Centrum
Monitorowania
Jakości w Ochronie Zdrowia

To report or not to report
The Polish experience

Basia Kutryba
National Center for Quality Assessment in Healthcare, Poland

Patient safety in medical system in Europe and Romania
Bucharest, 25.09.2019

European Funds
Knowledge Education Development

European Union
European Social Fund

NATIONAL CENTER FOR QUALITY ASSESSMENT IN HEALTHCARE(NCQA), 1994 - onwards; WHO CC 2006-2016

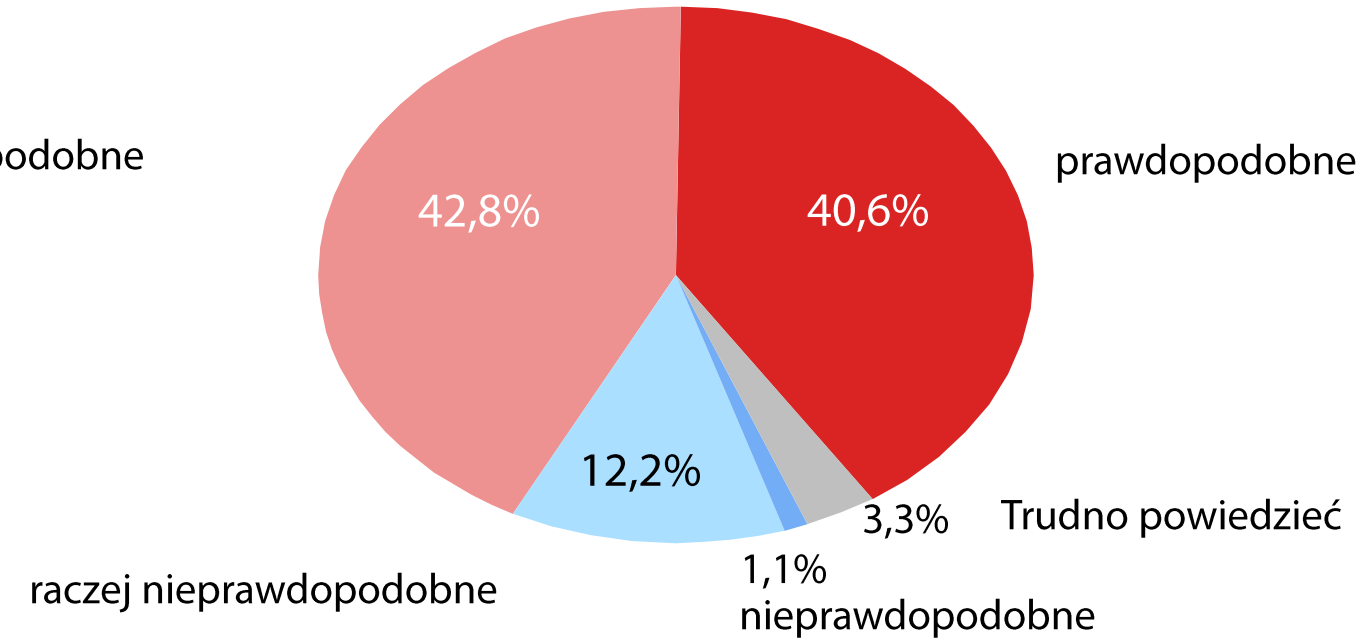
- Accreditation
- Patient safety programs: Surgical checklist; Clean Care is Safer Care; Medication Reconcilliation, Patient Safety Curriculum; Medication Safety
- Quality indicators (PATH system, OECD HCQI,)
- Patient opinion surveys (PASAT)
- Staff surveys (SAPER)
- Decubitus register
- Evaluation of high specialty procedures
- National ranking of hospitals „Safe Hospital”
- Partnership in EU projects (Marquis, Handover, Joint Action on Patient Safety and Quality of Care, Human Capital projects)
- Annual conference „Quality in Healthcare” since 1995
- Education and training in quality for healthcare professionals, managers and teams

Cooperation with WHO
BCA since 2003

- International PATH project 2006 - 2012
- Safe Surgery Saves Lives 2008/2009
- Surgical Checklist Adaptation - 7 surgical specialties 2012/2013
- Clean Care is Safer Care 2012/2013
- Medication Reconcilliation 2014/2015
- Education in Patient Safety for Multiprofessionals 2016/2017
- Global Challenge on Medication Safety 2018/2019

Survey on adverse events in citizens

How probable is that patients can be harmed while receiving hospital care?



