Dansk Selskab for
PatientS!kkerhed
Danish Society for PatientSafety

Up-stream: Improving Safety and Quality in Community Care across Denmark

Inge Kristensen

Vibeke Rischel

PS!

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Some facts about Denmark to set us off…

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Photos: unsplash.com

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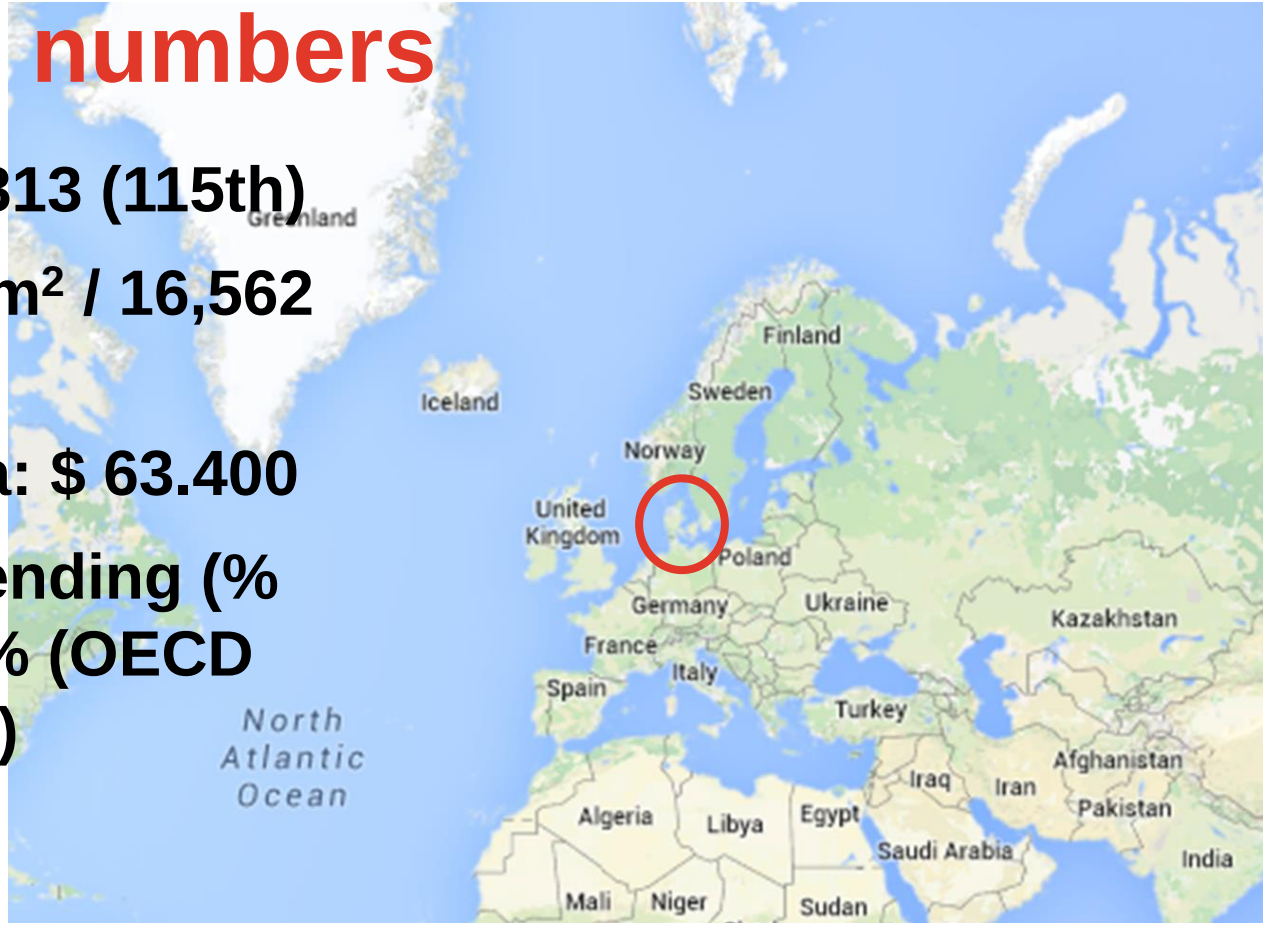
Denmark in numbers

- **Population: 5,813 (115th)**
- **Area: 42,916 km² / 16,562 mi² (133rd)**
- **GDP per capita: $ 63.400**
- **Healthcare spending (% of GDP): 10.9 % (OECD average: 9.3 %)**



Organization of the Healthcare System

National Level

Ministry of Health

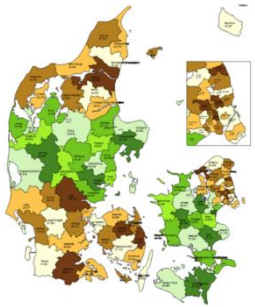
Regional Level

5 Regions

Local Level

98 Municipalities

The Danish Healthcare
Who is responsible for what?



