

Health Services Patient Safety: A Priority with Multiple Dimensions

Including a first look at the impact of Covid-19

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BACKGROUND INFORMATION

The International Society for Quality in Healthcare (ISQua) and the International Hospital Federation (IHF) have a long history of collaboration. This included representatives from one or the other organisations attending meetings on behalf of both organisations and reporting back to both. It also has become common for both organisations to prepare a joint statement for WHO meetings. In the spirit of this collaboration it was agreed that a concurrent survey would be held by the two organisations. The results would be shared and used to prepare a report.

This survey was designed to frame the WHO Global Consultation on Patient Safety [here after: *the WHO Global Consultation*], which was held from 24 to 26 February 2020 to kick off the development of the Global Patient Safety Action Plan. Already then, the pandemic-to-be was affecting various regions, before striking health systems worldwide. The question of patient safety is a critical one in the discussion about Covid-19: hygiene & hospital-acquired infections, non-suitable hospital architecture, delayed surgeries & procedures, lack of personal protective equipment (PPE) and much more affected the safety of patients as well as of health workers, to whom the [World Patient Safety Day 2020](#) [here after: WPSD 2020] is dedicated.

In February 2020, the IHF disseminated a short survey on national safety plans to its Full Members, hospitals' national / regional representatives. At the same time ISQua disseminated their survey asking how well incident reporting is in place, and if the outcomes improve the 'no blame no shame' approach to their Individual and Institutional Members.

The surveys were repeated in July 2020 to see if the onset of COVID-19 had made any positive or negative changes to the responses.

KEY POINTS

- A safety culture is critical for the protection of staff and patients.
- Psychological Safety for healthcare workers is an essential requirement of all safe health systems
- People (patient & health worker) safety is inherent in healthcare and Coproduction is the foundation of all initiatives .
- Measurement of what works well is essential so that there can be learning at all levels.
- Reporting of clinical incidents is a vital part of learning and needs to be undertaken within a just culture which is blame free, with clear accountability.
- The COVID-19 pandemic revealed experiences of good practice and areas where health services need to improve , particularly in the protection of staff and looking after their mental wellbeing.
- Crisis management is a critical part of health services management
- Managing the flow of people through the service is important to control infection.

IHF SURVEY

INTRODUCTION

In January, we send a survey to our Full Members (national / regional health service providers organizations) to question them about their patient safety frameworks. If they had such national / regional measures, we asked if they identified any gaps in their plans, and if some dimensions should be discussed during the WHO Global Consultation. If not, the respondents were asked which other measures were taken in hospitals regarding patient safety, and if a global plan or strategy was in planned or in process.

With the Covid-19 pandemic striking health system and societies worldwide in the following months, a simple report about this initial survey would not have allowed to account for the underlying dynamics around the safety culture, which was challenged during this crisis. In order to complement our initial report, two versions of a new survey were disseminated to the IHF Full Members: one for those who already took the survey early 2020, and another “two-in-one” version for those who did not. The second survey explored the – potential – impact of the Covid-19 pandemic on the perception of patient safety: was there going to be a revision of the national / national measures? Were some major gaps and crucial dimensions of patient safety identified during the crisis? And finally, what about health workers safety?

RESPONDENTS

Out of 31 countries / territories represented, we received 18 replies to the first survey and 17 to the second. Four countries / territories that did not participate to the initial survey responded to the second one; six countries / territories that participated to the first survey did not participate to the second one; twelve countries responded to both surveys. Some members may not have taken part in this research because they were too busy with the Covid-19 crisis. It may also have been too early to evaluate the impact of the pandemic on national/regional patient safety frameworks. Therefore, a similar survey could be launched by the end of the year or in the course of 2021 and bring some additional results.

	Countries/territories	Total
First Survey	Australia, Austria, Brazil, France, Germany, Indonesia, Japan, Republic of Korea*, Lebanon*, Morocco*, Netherlands, Norway*, Oman, Portugal*, Spain, Taiwan, UK*, USA	18
Second Survey	Australia, Austria, Brazil, Canada**, Finland**, France, Germany, Hong Kong**, Indonesia, Japan, Jordan**, Netherlands, Oman, Philippines**, Spain, Taiwan, USA***	17
Total	Australia, Austria, Brazil, Canada, Finland, France, Germany, Hong Kong, Indonesia, Japan, Jordan, Republic of Korea, Lebanon, Morocco, Netherlands, Norway, Oman, Philippines, Portugal, Spain, Taiwan, UK, USA	23

**only participated to the first survey*

***only participated to the second survey*

****responded that it was still too early to draw lesson & could currently not take the survey. This, however, was a relevant indicator and could be used for some of the analysis.*

The report below highlights the main results from our surveys. Through the results, we were able to obtain an overview of the types of national and / or regional strategies for patient and safety, the diversity of strengths and gaps within each of them, especially in times of Covid-19, and the importance of health workers safety.

