

PATIENT SAFETY STRATEGY

Recommendations of the Expert
Committee Workshop held on
February 8-9, 2005

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MINISTRY OF HEALTH
AND CONSUMER AFFAIRS

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The contributions set out herein are exclusively the OPINIONS and THOUGHTS individually set out by the experts called to take part in this workshop, whom the Quality Agency would like to thank for their time and effort.

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INTRODUCTION

Patient safety is considered a top priority in healthcare, an increasingly complex activity involving potential risks in which no system is capable of totally guaranteeing that no adverse event will ever occur, given that this is an activity entailing factors inherent to the system proper combined with human actions.

According to the statistics, medical errors may cause the death of up to 98,000 patients every year in the United States, a larger number of deaths than those caused by traffic accidents, breast cancer or AIDS. In Canada and New Zealand, nearly 10% of the patients hospitalized suffer negative consequences due to medical error, whilst this figure nears 16.6% in Australia. Added to these direct consequences in the care provided are their economic repercussions: additional hospitalizations, lawsuits, in-hospital infections and the pain and suffering proper of the patients and their families, along with the loss of income, disabilities and medical expenses, totaling an annual cost in some countries of 6-29 billion U.S. dollars. This information has led the community to give some deep thought as to it being absolutely necessary for measures of proven effectiveness to be taken to reduce the growing number of healthcare-related adverse effects and their repercussions on patients' lives.

The strategy-related positions within the scope of patient safety and risk management are aimed at error detection, systematic error recordkeeping, the analysis of the information gathered and turning this information into useful knowledge in order to achieve the continued improvement of the services. These actions are likewise aimed at providing the patients with the means to be able to report the errors which they are often the first ones to discover.

Within this scope, the World Health Organization (WHO) took the initiative of launching the World Alliance for Patient Safety, an initiative involving the Pan American Health Organization (PAHO), the U.K. Department of Health, the U.S. Health and Human Services Department and other organizations as partners¹.

This Alliance proposes actions including the following:

- *“Address the problem of healthcare-associated infections in a campaign called “Clean Care is Safer Care”.*
- *“Set out patient safety taxonomy useable for reporting adverse events. Identify and disseminate the “best practices”.*
- *Set up reporting and learning systems for facilitating the analysis of the root causes giving rise to errors and their prevention”.*
- *“Fully engaging active patient participation in the work of the alliance”.*

Some countries have already developed strategies for taking action concerning this problem by proposing plans and legislative measures in this regard. They have also undertaken the challenges in information system research and development

The programs which the Alliance is interested in getting under way over the next two years are:

- ***Global Patient Safety Challenge*** focusing on healthcare associated infection.

¹ Pan American Health Organization. For patient safety [online]
http://www.paho.org/Spanish/DD/PIN/ahora03_nov04.htm. Consultation: 15/02/2005.

- ***Patients for Patient Safety*** fostering the active involvement of patients, either individually or as groups, in the work carried out by the Alliance
- ***Taxonomy for Patient Safety*** ensuring consistency in concepts, principles, norms and terminology used in patient safety work.
- ***Research for Patient Safety*** developing a rapid assessment tool for developing countries and undertaking prevalence studies of adverse effects.
- ***Solutions for Patient Safety*** promoting existing interventions in patient safety and coordinating international efforts to develop solutions.

Along this same line, the 56th European Health Committee meeting held in 2004² recommended the governments of member states to:

