What is happening in Patient Safety in Denmark?

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What happens where?

- National authorities
  1. Patient ”ombud”
  2. Extension of the Law of Patient Safety
  3. The Danish Accreditation Model

- Stakeholders
  1. A national research network
  2. Danish Regions: Get the Boards on board
  3. Professional organisations: Seminars for employee representatives

- Danish Society for Patient Safety
  1. Political strategic perspective
  2. Dialogue among stakeholders
  3. Best Practise globally
  4. Develop solutions
  5. Train and develop tools
  6. Projects
     - Partnership
     - Safer Hospital Initiative
     - Patient Safety and Hospital Design

The role of the Patient Ombud

- Entry point of all patient complaints
- New opportunities to file a complaint:
  - Professional services of the health care system
  - Test of patients ´ rights
- Serves as secretary for the Disciplinary Council, Patient Injury Appeals Board and the Medicine Appeals Board
- In charge of the reporting system for adverse events
- Combines knowledge from files of complaint and the reporting system when learning is shared
- A four week vindow for a local dialogue

Say Sorry

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The political perspective on Patient Safety

Macro level:

- Alignment with the poltical agenda in health care
- Integration of Patient Safety in other poltical initiatives

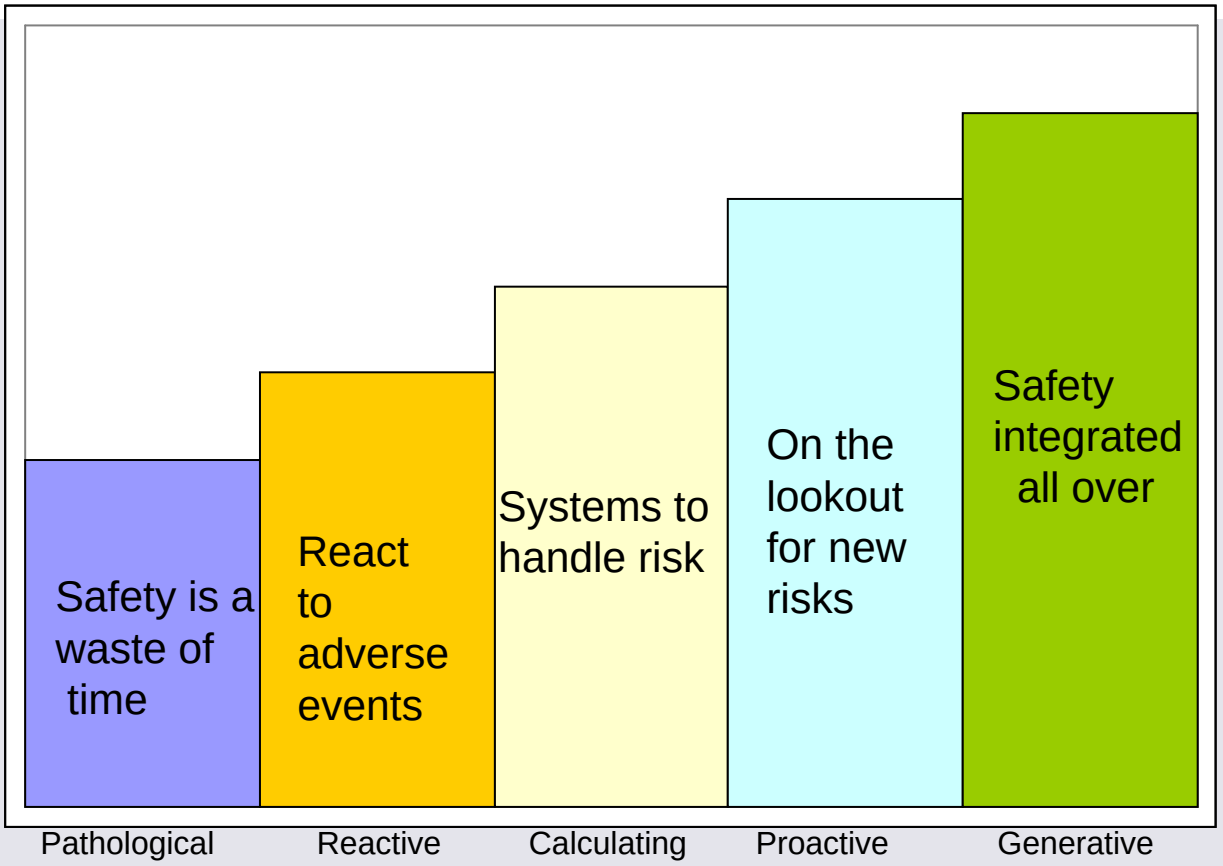
The Board and Patient Safety Council:

