Spanish Strategy on Patient Safety

Yolanda Agra MD, PhD
Ministerio de Sanidad, Servicios Sociales e Igualdad

HOPE_ Madrid May 2013
2006: Council of Europe Recommendations
(Committee of Ministers)
*Ensure that patient safety is the cornerstone of all relevant health policies*

2009: Council of the European Union
Council Recommendation on patient safety, including the prevention and control of healthcare associated infections

2004: Patient Safety Programme
“Primum non nocere”
To improve PS In NHS

- Patients
- Culture
- Education
- Research
- Safe Practices
- Reporting and learning systems
Alliances

Ministry of Health

Agreements

17 Health Regions & INGESA

Agreements and contracts

PROFESSIONALS
140 associations supporting PSS

PATIENTS AND CONSUMERS
22 associations supporting PSS

PUBLIC AND PRIVATE ORGANIZATIONS
• Universities
• Agencies
• Schools of health
• Others

Collaboration
Development of the Strategy

Expert recommendations

**ENEAS**
Professional statement
*Statement with WHO*

**Patient statement**
Medication errors
SYREC

**APEAS**
Bacteriemia zero (ICU)
Patients Network
Hand Hygiene Programme
EuNeTPaS

**IBEAS**
SINASP (N&LS)

**I Conference**
2005
BZ results
Strategy indicators

**II Conference**
2006

**III Conference**
2007

**IV Conference**
2008
PaSQ meeting

**V Conference**
2010
EU Presidency

**VI Conference**
2011
Pneumonia zero
EARCAS

**2012**

**2013**

**UPDATE**
Development of the Strategy
Main actions

1. **Patient safety culture**
   - Information
   - Teaching programme
   - Patient safety research

2. **Safe clinical practices**
   - HCAI
   - Medication
   - Procedures

3. **Notification & learning system**

4. **Patients participation**
Hand Hygiene

Click here to watch a video of the Hand Hygiene Campaign

Salvar vidas está en tus manos

Publications Online tutorials Newsletters Blog
<table>
<thead>
<tr>
<th>Setting</th>
<th>Questionnaire</th>
<th># of professionals</th>
<th>Problems detected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>Hospital Survey on PS Culture (AHRQ)</td>
<td>22 Hospitals (n= 2503)</td>
<td>.Managers support .Communication between Units .Human resources</td>
</tr>
<tr>
<td>ICU</td>
<td>Hospital Survey on PS (AHRQ) Pilot BZ</td>
<td>192 ICU (n=438)</td>
<td>.Managers support .Workload .Human resources</td>
</tr>
<tr>
<td>Primary care</td>
<td>Medical Officer Survey on PS (AHRQ))</td>
<td>15 Regions (n=4344)</td>
<td>. Workload</td>
</tr>
</tbody>
</table>
Promotion of culture and knowledge on Patient Safety

Education is the first step to change Professionals’ culture

OBJECTIVES:
Prevent, detect, analyze and minimize AE. Evidence and safe clinical practice

METHOD:
Multifaceted approach

CONTENTS:
AE Epidemiology and prevention
Risk management
EBM
Effective communication
Teaching programme on PS

2005

2006

2007

2008-2012

Master Degree (5 editions, 150 professionals)

Risk Management Online Course (22 editions, 1500 professionals)

Specific courses: Hand hygiene, BZ, NZ, SINASP

Basic Course at Regional level
Research: frequency of AE

**2006**

**ENEAS**
(n=5624)
9.3% (8.6-10%)
24 hospitals
5,624 patients
42,714 stays

Incidences

**2007**

**APEAS**
(n=96047)
1.1% (1.05-1.18)
48 PC centers
452 professionals
96,047 visits

Prevalence

**2008**

**SYREC**
40% Risk
Medication,
devices, catheters accesses.
ICU
Prospective

**2009-10**

**EARCAS**
AE related with:
.Medication
.HCAI
.Evaluation
Long term care facilities
Qualitative study

More than 50% of the AE would be preventable
Safe Practices: Funding areas

- HCAI
- Medication Use
- Patient Identification
- Surgery and Anaesthesia
- Nursing Care
- Patients Involvement
- Communication

