REPUBLIC OF SLOVENIA
MINISTRY OF HEALTH

# Modernisation of the system for monitoring and implementing measures for sentinel and other adverse events in Slovenia (SenSys)

Workshop in Slovenia
28 th February

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# Brief presentation of the work done

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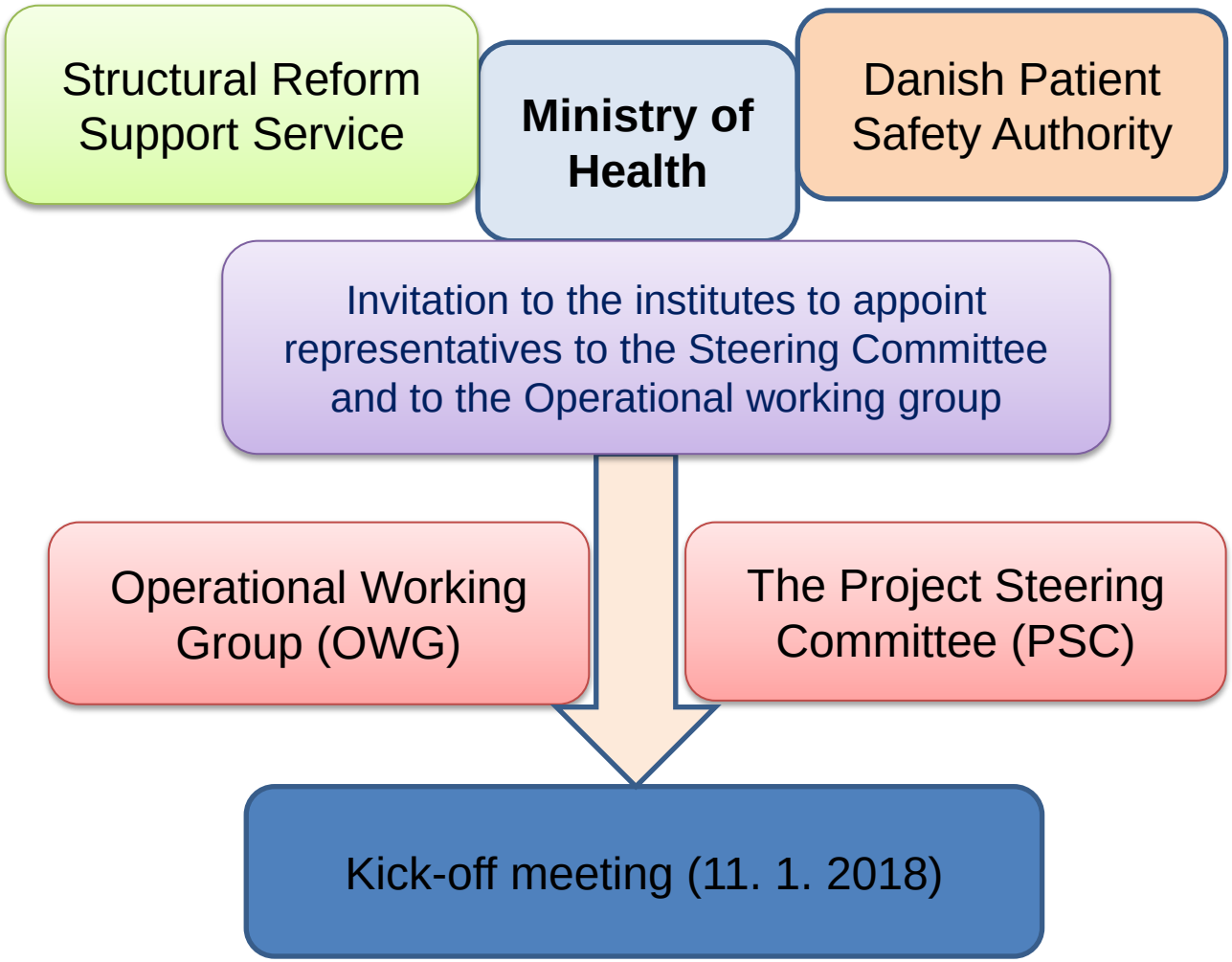
Structural Reform Support Service
Ministry of Health
Danish Patient Safety Authority
Invitation to the institutes to appoint representatives to the Steering Committee and to the Operational working group
Operational Working Group (OWG)
The Project Steering Committee (PSC)
Kick-off meeting (11. 1. 2018)

