

BESZÁMOLÓ A 2023-AS DÁN EGÉSZSÉGÜGYI MINŐSÉGÜGYRŐL ÉS A BETEGBIZTONSÁGRÓL SZÓLÓ KONFERENCIÁRÓL

NEMZETKÖZI TRENDEK AZ EGÉSZSÉGÜGYI MINŐSÉGMENEDZSMENT TERÉN

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61. NEVES Fórum: Megújult a NEVES jelentési rendszer

2023. június 8.



SEMMELWEIS
EGYETEM 1769



NEMZETI KUTATÁSI, FEJLESZTÉSI
ÉS INNOVÁCIÓS HIVATAL

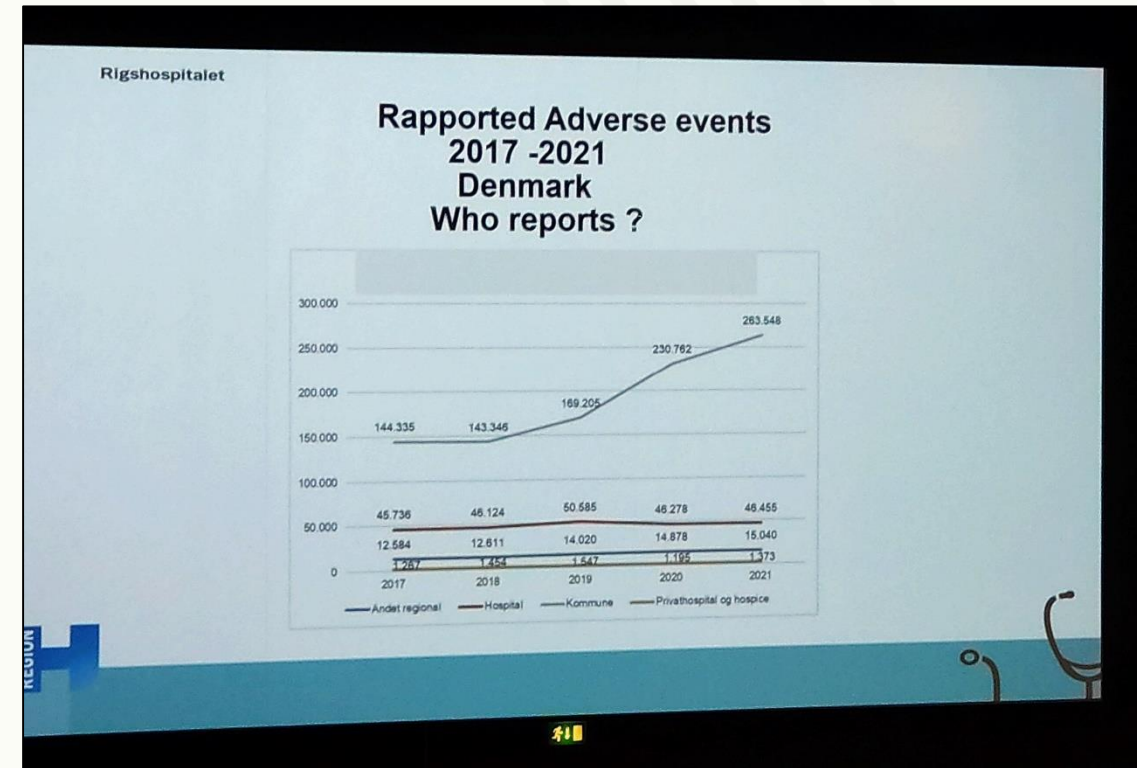
AZ NKFI ALAPBÓL
MEGVALÓSULÓ
PROGRAM

- 2023. május 15-17. között szervezték az **International Forum on Quality and Safety in Healthcare** című nemzetközi konferenciát Koppenhágában.
- A konferenciát évente kétszer szervezi a **British Medical Journal (BMJ)** és az **Institute of Healthcare Improvement (IHI)**.



