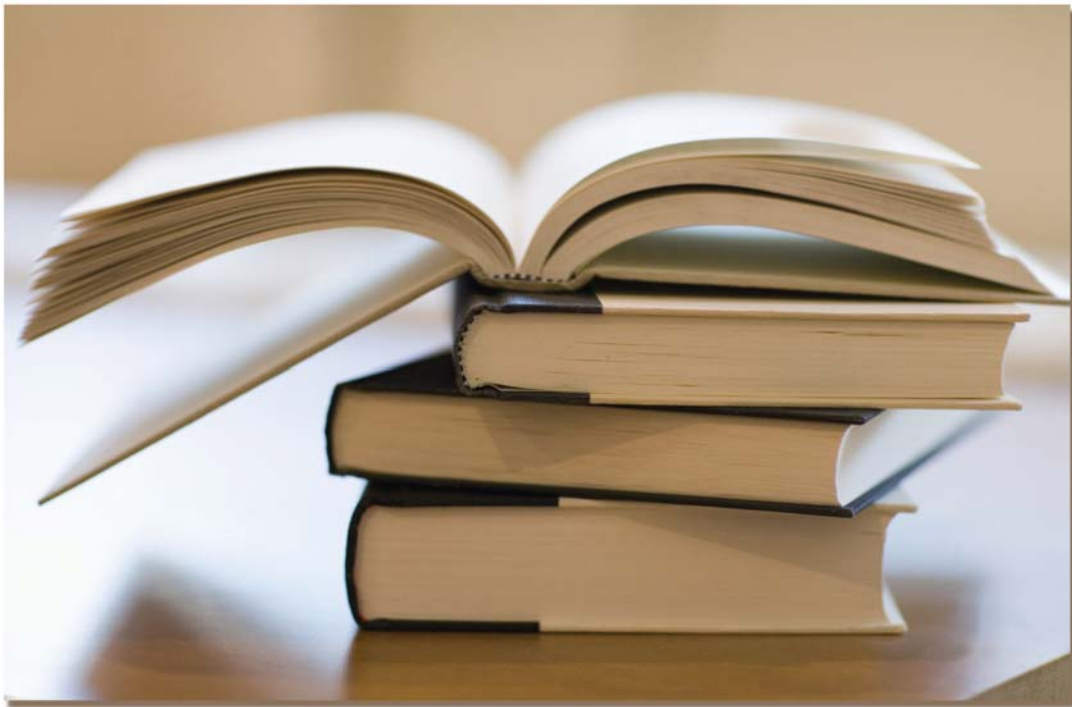


Patient safety in practice



Patient safety in practice

How to manage risks to
patient safety and quality in
European healthcare

REPORT ON HOPE AGORA

The Hague

11-12 June 2013

CONTENTS

1. INTRODUCTION	4 - 5
2. PATIENT SAFETY INITIATIVES	6
2.1. AT NATIONAL LEVEL	6 - 7
2.2. AT LOCAL AND HOSPITAL LEVEL	8
2.2.1. Communication tools for patients	8
2.2.2. Organisation	9
2.2.3. Risk management	10 - 11
2.2.4. Patient safety tools	12 - 15
2.2.5. Involvement of patients and professionals	16 - 17
3. COUNTRY INFORMATION	
AUSTRIA	18 - 19
BELGIUM	20
DENMARK	21
ESTONIA	22
FINLAND	23 - 24
FRANCE	25 - 26
GERMANY	27 - 28
GREECE	29
HUNGARY	30
LATVIA	31
LITHUANIA	32
MALTA	33
NETHERLANDS	34
POLAND	35
PORTUGAL	36 - 37
SLOVENIA	38
SPAIN	39
SWEDEN	40
SWITZERLAND	41
UNITED KINGDOM	42 - 43
FOOTNOTES	44

1. INTRODUCTION

From 10 to 12 June 2013, HOPE held its Agora in The Hague (Netherlands), concluding the 32nd HOPE Exchange Programme, a 4-week training period intended for hospital and healthcare professionals with managerial responsibilities.

“Patient safety in practice. How to manage risks to patient safety and quality in European healthcare” was the topic of HOPE Exchange Programme 2013.

The final evaluation meeting of the HOPE Exchange Programme was preceded by a conference on this theme on 11 June, organised by the Dutch Hospitals Association (NVZ) and the Dutch Federation of University Medical Centres (NFU), in collaboration with HOPE. 350 participants attended the conference.

The morning plenary provided an overview on cultural aspects that influence patient safety in hospitals and how managers can deal with this effectively. After an introduction and welcome by Ferry Breedveld (NFU), the session opened with a keynote speech from Leon van Halder (Dutch Ministry of Health, Welfare and Sports) who highlighted several Dutch initiatives and policies to promote patient safety and cultural aspects that determined them.

Niek Klazinga (Head of the Health Care Quality Indicators (HCQI) Project at OECD) illustrated the results of the EU-funded research project DUQuE, which assessed the relationship of various quality improvement governance approaches with quality indicators of hospital care. Wim van Harten (NKI-NVL) presented VMS, the Dutch programme for safety management in healthcare, whereas Erik Heineman (Groningen University) focused on the viewpoint of the medical specialist, highlighting cultural differences influencing their work in hospitals.

Finally, Diana Delnoij (Tilburg University) talked about patient participation in safety management, providing an insight into patients’ experiences and explaining how patients can be involved so to enable their active participation to their safety.

Concluding this session, Yvonne van Rooy (NVZ) further stressed that improving patient safety represents today an important priority. Stimulate mutual learning and exchange of experiences is fundamental since safety is the result of the close cooperation among many different professionals.

In the afternoon, several workshops were organised allowing attendants to share their views and experiences in a more interactive way. During the workshops, experts presented good practices from different European countries on seven themes (medication safety, reporting incidents, communication gaps, patient participation, infection prevention, safety in the operating theatre and working in teams).

The conference ended with an interview of Jean Bacou (coordinator of PaSQ Joint Action) and Pascal Garel (HOPE Chief Executive), who highlighted the close connection existing between the HOPE Exchange Programme and PaSQ Joint Action, both aiming at promoting and enabling knowledge and good exchange of practices. It was also stressed how flexibility and a bottom up approach are the way forward in order to take into account the different national contexts and realities existing in Europe.

During the evaluation meeting of the HOPE Exchange Programme, which took place on 12 June, the 141 participants on the 2013 programme presented the results of their experiences throughout the four weeks they spent in another country.

The attention was focused on risk management in a broad perspective and the way hospitals are trying to improve safety. Risk management is understood as a continuous and dynamic process, which is connected to the strategy of organising the daily operational activities, involving all the human resources both staff units and healthcare professionals.

The most prominent topics identified by participants were: the prevalence of a culture to report incidents and its diffusion within the hospital; the existence and use of an effective system of data collection; the identification of the “problem owner” of patient safety and of the management and professionals responsibility; the interrelation of the collected information through a patient safety management system.

Furthermore, HOPE exchange participants covered several issues with an impact on safety/risk management such as: medication safety; overall hygiene issues; patient involvement before and after the operation; standard operating procedures in each clinical path; patient records and organisation of the archives.

Each presentation explained which measures had been implemented in hospitals to improve patient safety, the most successful actions taken, and the ones which could be transferred to other European healthcare systems.



2. PATIENT SAFETY INITIATIVES

To synthesise the results identified by the HOPE exchange participants, patient safety initiatives in Europe can be clustered in the following four categories: initiatives at national level, initiatives at hospital level, initiatives involving professionals and initiatives involving patients. The “level of diffusion” of the measures depends on the prevailing culture on patient safety both at the national and hospital level.

2.1. AT NATIONAL LEVEL

Patient safety has become a priority issue on the European policy-makers agenda since the early 2000s. For this reason, many initiatives have been taken at national level.

In some countries, the instrument used to enhance initiatives is a legislative measure: the Government issued a specific legislation in order to define which are the rules the healthcare providers have to respect when implementing patient safety tools. In Denmark and Finland, Patient Safety Acts outlined the framework for patient safety strategy. In Poland and Sweden, legislation was used by the Government to support patient involvement within the national organisations.

In other countries, soft solutions were considered preferable. The local organisations have the possibility to choose the solutions that best match their own features: **guidelines, principles, strategy, standards** (Finland, France, Greece, Hungary, Portugal, Spain, Sweden and United Kingdom) and **programmes, plans, projects, campaigns** (Belgium, Denmark, Estonia, Finland, France, Hungary, Latvia, Lithuania, Malta, Poland and Spain).

In two of the participating countries, additional measures have been adopted: **contracts** and **agreements**. The Estonian Healthcare Service signed a contract where new indicators and standards have been approved to achieve better results in the field of quality. The Spanish Ministry of Health, in order to implement patient safety policies, started collaborations with professionals and patients and signed agreements with the sixteen Health Regions and INGESA (Instituto Nacional de Gestión Sanitaria), and agreements and contracts with public and private organisations.

In several host countries, **dedicated institutions** perform an important role in quality management and patient safety initiatives. In some cases, they support the Central Government to develop an effective activity of quality management and control at local level (Hungary, Latvia) and to develop a culture of quality (Andalusia in Spain); in other cases these institutions strengthen, with their presence at national level, the role of the centrality of patient in the health system (Hungary, Poland). In some countries, these institutions carry out a very important activity promoting the implementation of patient safety tools such as satisfaction surveys (Switzerland), checklists in the operating theatre (Switzerland) and complaining system (Latvia). In Lithuania, the National Patient Safety Platform, which includes twenty partners within governmental, non governmental and educational institutions, ensures the high quality of healthcare services and processes. Some activities promoted by this platform are mandatory for the local organisations. In Andalusia, Spain, the Observatory for Patient Safety and the Observatory for the Quality Training in Healthcare are two specific organisations by which it is possible to be accredited. In Finland, the National Institute for Welfare and Health, a public agency under the responsibility of the Ministry of Social Affairs and Health is involved in patient safety at the national level acting a “teaching role”, meaning that it promotes a web-based training programme for the professionals

working in healthcare institutions.

