



**NATIONAL INITIATIVE FOR IMPROVED PATIENT SAFETY**

# From blaming to improvement

Working together for the safest healthcare in the world

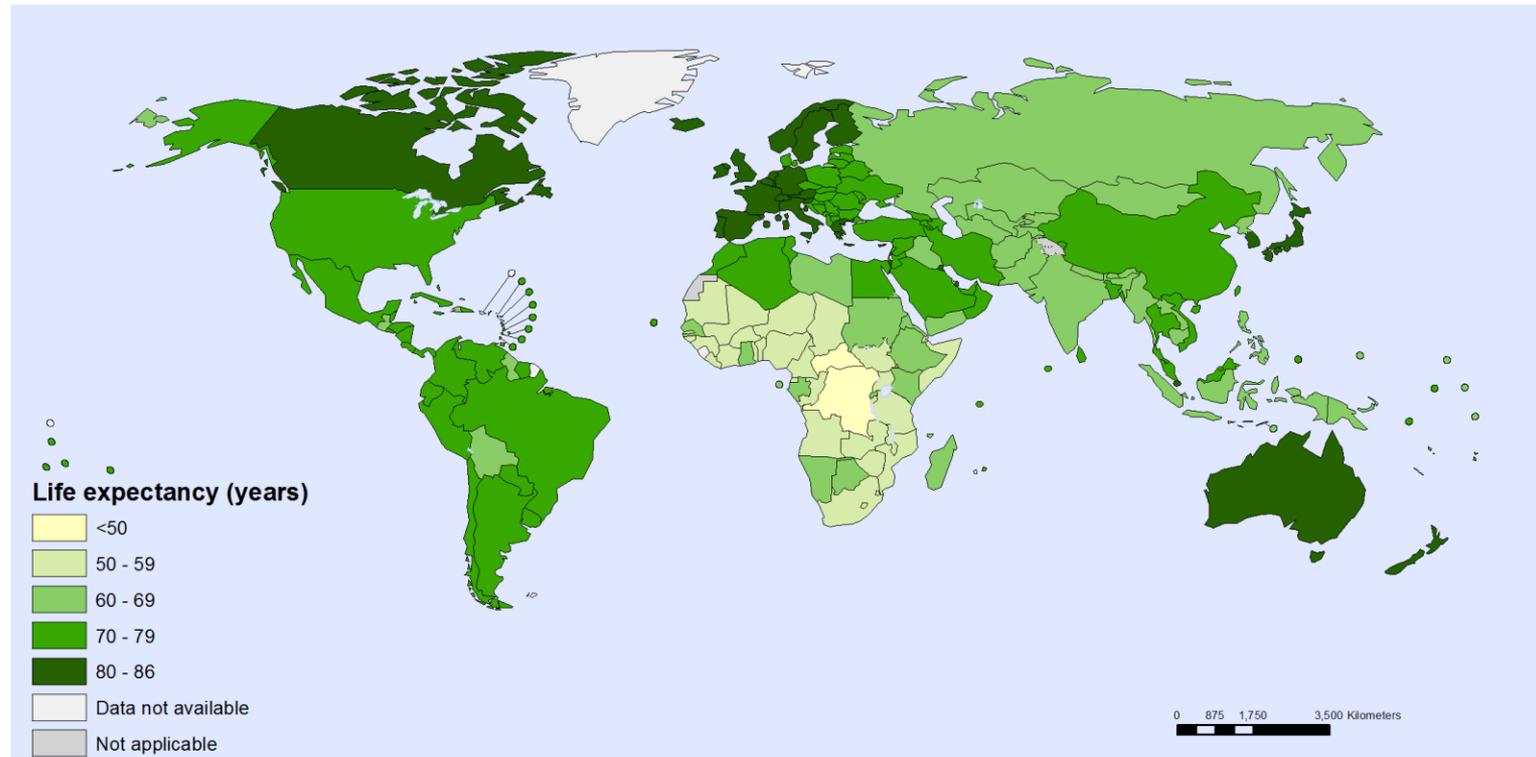
# The Swedish Associations of Local Authorities and Regions (SALAR)

- We act as an employer's organisation, and defend and promote the interests of our members.



