Developing patient safety systems in Croatia

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Workshop 2_Global Patient Safety Perspectives from Low and Middle Income Countries, 29 March 2017, Bonn
Outline

- Background information and regulatory framework
- Patient safety reporting
- Safe clinical practices
- Education and training
- Challenges and future directions
Background information

Croatia: population ~4.3 million

Health activities (level)

- Primary, secondary, tertiary

Health institutions

- 62 hospitals
- 49 health centers
- 2540 general practices
- 2300 dentists
- 230 pharmacies
- etc.

Source: https://commons.wikimedia.org
Institutional and regulatory framework for patient safety

**INSTITUTIONAL**
- Ministry of Health
- Agency for Quality and Accreditation in Health Care and Social Welfare (AQAH)
- Agency for Medicinal Products and Medical Devices
- Croatian Health Insurance Fund

**REGULATORY**
- Act on quality of health care and social welfare (2011)
- Ordinance on standards of health care quality (2011)
- Ordinance on hospital accreditation standards (2011)
Outline

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Patient safety indicators (since 2013)

- Regular data collection (AQAH)
  - 2013: Excel form
  - Since 2014: web application [https://pokazatelji.aaz.hr/](https://pokazatelji.aaz.hr/)
- Data quality control
- Indicator specifications
  - Continuous improvement
  - Publicly available
- Annual reports [http://aaz.hr/hr/izvjesca-zdravstvenih-ustanova](http://aaz.hr/hr/izvjesca-zdravstvenih-ustanova)
Sentinel events surveillance system (since 2012)

- Regular data collection (AQAH)
  - 2012: Excel form
  - 2014: web application
    https://pokazatelji.aaz.hr/
- Data specification
  - Publicly available
  - 2015: updated -WHO MIM PS
- Annual reports
  http://aaz.hr/hr/izvjesca-zdravstvenih-ustanova
## Sentinel events surveillance system

<table>
<thead>
<tr>
<th>Sentinel Events (SE) hospital reports 2012-2015</th>
<th>N=142</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide or attempted suicide</td>
<td>97 (68.3 %)</td>
</tr>
<tr>
<td>Maternal death related to labor</td>
<td></td>
</tr>
<tr>
<td>Death or permanent disability of a normal birth-weight infant &gt;2500 grams not related to congenital diseases</td>
<td></td>
</tr>
<tr>
<td>Severe neonatal jaundice</td>
<td>19 (13.4 %)</td>
</tr>
<tr>
<td>Transfusion reaction due to ABO incompatibility</td>
<td>8 (5.6 %)</td>
</tr>
<tr>
<td>Radiation therapy to the wrong body region</td>
<td></td>
</tr>
<tr>
<td>Radiation therapy 25% above the planned dose</td>
<td>7 (4.9 %)</td>
</tr>
<tr>
<td>Wrong-patient surgery</td>
<td></td>
</tr>
<tr>
<td>Wrong-site surgery</td>
<td></td>
</tr>
<tr>
<td>Retained surgical instrument or object left that requires additional operation or procedure</td>
<td>6 (4.2 %)</td>
</tr>
<tr>
<td>Kidnapping newborn</td>
<td></td>
</tr>
<tr>
<td>Infant discharge to the wrong family</td>
<td></td>
</tr>
<tr>
<td>Death, coma or serious harm due to inappropriate pharmacotherapy</td>
<td>0</td>
</tr>
<tr>
<td>+ Any other SE that causes death or severe injury (since 2015)</td>
<td>5 (3.6%)</td>
</tr>
</tbody>
</table>

### Hospitals reporting

![Graph showing hospitals reporting sentinel events](image)
Outline

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Safe clinical practices
WHO Surgical Safety Checklist

- Integration into Hospital information system
- Pilot project: 6 hospitals (2016)
- Monitoring „near miss“
Education and training

- Patient safety education and training at all levels
- To increase awareness of the patient safety issues among all stakeholders
Challenges and future directions

CHALLENGES

- Under reporting and safety culture
- Patient involvement
- Data quality
- Using data to drive improvement
- Implementing safe clinical practices (Medication reconciliation ...)

FUTURE DIRECTIONS

- Continuous improvement
- Extending to primary care