PATIENT SAFETY
High quality health care in Finland

PROMOTING PATIENT SAFETY TOGETHER

Finnish Patient Safety Strategy 2009–2013

Publications of the Ministry of Social Affairs and Health 2009:5

ISBN 978-952-00-2789-6 (pb)
ISBN 978-952-00-2790-2 (PDF)

ISSN 1236-2050 (print)
ISSN 1797-9854 (online)

URN:ISBN:978-952-00-2790-2
http://urn.fi/URN:ISBN:978-952-00-2790-2

Layout: AT-Julkaisutoimisto Oy
Print: Helsinki University Print, Helsinki 2009

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Finnish Patient Safety Strategy 2009–2013

SUMMARY

The first Finnish Patient Safety Strategy for 2009–2013, drawn up by the steering group for the promotion of patient safety set up by the Ministry of Social Affairs and Health: Promoting patient safety together. Helsinki 2009. 24 pp.
Publications of the Ministry of Social Affairs and Health, Finland 2009:5
ISSN 1236-2050 (print) , ISSN 1797-9854 (online)
ISBN 978-952-00-2789-6 (pb), ISBN 978-952-00-2790-2 (PDF)
URN:ISBN:978-952-00-2790-2

The Patient Safety Strategy was adopted at a meeting of the steering group for the promotion of patient safety in December 2008. The Ministry of Social Affairs and Health will publish the Strategy on 29 January 2009. The National Institute for Health and Welfare answers for updating the Strategy, and the Ministry of Social Affairs and Health then confirms the updates.

MISSION STATEMENT

We are promoting patient safety together.

VISION – target state by the year 2013

Patient safety will be embedded in the structures and methods of operation: care and treatment is effective and safe.

PERSPECTIVES

Culture, management, legislation, and responsibility.

OBJECTIVES

- The patient is actively involved in improving patient safety
- Patient safety is managed proactively and through learning
- Patient safety incidents are reported, and we learn from them
- Patient safety is promoted systematically and by means of adequate resources
- Patient safety is taken into account in health care research and teaching

Key words: health care, medical care, strategy, patient safety

EDISTÄMME POTILASTURVALLISUUTTA YHDESSÄ

Suomalainen potilasturvallisuusstrategia 2009–2013

TIIVISTELMÄ

Sosiaali- ja terveysministeriön asettaman potilasturvallisuuden edistämisen ohjausryhmän valmistelema ensimmäinen suomalainen potilasturvallisuusstrategia vuosille 2009–2013: Edistämme potilasturvallisuutta yhdessä. Helsinki 2009. 24 s.
Sosiaali- ja terveysministeriön julkaisuja 2009:5
ISSN 1236-2050 (painettu), ISSN 1797-9854 (verkkojulkaisu)
ISBN 978-952-00-2789-6 (nid.), ISBN 978-952-00-2790-2 (PDF)
URN:ISBN:978-952-00-2790-2

Potilasturvallisuusstrategia hyväksyttiin potilasturvallisuuden edistämisen ohjausryhmän kokouksessa joulukuussa 2008 ja sosiaali- ja terveysministeriö julkistaa strategian 29.1.2009. Strategian päivittämisestä vastaa terveyden ja hyvinvoinninlaitos, ja sosiaali- ja terveysministeriö vahvistaa päivitykset.

MISSIO – toiminta-ajatus

Edistämme potilasturvallisuutta yhdessä.

VISIO – tavoitetila vuoteen 2013 mennessä

Potilasturvallisuus on ankkuroitu toiminnan rakenteisiin ja toimintatapoihin: hoito on vaikuttavaa ja turvallista.

NÄKÖKULMAT

Kulttuuri, johtaminen, säädökset ja vastuu.

TAVOITTEET

- Potilas osallistuu potilasturvallisuuden parantamiseen
- Potilasturvallisuutta hallitaan ennakoivasti ja oppimalla
- Vaaratapahtumat raportoidaan, niistä opitaan
- Potilasturvallisuutta edistetään suunnitelmallisesti ja riittävin voimavaroin
- Potilasturvallisuus huomioidaan terveydenhuollon tutkimuksessa ja opetuksessa