Hand Hygiene: Stop HCAI
Zero Infection ICU
Hand Hygiene: Salvar vidas está en tus manos
PREVENT AND CONTROL HCAI

Hand Hygiene
Bacteriemia zero
Pneumonia zero
AMR
New born infection
Surveillance systems
Sepsis Code
Improving HH to reduce HCAI

Specific objectives in coordination with the Health Regions

To agree on common basic activities
To select indicators at different levels
To improve professionals’ HH education and training
Hand Hygiene Indicators
17 health Regions; 300 hospitals

- Rooms with ABH
- ICU with ABH
- PC with ABH
- Hospitals basic training
- Hospitals training 5 moments
- PC with basic training
- ABH at clinical site
- Hospitals with Observation 5…
- Hospitals with self evaluation

[Graph showing data with categories and years 2009, 2010, 2011]
SECONDARY OBJECTIVES

- To promote and strengthen PS culture in ICUs throughout the NHS.
- To create a network of ICUs implementing evidence-based safe practices.
National Organization

SMoH

HR Department

HR Coordinating Team
  Cordinator, ICU physician
  ICU nurse, preventivist

ICU-1  ICU-2  ICU-n

Physician, Nurse, Executive, infectious diseases comitee

Cofinancing & coordination
Monitoring & spreading

Information, engagement
Managers commitment
Leadership
Organize: Functions
Resources distribution

Training
Monitoring
Evaluation reports: results
Structure & Process evaluation

Training
Implementation
Self-evaluation
Improvement
RESULTS

230 ICU (85% of the NHS)
- National rate <4
- 117 avoided deaths
- 130 mill € saved in hospitalization
RESULTS:

- 230 ICU (85% of the NHS)
- National rate <9
- 280 avoided deaths
- 143 million € saved in hospitalization

DI NMV: NVM/1000 d MV (Mean)
ISMP-Medication Safety Self-Assessment Questionnaire

To identify the changes that occurred from 2007 to 2011 in medication safety practices in Spanish hospitals (105 hospitals in 2007 vs 165 in 2011)

Criteria (increase)

4: Automatic Communications (47%)
15: Continuous training In PS (46%)
17: Programs to reduce errors (49%)
18: Analysis of errors By professionals (84%)

Safe medication Use

Autoevaluación de la seguridad de la utilización de los medicamentos
Resultados por criterios esenciales
Objective:
To improve patient safety, learning from errors at local level

- **2006:** Bibliographic review
- **2007:** Meeting with HR and experts
  Focus group with patients
- **2008:** Survey to Scientific Societies
- **2009:** Piloted in 2 hospitals
- **2010-11:** Piloted in 4 HR
- **2013:** 6 HR (68 hospitals, 9 primary care health centers)
R&LS: Characteristics

- Voluntary
- Non punitive
- Confidential
- Anonymous (or not)
- Systems-oriented
- Expert analysis
Acceso al curso de formación del SINASP

Verificación de los Certificados del curso

La creación de un sistema de notificación y registro de incidentes y eventos adversos es uno de los objetivos incluidos en el Plan de Calidad para el Sistema Nacional de Salud (SNS), en el marco de la Estrategia en Seguridad de Pacientes desarrollada por el Ministerio de Sanidad y Política Social. El Instituto Universitario Avedis Donabedian ha colaborado con la Agencia de Calidad del Ministerio en el desarrollo y la coordinación de este proyecto.

El objetivo del SINASP es mejorar la seguridad de los pacientes a partir del análisis de situaciones, problemas e incidentes que produjeran, o podrían haber producido, daño a los pacientes. El objetivo principal del sistema está en el aprendizaje para la mejora. Aunque la notificación es voluntaria, se anima encarecidamente a los profesionales a utilizar el sistema, colaborando así en el aprendizaje y la mejora de la seguridad del paciente.

La información introducida en el SINASP es totalmente confidencial y está protegida por los más avanzados sistemas de seguridad. Más información sobre la seguridad del sistema.

En esta primera fase el SINASP está disponible únicamente para hospitales, aunque se valora su extensión a otros dispositivos asistenciales en fases posteriores. Sólo los profesionales de los hospitales que están dados de alta en el sistema podrán notificar incidentes en el SINASP.