In Austria and Portugal, national **platforms** and **databases** were implemented in order to ensure the quality of care through the collection of information and complaints and the mapping of risk events.

One of the most common initiative taken at national level is the **accreditation**, intended as the process, certified by a third body, through which the organisation accepts the requirements and standards needed to be accredited. The accreditation can be national or international, depending on the nature of the third body. National accreditation has been adopted in Denmark, France, Germany, Portugal and Spain (Andalusia). Accreditation is also seen as the external pressure which pushes towards a cultural change. In countries where patient safety is not strengthened enough, it could be the tool by which starting new processes and initiatives: this happened in Malta and Slovenia. Other countries like Austria, Hungary, Lithuania and Poland have not chosen for accreditation but adopted the **ISO certification** system for healthcare services.

Indicators and **reporting** can be included within the initiatives taken in consideration to improve patient safety at national level. In Belgium, a project on quality indicators is carried out by the Flemish Region. In France, the use of national indicators is listed as one of the best practices adopted in the whole country. In Sweden, the healthcare organisations have to produce an annual report, which allows the comparison between the different realities. The culture of reporting is well developed at all levels, an incident reporting system exists not only at central level but also in county councils and hospitals.



2.2. AT LOCAL AND HOSPITAL LEVEL

Strategies adopted and activities conducted in the visited healthcare organisations vary but there are recurring topics: communication tools for patients, new organisations, risk management, and patient safety tools.

2.2.1. COMMUNICATION TOOLS FOR PATIENS

Communication means here the activity conducted in the hospital in order to involve patients in their care pathway and sensitise professionals in strategy and concrete actions related to patient safety. During the HOPE Agora Evaluation Conference, it emerged that communication is a critical aspect, in particular the information provided to patients by professionals. The approach of professionals while they communicate with their patients depends on the culture, which prevails in the hospitals or in the country. In some cases, a strong hierarchy and a physician centred culture prevail: professionals do not share with patients any information about their path-care and patients are unaware about the events related to the treatments. In other cases, patients are informed about their conditions during the first contact with physicians. Sometimes, they are also involved by the professionals in defining the best treatment to be adopted.

According to the results identified, the most common tools used to communicate are the **intranet** system of the hospital, the **website** and the dissemination of **flyers**. In German hospitals, internal communication is based on an intranet shared system through which it is possible to collect input and information from the staff. Patients are informed about their care pathway through flyers. In Slovenia, the Community Health Centre of Ljubljana introduced on-line reservations on the website. Patients have the possibility to e-book an appointment with the doctor of their choice on the basis of the available time slots. This solution improved the access to care. Furthermore, the website itself provides information about health and lifestyle, focussing on prevention.



2.2.2. ORGANISATION

In parallel to national institutions, specific **organisational units** have been created in hospitals in order to dedicate resources (both financial and human) to quality and patient safety. In Germany, there are committees in charge of patient safety issues in all hospitals. In the Children Hospital of Riga (Latvia) a dedicated team made up of several professionals belonging to clinical and administrative units, has developed the hospital strategy.

The growing importance of the so called **patient safety leadership** attracted the attention of researchers and policy makers. Miller and Bovbjerg (2002) emphasised that there are two determinants of success in improving patient safety: a demand for safety from external factors (legal, market, and professional), and appropriate organisational responses that depend on internal factors such as leadership and governance, professional culture, information-system assets, and financial and intellectual capital¹.

In several European hospitals both professionals and managers recognised the importance of the issue and started working together to create awareness on patient safety issues in the organisation.

More leadership means better patient involvement in the definition of their care by professionals. In the United Kingdom, in particular, the Boards of hospitals are engaged and responsible for the patient safety strategy, rendering necessary a growing commitment of management, staff and carers. In Sweden, in the Psychiatric clinic of Borås, patients are actively involved in their own care and they define together with the healthcare professionals their own care plan.

As stated by the experiences of the exchange participants, **technological solutions** contributed to develop patient safety strategies, simplifying the information exchange among and within the healthcare organisations. In Andalusia (Spain) and in Sweden, for example, good ICT systems were found connecting all the actors involved in the care of the patients. The system facilitated the integration of primary care, hospitals and pharmacies. In Finland, Sweden and Valencia (Spain), ICT solutions were mainly used by the organisations to collect data and to improve the reporting system. In Austria, this tool was used to develop the standards and clinical guidelines at ward level. Technological tools and specific programs are also employed to make e-prescriptions. These instruments support the policy makers to evaluate and to choose. They allow the mapping of the real events and the identification of critical issues (incidents, for example), that can be prevented once recognised. ICT improves integration in health systems, allowing the system to offer proper care to patients using efficiently and effectively the available resources.

According to the United States Institute of Medicine report (2000), more use should be made of new technologies that could reduce the risk of errors. The authors give the example of the medication process where there were many opportunities for implementing better systems that would yield better human performance. Medication errors occur frequently in hospitals, yet many hospitals are not making use of known systems for improving safety, such as automated medication order entry systems, nor were they actively exploring new safety systems².

2.2.3. RISK MANAGEMENT

Risk management is a systemic process of identification, analysis and evaluation of actual and potential risks to estimate the costs and efforts that they request from the organisations. In hospitals, the risk management activity is done to safeguard the patient, reducing and foreseeing the adverse events and the medical errors through the mapping and the analysis of the root cause.

During the Evaluation Meeting, it emerged that many hospitals in several countries developed different risk management activities. These activities can be clustered as follows: Clinical Audit, Data Collection, Data Protection, Indicators/Benchmarking, Reporting System on Adverse Events/Root analysis, Complaining System. The effective implementation of those activities is related to the patient safety culture that prevails in the hospital.

Clinical Audit in modern healthcare systems is an activity conducted in the field of clinical governance to improve the standards of clinical practices. According to the results of the conference, the clinical audit is included in the set of solutions implemented in Austria, Estonia and Latvia as risk management instrument. In particular in Estonia, the aim is to understand the quality level of the care. In the Children Hospital of Riga (Latvia), a dedicated team in charge of developing the patient safety strategy carries out this kind of activity.

Data Collection is a tool used in order to provide information on the hospital activity. Through the information produced it is possible to compare if the measures put in place and the results obtained fit with the standards required by the procedures (Austria). Through this system it is possible to go back to the causes of an incident (Belgium and Finland) and to improve the clinical activity, strengthen the prevention of errors and mistakes or pathologies related to the patient stay at the hospital.

The privacy of the patients is safeguarded by a data protection system that, in countries such as Austria and Germany, restricts the access to the patient's documents in order to ensure confidentiality in handling medical record files. Generally, this system is supported by electronic programmes.

Policy makers support the use of **indicators** and the activity of **benchmarking** for the purpose of supervising the quality of healthcare services on an empirical basis and encouraging the hospitals to compare with different realities. In Austria, a report containing a set of quality indicators has to be addressed by the hospitals to the Ministry of Health in order to allow the national policy makers to check the respect of the defined standards. Often, it is mandatory to publish quality indicators (France) to make transparent the hospital activity.

Within the solutions adopted at hospital level to recognise the risk and to improve practices, the most frequently used instruments were the **incidents reporting** and the **root cause analysis**. Of the twenty hosting countries, fourteen chose at least one of these two tools to prevent, identify and learn from errors. Professionals report incidents often using specific web-based systems, in order to provide information (anonymously) used to understand which are the practices or the activities that increase the risk to blunder. Incidents reporting and root cause analysis support the top management and the professionals both to make strategic decision and to adopt good practices preventing errors. In the United Kingdom, the system of incident reporting is implemented at national and local level: every year thousands of reports are produced and their results are used to train the NHS workforce. In Spain, Hungary and Greece incidents reporting and root cause analysis need to be developed. In Malta, this topic is a critical issue related to patient safety culture. In this context, it is possible to say that the countries in which patient safety culture is more developed and effective are the ones where reporting incidents and root cause analysis produced positive results (Denmark and Finland for example).

Together with incident reports and root analysis, the **complaining system** contributes to collect useful data to analyse the causes related to adverse events. The information provided through the implementation of these elements is used to train the professionals with the intention to make them aware of the risks they could incur while performing their activity and to reduce errors.

The complaining system, if effective, allows the professionals to report their own mistakes anonymously, without suffering the consequence of losing their job (Austria).



2.2.4. PATIENT SAFETY TOOLS

Patient safety tools are the instruments or practices used by the professionals in order to prevent incidents and thus assure the high quality of care. They are connected to the risk management activities: if accurately used these instruments can reduce the risk of making errors carried out in clinical activities. During the Evaluation Meeting, several of them were presented: Checklists; Clinical Report; Control and Prevention of Fall, Infection and Ulcers; Guidelines; Hand Hygiene; Medication Safety; Patient Identification; Prevention; Process Management and Standard Procedures/Processes. The most common solutions implemented at hospital level are the checklists, the control of falls, infections and ulcers and patient identification. In almost 40% of the host countries at least one of the three tools were identified.

Checklists in operating theatres were found in half of the countries which hosted HOPE exchange participants. Hospitals usually opt for the WHO Surgical Checklist, which aims at “improving compliance with safety standards and proved to decrease complications from surgery [...] where it was evaluated. The checklist was established with a view to simplicity, wide applicability, and measurability. It divides the operation into three phases, each corresponding to a specific time period in the normal flow of a procedure (the period before induction of anaesthesia - Sign In, the period after induction and before surgical incision - Time Out, and the period during or immediately after wound closure but before removing the patient from the operating room - Sign Out), and a standardised approach to safety management. The success of the Surgical Safety intervention demonstrated by the significant reduction in surgery related morbidity and mortality has triggered a huge response³. The WHO Implementation Manual provides the information the checklist should contain. Additions and modifications to the content are encouraged in order to better fit the hospital/ward practice. In some cases, the adoption of the WHO checklist has been encouraged by national associations or authorities (Portugal and Switzerland).