NATIONAL / REGIONAL FRAMEWORKS

Most of our respondents (78%) have some type of national policy for patient safety implemented or created under the initiative of the government or a national agency. Out of the other 5 countries / territories, 2 are using national standards or key indicators as a roadmap, two favor regional or cluster approaches, and one follows the WHO Patient Safety Friendly Hospital Initiative. Among these 5, 2 are in process of creating their national Patient Safety Plan.

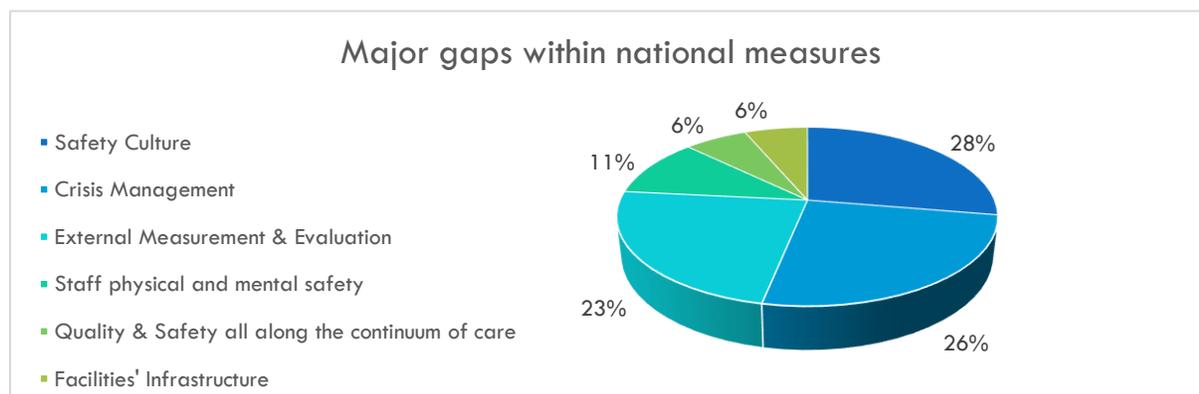
A more in-depth research could be dedicated to the diversity of each national framework, the monitoring and evaluation of the implementation and compliance, as well as to the nature of the competent authority. Among the questions raised, was the importance of having an objective and external assessment regarding quality and patient safety processes, hence the emphasis on accreditation standards and accreditation organizations within the responses.

In the second survey, out of 13 countries/territories having national measures for patient safety, 11 stated that their framework was regularly updated, currently under revision, or had a full revision scheduled. 3 had no revision scheduled yet, mainly because their plan/strategy was already comprehensive enough.

MAJOR GAPS

15 out of the 23 (65%) participating organizations believed that there were gaps within their national framework. 3 respondents that participated to both surveys stated in February that there were not any major gaps, but then identified some in July, following the Covid-19 crisis experience.

In the first survey, the responses were mainly related to measurement and evaluation processes, as well as to a better implementation of a safety culture. In the second survey, as could be expected, responses were much more related to the experience of the crisis: preparedness for crisis situation; psychosocial support (mainly for staff); importance of quality and safety in elderly care facilities/units, home care, mental health facilities, just to name a few.



After a first analysis, we simplified the respondents' responses into 47 key words, which can be summarized under 6 categories:

SAFETY CULTURE (28%)

"Basic" (patient) safety-related practices and processes should be further implemented through organizational management and leadership. These include the identification of good practice and better training, recognition and incentives for health professionals, safety culture implementation, patient involvement, and error reporting systems.

CRISIS MANAGEMENT & SAFETY (26%)

Second, crisis management and safety should be better addressed, through better preparedness and multiprofessional teamwork. The clinical processes to make ethical decisions regarding prioritization of essential services and resumption of delayed procedures remains unclear. Finally, the use of telemedicine was one of the opportunities which transformed care during the pandemic, and it should be further incorporated with policies and guidelines.

