Patient safety in Dutch hospitals clinical outcomes

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Overview

- Context 2004/2008/2012
- National patient safety campaign
- National quality indicators
- Sentinel event reports
- National results 2013

The iceberg

Adverse events	1
Incidents	10
Near missers	100

National Patient Safety campaign

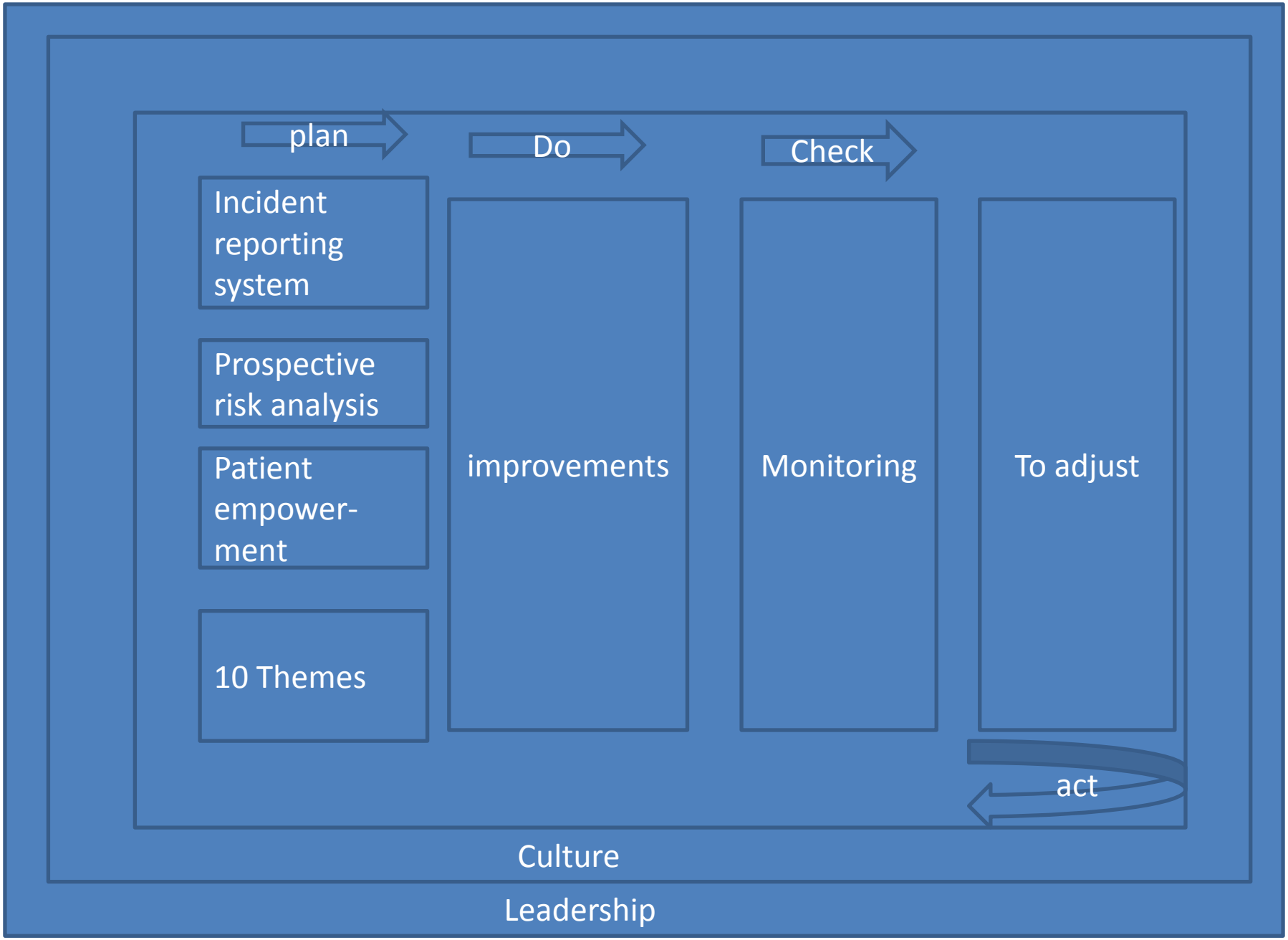
2008-2012

Goal: 50% ↓ preventable mortality

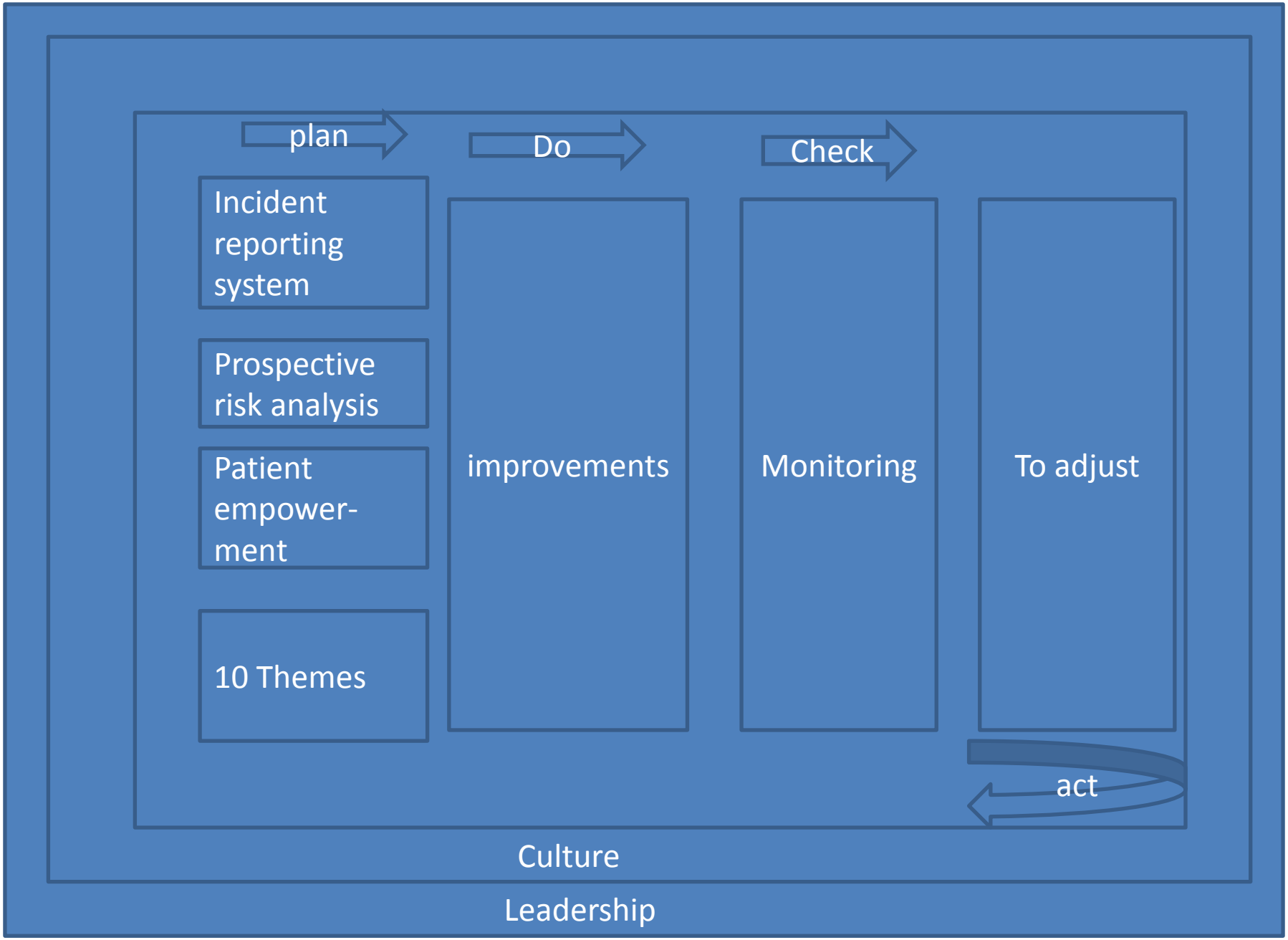
Two pilars:

