INTERNATIONAL CONFERENCE ON PATIENT SAFETY:
CHALLENGES AND REALITIES IN THE SPANISH NATIONAL HEALTH SERVICE

INFORMATION AND NOTIFICATION SYSTEMS ON PATIENT SAFETY: A CRITICAL ANALYSIS

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ICELAND

Nordic Council of Ministers

2000 – 2003

Working Group on Quality Measurements in Health Care

Quality Declaration

Quality Indicators

Nordic Council of Ministers

2004 – 2006

WORKING GROUP ON QUALITY INDICATORS IN HEALTH CARE

Charman: Jens Gøttrik, Chief Medical Officer, Danmark

GENERIC AND SPECIFIC INDICATORS

MENTAL HEALTH

PREVENTIVE MEASURES

PRIMARY CARE

PATIENT PERSPECTIVE

PATIENT SAFETY

Assessing Patient Safety Through Administrative Data

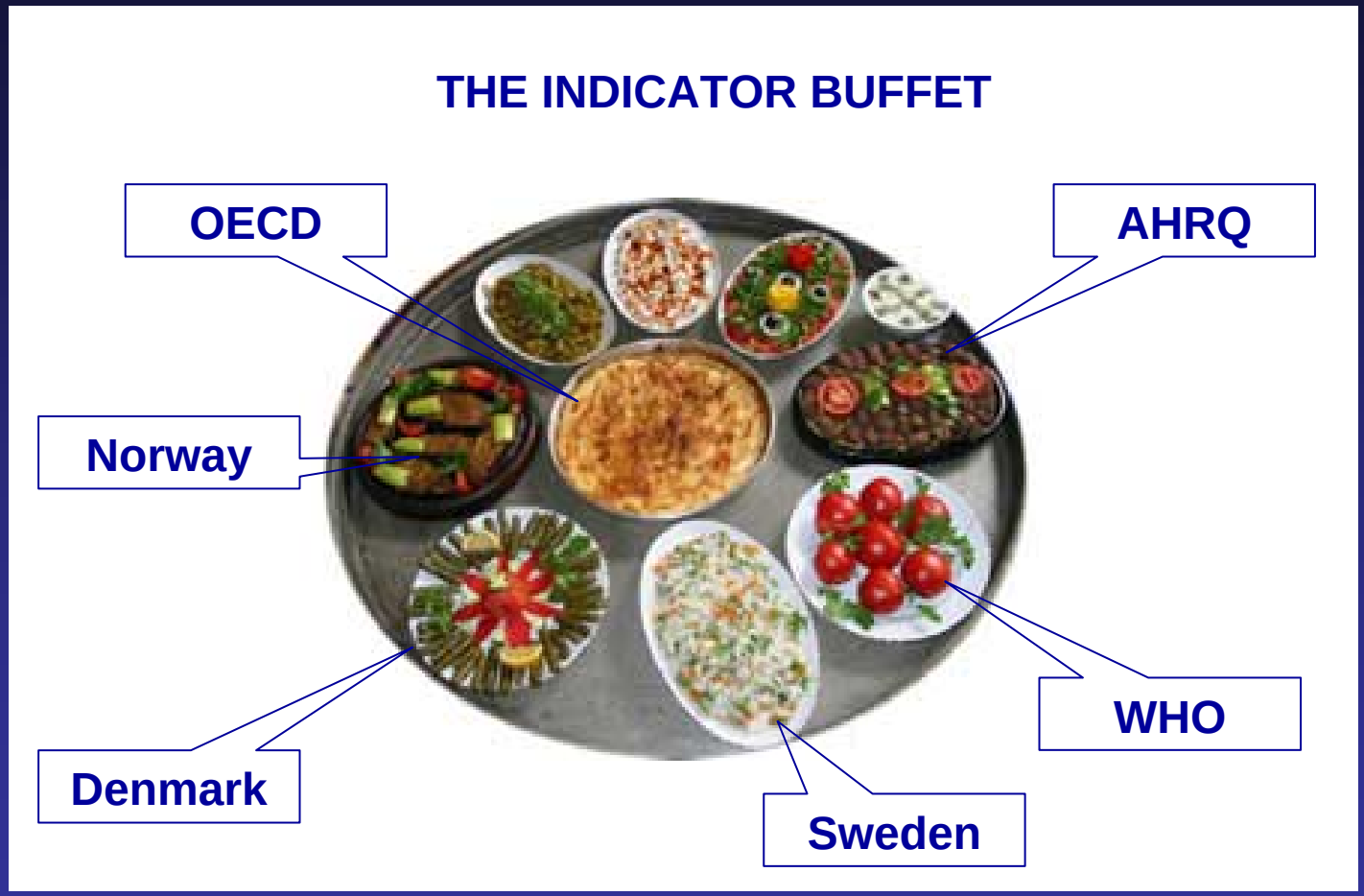
THE QUALITY JOURNEY OF "THE NORDIC PATIENT SAFETY GROUP"