State
- Legislation
- National health care policy
- The overall framework of the health care economy
- Specialty planning

Municipalities
- Home care
- Rehabilitation services outside hospitals,
- Treatment of drug and alcohol abuse
- Prevention and health promotion
- District nurses
- Children's dental services

Regions
- Hospital (somatic and psychiatric, in- and outpatient)
- Primary healthcare contracts (GP, specialists in private practice, adult dental services, physiotherapists, psychologists, chiropodist, chiropractor)
- Reimbursement of medicine

Community care in 98 local governments

- Community care aims at rehabilitation and selfcare
- Most elderly live by themselves
- 24 h open service of nursing and social care in private homes up to 8 visits a day depending on the need of care.
- 24 h services in residential and nursing homes.

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NGO

Since 2001

25 employees

Patient Safety and
Quality Improvement

Financially supported by
health care providers,
foundations and activities

Board

Danish Act on Patient Safety 2004

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

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.

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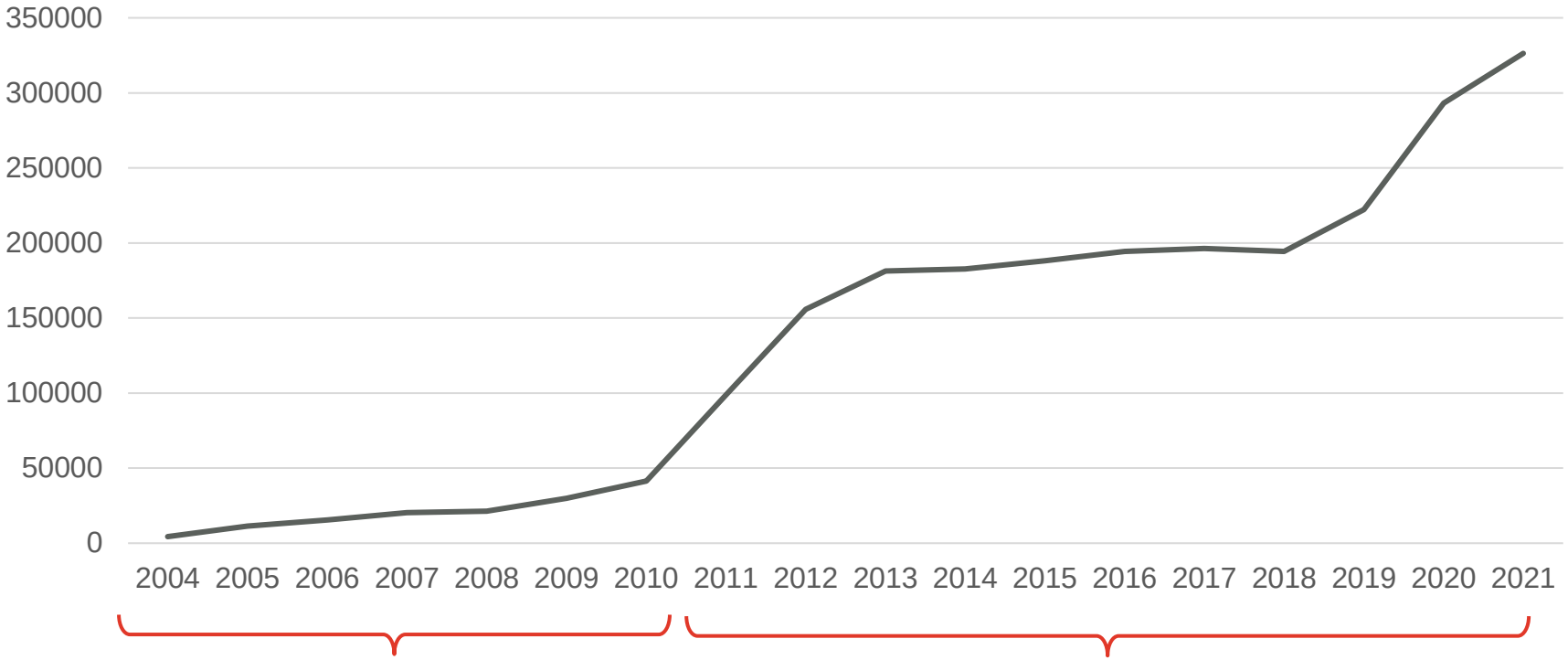
Reports of patient safety incidents, 2004-2021 in Denmark



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What do you think are the key factors of safety and quality programs in community care ?

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What do you think are the key factors of safety and quality programs in community care ?

ⓘ Start presenting to display the poll results on this slide.

