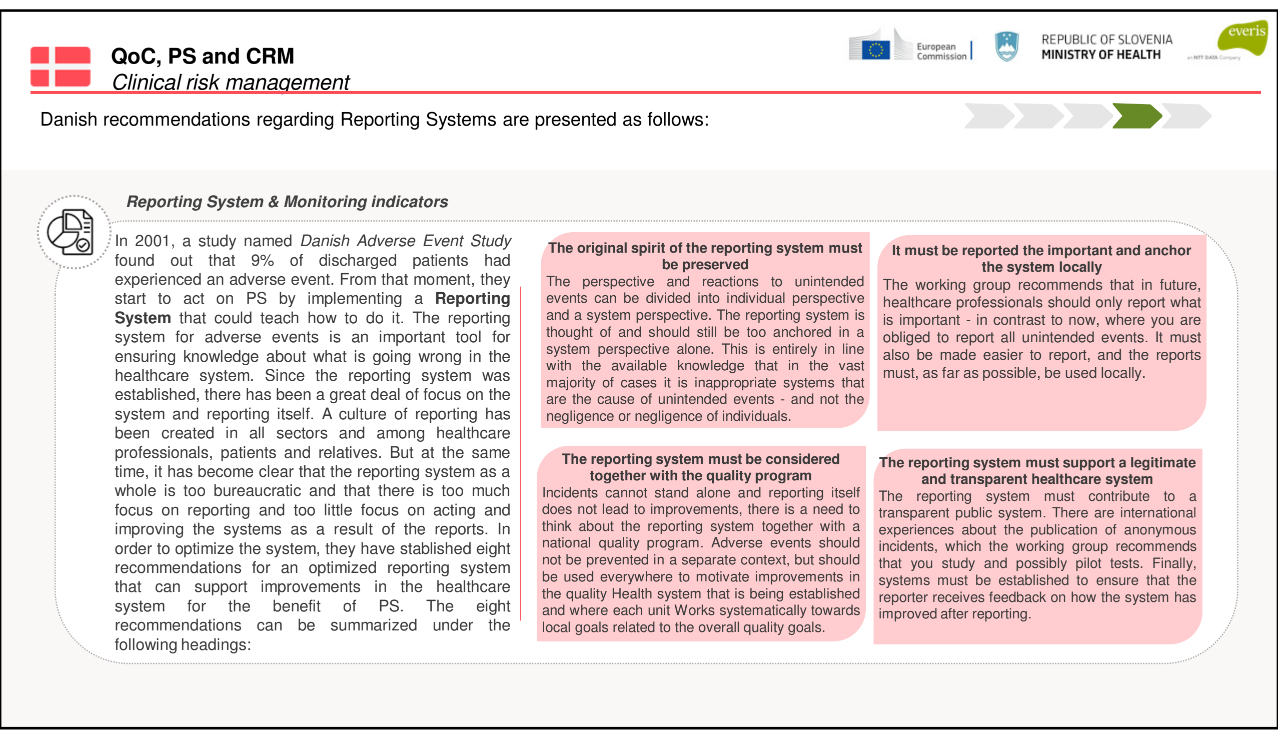

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QoC, PS and CRM

Clinical risk management

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CRM process and how risk is assessed are described as follows:

CRM process

The risk management process in Denmark consists of several main activities which are fundamental to the overall process. Risk management is a cross-organizational process, and involves many stakeholders with different tasks and areas of responsibility. Planning, coordination and communication are therefore always a backdrop in the risk management process, both before and after the implementation of the main activities. Management anchoring is crucial for a successful risk management process.

What is crucial for risk management is the following 3 activities:

- *Preparation of a risk management plan*
- *Management anchoring of risk management plan*
- *Implementation of risk management plan*

Figure 5: CRM process in Denmark

Risk assessment

The risk assessment is the foundation of the risk management process. This is where risks need to be:

- Identified and described (risk identification)
- Analysed and measured (risk analysis)
- Evaluated in relation to the risk tolerance (risk evaluation)

The risk assessment should always be carried out on the basis of an established method. The individual activities in the risk assessment are elaborated below. There is no method requirement in ISO 27001 for how the risk assessment is carried out. Choice of method can i.e. depend on the size and complexity of the organization. However, an assessment must always be made of the risk of loss of confidentiality, integrity and availability. How the risk assessment is carried out in practice must be stated in a process and method description, so that the risk assessment is systematic and the results comparable. Several of the activities will advantageously be carried out simultaneously. For example, many risks can be both identified and analysed by the same people.