THE INDICATOR JOURNEY OF THE GROUP

THERE ARE HUNDREDS OF WELL DEFINED INDICATORS

THE INDICATOR BUFFET

THE INDICATOR JOURNEY OF THE GROUP



EXAMPLES OF “DISHES” ON THE INDICATOR BUFFET TABLE

INDICATORS FROM OECD / AHRQ

- Postoperative pulmonary embolism or deep vein thrombosis
- Post op sepsis
- Obstetric trauma vaginal
- Postoperative hipfracture
- Decubitus ulcers
- Wrong site surgery
- Complications af aneasthesia

OTHER INDICATORS

- Hospital infections
- Foreign body left during procedure
- Safety culture
- Reoperations
- Prescription and distribution of pharmaceuticals
- Death in Low-mortality DRGs
- Interactions af pharmaceuticals
- Patient safety surveys
- Audit of medical records
- Readmissions

THE INDICATOR JOURNEY OF THE GROUP

DID THEY TASTE GOOD ?

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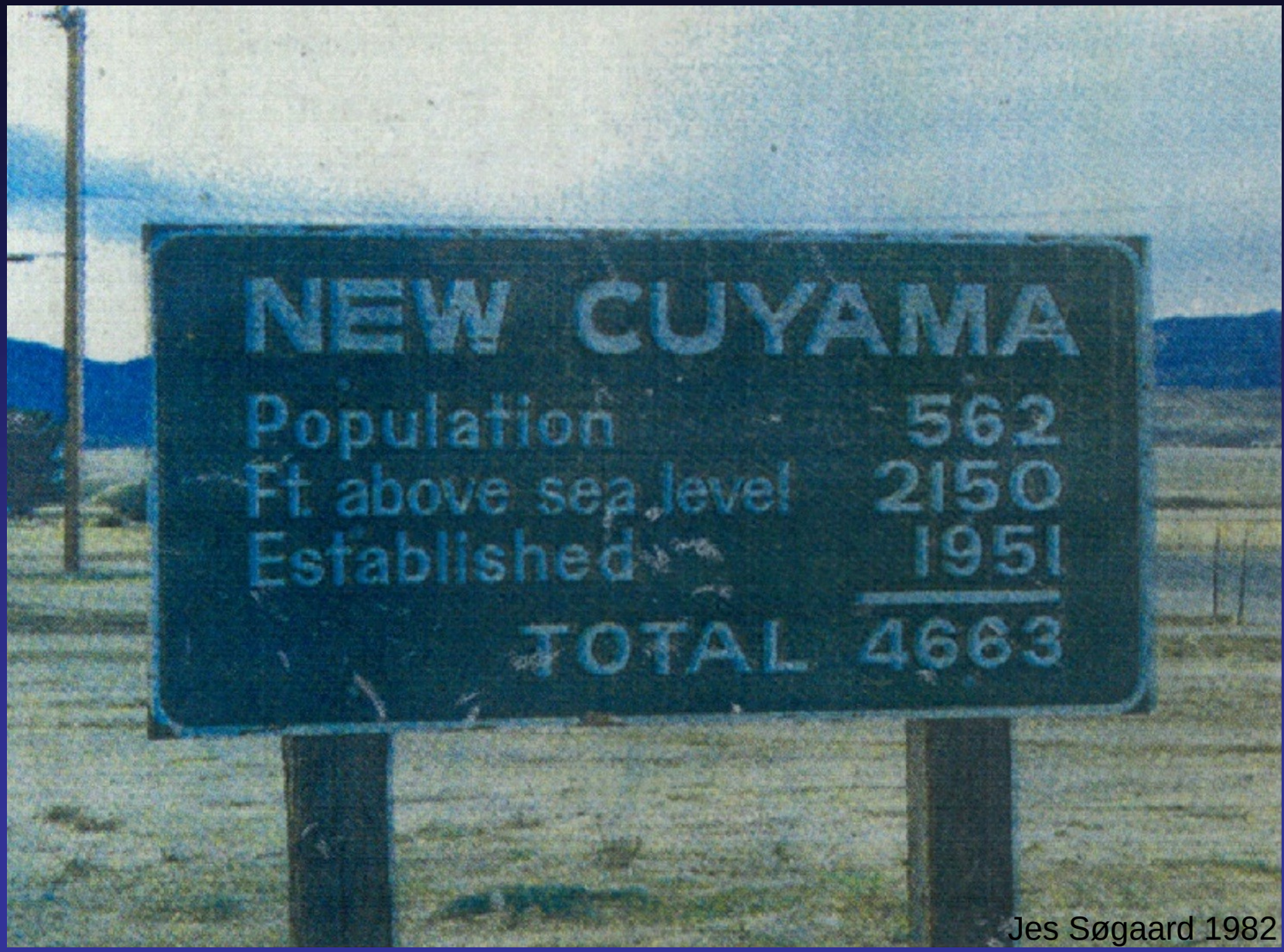


