Dansk Selskab for
PatientS!kkerhed
Danish Society for PatientSafety

Improving Patient Safety and Quality in Latvia

Riga, Latvia, June the 7th
2018

PS!

Simon Feldbæk Peitersen

- M.Sc. in Public Health

- National board of Health
  - National Health/Hospital Planning – Cancer Patient Pathways, Cancer Drugs, Emergency Preparedness Management, Infectious diseases/Vaccines
  - EU – Working Party on Public Health/Health Security
  - WHO – EB/WHA

- Danish Society for Patient Safety
  - European Network on Patient Safety and Quality of Care
  - Quality Improvement Programmes – hospitals, municipalities
  - Consultancy work – nationally and internationally

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Danish Society for Patient Safety

an independent organization working to improve patient safety across Danish healthcare. We strive to create a sustainable healthcare service, in which changes become lasting improvements.
Citizens and patients should experience a safe, effective and coherent healthcare – every person, every time.

- Patient Safety and Quality Improvement Projects (hospitals, municipalities, primary care)
- Campaigns
- Policy work

Consultancy work (National and internationally)

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Session 1:

Patient Safety culture in limited ressource setting

Patient safety – a journey that involves culture and learning – and how legislation can support the development

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Reporting and learning systems

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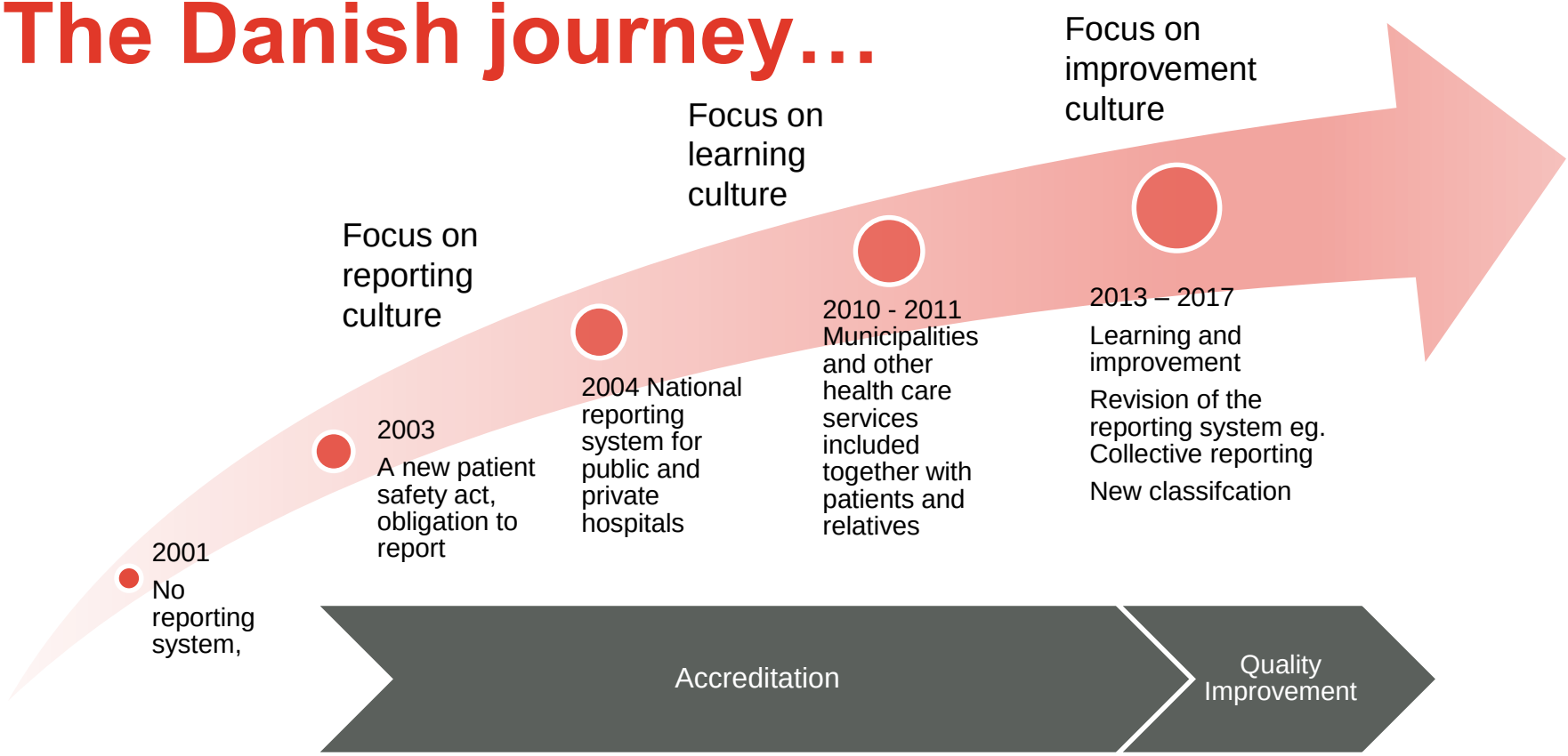
The Danish journey…