Japan		Sweden	
<b>Population</b>		<b>Population</b>	
2012 estimate	126,659,683	2012 census	9,555,893
Density	337.1/km <sup>2</sup>	Density	20.6/km <sup>2</sup>
<b>Area</b>		<b>Area</b>	
Total	377,944 km <sup>2</sup> 145,925 sq mi	Total	449,964 km <sup>2</sup> 173,745 sq mi
<b>GDP (PPP) 2012 estimate</b>		<b>GDP (PPP) 2011 estimate</b>	
Total	\$4.628 trillion	Total	\$381.719 billion
Per capita	\$36,266	Per capita	\$40,393
Gini (2008)	37.6	Gini (2005)	23
<b>HDI (2013)</b>	<b>0.912</b>	<b>HDI (2013)</b>	<b>0.916</b>

## Life expectancy at birth Both sexes, 2011



The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: World Health Organization  
Map Production: Public Health Information  
and Geographic Information Systems (GIS)  
World Health Organization



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# From blaming culture to improvement culture

- Patient safety is about how to prevent adverse events
- The purpose of this shift in culture is to learn from mistakes

# Adverse event

- Adverse event
  - Suffering, physical or mental harm or illness and death that could have been avoided if adequate measures had been taken in the patient's contact with healthcare services
- Serious adverse event
  - An adverse event that is lasting and not minor or has led to a significant increase in the patient's need of healthcare or to the death of the patient

Patient Safety Act, SFS 2010:659

# Reduce adverse events

To err is human - building a safer health system  
(Harvard 1999)

Swedish study, 2008

Huge problem

- Affect many – 105 000 patients
- Cause suffering – 10 000 patients suffered lasting harm
- Cost a lot of money – 630 000 care days

Knowledge exists

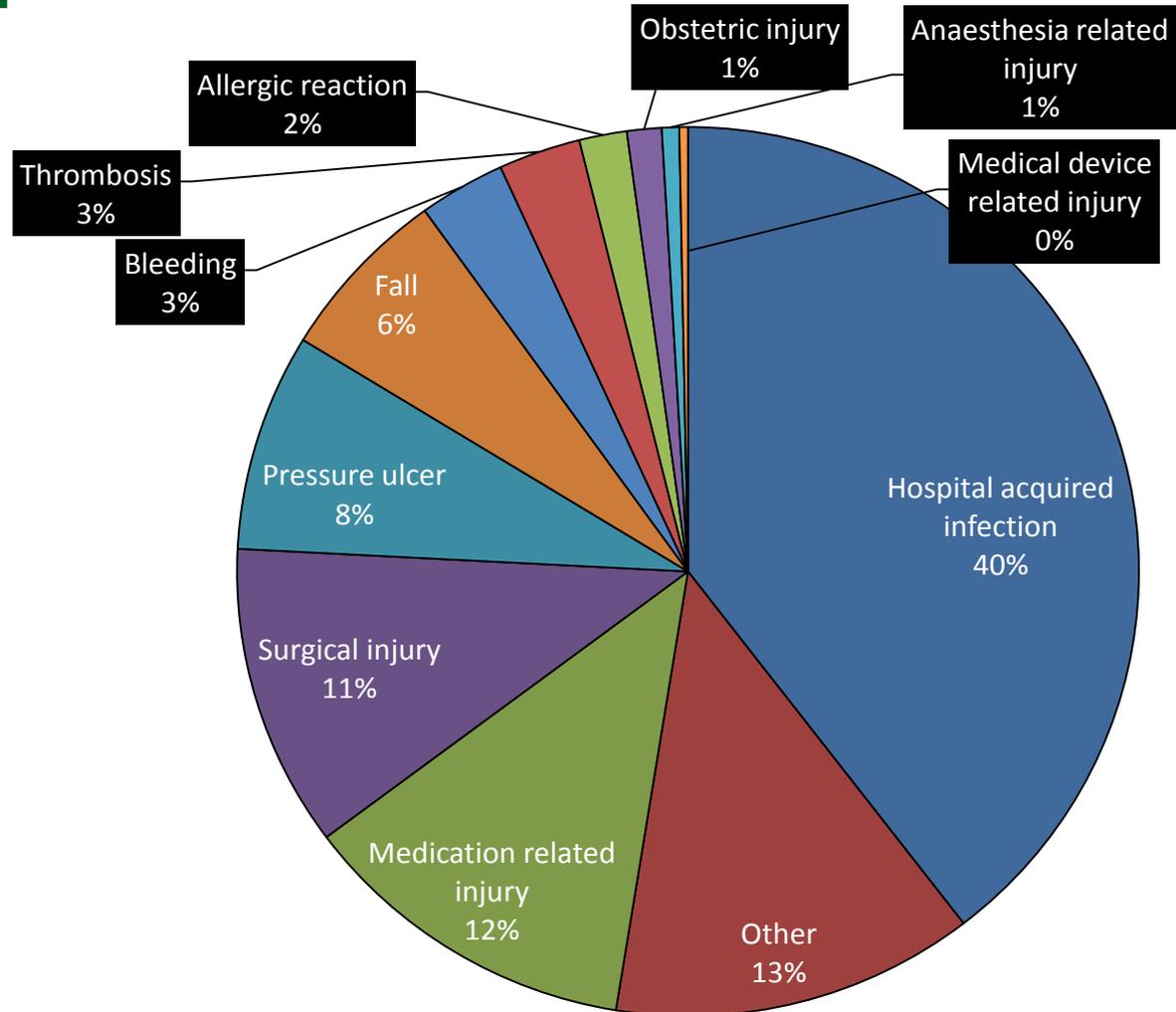
- 70 % could probably have been prevented