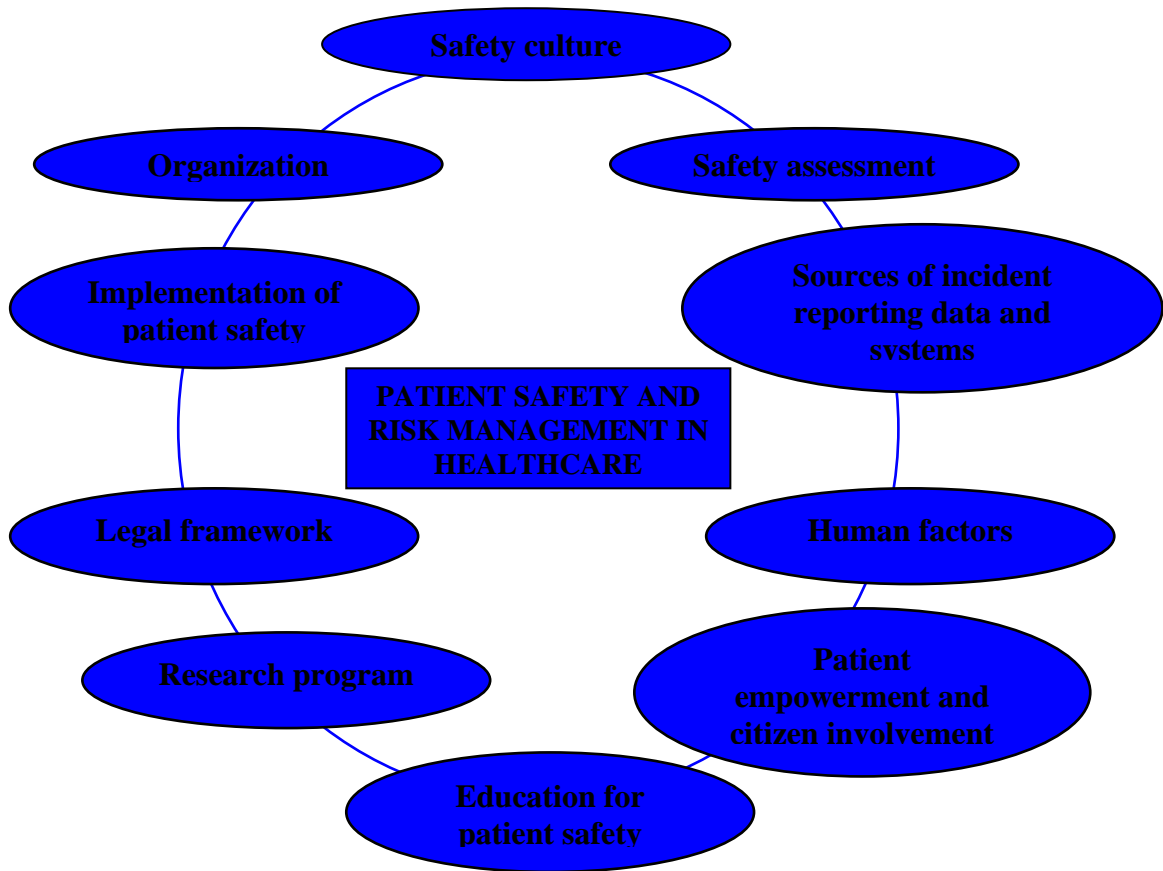
- *Ensure that patient safety is put at the core of all relevant health policies.*
- *Develop a patient safety policy framework.*
- *Develop a patient safety incident reporting system.*
- *Review the role of other existing data sources as complementary sources of information on patient safety.*
- *Develop educational programs for all relevant healthcare personnel, including managers, to improve the understanding of clinical decision-making, risk management and appropriate approach in the case of a patient safety incident.*

² The European Health Committee. Committee of experts on management of safety and quality in healthcare. Prevention of adverse effects in healthcare: a system approach. Council of Europe CDSP (2004) 41. Strasbourg, 2004.

- *Cooperate internationally to build a platform of mutual exchange of experience and learning on all aspects of healthcare safety.*
- *Promote research on patient safety.*
- *Produce regular reports on the action taken in the country to improve patient safety.*
- *Take, to this end, whenever feasible, the measures present in Recommendation Rec (2004) of the Committee of Ministers to member states on management of safety and quality in healthcare.*

The European Health Committee recognizes different elements within a system approach to risk prevention in healthcare:

- Organization
- Safety culture
- Safety assessment
- Sources of incident reporting data and systems
- Human factors
- Powers of patients and citizen involvement
- Education for patient safety
- Research program
- Legal framework
- Implementation of patient safety policy



Source: The European Health Committee. Committee of experts on management of safety and quality in healthcare. Prevention of adverse effects in healthcare: a system approach. Council of Europe CDSP (2004) 41. Strasbourg, 2004.

For the purpose of conducting an analysis of the current status in the field of patient safety and risk management in healthcare in Spain, to detect critical points and propose intervention strategies, the National Health System Quality Agency of the Ministry of Health and Consumer Affairs called a workshop of experts in Madrid to be held on February 8-9, 2005.

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OBJECTIVES

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The objectives proposed for the expert committee workshop were specifically as follows:

1. Identify the PROBLEMS of the National Health System on patient safety and risk management in healthcare from the perspective of each one of the experts.
2. Identify and prioritize the CRITICAL POINTS in patient safety and risk management in healthcare.
3. Identify INTERVENTION STRATEGIES in patient safety and risk in healthcare by assessing their importance and feasibility in order to guide the implement and development of policies within this framework.