- Ownership
- Naming the priority of interventions by the Society
- Consensus formation on initiatives

Basic principle:
Make it easy to do the right thing

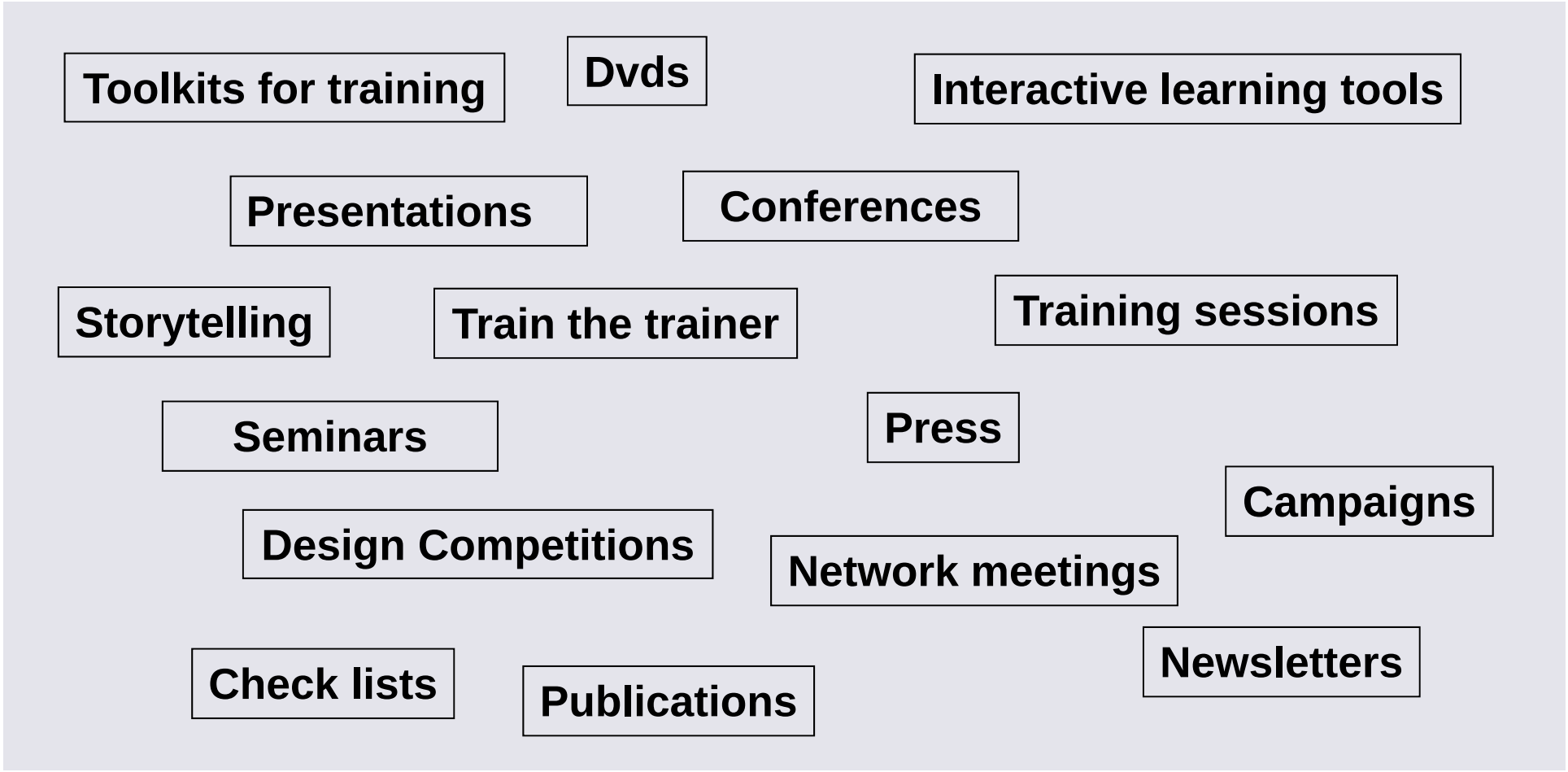
- Create motivation for change by
  1. Establish the burning platform
  2. Present the attractive alternative
- Build on and align with existing initiatives
- Disturb as few as possible
- Engage the stakeholders
- Test and adapt locally
- Adopt good ideas tested by others

How mature is the safety culture?

