

System for monitoring sentinel events and other adverse events in Slovenia

Where we are and where we want to be

Ana Medved, State secretary

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The Resolution on the National Health Care Plan 2016-2025

Together for the Society of Health

1. Priority area

- strengthening and protecting health and preventing illness

2. Priority area

- optimising medical care

3. Priority area

- enhancing the performance of the health care system

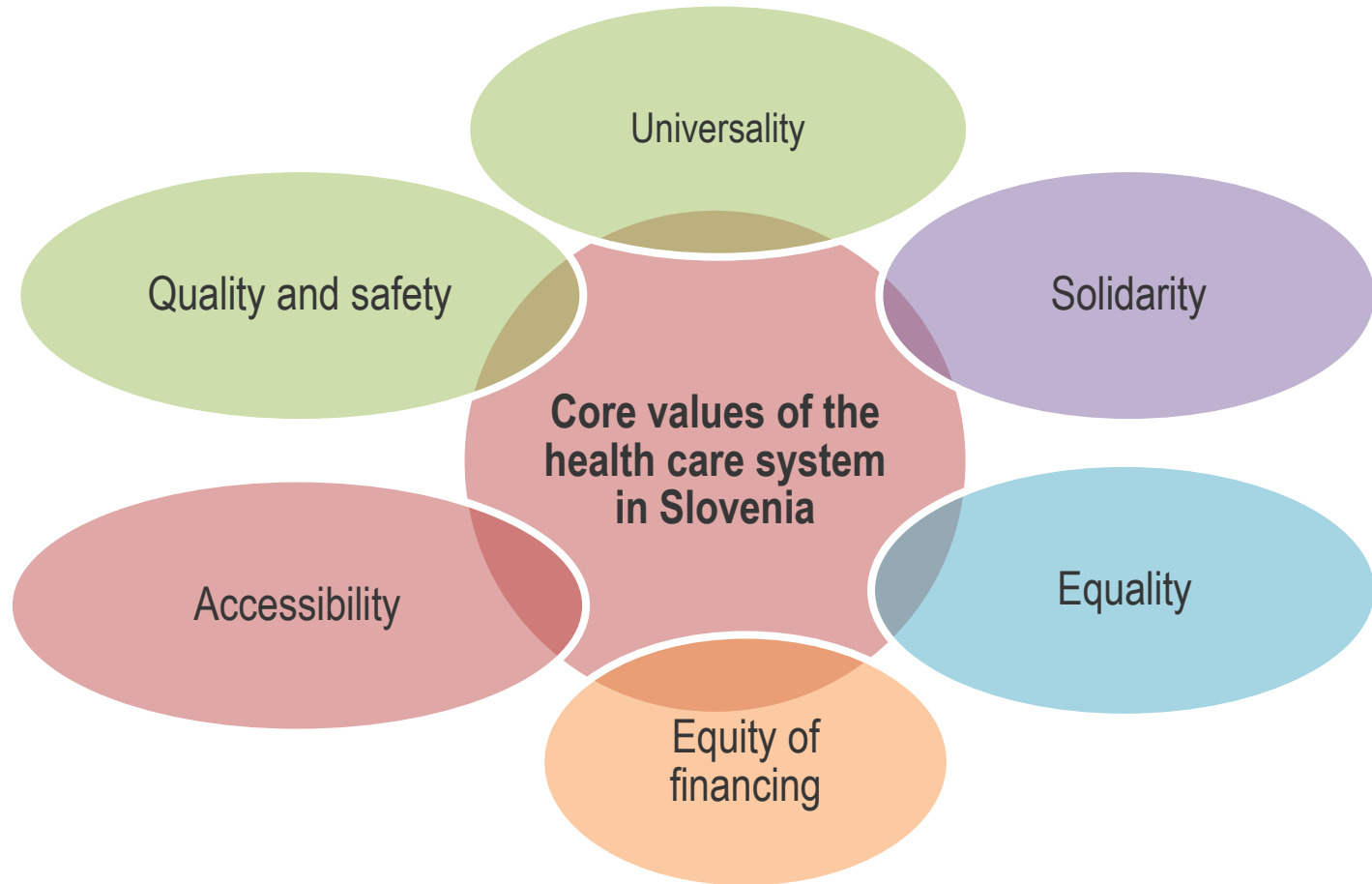
4. Priority area

- fair, solidarity-based and sustainable health care financing

The core values of the health care system according to the Plan in Slovenia



REPUBLIC OF SLOVENIA
MINISTRY OF HEALTH



Together for the Society of Health

Activities from third priority area: Enhancing the performance of the healthcare system

Ensuring the quality and safety of health care



Measure 1: Legislative changes for determining conditions and competences for ensuring the continuous improvement of quality and safety of health care treatment

Measure 2: Modernisation of the range of **quality indicators**

Measure 3:
Modernisation of the system for monitoring and implementing measures for sentinel events and other adverse events

Measure 4 Adoption of a national strategy for the **rational use of antimicrobial medicines** in human and veterinary medicine

Activities from third priority area: Enhancing the performance of the healthcare system

Ensuring the quality and safety of health care



Measure 5: Establishment of an **education and training system** in the field of quality and safety

Measure 6: Adoption of a national strategy for the **prevention and management of infections** in health care

Measure 7: Education on **communication in health care**, especially in communication with the patient

Measure 8: Providing **staff and financial resources** for the development of the **quality system and supervision**

Present system for monitoring and implementing measures for sentinel events and other adverse events

The Ministry of Health has established the Reporting and Learning System on adverse/sentinel events for Hospitals in 2002



- ← The instructions and reporting forms were prepared and are published on the website of the Ministry of Health
- ← Conferences and education are occasionally organized on the topic of adverse events in health care
- ← Some publications and scientific articles were also prepared and published

The number of reported sentinel and other adverse events differs slightly over the years. The highest number of reported events on an annual level was **25**.

The findings of the analysis for the year 2016



Reports of sentinel events for the year 2016 were submitted **only from 8 of the 29 public and private hospitals**



Only a third of the rapporteurs on the sentinel event informed the Ministry of Health within the agreed deadline of **48 hours**



In 2016, **only one of the respondent concluded the whole process of reporting** (implementation of the plan of action envisaged measures)

Our future wishes in the field of patients safety from 2017



We strive for evidence-based, ethical and equitable healthcare services



We are committed to interdisciplinary cooperation among doctors and other health professions



Every healthcare facility has its own learning system about patient safety



Expected outcomes

- **Establishment of suitable system solutions** at the level of structure, process and outcome both at local and national level
- **Increased awareness** of health workers and reporting
- Quantitative and qualitative **analysis** of the collected data and establishment of **reliable system of feedback and learning**
- Monitoring within the **quality indicators**
- **Improved patient safety**



Priority areas and objectives

- **Regulatory framework** and the legal regulations of the patient protection system
- **Protection of rights** of reporters and stakeholders included in event
- Precise definition of the **system's structure**, and **process and outcomes** from the perspective of the roles, responsibilities and activities of key personnel and required resources
- **Simplify** and **speed up** the **reporting** and **learning process** through the introduction of **e-support**
- **Exchange of good practices and learning at the interinstitutional level**



By modernising the system

we want to achieve **better system performance** both in terms of reporting as well as learning from sentinel and other adverse events



an **increase in patient safety**, the **safety of healthcare providers, healthcare professionals and healthcare employees** and other stakeholders and



continuously **improve** the **quality** and **safety** of health care treatment





Thank you for your attention!