Asiasanat: terveydenhuolto, sairaanhoito, strategia, potilasturvallisuus

VI FRÄMJAR PATIENTSÄKERHETEN TILLSAMMANS

Den finländska patientsäkerhetsstrategin 2009–2013

SAMMANDRAG

Den första finska strategin för patientsäkerhet för 2009–2013 utarbetad av den av social- och hälsovårdsministeriet tillsatta styrgruppen för främjandet av patient-säkerheten:Vi främjar patientsäkerheten tillsammans. Helsingfors 2009. 24 s.
Social- och hälsovårdsministeriets publikationer 2009:5
ISSN 1236-2050 (print), ISSN 1797-9854 (online)
ISBN 978-952-00-2789-6 (inh.), ISBN 978-952-00-2790-2 (PDF)
URN:ISBN:978-952-00-2790-2

Strategin för patientsäkerhet godkändes vid ett möte av styrgruppen för främjandet av patientsäkerheten i december 2008 och social- och hälsovårdsministeriet offentliggör strategin den 29.1.2009. Strategin uppdateras av institutet för hälsa och välfärd och social- och hälsovårdsministeriet bekräftar uppdateringarna.

MISSION – verksamhetsidé

Vi främjar patientsäkerheten tillsammans.

VISION – målbild fram till år 2013

Patientsäkerheten är förankrad i verksamhetens strukturer och praxis: vården är effektiv och säker.

PERSPEKTIV

Kultur, ledning, författningar och ansvar.

MÅL

- Patienten deltar i förbättrandet av patientsäkerheten
- Patientsäkerheten hanteras genom förutseende arbete och erfarenhet
- Riskhändelser rapporteras, vi lär oss av dem
- Patientsäkerheten främjas systematiskt och med tillräckliga resurser
- Patientsäkerheten beaktas i forskningen och undervisningen inom hälsovården

Nyckelord: hälso- och sjukvård, sjukvård, strategi, patientsäkerhet

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PROMOTING PATIENT SAFETY TOGETHER

Finnish Patient Safety Strategy 2009–2013

Promotion of patient safety is a part of the quality and risk management in social and health care. The aim of this strategy is to guide Finnish social and health care to adopt a uniform patient safety culture and to promote its implementation. The strategy supports the Government in deciding and issuing legislation on patient safety matters. The strategy serves the social and health care organisations, patients, clients and their family members in the provision of safe and effective care and treatment. The strategy is implemented in both public and private social and health care.

The steering group for the promotion of patient safety appointed by the Ministry of Social Affairs and Health has drawn up this first Finnish Patient Safety Strategy. The National Institute for Health and Welfare is responsible for updating the strategy, and the Ministry will confirm the strategy.

1 BACKGROUND

Patient safety should be defined as a major objective in social and health care.

Patient safety constitutes the basis for the quality of health care and medical care. Safe care and treatment is provided in the right way and at the right time. It makes use of the available resources in an optimal way. In safe care efficient methods are used so that the treatment does not cause unnecessary harm to the patient.

Health care and medical care is multifaceted and it is a demanding task to provide it. Patient safety incidents are possible although the staff is skilled and committed to its work and the field well regulated. Patient safety encompasses the principles and functions that ensure the safety of the care and treatment of patients. It includes control of errors and prevention of harms from them. The most important concepts regarding patient safety are specified in Appendix 1.

In a care unit patient safety refers to those principles and functions that aim at guaranteeing the safety of care and treatment and protecting the patient from injuries. Promotion of patient safety is cost-effective activity. Experience shows that patient safety is best guaranteed by shifting attention from individual employees and errors to reducing harm to patients and by assessing and examining the service system and eliminating risks in it.

Patient safety has received international attention and is being developed. Health care actors, experts, patients' organisations and researchers in the field are engaged in the global patient safety movement. The Council of Europe has prepared the issue in an expert group on patient safety set up by its Health Committee. Within the EU patient safety has been on the agenda of e.g. the Commission's high-level group dealing with health services and medical care. Furthermore, the European Commission submitted in late 2008 a draft recommendation on patient safety including prevention and control of healthcare-associated infections. The recommendation will probably be adopted in June 2009 at the earliest. WHO has initiated a programme called "World Alliance for Patient Safety". The working groups for quality indicators of the OECD and the Nordic Council of Ministers are developing indicators for monitoring patient safety. Information on indicators is published in the OECD's and NOMESCO's (Nordic Medico-Statistical Committee) statistical publications.