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Describe the key factors of safety and quality programs in community care

Example 1

In safe hands 2013 - 2023

Danish Society for Patient Safety
The Danish Ministry of Health
Local Goverment Denmark

I sikre hænder

15 years of National Program Improving Safety

Patientsikkert Sygehus

Sikre fødsler

S!kker Sammen—hæng

I sikre hænder

S!kkert Seniorliv

Sikkert Patient Flow

Sikker Psykiatri

Background

- Increased life-expectancy
- Care moving from hospitals to community
- Multi-morbidity increasing the need of care
- (Lack of) Staff

Improving care for the most vulnerable

Receiving nursing and social care at home

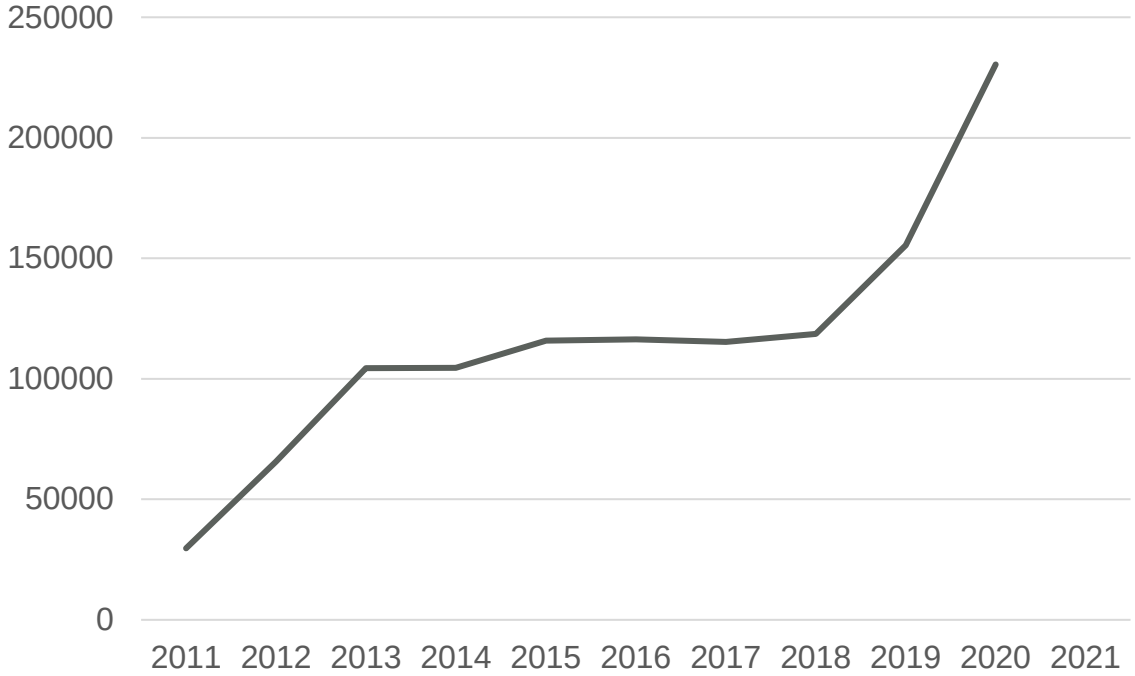
- 11,1 % > 65 years
- 29,8 % > 80 years

Living in residential homes

- 3,3 % > 65 years
- 0.6 % 65-69 years
- 16,1 % > 85 years

https://www.vive.dk/da/udgivelser/vives-kommunetal-20205-faerre-hjemmehjaelpstimer-til-aeldre-isaer-uden-for-hovedstadsomraadet-15076/
https://sundhedsdatastyrelsen.dk/da/nyheder/2020/plejehjemsbeboere_161220

Reports of patient safety incidents in community care



Reports in 2020

Incidents:
67,7 % medication
22,7 % falls

Severity of harm:
None 71,2 %
Low 24,5 %
Moderate 4,3 %
Severe 0 %

https://stps.dk/da/udgivelser/2021/aarsberetning-for-dansk-patientsikkerhedsdatabase-2020/~/media/34B5512CA00544F1B69B22918D2249DB

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Evidensbased bundles of care

- Elimination of **Pressure ulcers**
- Reduction of **Falls**
- Safe and reliable **Medication processes**
- Reduction of **Infections**
- Improvement of **Nutritional status**
- Early recognition of **Deterioration (EWS)**
- Partnering with patients and families
- Leadership