# Members of PcG (8 members)

**Dr Ana Medved**, state secretary, MoH
**Tanja Mate**, general director, MoH
**Vlasta Kovačič Mežek**, general direktor assistant, MoH
**Tit Albreht**, Public Health Institute
**Nataša Čarman Korenjak**, Association of Health Care Insurance
**Jelka Mlakar**, University Clinical Centre Ljubljana
**Tea Stegne Ignjatovič**, Primary Health Centre Ljubljana
**Marko Vudraga**, patient representative

The PcG is responsible for reviewing and commenting all documents submitted by the expert and for the acceptance of the final deliverables of the project.

# Members of OWG (23 members)

- **Vesna Zupančič**, leader, MoH, **Katarina Kralj**, MoH, **Vlasta Kovačič Mežek**, general direktor assistant, MoH, **Isabelle Querrioux**, MoH
- **Verena Balažič**, Ministry of Education, Science and Sport
- **Branka Florjančič**, Ministry of Justice
- **Damir Jurkin**, Ministry of Public Administration
- **Alenka Borovničar** and **Tina Zupanic**, Public health Institute
- **Nataša Čarman Korenjak**, Association of Health Care Insurance
- **Jurij Komar**, Health inspectorate of the Republic of Slovenia
- **Korazd Kalan**, Medical Chamber, **Zdenka Kramar**, Chamber of Nursing
- **Dominika Orsky**, Association of Health Institutes
- **Jernej Pečnik**, Primary Health Centre Ljubljana
- **Robertina Benkovič**, Primary Health Centre Ljubljana
- **Marija Magajne**, Primary Health Centre Ljubljana
- **Dušica Pleterski Rigler** and **Radoslav Kveder**, University Clinical Centre Ljubljana
- **Ivka Glas**, **Tatjana Kušar** and **Marija Zaletel**, patient representative
- **Vlasta Cafnik**, Patients' rights representatives

| Deliverables | Time schedule |
|---|---|
| Kick-off meeting | January 11th 2018 |
| Inception report | January 25th 2018 |
| Workshop I | February 26th – March 1st 2018 |
| Study visit | April 2018 |
| Expert mission | May 2018 |
| Workshop II | June 2018 |
| Workshop III | September 2018 |
| Workshop IV | First quarter of 2019 |
| Final report | December 2019 |

# ACTIVITIES IN THE MEANTIME

Meeting OWG and meetings subgroups

- **I. legislation**
- **II. IT support**
- **III. Pacient safety**

- Meetings with :

Agency for Medicinal Products and Medical Devices of the Republic of Slovenia

Ministry of Public Administration

Information Commissioner

University Medical Centre Ljubljana

# I. subgrup: Legislation

**2 meetings:**

**Topics:**

TECHNICAL BACKGROUND OF THE LEGAL FRAMEWORK FOR QUALITY AND SAFETY IN HEALTH CARE

- the field of adverse events (definitions, diferent internal systems)
- the field of identifying risk factors (we have protocols, various check lists)
- the field of human resources (educations, structure at the providers)

FINANCIAL BURDEN OF ADVERSE EVENTS AND COST-EFFECTIVENESS OF PATIENT SAFETY INTERVENTIONS

**PROTECTION OF REPORTER AND OTHERS**

**Open questions:**

- connection and delineation between the local and national system

What to report from a local to a national system?

