8.G. Workshop: Patient Safety: Challenges and opportunities to keep sustainability in the continuum of care

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Health care systems worldwide share common goals in order to improve the quality and safety of care, despite some differences in structure, resources, accountabilities and priorities. Patient safety is widely recognized as an essential component of health care. For that reason, improving patient safety has become a core issue for many countries. There is a great amount of evidence that health care services around the world occasionally and unintentionally harm patients. In recent years, different studies have estimated that around 4% to 17% of hospital admissions have resulted in an adverse event and that up to half of these events were preventable.

The effects of harming a patient are widespread and represent a significant burden from a clinical, economic and social perspective. There can be devastating emotional and physical consequences for patients and their families. For the staff involved too (second victims), incidents can be distressing, while members of their clinical teams can become demoralized and disaffected. Therefore, the occurrence of adverse events also has impact in healthcare organizations (third victim) in terms of reputation and the increase of costs.

Despite improvements in healthcare interventions, patient safety is nowadays a serious problem for all stakeholders, with several implications in different clinical areas and level of care, constituting a major contributor to the global burden of diseases and a concern for Public Health.

Objectives

Our aims with this workshop are to: 1) highlight the issue of patient safety and adverse events as a significant problem and a challenge for Public Health; 2) emphasized the importance of safety measurement across the continuum care; 3) discuss the role of communication and IT tools towards quality and safety improvement; 4) report from ongoing patient safety programs/ experiences/practices across Europe to inspire new learning and practices.

The workshop will consist of four presentations and a final plenary discussion. Our hope is that this sharing moment and the discussion that will arise can strengthen contacts and inspire the participants towards increasing the work across Europe for improving this important public health issue.

The first presentation gives us the perspective of how important is to measure the safety culture/climate in the healthcare organizations. The authors will share with the audience the results, in this area, that came out from the Norwegian Patient Safety Programme (2014-2018)

The second presentation describes a self-assessment tool for Clinical Risk Management (CRM) developed within the Italian National health system, and a set of performance indicators that aims to monitor CRM and improvements in different health care settings.

The third and fourth presentations focus on two important issues that are cross-sectional to patient safety in a logic of continuum of care: communication and IT tools and their role towards quality and safety improvement.

Key messages:

- Patient safety can be improved by learning from European and international research and from the discussion that arise from sharing experiences across the continuum of care in different countries.

- Despite improvements in healthcare interventions, patient safety still a serious problem in Europe and worldwide, and for that reason a concern for Public Health research and practice.

Safety culture and/or safety climate in hospitals, how to measure?
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The concept of safety culture is an outgrowth of 'safety climate', which is in turn a derivative of 'organisational climate'. After the Chernobyl catastrophe, increased attention was paid to safety climate or safety culture in workplaces with advanced technology, complex systems, and potential for catastrophes. A literature review has shown that safety culture and safety climate remain ill-defined concepts. One definition of safety culture is however: ''Shared values (what is important) and beliefs (how things work) that interact with an organisation's structures and control systems to produce behavioural norms (the way we do things around here)''.

Various factors and sub-components have been proposed for identifying and measuring safety culture. The criticism has been made that safety culture is reduced to a combination of administrative procedures and individual attitudes to safety, and that considerations of politics and power are absent. Also, there is some doubt of whether ''culture can be 'measured' at all using quantitative psychometric methodologies such as questionnaires or surveys'', or as the only measurement tool.

In the Norwegian Patient Safety Program (2014-18) a model of patient safety culture includes six factors:

- Team work climate
- Safety climate
- Management focus on patient safety
- Job satisfaction
- Working conditions
- Stress awareness

The two first factors were measured in 2014 in a national survey at hospitals by an international Safety Attitude Questionnaire to 77.457 health personnel in 2.372 units. Response rate was 62%. Results show that 56% of the units report a ripe safety climate. Recommendations on a systematic improvement on safety culture are developed. One of the aims of the program is that in 2018 at least 80% of respondents from the health units will report a ripe patient safety climate. A challenge is, however, how to include the other four factors into an investigation, and how to operationalize the safety culture concept.