Days without pressure ulcers

100 days:
59 units

200 days:
47 units

300 days :
30 units

500 days:
nits

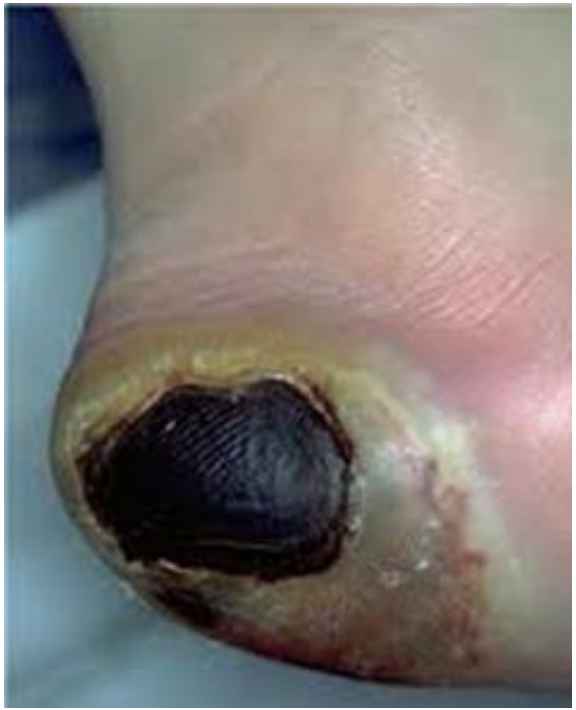
600 days :
6 units

Harm Eliminated

Unit = one nursing home, residential home or homecare service

Reducing harm and saving money

- Using the PUB caused a **63% reduction** in the incidence of pressure ulcers in the municipality of Sønderborg. Furthermore, the overall costs associated with pressure ulcers in the municipality decreased, despite the implementation of preventive measures.
- For **each** pressure ulcer prevented using the PUB, the municipality has effectively gained 8153 DKK (1100 eur/ 940£) can be used elsewhere.