N=2937

Research methodology

Computer Assisted Personal Interviewing (CAPI)

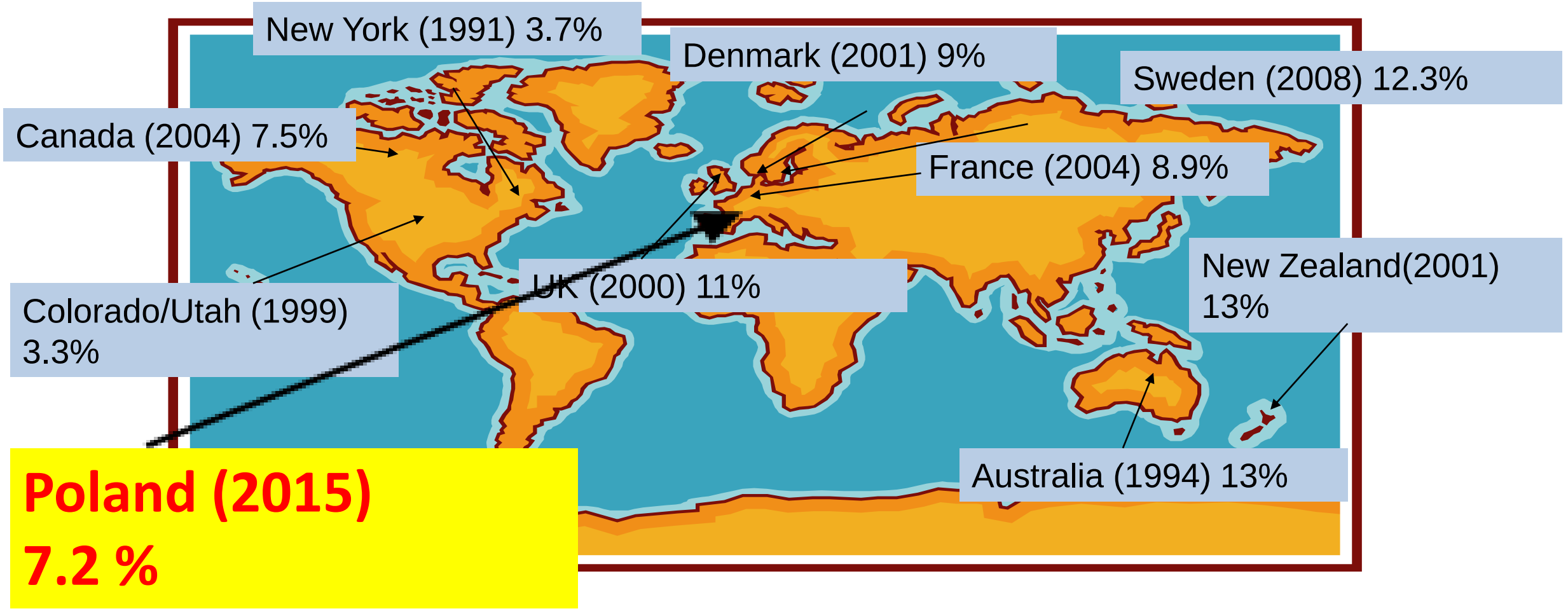
Adverse event

Harm caused within diagnostics and/or treatment not related to the natural cause of disease and patient condition.

Near Miss

Situation, which due to the circumstances or staff resilience had good outcome, so that the adverse event has not reached the patient and patient was not harmed.