As regards ensuring safety, health care is lagging behind other high-risk sectors. Many changes affecting patient safety are taking place in the service system and its operating environment. Medicine and technologies are developing at a rapid pace. The division of duties and responsibilities between the different professional groups is being reformed. The electronic patient record system will be introduced throughout the service system. Placing emphasis on efficiency will increase pressures at work since the staffing is often insufficient and employee turnover is high. Competitive tendering leads to decentralisation of production to several producers. The patients' freedom of choice in regard to the place of treatment will increase.

The Ministry of Social Affairs and Health has set up a steering group for promoting patient safety for a three-year period 11/2006–10/2009. The group has prepared the National Patient Safety Strategy. In addition, the steering group and the working groups under it have laid the foundation for the national patient safety work by evaluating, developing and furthering good operational practices that promote patient safety in Finland and by developing the system of reporting of errors and learning from them, as well as by influencing patient safety culture and the education and training of health care professionals. The national patient safety network serves as a discussion forum for disseminating information and as a contact point for the EU's patient safety network EUNetPaS. Patients' representatives are involved in the work of the groups.

II MISSION STATEMENT AND TARGET STATE 2013

MISSION statement

Promoting patient safety together.

VISION – target state by the year 2013

Patient safety will be embedded in the structures and methods of working: care and treatment is effective and safe.

III TOWARD SAFE AND EFFECTIVE CARE

In the present strategy, patient safety is dealt with from four perspectives: safety culture, responsibility, management, and legislation. The vision is to ensure safe and effective care and treatment. The objectives of the strategy are related to provision of information to the patient and empowerment of the patient, anticipation of risks, reporting of patient safety incidents and learning from them, and ensuring staff skills and adequate resources for the patient safety work. Figure 1 presents the essential content of the Patient Safety Strategy.

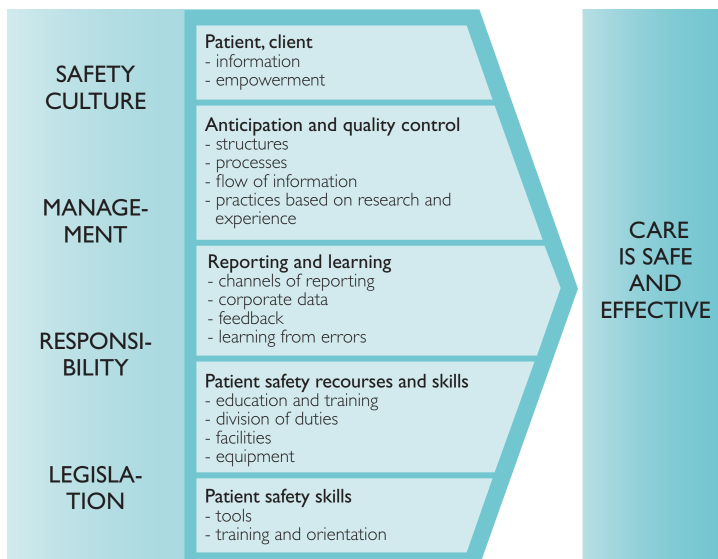


Figure 1. The essential content of the Patient Safety Strategy.

Safety culture

In health care, safety culture means that individuals and the community always act in a way ensuring the safety of the care and treatment received by patients. Patient safety culture involves a systematic way of working that promotes the safe care and treatment of patients, and the management, values and attitudes underpinning it. Patient safety culture encompasses risk assessment, preventive and corrective measures, and continuous development of activities. Risks related to care and treatment as well as harms to patients in the course of treatment can be reduced by reinforcing the safety culture. This presupposes assuming joint responsibility.

Errors, near misses and adverse events observed in a reliable and open atmosphere are dealt with in an open way as a part of development of the functions. Staff members, patients and their relatives have the courage to express their concerns and questions as well intervene in factors threatening safety that they notice in some activities or the care settings. The patients, their significant others and the professionals involved in the adverse events will be provided with support.

It is vital to improving patient safety to apply practices based on research and experience that have been jointly agreed upon. A multiprofessional way of working, an open atmosphere and a continuous development of activities are essential. The foundations for safety culture are already laid in the context of the education and training of professionals.

Responsibility

The leadership of the organisation bears the overall responsibility for patient safety. Patient safety is an issue of common interest to all the professionals working in social and health care as well as to patients. Professionalism essentially involves the responsibility of every employee and professional group for patient safety and their commitment to furthering it by assessing and developing their own work, skills and activities so as to be safer.