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Four pillars of Patient Safety [DK]

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The patient safety act – national health act

- According to the act, chapter 61, on patient safety
  - Frontline staff shall report adverse events
  - A patient og family member can report adverse events
  - A national patient safety database → report to providers → Analyze and learn → ”Closed case” → # in database
  - The person who report the adverse event **cannot** undergo disciplinary sactions

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Sanction free reporting - IMPORTANT

- *The reporting individual may **not** as a consequence of reporting be submitted to disciplinary investigations and measures by his or her employer, supervisory measures by the National Health Authority/Patient Safety Authority or penal sanctions by the courts.*

The Danish Patient Safety Database

- Patient Safety Act 2004
- One national reporting system
- Entire health sector – hospitals, primary care, municipalities
- Healthcare professionals
- Patient and relatives voluntary

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Why have a report system

- To support learning
- Developing and improving healthcare services
  - Where to focus your efforts
  - No data, no problem, no problem, no action
  - Help to build culture of learning
  - Focus on system level

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Learning

- National:
  - National reports on adverse events based on aggregated data
  - National conference around learning from adverse events
- Regional:
  - Root cause analysis / learning / action
  - Aggregated data
  - Severe events
- Local:
  - Root cause analysis / learning / action
  - Learning based on each event

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8 learning points…

1. Only report incidents of importance
2. Reporting should be effortless
3. The reporting system must still have a clear division of disciplinary and learning functions
4. The reports must be handled at the right level
5. Learning must be shared across units (e.g. regions and municipalities)
6. Incident reporting should not stand alone but must be an integrated part of quality improvement initiatives and aims.
7. Incident reporting should add to a transparent public system
8. The reporter must receive individual feedback about actions

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Compensation system

- The Patient Compensation Association (PCA) is responsible for managing the part of the law that deals with injuries occurring in connection with a treatment in the public and private healthcare system
- PCAs duty to ensure that patients receive the compensation patients are entitled to by law.
- The scheme covers practically the entire health service.
- Patients report an incident free of charge
- Don’t need to not hire a lawyer.
- Healthcare professionals are obliged to inform patient about PCA if they believe they have sustained an injury that entitles you to compensation. They must also help you to report the injury if necessary.
- **Danish Act on the Right to Complain and Receive Compensation**
- **The Danish Liability for Damages Act**

No-fault compensation systems

- Removal of the fear of litigation would improve the safety of medicine through more open reporting and enhanced learning