Reference:https://www.isikrehaender.dk/media/2486/business-case-tryksaar-ish.pdf

Days without medication errors that requires visit at GP or acute care

100 days :
39 units

200 days:
25 units

300 days :
20 units

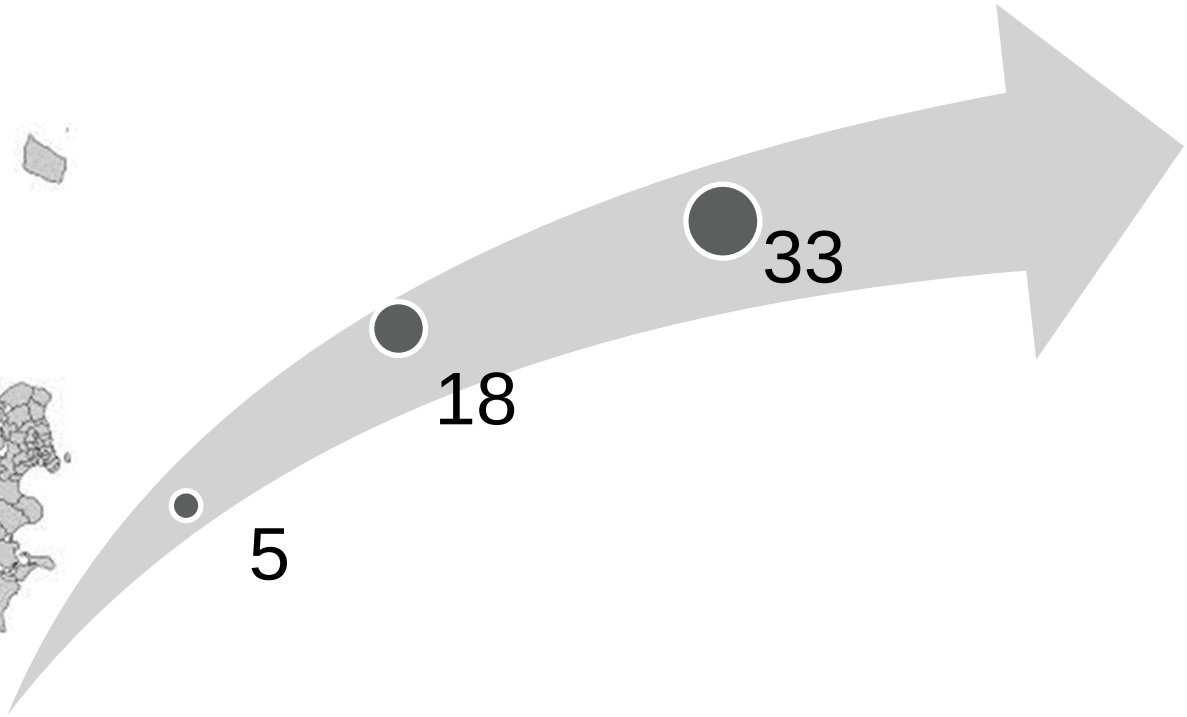
600 days:
4 units

Harm Redution in more than 50%

Unit = one nursing home, residential home or homecare service


Bolig 2.10-2.12
Bolig 2.13-2.15

From 5 to 98



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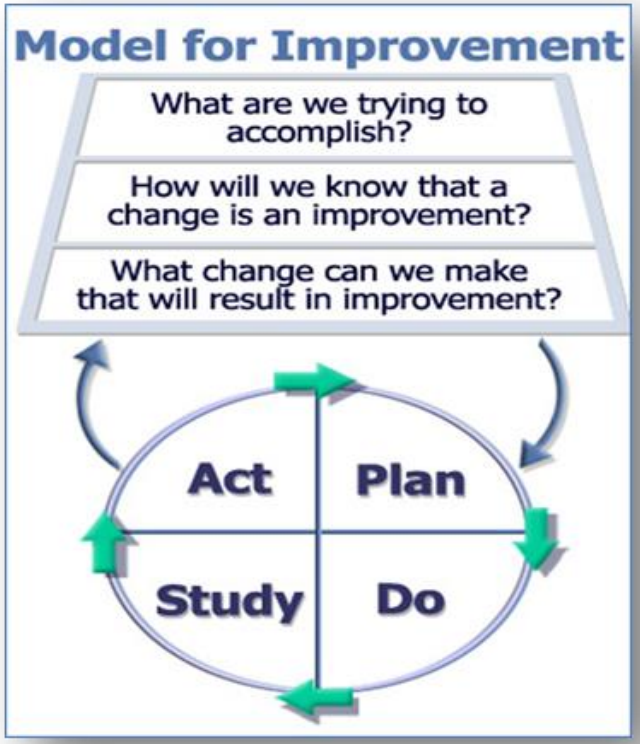
Aims I Sikre Hænder 2019 - 2023

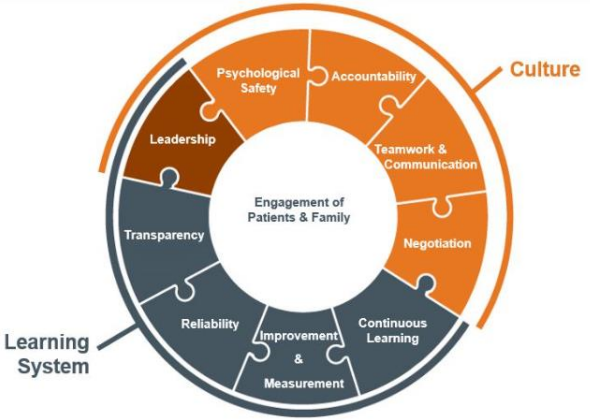
- The right and safe care for the right person at the right time
- Reduce the numbers of harms and improve out-comes
- Promote safety culture
- Promote learning system
- Create sustainability & strategy for scale up

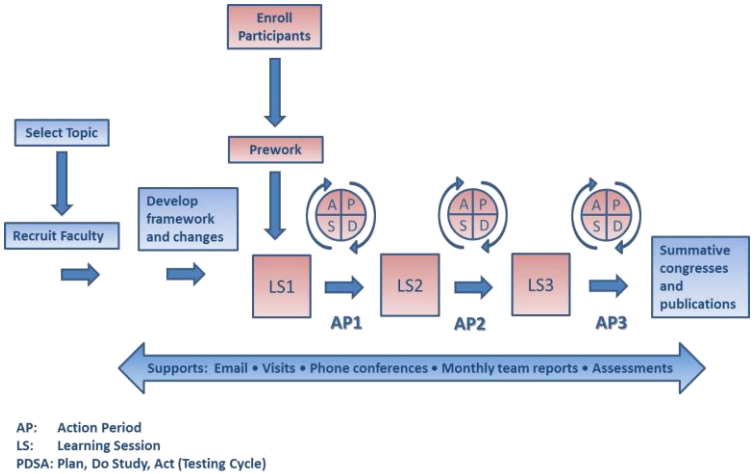
Understand the context – QI in community care

- Private home vs institution
- Care delivered by individuals vs by a team
- Each visit finalized before the next is started vs simultaneous process
- Scheduled workflow vs adapted to situation

Reliable use of methods







Reference: IHI.org

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Wonderful
Copenhagen

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Describe the key factors of safety and quality programs in community care

Example 2

15 years of National Program Improving Safety

Patientsikkert Sygehus

Sikre fødsler

S!kker Sammen—hæng

I sikre hænder

Sikkert Patient Flow

S!kkert Seniorliv

Sikker Psykiatri

“In Safe Hands” – outside Health Care

”Safe Medication in housing for people with physical and mental disability”

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Improving care for the most vulnerable

Housing for people with disability

- 24.000 people
- 7780 places
- Under the act of social services
- Highly multidisciplinary (mostly non-healthcare stafff)

Søparken

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The pioneers

Sådan er vi lykkes med 2200 dage uden alvorlige medicinfejl

Bofællesskabet Albo i Bjerringbro har i en årrække arbejdet med sikker medicinhåndtering og skabt både nye arbejdsgange og en ny kultur. Nu høster de frugterne.

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Understand variation

420 medication-procedures in 4 patients

Bundle and tools for safe medication

Medicinprocessen

Modtagelse af medicin-ordination	Bestilling af medicin	Modtagelse af medicin	Opbevaring af medicin	Ophældning af medicin	Givning af medicin	Observation af virkning og bivirkning	Bortskaffelse af medicin
Arbejdsgange	Arbejdsgange	Arbejdsgange	Arbejdsgange	Arbejdsgange	Arbejdsgange	Arbejdsgange	Arbejdsgange

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Hvad vil vi undersøge: Årsager til at borger ikke får rette medicin til rette tid	Borgeren ville ikke samarbejde	Travlhed med andre opgaver	Der er fejl i den ophældte medicin	Borgeren var ude af huset	Borgeren sov	Tidspunkt passer ikke med borgerens rutiner				Andet

Hvordan gør I?