Management

The leadership of an organisation includes assuming, in a visible way, responsibility for patient safety and for securing the prerequisites for it in the unit. The management may not delegate this responsibility to any other body or person. The management should stress the importance of patient safety in all activities and ensure that the working conditions are such as enable the safe provision of care and treatment. It must ensure that the organisation has enough staff and that the employees have adequate skills and knowledge to carry out their work.

All decisions, including economic ones, must also be assessed from the point of view of patient safety. The responsibilities of both the management and staff for patient safety and the quality of services have to be defined in the unit.

The management bears the main responsibility for the analysis of safety risks and for preparing for risks. The management is also responsible for quality and risk management and for seeing to it that information on adverse events will be made use of in the development of teams, the whole of the organisation and the service system.

An essential principle in the promotion of patient safety is the no-blame policy. It is, however, possible that a patient safety incident is also dealt with from the perspective of supervision. The management of the organisation and the chiefs must ensure that the employees involved in the patient safety incident are provided support in all phases of examinations and possible consequences.

Legislation

The health care legislation requires that the activities must be professionally and scientifically appropriate, based on evidence and good care and rehabilitation practices, safe and of a high quality. A list of the central legislation related to the management of errors and patient safety is provided in Appendix 2.

IV OBJECTIVES

The patient is actively involved in improving patient safety

The patient, the client and his or her significant others must be involved in the promotion of safety in care. The patient has to be cared for in mutual understanding with him or her. The patient shall be heard and be involved in the planning and implementation of care. It is important that the patient gives the necessary background information. The patient should be encouraged to tell about his or her symptoms, hopes and concerns, as well as to ask questions relating to care.

The patient's empowerment presupposes access to adequate information and counselling. The patient shall be given information about his or her illness and its treatment, in particular medicines, in an understandable way. The risks and expected results of treatment must be discussed with the patient. This information must, if the patient so wishes, also be provided to a trusted person, relative

or significant other of the patient. The patient shall also be told whom he or she may contact in issues relating to patient safety.

In case an adverse event happens it must be told openly to the patient and, if he or she so wants, also to the patient's significant other. The event and possible consequences have to be discussed with them. Apologizing for the event contributes to openness.

In a confidential atmosphere patients have the courage and an opportunity to take up safety concerns that they have noticed. Those will be tackled rapidly and openly. Uniform procedures for the aftercare of adverse events help the staff to act openly. An analysis of the information on adverse events contributes to promoting openness.

By the year 2013

- The organisation will have procedures by means of which patients and clients can tell about the safety concerns they have observed and receive feedback on that.
- The organisation will have practices according to which the patients are told about risks linked with treatments.
- The organisation will have jointly agreed procedures for the aftercare of adverse events.
- The staff will have been made familiar with the patient safety procedures and practices through in-service training.
- Representatives of patients and patients' organisations will be included in groups for ensuring patient safety.

Patient safety is managed proactively and through learning

Patient safety is improved by quality and risk management. There are often hidden factors behind the patient safety incidents that should be disclosed before any adverse effects will emerge. Anticipation and analysis of different types of safety risks and intervention in them are important in the prevention of adverse events.

The possibility of general adverse events will diminish when the organisation applies good practices and policies based on research and experience that are safe and have been agreed jointly. A continuous development of structures, processes and information flow are essential means of reducing safety risks and the possibility of erring. Patient safety risks are related in particular to data management, organisational reforms and introduction of new technologies and new care practices.

By the year 2013

- The organisation will have a comprehensive risk and quality management system.
- The organisation will ensure staff skills and professional development.
- The organisation will make use of other actors' good patient safety practices.

Patient safety incidents are reported and learned from

A safe and high-quality organisation has clear procedures for the reporting, monitoring and handling of errors and patient safety incidents. Within an organisation patient safety incidents are learned from by reporting them in a certain way. The information that has been gathered will form local and regional feedback that will be dealt with by the management and staff on a regular basis. The aim of the low-threshold reporting is a continuous improvement of the quality and safety of care. Therefore, information about adverse events and near misses will be made use of in developing activities.

The organisation must have instructions for the reporting, handling and feedback regarding adverse events with serious consequences or that are otherwise significant. The principle of no-blame and of supporting the parties are prerequisites for learning from serious injuries and for their prevention.