Centrum Monitorowania Jakości w Ochronie Zdrowia; projekt „Wsparcie szpitali we wdrażaniu standardów jakości i bezpieczeństwa opieki.Zarządzanie Bezpieczeństwem Opieki”


New York (1991) 3.7%
Denmark (2001) 9%
Sweden (2008) 12.3%
Canada (2004) 7.5%
France (2004) 8.9%
UK (2000) 11%
Colorado/Utah (1999) 3.3%
New Zealand(2001) 13%
Australia (1994) 13%
Poland (2015)
7.2 %

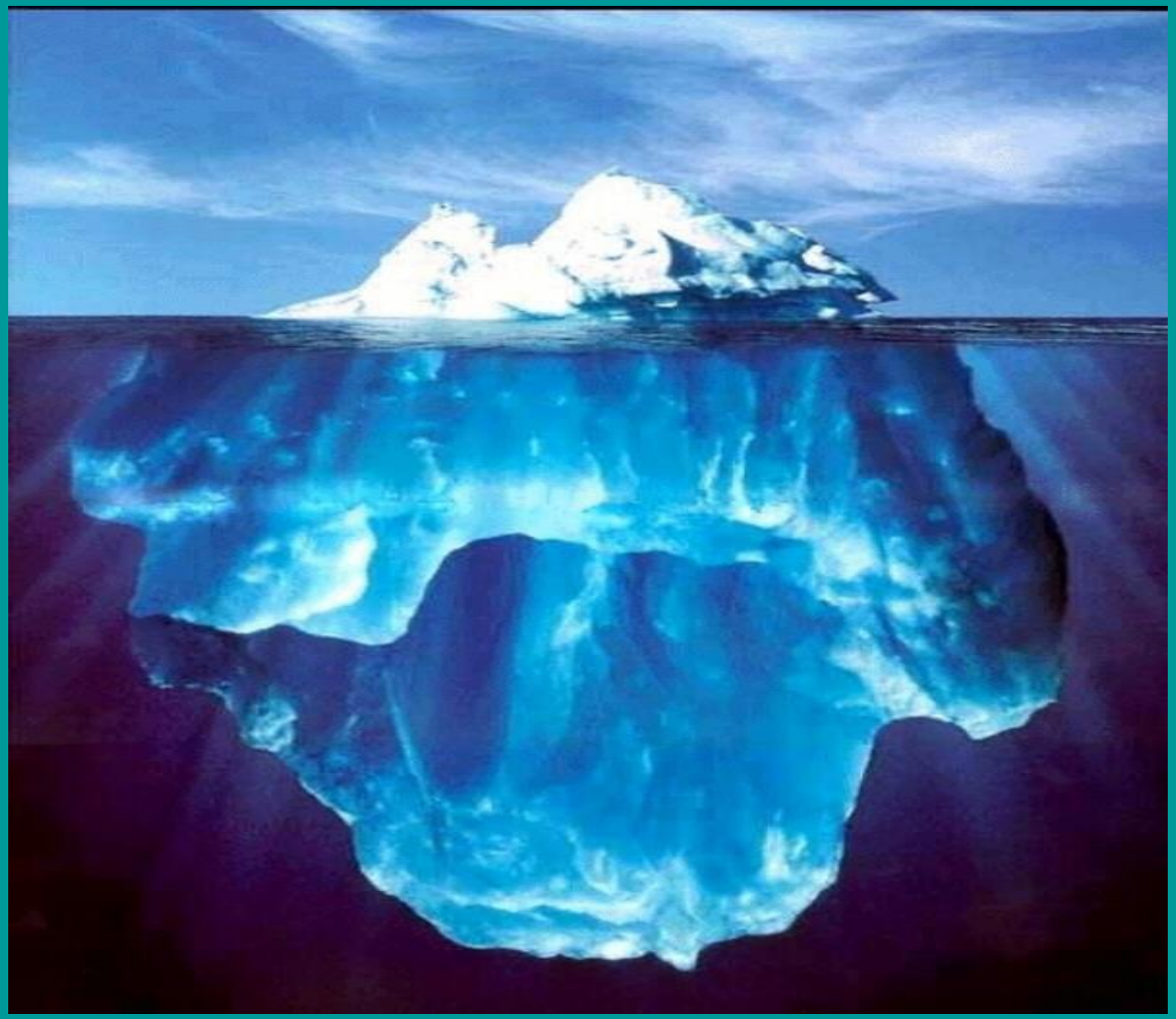
Survey on adverse events in healthcare staff

2004 – Polish Society for Quality Promotion in Healthcare (TPJ)