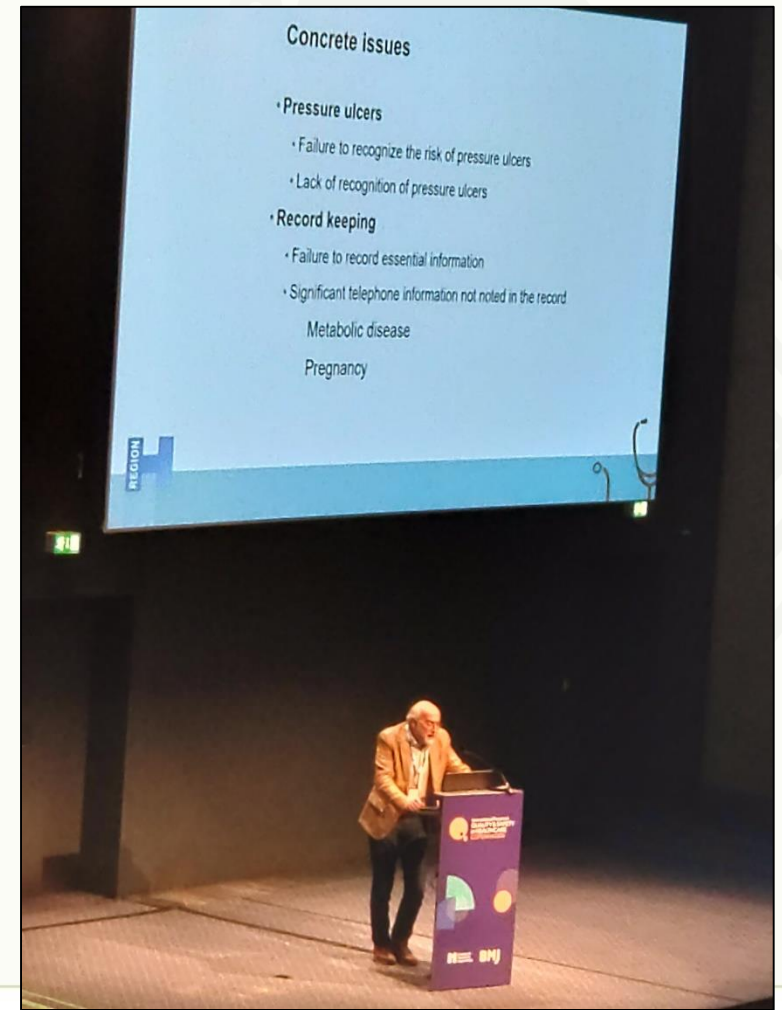
Dán betegbiztonsági jelentési rendszer

- A dán betegbiztonsági jelentési rendszerbe az **egészségügyi dolgozóknak 7 napon belül kötelező jelenteni** a nemkívánatos eseményt.
- A **betegek és hozzátartozók is jelenthetnek** ebben a rendszerbe. Akár 7 napon túl.
- Ezt a megközelítést az ország **kulturális adottsága** teszi lehetővé.



Más ország, ugyanazok a problémák

- A nyomási fekély kockázatát nem mindig ismerik fel.
- A kialakult nyomási fekélyt nem mindig ismerik fel.
- Lényegi információk nem mindig kerülnek rögzítésre.



Angol betegbiztonsági jelentési rendszer



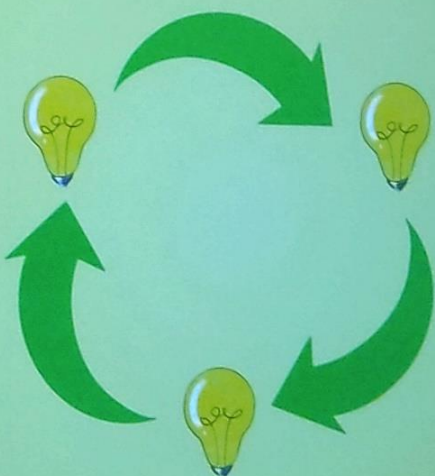
- A nemkívánatos események kivizsgálása nem úgy történik az angol NHS-ben, ahogy a beteg, a hozzátartozók és az egészségügyi dolgozók elvárják.
- Az esetek **40%-ban** a kivizsgálások **nem tudtak magyarázatot adni**, hogy az esemény miért következett be.

Angol betegbiztonsági jelentési rendszer


- Új megközelítés:
 - Patient Safety Incident Response Framework (PSIRF)
 - Betegbiztonsági eseményekre reagáló keretrendszer
- A „súlyos nemkívánatos események” fogalmát kivezetik.
- A visszaható és bürokratikus megközelítés helyett a tágabb rendszerszemléletet támogatják.