Jes Søgaard 1982

THE GROUPS PRESENT MENU

- OECD INDICATORS
- STANDARDISED IN-HOSPITAL MORTALITY
- IHI´s TRIGGER TOOLS
- SAFETY CULTURE (AHRQ)

SAFETY CULTURE

Shared values (what is important) and beliefs (how things work) that interact with an organisation's structure and control systems to produce behavioural norms (the way we do things around here).

(James Reason 2006)

UNSPOKEN NORMS

SAFETY CULTURE

Western airline

Airline from former eastern Europe

Probability of fatal outcome

1/11.000.000

1/250.000

DIFFERENCE = CULTURE

Health Care
1/1.000

PATIENT SAFETY CULTURE

AHRQ

HSPSC Hospital Survey on Patient Safety Culture

Indicator ?: Evaluation of patient safety culture			
Is there a program for evaluation of safety culture ?	**Yes**	**No**	**Notes**
National level			
Regional level			
Institutional level			

Postoperative pulmonary embolism or deep vein thrombosis

OECD INDICATOR PS 07 - AHRQ PSI 12

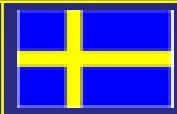
Definition:	Cases of deep vein thrombosis (DVT) or pulmonary embolism (PE) per 100.000 discharges

Indicator				
All surgical procedures		318	137	

“NEW” INDICATOR

Postoperative pulmonary embolism or deep vein thrombosis after knee or hip replacement

Definition:	Cases of deep vein thrombosis (DVT) or pulmonary embolism (PE) per 100.000 discharges. Operational procedures: Knee and hip replacements.

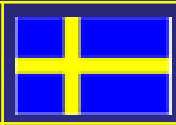
Indicator				
Knee or hip replacements		204	208	18%*)

*) Richard FO, et al.The prevalence of venous thromboembolism after hip and knee replacement surgery. Medical Journal of Australia 2005; 182: 154-160.

Post op sepsis

OECD INDICATOR PS 08 - AHRQ PSI 12

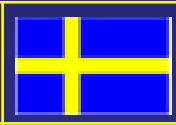
Definition: Cases of sepsis per 100.000 discharges with an operating room procedures

Indicator				
All surgical procedures		231	662	

“NEW” INDICATOR

Post op sepsis after knee or hip replacements

Definition:	Cases of sepsis per 100.000 discharges after knee or hip replacements

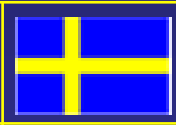
Indicator				
Knee or hip replacements	290	181	69	1%*)

*) Nasser S. The incidence of sepsis after total hip replacemant arthroplasty. Seminars in Arthroplasrty 1994; 5:153-159.

“NEW” INDICATOR

Post op sepsis after Bowel surgery

Definition:	Cases of sepsis per 100.000 discharges after bowel surgery

Indicator				
Bowel surgery		892	830	

Foreign body left during procedure

Foreign body left during procedure		
COUNTRY	Reported incident: Yes / No	
Denmark	☐ Yes	☐ No
Finland	☐ Yes	☐ No
Iceland	☐ Yes	☐ No
Norway	☐ Yes	☐ No
Sweden	☐ Yes	☐ No

“NORDIC” INDICATORS

WE HAVE COLLECTED DATA ON MANY INDICATORS WHICH WILL ALLOW COMPARISON BEETWEEN THE NORDIC COUNTRIES

SUMMARY

- There exist many usable scientifically validated patient safety indicators
- We have experienced inadequate documentation in our administrative datasystems
  We have to live with that
- By fragmenting indicators it is maybe possible verify if existing administrative data are reflecting the real world
- Safety culture is maybe the single most important factor when it comes to patient safety

SAFETY CAN BE LOOKED AT FROM MANY DIFFERENT ASPECTS