78,5%

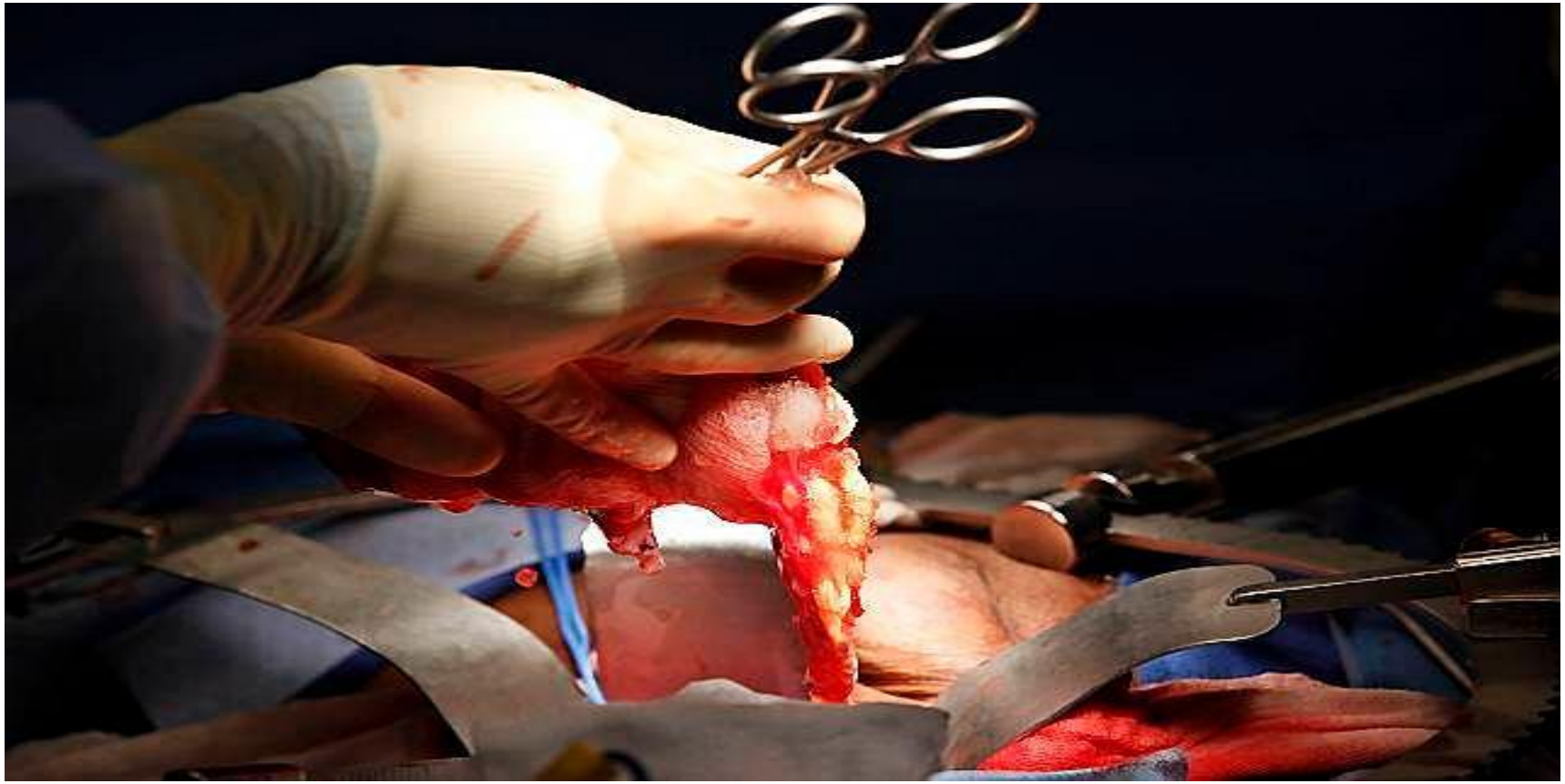
2015 – NCQA study

86,5%



Removed healthy kidney instead of the ca kidney

26 July 2011 | 01:00



W Centrum Onkologii w Warszawie pacjentowi wycięto zdrową nerkę.
Czy to zdecydowało o nagłym odwołaniu dyrektora prof. Macieja Krzakowskiego?