- Safety Management System
- 10 themes

Zegers M, et al. Adverse events and potentially preventable deaths in Dutch hospitals: results of a retrospective patient record review study. *Qual Saf Health Care*. 2009 Aug;18(4):297-302.


plan
Do
Check
Incident reporting system
Prospective risk analysis
Patient empower-ment
10 Themes
improvements
Monitoring
To adjust
act
Culture
Leadership

http://www.youtube.com/watch?v=vJG698U2Mvo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Patient participation

www.mijnzorgveilig.nl/kaart/details.php?kaart_id=625

medicinechart.pdf

10 themes

- Surgical site infections
- Rapid response Teams
- Pain
- Medication reconciliation
- Central line infection
- Acute coronary syndrome
- Vulnerable elderly
- Renal failure due to contrast
- Wrong site surgery
- High risk medication

Some hospitals introduced theme 11:

- Communication

Communication part 1

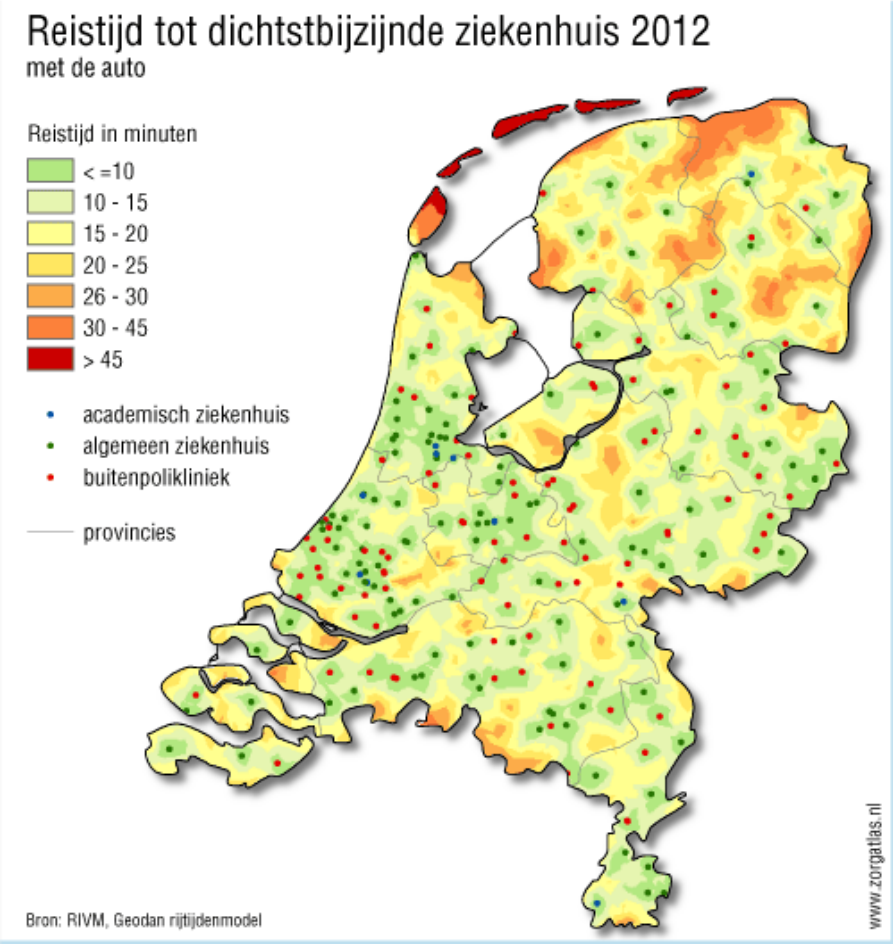
Noncompliance-house.wmv

Communication part 2 SBAR

www.youtube.com/watch?v=7qHCmJzJiAo

www.youtube.com/watch?v=vHXHdWEhX5w&list=PL84C9F06FFF8545EE

The Netherlands



Context- laws

- "BIG" registry for license
- Quality of care is responsibility of professional
- Quality of care is responsibility of Board of Directors
- Disciplinary board for professional conduct