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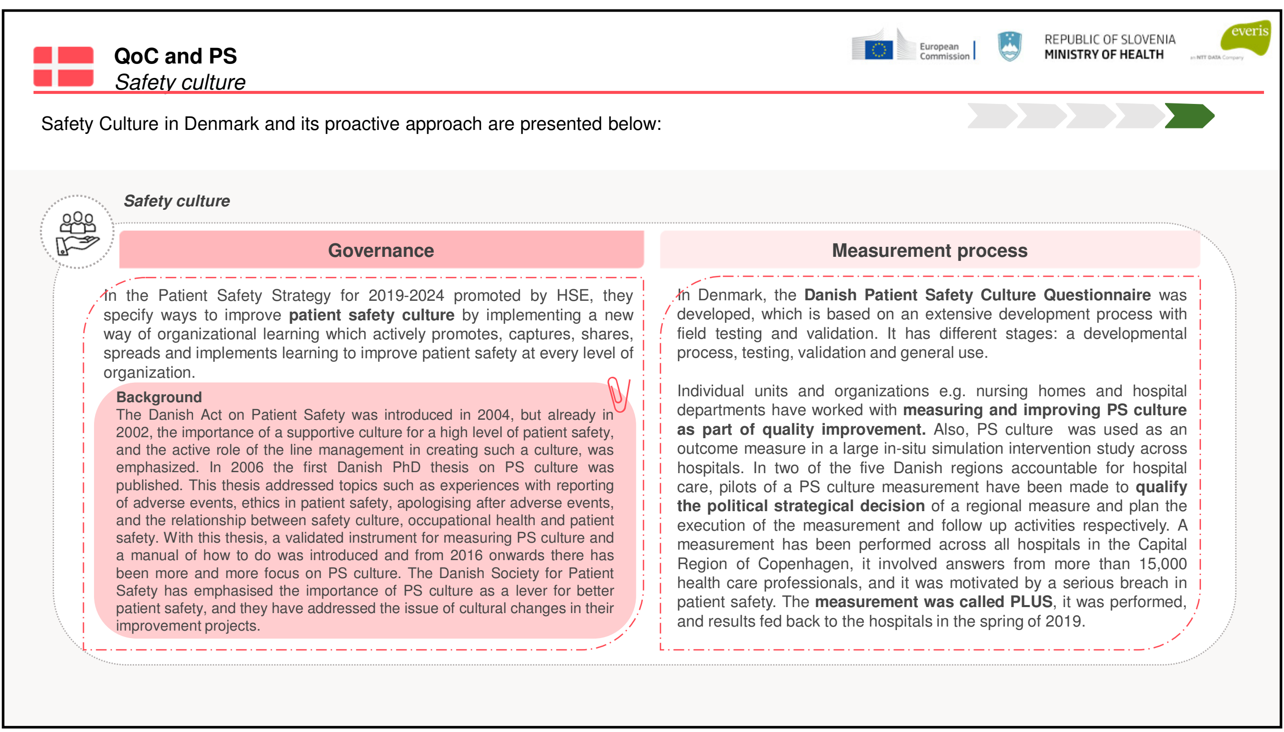

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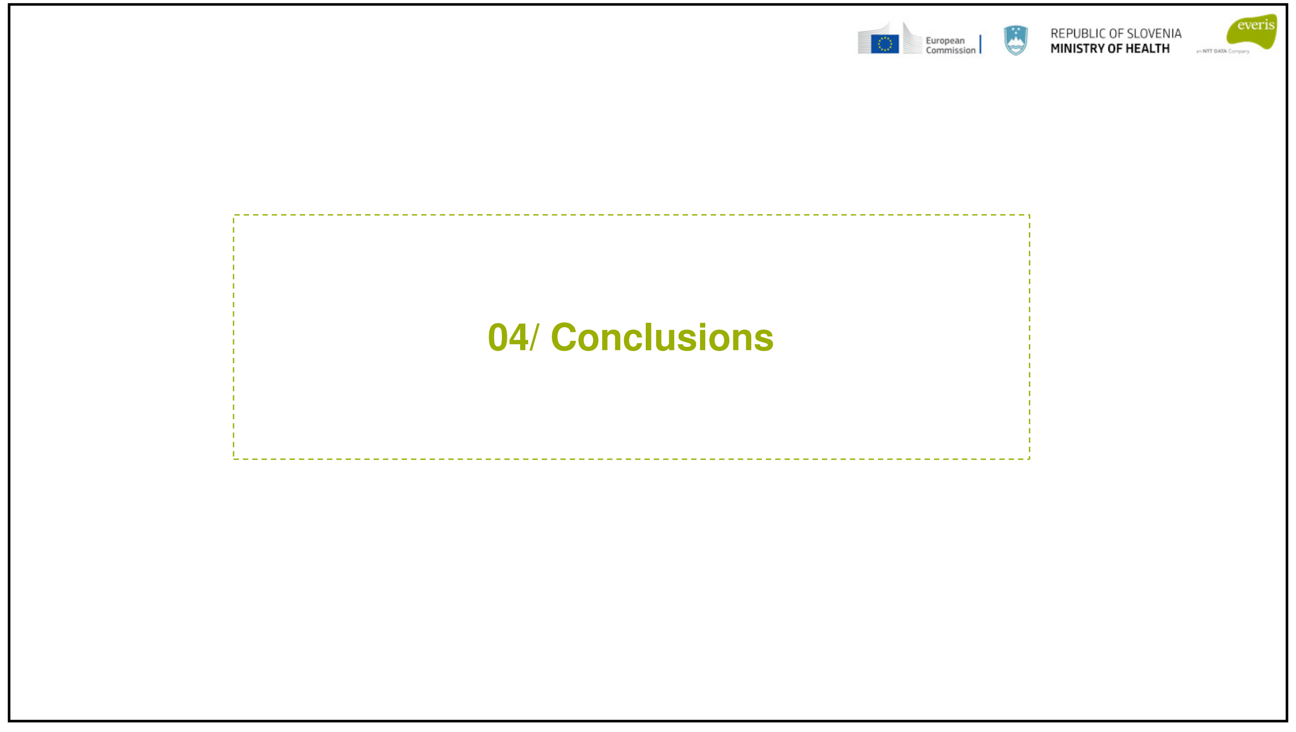