EXECUTIVE SUMMARY

The classical principle “*primum non nocere*” is currently even more pertinent than in Hippocrates’ times, given that healthcare is considerably more complex today, thus entailing more potential risks. The existence of many factors conditioning clinical decisions, the care provided and care outcomes, it being possible to cause harm or even the death of the patient as a result thereof. The healthcare, social and economic consequences of errors in healthcare have led international organizations to give some deep thought to patient safety and healthcare risk management and to develop recommendations regarding the prevention of adverse effects in healthcare and the setting out of strategies in this areas, such as the Global Alliance for Patient Safety promoted by the World Health Organization, stressing that the safety strategies and the safety systems must include actions aimed at the prevention, detection and mitigation of adverse effects every time they occur, as well as the analysis of their causes, learning from error and the dissemination of the lessons learned.

Within this context and for the purpose of conducting an analysis of the current status of patient safety and risk management in healthcare in Spain, as well as detecting critical points and proposing intervention strategies, the National Health System Quality Agency of the Ministry of Health and Consumer Affairs called an expert committee workshop in Madrid on February 8-9, 2005, the specific objectives of which were:

- **Identify the problems** of the National Health System in relation to patient safety and risk management in healthcare from the perspective of each one of the experts.
- Identify and **prioritize the critical points** in relation to patient safety and risk management in healthcare.
- **Identify intervention strategies** in patient safety and risk management in healthcare by evaluating their importance and feasibility in order to guide the implementation and development of policies within this framework.

To achieve these objectives, highly structured qualitative methods were employed which would favor a consensus being reached among the experts, expediting the specific setting out of agreements within minimum debate sessions. The population of experts was broken down according to the “professional field” variable, a total of six profiles having resulted: regulation, assurance, institution management, provision of services and the academic field. The experts worked in simultaneous groups, employing different methods for each one of the objectives.

The first objective was achieved by means of the use of a panel discussion dynamic in which the participants were asked to identify the problems in patient safety and risk management.

The second objective was covered by means of a nominal group technique by detecting and prioritizing the critical points identified.

The third objective was achieved by means of an adapted nominal group technique in which, in addition to identifying the intervention strategies to be incorporated into the National Health System in this field, these interventions were prioritized in terms of the criteria of importance (understood as the strategy’s impact for the NHS) and feasibility (with the current resources and organization, the economic feasibility and the social acceptability).

The findings were presented to the group at the outset of the debate session and were sent out in a preliminary findings report in which the problems and strategies were grouped into categories. Lastly, the findings were triangulated with the information taken from documents published by international organizations

A total of 97% of the experts taking part in the workshop considered the National Health System to have some important or highly important problems to be addressed with regard to patient safety and risk management in healthcare. The problems identified had to do with the following aspects:

- ✓ *Organization*
- ✓ *Culture*

- ✓ *Training*
- ✓ *Information and record-keeping systems*
- ✓ *Assessment*
- ✓ *The human factor*
- ✓ *Active citizen involvement*
- ✓ *Legal framework*
- ✓ *Research*

The critical points identified which were considered to be top-priority by the experts (higher average score and lower standard deviations) were:

- Providing training out of an exercise of safety culture among the healthcare personnel ($\chi=9.13$; $\delta=1.31$).
- The true size of the problem is as yet to be known and publicized ($\chi=9.11$; $\delta=0.59$).
- Incorporate safety indicators into the assessment of the Healthcare Services (Processes) ($\chi=9.00$; $\delta=0.75$).
- Training and information on the existence of risks (Healthcare personnel and population) ($\chi=8.75$; $\delta=1.31$).
- Provide incentives through the NHS for quality-approved systems for risk identification and management with the participation of professionals, consumers and managers ($\chi=8.25$; $\delta=1.44$).
- Professional attitude training deficit: good physicians never makes mistakes; professionals and those who teach them – much less so – they never fail; uncertainty is not acceptable; error is not tolerable; we do not know how to convey or share uncertainty ($\chi=8.22$; $\delta=0,57$).
- A changeover to a non-blame-placing focus regarding safety problems ($\chi=8.22$; $\delta=0.69$).
- Raising the awareness of executives and professionals as to there being a safety problem ($\chi=8.18$; $\delta=1.14$).

- Getting the healthcare professionals actively involved in patient safety ($\chi=8.13$; $\delta=0.22$).
- Information circulation deficit ($\chi=7.91$; $\delta=1.01$).
- Avail of information technologies which will aid clinics to do things better (reminders, etc.) ($\chi=7.75$; $\delta=1.06$).
- Lack of quality controls in healthcare ($\chi=7.64$; $\delta=1.37$).

Of all of the intervention strategies proposed by the experts, the seven from each group which scored the highest in regard to importance were selected. The resulting 28 strategies were evaluated and prioritized by all of the experts as a whole. The following were thus attained as intervention strategies to be undertaken on a **short-range basis** (highly important and highly feasible).

