Collaborating to increase Patient Safety

Denis Herbaux, CEO PAQS ASBL
The Economics of Patient Safety – March 2017

• About 10% of hospital admissions will suffer from an adverse event. Among those, between 2% and 14% may lead to the death of the patient.
  • Between 5,000 and 35,000 deaths in Belgium?

• Overall, the available evidence suggests that 15% of hospital expenditure and activity in OECD countries can be attributed to treating safety failures

• Most of the burden is associated with a few common adverse events. The most burdensome include healthcare-associated infections (HAI), venous thromboembolism (VTE), pressure ulcers, medication error and wrong or delayed diagnosis.
In Belgium (ISP-WIV)

• HAI prevalence in Belgium
  • Hospitals: 7.1 %
  • LTCFs: 3.5 %

• Estimated number of patients per year with an HAI in Belgium
  • Hospital: 111,276
  • LTCFs: 170,090

• HAI would cause about 2,600 death/year (KCE, 2007)
MRSA & ESBL in Belgian hospitals

MRSA and ESBL-positive E. coli & K. pneumoniae from clinical samples in Belgian acute care hospitals (1/1000 admissions) 1994 - 2015

Source: National surveillance, B. Jans
What is not working?

- Absence of/unknown/poorly designed procedures
- Lack of adherence to hand hygiene precautions
- Physicians vs. nurses
- Staffing
- Antibiotic stewardship
- Environmental cleaning
- Infection control programs
- ...
PAQS ASBL

Collaborating to increase Patient Safety
We are

• A young (2014), Not-for-profit and small organization (7 FTE - 650,000 euros/year)

• Working at the regional level (Brussels and Wallonia)...
• ... with partnerships at national and international levels

• Created by healthcare stakeholders (hospitals, sickness funds, universities, physicians, nurses, ...) for healthcare institutions and professionnals

• With one priority: **Improving Patient Safety**
Patient Empowerment

Team Work

Leadership

Accreditation

Indicators
- QI
- PROMS & PREMS
- Patient Safety

Themes:
- Communication
- High-risk medication
- Identity vigilance
- Infections
- Safe surgery

Step 1: Engagement
Step 2: Training
Step 3: Measures
Step 4: Collaboratives
Step 5: Best practices

Safety Culture – Communication – Events – Education
Thématique

Ensemble pour l'AMELIORATION des soins de santé

all teach, all learn

How can I improve healthcare today?
Model for Improvement

THE MODEL FOR IMPROVEMENT:

**What are we trying to accomplish?**

**How will we know that a change is an improvement?**

**What change can we make that will result in an improvement?**

**AIM.** Determine which specific outcomes you are trying to change.

**MEASURES.** Identify appropriate measures to track your success.

**CHANGES.** Identify key changes that you will actually test.

**Multiple PDSA Cycles:**

- Hunches, theories and ideas for changes that result in improvement.
HAI as an example

• 20 hospitals (1/3) are working together
• They
  • meet regularly (every 6 weeks)
  • Implement actions and present results
  • Share new ideas, new tools, new methodologies
• We offer
  • A place to meet
  • Resources
  • Training (in person and online)
• What we want to achieve
  • Identify best practices, and spread them at the system level
  • Increase patient safety