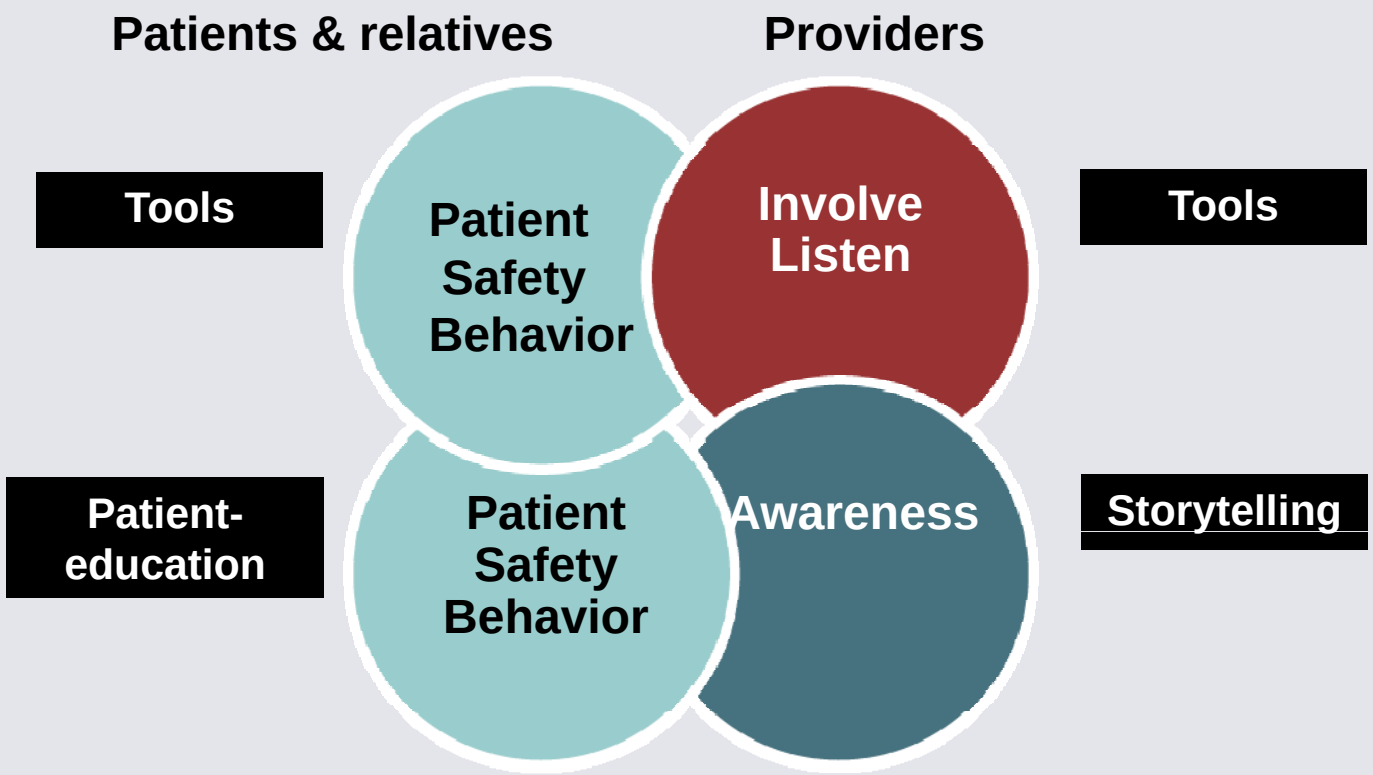


Ref.: The Manchester Patient Safety Framework (MapSaF). Dianne Parker, University of Manchester.

Methods for distribution



Focus of the Partnership project



Patientsikkert Sygehus

Aims

Aims:

- 15% reduction in mortality (30 days)
- 30% reduction in unintended harm (measured by GTT)

Examples of intermediate aims

- 50% reduction in pressure ulcers
- 30% reduction in unexpected cardiac arrests at general wards
- 20% reduction in the postoperative mortality rate
- 20% reduction in readmissions after surgery
- Eliminate respirator-related lung-infections, min. 300 days between each case
- Eliminate CVC-infections, a minimum 300 days between each case

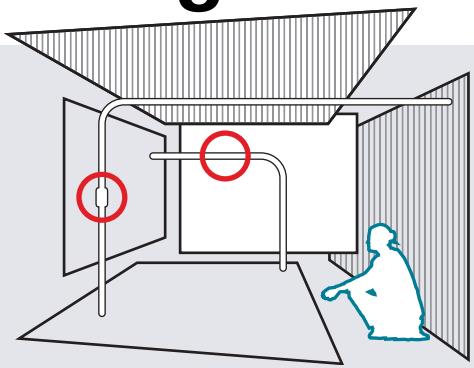
Five tracks

- Leadership
- Intensive Care
- Inpatient wards
- Medicine handling
- Surgery

Patient Safety and Hospital Design

Publications:

- Orden og oprydning
- Selvmordsforebyggelse
- Kommandobroen
- Faldforebyggelse



An adverse event

A patient admitted to a closed ward is found lifeless hanging in a curtain which was fastened to pipes.