- **Organization:** Getting healthcare risk management programs under way; providing incentives for the activities aimed at improving patient safety at each institution with involvement of professionals; incorporating safety-related indicators into whatever management or similar contracts may be made; fostering the meetings for constructively criticizing the healthcare services in relation to adverse outcomes, whether individual or organization outcomes.
- **Information and recordkeeping systems:** Information on risk areas and factors to professionals and patients.
- **Training:** Training groups for analyzing specific safety problems at each center; funding and providing incentives for safety-related training among the healthcare personnel.

The intervention strategies proposed to be undertaken on a **medium or long-range basis** (highly important but less feasible) revolved around:

- **Culture:** Raising cultural awareness of professionals in risk prevention.
- **Information and recordkeeping systems:** Implementing effective systems for reporting and planning measures for their reduction; promoting incident

notification and analysis systems; setting up protected information systems for notifying adverse events.

- **Training:** Providing healthcare executives and personnel with patient safety training.
- **Evaluation:** Setting out valid, reliable indicators for being able to compare position to degree of safety-related duty fulfillment at different organizational levels in the system.

In the final debate, the experts required some aspects which were not to be found in the initial working groups and reinforced the ideas related to the points critical to the system, such as:

- The need of focusing on the actions in order to get the strategies proposed under way.
- The importance of generally agreeing on a taxonomy which will homogenize concepts, terms and principles in patient safety and healthcare risk management.
- The importance of culture, raising awareness, the training of professionals and active citizen involvement.
- The need of addressing the funding-related aspects.

Apart from the above, the experts stressed the opportunities for exchanging knowledge, interests, points of view and professional disciplines provided by these types of discussion groups and meetings.

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FINDINGS

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PROBLEMS AND CRITICAL POINTS

The following similar aspects were found in the comparative analysis in relation to problems and critical points:

- No safety and quality culture.
- No information or incident recordkeeping and analysis systems.
- Reticence and lack of commitment among the different professional groups (healthcare professionals and managers).
- Lack of incorporation of risk management routines into the overall healthcare management system.

The aspects differentiating the profiles are concentrated into: the view from the healthcare organization perspective vs. the patients' and citizens' view. The problems identified by the participants are provided in the tables in following.

TABLE 1. PROBLEMS AND PRIORITIES FOR THE NHS IN PATIENT SAFETY AND RISK MANAGEMENT

PROBLEMS IDENTIFIED
<ul style="list-style-type: none">• The insufficient culture concerning the recognition of adverse effects and of the need of promoting the investigation of their causes.• Lack of patient-physician and physician-attorney dialogue.• No risk management at any level of action.• The patient and their family members being all alone in view of the adverse outcomes (the system's imperviousness).• Lack of active involvement of the patients, family members and institutions in risk and quality management.

PROBLEMS IDENTIFIED (cont'd)

- The lack of a safety-quality culture and the executives and professionals lacking knowledge of / being out of touch with these matters.
- The existing information (complaints) is not used to improve safety.
- Lack of sensitivity on the part of executives and professionals concerning safety and risk management: they not analyzing or acting specifically.
- Cultural question.
- The lack of knowledge of the problem on the part of professionals and patients.
- The healthcare professionals, citizens and society in general are not sufficiently aware of the major magnitude of the safety problems in healthcare.
- Lack of interest in identifying adverse effects and incorporating actions for improvement on the part of all of the professionals.
- Nosocomial infections.
- Lack of reliable information on the problem, resulting in a lack of sensitivity on the part of clinics.
- There are communicating problems between the healthcare professionals and citizens which have not been worked out by the administration and which are a hindrance to possible errors in healthcare measures being recognized.
- Little or no explicit attention to this matter as part of the routine management of the healthcare institutions.
- Care effective in secondary prevention of cardiovascular problems not used to a sufficient degree.
- Very little actual, permanent commitment on the part of the managers and authorities with regard to improving quality and safety.
- The variability in clinical practice.
- Patient safety and adverse effects are neither analyzed nor questioned using a scientific methodology.
- The complete lack of any risk identification, management and prevention culture.
- Complete lack of individualization in decision-making.
- Presence of inappropriate, high-risk prescribing profiles.
- Lack of safety in the use of particularly risky medications due to a complete lack of quality controls in the circuits.
- No risk management policy exists on the part of the authorities.