May 12, 2015

Outstanding doctors' errors. Patient's healthy kidney removed! The second time!!!

Lekarze wycięli zdrową ner...

www.fakt.pl/Lekarze-wycieli-zdrowa-nerke-Pomylili-sie,artykuly,110237,1.html

Program Firefox uniemożliwił uruchomienie nieaktualnej wtyczki „Adobe Flash" na stronie http://www.fakt.pl.

Kontynuuj blokowanie | Zezwól...

Fakt.pl > Wydarzenia > Polska > Lekarze wycięli zdrową nerkę! 27.07.2011 10:27

Lekarze wycięli zdrową nerkę! Pomylili się

REKLAMA

Dieta do Domu z

Zwolniono lekarza, który w...

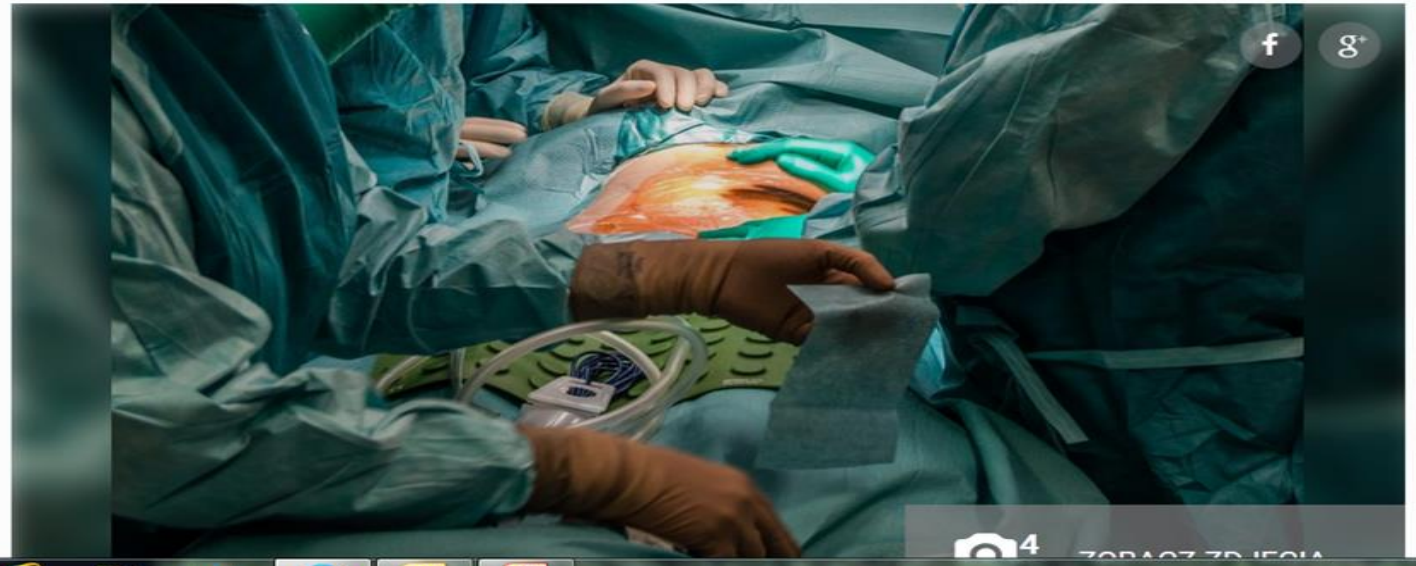
www.fakt.pl/wroclaw/zwolniono-lekarza-ktory-wycial-zla-nerke,artykuly,550669.html

Program Firefox uniemożliwił uruchomienie nieaktualnej wtyczki „Adobe Flash" na stronie http://www.fakt.pl.

Kontynuuj blokowanie | Zezwól...

PO FERALNEJ POMYŁCE WE WROCŁAWIU

Wyciął złą nerkę. Szpital go zwolnił



REKLAMA

DZIAŁA AŻ DO 6H

ZWALCZA SILNY BÓL

Jak naprawdę umarł Jackson?