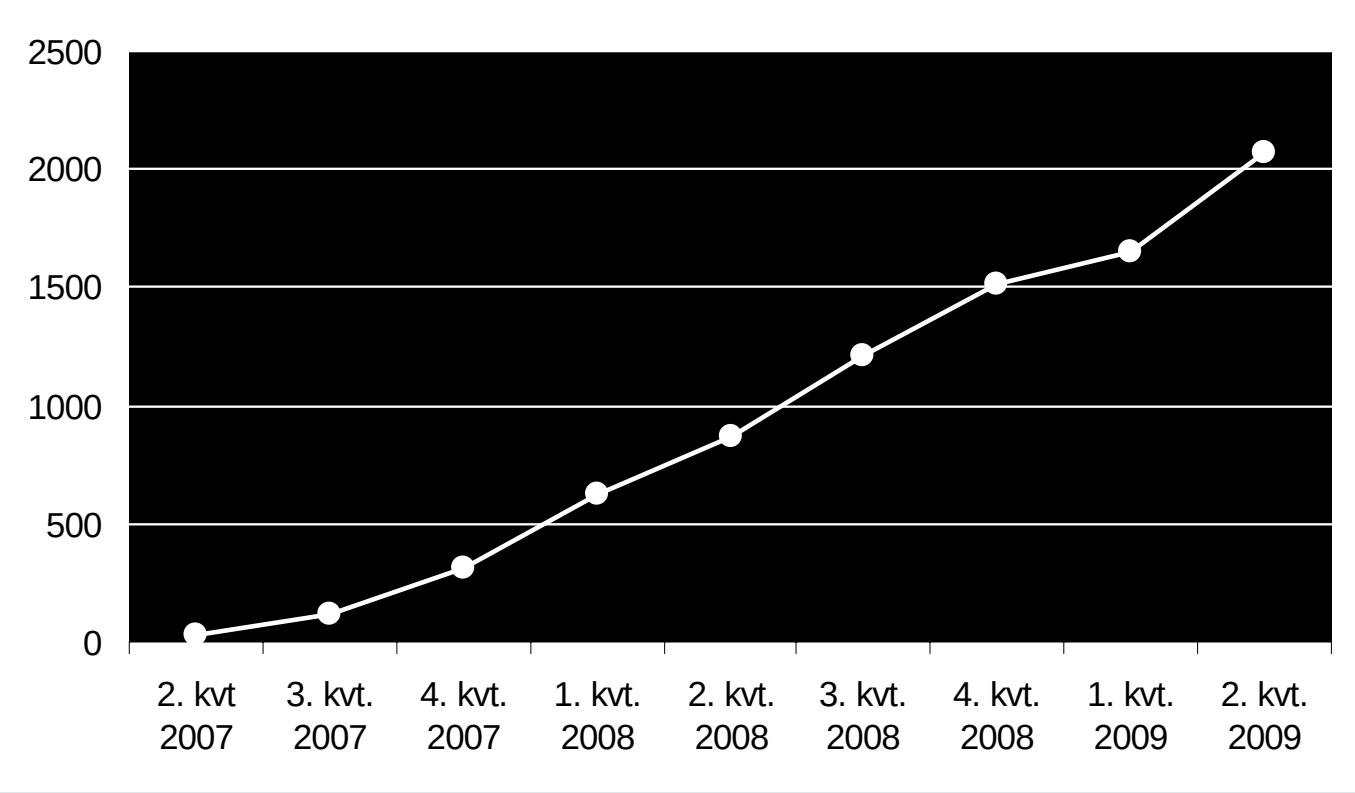
Suggested initiatives

Pipes should be concealed.

Search words

Suicide resistant products, *ceiling grid* and *ceiling tiles*.

Operation Life results



Safe Surgery
DSFP's collaboration with clinical departments

Material:

- Guidelines
- Movies
- Posters

Meetings/presentations
Telephone conferences
Construction of compliance-chart and –graphics

www.patientsikkerhed.dk

Safe Surgery: Postoperative mortality

Næstved Hospital, 2008 - 2010