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04/ Conclusions

The following are the main conclusions of the comparative analysis on QoC, PS and CRM systems:

Health-system organization

1. In all analysed countries, health expenditure ranges between 5 and 10% of GDP, and all of them follow the Beveridge healthcare model, except for Australia who owns a mixed model.

Governance structures

2. All analysed countries own governance structures (public organizations or institutions) responsible for overseeing QoC and PS issues (except for the Tuscany region whom institution focuses on CRM and PS).

   2.1. Each of the analysed countries adequate its governance structure to its specific characteristics and all of them depend on their respectively MoH.

   - In Tuscany, the Clinical Risk Management and Patient Safety Centre is directly instituted by the Tuscany region council. This organization is also observed in Catalonia, where the different stakeholders for quality and patient safety governance (the Patient Safety department, the Alliance for Patient Safety and the Agency for Quality and Sanitary Evaluation) are competencies of the local government.
   - In Ireland and Denmark, the directorates in QoC and PS directly depend on the MoH.
   - In Australia, the Commission on Safety and Quality in Health Care is an independent institution despite the funding of the Australian and territorial government.

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04/ Conclusions

The following are the main conclusions of the comparative analysis on QoC, PS and CRM systems:

Plans and strategies

3. All analysed countries have one or more strategic plans specifically about Quality and Patient Safety.
   - The period for the development of the work plans ranges between 2 and 5 years.
   - In Ireland, they have two separated plans: one for Quality improvement and another one for patient safety.
   - In Australia, there is a global framework for Safety and Quality and a specific 2-years work plan.
   - In Denmark, the QoC and PS are addressed trough a specific Quality Programme.
4. All the strategic plans pursue similar key objectives, even though each country shares the vision of those goals with a different approach. All plans emphasize:

   4.1. Importance of **continuous quality** improvement to achieve better QoC

   4.2. Improvement based on **patient-centred** culture and patient experience

   4.3. Promotion of **safety culture** through the oversee, identification, and prevention of **adverse events**

   4.4. Support to health professionals through patient safety **education/training programmes**

   4.5. Establishment of a **patient safety strategy** and development of a **communication plan**

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04/ Conclusions

The following are the main conclusions of the comparative analysis on QoC, PS and CRM systems:

Clinical Risk Management

5. In terms of CRM, the five studied countries follow the **ISO 31000 Risk Management Standards,** which clearly defines the CRM process.

    5.1. Regarding Reporting Systems, each country has established specific reporting systems: some countries have more standardized and systematized reporting, based on the gathering of multiple quality indicators through medical records, while others use particular tools/platforms to register and report events manually and not systematically.

    - In Tuscany, a tool that allows front-line healthcare workers for voluntary reporting is used. Similarly, in Catalonia, a reporting system is used to inform about any type of incident related to patient safety in the public hospital network.
    - Ireland and Australia utilise monitoring indicators. In Ireland, the National Healthcare Quality Reporting System (NHQRS) is based on 52 indicators for 5 key domains; while in Australia, indicators for reporting systems are classified in 5 indicators sets.
    - Denmark does not offer specific information about the reporting system and emphasize the importance of working on the improvement actions rather than in the reporting

    5.2. Concerning risk mitigation, countries are less specific in terms of the procedures applied to compensate for risks. Only Ireland provides information about the general framework for risk mitigation.