→ Better patient safety

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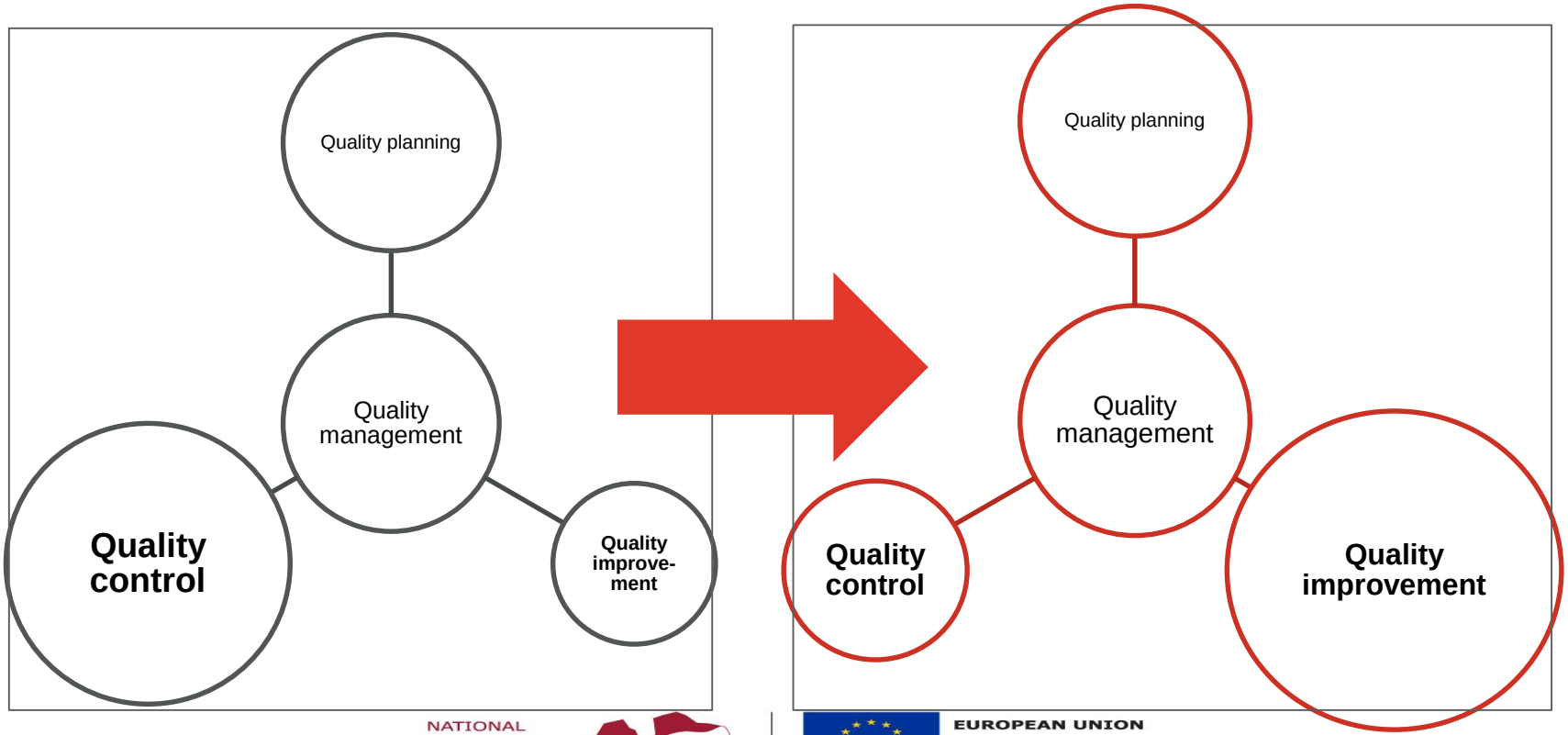
Juran Triology of Patient Safety/Quality



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So what to do…

- Patient safety should be supported by legislation
- Blame- and sanction-free environment
- No-fault-compensation system
- System-perspective – individual vs. system-perspective
- Culture – don’t do a culture project – do a patient safety and quality improvement project – that will change culture
- Learning, learning, learning
- Commitment to execute and implement!

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Quality Improvement in Healthcare

- Learning, learning and learning
- Failure is an option - culture
- Improve yourself – no benchmarking
- Use adverse events and other data sources – patient views
- Small test of change
- Data data data – realtime data
- Awareness at all levels – local, regional, national and global

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Thank you!

Homepage: www.patientsikkerhed.dk

Mail: Simon.peitersen@patientsikkerhed.dk

Twitter: @Simon_FK

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