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How to improve Patient Safety

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We realise a lot…
…but not all of it!

How do we catch adverse events

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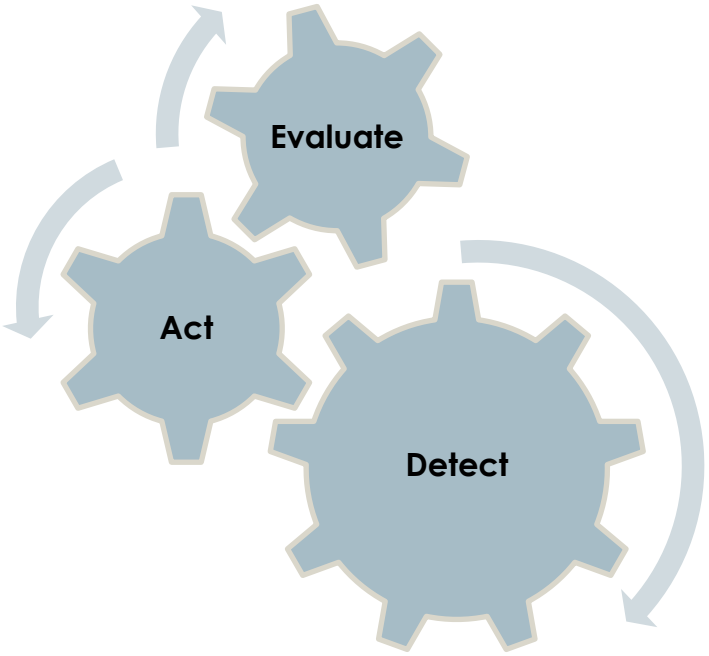
The process of reporting adverse events

1. Sense of correct/expected and not Everyone
2. Identify and report adverse and sentinel events Everyone
3. Handle and analyse
4. Take direct action
5. Plan and do preventive action
6. Summarise and give feed back
7. Evaluate effect of action



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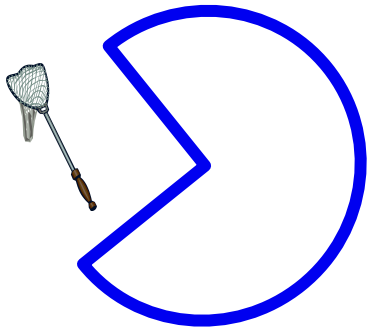
Can we make the circle more complete?



GTT – Global Trigger Tool

- Medical records reviewed retrospectively
- Global Trigger Tool initially described by IHI
- Internationally acknowledged method
- Performed as team work by nurses and MD:s
- Randomly selected records reviewed on hospital level
- Adverse events causing harm to patients are identified
- Method in Sweden adjusted to include also assessment of avoidability

Medical record review by GTT in Sweden at present

- Somatic care of adults is reviewed in all acute care hospitals since 2012
- GTT used also in many departments
- National collection of results
- GTT-method developed also for somatic care of children and psychiatry.
- Adjustment for GTT in home care under way