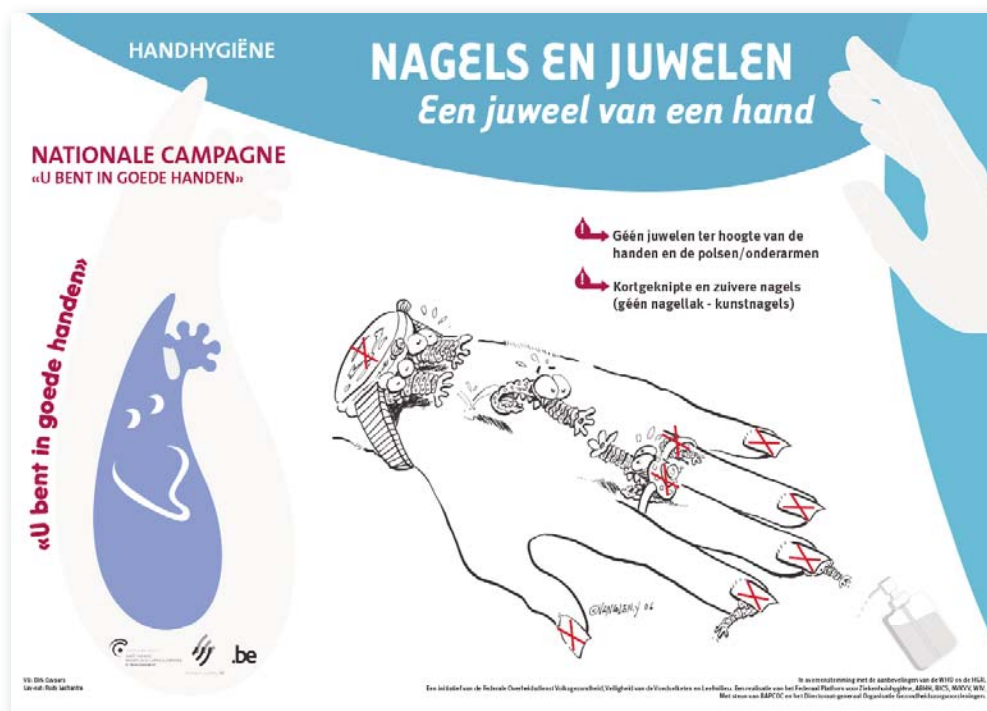
During the Workshop on patient safety in the operating theatre, which took place during the first day Conference on Patient Safety in Practice, it emerged that the SURgical PATient Safety System (SURPASS) checklist, developed in the Netherlands, has been an effective method to be adopted during a surgery procedure in order to prevent errors and adverse events. A prototype checklist was constructed based on literature on surgical errors and adverse events, and on human-factors literature. The items on the theory-based checklist were validated by comparison with process deviations (safety risk events) during real-time observation of the surgical pathway. Subsequently, the usability of the checklist was evaluated in daily clinical practice. The multidisciplinary SURPASS checklist accompanies the patient during each step of the surgical pathway and is completed by different members of the team. The SURPASS checklist covers the vast majority of process deviations suitable for checklist assessment and can be applied in clinical practice relatively simply. It is the first validated patient safety checklist for the entire surgical pathway⁴. Through this specific tool, it has been estimated that it prevented 40% of deaths and 29% of incidents leading to permanent damage⁵.

Along with the use of checklists, the **control and prevention of falls, infections and ulcers** is one of the most common tools adopted both at hospitals (Estonia, Spain, United Kingdom) and national level (Portugal) but also in primary care (Finland). In general, the effectiveness of this measure is assessed in terms of improved quality of care (Latvia, Lithuania) and its implementation is supported by an electronic system which collects all the data related to the event (Belgium). Periodically, a report is produced in order to analyse all the circumstances which contributes to falls, infections or ulcers (Austria). In some cases (United Kingdom) a holistic approach has been adopted in the prevention of falls, in order to reduce their impact on the NHS.

Clinical guidelines have been mostly implemented at hospital level and adapted to specific contexts. They can be defined as a set of recommendations to follow in executing the clinical activity in order to reduce the risk of adverse events, incidents or errors on patient identification (Austria, Finland and Portugal). At European

level, hospitals boards or dedicated staff (Latvia) focused increasingly their attention on clinical guidelines in order to support the staff in following standards and procedures (the Netherlands). This choice allowed an easier control, risk reduction and high quality of care.

Among the **guidelines** adopted at supranational level, it is important to mention the **WHO Guidelines on Health Hygiene in Health Care**, which development began in the autumn of 2004. They provide a comprehensive review of scientific data on hand hygiene rationale and practices in healthcare. This extensive review includes in one document sufficient technical information to support training materials and help plan implementation strategies⁶. Beside this document, WHO developed also a global campaign called **Clean Care is Safer Care** in order to improve hand hygiene among the healthcare workers and to support the reduction of healthcare-associated infections and their consequences. The **WHO Clean Hands Net** started as an informal network of national, sub-national and regional hand hygiene campaign in 2007. At this moment the network counts 48 participants worldwide, involving the following European countries: Belgium, Bulgaria, Croatia, Denmark, France, Germany, Hungary, Ireland, Italy, Luxembourg, Norway, Portugal, Spain, Sweden, Switzerland and the United Kingdom.



Medication is an area where adverse events regularly happen and, for this reason, **medication safety** becomes a priority on the agenda (Denmark). During the Evaluation Conference it emerged that at hospital level common measures have been adopted in order to guarantee a safe method of pharmaceuticals administration. Medication safety is not only about the administration but it concerns also the storage and transport (Estonia). One of the solutions broadly implemented is the presence of a dedicated pharmacist on the ward who ensures the risk reduction on pharmaceuticals dispensation and controls the drug omission (Belgium, United Kingdom). Other initiatives to guarantee a safe medication are the use of single-dose packages (Belgium) or the identification through different labels of syringes and pharmaceuticals (Lithuania). In Finland for example, hospitals adopted the Evidence-Based Medicine electronic Decision Support, a system which receives structured patient data from electronic health records and returns reminders, therapeutic suggestions and diagnosis-specific links to guidelines.

Patient identification is one of the most used measures, implemented in almost half of the host countries of the Exchange Programme. The tools adopted to identify patients with a specific pathology and address them to the correct clinical-path are bracelets and the implementation of a triage system. Each bracelet corresponds to a process, in which the patient is led to (Austria, Estonia, Latvia and Portugal). Triage is the process of determining the priority of patients' treatments based on the severity of their condition.⁷ It is necessary to ensure that patients are treated in the order of their clinical urgency and that the treatment is timely appropriate. It also directs the patient to the proper treatment area and provides information that helps to describe the departmental case-mix. Urgency refers to the need for time-critical intervention⁸ (Latvia, Lithuania and Slovenia). At the Lucus Augusti Hospital in Galicia (Spain), a system of patient identification has been implemented to distinguish patients affected by several pathologies but also to track blood transfusion. In the United Kingdom, slipper socks are used for patients who risk falling.



Prevention campaigns have been introduced both at national (Portugal) and hospital level (France), in order to sensitise professionals to respect patient safety measures, such as for example hand hygiene standards (Estonia). These programmes concern mainly the prevention of infections (Lithuania) but also other diseases like breast cancer (Malta).



Healthcare practices are characterised by complex clinical processes in which high-risk activities take place. A clinical process can be seen as a particular work flow where medical (e.g. treatments, drugs administration, guidelines execution, medical examinations, etc.) and non-medical (e.g. patient enrolment, medical record, etc.) activities and events occur. A successful approach for reducing costs and risks and enhancing patient safety is a process-oriented vision of healthcare services and practices. Systems providing clinical processes design, execution and analysis functionalities can change clinical practices and can help the diffusion of a process and quality awareness in healthcare organisations⁹. During the HOPE Evaluation Conference, it emerged that in some European hospitals, the **process management** became a strategic activity in which all the professionals are involved, not only the top-management (Belgium). Many resources have been invested in order to update the processes (United Kingdom) and their management is a future challenge to be developed at NHS level (Spain), since it obtained further relevance in the policy makers' agenda.

The use of **standard procedures** and **protocols** is a measure implemented in order to give professionals clear indications to follow in conducting the clinical activity. The purpose is to reduce the risk of adverse events through the application of strengthened suggestions in treating the patient. According to the HOPE exchange participants' experience, this tool has been adopted in hospitals situated in Austria, Belgium, Finland, Spain and the Netherlands. Standard procedures and protocols could refer to the activities carried out in the operating theatre (e.g. checklists) or in providing care to patients with specific diseases.

2.2.5. INVOLVEMENT OF PATIENTS AND PROFESSIONALS

It has been argued for a long time that patients have the right to be involved in the care they receive. Vincent and Coulter (2002) asserted that this necessity increased by the recent emergence of concern on patient safety. HOPE exchange participants identified several instruments used in the European hospitals (Estonia, Finland, France, Poland, Portugal, Spain, Sweden, Switzerland and the Netherlands) to involve the patients: **surveys**, mainly about satisfaction related to the care received, and the implementation of a **system of complaint**.

PATIENT SATISFACTION SURVEY
_____ Hospital

Share your opinions!

We need your help! Your answers to the following questions will be an important part of the quality assurance process for our hospital. Please take a few minutes to complete this survey, and return it in the enclosed postage paid envelope today. The information you provide will be completely anonymous. We are asking you to "rate" your recent experience at our hospital by circling your level of satisfaction with various services provided throughout your inpatient stay. If you did not receive specific services mentioned, simply circle the number "6" for NA (not applicable).

Your zip code: _____

I. _____ Hospital Emergency Room/Department Ratings
(please skip to item II if you were not admitted through the ER)

Circle the number that most closely approximates your experience in the ER.