Actualidad SINASP

PUBLICADO EL PRIMER INFORME PARA LA PREVENCIÓN DE ERRORES DE MEDICACIÓN DEL ISP, QUE UTILIZA DATOS DEL SINASP

El boletín para la prevención de errores de medicación publicado por el ISP en octubre de 2012 incluye por primera vez el análisis de incidentes notificados al SINASP y está accesible.

Más noticias

News
RCA
Notifications received in one year

n=3.512

Type of incidents

<table>
<thead>
<tr>
<th>Incident</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td>1214</td>
</tr>
<tr>
<td>Identification</td>
<td>528</td>
</tr>
<tr>
<td>Falls</td>
<td>440</td>
</tr>
<tr>
<td>Devices</td>
<td>355</td>
</tr>
<tr>
<td>Procedures related with treatment</td>
<td>279</td>
</tr>
<tr>
<td>Organization</td>
<td>286</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>219</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>194</td>
</tr>
<tr>
<td>Others</td>
<td>149</td>
</tr>
<tr>
<td>Transport</td>
<td>125</td>
</tr>
<tr>
<td>Blood and blood products</td>
<td>125</td>
</tr>
</tbody>
</table>
- Support the Recommendation of the CoEU regarding Patient Safety and Healthcare Associated Infections

- Strengthen cooperation between MS, stakeholders and International organizations on issues related to Quality of care, Patient Safety and Patient Involvement

Exchange of PSP & GOP
Implementation PSP
Sustainable Network

PSP: patient safety practices
GOP: good organizational practices
WP transversal

1 Coordination France (HAS)
2 Communication Croatia (AQAH)
3 Evaluation Greece (NKUA)
4 Identification PSP Exchange PSP Denmark (DPS)
5 Implementation PSP Germany (AQuMeD)
6 Description of QMS Identification GOP Exchange GOP Spain (MSSSI)
7 Sustainability Slovakia (MoH)

WP central

Exchange Mechanism
PROJECT

The European Union Network for Patient Safety and Quality of Care, PaSQ Joint Action is co-funded and supported by the European Commission within the Public Health Programme.

It is building on European Union Network for Patient Safety (EUnetPaS) experience and network to promote the organisation of Patient Safety and Quality of Care platforms in all European Member States to improve Patient Safety and Quality of Care through sharing of information, experience(s) and the implementation of good practices. These platforms will be organised around PaSQ National Contact Points (NCPs) who will be also the contact persons for PaSQ matters in their respective countries.

WORKING PATTERN

It will run for 36 months (April 1st 2012 – March 31st 2015) and will be performed through seven (7) Work Packages.

OBJECTIVE

The main objective of PaSQ is to support the implementation of the Council Recommendation on Patient Safety. PaSQ unites representatives of the European medical community and the institutional partners involved in Patient Safety and Quality of Care in the Member States of the European Union.

Read more...
What about the patients?

When we want your opinion we’ll give it to you
Patients participation in the PS strategy
Next steps

• Healthcare associated infections
  ✓ Hand hygiene
  ✓ Zero infection in ICU: resistance zero
  ✓ Antomicrobial resistance strategy
  ✓ Sepsis code

• Safe medication
  ✓ Medication errors
  ✓ High risk medication list for chronic patients
  ✓ Medication reconciliation

• Notification and Learning System
  ✓ Primary Care

• Others
  ✓ Evaluation of teaching hospitals
What we have achieved?

- National alliances around Patient Safety
- Dissemination of the safety culture in the NHS
- Generation of a significant critical mass of professionals involved in the strategy
- Knowledge about security problems in the NHS
- Knowledge of the tools to prevent and control them
- Available data showing effectiveness and efficiency of the practices implemented
Key elements for success

- Leadership
- Commitment
- Education
- Implementation
- Evaluation
- Feedback
CHALLENGES

NHS SAFETY

Improve PS culture

- Evaluation
- Patients
- Manager leaders
- Clinical leaders
We need more than ever leaders able to lead their teams in the worst conditions, towards achievable goals.
Thank you!
yagra@msssi.es