- connection and delineation between other systems

# STARTING POINTS

- Reporting system must be protected and safe!
- Protection of documentation, rapporteurs and other participans must be guaranteed.
- The system should not be a source of data for lawsuits.
- Explanation of the separators and connecting points through the appeal procedure, civil and criminal proceedings must be clear.
- Education and testing of knowledge at all levels of studies, professionals and colleagues must be established.
- We have problems trying to estimate the costs of adverse events.
- In preparing the proposal of legislation, we will use the useful content of the already prepared materials.
- in implementing the recommendations of the EU, we have problems, because we do not legal basis.

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# II. Subgrup: IT support

**1 meeting**

**Topics:**

ICPS CLASSIFICATION

FORM FOR REPORTING

EXISTING IT SUPPORT SYSTEMS FOR THE INTERNAL REPORTING SYSTEM

**Open questions:**

Which terminology is best to use?

What makes sense to report? Which event?

How to provide feedback informations and informed about the event other?

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# STARTING POINTS

- ICPS is merely a framework that needs to be adapted to the Slovene situation.
- Study visit will be very usefull.
- Proposal classification structure using internationally accepted terminology will be presented at the next workshop.
- It is necessary to check the usefulness of the existing solutions.
- It is necessary to take into account other systems for monitoring adverse events.

Institute of the Republic of Slovenia for the Transplantation of Organs and Tissues

Blood Transfusion Centre of Slovenia

Agency for Medicinal Products and Medical Devices of the Republic of Slovenia

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# Subgrup III: Pacient safety

**2 meetings:**

*Topics:*

THE STRUCTURE EMPLOYED TO ENSURE THE QUALITY AND SAFETY

(proxies for safety, quality management system coordinators)

METHODS TO IMPROVE CULTURE OF SAFETY

***Good practices at primary health care centres and hospitals***

SAFETY INDICATORS

THE ROLE OF PARTICIPANTS IN THE SYSTEM

Questions:

- What healthcare providers would need from the Ministry of Health to support the development of quality and safety?
- What is the role of the National Institute of Public Health in the quality assurance system in Denmark?

## ***Mechanisms to raise safety culture***

- ***promoting education***
- ***simulation center*** *on the primary level: education of employees, the introduction of new employees*
- *education in the field of communication: solving communication noise*
- ***Educational Safety Day, Quality Week***
- *Annual interviews, personal training plan, partnership agreement, evaluation*
- *talk about individual cases; preventive safety talk (hand hygiene), safety conversation directly after the event, safety conversation about realization necessary measures,*
- ***Simulations in situ****, Internal and external audits*
- *Quality circles, annual review of files, quality indicators, safety visas, compliments and complaints.*
- ***risk management and risk register****,*
- ***innovations***

# STARTING POINTS

- The Ministry of Health must support the top management of healthcare providers.
- The top management of healthcare providers must support their middle management (fields: education, motivation, financial support, feeling of belonging).
- It is impossible to separate the culture of safety from quality efforts.
- The roles of all key stakeholders must be known.

# Workshop I

**The workshop will cover the following aspects**:

- discussion of a funding model based on estimates of costs of adverse events in healthcare (PM)
- capital and financial resources for the operation of a system upon the planned expansion of reporters in line with the action plan (PM)
- identification of institutional procedures for implementing The Patient Safety Incident legislation/ definition of the needs for and importance of the legal basis (TI)
- definition of the measures for legal/institutional/organizational protection of reporters of patient safety incidents and other stakeholders (e.g. patients, relatives, health professionals) (TI)

- definition of the types of patient safety incidents to be reported in the national system using the WHO international classification system, ICPS (TII)

- description of the division of roles between local and central levels (TIII).

**The main expected outcomes of the workshop are:**

- increased expertise
- proposals for a funding mechanism
- proposals for measures for the protection of reporters
- a plan for the implementation of the WHO international classification system ICPS
- proposals for the institutional/organizational structure for the operation of a system

# Questions?