	Completely Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Completely Dissatisfied	NA
a) Over all rating of ER services	1	2	3	4	5	6
b) Level of care provided	1	2	3	4	5	6
c) Wait time	1	2	3	4	5	6
d) Explanation of procedures or services provided	1	2	3	4	5	6
e) Emergency department facility	1	2	3	4	5	6
f) Attending physician personality	1	2	3	4	5	6
g) Nursing staff personality	1	2	3	4	5	6
h) Quality of aftercare instruction	1	2	3	4	5	6

If you were somewhat or completely dissatisfied with any of the above items, please tell us why: _____

Surveys are generally collected at the moment of the discharge with the aim to investigate if the patients are satisfied or not about the quality of the care they received while hospitalised. In some countries, surveys have to be compulsory submitted (Switzerland) at least every one or two year (Finland). The results obtained are collected in a report and used by the professionals with learning purposes. In the Psychiatric clinic of Borås, Sweden, patients participate actively with the professionals in the definition of their care-plan as well as surveys and root cause analysis.

Another initiative (Portugal and the Netherlands) through which patients give their feedbacks is the introduction of a complaint system: committed staff takes in charge the complaints of the patients, giving them a reply within a few days.

The necessity to involve professionals on patient safety issues makes policy makers at all levels aware about the importance of **education, training and learning** activity.

A wide variety of ideas is presented in the literature with regard to education. Several articles emphasise the need for training at all levels in the system. For example, Elkin and Gorman (2002) argued that it was necessary to design and implement training in patient safety that covered all levels and types of formal, informal, and continuing medical education programmes¹⁰.

Education, training and learning programmes have been organised all around Europe at national (Finland, Hungary and Portugal), regional (Portugal and Spain) or hospital level (Austria, France, Latvia and Sweden). In hospitals there is often a team specifically educated to organise training courses for professionals (Latvia). In some cases, courses are mandatory (Portugal) with a periodic regularity. Training programmes could have a specific topic: for example emergency (Germany), mediation (Slovenia), medication safety (Finland) or infection control (Finland and Portugal). In Cantabria (Spain) and the United Kingdom, professionals are trained through simulations of the environment where they usually work. The purpose is to reproduce a real situation in order to teach them the best practices to adopt.

Exchange programme participants' experiences showed that education, training and learning activity is often connected to a **reporting system** on adverse events. Through the analysis of the report results, it is possible for the professionals to identify the causes of errors and to learn from the incidents. Thus, the risk related to an adverse event could be reduced in the future. The premise to allow an effective activity of education, training and learning is to develop a strong patient safety "not blame, not shame" culture based on transparency and good communication within the professionals, the patients and their family.

An innovative experience was explained during the first day conference workshop. Dr. Ian Leistikow from the University Medical Center in Utrecht (the Netherlands) and his team, created a video game called Air Medic Sky One (AMS1) with the aim to train young doctors about patient safety. Despite their high level of training, all doctors at some point in their career will be involved in harming a patient. When doctors are involved, the cause is seldom a lack of medical knowledge. More often it is the organisational and situational contexts in which doctors have to work that deny them the opportunity to apply their knowledge to the best of their abilities. This frustrates doctors and harms patients. AMS1 fills a void in current medical training by teaching doctors about non-medical factors which can influence their performance¹¹.

3. COUNTRY INFORMATION

FINDINGS PRESENTED BY HOPE EXCHANGE PARTICIPANTS

AUSTRIA

HOPE National Coordinator	Gertrud Fritz
Exchange Participants 2013	Hanne Christiansen (Denmark) Dorte Dall-Hansen (Denmark) Inger Lähdesmäki (Finland) Ioannis Kasimis (Greece) Kristina Bidzane (Latvia) Carmen Arranz-Rementeria (Spain) Miguel Perez Tabares (Spain)

According to the information collected by exchange participants in Austria, two kinds of risk management systems prevail, each based on its own culture: the first one on errors and the second one on safety. The risk management and its tools are the most used instruments to ensure patient safety in the hospital daily practices.

Periodical audits are conducted to improve the quality and a complaining system, called CIRS, has been introduced to allow the employees to report incidents or errors anonymously. The data collected are used to produce a report, providing information necessary to train professionals in the correct procedures to adopt with patients. Besides this, a strong data collection system on hygiene procedures, nosocomial infections and the use of disinfectants has been implemented to track the gap between what has been done and what should have been done. The so called "A – IQI" Austrian Inpatient Quality Indicators, is a set of more than one hundred indicators, collected in a yearly report and addressed to the Ministry of Health, that are used to measure the quality and patient safety level in the hospitals.

Within the organisational measures taken at hospital level, technological solutions have been implemented to strengthen the ICT system in order to develop standards and clinical guidelines in the ward.

Patient safety tools implemented at hospital level are: surgical checklists based on WHO indications and clinical guidelines promoted to prevent and register decubitus and falls.

The control and prevention of falls and decubitus is at the top of the strategic agenda and, for this reason data collection and an electronic measurement system have been introduced to report all the events related to them.

The standard processes in pathways entail the implementation of patient identification measures such as the use of bracelets, through which patients are led to a specific path identified by a bracelet with a specific colour. In Austria, hospitals involve the patients in their activity through surveys and the introduction of a complaining system.

At national level, several certifications have been adopted to ensure the quality of the activity carried out in the hospitals and in particular in pharmacies, laboratories and areas dedicated to non-clinical activity, such as kitchens.

The culture which prevails in Austrian hospitals is focused on risk management, complaining system and quality management.

The future challenge is the implementation of an electronic system, called ELGA, which allows patients to access to their own data and decide if denying or not the access to their documents. It will be implemented from 2014.

The good practices to export abroad are: patient identification system, complaining system for professionals and a solid data collection system.

Elements to Support Patient Safety

- Risk Management
- Complaints Management
- Process Management
- IT Tools



Elements to Support Patient

- Quality indicators
- Hygiene data
- Certification
- Education in RM, PcM, Complaints MM, QM, etc.



BELGIUM

HOPE National Coordinator Colberte De Wulf

Exchange Participants 2013 Florian Laber (Austria)
Dorte Hendel Møller (Denmark)
Timo Palander (Finland)
Claire Delmotte (France)

Patient safety is a topic discussed at all levels in Belgium. Although it is not legally regulated, important measures have been taken at national level such as: the launch of the second federal five years plan, a federal campaign on hand hygiene and the introduction of a Flemish Quality Indicator Project.

At hospital level, risk management instruments have been adopted. Several hospitals took the initiative to obtain an international accreditation (JCI - NIAZ). An effective data collection system was implemented in order to prevent falls, the most common adverse events in the care of elderly. First, the system analyses the time, the place and the severity of falls and then, the results of the analysis are used to prevent and improve.

Concerning patient safety tools, the focus is on the processes which are the key to guarantee high quality standards as well as patient safety and to avoid the waste of time. In UZ in Gent, for example, the ratio used to define the processes and the new structure of the policlinic was simplicity: they have been thought in advance and the building was adapted respecting the nature of the processes and pathways. This hospital is characterised by a recognisable layout for every room and an intimate atmosphere. The attention was focused also on paperless workflow. Healthcare professionals use the checklist in the operating theatre and a three-separated-level trolley for surgical instruments: each level is dedicated to a specific phase (pre-operation, intra-operation and post-operation).

Medication safety is, together with falls, an area where adverse events regularly happen. A way to reduce medication errors is using "mono-dose" packages. A new approach is to dedicate 0.5 full time equivalent pharmacists to the ward in order to reduce the risks connected to pharmaceutical delivering. Pharmacists stay in the ward for a half-day and they meet patients on request.

The professionals are all involved in the definition of a patient safety strategy. This approach contributed to develop a decentralised management and created ownership. Not only professionals but also patients and their safety are involved at all hierarchical levels.

7 Involvement

Patient safety is **not only** an issue for **top management**.

It goes **top down** as well as **bottom up**.

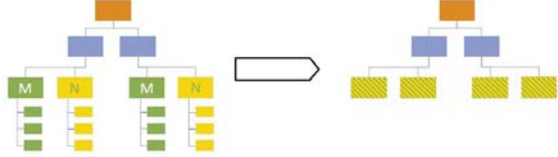
Every one has to contribute to patient safety.



BELGIUM
Hope Agora 2013 Den Haag

7 Involvement UZ Gent (Gent)

Change from **centralised** structure to a **decentralised cluster management** and thereby creating ownership.



BELGIUM
Hope Agora 2013 Den Haag

DENMARK

HOPE National Coordinator Allan Tambo Christiansen

Exchange Participants 2013

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 Dave Allegaert (Belgium)
 Katja Laitila (Finland)
 Laure Tharel (France)
 Jan-Hendrik Lampart (Germany)
 Stella Ilioudi (Greece)
 Christian Axiak (Malta)
 Charlotte Tijssen (Netherlands)
 Carla Matos (Portugal)
 Raúl Mallaina García (Spain)
 Astrid Erbsen (Switzerland)
 Mohita Mungur (UK-England)

In Denmark, many national initiatives have been adopted at central level. The Act on Patient Safety adopted in 2004 is the framework for strategies and measures implemented at local level. The Danish model of accreditation PDSA (Plan, Do, Study, Act) is a mandatory system for public hospitals which purpose is to promote quality, coherence and transparency. Through PDSA, three kinds of standard processes have been introduced in the five pilot hospitals where the model has been implemented.

The Danish Safety Hospital Programme 2010-2013 encourages hospitals in adopting some of the indication listed and to reach the goals suggested. Those goals can be for example: reducing mortality and harms by a certain percentage, commitment by leadership and staff, creating a good working environment and learning from data.

Danish hospitals introduced, among the risk management tools, a reporting and learning system for adverse events in order to analyse all information related to these events and to reduce the risks that they could happen again. The data collected are not used to apply penalties measures to the employees.

The measures implemented at hospital level in order to guarantee a proper patient involvement and transparency are the complaining system and the introduction of a digital process that allows the citizens to access their electronic health records.