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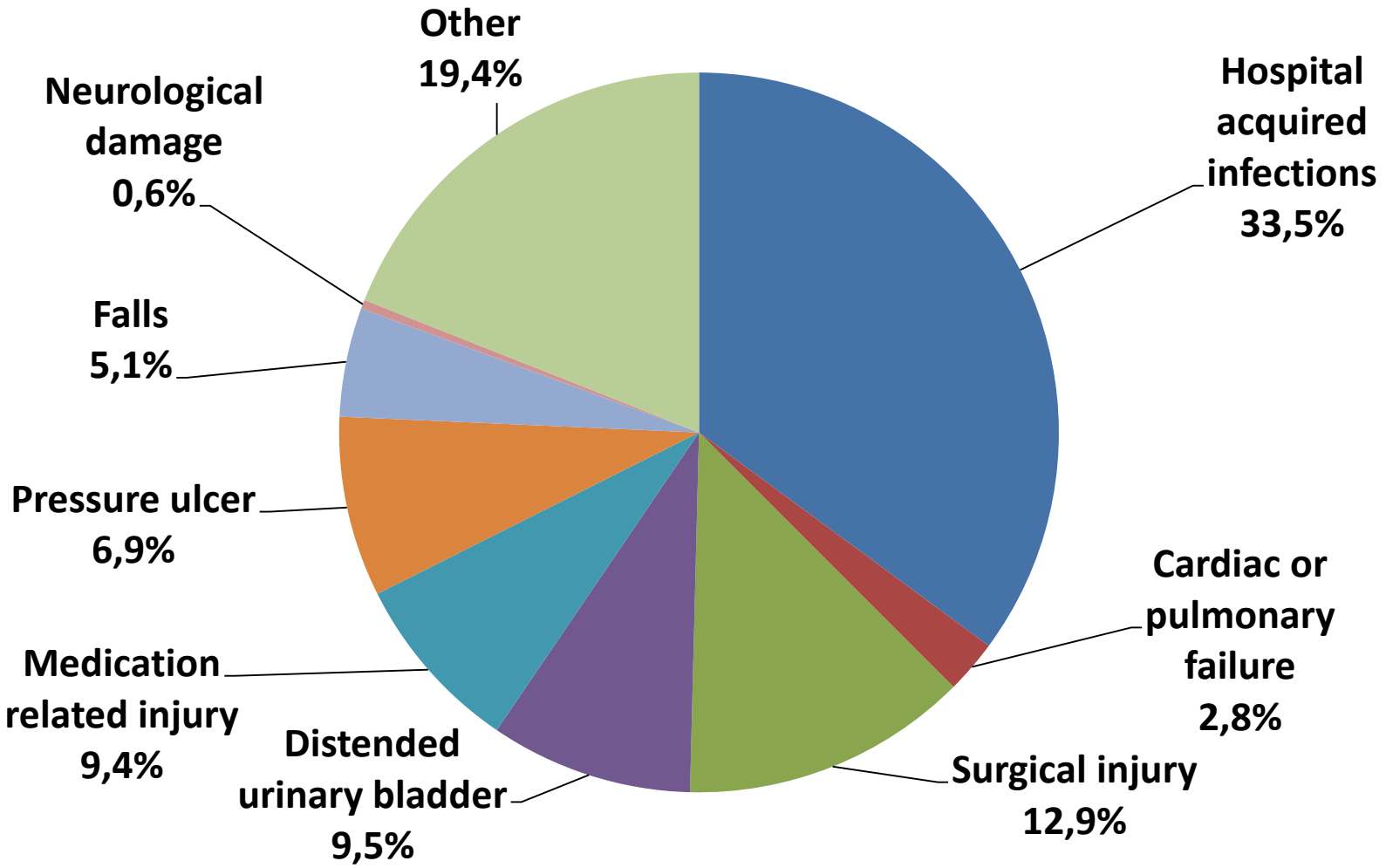
Harm categories