PSIRF is a movement





- PSIRF is NOT an investigation framework
- Serious Incidents no longer feature
- Advocates a coordinated data-driven approach to learning and improvement
- Embeds patient safety incident response within a wider system of improvement
- Prompts a move away from a reactive and bureaucratic approach to safety towards systematic safety management
- Supports a significant shift in safety culture
- Testing and revision has been a formal part of the development cycle



Angol betegbiztonsági jelentési rendszer



Achieving effective learning and improvement

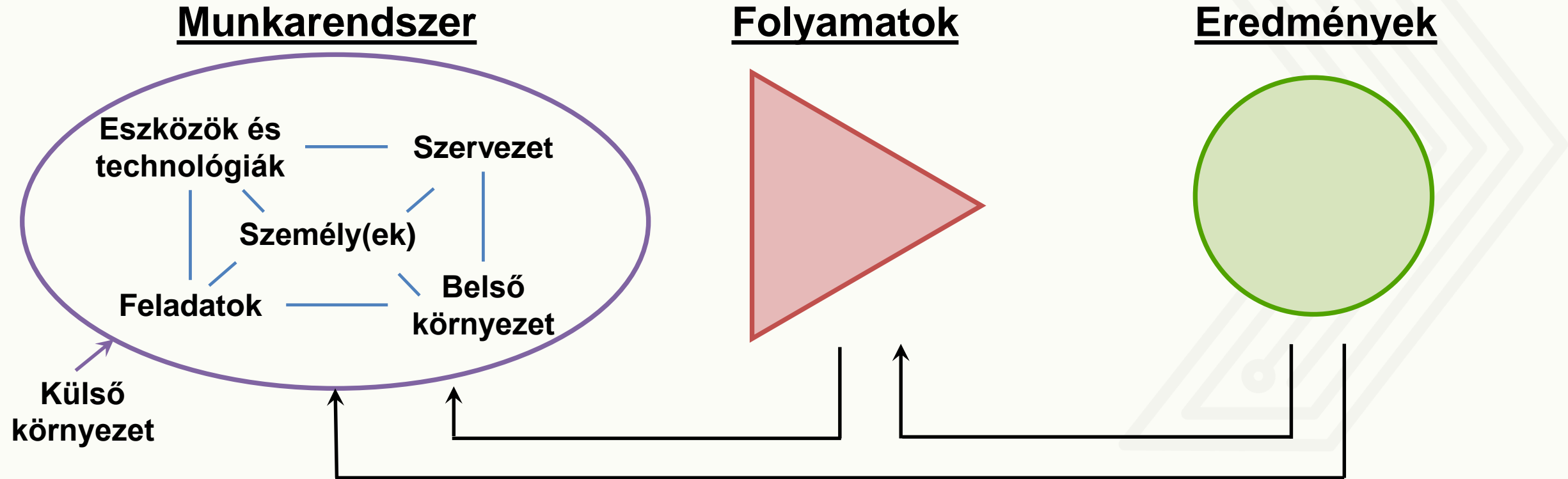
-  COMPASSIONATE ENGAGEMENT & INVOLVEMENT OF THOSE AFFECTED BY PATIENT SAFETY INCIDENTS
 - Distinction: engagement and involvement
 - Includes both families and staff affected
-  APPLICATION OF A RANGE OF SYSTEM BASED APPROACHES TO LEARNING FROM PATIENT SAFETY INCIDENTS
 - RCA no longer recommended
 - 'Window on the system'
-  CONSIDERED AND PROPORTIONATE RESPONSES TO PATIENT SAFETY INCIDENTS
 - Planning
 - Stakeholder involvement
-  SUPPORTIVE OVERSIGHT FOCUSED ON STRENGTHENING RESPONSE SYSTEM FUNCTIONING AND IMPROVEMENT
 - Emphasis on collaboration
 - Decisions made together
 - Non-hierarchical

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- A **gyökér-ok elemzést** már **nem ajánlják** az NHS szakemberei:
 - „Túlságosan lineáris”
 - „Az ipari szektorra találták ki”
- Inkább érdemes **az egész ellátási folyamatot együtt vizsgálni.**
- A belgák csodálkoztak a kijelentésen.
- A hollandok megerősítették, hogy ők sem alkalmazzák már ezt a módszert.

Systems Engineering Initiative for Patient Safety (SEPIIS)

Rendszermérnöki kezdeményezés a betegbiztonságért



Tools & Technology

- Describe the equipment/tools you use
- Describe the equipment design
- Share your insights into equipment availability and appropriateness
- Share your insights into equipment reliability
- Describe how information is presented (eg records/IT systems)
- Describe alarms and alerts
- Are any tasks automated?
- Describe where equipment is positioned. Is this optimal?
- Are tools/technology maintained and updated?
- Are manuals, procedures and supports accessible?