Huge potential for improvement

# Adverse events are the consequences of

- Missed or delayed diagnoses
- Incorrect surgical procedures and treatments
- Medication errors
- Poor hygiene leading to severe infections

# Types of adverse events



# Before the Act

- Blaming culture
- Healthcare professionals could be given a warning and a reminder (disciplinary sanctions) – Medical Responsibility Board
- People were afraid to admit their mistakes
- Changes and improvements were difficult to achieve



Sveriges Tandläkarförbund



Patientnämnderna



# Why a new act?

- The former Healthcare Professionals Act was not effective enough to reduce adverse events
- Wish for a more proactive Act
- Wish for more of a system perspective instead of an individual perspective
- Strengthen patient rights

# What does the new Act involve?

- To make healthcare safer
- The healthcare provider is given a clear responsibility to conduct systematic work on patient safety
- Preventive approach - prevent adverse events
- Patients and their close relatives will be invited to take part in the work to improve patient safety
- The disciplinary sanctions of a warning and a reminder are removed and replaced by the possibility of directing more criticism at and taking action against both healthcare providers and healthcare professionals.
- Expands the possibilities of ordering a three-year trial period which includes support for licensed healthcare professionals and can order the withdrawal of licences to practice - The Medical Responsibility Board
- Complaints – the whole event is investigated

# Systems thinking

- An adverse event is a result of deficient interaction between individuals and systems. It is when the interaction between humans, technology and organisation is inadequate that near accidents and adverse events can occur
- In a good safety culture , professionals are encouraged to conduct risk analyses and report incidents that could have led to an adverse event
- This approach encourages learning and increases risk awereness
- ”It should be easy to do the right thing and hard to do the wrong thing” captures an important aspect of the term safety culture

# Improvement culture

- Management engagement
- Knowledge about the problem
- Measurements
- Openness regarding results
- Aims
- Improvements

# Patient Safety Culture

**Healthcare is a high-risk sector  
- a dynamic and complex system**



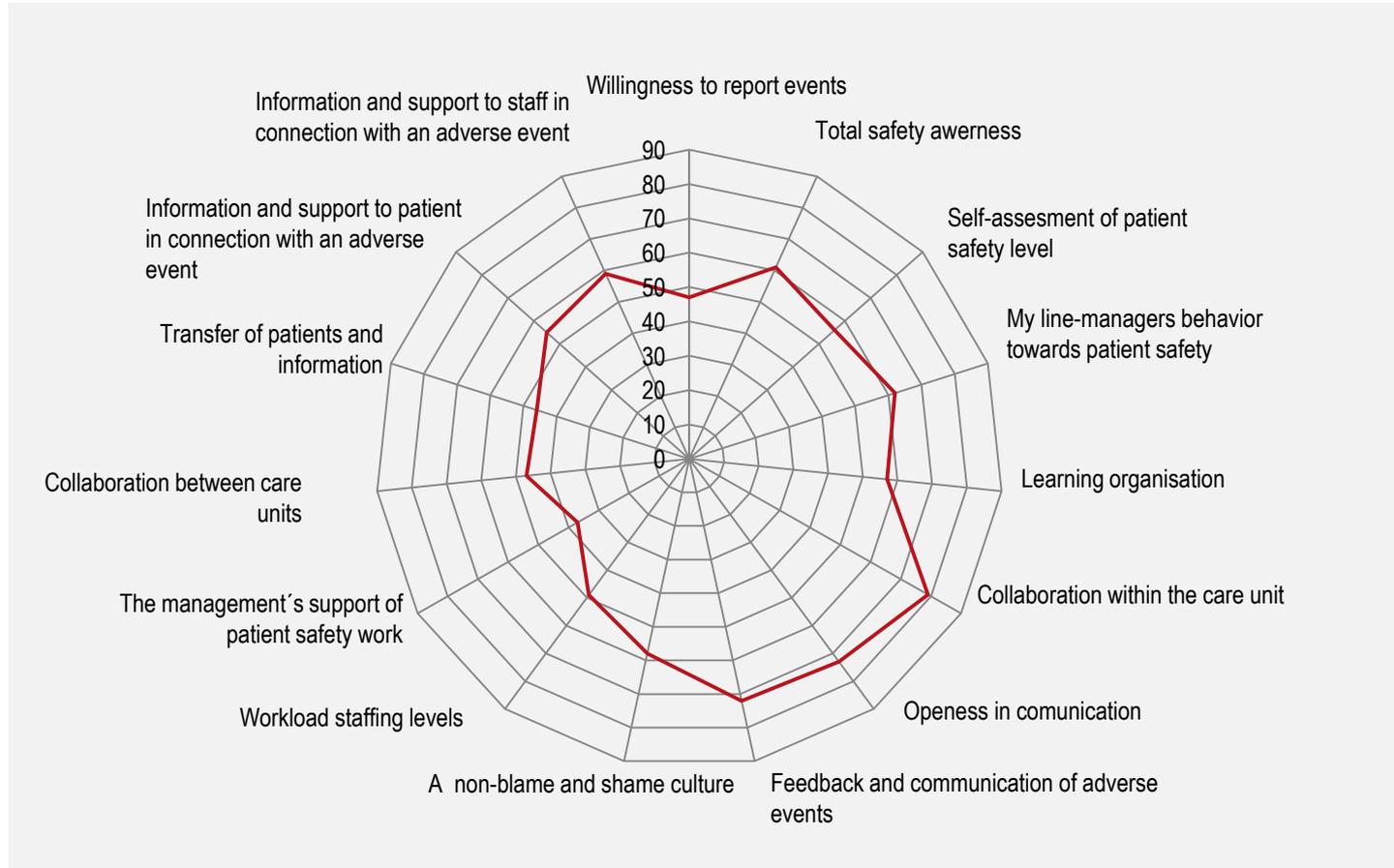
- The approaches and attitudes which an organisation and its professionals have towards risks