Quality indicators for hospital care

- Annual reporting to Healthcare Inspectorate
- 12 themes of indicators
- 62 indicators
- Outcomes are openly accessible

Quality indicators for hospital care

- Surgical care
- Acute care
- Nursing processes
- Intensive Care
- Oncology,
- Heart & Vascular,
- Infectious disease
- Gastroenterology
- Obstetrics
- Child abuse
- MD performance monitoring
- HSMR

Example of quality indicators

Surgical care

- % pts with painscore > 7 in first 72h post-op
- % re-operations after hipfracture
- % correctly performed time-out
- % on-time pre-operative antibiotic administration
- Volume bariatric surgeries
- % pts included in national cataract registry

Basisgegevens UMCU 2012 (incl spiegeldata)

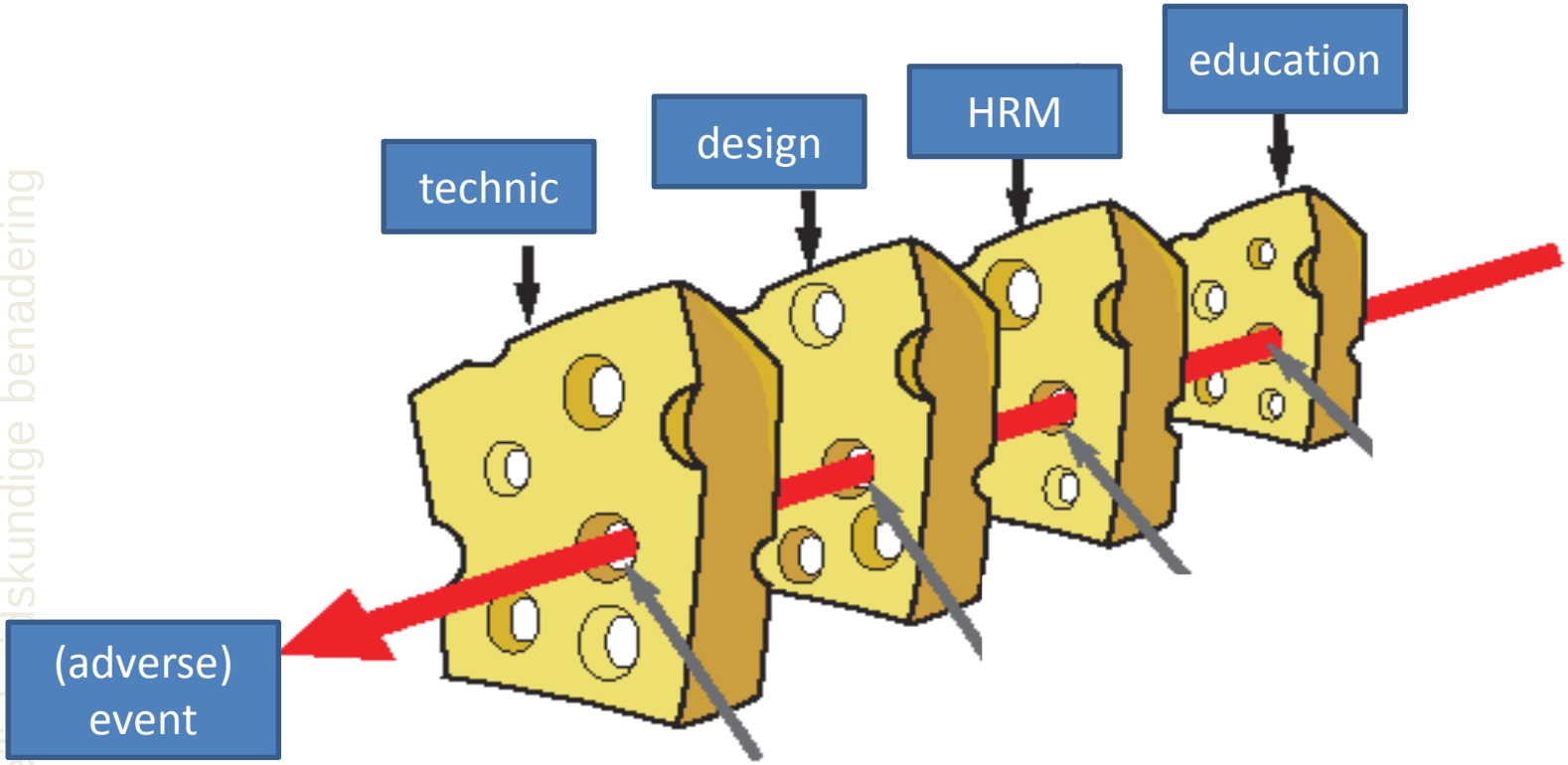
xlsxSignaleringslijst 1 umcu.xls

Sentinel Event reports:

- Hospitals are mandated to report
- Hospitals do their own analysis
- Inspectorate judges quality of analysis based on WHO criteria

Goal: hospitals learn from mistakes

Swiss cheesmodel Reason



Safe emergencykit?


Adenocard
Adenocard
Adenocard
10% CALCIUM CHLORIDE
ATROPINE SULFATE

WHO Principles of PS

Goals of Incident Analysis are to determine:

- ☐ what happened;
- ☐ why it happened; and
- ☐ what can be done to reduce the likelihood of a recurrence.

WHO principles of PS

Incident Analysis:

- Is timely, beginning as soon as possible
- Is inter-disciplinary
- Involves those most familiar with the situation
- Continually digs deeper by asking why, why, why at each level of cause and effect
- Identifies changes that need to be made
- Is as impartial as possible

WHO principles of PS

To be thorough, Analysis must include:

- Description of the incident
- Analysis of underlying cause and effect
- Identification of all contributing factors
- Formalization of recommended improvements in processes or systems
- Documentation of the findings and recommendations