1. Vælg et område, der er vigtigt ift medicinfejl
2. Skriv kategorier i de hvide bokse
3. Hæng sedlen i et lokale, hvor personalet ser den.
4. Bed personalet om at sætte krydser i relevant kolonne, når de oplever problemet
5. Bed personalet om at skrive en note, hvis de sætter kryds i "Andet"
6. Når der er sat krydser ca. 20 krydser, kan i kigge på hvilken kategori, der har fået flest krydser

Aims to reduce medication errors and increase collaboration…

A larger barrier than anticipated…

- Enhancing collaboration and understanding between social workers and health care workers

Social pedagogy vs health care

- Knovledge about and working with people
- Relations
- Indenpendent
- Self-determination

- Components of need theory:
  - Breathe normally.
  - Eat and drink adequately.
  - Eliminate body wastes.
  - Move and maintain desirable postures.
  - Sleep and rest.
  - …….

Results - clinically

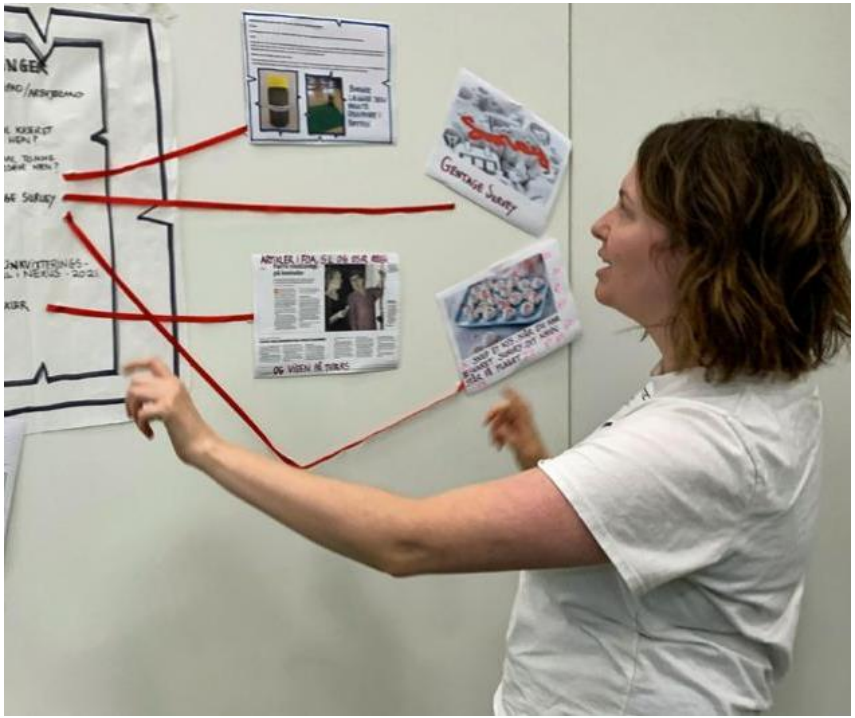
That several units have experienced a significant reduction in the number of medication errors, where it was necessary to call a doctor

One unit has e.g. 55 days without medication errors.

Reduction in delays of medication

Results - culture

- A strengthened patient safety culture, where active and systematic work is now done with reporting and learning of adverse events and medication errors



Results - collaboration

A STRENGTHENED PROFESSIONALISM AND EMPLOYEE SATISFACTION ON THE HOUSING OFFERS IN THE FORM OF A STRENGTHENED SENSE OF RESPONSIBILITY, CITIZEN INVOLVEMENT AND KNOWLEDGE ABOUT MEDICATION MANAGEMENT AMONG NON-HEALTH PROFESSIONAL STAFF

INCREASED INTERDISCIPLINARY COLLABORATION BETWEEN HEALTH PROFESSIONAL AND NON-HEALTH PROFESSIONAL STAFF WITH THE RESULT THAT THE WORK HAS BEEN STRENGTHENED AROUND MEDICATION FOR CITIZENS ON SOCIAL WORK HOUSING OFFERS

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Describe the key factors of safety and quality programs in community care

Example 3

15 years of National Program Improving Safety

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I sikre hænder

S!kkert Seniorliv

Sikkert Patient Flow

Sikker Psykiatri

Co-creating population health

- There are healthcare issues that professionals cannot solve alone.
- Co-creation requires an openness about the approach.
- The synergy includes ideas and solutions that neither healthcare professionals nor volunteers could have come up with alone.