# Improved culture presupposes a good Patient Safety Culture

A good patient safety culture is characterised by:

- ▶ ..the professionals and the management admitting that errors can be made in the organisation
- ▶ ..the professionals feel that they can report errors and risks without fear of "blame and shame"
- ▶ ..there is good cooperation between all levels to find solutions to patient safety issues
- ▶ ..there is specific provision of resources

# Patient Safety Culture in 2011



# Patient Safety Agreement 2011-2014

The agreement between the Government  
and SALAR on improved patient safety

# Aim

- To reduce the number of adverse events by strengthening and intensifying the patient safety work
- To support implementation of the Patient Safety Act
- Structure – process – result- context

# Model for financial incentives for improved performance – 380 million dollars in four years

## Basic requirements to be eligible for funds

Indicators to ensure a broad patient safety work

Indicators for specific areas

Level 1

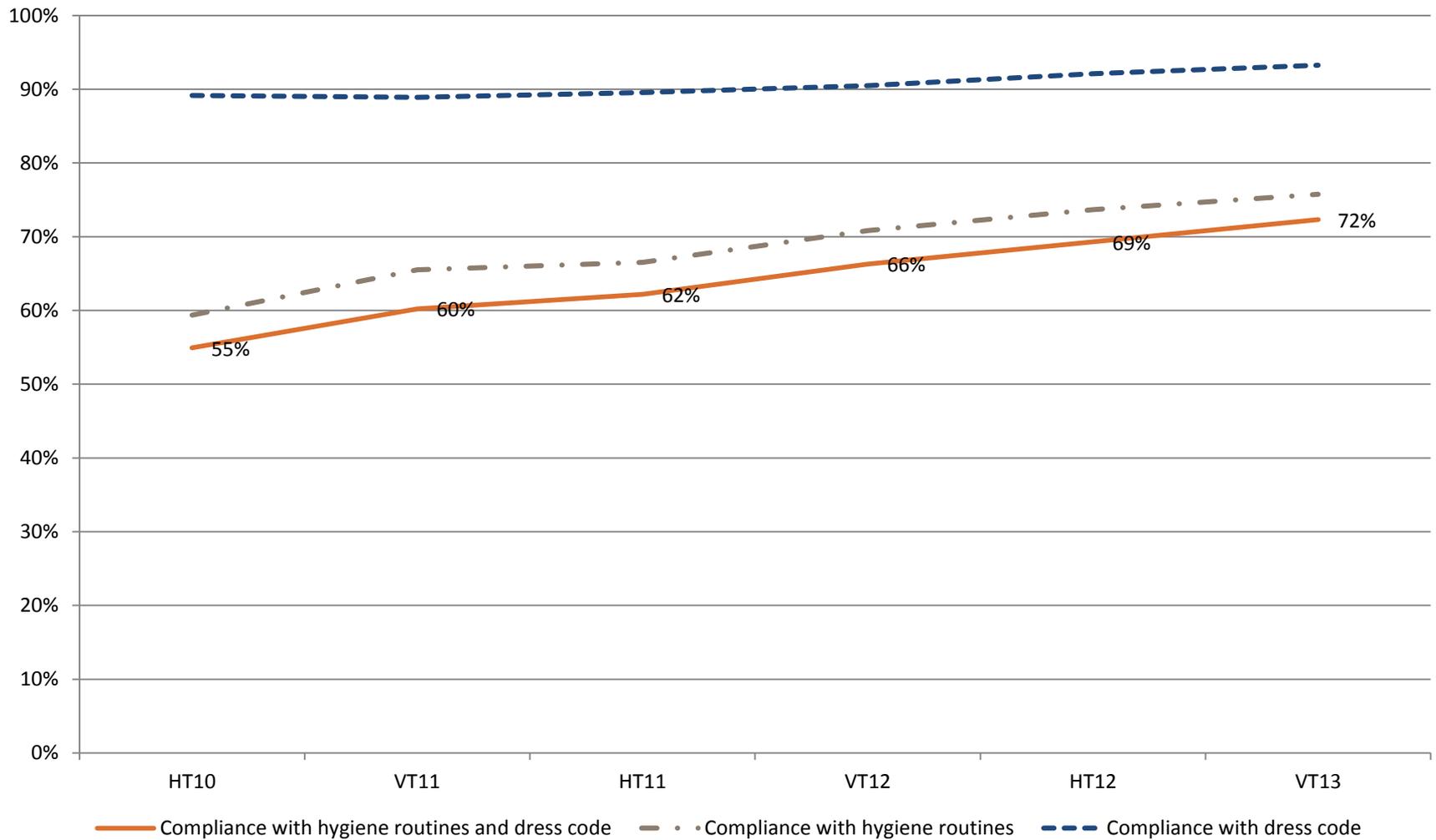