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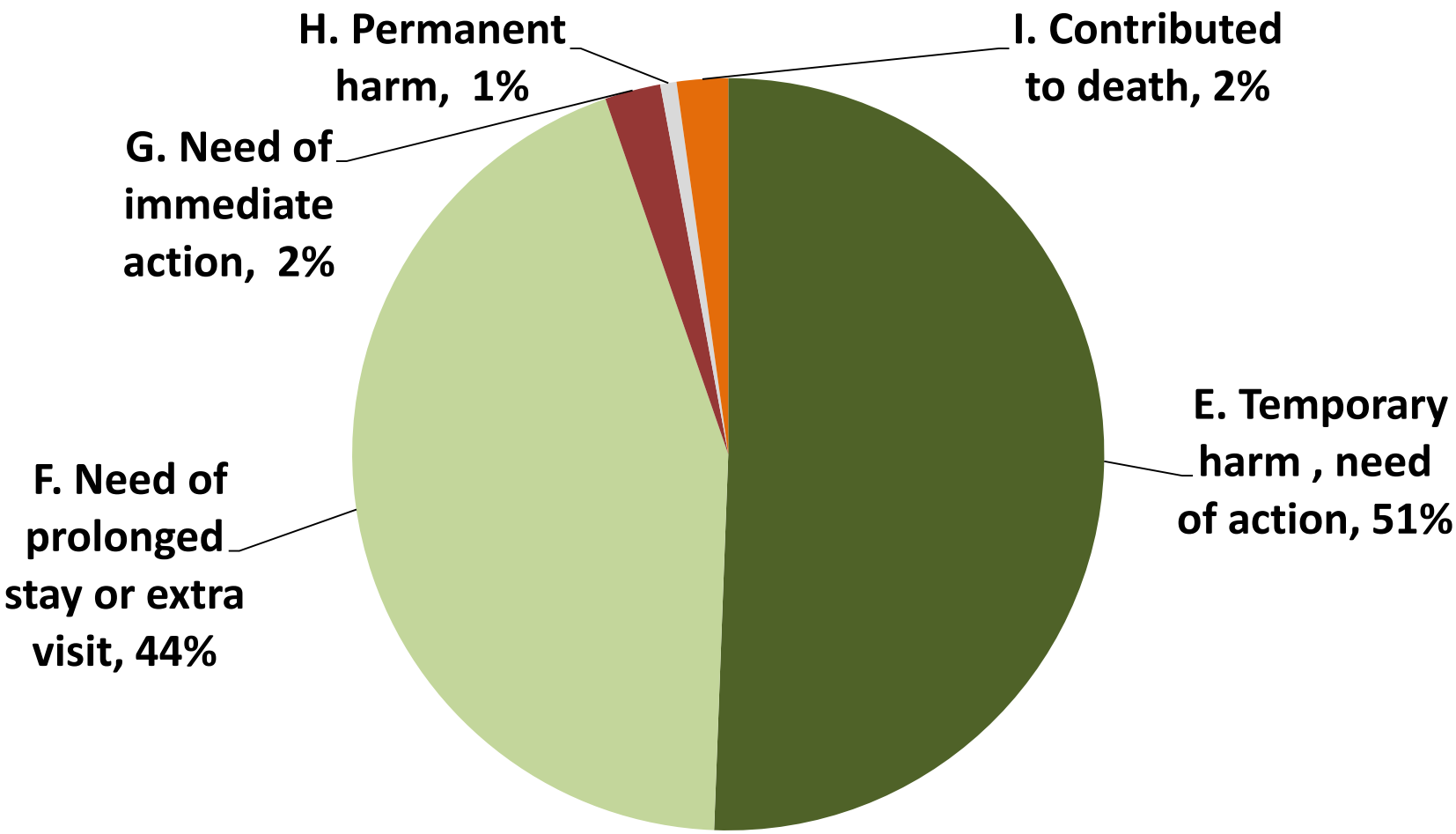
Severity level of detected harm