The future challenges Denmark has to face related to patient safety are : improving coordination between the local entities (after the 2007 Danish Municipal Reform the organisation of the State changed with five new Regions replacing the former counties and the reduction of the number of municipalities); introducing effective medication safety measures in order to reduce the adverse events related to them; reducing the average length of stay strengthening the primary care; extending the digital processes and promoting a proactive patient safety culture with the intent of preventing the adverse events before they happen.



ESTONIA

HOPE National Coordinators

Hedy Eeriksoo
Pamela Ilves

Exchange Participants 2013

Sami Hadad (Denmark)
Eleni Pagoni (Greece)
Concepción Boluda Mud (Spain)

The Central Government implemented national initiatives. The Estonian Healthcare Service has introduced a contract in which new indicators and standards have been approved to achieve better results in the field of quality. The model which came out from this contract is patient centred but at the same time cost-effective. The goals to reach are the following: quality improvement and assessment, health service planning and contract monitoring.

Risk management tools such as indicators and benchmarking activity are adopted at hospital level. The aim of the clinical audits is to verify which is the level of quality of cares. In Estonia, the data of the patients are collected through medical records. The activity of control is related to budget and contract planning, needs assessment and selection of provider of services.

In Estonian Hospitals, patient safety tools were implemented in the field of medication safety, infection prevention and patient identification. The procedures regarding the storage, the transport and the administration of pharmaceuticals or blood products have to be checked by two persons or double checked by one. The infection prevention is based on the adoption of hands hygiene policies and measures regarding the equipment sterilisation department. Patients are recognised by their name, ID number and bracelet and protected through their protection bracelet.

Patient involvement takes place through reports and the implementation of a feedback system and both are used to investigate the patient satisfaction level. The results are adopted to formulate the best strategy and to organise training activity for professionals. Surveys are used as well.

According to a programme drawn up by Health Care Institutions to involve professionals, education and training courses, of at least sixty hours, have been organised on the basis of their specialisation. In order to push professionals to participate to education and training courses, Health Care Institutions implemented some motivational measures at the end of the program such as: special free days, facilitated shifts and higher salaries.

Estonia is characterised by the so-called "nursing hospitals" that ensure the continuity of care in the NHS.

The best practices that could be transferred to other countries are the education and training courses with a minimum amount of hours and the concept of nursing hospitals.

Education and Training

Legislation

The health care institution draws up a plan for the workers according to his/her speciality at least for 60 hours.

Motivation measures

- 1.Special free days
- 2.Facilities shifts
- 3.Higher salaries after the end of education.



FINLAND

HOPE National Coordinator

Arto Salo

Exchange Participants 2013

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 Hanne Brammer Pedersen (Denmark)
 Janne Hjorth (Denmark)
 Christian Queckenberg (Germany)
 Árpád Tóth (Hungary)
 Edmée Bovy (Netherlands)
 Ana Morão (Portugal)
 Petar Gabric (Serbia)
 Majda Cotič Anderle (Slovenia)
 Carlos Barreda Velazquez (Spain)
 José Jonay Ojeda Feo (Spain)
 Juan Pérez Pena (Spain)
 Märta Karlsson (Sweden)
 Giovanni Distefano (UK-England)

Finland is characterised by a very well established patient safety culture. The country adopted national initiatives such as the Finnish Patient Safety Strategy for 2009-2013 and the Health Care Act 1.5.2011, on the



basis of which patient safety plans are mandatory for all healthcare providers, both hospitals and primary cares.

The aim of the Finnish Strategy 2009-2013 is to promote shared policies and guideline for operations. The goals to reach are: the involvement of the patient; the implementation of a continuous activity of training and learning; the introduction of a solid system of incidents report. Since patient safety is a priority in the agenda, it has to be promoted with adequate resources and taken into account in healthcare research and teaching.

Finnish hospitals implemented measures regarding the organisation. A very important figure in the definition of the hospital strategy is the patient safety leader. The implementation of successful technological solutions, which improve the management of patient safety tools were ICT measures such as:

- e-prescribing system;
- HaiPro which is a web based tool used to report incidents. It is used in over 170 social service and healthcare organisations all around the country and it supports the development of procedures within the organisation. This tool provides an indication of the sufficiency of current preventive procedures and can also be used to assess the effect of new measures¹²;
- EBMeDS which is the abbreviation for the Evidence-Based Medicine electronic Decision Support, a system which receives structured patient data from electronic health records and returns reminders, therapeutic suggestions and diagnosis-specific links to guidelines.

During the Evaluation Conference, the HOPE exchange participants mentioned as risk management

instruments implemented at the hospital level in Finland, not only a reporting incidents system but also a solid system of clinical data collection whose information is used for benchmark activity and trend analysis.

The patient safety tools implemented at hospital level to reduce the clinical variation and to support decisions are: the use of checklists and standard procedures in the operating theatre; the implementation of clinical guidelines; the control and prevention of falls, infections and ulcers; the use of medication safety protocols. Patient and professionals involvement is a widespread policy in Finnish hospitals. The use of patient safety Culture Survey has a bi-annual frequency and its results are shared with the whole staff, in order to promote learning activity and share knowledge. The implementation of this tool made the professionals more responsible and improved their job quality and skills. Other activities to involve the patients are: empowering the role of the parents in the care of patients in neonatology; creating a call centre for emergency for patients who need to find their pathways and getting the proper care; organising the healthcare services close to patients houses, in order to let feel them confident and secure.



In Finnish hospitals wide importance has been given to provision of training and resources. Patient safety training is a steady activity including continuous professional development and e-learning initiatives for staff. Education and learning activities are focused mainly on the infections control and the management of the drugs in order to reduce the risk connected to their administration.

Non clinical measures were taken like the use of a smartcard on which a unique number identifies the patient, research in patient safety, and security guards in healthcare and facilities.

The best practices implemented were information technology solutions and the use of standardised processes. The future challenges for Finland concerns the empowerment of patients and the introduction of patient e-record in all welfare services.

FRANCE

HOPE National Coordinator Cédric Arcos

Exchange Participants 2013

- Henrik Hansen (Denmark)
- Sari Palojoki (Finland)
- Cornelia Ullmann (Germany)
- Alan Moran (Ireland)
- Cristina Fernandes (Portugal)
- Virginia Pereira (Portugal)
- Nemanja Djurovic (Serbia)
- Pilar Calvo Pérez (Spain)
- Tino Marti (Spain)
- Mariano Martin-Macho Martínez (Spain)
- Marta Portela Diéz (Spain)
- Purificacion Suarez Herranz (Spain)
- Noelia Varela Aller (Spain)
- Marco Alfonsi (Switzerland)

In France patient safety strategies have been taken at three levels: national, hospital and professional.

The most important national level measures were: national accreditation; the adoption of national four years programmes of improvement; implementation of patient safety indicators; the introduction of homogeneity and transparency measures due to the fact that it is mandatory to publish quality indicators; the support of hospital competition; the development of a culture based on open-minded discussions on risk management and the strengthening of patient participation.

National Level

- National Accreditation
- National Programmes of Improvement
- Patient Safety Indicators
- Homogeneity
- Transparency
- Hospital competition
- Patient Safety Culture development
- Patient participation



Hospital Level



- Prevention programmes
- Vigilance systems
- Risk Mapping
- Reporting and Feedback System (adverse incidents)
- Discharge Satisfaction Survey

At hospital level, many tools to improve quality have been adopted such as: prevention programmes, vigilance system, risk mapping system through electronic method, reporting and feedback system of adverse events, discharge satisfaction surveys.

Professional Level

- Continuous Health Education
- Professional practice assessment
- “Commission factory”



LES PROFESSIONNELS DE SANTÉ ONT À VOUS ÉCOUTER
 Vous seul pouvez les informer en répondant à leurs questions
 Vous patient, vous avez des questions
 N'hésitez pas à les poser, il est normal d'être ignoré

Professionals are concerned as well by patient safety issues. They have to follow constantly health education programme and participate to practice assessments. A specialised commission has been established in order to discuss if there are problems related to risk issues.

Within the best practices implemented, it is worth mentioning:

- national accreditation, which allows hospitals to work on patient safety issue in a structured way;
- patient satisfaction;
- patient safety indicators.

Within the transferable measures to other countries, France implemented:

- patient safety indicators;
- transparency in hospitals and department;
- transparency with the patients and within the professionals;
- report and feedback of adverse events.

Measures taken at national and hospital levels are effective but it is necessary to improve measures at professional level.

GERMANY

HOPE National Coordinator

Peer Köpf

Exchange Participants 2013

Sabine Lengauer (Austria)
 Manuela Maria Milly (Austria)
 Hans Henrik Strange-Vognsen (Denmark)
 Pietari Perkinen (Finland)
 Lotta Ylimaula (Finland)
 Mary Gauci (Malta)
 Maria do Céu Cajadão (Portugal)
 Oliver Stojanov (Serbia)

In Germany, patient safety initiatives have been promoted mainly at hospital level, except for the Data Protection Act, which should be integrated with a detailed policy in order to ensure data protection and confidentiality in handling patients medical records files, from one ward to the other. The access to patients data is restricted and an effort has been done to transfer all information from papers to electronical files.

Data Protection

- *In addition to the general Data Protection Act, a specific and detailed policy is required to ensure confidentiality in handling patient's medical records files, from one ward to the other etc...*
- *Restricted access to patients' data base.*
- *All Data should not just be hand written in personal files but also inserted electronically in the Patients' Data base.*

Patient safety strategy at hospital level is based on two key words: culture and communication. Strategy on communication is internal, if referring to professionals and external if referring to patients. Internal

COMMUNICATION

- **INTERNAL**
employees
- **EXTERNAL**
employees & patients

communication is based on an intranet shared system through which it is possible to collect input and information from the staff. Doctors and nurses liaise with the marketing department to create flyers for patients. Flyers are necessary to give the patients all information they need: the most the patients are informed the most they will feel safe in the structure. Initially the draft goes through Intranet so that all employees can contribute. External communication strategy is addressed to patients, who have to be informed on all the procedures they are involved in. To allow the patients to get easily in touch with the hospital, it is necessary to promote a simplify access to the hospital website.