EXTERNAL MEASUREMENTS & EVALUATION (23%)

This category, which was mainly present in the responses from the first survey, is related to safety practices / processes measurement and evaluation, through external assessors. A good governance is also called for, to standardize indicators and benchmarks throughout the nation, in order to lead relevant regional monitoring.

STAFF PHYSICAL AND MENTAL SAFETY (11%)

This has always been an issue, and yet this crisis allowed to underscore this critical aspect more than ever. A genuine and comprehensive support

must be in place for healthcare workers to ensure their safety, in order to optimize the safety of patients.

QUALITY & SAFETY ALL ALONG THE CONTINUUM OF CARE (6%)

Also one of the major learnings of the pandemic is the importance of ensuring that enough resources are available all along the continuum of care and across facilities/settings (ambulatory care, home care, nursing homes and long term care, among others).

FACILITIES INFRASTRUCTURE (6%)

Finally, some respondents identified the infrastructure and hospital flow as a gap within their policies. Indeed, the flow of outpatients and inpatients as part of hygiene and infection control was a challenge for many, as also indicated below in the critical dimensions of patient safety identified during the crisis.

CRITICAL ASPECTS OF PATIENT SAFETY DURING / AFTER THE COVID-19 CRISIS

This question was solely asked in the second survey. While the responses present some similarities with the question on “gaps within national policies”, this question’s aim was to see if any dimension of patient safety was identified as paramount to deal with Covid-19. Most of the healthcare facilities around the world faced/are facing pandemic. One could hope that having common challenges could lead to common values; hence, these areas could become a vector to promote safety culture.

16 countries / territories shared dimensions of safety that they considered as critical / crucial during the crisis. After a first analysis, we simplified the respondents’ responses into 26 key words, which can be summarized under 4 categories:

CRISIS MANAGEMENT & SAFETY (58%)

This category is largely about ensuring having human, financial and material resources (57%) to manage a crisis without jeopardizing staff and patient safety. Personal protective equipment were often mentioned, as well as having a pool of qualified professionals. This goes along with being prepared for crisis situations (21%), both through efficient training and a reliable supply chain. Finally, as also noticed in the gaps withing safety measures, clinical procedures regarding delayed procedures, resumption, and ethical decision-making all along the continuum of care were also mentioned (21%).

PEOPLE FLOW AND INFRASTRUCTURE AS PART OF INFECTION CONTROL (17%)

Overloaded hospitals, the flow of Covid-19 patients – including asymptomatic ones –, non-covid patients and visitors put a great pressure on the organizations. All this pushed health systems to quickly adapt their infection control management, through improved “people” flow, both inside and outside the hospital.

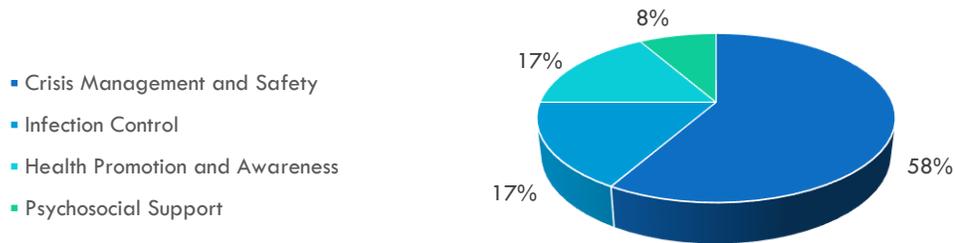
HEALTH PROMOTION, AWARENESS & COMMUNICATION (17%)

This pandemic demonstrated once more the social dimension of health. Several respondents deplored the lack of staff and community awareness and the difficulties that this led to. Health promotion strategies to get the communities to adopt good behaviours regarding hygiene and physical / social distancing should be well implemented before a crisis or an outbreak occurs. Transparent and up-to-date communication inside and outside the hospital is also paramount to keep the trust of the community and maintain a good level of awareness.

PSYCHOSOCIAL SUPPORT (8%)

Finally, psychosocial support for both patients and the healthcare workers was mentioned. “lockdowns” and other social distancing strategies led to patient solitude, which impacts their mental – and physical to some extent – safety. As already described in the chapter above, supporting healthcare workers which are under constant pressure is fundamental, even though it has been – and still is – often neglected.