Organisation

- Tell me about how the patient pathways work
- Describe the information flow (how information is communicated)
- What is the communications workload like?
- Tell me how new information is flagged
- Where is new information held?
- Describe the leadership and supervision arrangements
- Describe how works is scheduled/allocated
- Describe staffing levels and resourcing
- Describe the safety/organisational culture
- Describe how change management works

Tasks

- Tell me about the task demands you face
- Describe the tasks which are complex or challenging to carry out
- Talk me through your experiences of the workload
- Are there time pressures? If yes please tell me more
- Does task repetition/monotony occur in this work system?
- Do you have to re-prioritise/reorganise?

External environment

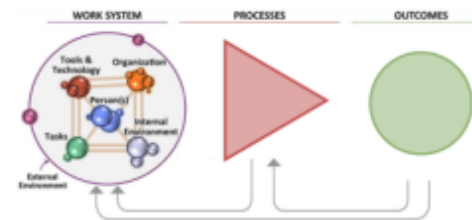
- Describe any relevant national targets
- Tell me how the following impacts (if at all):
 - Policy and regulatory demands
 - Accreditation standards
 - Political decision making
 - Global events

Person

- Tell me about the patient mix
- Describe the team who deliver patient care
- Who else is part of the team (eg admin, domestic)?
- How familiar are team members with care processes/pathways?
- Are roles/responsibilities clearly defined?
- Describe how training is organised to support safe care
- Describe the team dynamics
- Describe the impact of personal factors (eg stress, morale, tiredness)

Internal environment

- Does the workspace support safe patient care/task performance?
- Share your thoughts on the layout of the environment
- Is the workspace appropriate for the task?
- Where are tasks completed?
- Describe any distractions you experience regularly
- Do interruptions impact patient care/task performance? If yes, how?
- Describe the impact of the ambient environment (eg lighting, noise, air quality)



Desired Outcomes

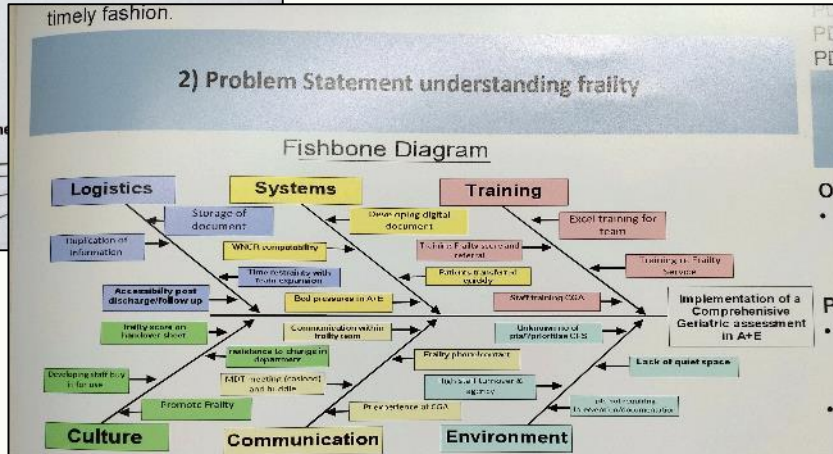
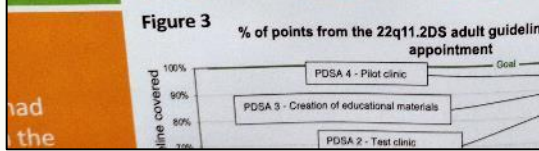
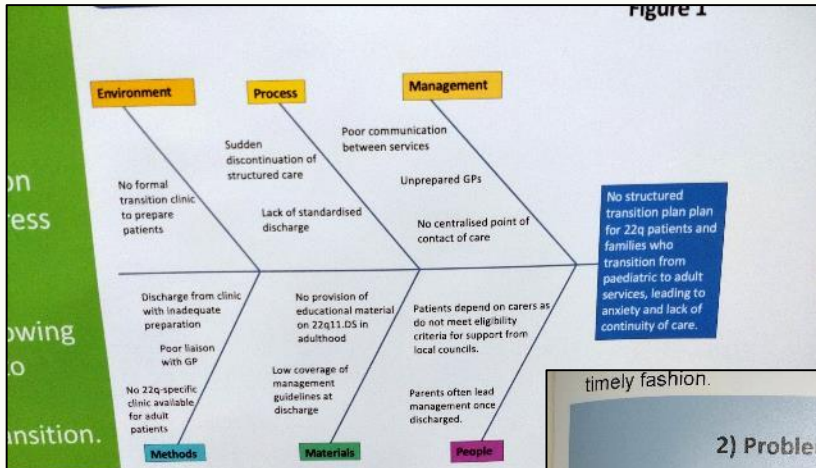
System Performance:

Human Wellbeing:

Appreciative inquiry question:

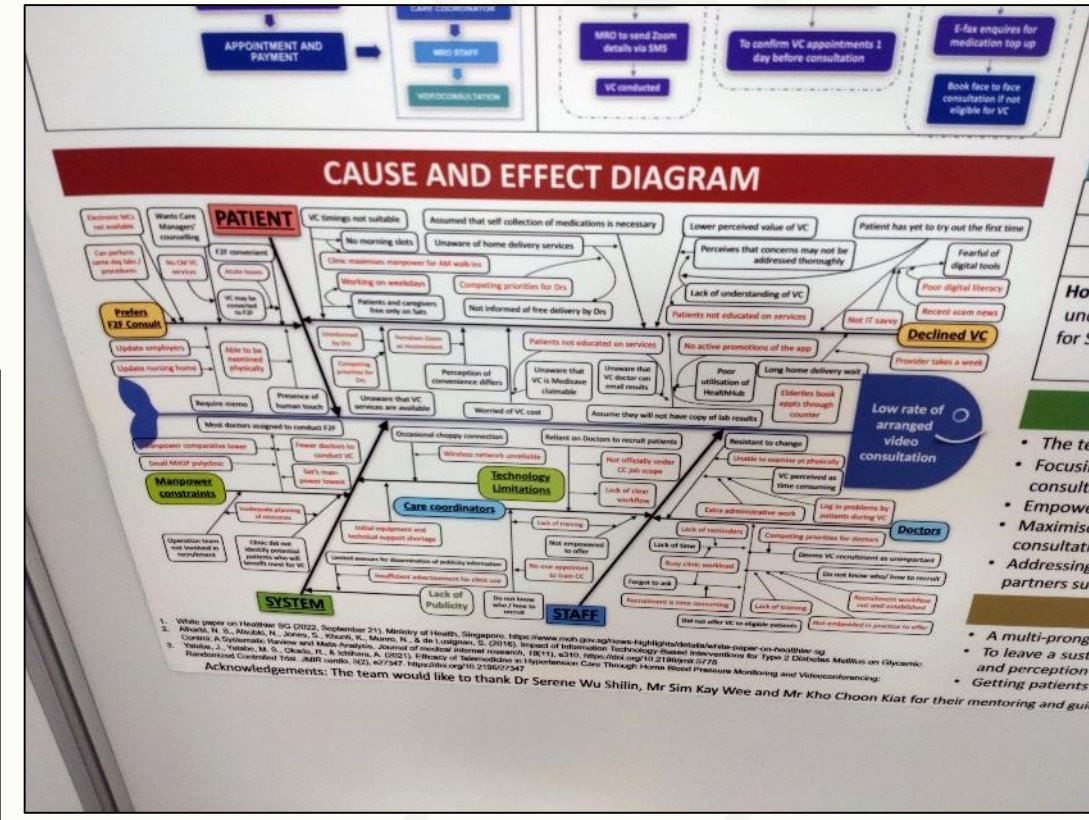
The SEIPS model sets out desired outcomes– what are you aiming to achieve when you deliver patient care?