The National Institute for Health and Welfare collects and analyses information on patient safety by means of national databases and registers. This information is made use of in national development and international cooperation.

The education and training of all health care professionals should include skills in reporting of errors and learning from them. The handling of report samples should be included in on-the-job training.

By the year 2013

- The organisation will have clear procedures for the internal reporting, monitoring and handling of errors and patient safety incidents.
- The organisation will observe the joint policy for national reporting.
- The organisation will use the national information on patient safety indicators for promoting patient safety.

Patient safety is promoted systematically and by means of adequate resources

The management of the organisation is responsible for the patient safety as a whole and for its implementation. All the parties involved in care are responsible for patient safety for their own part.

A specific patient safety plan is part of the larger whole of risk and quality management. The drawing up of the patient safety plan is the responsibility of the management. The management appoints the persons coordinating the patient safety work and enables their work according to the assignment.

By the year 2013

- The organisation will have drawn up a patient safety plan and appointed the persons coordinating the promotion of patient safety.
- Promotion of patient safety is a part of the action and economic plan.
- Professionals will observe in their work the central principles of promoting patient safety, apply its most important methods and make use of the available tools, handbooks and recommendations for patient safety promotion.

Patient safety is taken into account in health care research and teaching

Professional skills are a major prerequisite for the provision of safe care and treatment. Every health care employee is responsible for having adequate skills. The employer is in charge of ensuring that every employee has received adequate orientation and training in their tasks. In an open culture an employee has courage to admit that he or she does not know how to do something and to tell which tasks he or she does not master.

Patient safety promotion is an issue for the entire staff, not only for those involved in the care of patients. Promotion of patient safety must be a part of both basic and continuing education and training. The patient safety perspective must also be integrated into the work of professional and scientific organisations and into the education provided by them.

In health care it is important to learn from other risk-prone branches, such as aviation and nuclear power industry. Practices that are suitable to be used in health care, too, are found in these branches. Nevertheless, information must be gathered also through research on patient safety carried out in the health care field. Research enables seeking reasons for adverse effects and methods that improve patient safety and are cost-effective.

By the year 2013

- Patient safety will be taken into account in the orientation of all health care professionals employed in the organisation, in training of students, and in employee skills assessment. Particular attention will be paid to verifying the skills and competence of fixed-term employees.
- The organisation will have the resources for making surveys of patient safety promotion and take part in research projects in the field.

NATIONAL POLICY LINES

- The steering instruments are legislation and recommendations.
- The Ministry of Social Affairs and Health is in charge of drafting the legislation on patient safety.
- Agencies and institutions under the Ministry of Social Affairs and Health develop and coordinate patient safety at the national level. The performance agreements made with them specify their duties and the coordinating body.
- Development of patient safety and subsequent supervision by authorities are separate functions in administrative terms.
- The National Institute for Health and Welfare shall:
    - support the practical implementation of the Patient Safety Strategy and its embedding in different care units,
    - develop equipment and methods of work,
    - promote the research on patient safety,
    - monitor the development of patient safety by means of national indicators,
    - further national cooperation between social and health care organisations, and
    - take part in international cooperation in the field.
- Patient safety is incorporated in professional and vocational basic and continuing education in the social and health care sector, as well as in leadership training.
- Patient safety and the quality of health care are promoted by means of funding allocated to research.

APPENDIX I

A PATIENT SAFETY GLOSSARY

PATIENT/client

- A person using health and medical care services or otherwise being subject to them

HEALTH AND MEDICAL CARE SERVICES

- Measures to define the health state of the patient or to restore or maintain the patient's health. Those are carried out by health care professionals or in a health care unit or under the guidance or supervision of a health care professional.