80-year old Red Cross volunteer presents driver diagram at workshop

Volunteers, healthcare workers and leadership developing interventions - doing PDSAs together

Understanding variation - by age

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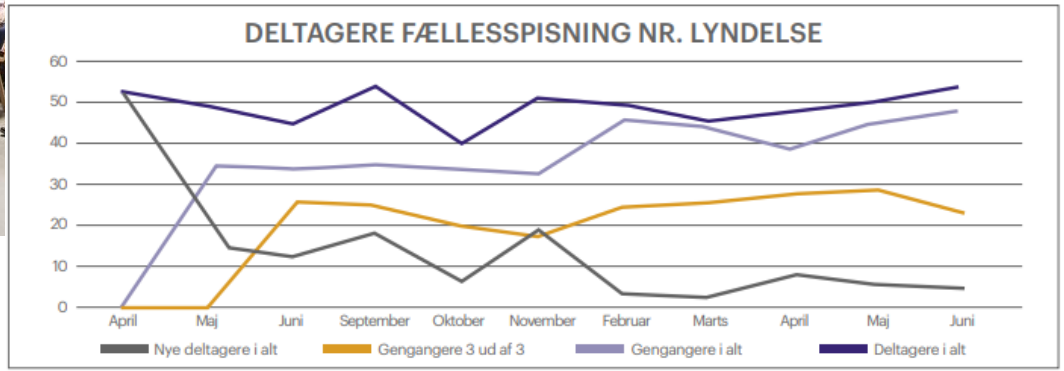
Data collection at the point of care – shared dining



Why do you attend shared dining?

- It is sad to always eat alone.
- I get to know new people, and now I enjoy meeting people at the supermarket. Because we have something to talk about.
- I needed to see other people, and it is nice to eat together with others.

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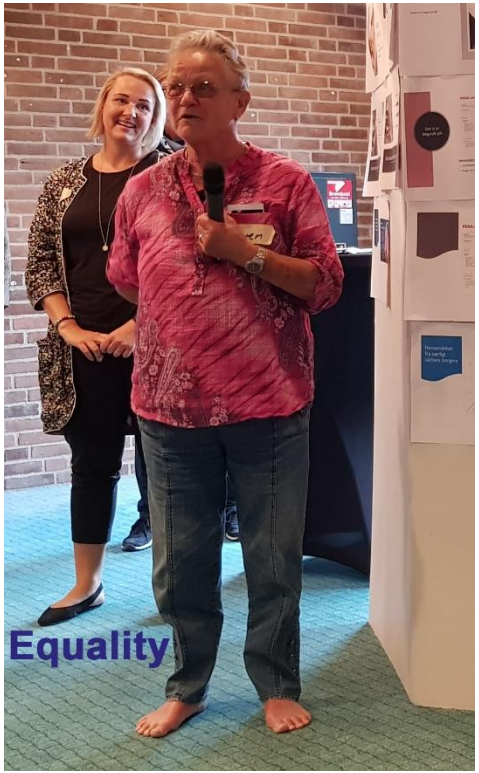
Co-creation the way to improve population



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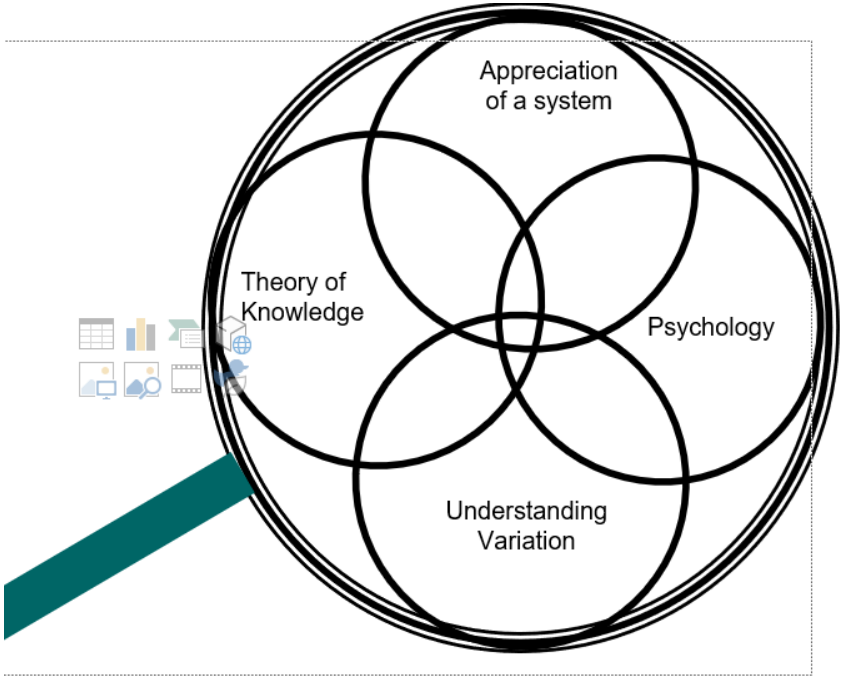
Key factors ~ Deming's System of Profound Knowledge

- Baseline data of (a) problem(s)
- Evidensed based intervention that can improve out-comes
- Will to change
- Capacity to change



Ref. Langley et al, 2009

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”No data No Problem”

”No Problem No Action”

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What do you think are the key factors for building will in multidisciplinary teams?