    - In Ireland, there is a National Risk Assessment which acts as a guide for risk. The Lead Government Department decides about prioritizing and resourcing of appropriate mitigation measures and monitors and reports internally the progress on mitigation. They stablish a five-stages procedure for risk assessment.

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04/ Conclusions

The following are the main conclusions of the comparative analysis on QoC, PS and CRM systems:

Patient Safety

6. All analyzed countries implement a **patient safety culture** prioritizing **education, training, and research** on patient safety to healthcare professionals, making the special focus on Managers and Directors capacitation.

    6.1. Particular strategies differ among countries, but they pursue these goals through initiatives like specific training programs, masters, forums, newsletters, etc.

    - In Tuscany and Ireland, the promotion of safety culture is supported through training programmes, including certified master's courses taught by regional CRM centres or the Executive Health Service to promote a new safety culture, with a special focus on manager training.
    - In Catalonia, the Department of Health has implemented the Functional Patient Safety Units to promote patient safety in the medical centres. These units work in the promotion and implementation of patient safety strategies and measures in their centre.
    - Australia also emphasises the measurement of the patient safety process and, the Commission is developing a toolkit that includes a short validated survey and an implementation guide for regular patient safety qualitative monitoring.

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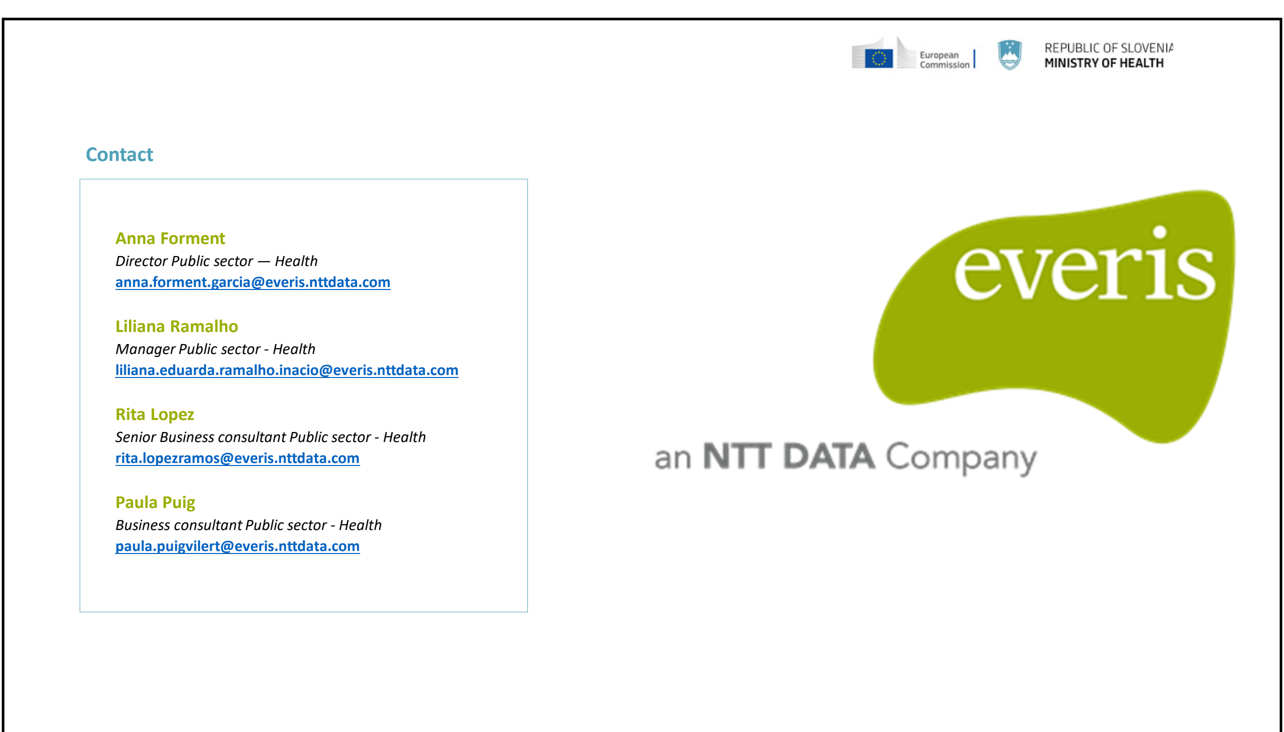

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