Act on Patient Safety in the Danish Health Care System

A National Reporting System for Adverse Events

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Something is rotten in the state of Denmark.

Danish Adverse Event Study published 2001: 9% of discharged patients had experienced an adverse event.
Act on Patient Safety - A Reporting System for Learning

- Frontline Personnel obligated to report
- Hospital Owners are obligated to act
- Board of Health is obligated to communicate
Handling of Adverse Events

Patient Insurance
Complaint System
Supervisory System
Act on Patient Safety
The organization of the Danish Reporting System

National Board of Health

Regional Patient Safety Units

Hospitals

The regional level
Reporting

Data anonymized

P.S.O.

Head of dep.

PSM/CEO

Data anonymized

Frontline Staff  Hospital  Regional Unit  Board of Health

LEARNING  FEEDBACK
How to prioritize the analyses:
Score-Matrix

<table>
<thead>
<tr>
<th>Severity and Probability</th>
<th>Catastrophic</th>
<th>Major</th>
<th>Moderate</th>
<th>Minor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Occasional</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Uncommon</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Remote</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Potential and Actual Injury
Reference NCPS, VA gov

Legend:
- SAC 3 RCA
- SAC 2 Aggregated RCA
- SAC 1 Local action
Og vi snupper lige FEM TRIN
Fra 1. maj tager vi fem trin, der skal forhindre forøvelsensindgreb:

1. Santrykke
   Tegn op til det rådende indikation og dokumentation.

2. Markerings
   Opfølgelse med opskrift på det rådende indikation og dokumentation.

3. Identifikation
   Brug et afdækkek til at poinisere et indikation og dokumentation

4. Dokumentation
   Udfør det tilsvarende indikation og dokumentation

5. Time Out
   Tegn et afdækkek til at poinisere et indikation og dokumentation

Læs mere på www.dssts.dk
Reported adverse events

- Q1 2004
- Q2 2005
- Q3 2005
- Q4 2005
- Q1 2005
- Q2 2005
- Q3 2005
Simple low tech, low cost system
The NPSA National Reporting and Learning System (NRLS): “A grand experiment”?

Richard Thomson
Director of Epidemiology and Research
NPSA
To err is human
To cover up is unforgivable
To fail to learn is inexcusable

Sir Liam Donaldson
Chief Medical Officer
England
Figure 1: The National Reporting and Learning System

NHS Net
Local risk management system

Service eForm

Encrypted traffic

WWW
Open access staff eForm
Patient and public eForm

National Reporting and Learning System
Secure database
Cleansed database
Analysis

Feedback
NRLS: reported incidents and number of reporting trusts

- Number of Trusts Reporting vs. Reporting Month
- Number of Incidents vs. Reporting Month

No. of Trusts Reporting: 0, 50, 100, 150, 200, 250, 300, 350
No. of Incidents: 0, 5,000, 10,000, 15,000, 20,000, 25,000, 30,000, 35,000

National Reporting & Learning System

- **Statutory function of NPSA:**
  - implement a national reporting system for patient safety incidents
  - collect and appraise information to promote patient safety

- **Key points**
  - all specialties and care settings (607 health care organisations in England and Wales)
  - all levels of severity including “no harm”
  - capacity to analyse very large dataset (data mining)
  - confidential (anonymisation) – no legal protection
  - single data entry - implications
  - publication of data
  - for national and local learning, including feedback
## Settings of incidents reported to the NRLS

<table>
<thead>
<tr>
<th>Care setting</th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute/general hospital</td>
<td>226002</td>
<td>74.7</td>
</tr>
<tr>
<td>Mental health service</td>
<td>41809</td>
<td>13.8</td>
</tr>
<tr>
<td>Community nursing, medical and therapy service (including community hospital)</td>
<td>24895</td>
<td>8.2</td>
</tr>
<tr>
<td>Learning disability service</td>
<td>7428</td>
<td>2.5</td>
</tr>
<tr>
<td>General practice</td>
<td>1185</td>
<td>0.4</td>
</tr>
<tr>
<td>Ambulance service</td>
<td>1093</td>
<td>0.4</td>
</tr>
<tr>
<td>Community pharmacy</td>
<td>192</td>
<td>0.1</td>
</tr>
<tr>
<td>Community and general dental service</td>
<td>56</td>
<td>&lt; 0.1</td>
</tr>
<tr>
<td>Community optometry/optical service</td>
<td>3</td>
<td>&lt; 0.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>302663</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Source: Reports in the NRLS database up to 30 September 2005
Reported degree of harm to patients

Source: Reports in the NRLS database up to 30 September 2005
Reported incident rate for acute trusts

Incident rate per 100 admissions

Trust

Average = 5.1 per cent
Building a memory: Preventing harm, reducing risks and improving patient safety
PSO/NRLS

It is of the highest importance in the art of detection to be able to recognise out of a number of facts which are incidental and which are vital.

Arthur Conan Doyle (1859 - 1930)
EVALUATION

OTHER ORGANISATIONS

PATIENTS/PUBLIC

PRIORITISATION

SOLUTIONS

EVALUATION

NHS Feedback & Bounceback

R&D

PATIENTS/PUBLIC

Surveillance & Monitoring

OBSERVATORY

Patient Safety Research

Other bodies & their views e.g.
- NICE
- DoH/Ministers
- VOs/Charities

Public/Patient eForm

Other confidential reporting systems

Sources of Intelligence
- Healthcare Commission
- Expert Groups
- Patient/Public Views
- Individual Patients
- Interest Groups etc.

Other dataset relevant to patient safety e.g.
- Clinical negligence data
- MHRA
- Hospital Episode Stats
- RCGP Database
- NHS Direct

Research

NRLS
People will only report to a national system if there is legal protection

1. Strongly agree

2. Agree

3. Disagree

4. Strongly disagree
§6 in Act on Patient Safety

A frontline person who reports an adverse event cannot as a result of that report be subjected to investigation or disciplinary action from the employer, the Board of Health or the Court of Justice

Confidential reporting: > 90%

Anonymous reporting: <10%
Data protection act

Human rights act

Caldicott principles

Freedom of information act

Section 60 Health and Social Care Act

Data sharing protocol

Security policies and firewalls etc

Anonymisation

Contracts and staff training/induction

Stats publication policy

Confidentiality policies
Phases of the Danish Reporting System

Phase 1: Hospitals

Phase 2 and 3: Primary Care and Patient Reporting
A hospital reporting rate rises over time. What is the most likely explanation?

1. the number of incidents in the hospital is increasing

2. the reporting culture is improving

3. there is an error in the data

4. none of the above
Reporting systems - The Top of the Iceberg
The Needle in the Haystack