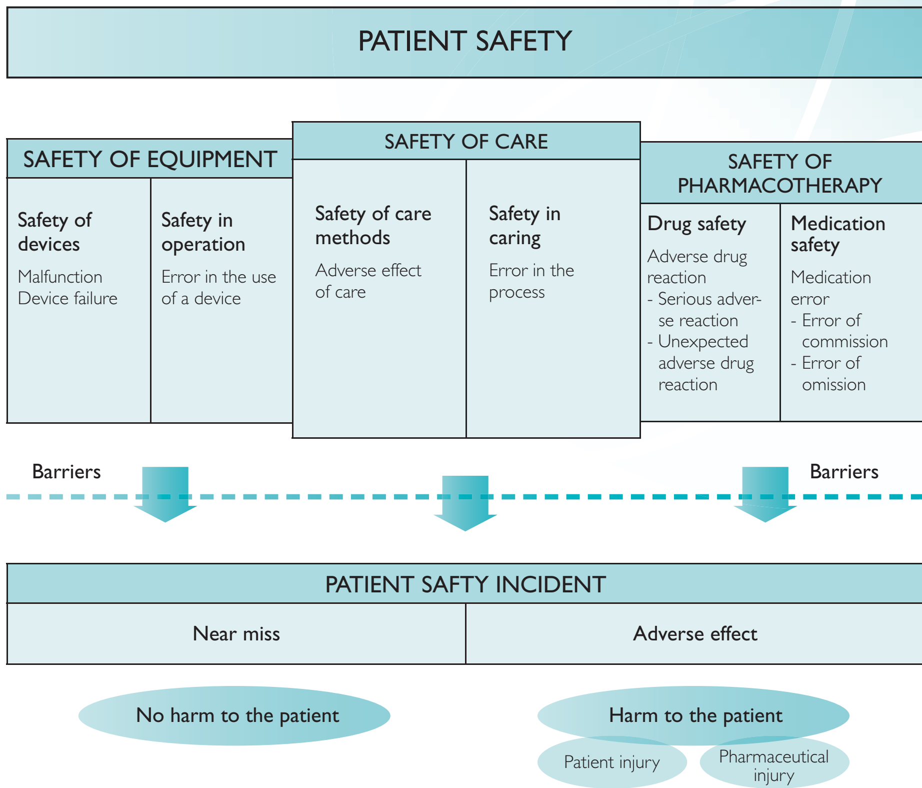
PATIENT SAFETY

- The principles and actions of individuals employed in health care and of the organisation for the purpose of ensuring patient safety and protecting the patient from being harmed;
- From the patient's point of view it involves that the patient receives the needed and correct care that will cause as little harm as possible;
- Covers the safety of care, medication safety, safety of equipment, and is a part of the quality of care.

PATIENT SAFETY CULTURE

- A systematic way of working that promotes the safe care of patients, and leadership, values and attitudes underpinning it. Includes risk assessment, preventive and corrective measures, and continuous development of activities.

Figure 2. Main concepts of patient safety (www.rohto.fi)



APPENDIX 2

A LIST OF LEGISLATION

- Constitution of Finland 731/1999
- Act on the Status and Rights of Patients 785/1992
- Act on Health Care Professionals 559/1994
- Patient Injuries Act 585/1986
- Personal Data Act 523/1999
- Act on the Openness of Government Activities 621/1999
- Language Act 423/2003
- Act on Restructuring Local Government and Services 169/2007
- Bill for a new Health Care Act. Memorandum of the Working Group Preparing the Health Care Act. Reports of the Ministry of Social Affairs and Health, Finland, 2008:28.

APPENDIX 3

WEB SITES ON PATIENT SAFETY

http://ec.europa.eu/health-eu > Patient safety
http://haipro.vtt.fi
http://www.coe.int
http://www.laakelaitos.fi
http://www.nom-nos.dk/
http://www.norden.org/social/sk/kvalitetsmaaling.asp?lang=&p_id=868
http://www.oecd.org
http://www.pvk.fi
http://www.rohto.fi
http://www.stm.fi > Strategies and projects
http://www.stuk.fi
http://www.thl.fi
http://www.valvira.fi
http://www.who.int/patientsafety

PUBLICATIONS OF THE MINISTRY OF SOCIAL AFFAIRS AND HEALTH
ISSN 1236-2050 (pb)
ISSN 1797-9854 (PDF)

2009: 1 Tarja Nieminen. Jämställdhetsbarometer 2008.
ISBN 978-952-00-2750-6 (pb)
ISBN 978-952-00-2751-3 (PDF)

2 Tarja Nieminen. Gender Equality Barometer 2008
ISBN 978-952-00-2752-0 (pb)
ISBN 978-952-00-2753-7 (PDF)

3 Edistämme potilasturvallisutta yhdessä. Suomalainen potilasturvallisuusstrategia 2009–2013.
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ISBN 978-952-00-2788-9 (PDF)

5 Promoting patient safety together. Finnish Patient Safety Strategy 2009–2013.
ISBN 978-952-00-2789-6 (pb)
ISBN 978-952-00-2790-2 (PDF)