In parallel with internal and external communication measures, dedicated organisational units called Committee on Patient Safety are settled in all hospitals.

As risk management tools adopted at the hospital level complaining system and reports on errors are used in order to prevent, identify and analysing errors.


In Germany five successful initiatives are recognised:

- security measures including fire-prevention and fire-fighting are well advanced;
- clean hands system is well practised and stickers or posters are allocated all over the hospital;
- patients equipment is regularly checked and certified;
- defective items are duly repaired or boarded out immediately.

PATIENTS' COMPLAINTS

By e-mail or hospital's post box

*If the patients feel unsafe or are unsatisfied with the way they were treated in the hospital, they have the possibility to report this to the management via Internet or by placing a letter of **complaint** in the local hospital complaint post box.*



Patients are involved through the possibility to report to the management their level of satisfaction for the care received through the hospital website or letters of complaint.

To develop a patient safety culture the involvement of professionals is necessary through the organisation of periodic staff-training on theory and practice, in particular on what would be required in emergencies. Hospital staff needs a multi-skills training in order to achieve a better outcome for the patients. Resources invested in seminars to promote a culture of noble values, are highly beneficial to enhance the quality of healthcare service to the patient.

GREECE

HOPE National Coordinator George Tsimopoulos

Exchange Participants 2013 Herbert Kaloud (Austria)
Mladena Kojic (Serbia)
Anna Soteras Prat (Spain)

In Greece, a changing process regarding safety culture has been set in from a “culture of shame and blame” to a systematic, proactive and continuous culture, working on forecasting in order to prevent adverse events.

Risk management is a process of identification, analysis and evaluation of actual and potential risks, taken at hospital level, in order to estimate the costs and efforts they produce in the organisations. Adverse events represent one of the first 10 reasons of mortality and the average cost per patient varies from 4.000 euro to 8.000 euro. Risk management activity contributed to decrease this cost containing the average length of stay and the level of morbidity; limiting the legal trials against the hospital and the insurance costs.

Greece implemented the EN 15224, a European Standard focused on the importance to adopt a valid system of clinical risk management in order to reduce adverse events and improve the level of quality of care. The information gathered contributes to train professionals on how to prevent errors and incidents.

EN 15224: Point. B.4.2.3.

Riskmanagement: Adverse Events

(Experience in Northwestern Greece / Ioannina)

- ..Documentation about adverse events..
- ..Analyses about adverse events..
- ..Information System about results out of RM..
- ..Safety of patients, medical staff and all persons coming into hospital will be rising up..
- ..Learning effort out of mistakes that were already made by medical staff somewhere else..

EN 15224: Point. B.4.2.4.

Risikmanagement: Prevention

(Experience in Southern Greece / Athens)

- ..Qualyfied stuff studded in RM..
- ..Work should be based on sientific knowledge and results of mesurement in QM..
- ..High standards in hygienic, infection control..
- ..Controlling system about Quality of medical products and technical invironment..
- ..PDMS..
- ..Management in case of technical damage..

HUNGARY

HOPE National Coordinator

György Harmat

Exchange Participants 2013

Angela Guzmán Carrasco (Spain)
Robert Johansson (Sweden)
Audrey Bell (UK-Scotland)

In Hungary patient safety initiatives concerns mainly the national level. The Ministry of Health is the authority which oversees the NHS.

GYEMSZI
National Institute for quality and organisational development for healthcare and medicine.
Established May 2011

- Starting point – restructuring of Healthcare ref Semmelweis Plan
- Development Centre established to lead change
- Objective to create effective healthcare function and efficiency
- Responsible for
 - governance of healthcare system
 - Formulation of strategies for improvement and patient safety
 - Management of patient pathways
 - Professional development
- Crisis management issues e.g. Ambulance services

In 2011, GYEMSZI - National Institute for quality and organisational development for healthcare and medicine – has been established: it is in charge of defining the healthcare system governance and the strategies for patient safety, managing the pathways and the development of the professionals. The GYEMSZI has been created to lead the change and to create an effective and efficient healthcare system. Through this institution, the hospitals report to the central Government their activity and initiatives also regarding patient safety.

The National Institute of Patient Rights and Documentation (OBDK) has been created in September 2012 to strengthen the figure of the patient as active actor in the National Healthcare Service. In the same year, it has been introduced also the National Public Health Institute. At national level, the Hungarian National Reporting and Learning System (NEVES) is involved in: promoting patient safety culture within patients and supporting staff on patient safety related research; conducting analysis to investigate the root cause of adverse events and expressing recommendations in order to prevent them; promoting learning activity in the whole organisation and disseminating good practices and patient safety culture.

Initiatives have been taken at hospital level especially in the rehabilitation wards. For this reason, the quality of the services for this kind of speciality is very high. Tailored programmes from two to six weeks are organised for the patients. The professionals collaborate in order to define a proper path of care.

The exchange participants hosted in Hungary pointed out that the best practices regarding patient safety are:

- good staff attitude;
- ISO accreditation;
- high standard reached in training of physicians;
- national control strategy.

The aspects to improve concern the culture, the lack of resources (both human and budgetary) and the absence of standards for building and equipment. It is necessary to improve at hospital level some risk management tools such as: reporting system on adverse events, data collection about patients. Concerning professional involvement, it is essential to reach an appropriate level of training of healthcare workforce and to build a learning system based on the adverse events reported. In general, patient safety issues have to be globally improved as well as the collaboration between departments and organisations.

LATVIA

HOPE National Coordinator Evija Palceja

Exchange Participants 2013 Eugenia Garcia-Sastre Garcia (Spain)
Brenda Yorston (UK-England)

Patient safety in Latvia gained a growing importance at national level. Indeed, Latvia is both member of European Union Network for Patient Safety and quality of care (PaSQ) and responsible to facilitate knowledge exchange within Member States on this topic. Examples of the practices that this country promoted throughout Europe are: alcohol based hand rub to improve hand hygiene and safety in surgical procedures by introduction of surgical checklists.

The Health Inspectorate is the national institution that regulates compliance on minimum requirements for the NHS organisations and their structural units doing quality control of medical services provided. It is also in charge of collecting patient complaints and recommendations as well as improvement actions on Health Care Services.

The development of a quality management system and quality standards for health are officially claimed to be important and, for this reason, it is necessary to strengthen the patient safety leadership, the staff knowledge and the organisational structure to allow the implementation of an effective strategy.

Involving staff in patient safety

- Departmental visits to talk to frontline staff
- Workshops / focus groups
 - brainstorming
 - learning from industrial models of change
- Staff training from Patient Safety team
 - adverse event reporting
 - Analysis of event – fish bone, 5 whys
 - no blame culture
- Audit lead by Head Nurses – clinical guidelines

Within the hospital initiatives, at the Children Hospital in Riga patient safety strategy is developed by a dedicated team made up of a manager, a trainer/facilitator, an auditor, a member of the hospital board, clinical leaders from different departments (surgeons/physicians) and head nurses. This team has specific role and responsibilities such as: evaluating projects on safety improvements, analysing adverse events and reporting root cause, doing clinical audit and risk management. The activity of the team consists in organising departmental visits to talk to frontline staff, workshops/focus groups, brainstorming, staff training, audit leads by head nurses, analysing and

developing clinical guidelines.

Record keeping and reporting system on adverse events are the risk management instruments implemented at hospital level to produce information and to analyse the causes of errors or incidents.

Several patient safety tools were introduced to improve the quality of care of Latvian hospitals: checklists in operating theatres; infection control; medication safety policies and patient identification through ID bracelets. Regarding the implementation of a triage system, in Riga Children Hospital nurses need training in order to understand how to allocate triage code to the patients. It is also necessary to dedicate a specific area to welcome patients and to allow their registration in the most efficient way, in order to reduce the risk connected to provide unnecessary treatments. Professionals are involved through the staff training activity.

Latvia is committed to enhance patient safety initiatives and many processes were started to introduce changes and reach a higher level of quality. The measures to improve are related to triage system and the registration of the patients.

LITHUANIA

HOPE National Coordinator Daiva Zagurskiene

Exchange Participants 2013 Carlo Bagliani (Italy)
José Manuel Fernandez Carreira (Spain)

At national level, the Programme for the Quality of Healthcare Assurance for 2005-2010, was approved in 2004 by the Ministry of Health: "This programme [...] seeks to direct healthcare more clearly towards the needs of patients and the public; to improve quality and safety; to develop healthcare quality management"¹³. Its aim consists in: developing patient-centred healthcare; improving quality, safety and access to the healthcare services; improving healthcare quality management systems. In this context, Patient safety is defined as a type of process or structure which reduces the probability of adverse events resulting from exposure to the healthcare system.



The second initiative taken at national level was the creation of a National Patient Safety Platform whose mission is to improve healthcare quality and safety. The activities carried out are:

- licensing of the healthcare organisations and health professionals;
- accreditation of healthcare organisations ;
- regulation and management of medical devices;
- health technologies assessment;
- supervision and control of quality of health procedures ;
- supervision of patient rights.

In the Lithuanian University of Health Sciences Kaunas Clinics, Quality and Safety hospital initiatives were agreed both at organisational and strategic level. They cover: the establishment of internal audit department; the definition of Quality and Safety goals in relation to infection prevention, medication safety, radioactivity control, medical equipment safety, blood transfusion and transplant control. Furthermore, a Quality Management System according to the requirements of International Standard of accreditation ISO 9001:2008 was adopted.