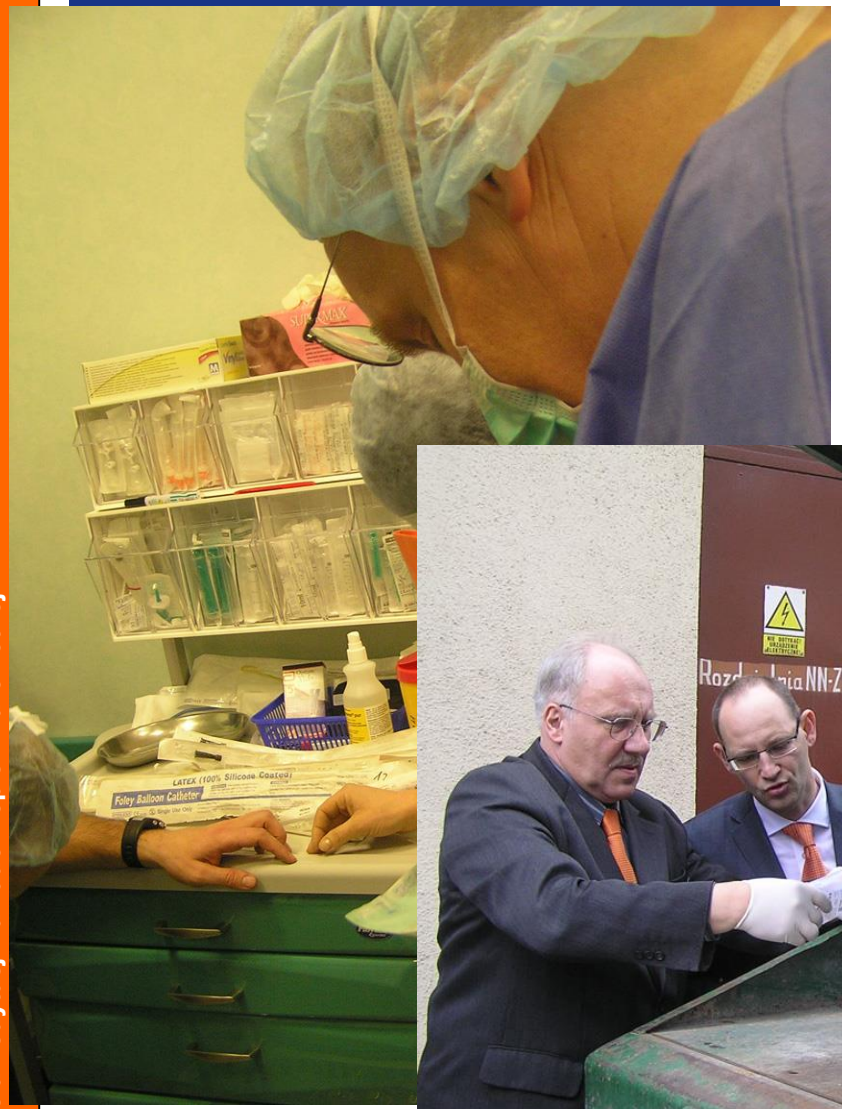
Przed śmiercią wypowiedział niepokojące słowa...