WHO principles of PS

- **To be credible, an Analysis must:**

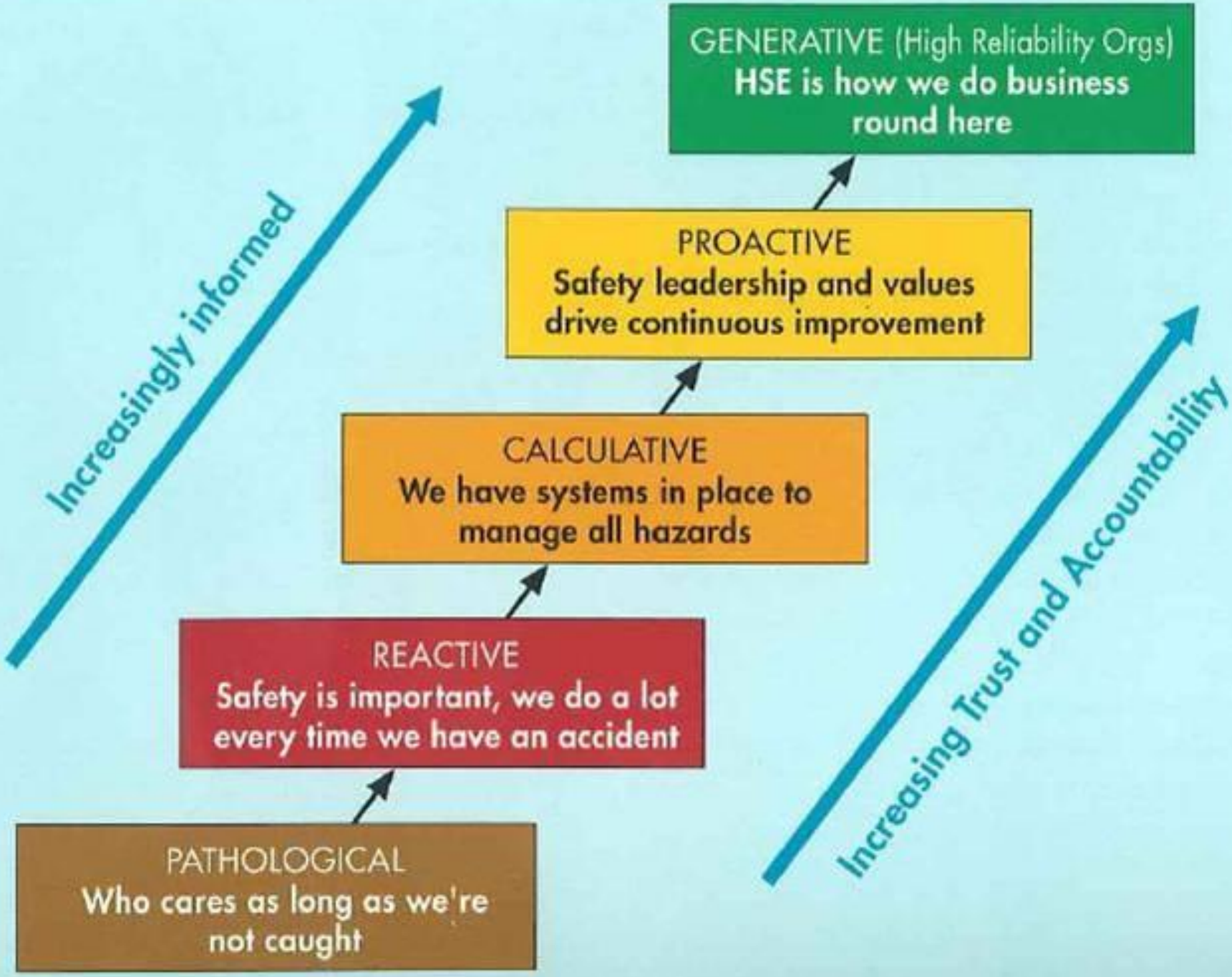
•Include participation of leadership and those closely involved

