Experiences from the Danish Confidential and Non-Punitive Adverse Event Reporting System

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Extended abstract

Summary
The main purpose to this presentation is to review key experiences and recommendations from the world's first nation-wide non-punitive adverse event reporting system. In addition, we will outline the major features of the next generation of the reporting system to be introduced in 2010. After six years of operation, a number of lessons have been made with regard to finding a proper balance between central and local efforts and how to optimize safety management resources. The authors will review data about experiences gathered both at the local and the central level of dealing with adverse event reporting and learning.

Methods:
The Danish Act on Patient Safety, enacted in January 2004, is the first confidential, non-punitive and mandatory national system for the reporting of and learning from adverse events in healthcare was introduced. The explicit purpose of the reporting system is to learn from adverse events – not to punish healthcare staff so that lessons may benefit future patients. The law explicitly protects healthcare personnel from sanctions by stipulating that no health care person can be "subjected to investigation or disciplinary action [based on a report of an adverse event] by the employer, the Board of Health or the Court of Justice."

To perform the present review data were analyzed derived from (a) surveys of the perception of risk managers and health care staff, and (b) statistics and summaries from the Danish Patient Safety Base. In addition, information from the development and planning of the new reporting and learning system has been collected and analysed.

Results
The reporting system is two-tier system where clinics, hospitals and hospital owners (primarily local authorities, i.e., counties or regions) collect reports and provide feedback at the local level to staff members who have submitted reports. After de-identification of reports, they are then

sent by the local authorities in anonymous form to central Board of Health and collected in the Danish Patient Safety Database.

Results show that at the local level there is a high degree of confidence in the confidentiality of the system, that the current classification system (taxonomy) of events needs improvement and, perhaps most importantly, that efforts spent on classifying reports in terms of taxonomic classes are not seen as an efficient way of promoting learning and patient safety improvements.

Future perspectives

While the overall objectives and policies behind the reporting system remain the same, three major changes are being implemented for an updated system: first, reporting is extended to include the primary sector, specialist clinics, and care centre; second, a event classification system (the International Patient Safety Event Taxonomy initiated by the World Health Organization) is implemented, and finally, a structured learning system is developed to facilitate knowledge sharing about interventions, follow-ups and effects.