Level 2

} linked to performance-based remuneration

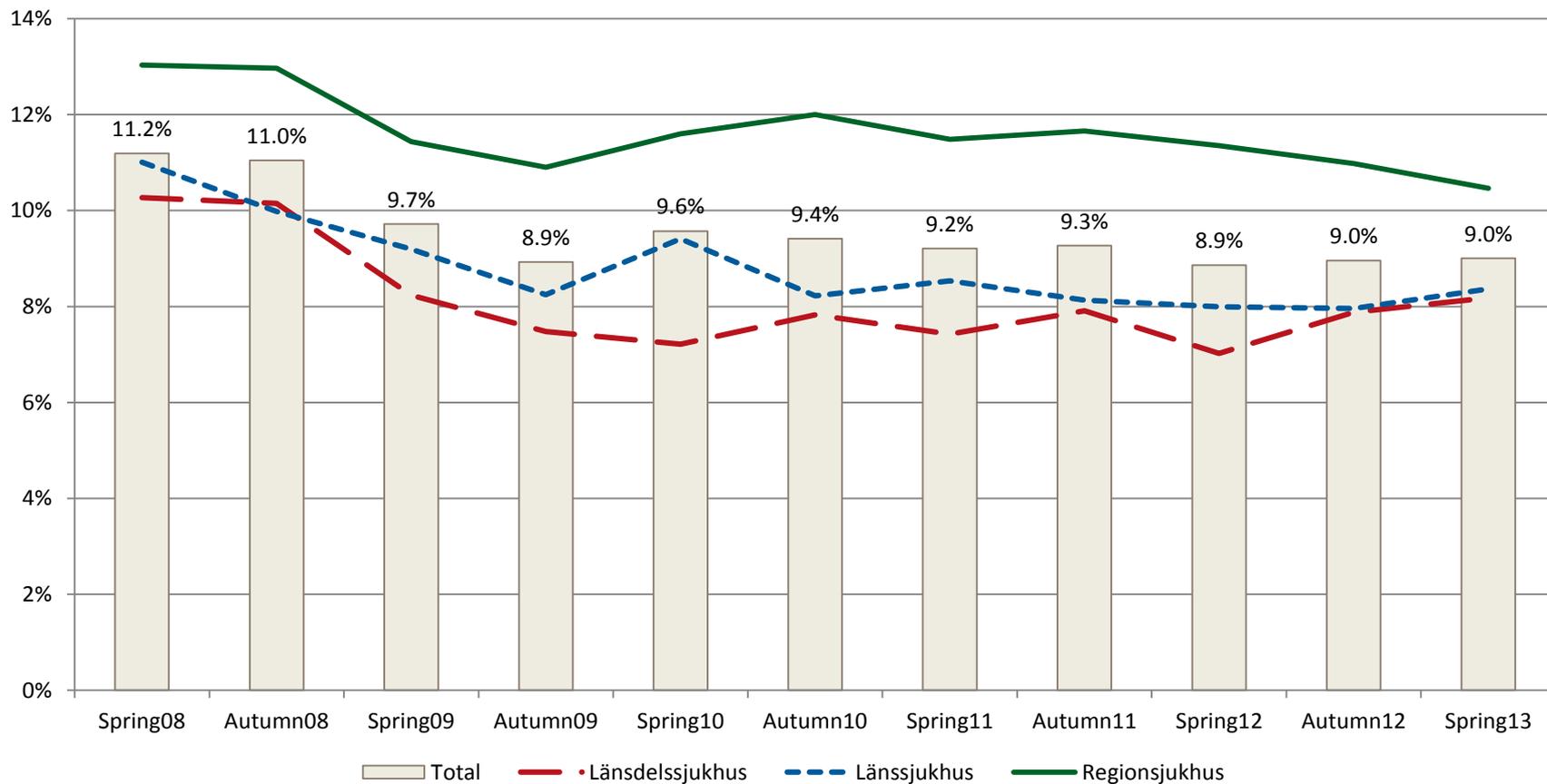
# Patient Safety Agreement

- Patient safety annual report
- Quality of care experienced by the patient
- National patient overview
- Patient safety culture
- Structured record review
- Hygiene routines and clothing rules
- Reduced prescription of antibiotics
- IT-support, the Infection tool
- Drugs
- Pressure ulcers
- Overcrowding

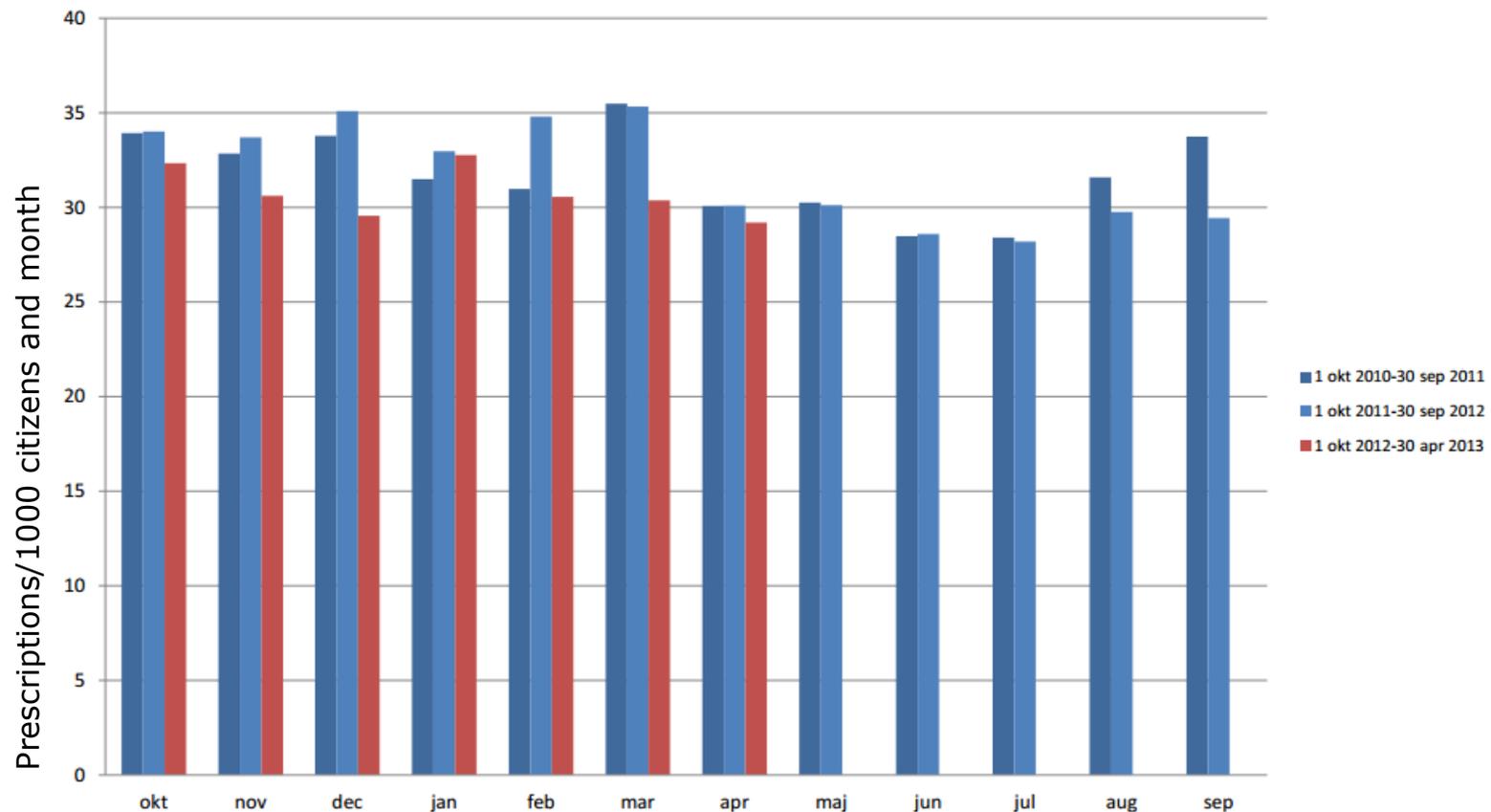
# Hygiene Compliance 2010-2013 inpatient wards