•Address conclusions with recommendations for reducing risk

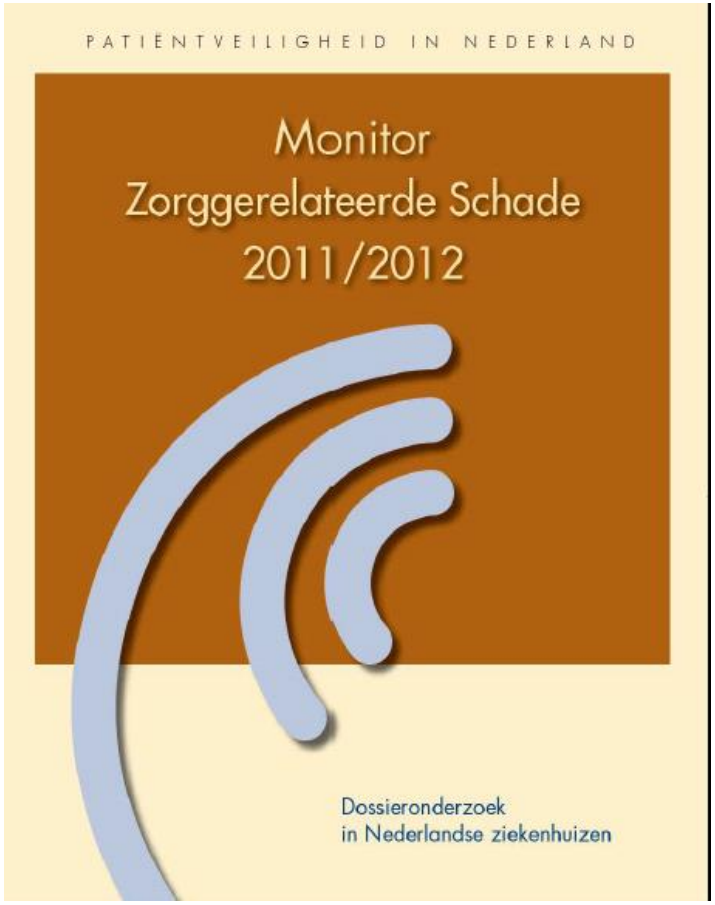
•Include consideration of relevant literature and other sources of information