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Identify the core components to build will in multidisciplinary teams and settings

Film 3, Søparken

Build capacity to improve

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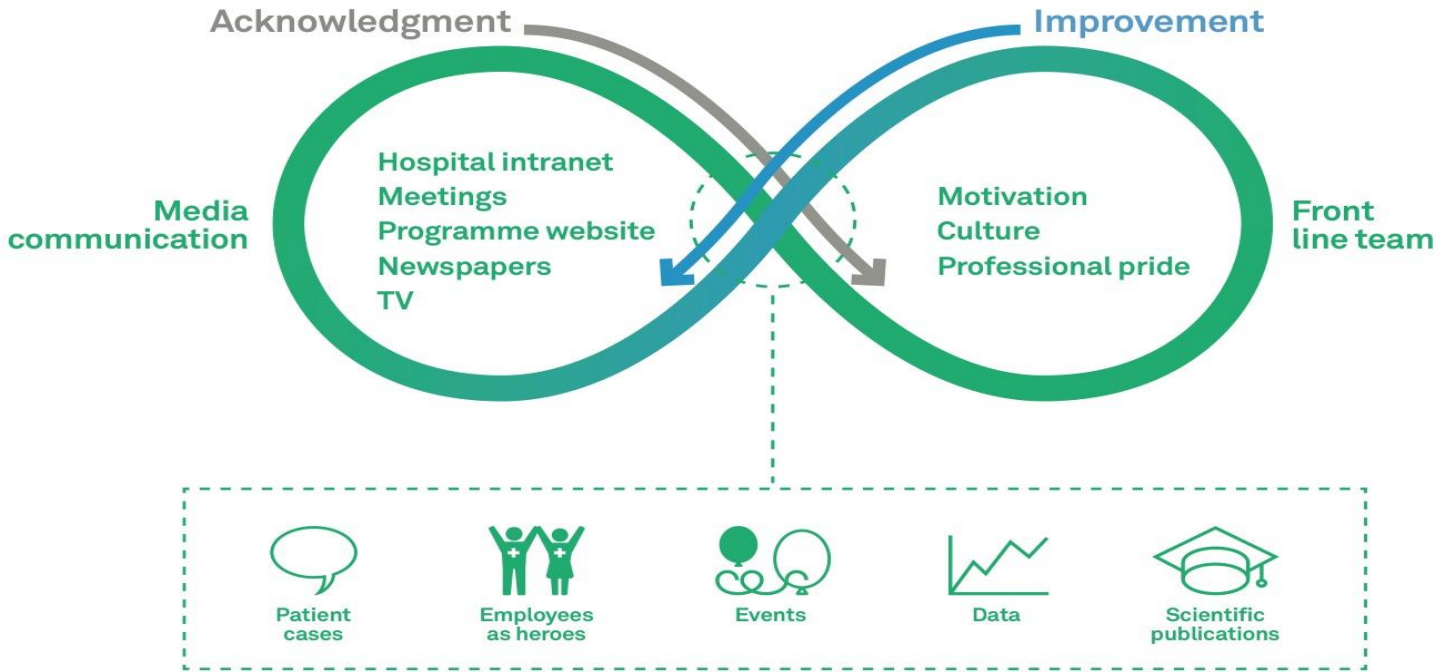
FORBEDRINGSIDEER
DELEGATION
TILGÆNGELIGHED
PROCESANALYSE - ARBEJDSGANGE
PROBLEMSTILLER UNDER MEDICINADMINISTRATION
SURVEY
UTH LAPLINE
Pixi - 2022.
HANDLINGER
GENTAGE SURVEY
MEDICINKVITTERINGS-MODUL I NEXUS - 2021
ARTIKLER
GENTAGE SURVEY
Patientsikkerhedskalender
1 2 3 4 5 6
7 8 9 10 11 12
13 14 15 16 17 18
19 20 21 22 23 24
25 26 27 28 29 30
31
BELØNNING VED 1 MÅNED UDEN UTH

Transparency

Communication – part of the execution



#QiComms

patientsikkerhed.dk/qicomms/

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Celebrate the results!

Take home messages

Those who make change, are those who touch patients.

Build on the will and engagement of frontline staff

Scale up on QI capacity and leadership

Scale up on QI methods rather than care-bundles

Engage with service users/patients – co-creation

Respect and take different professions into account

Thank you – see you in Copenhagen 2023

- **International Forum on Quality and Safety in Healthcare: Copenhagen (May 15.-17. 2023)**

internationalforum.bmj.com
@QualityForum

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Thank you!

PLEASE SUBMIT YOUR FEEDBACK

Join at slido.com
#quality2022