PROBLEMS IDENTIFIED (cont'd)

- Opposition on the part of the professionals to take part in patient safety programs.
- Delays in diagnosis in serious diseases.
- Nearly complete lack of any knowledge on the part of departments, services, organizations, etc. regarding the concept, methodology, tools related to risk management.
- Cases of exitus occur due to excess decoagulation in patients with chronic anticoagulant treatment (especially when treated in emergencies).
- There is a cultural problem, there being a blame-placing environment, and there being a tendency toward concealing and not recording the information due to a corporative culture.
- The NHS and its professionals not being aware of the magnitude, the typology and the causes of the risks involved in the processes which lead to lessening patient safety.
- The presence of unexpected, relevant, hard-to-explain effects.
- Lack of dimensioning, evaluation and management of this matter along with reticence on the part of professionals and institutions.
- Lack of accessibility to the healthcare system.
- Frequent parceling-out focus (hospital admission) without developing in-sync primary care-outpatient care information systems.
- Lack of information to patients which has an impact on making it difficult to hold persons responsible.
- Moving away (due to different circumstances) from the rights and needs of patients (responsible) for the sake of scientific advancement.

Source: Prepared based on the information gathered at the expert workshop on patient safety and risk management in healthcare. Ministry of Health and Consumer Affairs. Madrid, February 8-9, 2005.

TABLE 2. PROBLEMS AND PRIORITIES FOR THE NHS IN PATIENT SAFETY AND RISK MANAGEMENT

CRITICAL POINTS IDENTIFIED

- Complete lack of information and research strategy lines.
- Information circulation deficit.
- Availing of risk management commissions at hospitals.
- Lack of safety / quality culture and therefore the executives and professionals lacking knowledge of and/or being out of touch with these matters.
- Complete lack of data on what the problems are and the size thereof.
- Fully engaging the active involvement in patient safety on the part of the healthcare professionals.
- Deficit in active involvement on the part of the professionals (misconception on the part of the professionals concerning what clinical safety actually means).
- A changeover to non-blame focus regarding safety problems.
- Change over to a non-penalizing error management culture.
- Raising the awareness of executives and professionals as to the existence of a safety problem.
- Individualized decision-making (clearly define responsibilities).
- Training and information on the existence of risks (population and healthcare personnel).
- No manager without a commitment to quality and safety.
- Availing of an information system on the work done by the healthcare organizations in the areas of quality and safety.
- Availing of information technologies which will help the clinics to do things better (reminders, etc.).
- The true size of this problem is as yet to be known and publicized.
- Professional attitude training deficit: good physicians never makes mistakes; professionals and those who teach them – much less so – they never fail; uncertainty is not acceptable; error is not tolerable; we do not know how to convey or share uncertainty
- The acceptance of the part of professionals as to the adverse effects having to be studied in order to prevent them in the future. Accepting the study of adverse effects.
- Complete lack of legislation protecting the information obtained for making improvements.
- Lack of quality controls in healthcare.
- Difficulty in processing the information in environments of care-providing under pressure.

CRITICAL POINTS IDENTIFIED (cont'd)

- Lack of motivation / taking responsibility on the part of the clinical link.
- Requiring a system of skills prior to activities involving professional risk.
- Redefining the profile the 21st-century healthcare professional who knows how to convey their knowledge.
- Creating training and culture among the healthcare personnel.
- Getting professional groups actively involved in the risk management culture.
- Providing incentives through the NHS for quality-approved systems for risk identification and management with the participation of professionals, consumers and managers.
- The knowledge of the size, extension and seriousness of the problem.
- Adapting the indication/prescribing of anticoagulants in chronic patients to the available scientific evidence.
- Complete lack of individualization in decision-making.
- Incorporating safety indicators into the evaluation of the Healthcare Service (Processes).
- Having at our disposal the publication of the adverse outcomes among professionals for their analysis.
- Lack of coordination in the care-providing process: the points in time of professional interrelationship throughout the care-providing processes: organizational aspects, roles, etc.; very little systematization of the care-providing processes.
- Lack of specialists in risk management.
- Protocolizing the healthcare decisions.

Source: Prepared based on the information gathered at the expert workshop on patient safety and risk management in healthcare. Ministry of Health and Consumer Affairs. Madrid, February 8-9, 2005.

STRATEGIES

In regard to the strategies, ideas related to the implementation of incident reporting systems and indicator-based patient safety monitoring and evaluation systems are provided.

TABLE 3. INTERVENTION STRATEGIES

PROPOSED INTERVENTION STRATEGIES
<ul style="list-style-type: none">• Implement effective reporting and measure planning systems for the reduction thereof.• Information on risk areas and factors to professionals and patients.• Train groups for analyzing specific safety-related problems at each center.• Train specialists in risk management.• Implement a computerized medical record clearly stating the key data for the clinical decision.• Foster incident reporting and analysis systems.• Eliminate penalties for adverse effects for the healthcare personnel.• Implement a risk management recordkeeping system.• Institutional coordination among the risk management commissions and the complaints commissions provided that adverse outcomes were to exist.• Foster multi-social training-information-action groups (professionals, managers and politicians) at descending levels.• Training for executives and professionals for developing a climate of safety.• Improve the information systems and redesign processes.• Accreditation model centered around patient safety.• Getting healthcare risk management programs under way.• Creation and dissemination to the medical and legal professionals of databases on adverse events.• Charging the centers the resulting costs of the claims.• Promote joint decision-making and the habit of reflecting upon the difficult situations.• NHS invitation for research projects in the field of safety for professionals in direct contact with patients.• Foster meetings for constructively criticizing the healthcare services concerning adverse outcomes, whether they be individual or organization outcomes.