Critical Aspects of PS identified during/after the Covid-19 crisis



HEALTH WORKER SAFETY

In line with WPSD 2020's theme, we included a question about the mention of health worker safety within the second survey. According to the responses, 15 countries / territories (88%) had national measures which included health workers safety. However, 9 out of them (60%) declared that these mentions should become more comprehensive, mainly regarding the education on safety issues (e.g. proper use of PPE) and organizational support when health care workers are physically ill or need psychosocial help.

ISQUA SURVEY

INTRODUCTION

The initial survey link was sent via email to our full Membership list of 1,480 contacts in February 2020. Of this, a total of 94 Members clicked on the survey link and of this, 32 Members from 19 countries completed the survey. A large percentage of our Members do not work in hospitals so the survey would not have been relevant to them.

The updated survey link was sent via email to our full membership list of 1043 contacts in July 2020. Of this, a total of 65 Members clicked on the survey link and of this, 29 Members from 27 countries completed the survey. Seven of the respondents had previously completed the February survey.

The results from both surveys showed that while most organisations do have some sort of Incident Reporting System in place, there is a drop in teaching and informing the staff about the incidents, and in including and informing patients of the outcomes.

Staff and Patient involvement is a critical component of a successful reporting system.

	Countries/territories	Total
First Survey	Australia, Bahrain, Egypt, Ethiopia, India, Ireland, Japan, Jordan, Kenya, Lebanon, New Zealand, Nigeria, Peru, Philippines, Qatar, Saudi Arabia, Taiwan, UAE, USA	19
Second Survey	Australia, Azerbaijan, Ghana, India, Indonesia, Ireland, Jordan, Kenya, Kuwait, New Zealand, Nigeria, Peru, Qatar, Saudi Arabia, Switzerland, Taiwan, UAE, UK & NI, USA	19
Total	Australia, Azerbaijan, Bahrain, Egypt, Ethiopia, Ghana, India, Indonesia, Ireland, Japan, Jordan, Kenya, Kuwait, Lebanon, New Zealand, Nigeria, Peru, Philippines, Qatar, Saudi Arabia, Switzerland, Taiwan, UAE, UK & NI, USA	25

Countries in Bold also took part in the IHF survey

SURVEY QUESTIONS

The below questions were asked through SurveyMonkey:

1. Does your organisation have an Incident Reporting System in place? [Open text box]
2. How are incidents investigated? [Open text box]
3. Is there a learning process in place, in relation to incidents? [Open text box]
4. How do you learn? (Close the Gap etc) – [Option to give three examples]
5. How do you know that there have been changes? [Open text box]
6. How do you involve your patients in the process? [Open text box]
7. In what country do you work? [Dropdown list]
8. Name of your organisation (optional) [Open text box]

The following questions were added for the July 2020 survey:

1. Did you complete the February 2020 survey on incident reporting? [Yes/No]
2. Has your organisation's Incident Reporting System changed since or due to the COVID-19 pandemic? [Yes/No]
3. If you answered yes, please provide information on the changes [Open text box]

SURVEY OUTCOMES

Does your organisation have an Incident Reporting System in place?

February – 90% responded Yes

July – 86% responded Yes

Has your organisation's Incident Reporting System changed since or due to the COVID-19 pandemic? If you answered yes, please provide information on the changes

20% of the respondents said that they're Incident Report System had changed since or due to COVID-19. Half of those who saw a change had previously completed the survey in February 2020. Changes included a switch from paper to electronic, dedicated personal, and reduced time frames for investigations.

How are incidents investigated?

The response to how incidents are investigated were similar in the February and July survey. The most common investigation process was a Root Cause Analysis. Of the respondents, only three mentioned that a National Framework is in place for incident reporting, Ireland, Japan, and Taiwan.

Word Cloud from February Survey

sentinel event form Use committee patient safety sent
investigation analyze RCA analysis report review
incident action plan quality trying department involved
root cause analysis process manager investigate



Word Cloud from July Survey

root cause analysis sentinel events RCA required review serious
reporting based investigation system incidents analysis



Is there a learning process in place, in relation to incidents?

While 90% of the respondents in February said that they had an Incident Reporting System in place, only 73% of these also has a learning process. From the July survey, only 72% of those who have a system in place, also have a learning process.

Dissemination appears to me the main issue with the process. While most of the organisations acknowledge and record incidents, there is not enough post-incident learning/teaching to ensure that the incident is not repeated.

How do you learn? (Close the Gap etc.)