Patient Safety in different hospital settings: monitoring the state of the art through indicators and a validated self-evaluation tool
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In the last decades much attention has been given to patient safety, but the greatest number of studies focused on hospital care despite a wide portion of health care being delivered in other settings like local health authorities. Friuli Venezia Giulia Region is using CARMINA (Clinical Assessment of Risk

Management and a set of performance indicators to monitor CRM and improvements in different hospital settings.

Methods

From 2015, CARMINA has been used every two years by local Risk Managers for self-evaluation of CRM state of the art in 4 different hospital settings. Since 2011, 17 performance indicators have been routinely collected in the same settings, 7 of whom have been expanded to LHA in 2015. Improvement goals are set at regional level every year.

Results

The first CARMINA survey described different level of maturity on CRM between the different hospital settings, with academic hospitals being more advanced (50/52; 96.2%) than local (42/52; 80.8%) and private hospitals (40/52; 76.9%). Among the standards, all the Organizations reached maximum level of improvement on those directly related to Regional programmes (e.g. patient falls, pressure ulcers, infection control). Performance indicators related to those programmes, however, described a more articulated picture with smaller CRM organizations performing slightly better (89.9% and 89.4% overall compliance for private hospitals and LHA, respectively) than larger organizations (84.0% and 83.2% overall compliance for academic and local hospitals, respectively).

Conclusions

CARMINA application highlighted different CRM development among hospital settings in FVG Region, with stronger level of attention on patient safety from complex organizations such as academic and local hospitals.

Patient Safety and Communication - a National Survey in Germany
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Effective communication at hospitals and in the healthcare system, contributes to the development and sustainability of a culture of safety. We know that communication failures are one of the most common causes of medical errors. There are only a few studies about information-, decision, and -communication behavior between patients and doctors. In order to prevent miscommunication, we need more knowledge to ensure a more successful patient-doctor- communication relationship. The results of the study ''KomPaS'' - a national Survey on communication and Patient-Safety, aim to identify specific aspects for improving the quality of communication in health care.

The survey will describe information and communication in health care in Germany from the patient's point of view. It will focus on the following issues:

Information Needs:

Information and knowledge have primary importance for an efficient health-communication; for example during medical decision processes, in the selection of medical products, and for the exercise of patient rights.

Health Literacy:

Studies show, that a low level of health literacy is correlated with a high level of health problems and risk factors. The ''KomPaS'' – study is expected to obtain new findings of health literacy.

Patient-Safety:

Patient satisfaction and patient behavior regarding complaints, give important information for successful communication and cooperation between patients and doctors.

The survey is funded by the Federal Ministry of Health in Germany. A national representative sample will be reached by telephone – landline or mobile phones in private households. The survey will be carried out in May 2017. The first results are expected in autumn 2017.

Health Information Systems (HIS)-induced patient safety incidents – experiences of physicians in Finland
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The first survey (2010) on Finnish physicians' experiences of health information systems (HIS) as work tools, raised concerns of serious patient safety risks posed by IT. A patient safety-specific module was included in the 2014 survey, key findings of which we present here.

Methods

Data was collected through a self-administered web-based questionnaire in February - March 2014. A response link was sent via email to all working physicians in Finland, registered as Medical Association's members at the time of study. Patient safety questions aimed at identifying the type of HIS failure involved in patient safety incidents, mapping whether physicians reported the observed incident and if not, what was the rationale for their choice. Descriptive statistics were calculated for patient safety module variables using IBM SPSS v.21.

Results

In total 3781 physicians responded to the survey as a whole (response rate 23,1%) and 1070 of them specifically on patient safety. The majority of patient safety module respondents were specialists in hospital settings ($\approx$ 67%). Top three failures in HIS use were system down-time (82,4% in hospitals, 75% in primary care, 70,1% in private practices), error-prone medication ordering interface (39,2% in primary care to 26,4% in private practices) and presentation of wrong patient data (primarily an issue for hospitals, at 31, 4%). Upon observing a HIS-induced patient safety incident, almost half of respondents chose to discuss the event with a colleague. Reporting of incidents locally ranged between 10,5% and 29%. Reasons for not reporting focused on incidents being near-misses or the demands of the reporting process, but not on fear of consequences.

Conclusions

Finnish physicians working in exclusively paperless environments experience similar patient safety risks as reported earlier in the literature. Systematic follow up of HIS-induced patient safety incidents is recommended given the growing role of digital solutions in healthcare.