Within the patient safety tools implemented, the exchange participants mentioned: medication safety procedures, which introduced a system of identification for syringes and drugs by labels of different colours; the adoption of the surgical equipment checklists in the operating theatre that have to be ticked before and after each surgical procedure; the prevention of infection by monitoring the epidemiological surveillance incidence and conducting prevalence studies. Patient safety tools have been adopted also for radiation control and to implement a system of triage.

The Lithuanian best practices to be transferred are:

- the presence of general practitioners in emergency rooms for patients identified with white or green triage code;
- the use of coloured labels for drugs and syringe mainly in emergency rooms and operating theatres;
- the excellence in rehabilitation;
- the implementation of a National Patient Safety Platform.

MALTA

HOPE National Coordinator

Edward Borg

Exchange Participants 2013

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Margareta Rolfhamre (Sweden)

Louise Page (UK-England)

In Malta, the Breast Screening Program can be mentioned as a high quality national initiative taken to improve patient safety in the whole country. A valid inter-disciplinary team was committed and patients were involved in their path, evaluating their experience.

Breast Screening Programme

- Part of the National Screening programme
- High quality programme
- True inter-disciplinary team
- Excellent quality assurance measures
- Evaluating the patient experience



Door knockers, Mdina

At hospital level, patient safety became a priority in the agenda and foreign experts gave an input on international accreditation by external authorities. In relation to risk management initiatives, some databases were created in order to collect information about patients. Moreover, several projects are conducted to improve patient safety and quality and to develop a new culture with the intent of promoting a change.

The national and hospital initiatives listed above were successful despite the critical issues related to patient safety culture such as: lack of professional involvement and strong hierarchy prevalence; weak use of incident reports; patient led demand system. Patients are poorly involved in the definition of their care pathway and they do not receive the information about their treatment.

The challenges for the future consist in promoting investment in primary and community care and enhancing a strong national patient safety culture.

How have these risks been managed in Malta?

- Core people are advancing patient safety
- External input from world renowned experts
- Individuals have created computer databases
- A number of projects in place with a strong patient safety and quality focus
- Some have worked within the "culture" some have effected a local change in culture



Infection Control posters at Mater Dei



NETHERLANDS

HOPE National Coordinator


Hans de Boer

Exchange Participants 2013

Gunar Stemer (Austria)
 Marie Bussey Rask (Denmark)
 Karolina Peltomaa (Finland)
 Olivia Deschamp (France)
 Anna Nárcisz Najat (Hungary)
 Jana Pavare (Latvia)
 Goran Bicanin (Serbia)
 Lydia Padro Pitarch (Spain)
 Kerstin Danielsson (Sweden)
 Görel Nergelius (Sweden)
 Richard Apps (UK-England)

In the Netherlands, there is a very strong culture of patient safety and risk management, involving both patients and professionals. The health system is insurance based and patients contribute voluntarily with a 300 euro/year out-of-pocket payment in self risk. Since almost all the hospitals are private, there is a sort of competition within them in order to attract the patients. On the supply side, there is a high attention on patient safety and providing safer treatment in hospitals and primary care is a further incentive as well as a parameter of competition.

Patient safety culture started at national level, with the introduction of a learning system based on mistakes and dialogue: "not blame, no shame culture". The strategy is bottom-up, as the healthcare organisation is decentralised and based on two pillars: patients and professionals.



Pillar: Patients

- **Patients contribute to safety of own care**
 - Patient empowerment and education
 - Patient information leaflets
- **Patients contribute to improve healthcare**
 - Satisfaction surveys, mirror meetings, complaint management

Patients are aware of the risks connected to the treatments and contribute actively to their own care through the empowerment of their role and of education. Hospitals encourage patients to have their feedback using different tools such as satisfaction surveys, mirror meetings, focus group and communications to complaint management. The patients are constantly informed through the leaflets. Professionals are highly involved and committed in

finding and proposing proactive solutions about patient safety. Also in this case, the hospitals' strategies are bottom-up consisting in continuous education, use of safety protocols, in particular checklists and reporting of critical incidents and feedbacks. All professionals are aware of the risk and they follow guidelines in carrying out the clinical activity.



Pillar: Professionals

- **Quality-Safety-Management Systems**
- **Professionals are highly involved and committed**
 - Continuous education on patient safety
 - Safety protocols (e.g. check lists)
 - Reporting of critical incidents
 - Feedback



POLAND

HOPE National Coordinator Bogusław Budziński

Exchange Participants 2013 Jasmina Savic-Joksimovic (Serbia)
Olivia Pérez Corral (Spain)
José Luis Trigo Izquierdo (Spain)
Inger Bodin (Sweden)

Poland is a European Member State characterised by the strong presence of a National Authority which entails a heavily regulated public sector and lacking independence of sub-national authorities due to stringent budget constraints.



At national level, the Polish Patients Federation and the Institute of Patient Rights and Health Education have been created and, in addition, 11.500 NGOs involved in health protection and promotion and in activities aimed at ensuring equal access to healthcare registered in an online database.



In 2008, the Law on Patient Rights and the Patient Rights Ombudsman were approved to allow access for patients to the information regarding their health status.

At hospital level, surveys on the quality of treatments received accredited by International Organisation for Standardisation (ISO) 9001 were introduced with the intent of involving the patients in evaluating their path of care.

According to the exchange programme participants' experience the future challenges are:

- improving patients experience of care;
- promoting shared decisions making and involving the patients;
- building a system of data collection;
- promoting health and reducing health inequalities;
- strengthening the role of the NGO involved in health protection and health promotion and ensuring equal access to healthcare for all;
- developing communication campaigns to support a "culture of prevention";
- making the public services accountable.

PORTUGAL

HOPE National Coordinator Francisco Matoso

Exchange Participants 2013 Annette Bjerre Vedstesen (Denmark)
 Jarmo Toivola (Finland)
 Irmgard Eder (Germany)
 Rajko Pflügel (Germany)
 Dita Raiska (Latvia)
 Maria Antonia Blanco Galán (Spain)
 Arran Banks (UK-England)

Portugal implemented patient safety initiatives mainly at national level. At the same time, several measures have been taken at hospital level. The Government promoted the development of a strong culture based on teamwork, leadership, adverse event reporting and learning. The idea is to implement these initiatives at regional level.

The national initiatives have been set up on the basis of a national strategy founded on an accreditation system involving all the healthcare units in the implementation of national guidelines. The use of technologies helped, in this phase, to facilitate the exchange of patient information through electronic records.

To enhance the risk management activities, the General Directorate of Health developed a national platform in which is collected information related to risk events in hospitals. The General Directorate assesses the events, expressing an opinion in relation to the level of gravity of the risk. The second national initiative is the introduction of the SINAS (National System of Health Quality Assessment) which is an evaluation system for the quality of healthcare structures in five dimensions: clinical excellence, patient safety, adequacy and comfort of facilities, patient satisfaction and patient focus.

Within the patient safety tools introduced by the Government, the activity of Preventing Healthcare Associated Infections & Antimicrobial Resistance was implemented in order to decrease the healthcare associated infection rate (10.6% in 2012) and to control the antimicrobial consumption rate (45.4% in 2012).

WHO Patient Safety Campaign

- Clean Care is Safer Care: National Hand Hygiene Campaign**
 - 2008: WHO national commitment
 - 2009: Hand Hygiene Campaign in Hospitals
 - 2010: Hand Hygiene Campaign in Primary Care Units and in Long Term Care Facilities
 - 2012/2013: Translating the WHO document "Hand Hygiene in Outpatients and Home-based Care and Long-term Care Facilities".
- Safe Surgery Saves Lives: Surgical Safety Checklist**
 - 2009: National Commitment & Guidelines, Translation of WHO documents "WHO Surgical Safety Checklist"
 - 2013: New National Guidelines

Group Portugal, 2013


Furthermore, the adoption of WHO Patient Safety Campaign from 2009 to 2013 was promoted in order to improve the practices related to hand hygiene in hospitals, primary care unities and facilities. In operating theatres, surgical checklists have been introduced.

To reduce the risk concerning the patient identification, guidelines and recommendations have been developed and a system of triage introduced. Also at the local level, the identification of the patient with allergies and/ or under risk of fall is possible through a bracelet.

Medication safety is supported by a research activity in collaboration with the Research Institute for Medicines and Pharmaceutical Sciences, with the intent of evaluate the correct use of pharmaceuticals in Portuguese hospitals.

NHS Patient Complaints System (SIM – Cidadão)

- The official complaints book – the yellow book
- The [DGS homepage](#) – online form
- Forms in the wards, letters, email etc.
- Local patient satisfaction surveys are conducted



Group Portugal, 2013

At the NHS level, a patient complaints system was introduced in 2007 as well as a national database to collect complaints, praises and suggestions. All hospitals have a dedicated office in charge of responding to patients within fifteen days after the complaints have been presented and once a year an annual report has to be produced with all the information collected. Patients are involved also through the introduction of surveys of their satisfaction.

At regional level, mandatory training programmes for healthcare professionals on quality and patient safety have been organised. The training programmes are focused on infection prevention and control and, in particular, the goal to reach is preventing sepsis and reducing its mortality rate.

The future challenges Portugal has to face are:

- strengthening the national database for adverse events;
- improving the hand hygiene measures and developing an hand hygiene culture in the community;
- promoting hospital surveys on patient safety culture.



SLOVENIA

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In Slovenia, a wide range of developments regarding patient safety and quality are taking place at national level. Moreover, healthcare providers are at different positions with gaining international accreditation, which has been a clear driver to influencing cultural change and strategy to improve quality and safety. According to the experience of HOPE exchange participants hosted in Slovenia, there is a need for institutions and healthcare providers to develop closer working partnerships for the different processes and pathways to converge, to become more integrated and achieve implementation of a shared strategy.

At hospital level, three different initiatives have been adopted in Ljubljana, in order to improve the quality and the accessibility of the healthcare services. The Community Health Centre has introduced the online booking appointment on the website which allows patients to e-book an appointment independently. This made healthcare service more accessible and offered a good source to patient to have information about health and lifestyle.