•Include an evaluation plan to determine if recommendations are implemented and if so, what impact was achieved (if any)

Beoordeling calamiteitenanalyse P1.docx


GENERATIVE (High Reliability Orgs)
HSE is how we do business round here
PROACTIVE
Safety leadership and values drive continuous improvement
CALCULATIVE
We have systems in place to manage all hazards
REACTIVE
Safety is important, we do a lot every time we have an accident
PATHOLOGICAL
Who cares as long as we're not caught
Increasingly informed
Increasing Trust and Accountability

National results



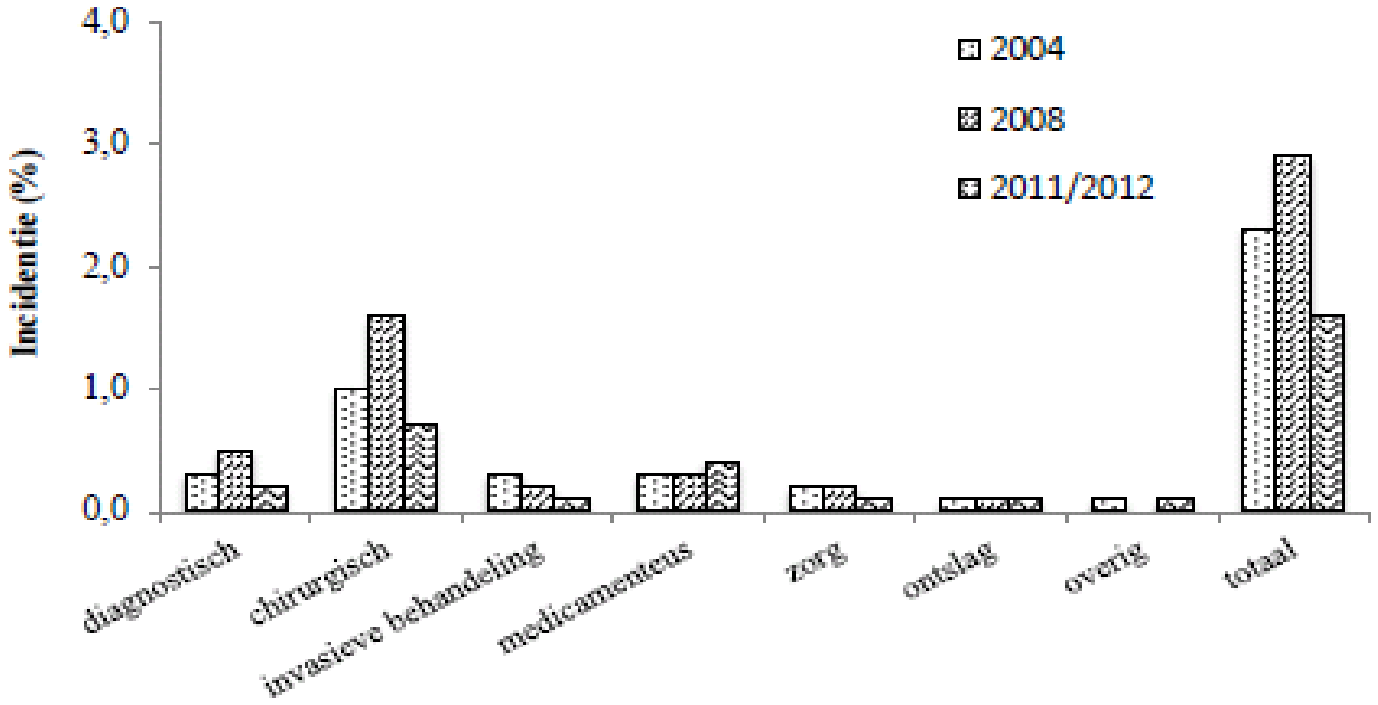
Langelaan M. et al. Monitor Zorggerelateerde schade 2011/2012