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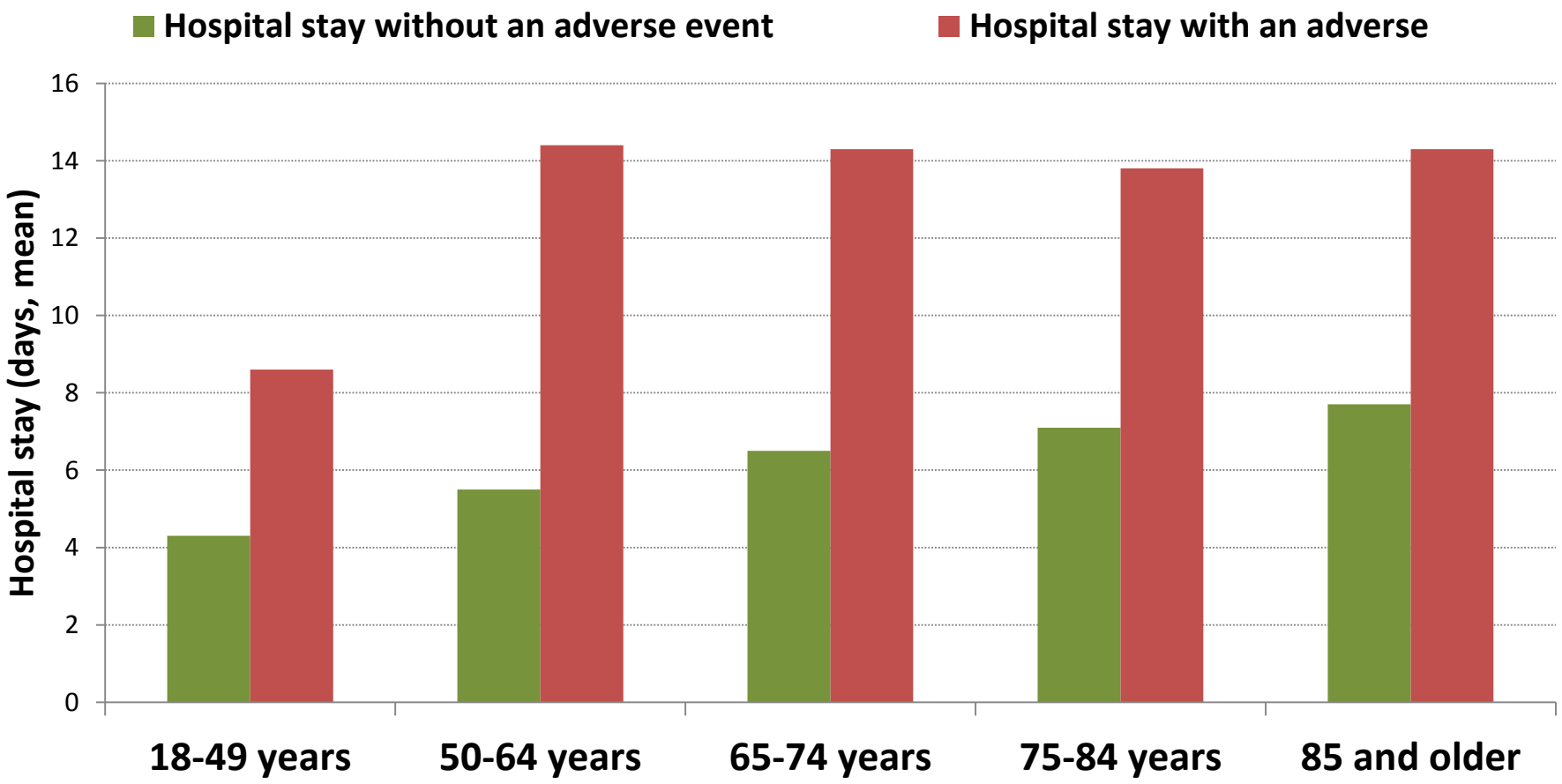
Hospital stay for patients with and without an adverse event or harm