PROPOSED INTERVENTION STRATEGIES (cont'd)

- Regulatory change to facilitate the reporting of adverse effects.
- Research on attitudes of all of the professionals and determining factors related to the problem.
- Monitoring the adverse effects in the existing information systems.
- Raising the awareness of professionals concerning the risk prevention culture.
- Set up systems for the surveillance of the magnitude and characteristics of the risks.
- Identify the latent factors which have a bearing on each center.
- Undertake campaigns to inform and heighten the awareness of citizens concerning healthcare risks.
- Set out valid, reliable indicators in order to be able to compare position to degree to which duties are performed concerning safety at different organizational levels in the system.
- Fund and encourage training in safety among the healthcare personnel.
- Incorporate safety-related indicators into whatever management or other similar contracts which may be made.
- Creation of an intelligence center/network supporting data being processed into information for clinical and healthcare management.
- Creation of a State-level observatory on safety and risk prevention.
- Plan for investments in communications and information technologies at the service of the management, clinical practice and patients.
- National program for raising awareness concerning safety and risk prevention addressed to the healthcare centers.
- Studies on epidemiology of adverse effects and dissemination of findings.
- Marketing plan through the quality agency.
- Generally agreed undergraduate and graduate training plan.
- Training program for all professionals based on the effectiveness of preventive measures.
- Risk management and training programs through the Ministry of Health and Consumer Affairs.
- National adverse effects registry.
- Advertising campaigns addressed to citizens concerning clinical safety.
- Provide healthcare personnel and executives with training on patient safety.
- Set up protected information systems for reporting adverse effects.
- Motivate the healthcare professionals and executives by explaining the advantages of implementing quality controls.
- Set up specific risk management units at the institutions.

PROPOSED INTERVENTION STRATEGIES (cont'd)

- Training of all of the service's personnel by previously-trained local leaders.
- Provide incentives for the activities for improving patient safety at each institution with participation of professionals.
- Incorporate undergraduate and graduate training programs.
- Recruitment and training of local leaders at the care-providing services or departments level as a priority.
- Creation of a State-level multidisciplinary group to design, generally agree upon and implement a risk management system and a risk assessment system for the entire NHS.
- Prepare and implement a clinical practice guide for the prevention, diagnosis and treatment of thromboembolic diseases at the European level.
- Set up a new system for the participation in risk management on the part of patients or their institutions.
- Implement digital technology (decision-making support, risk alert programs, etc.) at the points where clinical care is provided for the patients.
- Add as a criterion for evaluating the professional career models or systems that of having taken part or taking part in clinical or institutional environment risk management, improvement or reduction programs.
- National and Autonomous Community-level accreditation system for centers and professions on motivated risk management.
- Foster public debate on healthcare errors.
- Motivate the preparation of risk maps by centers.
- Dissemination of externally-validated findings to professionals, institutions and consumers.
- Selection of indicators generally agreed with the professionals of each process or procedure on a general basis (not at each individual center).
- Undergraduate training on patient safety and risk management for all levels of professionals.
- Dissemination of methodologies and sharing of experiences in risk management.
- Homogeneous registries setting minimums.
- Explain the advantages of risk management to the professionals.
- Identify the profile or type of information necessary for the different levels of professional fields and patients.
- Convey the information on safety from where it is generated down to the very last person who needs the same and make this information efficiently accessible.

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TRIANGULATED FINDINGS

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The strategies proposed by all of the experts as a whole cover all of the areas suggested in the European Health Committee model of analysis:

Organization

- Get healthcare risk management programs under way.
- Patient safety-focused model of accreditation.
- Marketing plan through the quality agency.
- Dissemination of methodologies and sharing of experiences in risk management.
- Training groups for analyzing specific safety problems at each center.
- Charging the centers for the costs resulting from claims.
- Provide incentives for the activities for improving patient safety at each institution with the participation of professionals.
- Incorporate safety-related indicators in whatever management or other similar contracts which may be made.
- Set up specific risk management units at the institutions.
- Prepare and implement a clinical practice guide for the prevention, diagnosis and treatment of thromboembolic diseases at the European level.
- Foster meetings for constructively criticizing the care-providing services on adverse outcomes, whether individual or organization outcomes.
- Creation of a nationwide observatory on safety and risk prevention.