The examples given across both surveys show similar themes in most countries. Learning comes from discussions in huddles/teams, changes in behaviour, root cause analysis, close the gap and feedback. A takeaway from this is the importance of openness of the issues with staff and allowing staff to talk about incidents.

How do you know that there have been changes?

It is important to staff to know that when an incident report has been made that changes will be made in line with the outcomes of the investigation. However, from our survey in February, 28% of the responders reported that changes were not addressed, or that there was a passive change (i.e. 'stories' about improvements but events are not monitored). In July, 24% gave the same response.

Word Cloud from February Survey



Word Cloud from July Survey



How do you involve your patients in the process?

Patients are normally the main actor in an adverse incident. Patients can add views and a different perspective to an incident. As the incident, in most situations, happens to them, they should be included in the process and know the outcome. However, from our survey, it is clear that open disclosure happens in only a minority of countries / organisations.

In our February survey, only 43% provided some form of open disclosure to patients or the patients family. From the remaining 57% of respondents, 34% do interview patients, or ask for feedback in patient surveys. 21% do not involve patients in the process at all. In the July survey only 24% provided some sort of open disclosure process with their patients. 55% of the respondents do interview patients at the initial stage of the process or ask for patient feedback. 20% do not include the patient at all in the process.

FOLLOWING UP ON WHO GLOBAL CONSULTATION

On the occasion of the WHO Global Consultation, IHF and ISQua released a joint statement highlighting key learning from these three days. These include:

1. Leadership and the development and facilitation of a **culture of safety** are key foundations for a safe system. This includes psychological safety of individuals.
2. Patient safety must be included in **health policy** as well as other policies that impact on health.
3. The people's voice and **coproduction** of safety with citizens, patients and their families is a non-negotiable part of developing a safe healthcare system
4. A focus on **human factors** and designing systems for safe care delivery is fundamental to safe care.
5. Providers and all relevant staff must be **educated** in the science and practice of patient safety. Patient safety should be embedded in higher education as well as in continuous professional development.
6. **Learning systems** need to be established to share best practices, people's experiences, as well as from critical incidents across the globe.
7. Safety must be an integral part of Universal Health Coverage all along the **continuum of care**.
8. **Measurement** must be practical, easy to do, and valuable to those taking the measures. Resulting data should be able to tell a story, demonstrate an impact and relate to relevant indicators to ensure continuous improvement.
9. All interventions need to be based on **research** in patient safety, required to provide the evidence base.
10. Global challenges and infection control **awareness campaigns** must be conducted, and learnings must be spread.
11. Sufficient human and financial **resources** must be allocated to support the proper development of all key points above.

The road is still long for the safety culture and the responses are still heterogeneous between countries / territories and organizations, but it is encouraging to see that most of these elements are present within our members' responses. Such results can be seen as a sign for a more globalized understanding of patient safety fundamental principles, and could be the basis for a code of conduct that our members would commit to, to advance the implementation of a safety culture withing their organizations.

CONCLUSION

Out of our surveys' results, several conclusions can be put forward:

People (patient & health worker) safety is inherent in healthcare and is based on coproduction. It is a holistic culture that should be promoted throughout the continuum of care, from organizational processes to individual practices, and by all stakeholders (including the patients). The diversity of dimensions cited by the participants confirms what was promoted by more than a hundred experts at the WHO Global Consultation. As part of this, measurement, research, and identification of best practices should not be neglected.

Health worker physical and mental health are paramount. As mentioned by one of the participants, "the importance of health workers safety is one of the lessons learnt of the Covid-19 crisis". This calls for a reinforcement of occupational safety programs; proper training for qualified professionals; efficient guidelines for an increased crisis preparedness and management; and positive practice environments for a motivated staff.

Finally, the Covid-19 crisis is an opportunity to learn. The shift noticed in the gaps identified within safety measures before and after the crisis highlight the fact that this pandemic, despite its dreadful impact on many lives and healthcare systems, is also an opportunity to learn and increase people safety culture. It is now important to share the lessons learnt worldwide, favour system-based approaches, and promote good practices to optimize the quality of care and the safety of people.

The analysis in this report are based on the responses to IHF and ISQua's surveys. If you wish to know more, you can send a request to Sylvia Basterrechea (sylvia.basterrechea@ihf-fih.org) or Sinead McArdle (smcardle@isqua.org) and we will send you the detailed anonymized results.