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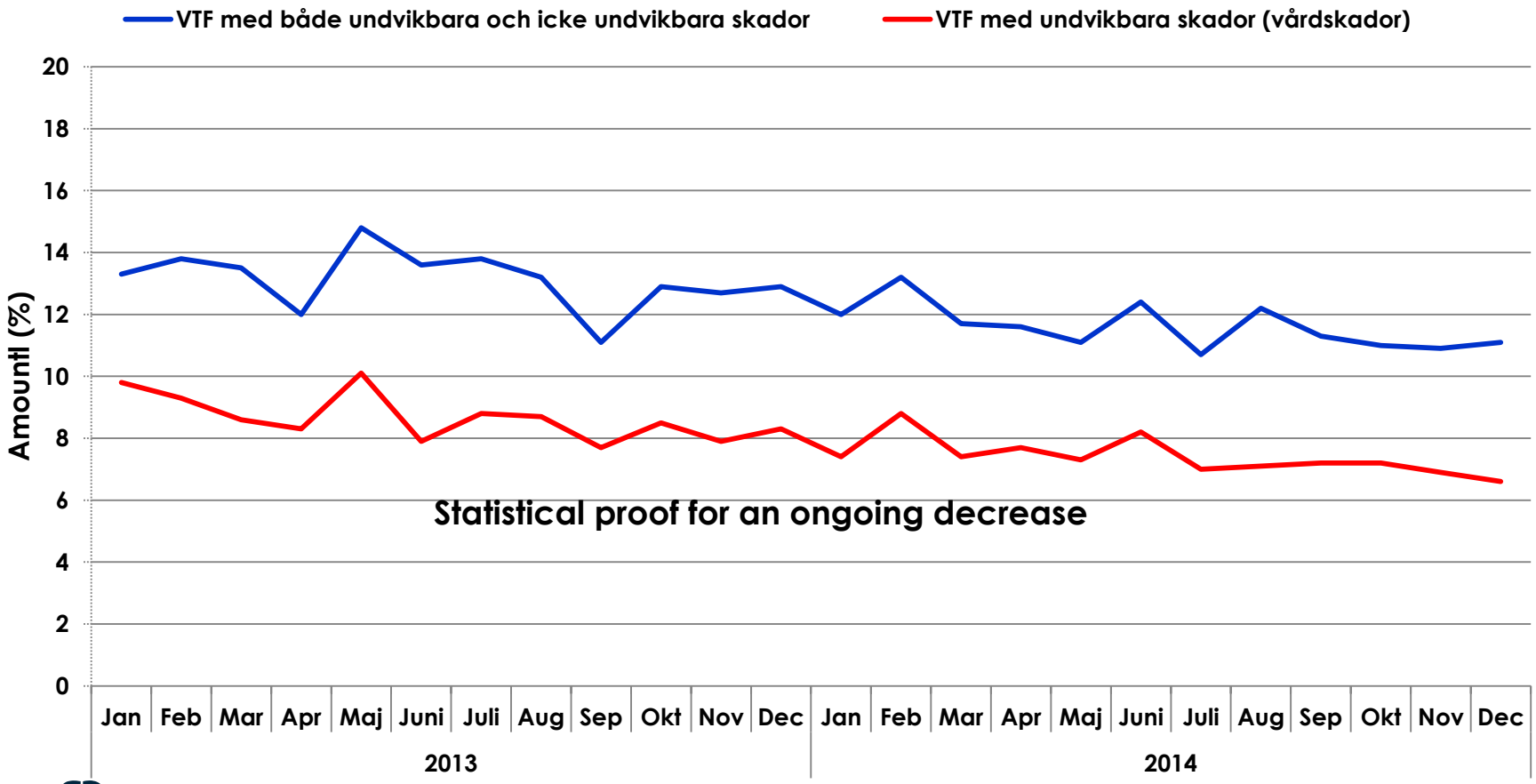
Amount of hospital admissions with and without identified harm and avoidable harm



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Where does GTT lead us?

- AE and harm is identified
- Avoidability will be considered
- ”Complication” och ”known side-effect” challenged
- Patients perspective and pathway
- Analysis and re-evaluation of care
- Basis for development of patient safety and quality in care

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Lack of quality also identified by GTT

- Triggers aim at areas of risk
- Compliance to guidelines revealed
- Deficiencies in quality identifiable even if patient not harmed
- Tool for systematic inhouse control

The Patient Safety Act

Under the Patient Safety Act (2010:659) an adverse event means suffering, physical or mental harm or illness and death that could have been avoided if adequate measures had been taken in the patient's contact with healthcare services.