Poszter szekció - halszálka-diagram használata



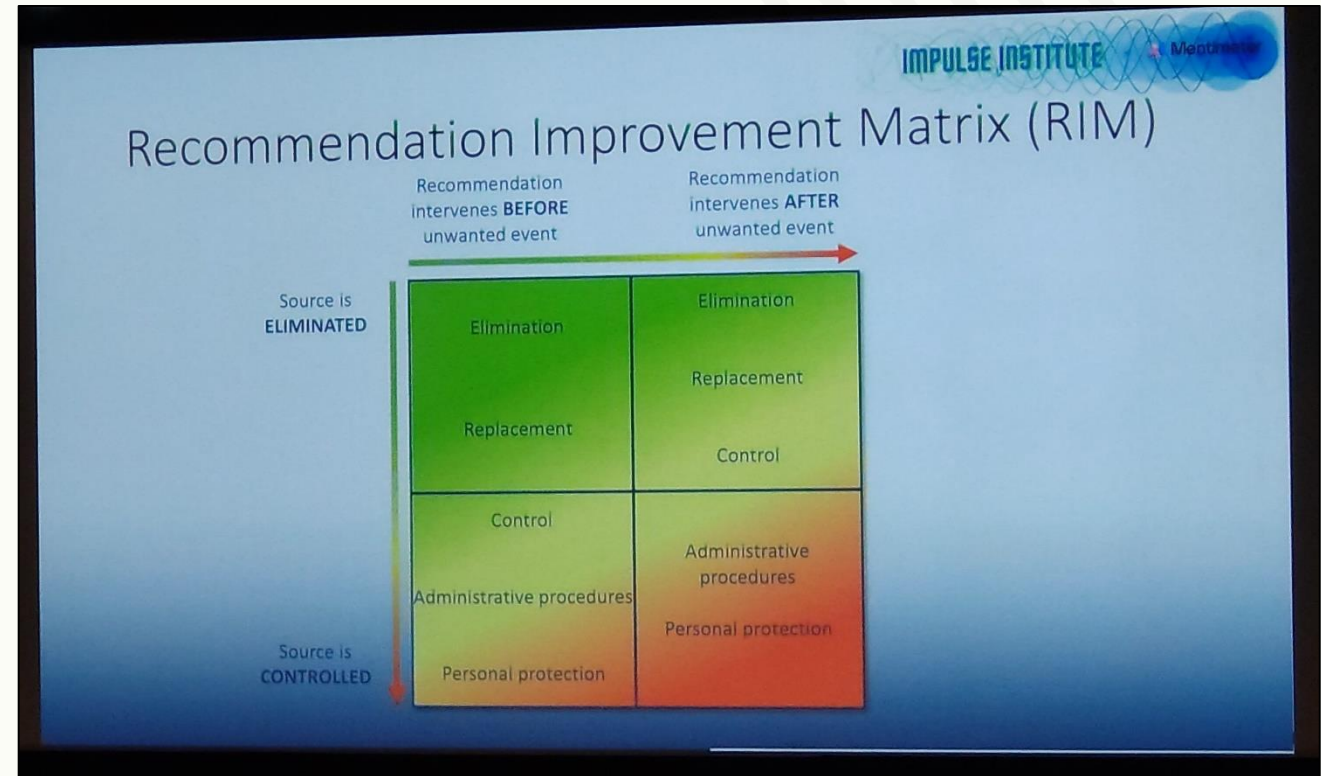
To share our vision of quality care for people living with frailty, we needed to ensure everyone understood frailty and the importance of recognising the clinical frailty score (CFS). This would enable everybody to become involved and speak the same language when discussing frail patients.

The starting point aim: increase awareness of frailty, staff recognition of frailty in patients, and establishing CFS on Clinical Decisions Unit (CDU) handover sheets.