# Prevalence of healthcare associated infections in inpatient wards

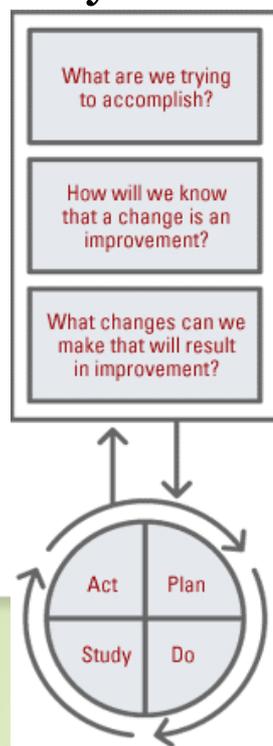


# Outpatientns prescriptions of antibiotics – National



# Measures to prevent adverse events

- SALAR has commissioned a number of experts to compile measures based on scientific and proven experience
- Applied consistently, they reduce the risks of adverse events



# Care bundles, handbooks, management and leadership for improved patient safety

Prevention of healthcare associated infections, pressure ulcers, medication errors, drug-related problems, fall injuries, malnutrition

Structured record review, root and cause analysis, Measuring patient safety culture

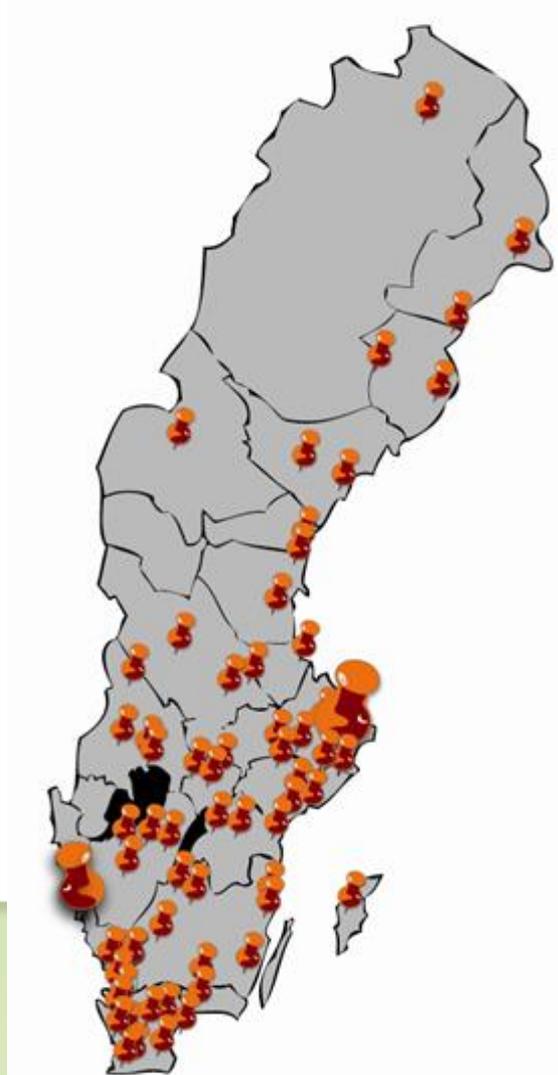


# Tools for increased patient involvement within patient safety work

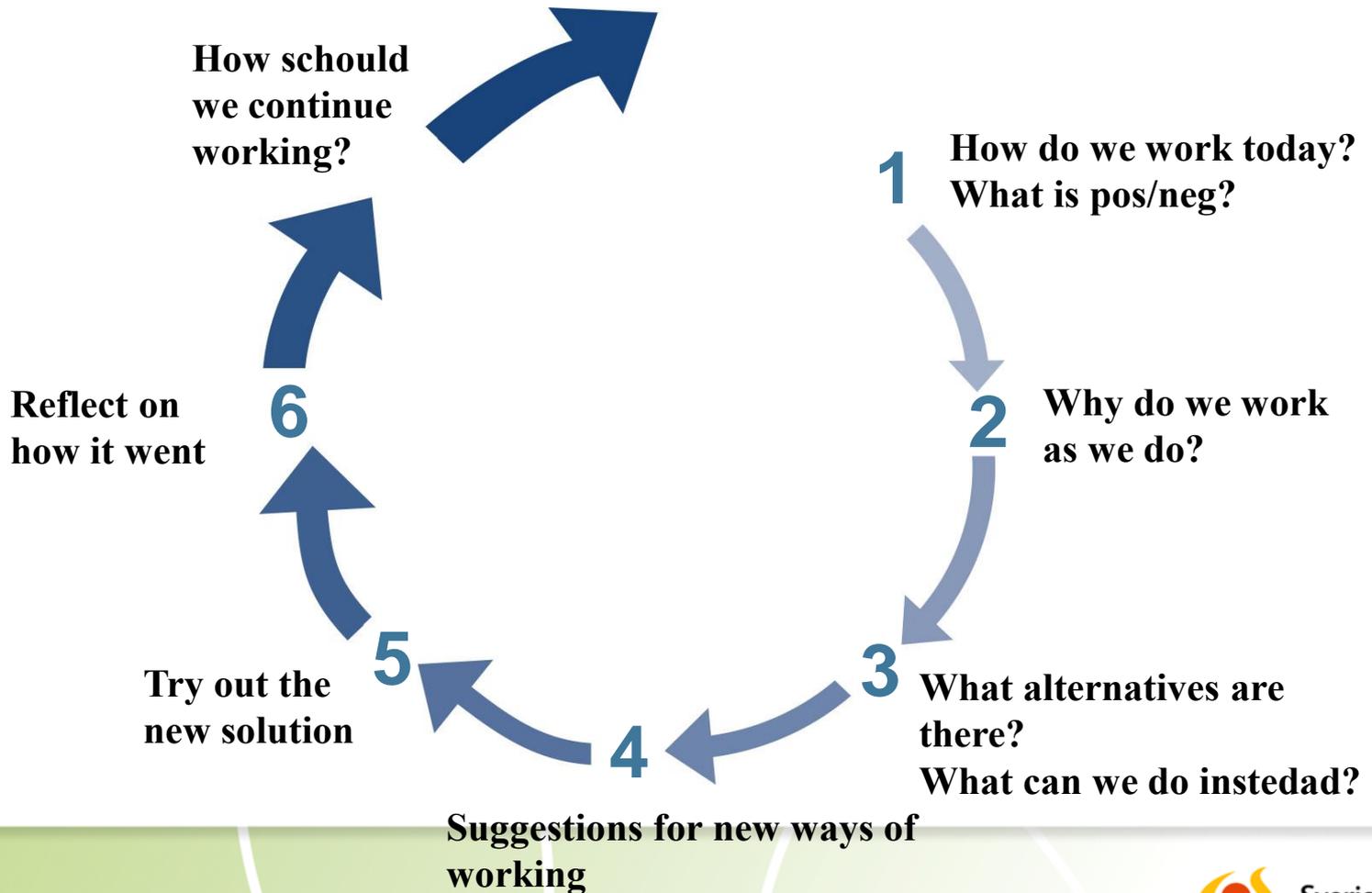
When an injury occurs, information for the healthcare professionals, information for the patients, patient involvement in risk analysis, Handbook for both patient and healthcare professionals about how to improve and develop healthcare, advise for better communication between patients and professionals, what can you do yourself, The difference between bacteria and viruses, when it is appropriate to take antibiotica



# Surgical Safety Checklist - WHO



# A model for implementation based on making improvements



# Today

- Increased commitment to patient safety

From 300 to 2 400 participants at the Swedish Patient Safety Conference (2003 -2013)

- Patients Safety Act

The Act has strengthened patient rights, stressed the importance of system perspective and a proactive approach

- The Agreement between the Government and SALAR

The agreement between the Government and SALAR has been successful and all counties have improved their performance.

- Structure – process – result

We have built structures for patient safety in Sweden. The measures are being applied consistently in a systematic way to prevent the risks of adverse events and for safer processes which in turn leads to better results for the patients. It requires a continued purposeful and sustained work.

# Challenges now and in the future

- Patient involvement
- Management and leadership for improved patient safety
- Use the results of the measurements to make healthcare safer
- Training and education in patient safety
- Continued development and research in the field

# Gains – from blaming to improvement

- Reduced suffering for the patients
- Better improved culture
- Improved patient safety
- Reduced costs
- Better working environment
- Increased confidence in the health care system

# SALAR´s Patient Safety Work

## Keep updated

- SALAR`S website about patient safety
  - [www.skl.se/patientsakerhet](http://www.skl.se/patientsakerhet)

## Order publications

- [www.skl.se/publikationer](http://www.skl.se/publikationer)

# Healthcare doesn't become safer by itself – it needs action

We have to start **working** in a different, better and safer way on **all levels!**

Create a safe day every day!

Thank you for your attention!

Eva Estling

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