- Creation of a State-level multidisciplinary group to design, generally agree upon and implement a risk management system and a risk assessment system for the entire NHS.
- National and Autonomous Community-level accreditation system for centers and professions on motivated risk management.
- Add as a criterion for evaluating the professional career models or systems that of having taken part or taking part in clinical and/or institutional environment risk management, improvement or reduction programs.

Culture

- Eliminate penalties on the healthcare personnel for adverse effects.
- Promote joint decision-making and the habit of reflecting on difficult situations.
- National program for raising awareness concerning safety and risk prevention addressed to healthcare centers.

Training

- Through the Quality Agency, the Ministry of Health and Consumer Affairs will promote Patient Safety and Risk Management training policies.
- A) Offered for the Professionals at both the basic and specialized levels for a certain number of professionals, which will make it possible, in any case, to deploy the basic safety strategy network.
- B) Undergraduate training: For all those who are in training in the different healthcare disciplines.
- C) Promote multi-social training-information-action groups (professionals, managers and politicians) in descending levels.
- D) Specific training mechanisms will be implemented for the different social agents objectively involved in patient safety.
- Training of executives and professionals to develop a climate of safety.
- Raising awareness of professionals in risk prevention culture.

- Motivate the healthcare professionals and executives by explaining the advantages of implementing quality controls.
- Explain the advantages of risk management to the professionals.
- Provide training in patient safety for healthcare professionals and executives.
- Train specialists in risk management.
- Fund and provides incentives for training in safety among the healthcare personnel.
- Training of all the service's personnel by previously-trained local leaders.
- Recruitment and training of local leaders at the care-providing services or departments level as a priority.
- Undergraduate training on patient safety and risk management at all professional levels.

Evaluation

- Provide incentives for the preparation of risk maps by centers.
- Set up systems for monitoring the magnitude and characteristics of risks.
- Selection of safety indicators generally agreed with the professionals of each process or procedure on a general basis (not at each individual center).
- Set out valid, reliable indicators for being able to compare position to degree of safety-related duty fulfillment at different organizational levels in the system.
- Dissemination of externally-validated findings to professionals, institutions and consumers.
- Monitoring of the adverse effects in the existing information systems.

Information and recordkeeping systems

- National adverse effects registry.
- Homogeneous registries, setting minimums.
- Improve information systems and redesign processes.

- Implement effective systems for reporting and planning measures for their reduction.
- Information on risk areas and factors to professionals and patients.
- Implement a computerized medical record clearly stating the key data for the clinical decision.
- Promote systems for notifying and analyzing incidents.
- Creation and dissemination to the medical and legal professionals of databases on adverse events.
- Set up protected information systems for reporting adverse effects.
- Implement a risk management recordkeeping system.
- Identify the profile or type of information necessary for the different levels of professional fields and patients.
- Convey the information on safety from where it is generated down to the very last person who needs the same and make this information efficiently accessible.
- Implement digital technology (decision-making support, risk alert programs, etc.) at the points where clinical care is provided for the patients
- Plan for investments in communications and information technologies at the service of the management, clinical practice and patients.
- Creation of an intelligence center/network supporting data being processed into information for clinical and healthcare management.

Research

- Studies on epidemiology of adverse effects and dissemination of findings.
- Identify the latent factors which have a bearing on each center.
- Research on attitudes of all of the professionals and determining factors related to the problem.
- NHS invitation for research projects in the field of safety for professionals in direct contact with patients.

- Regulatory change to facilitate the reporting of adverse effects.

Citizens






- Foster public debate on healthcare errors.
- Advertising campaigns addressed to citizens concerning clinical safety.
- Undertake campaigns to inform and heighten the awareness of citizens concerning healthcare risks.
- Set up a new system for the participation in risk management on the part of patients or their institutions.

RECOMMENDATIONS

A total of seven of the strategies proposed which scored highest in the importance-related criterion in each group were selected, a list of 28 strategies then having been prepared in order for the experts to re-assess their importance and feasibility. The following strategies were selected.

For reasons of providing a clear explanation and so that these recommendations may be approached in a more operatively, they have been grouped into 5 categories considered to appropriately reflect the opinions of the participating experts:

The categories or groupings are:

-  1. On the Organizations (O)
-  2. On training and culture (T)
-  3. On evaluation (E)
-  4. On Information Systems (S)
-  5. On research (R)

1. On the Organizations (O)

- Set up specific risk management Units at the Institutions.
- Set up a new system Set up a new system for the participation in risk management on the part of patients or their institutions.
- Plan for investments in communications and information technologies at the service of the management, clinical practice and patients.
- Creation of an intelligence center/network supporting data being processed into information for clinical and healthcare management.
- Provide incentives for the activities for improving patient safety at each institution with the participation of professionals.