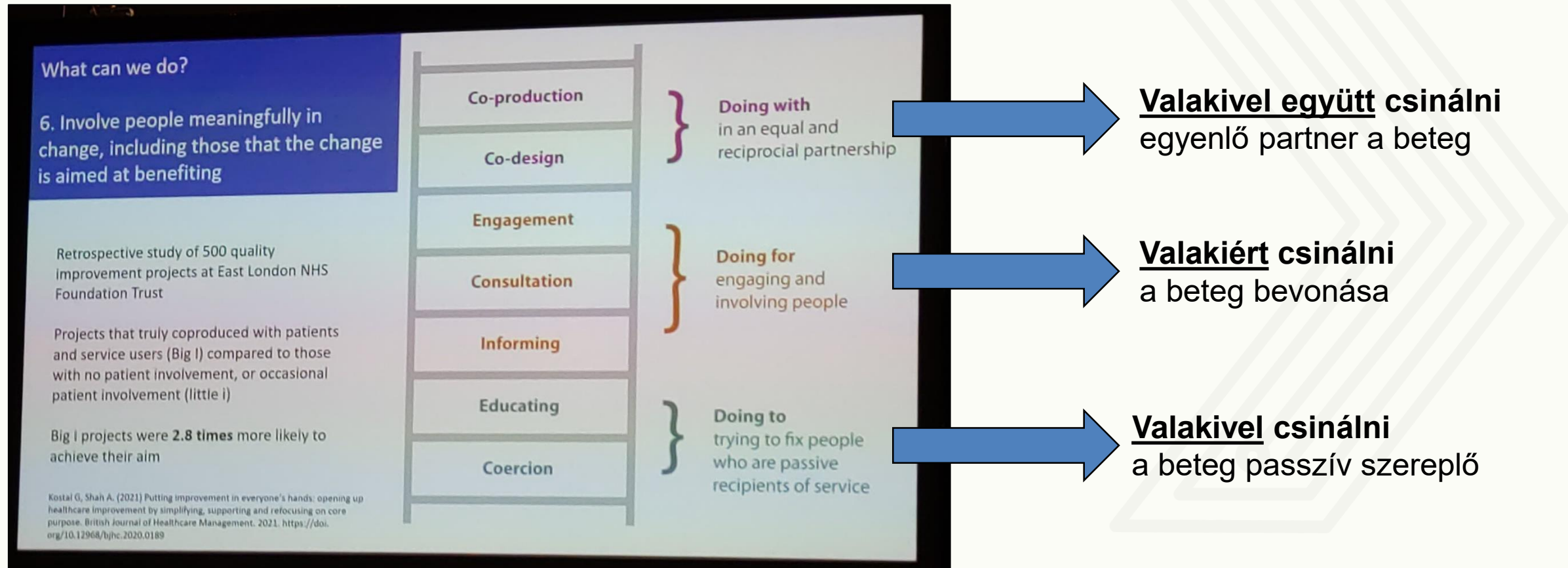


Rendkívüli események szabályozása Hollandiában

- Azokat a szabályozásokat kell előtérbe helyezni amelyek:
 - A nemkívánatos események bekövetkezése előtti állapotot szabályozzák.
 - A nemkívánatos események okát megszüntetik.
- Ezeknek a feltételeknek nem minden szabályozás tud eleget tenni.



Betegek bevonása ez egészségügyi ellátásba



Integrált egészségügyi ellátás

- Az integrált egészségügyi ellátás egy olyan megközelítés, amelyet az egészségügyi szakemberek közötti magas szintű együttműködés és kommunikáció jellemez.
- A betegellátással kapcsolatos információk megosztása, valamint a beteg biológiai, pszichológiai és szociális szükségleteit kielégítő átfogó kezelési terv felállítása teszi egyedivé.

Forrás: American Psychological Association honlapja

Asking the community of an Integrated Care System what matters to them

Health and wellbeing for children and young people
What matters?
Spring 2021

Who participated?

- Children and young people with long term conditions, educational needs and disabilities
- Parents and carers
- Families and young people with English as a second language
- Looked after children
- Young peoples health and wellbeing advocates
- Community volunteers
- Health research teams
- Health and social care champions (HealthWatch)

Six priorities emerged:

1. Access to mental health support
2. Mental health support in schools
3. Navigating the system
4. Young people's ownership of their healthcare
5. Pressures on parents
6. Maintaining a healthy weight

Key terms: GP communication, mental health, stress, delays, waiting, complicated system, waiting list.

NHS North West London Clinical Commissioning Group
connecting care for children
NIHR | School Health



GENERAL CAUSES AND TREATMENT OPTIONS FOR ADVERSE EVENTS WITHIN HEALTH CARE BASED ON THE REPORTS RECEIVED IN THE HUNGARIAN REPORTING AND LEARNING SYSTEM

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²NEVES Society for Patient Safety, Budapest, Hungary

Background
 Employees of the Department of Patient Safety at Semmelweis University operate the NEVES (Unexpected Events) reporting system, in which adverse events related to healthcare in Hungary are reported voluntarily and anonymously. Data has been collected in the NEVES system since 2008. In the reporting system, it is possible to submit reports in 21 topics. Of these, 7 commonly occurring adverse event topics were selected for research aimed at uncovering the causes and identifying prevention options.

Methods
 20,232 adverse events reported from 2008 to 2020 were analysed. Descriptive statistical analyses were used to establish the correlations based on the data from the reports, and then we searched for the basic causes with an Ishikawa diagram. We evaluated them with a risk matrix. Based on focus group discussions, we collected possible solutions and selected the most important ones by prioritizing. Finally, summary tables were created from the results of the working groups.