Tabel 8.3 Verschillen tussen 2004, 2008 en 2011/2012 uitgesplitst naar (potentieel vermijdbare) schade en potentieel vermijdbare sterfte bij patiënten die in het ziekenhuis zijn overleden

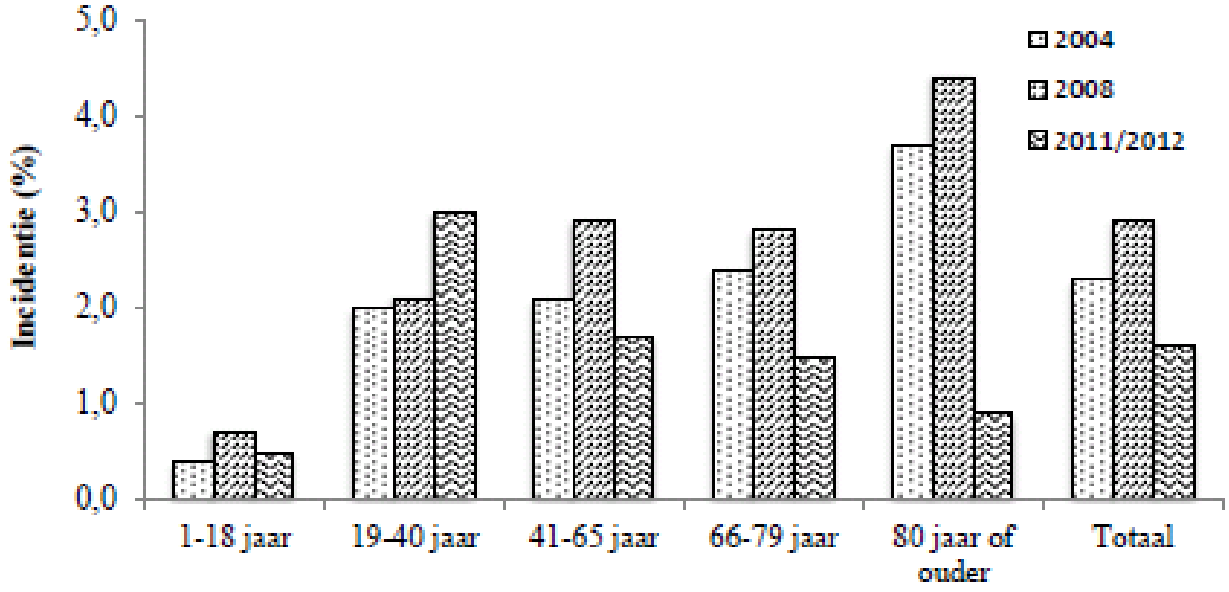
	2004	2008	2011/2012
Percentage zorggerelateerde schade, % (en 95% BI)*	10,7 (9,8 – 11,7)	15,6 (14,0-17,3)	11,9 (10,6-13,4)
Percentage potentieel vermijdbare schade, % (en 95% BI)*	5,2 (4,5 – 5,9)	7,3 (6,2-8,6)	4,0 (3,2-4,9)
Percentage potentieel vermijdbare sterfte, % (en 95% BI)	4,1 (3,5 – 4,8)	5,5 (4,5 – 6,6)	2,6 (2,0-3,4)

* Gewogen percentages; voor uitleg over de weging zie bijlage B.

Figuur 8.2 Incidentie potentieel vermijdbare schade per klinisch deelproces en het totaal van alle deelprocessen



Figuur 8.3 Incidentie potentieel vermijdbare schade per leeftijdscategorie



James Raeson

We can’t change human conditions, but we can

change the condition under which human work.

Questions?