The University Medical Centre has adopted a trial of radio frequency patient tracking in the Emergency Department. Patients are more informed about their waiting times and simultaneously there were progresses through triage and assessment stages. It also assists the monitoring of quality and efficiency. A drive thru pharmacy has recently been opened by the Rehabilitation Institute. This example is a direct response to the needs of patients with different physical abilities. This solution was thought to allow patients who find physically challenging to move independently and safely to a conventional pharmacy.

In Slovenia, mediation is assuming an emerging role. The background to the development of mediation in healthcare matters is the legislation. General legislation on court related mediation and alternative dispute resolution has been backed up by special legislation in relation to patient's rights, to establish alternative pathways of resolution in cases of damages caused by healthcare. According to some research results, people decide to take legal action due to poor communication, insensitive handling or suspicion of a cover-up. At the same time, there are personal and professional dilemmas: the stress caused by making an error, fear of reputational damage, future employment or worse. In an effort to better manage and learn from these difficult events the healthcare profession has shown an increased interest in alternative or effective dispute resolution, which is a structured method of settling disputes by means of a third independent person.

The Association of Health Institutions in Slovenia trains healthcare mediators. Strict requirements are in place related to training, and case experience is needed to mediate. The importance of experienced mediators is necessary to ensure quality and reliability of a trusted process.

Communication plays an important role in the success of any initiative to improve safety and quality. To avoid misunderstandings healthcare professionals have to involve the patients and their family in the care.

"Why don't you ever pick up the phone?...This is a two way process."



"When were you planning on telling us this is what was going on?...and why?"

informacijski

SPAIN

HOPE National Coordinator

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The Ministry of Health has taken national initiatives, in order to implement patient safety policies, such as agreements with 17 Health Regions and INGESA (Instituto Nacional de Gestion Sanitaria), collaborations with professionals and patients and agreements and contracts with public and private organisations. The patient safety strategy was launched in 2005 and ended in 2010 with the presentation of results and indicators.



Moreover, the Ministry of Health created an organisation called Agencia de Calidad Sanitaria de Andalucía in order to promote and develop quality policies in the Andalusian Regional Health System. The instrument through which this organisation acts is the accreditation, supported by ICT.

At hospital level, organisational measures, such as the implementation of technological solutions, have been adopted with the intent of supporting the collection of data and information (Lucus Augusti Hospital and Denia and Manises Hospital). ICT solutions have been used in Catalonia to integrate hospitals and primary care. In Extremadura on the other hand, the integration exists in the pharmacy system.

The most adopted patient safety tools are: checklists; clinical reports; control and prevention of infections, ulcers and falls; hand hygiene; medication safety and patient identification. Professional involvement is possible through a strategy oriented to education and training. In particular in Cantabria, the activity of training consists in simulation of the environment where the professionals work. The purpose is to reproduce real situations.

Future challenges regard mainly the reduction of adverse events, which produce an impact both on patient conditions and on NHS sustainability in term of costs. For this reason, it is necessary to:

- define processes, protocols and flowcharts;
- improve clinical governance;
- implement lacking patient safety tools;
- record clinical data by the hospital admission information;
- introduce computerised warehouses and hospital pharmacies;
- enhance patients and professionals involvement;
- register and evaluate clinical incidents.

SWEDEN

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In Sweden, the Patient Safety Act has been adopted in 2001. This measure is seen as the foundation of patient safety culture. According to this, organisations must work together to prevent harm and involve the patients in their activities. They also have to report the results annually in order to allow an open and transparent comparison. The instruction manual is the second initiative taken at national level, which defines eight care “bundles” to be focused on regarding patient safety initiatives: central line infections, urinary tract infections, surgical site infections, pressure ulcers, falls and fall injuries, malnutrition, medication errors and drug-related problems.

In order to assist the patients in the safest way as possible, the Government decided to strengthen the coordinated care and promote a steady connection between primary care and hospitals. Doctors provide care to patients at home and, at the same time, patients are constantly involved in defining a proper care plan.

The Swedish Healthcare System is characterised by the adoption of risk management measures to identify high risk patients and to manage them in the community. At hospital level, the planning of discharge is adopted.

Within the best practices to mention, Sweden has a very good system of communication which is consolidated at national, county and hospital levels. This is possible thanks to a strong ICT system which allows information exchange and data reporting across the hospitals, within the pharmacies, between the community and primary healthcare. The implementation of incidents reporting systems at all levels allows the collection of information.

Patients are involved in evaluating their experience through two tools: surveys of their satisfaction and reports. In the Psychiatric clinic of Borås, for example, patients participate actively on their own care because they can create together with the healthcare professionals the plan. They also participate to the analysis of the root cause for all serious incidents. The results are reported at a national level.

The measures to export are:

- coordination at all levels;
- good reporting system;
- transparent data;
- efficient and effective ICT system;
- patient safety leadership;
- patient involvement.

FAQ Safety Act Safety Manual Coordinated Care Information Customer Care

Patient Safety Act (2011)

“No patient should suffer from avoidable damage due to care or health treatment”

- Foundation for patient safety culture
- Organisations must work to prevent harm
- Patient involvement
- Reporting results annually
- Open comparison

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In Switzerland two associations are nationally involved in patient safety and quality measures to be implemented in hospitals: the National Association for Quality, in charge to develop surveys on patient satisfaction and the National Patient Safety Association, which runs several projects such as the one for the implementation of surgical safety checklist in operating theatres.

Patient satisfaction survey

- National Association for Quality Development (ANQ)
- Development of a national patient satisfaction survey
- Annual survey
- 5 questions



For every Swiss hospital it is mandatory to adopt a system of reporting. The information contained in the reports is not public. For this reason it is not possible to benchmark activity between hospitals. It is also mandatory to submit patient satisfaction surveys to

1. Would you return to hospital for the same treatment?
2. How was the quality of your treatment?
3. Satisfaction with information provided by doctors?
4. Satisfaction with information provided by nurses?
5. Treatment of patient with respect and dignity?



understand which is the current level of quality in healthcare. The survey has an annual frequency and it has five simple questions. Surveys are effective and, for this reason, they can be mentioned within the best practices implemented.

Patient safety tools implemented at hospital level are: readmission avoidance; control of falls, infections and ulcers; hand hygiene procedures and checklists.

In Switzerland, future challenges to face are:

- cooperation between hospitals in different cantons;
- transparency on quality indicators from hospitals on a national level;
- introduction of measurable quality indicators.

UNITED KINGDOM

HOPE National Coordinator

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In the United Kingdom, the patient safety strategy is person-centred and based on standards and guidelines that the hospitals have to respect. The patient is the person around which the job of healthcare professionals turns. Professionals work in collaboration with each other, adopting a holistic approach. Healthcare workers are regularly trained and they learn from a system of incident report. At NHS level, resources have been invested in order to update the processes.

At organisational level, all human resources are involved in patient safety issues. Boards of hospitals are engaged and responsible for the patient safety strategy, which has to be concrete giving a level of priority to the measures putting in place and switching from feedbacks to actions. Leadership has to be adopted at local level.

Good practices on patient safety concern mainly the implementation of risk management instruments and tools as well as training and learning activities.



Incident reporting system is implemented both at national and local level and is based on a “no blame culture”. Every year 10.000 reports are produced in order to understand which has been the cause of the problem and the results are used to train the staff. The management is involved in this activity through the so called “incident groups” which are: the Risk Validation Group, the Serious Incident Group, the Risk Management Board and Board of Directors. On the basis of incident report system there are risk management tools such as: RCA, FMEA and London Protocol.

Good practice - Medication Safety

- New technologies
 - Releases staff and reduces medicine wastage
 - Right drug for right patient
- Pharmacists on wards
- Reduce adverse events
- Control drug omission



1. Patient Safety in the NHS 2. Leadership in Patient Safety 3. Good practices 4. Take home message

Medication safety strategy has been adopted to release the staff from responsibilities and decrease the pharmaceuticals wastage. Through this system the risk to give to the patients the wrong medicine is reduced. The presence of pharmacists in wards attenuates the probability that adverse events could happen and control the drug omission.

Good practice - Infection Control

Joint Infection Control Team

- Meeting on a monthly basis
- Attendees: Deputy Director of Nursing, Physicians, Microbiologists, Infectious Disease Nurses, Epidemiologists, etc.
- Discussion on current and upcoming topics
- Link to all relevant Committees



Main Topics

Guidelines and Policy
MRSA, MSSA, E. coli-Surveillance
Norovirus season review
Hand Hygiene
Infection Control Accreditation
Education e-learning
Influenza - Winter Planning
Complaints & Incidents

1. Patient Safety in the NHS 2. Leadership in Patient Safety 3. Good practices 4. Take home message

Infection control has been achieved through the creation of the Joint Infection Control Team which organises meetings on a monthly basis on current and upcoming topics on this issue as well as makes an analysis on the potential threats. The healthcare professionals involved in this team are: the deputy director of nursing, physicians, microbiologists, infectious disease nurses and epidemiologists and they have a link to all relevant Committees.

Good practice - Training & Learning



- Mandatory training
- Simulation training
- E-learning
- Team training
- Learning from errors



Learning from incidents - Case 1
Pain Management in Renal Failure: Opioids



1. Patient Safety in the NHS 2. Leadership in Patient Safety 3. Good practices 4. Take home message

Training and learning activities consist in simulation, e-learning, team training and learning from incidents and are organised at a team level.

In United Kingdom, the cost of falls to the NHS and Social Care is around 1.8 billions of pounds per year. In addition, two millions of hospital bed days per year lead to 40% of all long term admission. To reduce the impact of falls on the NHS, a holistic approach has been adopted and some tools have been used, such as: bed/chairs alarms to prevent falls, slipper socks to identify the patients and low profiling beds.

Some of the measures to be transferred to other countries are the implementation of a system of incident report and patient safety leadership.

FOOTNOTES

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