Results

TABLE 1: The nine main causes regarding patient safety that could be identified from the reported events

Main groups of causes	Possible general causes
Following rules	Employees deviate from the rule; they don't agree with it; they don't feel it is important to follow it; they do not know it; the conditions are not met (missing, inappropriate equipment, material); lack of time; interference; lack and insufficiency of control and feedback.
Regulation	There is no regulation; not understandable; not up to date; cannot be executed; is not known to those involved; it contains actions contrary to other regulations.
Shortcomings of the activities carried out	Lack of regulation; the designation of those responsible is missing or not clear; lack of knowledge; inexperience; untrained or unprepared; lacking human resources.
Lack of learning from events	Hiding errors and adverse events that occur; fear of punishment; lack of knowledge to explore the causes leading to the events; there are no honest discussions analysing errors, which can result in a focus on treating the root causes.
Communication and documentation	The information does not reach the person it concerns; the collection and transfer of the necessary information is delayed, distorted or absent; the documentation of information is incomplete or absent; the transfer of information is unstructured, incomplete, inaccurate, lost; the designation of those responsible is missing or not clear; regulatory and rule-following problems.
Education	It does not cover all necessary topics; does not have a uniform approach and content; does not reach everyone involved; the quality and frequency of education is not adequate; the lack of educational aids; the inadequacy of the educational curriculum and skills; insufficiency of patient education.
Human resources	Lack of motivation; the lack of setting an example; overwork; stress; lack of evaluation, feedback; staff shortage; underkilled workers; fluctuation; lack of teamwork.
The usage of devices	Few, missing, faulty tools; incorrect application practice; lack of knowledge; confusion; there is no or not the right tool available.
Infrastructure problems	Problems with the design of the ward and bathroom; lack of use of markings and signs, or they are incorrect or dangerous.

The proposed solutions: actions regarding the creation and everyday usage of regulations; organizing and conducting educations; procurement based on needs; improving communications; learning from mistakes and adverse events; using motivation tools.

Discussion

The cause structure of the occurring adverse events has a similar pattern. Therefore the most important causes to be handled can be determined based on the collection and analysis of information about the events. Analyses at the national level can be a starting point for identifying local characteristics and development directions. The safety of patient care can be improved not only in the topics included in the research, but also in general, by eliminating and treating the operational weaknesses revealed based on the research.

Funding: The creation of the poster is supported by the European Union and the Government of Hungary, financed under the National Laboratory for Health Security (NF-2.3.1-21-2022-0006) funding scheme. The underlying research was carried out within the EFOP 1.0.0 - VEGOP 17 "Professional Methodological Development of the Health Care System" project funded by the European Union.

TRENDS AND CONTRIBUTING FACTORS OF SHORT TERM HIP FRACTURE MORTALITY IN HUNGARY

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Background
 Hip fractures are frequent among the elderly, their treatment burdens healthcare systems worldwide. Hip fracture mortality in Hungary is high according to previous researches, but the causes behind the rates are unknown. The most critical period is the first 90 days following the fracture related hospital admission.

Methods
 Our analysis aimed to identify the possible causes of short term (90-day) mortality and the key points for improvement in hip fracture care in Hungary.

Results

- Decreasing 90-day mortality, but the effects of the coronavirus pandemic are clearly visible in 2020-21 (Fig. 1). Regional differences remained strong (Fig. 2).
- Rehabilitation rates: increasing but still low between 2005-15 (Fig. 3).
- We identified preventable (care related) and not preventable factors (e.g. age, sex and comorbidities of patient) of mortality.

Most important preventable factors of mortality:
 • healthcare related complications (OR: 4.94)
 • delayed surgery (OR: 1.21-1.35)
 • lack of rehabilitation (OR IF rehabilitation happened: 0.35-0.16)

Discussion
 Based on our results we have identified several points of intervention to consider:
 • Improving infection control and prevention in- and outside of hospital care to minimise healthcare related infections.
 • Increase inpatient rehabilitation rates.
 • Focusing on patient pathway management from the first admission, through timely surgery to the end of rehabilitation can minimise the risk of mortality.
 Follow-up researches will include Home rehabilitation practices, their relation to inpatient rehabilitation and effect on mortality.

Funding: This poster is introducing 2 researches. The causal research of hip fracture mortality is supported by the European Union and the Government of Hungary, financed under the Health Security National Laboratory for Health Security (NF-2.3.1-21-2022-0006) funding scheme. The analysis of patient pathways has been carried out in the framework of the project no. TIT/2020-NKFI-21, which has been implemented with the support provided by the Ministry of Innovation and Technology of Hungary from the National Research, Development and Innovation Fund, financed under the TIT/2020-1-USA/19/2021-NVA/19/2021-NVA/19 funding scheme.

Köszönjük a megtisztelő figyelmet!



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