2. On training and culture (T)

- Get healthcare risk management programs under way.
- Raise awareness of professionals in risk prevention culture.
- Fund and encourage training in safety among the healthcare personnel.
- Information on risk areas and factors to professionals and patients.
- Undergraduate training on Patient Safety and Risk Management at all professional levels.
- Undertake campaigns to inform and heighten the awareness of citizens concerning healthcare risks.
- Training of all the service's personnel by previously-trained local leaders.
- Provide healthcare personnel and executives with training on patient safety.

3. On Evaluation (E)

- Creation of a State-level multidisciplinary group to design, generally agree upon and implement a risk management system and a risk assessment system for the entire NHS.
- Patient Safety-focused Model of Accreditation.

4. On the Information Systems (S)

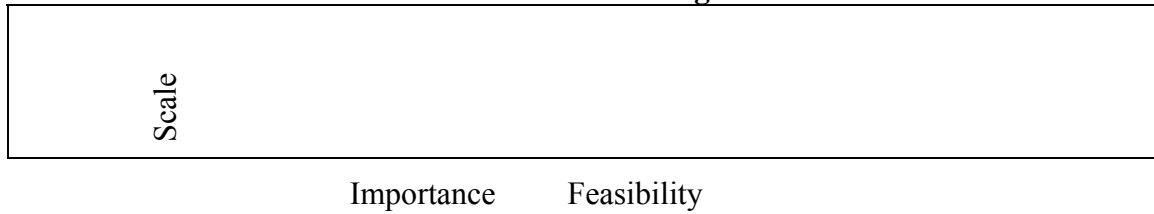
- Improve the information systems and redesign processes.
- Foster incident reporting and analysis systems.
- Set up protected information systems for reporting and notifying adverse effects.
- Set out valid, reliable indicators for being able to compare position to degree of safety-related duty fulfillment at different organizational levels in the system.
- Set up systems for the surveillance of the magnitude and characteristics of the risks.

5. On Research (R)

- Implement digital technology (decision-making support, risk alert programs, etc.) at the points where clinical care is provided for the patients.
- Identify the latent factors which have a bearing on each center.

The final evaluation made by the experts on the 28 strategies proposed is provided in the following graph:

Intervention Strategies



Source: Prepared based on the information gathered at the expert workshop on patient safety and risk management in healthcare. Ministry of Health and Consumer Affairs. Madrid, February 8-9, 2005.

For constructing the intervention strategy prioritization matrix, the importance and feasibility medians were used as a cutoff point.

Importance



Feasibility

Dimensions

Source: Prepared based on the information gathered at the expert workshop on patient safety and risk management in healthcare. Ministry of Health and Consumer Affairs. Madrid, February 8-9, 2005.

The prioritization matrix was thus constructed as follows:

	High feasibility	Low feasibility
High importance	1, 3, 9, 12, 13, 15, 16	2, 5, 6, 7, 10, 11
Low importance	14, 19, 22, 25	4, 8, 17, 18, 20, 21, 23, 24, 26, 27, 28

Source: Prepared based on the information gathered at the expert workshop on patient safety and risk management in healthcare. Ministry of Health and Consumer Affairs. Madrid, February 8-9, 2005.

The intervention strategies thus recommended for being undertaken on a **short-range** basis were related to:

- **Organization:** Getting healthcare risk management programs under way; encouraging the activities for improvement in patient safety at each institution with participation of professionals; incorporating safety-related indicators into the management or other similar contracts which may be made; fostering the meetings for constructively criticizing the healthcare services in relation to adverse outcomes, whether individual or organization outcomes.

- **Information and recordkeeping systems:** Information on risk areas and factors to professionals and patients.
- **Training:** Training groups for analyzing specific safety problems at each center; funding and providing incentives for safety-related training among the healthcare personnel.

The intervention strategies proposed to be undertaken on a **medium or long-range** basis revolved around:

- **Culture:** Raising cultural awareness of professionals in risk prevention.
- **Information and recordkeeping systems:** Implementing effective systems for reporting and planning measures for their reduction; promoting incident notification and analysis systems; setting up protected information systems for notifying adverse events.
- **Training:** Providing healthcare executives and personnel with patient safety training.
- **Evaluation:** Setting out valid, reliable indicators for being able to compare position to degree of safety-related duty fulfillment at different organizational levels in the system.