The intention with the Patient safety Act

- A Healthcare provider has a duty to do everything needed to **ensure that patients are not harmed** by adverse events
- Healthcare professionals are required to **report risks** that they notice in the service
- The Act is also intended to promote a **good patient safety culture**, where **both staff and patients** take part in efforts to improve patient safety

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The definition of a serious adverse event

A serious adverse event means an adverse event that:

- is **lasting and not minor** or
- has led to a significant **increase in the patient´s need** of healthcare
- has led to **to the death** of the patient

Approx the same as a

"sentinel event"

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Health and Social Care Inspectorate

Supervision of social service, health care and professionals

- **Complaint cases from individual patients or relatives**
  - Approx 7.000 per year
- **Report cases from social service and health care according to the law**
  - Approx 1.200 and 2.500 per year respectively
- **Own initiated cases and government assignments**

Patient Insurance Company

- **Publically financed, mutual insurance company**
- **Financial compensation to patients**
  - Avoidable harm of some dignity
  - Application by the patient or family
  - Approx 15.000 applications per year
  - Approx 40 % are compensated
- **Contribute to reduction of sentinel events and harm to patients**
  - Support to diversity of projects as:
  - Safer obstetrical service
  - HAI in relation to prosthesis-surgery should be avoided

Patient Advisory Committees

- Regional institution per county
- Complaint cases from individual patients or relatives
- Give support and counselling regarding that information and treatment the patient has experienced
- Support the patient to get correct information and contacts
- Summarise complaints, analyse and give feed-back reports regarding departments, processes and hospitals

The patients perspective

When You suffer from an adverse or sentinel event, harm or mistrust You can:

1. **Discuss with your doctor or nurse**
2. **Contact a "patients councellor" at the hospital**
3. **Contact the regional Patient Advisory Committee**
4. **Send a report to the Health and Social Care Inspectorate**
5. **Apply for financial compensation from the "LÖF" insurance company**

Litigations and processes in court are very rare in Sweden

How to commit the providers to report

- **Must be considered to be meaningful and thus requested from all**
  - politicians, managers at all levels, front line leaders, professionals
- **Improvement for the patients is the aim**
- **Visible that it leads to action**
- **Sense of requested attitude and action**
- **Mechanisms generic and in work at all levels – the energizers are the same allover!**

How to commit patients ro contribute

- Meaningful and worth while
- Sense that reports and ideas are requested and welcome
- Questions are asked and answers welcome
- Open presentation of results – good and bad
- Visible improvement work and results

How to promote the safety culture?

Safety issues natural part of improvement work

Reports on adverse events and deviances are

- seen as important information and feed the ongoing work
- part of a learning system thinking
- part of working environment improvement efforts
- part of financial management

Systems perspecitve as concept – avoid scapegoats!

Measurements of quality indicators can be used as driver

Promotion of safety is based on ethics and a humanistic view of life!

Hippocrates: Primum non nocere!

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Information system for monitoring and implementing

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Systems for reporting

- **Most important work done locally**
  - Detection, report, analysis, action, follow up
  - Accordance to the law but formed to fit
- **National overview and feed back**
  - Aim since 1930'ies
  - Authority task
  - Under the law

Local reporting

- **IT-based systems for reporting and handling**
- **Reporting for the front line person should be**
  - Easy, without need of specific education, quick, straight forward and self evident
  - Questions and cathegories limited and understandable
- **Analysis and handling by 1:st line manager**
  - Easy, without need of specific education, quick, straight forward and self evident
  - Questions and cathegories limited and understandable

Reporting to authorities

- IT-based preferable, but…
- Cathegorisation in data base and possible to search
- Regular reports and feed back
- Option for specified questions and projects

Reporting also a question of…

- To feel safe personally and regarding colleagues
- To experience it to be meaningful
- To realise it to be beneficial for the patients
- To make it a priority of some dignity

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