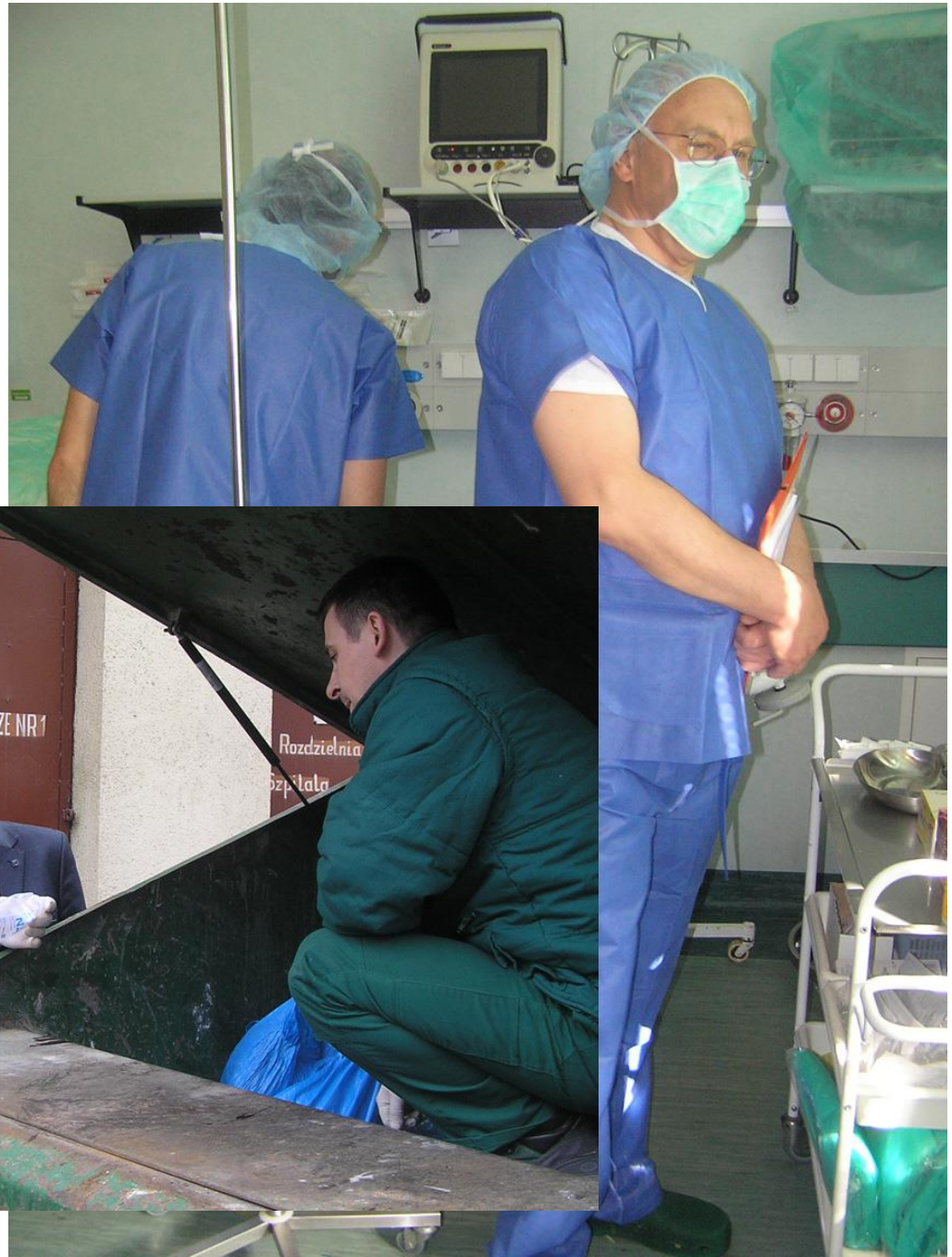
gwiazd

Tak gwiazdy bawiły się na

PL 12:56 2016-01-11

221 standards in 15 chapters





Wsparcie akredytacji zakładów opieki zdrowotnej

NEW OPENING

Supporting hospitals in implementing quality and safety standards

„Management of the Safety of Care”

Reporting and learning from adverse events

25 hospitals

teaching, specialist, regional, district, municipal, others

June 2017 - December 2019

Mary, age 4

MAJOR PRINCIPLES

1. Local, hospital system
2. Not aiming to identify the reporters
3. System oriented approach – signals deficiency of the system, no pointing at the individual
4. Analysis of HOW and WHY and not WHO
5. Clear defining of rules, confidentiality, annonymous data
6. Conditional – confidential reporting; data and information deleted within 15 days since reporting
7. Reporting by all hospital staff
8. Paper and e-reporting (IT application)

WHO Minimal Information Model for Patient Safety

1. Reporter's role – profession/position
2. Patient – sex, age, hospital ID

Personal data of patient and reporter are deleted within 15 days since reporting

3. Time of AE: year, month, day, hour, min.
4. Place where AE occured
5. Agents involved
6. Type of AE
7. Resulting actions – for patient and hospital
9. Free text: comments

For every complex problem, there is a solution that is simple, neat, and… wrong

Henry Louis Mencken, Baltimore